



Research report

Prevalence and correlates of lifetime deliberate self-harm and suicidal ideation in naturalistic outpatients: The Leiden Routine Outcome Monitoring study

Suzanne de Klerk^{a,1}, Martijn S. van Noorden^{b,*,1}, Anne E. van Giezen^c, Philip Spinhoven^c, Margien E. den Hollander-Gijsman^b, Erik J. Giltay^b, Anne E.M. Speckens^a, Frans G. Zitman^{b,d}

^a Department of Psychiatry, Radboud University Nijmegen Medical Center, Nijmegen, The Netherlands

^b Department of Psychiatry, Leiden University Medical Center, Leiden, The Netherlands

^c Unit of Clinical Psychology, Leiden University, Institute of Psychology, Leiden, The Netherlands

^d Rivierduinen, Regional Mental Health Provider, Leiden, The Netherlands

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ABSTRACT

Background: Deliberate self-harm and suicidal ideation (DSHI) are common phenomena in general and mental health populations. Identifying factors associated with DSHI may contribute to the early identification, prevention and treatment of DSHI. Aims of the study are to determine the prevalence and correlates of lifetime DSHI in a naturalistic sample of psychiatric outpatients with mood, anxiety or somatoform (MAS) disorders.

Methods: Of 3798 consecutive patients from January 2004 to December 2006, 2844 (74.9%) patients were analyzed (mean age = 37.5, SD = 12.0; age range: 18–65; 62.7% women). Lifetime DSHI was assessed with routine outcome monitoring (ROM), including demographic parameters, DSM-IV diagnosis, depressive symptoms, symptoms of anxiety, general psychopathology and personality traits.

Results: Of the 2844 subjects, 55% reported lifetime DSHI. In multivariable logistic regression analysis, the most important factors associated with lifetime DSHI were being unmarried, low education, high number of psychiatric diagnoses, lower anxiety scores, higher depression scores and the personality trait of emotional dysregulation.

Limitations: Deliberate self-harm may have been under-reported in self-report questionnaires; The assessment of personality traits may have been influenced by state psychopathology; traumatic events were not assessed.

Conclusions: The findings suggest that DSHI is common among psychiatric outpatients with MAS disorders and that current symptoms and underlying personality vulnerabilities were independently involved in DSHI. Whether symptoms of somatic anxiety are protective should be confirmed in subsequent studies. These findings may help clinicians in identifying patients at risk for deliberate self-harm and suicide.

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* Corresponding author at: Leiden University Medical Center, Department of Psychiatry, Albinusdreef 2, P.O. Box 9600, 2300 RC Leiden, The Netherlands. Tel.: +31 71 5263785; fax: +31 71 5248156.

E-mail address: m.s.van_noorden@lumc.nl (M.S. van Noorden).

¹ The first two authors contributed equally to this study.

1. Introduction

Deliberate self-harm is a common problem in the general population, as well as in psychiatric populations (Briere and Gil, 1998; Klonsky et al., 2003). It has been defined as the intentional self-injury without (conscious) suicidal intent (Chapman et al., 2006; Klonsky et al., 2003), or as behavior that was self-initiated with the intent to harm the body,

regardless of intent to die (De Leo et al., 2004; Schmidtke et al., 2004). In the current study, both non-suicidal and suicidal self-harm, as well as thoughts about self-harm and suicide were analyzed (deliberate self-harm or ideation; DSHI).

With regard to deliberate self-harm behavior, a lifetime prevalence of 4% was found in nonclinical populations in the US (Briere and Gil, 1998; Klonsky et al., 2003). Prevalence rates in selected populations were higher, especially for adolescents (7%–9%; Hawton et al., 2002; Skegg, 2005) and psychiatric inpatients (21%–61%; Briere and Gil, 1998; Suyemoto, 1998). In the UK, an estimated 170,000 deliberate self-harm patients per year are admitted at emergency departments of general hospitals with deliberate self-poisoning (Kapur et al., 1998). The most frequent presentations of deliberate self-harm behavior are skin-cutting and self-poisoning (Hawton et al., 2002; Schnyder et al., 1999). With regard to deliberate self-harm ideation in community samples, lifetime prevalence rates of 11%–14% were found for adults (Kessler et al., 1999; Ten Have et al., 2009) and 19% for adolescents (Evans et al., 2005a). Besides the fact that DSHI is a prevalent problem in various populations, persistence is also very common (Owens et al., 2002) and a history of DSHI increases the risk of a completed suicide (Cooper et al., 2005; Hawton et al., 2003; Hawton and Harriss, 2007; Kapur et al., 2006; Suominen et al., 2004; Sinclair et al., 2010).

According to a large adult community survey the factors that were associated with deliberate self-harm and respectively with suicidal ideation were largely identical (Ten Have et al., 2009). Sociodemographic factors such as younger age and female sex were found to be related to DSHI (Kessler et al., 1999, 2005; Schmidtke et al., 1996; Evans et al., 2005b). Subjects with low socio-economic status (Schmidtke et al., 1996) and divorced subjects (Kessler et al., 1999; Petronis et al., 1990) were more likely to engage in DSHI.

Disease-related predictors of DSHI in community and clinical populations were the presence of psychiatric symptoms and disorders, such as major depression, substance abuse and anxiety disorders (Kessler et al., 1999; Haw et al., 2001; Plener et al., 2009). With regard to psychiatric symptoms, adolescents with DSHI showed higher levels of depressive (Hawton et al., 2002) and anxiety symptoms, and used more alcohol (Haavisto et al., 2005; Ross and Heath, 2002; Tuisku et al., 2009).

General vulnerability factors such as personality traits and emotion regulation difficulties were found to be related to DSHI in community and clinical samples. The presence of DSHI was increased in patients with personality disorders, especially in patients with borderline personality disorder (Shearer et al., 1988; Haw et al., 2001). Some of the Big-Five personality traits (neuroticism, agreeableness, extraversion, conscientiousness and openness to experience) were also described to be related to lifetime DSHI. In several community sample studies neuroticism was significantly higher in patients with a history of DSHI compared to non-DSHI patients (Brown et al., 2007; Kessler et al., 1999; Klonsky et al., 2003; Williams and Hassanyeh, 1983). Brown found higher levels of neuroticism and openness to experience, and lower levels of agreeableness and conscientiousness in college students who had a history of (non-suicidal) self-harm compared to controls (Brown, 2009). Additionally, in a study by Klonsky et al., military recruits reporting a history of self-harm showed

more personality pathology traits (borderline, schizotypal, dependent and avoidant) compared to the non-self-harm group (Klonsky et al., 2003). They also found a coherent 'self-harm personality profile', according to self- and peer reports: individuals with a history of self-harm tended to have strange and intense emotions and a heightened sensitivity to interpersonal rejection. 'Emotion dysregulation' difficulties in responding to one's own emotions as a personality trait, may play a central role in DSHI (Chapman et al., 2006; Linehan, 1993; Gratz and Roemer, 2008). A study of DSHI risk factors in male students (Gratz and Chapman, 2007) found emotion dysregulation to distinguish between men with and without DSHI.

Most studies of DSHI focus on the general community, students or inpatients. Knowledge about DSHI-related factors regarding outpatients with common mental disorders such as mood, anxiety and somatoform disorders in a naturalistic mental health care setting is scarce. Identifying associative factors of DSHI is of clinical importance and may assist clinicians, social workers, prevention workers and policy makers in the identification, prevention and treatment of DSHI and eventually, in preventing suicide. In this explorative study, we aimed to investigate the prevalence rate of lifetime DSHI and its demographic and disease specific correlates in a large Dutch naturalistic outpatient mental health population.

2. Methods

2.1. Subjects and procedure

The sample consisted of 3798 outpatients from the Dutch Regional Mental Health Provider (RMHP) Rivierduinen and the psychiatric outpatient department of the Leiden University Medical Center (LUMC). Patients were referred to one of these locations for treatment of a mood, anxiety or somatoform (MAS) disorder between January 2004 and December 2006. All outpatients that enter the clinics were routinely assessed with routine outcome monitoring (ROM), as part of the usual diagnostic procedure (De Beurs et al., 2011). ROM consists of an extensive battery of psychometric instruments, both self-report and interviewer-based. All interviewer-based measurements were carried out by trained research nurses or psychologists. Self-report questionnaires were completed using a touch-screen computer. The assessment took about 120 min. Only patients with insufficient mastery of the Dutch language and patients who were unable to complete computerized and written questionnaires were ineligible for ROM. Approximately, 80% of the referred MAS patients were assessed with ROM in the study period. For the current study, we used baseline ROM assessments only.

Of the 3798 outpatients, 2844 patients between the age of 18 to 65 had complete data on variables of interest and were analyzed (74.9%; Fig. 1). In total, 116 patients were excluded because of their age and 838 patients were excluded because they had missing data. The main reason for missing data ($N=395$) was that the Dimensional Assessment of Personality Pathology-Basic Questionnaire short form (DAPP-SF) had been introduced in ROM gradually. Mean age of the excluded patients was significantly higher in comparison with the included group ($M=39.6$ vs. 37.5 , $p<0.001$). The excluded patients had significantly

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