

## Deliberate Self-harm seen in a Government Licensed Private Psychiatric Hospital and Institute

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### ABSTRACT

Majority of the published studies on suicide deal with identifying the sociodemographic and psychosocial aspects of suicide attempters and those who have completed suicide or to identify the characteristic differences between the two groups. There are very few studies focusing mainly or only on deliberate self harm. Most of these are hospital based studies or in a setting of general hospital psychiatry units. The present study is from Ram Psychiatry Hospital and Institute, a government licensed private psychiatric institute at Madurai, Tamil Nadu. It is a prospective study of individuals with self harm behavior mostly without the intention to kill, attending the psychiatry outpatient department of the hospital for the period of one year (January to December 2014) a total number of 140 cases are registered. Sociodemographic, clinical profiles with Axis I or Axis II diagnosis or otherwise, and the initiating or precipitating cause or mode of self-injury or self-harm are studied. The results are presented and discussed.

**Key words:** *Deliberate self-harm, intentional self-harm, self-injury*

### INTRODUCTION

Suicide is defined as self-intentioned, self inflicted, cessation of life. It is fatal and completed. Attempted suicide is a potentially self-injurious action with a nonfatal outcome for which there is evidence, either explicit or implicit that the individual intended to kill himself but may accidentally die during the act. Nonfatal suicidal behavior is known by various terms such as deliberate self-harm (DSH), auto-aggression, focal suicide, self-attack, self-mutilation, symbolic wounding,<sup>[1]</sup> purposive accidents,<sup>[2]</sup> parasuicide,<sup>[3]</sup> self-injurious behavior, and DSH syndrome delicate self-

cutting.<sup>[4]</sup> These terms are used interchangeably and to define subjects who present with self-harm. Although some of the authors<sup>[5]</sup> have tried to separate these categories based on the suicidal intent at the time of the act, clinically it is not possible to do so in every case.

As in many countries, DSH in India is an unrecognized, hidden, and a silent epidemic. DSH is a strong predictor of suicide. Within the 1<sup>st</sup> year after self-harming 16% of people self-harm again,<sup>[6,7]</sup> 0.5-1.8% die by suicide,<sup>[8]</sup> and 2.3% die by any cause.<sup>[9]</sup> DSH is strongly linked

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to reoccurring suicidal behavior and mortality. World Health Organization (WHO) emphasizes the need for health care providers to implement suicide prevention through effective management in persons with DSH.<sup>[10]</sup>

DSH defined as “self-poisoning or injury, irrespective of the purpose of the act”<sup>[11]</sup> is one of the top five causes of acute medical admissions for both men and women.<sup>[12]</sup> DSH an act with nonfatal outcome, in which an individual deliberately initiates a nonhabitual behavior that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences.<sup>[13]</sup>

### Diagnosis and deliberate self-harm

DSH is a hallmark of many psychiatric disorders and interpersonal problems. However at times persons with no obvious psychiatric illness may injure themselves. Certain self-harm behavior such as tattooing, cutting of the body with blades during religious festivals is culturally accepted. Among Axis I disorders affective disorder and schizophrenia are the most common psychiatric illness associated with DSH and mostly present with the severe form of self-mutilation, genital mutilation, enunciation of eyes, etc. In schizophrenia, it is associated with bizarre thinking, delusions or command hallucinations. Comorbid substance abuse may substantiate DSH behaviors or substance abuse disorders *per se* may present with repetitive DSH. Obsessive-compulsive disorder (OCD) can also present with DSH.

Most of the personality disorders are associated with DSH. Emotionally immature personality disorder is the most common personality disorder seen in clinical practice presenting with DSH. In Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)<sup>[14]</sup> nonsuicidal self-injury (NSSI) is considered as a symptom of borderline personality disorder. A primary feature of borderline personality disorder is impulsive self-destructive behavior including reckless driving and spending, bingeing and purging, substance abuse, risky sexual behavior, self-mutilation, and suicide attempts. Sansone *et al.*<sup>[15]</sup> in their study reported that participants with bipolar disorder endorsed significantly more self-harm behavior than nonborderline personality disorder participants. Individuals with a history of deliberate and particularly repetitive self-harm also show a significantly greater degree of impulsiveness and are likely to have a diagnosis of borderline personality disorder. In addition, repetitive self-mutilators who became depressed and demoralized may be at increased risk for suicide attempts. Anti-social personality and histrionic can also present with DSH.

Body dysmorphic is another clinical entity associated with DSH. A few cases of binge eating behavior may be associated with DSH.

International Classification of Diseases, Tenth Revision (ICD-10)<sup>[16]</sup> uses the term intentional self-harm to describe DSH without Axis I or Axis II diagnosis. Whereas in DSM-IV NSSI was considered a symptom of borderline personality disorder, in the revised manual DSM-V<sup>[17]</sup> it is recognized as a distinct condition.

### Aims and objectives

The majority of the published studies on suicide have dealt with identifying the sociodemographic and psychosocial aspects of suicide attempters and those who have completed suicide. Some of these have also attempted to identify the characteristic differences between the two groups. Most of these were hospital-based studies, in a setting of general hospital psychiatry units. There are very few studies only focusing mainly on DSH.

This study is from Ram Psychiatry Hospital and Institute a government licensed private psychiatric institute at Madurai, Tamil Nadu. The study is on the sociodemographic and clinical profile of individuals presenting with self-harm behavior mostly without the intention to kill attending the Psychiatry Outpatient Department of Ram Psychiatric Hospital and Institute, with a prospective study design for the period of 1 year (January to December 2014).

## MATERIALS AND METHODS

Ram Psychiatry Hospital and Institute is a recognized independent acute psychiatric care institute and hospital. Focus is exclusively on providing acute care to the patients with best possible treatment of psychiatric illness and addictive disorders in the best possible environment to stabilize patients and provide symptom reduction in a safe environment. Acute care services for adults and adolescents focus also on rapid evaluation and relief of symptoms of illness of comorbid psychiatric and substance abuse disorders. Patients presenting with DSH were studied for the sociodemographic factors. We undertook a detailed assessment of the interpersonal problems, method of self-arm, previous history of self-harm, and personality factors. Psychiatric assessment was performed by present mental status examination by experienced psychiatrists. Diagnosis was made according to ICD-10. The patients were screened clinically for existing comorbidity.

## RESULTS

During the study period (2014), a total of 1605 cases were referred to psychiatric referral services, of which 140 cases were of intentional self-harm, which gives a

prevalence figure of 8.7% of intentional self-harm cases in the independent private hospital setting.

**Sociodemographic profile**

There were more number of males than females (total 140: M90:F50) with a mean age of a sample of 27 years (standard deviation: 13.11) with an age range of 14-62. They were mostly educated up to plus two, unemployed, from Hindu religion, 85% belonged to nuclear family, from — middle socioeconomic class and from urban area. Age group 15-30 was associated with mild and moderate self-harm whereas age group 30-50 was associated with a severe form of self-injurious behavior, e.g., hanging, self-immolation, and genital mutilation. More than 90% of the study population had not consulted any psychiatrist in the past. Only 16% of the population had a previous history of self-harm.

**Deliberate self-harm and diagnosis**

The most common Axis I diagnosis was depression (22.1%) followed by schizophrenia 15.7% and adjustment disorder. There were a few cases of OCD, substance abuse and substance-induced psychosis. There were no cases of mental retardation and eating disorder.

Personality disorder was the most common Axis II diagnosis (39.7%). Of this personality disorder emotionally unstable personality disorder was most prevalent. 24.2% presented with borderline personality and 8.5% presented with an impulsive personality disorder. There were few cases of antisocial (4.2%) and histrionic (2.8%) personality disorder. The most striking observation was patients diagnosed as intentional self-harm as per ICD-10 diagnostic code of X60-84 when they did not fulfill criteria for Axis I or Axis II disorder was very low 3.5% [Table 1].

**Deliberate self-harm and causes**

The most common reason for DSH was interpersonal relationship with family member’s friends and spouses (62%) followed by thinking disturbance and delusions 22.8%. About 63.5% study population had more than one reason for the DSH behaviour [Table 2].

**Deliberate self-harm and methods**

More than 80% of the patients presented with superficial or deep cut injury with varying severity of mild, moderate, or severe form. Burn injury with cigarette buds over the forearm was another common method of self-injury. There were a few cases of severe forms in the nature of self-immolation, hanging, gunshot injury of the abdomen, and amputation of penis. The percentage of patients with self-harms by insecticide, psychotropic drugs and organophosphorus poisoning was low.

**Table 1: Deliberate self-harm and diagnosis**

Clinical psychiatric diagnosis	n (%)
Intentional self-harm	05 (3.57)
Depression (unipolar/bipolar)	31 (22.1)
Adjustment disorder	11 (7.8)
Schizophrenia	22 (15.7)
Emotionally unstable PD	
Impulsive	12 (8.57)
Borderline PD	34 (24.2)
Other PD	
Histrionic PD	04 (2.8)
Antisocial PD	06 (4.2)
OCD	02 (1.42)
Substance abuse	11 (7.8)
Other psychiatric diagnosis (mental retardation, Lesch-Nyhan syndrome, van Gogh syndrome, bulimia and eating disorders)	02 (1.42)

PD – Personality disorder; OCD – Obsessive compulsive disorder

**Table 2: Deliberate self-harm and causes**

Reason/precipitating event prior to DSH	n = 140 (%)
Interpersonal relationship problems with family members	66 (47.1)
Interpersonal relationship problems with spouse	16 (11.4)
Interpersonal relationship problems with friends	05 (3.57)
Job-related stress	08 (5.71)
Delusions and thinking disorders	32 (22.8)
Depressive cognitions	12 (8.57)
Failure in exams	06 (4.28)
Broken love affair	08 (5.71)
Insufferable pain	02 (1.42)
More than one reason	89 (6.35)

DSH – Deliberate self-harm

**DISCUSSION**

Most of the Indian studies<sup>[18-26]</sup> focus on the sociodemographic and clinical profiles on DSH, and self-injurious behaviors are hospital-based either in general hospital psychiatric units or from consultation-liaison psychiatric unit. The present report is unique in that it is first of its reported from a government licensed private psychiatric institute and hospital from an urban area.

The sociodemographic profile of this study was almost similar to most of the Indian studies from hospital setting reported below.

The most important observation in this study was a low percentage of intentional self-harm. Patients diagnosed as intentional self-harm as per ICD-10, when they did not fulfill the criteria for any Axis I or Axis II disorder with a diagnostic code of X60-84 was low in our present study and was only 3.57%. This observation was strikingly different from other Indian authors who reported a range varying from 39.2% to 18.5%.<sup>[21,23]</sup> Probably, studies and screening of general population

or specific groups, e.g., college students teenagers may reveal a high incidence of intentional self-harm.

The most common Axis I diagnosis in our group was depression followed by schizophrenia. The other diagnosis included OCD, substance abuse, and substance-induced psychosis. Mental retardation and eating disorders were absent.

Personality disorder was the most common Axis II diagnosis seen in our group in the following order of frequency: Impulsive 8.57%, borderline personality 24.2%, antisocial personality 4.2% and histrionic personality 2.8%. The younger age group was associated with an emotionally unstable (impulsive and borderline) personality disorder, and substance abuse. They had more self-harm behavior by superficial and deep cuts, burn injury with cigar buds and psychoactive drugs. The older group was associated with a severe form of self-injury with hanging gunshot wounds, genital mutilation. Nath *et al.*<sup>[25]</sup> made similar observation in their comparative study of personality disorder associated with DSH in two different age groups (15-24 years and 45-74 years). Sarkar *et al.*<sup>[20]</sup> attempted to present a profile of those who commit DSH in comparison with those who expected to die after the suicide attempt. Those attempting DSH were younger, chose less lethal methods to attempt suicide, were more impulsive and had strong histrionic and unstable traits in personality and had an absence of a family history of suicide attempts. In their study on DSH, Chowdhury *et al.*<sup>[26]</sup> identified women exposed to domestic violence as a vulnerable group. Majority of them experienced more than one form of domestic violence.

The WHO/EURO Multicentre Project on Parasuicide<sup>[27]</sup> is part of the action to implement target 12 of the WHO program, "health for all by the year 2000," for the European region. 16 centers in 13 European countries are participating in the monitoring aspect of the project, in which trends in the epidemiology of suicide attempts are assessed. The methods used were primarily "soft" (poisoning) or cutting. More than 50% of the suicide attempters made more than one attempt, and nearly 20% of the second attempts were made within 12 months after the first attempt. Compared with the general population, suicide attempters more often belong to the social categories associated with social destabilization.

## CONCLUSION

It is apt to conclude the following remarks from the recent editorial of lancet titled "Outside in: From observation to etiology."<sup>[28]</sup>

Only a small group of people who harm themselves seek medical attention. The stigma that surrounds self-harm and the unhelpful responses from healthcare professionals cannot be overlooked and need to be addressed, but we should also remember that many people do not view their actions as pathological. Many varieties of what might, through a specific prism, be regarded as self-harm have been described for centuries and continue today—for example, tattoos, piercings, and more extreme body modifications such as dermal implants. A broader definition of self-injury might thus lead to the danger of pathologizing so-called normal life; or it might help us understand the complex motivations behind distressing acts of self-harm that require medical, psychological, and social support. Deliberate injury can fulfill many functions from the relief of inner turmoil to distraction from severe anxiety states and to formation of a cultural identity. Discussions with individuals who have self-harmed will reveal that many different pathways lead to the same phenotype.

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## Conflicts of interest

There are no conflicts of interest.

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