DELIBERATE SELF HARM!
AN INQUIRY OF A POTENTIAL LINK WITH DEPRESSION

Abid Aftab , Furrukh Hayat Khan, Tarique Arain

PNS Shifa Karachi

ABSTRACT

Objective: To determine the frequency of depression in patients of first episode of Deliberate Self Harm in patients visiting Emergency Dept of a tertiary care hospital.

Place and Duration of Study: PNS Shifa hospital, Karachi. One year 1st Jan 2007 to 31st Dec 2007

Patients and Method: In this study all the patients (n=60) reporting to Emergency Dept with history of self harm were assessed. All the first episode cases between age groups 14-40 yrs (n=60) were included after formal consent. Statistical ratios and percentages were calculated and various variables between the male vs. female, depression and suicidal intentions and other data were computed and plotted using SPSS program and presented on charts and tables.

Results: Male to female ratio was 2:1, Married to single ratio was 2:3, 37 (62%) had mild-moderate one (2%) was severely depressed and rest of the sample (n=22) had no or minimal scores on HAM-D 17. Intent of suicide on Beck suicide scale was low or nil 80% patients; and 20% patients had a moderate or high intent of suicide.

Conclusion: The study shows a high percentage of depression in deliberate self harm group. Patients of deliberate self harm often go unidentified; Prompt management and assessment of the high risk group especially those with depression is required to prevent and to decrease overall mortality and morbidity associated with deliberate self harm.

Keywords: Depression, deliberate self harm, psychiatric disorders

INTRODUCTION

Deliberate self-harm (DSH) is, when one deliberately inflicts physical harm on oneself. Deliberate self-harm is not necessarily a suicidal attempt, and engaging in self-harm may not mean that someone wants to die. "Deliberate self-harm is willful self-inflicting of painful, destructive, or injurious acts without intent to die"[1].

The DSH is one of the top five causes of acute medical admissions for both women and men[2]. In the year after an episode of deliberate self harm, the suicide rate is 100 times[3], that in the general population[4]. The suicide rate is highest in the first year after an episode of deliberate self-harm[5-7]. Median time to repetition among those with a history of self-harm is about 72 days[8]. The purpose of the assessment is to identify depression and to assess continuing risk of suicidal behaviour. As many as 1.8 % of the DSH patients die by suicide in the year following the incident[9] and 8.5% die by suicide over the next 22 years[10]. Hence prompt and enhanced treatment of those who harm themselves reduces the future suicide[11] and additional psycho social interventions following self harm might further reduce the rate of subsequent suicide by 25%[12,13].

PATIENTS AND METHOD

All patients (n=60) brought to emergency dept/psychiatry OPD were registered and after informed consent were included in the study. Duration was one year i.e. from 1st Jan to 31st Dec 2007. The patients having first episode of DSH were included in the study

All the patients (n=60) reporting to Emergency dept of a tertiary care hospital with history of self harm were assessed. Hamilton Rating Scale for Depression (HAM-D 17 item scale)[14] was used to assess the severity of depression and Beck Suicide Intent Scale[16] to evaluate the intent of suicide. These scales were applied to all the patients on the next day of their admission.

Correspondence: Surg Capt Farrukh hayat Khan, Head Dept of Psy, PNS Shifa Karachi

Received: 03 Dec 2008; Accepted: 12 Feb 2010

Statistical ratios and percentages were calculated and various variables like the male vs. female, depression and suicidal intentions, severity of depression and other data were computed and plotted using SPSS program and presented on pie charts and tables.

RESULTS

Total sixty patients were included in the study. Forty (67%) were male. Male and female ratio was 2:1. Mean age of the patients was 23.79 years (23.45 years for males and 24.13 years for females). Twenty four (40%) were married where as 36 (60%) were single. Out at 60 patients, 37 (62%) had mild to moderate depression, one (2%) was severely depressed while 22 (37%) have no minimal scores on HAM-d 17. Intent of suicide on beck suicides scale was low or nil in 48 (80%) patients while 12 (20%) patients had a moderate to high intent of suicide. Preferred time was evening and late night 85%, while in just 15% it was noon or morning (Fig. 1). Most common method adopted was ingestion of either insecticides or over dosage (78%) where as 22% were either laceration of jumping either in sea of from heights (fig. 2)

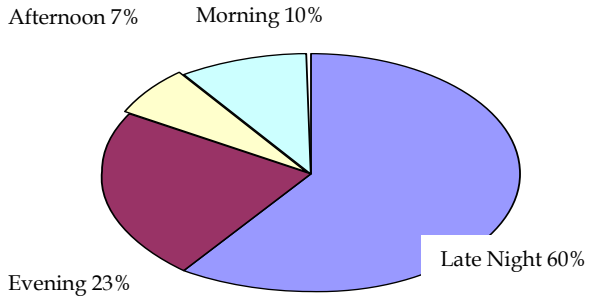

Fig.1: Preferred time of self harm (n=60)

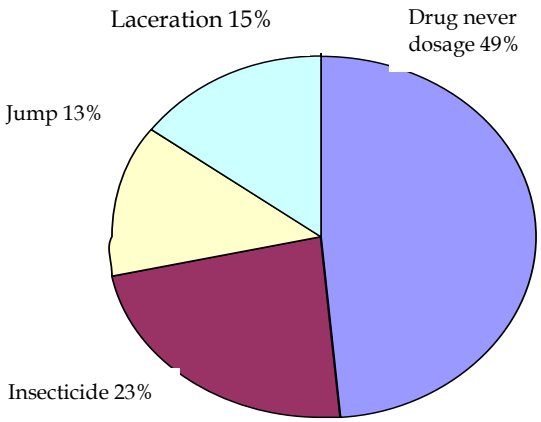

Fig.2: Preferred Methods (n=60)

DISCUSSION

Deliberate self harm is relatively common among young people. Self harm is understood to be a maladaptive coping strategy intended to relieve negative emotions such as anger, anxiety, frustration, or guilt. It is usually unrelated to an immediate suicide attempt. Among adolescents who deliberately harm themselves, the factors that are most likely to be associated with a higher risk of subsequent suicide include; male gender, older age, high suicidal intent, psychosis, depression and hopelessness. Other common risk factors include poverty, social deprivation, bullying, rural isolation, and physical and sexual abuse.

Although previously there were between 2 or 3 times as many episodes of deliberate self harm in females as compared to males. These figures have steadily drawn closer so that self-harm is now only slightly more common among women than men[15]. Some hospitals now deal with more referrals of men than women[16]. This study also showed slightly high levels of DSH in men as compared to females i.e. 2:1 (67%: 33%).

The mean age of the self-harm population was in the early 20s for both sexes, the peak age for presentation being 15–24 years for women and 25–34 years for men[17]. This study also showed a mean age of DSH being 23.79 yrs.

In most cases, people report that they have taken an overdose in response to social problems[2]. This study also showed drug over dosage as the leading mode of DSH, (drug over dosage 49% followed by insecticide ingestion 23%). Common problems included difficulties with housing, unemployment, debt, poor personal health, and conflict or loss in personal relationships[18].

There is some evidence that repetition of self-harm may occur despite resolution of personal problems[19]. Following an episode of deliberate self-harm, about 30–40% of hospital attenders are given a psychiatric diagnosis, and about a third have had prior contact with the

psychiatric services[20]. The findings in this study replicate the other studies[21]. This study also showed 69 % depression. The most common diagnosis is some form of depressive disorder[22]. Alcohol dependence is diagnosed in about 10% of cases[23]. Mental illnesses such as schizophrenia and bipolar disorder are diagnosed in less than 10% of episodes of deliberate self-harm[24]. Median time of repetition among those with a history of self-harm is about 72 days[8]. In suicide subsequent to deliberate self-harm; twenty four studies reported higher suicide rates and intentions in the first year after an episode of self-harm[9] ranging from 0% to 6% (median 1%).The most studies reports a 1-year suicide rate of 1%, very similar to the median for all the reviewed studies, and 100 times the suicide rate of the general population[3]. This study also showed 1.6% as having high risk suicide intent on Beck's Scale.

CONCLUSION

This study definitely shows a high percentage depression in the deliberate self harm group which is close to international studies. Young patients at risk often go unidentified; as a result their psychological problems may not be treated. Prompt management and assessment of the high risk group especially that with depression is required to prevent the repetition of the act and to decrease overall mortality and morbidity associated with deliberate self harm.

REFERENCES

1. Carroll,P.,Beyond the tower of Babel,Suicide Threat,1996;237
2. Hawton, K., Fagg, J,. Trends in deliberate self poisoning and self injury in Oxford, 1976–90.BMJ 1992;304:1409–11.3
3. Greer. S., Bagley, C., Effect of psychiatric intervention in attempted suicide: a controlled study. BMJ 1971; 1:310–2.34.
4. Owens,D.,Fatal repetition of self harm, BJPsych,2002;181
5. Sakinofsky, I., Roberts, R., Brown, Y., et al. Problem resolution and repetition of parasuicide. A prospective study. Br J Psychiatry 1 9 9 0 ; 1 5 6 : 3 9 5 – 9.
6. Hawton. K., Fagg, J,. Suicide, and other causes of death, following attempted suicide. Br J Psychiatry 1988; 152:359–66. 35.
7. Van Sande, R., Van Rooijen, L., Buskens, E., et al. Intensive in- patient treatment and community intervention versus routine care after attempted suicide. Br J Psychiatry 1997; 171:35–41. 66.
8. Wilkinson, G., Smeeton, N,. The repetition of parasuicide in Edinburgh 1980– 1981. Soc Psychiatry 1987; 22:14–9. 38.
9. Owens,D.,Fatal repetition of self harm, BJPsych,2002;181
10. Jerkins,G,R.,Suicide rate,22 yrs study,BJM,2002;325:1155
11. Mann,J,J.,Religius affiliation & suicide. Am J Psy,2004;161:2303
12. Lewis, G,. Sloggett, A,. Suicide, deprivation, and unemployment: record linkage study. BMJ 1998; 317, 1283-1286.
13. Crawford,J,M.,Risk of suicide. Arch Gen Psy,2007;64:1123
14. Adapted from Hamilton MA rating scale for depression. Journal of Neurosurgery & psychiatry 1960; 23:56-62
15. Implications for clinical services and the prevention of suicide. Br J Psychiatry 1997;171:556–60
16. House, A., Owens, D., Storer, D., Psycho-social intervention following attempted suicide: Is there a case for better services? Int Rev Psychiatry 1992; 4:15–22.
17. Haw,C,. Hawton,K,.Psychiatric and personality disorders in deliberate self- harm patients, The British Journal of Psychiatry *(2001) 178: 48-54*
18. Urwin, P,. Gibbons, J, L,. Psychiatric diagnosis in self-poisoning patients. Psychol Med 1975; 9:501–7.
19. Sakinofsky, I,. Roberts, R,. Why parasuicides repeat despite problem resolution. Br J Psychiatry 1990; 156:399–405.
20. Sakinofsky, I,. Roberts, R,. Brown, Y,. et al. Problem resolution and repetition of parasuicide. A prospective study. Br J Psychiatry 1 9 9 0; 1 5 6: 3 9 5 – 9.
21. Beautrais, A,L,. Annette, L,. Suicide and Serious Suicide Attempts in Youth: A Multiple-Group Comparison Study Am J Psychiatry 2003; 160:1093-1099.
22. Morgan, HG,. Burns,C,C,. Pocock, H,. et al. Deliberate self-harm: clinical and socioeconomic characteristics of 368 patients. Br J Psychiatry 1975; 127:564–74.
23. Suokas, J,. Lonnqvist, J,. Suicide attempts in which alcohol is involved: a special group in general hospital emergency rooms. Acta Psychiatr Scand 1995;91:36–40.
24. Wylie, K,. House, A,. Storer, D,. et al. Deliberate self-harm and substance dependence: The management of patients seen in the general hospital. J Ment Health Admin 1996; 23:246–52.