Asian Journal of Psychiatry 20 (2016) 3–10

Contents lists available at ScienceDirect

Asian Journal of Psychiatry

journal homepage: www.elsevier.com/locate/ajp

Demographic, clinical and psychological characteristics of patients with self-harm behaviours attending an emergency department of a tertiary care hospital

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ARTICLE INFO

Article history:
Received 6 June 2015
Received in revised form 12 December 2015
Accepted 1 January 2016

Keywords:
Self-harm behaviours
Personality
Psychiatric disorder
Impulsivity

ABSTRACT

Understanding the characteristics of those with self-harm behaviour may help in identifying those at risk and providing targeted interventions to this group of patients, especially in the emergency services. The present study aimed to compare the suicidal intent, hopelessness, severity of depressive symptoms, and personality traits of those with and without psychiatric disorders, presenting with a self-harming behaviour to the emergency setting. For this, patients presenting to the emergency department of a tertiary care hospital with self-harm behaviour were evaluated for presence or absence of a psychiatric diagnosis, suicidal intent, personality traits, depressive symptoms and hopelessness by using structured instruments. The present study included 132 participants. The mean age of the sample was 28.7 years and the male: female ratio of 1.28:1. At least one psychiatric diagnosis was present in 41.7% of the sample, depression and substance use disorders being most common among them. Impulsive suicide attempt was present in 40.2% of the sample. Those with a psychiatric diagnosis were more likely to be older, males, married, have higher suicidal intent, more planned attempts and higher depressive symptoms as compared to those who did not have a psychiatric disorder. Impulsive suicide attempters had lower suicidal intent than non-impulsive attempters. Present study suggests that those presenting to the emergency with self-harm behaviour comprises 2 interrelated groups, differing on certain demographic features, severity of depressive symptoms, suicidal intent and impulsivity.

1. Introduction

Suicides claim more than 100,000 lives annually in India (“Accidental Deaths and Suicides in India”; NCRB, 1986), and it is among the most common causes of death among the young adult population (Aaron et al., 2004; Heuveline and Slap, 2002). It is also known that a significant proportion of patients indulge in self-harm behaviour before completing suicide (Borowsky et al., 2001; Schmidtke et al., 1996). Still, each self-harm behaviour carries a potential fatality, and often requires treatment in an emergency setting. Emergency departments across the globe are inundated with cases of self-harm behaviours, and are first contact with psychiatric services for treatment of underlying distress (Baraff et al., 2006; Kennedy et al., 2004).

Among the various predictors of self-harm behaviours, presence of psychiatric disorder seems to be an important determinant for such behaviours. Depression has been reported to be commonest disorder among the self-harming individuals (Radhakrishnan and Andrade, 2012; Vijayakumar, 2010). Apart from psychiatric diagnoses, certain personality traits have also been reported to portend towards maladaptive coping, which may result in a self-harm behaviours (Beautrais et al., 1999; Brezo et al., 2006). Neuroticism seems to be associated with increased risk of self-harm behaviour while extraversion has been linked to lower risk of self-harming behaviour. Other psychological attributes like hopelessness and sub-syndromal depressive symptoms may also result in increased propensity to attempt self-harm (Balázs et al., 2013; Kovacs and Garrison, 1985).

Several Indian studies have reported that a substantial proportion of persons who present to different treatment set-ups do not have a diagnosable Axis-I psychiatric illness (Das et al., 2008; Jain et al., 1999; Kattimani et al., 2015b; Narang et al., 2000; Sharma, 1998; Srivastava et al., 2004). Studies evaluating patients

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http://dx.doi.org/10.1016/j.ajp.2016.01.006
1876-2018/

being brought to emergency services reflect that many of the self-harm behaviours stem from psycho-social stressors like financial losses, academic failure, inter-personal problems in the family and break-up of romantic relationships (Mohanty et al., 2007; Narang et al., 2000; Sharma, 1998; Srivastava et al., 2004). Many of such self-harm behaviours might be considered a reaction to the psycho-social adversity, and the patient might not fulfil the criteria of a diagnosable psychiatric disorder (Kattimani et al., 2015b). The nature and focus of intervention for such self-harm behaviours might be quite different from those suggested for patients with concomitant psychiatric disorder.

Those with impulsive self-harm behaviours form another group of individuals who attempt without much forethought into the act. Typically, impulsive self-harm behaviours are characterized on the basis of the duration elapsed between the time of onset of thought and the conduct of the act of self-harm (Kattimani et al., 2015b; Wei et al., 2013; Wojnar et al., 2009). Those with impulsive self-harming behaviours are also likely to suffer from psychiatric diagnoses, though the methods and the reasons of the self-harm behaviours may be different among them as compared to those who indulge in self-harm in a relatively planned manner (Kattimani et al., 2015b).

The characteristics, motivations and psycho-social vicissitudes of self-harm behaviours in India are at a considerable variance from elsewhere (Adityanjee, 1986). Though studies from India have evaluated the presence of psychiatric diagnoses, very few have attempted to assess for personality traits among those with self-harm behaviours. Moreover, none of the studies have assessed the relationship of hopelessness, suicide intent and personality features among those who present with self-harming behaviour in the presence or absence of a psychiatric diagnosis. Also, studies assessing the relationship of impulsivity with hopelessness, suicide intent and personality traits have been lacking. Hence, this study attempted to compare the suicidal intent, hopelessness, severity of depressive symptoms, personality traits among those with and without psychiatric disorders, presenting with a self-harming behaviour to the emergency setting. Secondary aim of the study was to compare those with and without impulsive self-harming behaviour for hopelessness, severity of depressive symptoms, personality traits and prevalence of psychiatric disorders.

2. Methods

2.1. Setting and participants

The present cross-sectional study was conducted at the emergency department of Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh. PGIMER is a central government funded tertiary-care hospital in north India which caters to both referred and non-referred patients. The emergency department of the institute is the first point of contact at the hospital for patients who are critically ill. The emergency department is staffed by trained medical and surgical personnel, and provides round-the-clock care. After medical stabilization, the patients are shifted to respective medical or surgical specialty for further inpatient care. The emergency department is also attended to by a resident from the department of psychiatry under the supervision of a senior resident and a consultant psychiatrist.

The present cross-sectional study was conducted among patients brought to the emergency department with a self-harm behaviour. The study included consecutive patients who presented with self-harm as the primary reason of seeking treatment. Patients were included after medical stabilization before being transferred to another inpatient ward or discharged from the emergency. Patients were recruited after obtaining written informed consent. For patients who were aged below 18 years, informed consent was obtained from the legal guardian, and assent was obtained from the patient. Patients were excluded if they refused informed consent, were too sick to be evaluated prior to being shifted out of emergency and expired prior to assessment. In case a patient presented to emergency on more than one occasion with self-harm behaviour they were assessed only once as part of the study.

2.2. Procedure

Patients who fulfilled the inclusion and exclusion criteria were recruited into the study after obtaining the informed consent/assent. Patients were assessed in the emergency department after stabilization of the physical condition using a structured proforma. The demographic characteristics of the patient were noted which included age, gender, marital status, educational level, employment status, religion, type of family and the residential background (rural or urban). Initially the patients were evaluated for a psychiatric disorder as per the International Classification of Disease, 10th Revision criteria by using a semi-structured interview by a qualified psychiatrist. Based on the presence or absence of axis-I diagnosis, the study sample was divided into two groups. Hopelessness among the participants was ascertained using Beck Hopelessness Scale (BHS) and depressive symptoms were assessed using Beck Depression Inventory (BDI). The suicidal intent was assessed using Emergency Department Self-Harm Proforma (EDSHP). The Psychoticism Extraversion and Neuroticism (PEN) Inventory was used to assess for personality characteristics. Information was collected in a single sitting by a psychiatrist. Data was gathered from the patient as well as family members when available. The study had institutional ethics committee approval. The data collection lasted from March 2013 to December 2013.

2.3. Instruments

International Classification of Disease, 10th Revision (World Health Organization, 1992)**:** ICD-10 criteria were used to establish the psychiatric diagnosis.

Beck Hopelessness Scale (BHS) (Beck et al., 1974)**:** This is a self-report instrument that comprises 20 true–false statements. It is designed to assess the extent of positive and negative beliefs about the future during the past week. Each of the 20 statements is scored as 0 or 1, and the total scores can range from 0 to 20. Higher BHS scores represent greater degrees of pessimism. This brief instrument takes less than 5 min to administer. Reliability of BHS is high and this instrument has been considered to have good predictive validity for suicide attempts.

Beck Depression Inventory (BDI) (Beck et al., 1961)**:** It is a self-rated questionnaire which comprises 21 questions rated on 4 point Likert scale from 0 to 3. The total scores can range from 0 to 63. It can be used as self-report questionnaire or can be administered by trained personnel. The BDI has been a sensitive screen for assessment of depression and has been shown to have good internal consistency and test-retest reliability. Scores of 0–9 are considered as not having depression, 10–18 as mild depression, 19–29 as moderate depression and more than 29 as severe depression (Beck et al., 1988). A Hindi translation of the scale had been used for the present study.

Emergency Department Self-Harm Proforma (EDSHP) (Haq et al., 2010)**:** This instrument has been developed to assess for risk factors for suicide and to assess for suicidal intent. This is a 12 item instrument with total scores ranging from 0 to 18. Higher scores represent greater suicidal intent. The suicidal intent can be classified into mild, moderate or severe based upon the scores. This brief proforma has been suggested to be useful for the