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Caregivers' perspective on non-fatal deliberate self harm

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Abstract:
Background: *Non-fatal suicidal behaviour (NFSB) includes all these behaviour except the competed suicide. Deliberate self-harm (DSH) or parasuicide is an umbrella term for any self-harm behaviour with or without the intent to kill self, while suicide attempt has definite intent to kill self. Research suggests that if you have self-harmed before then you are likely to repeat some form of self-harm. A significant association was found between repetition of an act of deliberate self-harm and the perception of an unsympathetic attitude within the family.*
Method: *Fifty consecutive patients from tertiary care hospital were included in study. They were evaluated using a semi structured proforma which included socio-demographic characteristics, clinical profile of patients including any DSM-IV-TR psychiatric diagnosis with details of treatment and any comorbid medical illness. Beck's Suicide Intent Scale was used to measure intensity and characteristic of suicide attempt. Caregivers/family member's attitude towards suicide attempt was measured with a 15-item questionnaire.*
Results: *Common characteristics of NFDSH were patients attempted when somebody was in visual or vocal contact(64%), absence of suicide note (94%), no history of previous attempt (90%), alleged purpose were to escape, surcease, solve problem(54%), to manipulate environment, to get attention, revenge (30%).*
Keywords: *Attitude, Caregiver, Deliberate self-harm (DSH),*

I. Introduction

Suicidal behaviour represents a spectrum ranging from suicidal ideation to suicidal plan, to suicidal attempt, to completed suicide. Non-fatal suicidal behaviour (NFSB) includes all these behaviour except the competed suicide. Suicidal attempt, as conceptualized currently, is a potentially self-injurious action with a non-fatal outcome for which there is evidence, either explicit or implicit, that the individual intended to kill him or herself [1].Deliberate self-harm (DSH) or parasuicide is to indicate that the behaviour is not accidental while making no presumption about the presence of a desire for death [2]. DSH is an umbrella term for any self-harm behaviour with or without the intent to kill self while suicide attempt has definite intent to kill self.

Some doctors and other professionals think of self-harm simply as behaviour, resulting from other difficulties. However, others suggest that it is a psychiatric disorder involving problems with perception, thought, emotions and/or behaviour. Many people who self-harm have signs of other psychiatric disorders such as depression, psychosis or personality disorder. Some research suggests that low levels of a substance in the brain called Serotonin may be involved with self-harm [3]. Research suggests that if you have self-harmed before then you are likely to repeat some form of self-harm. One study found that within two years 11 % of patients who self-harmed went on to self-harm again [4]. Approximately 10 % of people who self-harm go on to commit suicide within ten years.There are 15 to 45 non-fatal suicide attempts for every adolescent who dies by suicide [5]. Within the 12 months following a suicide attempt, risk of suicide or another attempt has been estimated to be as high as 100 times greater as those who have never made an attempt.As prospective studies have emphasized the high subsequent suicide rate in clinically presenting suicide attempters [6], the evidence linking NFSB to later complete suicide, has brought a particular focus on the study of NFSB. Across different cultures, the prevalence of NFSB, has been found to be alarmingly high and particularly among adolescents. In the USA, suicide ranked as the third leading cause of death for adolescents in 1999, accounting for 12.7% of death in this age group, after motor vehicle accident and homicide [7]. Life-time suicidal ideation rates have ranged from 20 to 54% and life-time suicide attempt rates mostly lie between 7 and 10% with some studies showing higher rates of up to 15%[8].One year prevalence rates for suicide attempts have ranged from 1.5 to 3%. Some studies have shown higher rates of up to 9% [8]. In one Indian study a total of 1205 adolescents, aged 12-18, were to fill out a questionnaire. Life time prevalence rates for suicidal ideation 21.7%, DSH 18%, suicide attempt 8%. One year prevalence rate for suicidal ideation 11.7%, DSH 6.1%, suicidal ideation 3.5% [9].Deliberate self-harm (DSH) may be an outcome associated with poor emotion regulation as well as an

invalidating family environment. Emotion regulation partially mediated the relationship between family climate and DSH, and direct effects were also observed [10].

Caregivers' attitudesmatter much when person attempts self-harm.Parents' responses to their children's emotional expressivity have been shown to significantly influence children's subsequent psychosocial functioning. Adolescents who self-injured reported that this behavior reduced their negative emotional states. A significant association was found between repetition of an act of deliberate self-harm and the perception of an unsympathetic attitude within the family [11].Patients with a history of deliberate self-harm who no longer harm themselves talk about their experiences in terms of lack of control over their lives, either through alcohol dependence, untreated depression, or in adolescents, uncertainty within their family relationships[12].The study suggests that an incident of DSH by their son or daughter is an extremely traumatic experience for parents. Parents reported being deeply distressed with feelings of helplessness, they had concerns regarding coping with their child on discharge from hospital and were worried about the possibility of future incidents. These results suggest that parents need more support and if given this they might be enabled to better contribute for improving the long term prognosis for their child [13].

II. Materials and Methods

Fifty consecutive patients who admitted in medical ward of B. J. medical college, Civil Hospital, ahmedabad were included in study. Patients were medically managed by medical staff in emergency hours as all patients admitted in emergency hours. After improvement of general condition patients were shifted to medical ward and later on psychiatric help was sought for suicidal behaviour. In this study children were excluded and only those patients who were medically reasonably fit and those who did not have cognitive deficiency like delirium were included. Patients and family member interviewed at Psychiatry Department of Civil Hospital, ahmedabad using a semi structured proforma which included socio-demographic characteristics, clinical profile of patients including any DSM-IV-TR psychiatric diagnosis with details of treatment and any comorbid medical illness. All data were collected over eight months of period (May to December 2008). Beck's Suicide Intent Scale was used to measure intensity and characteristic of suicide attempt. Caregivers/family member's attitude towards suicide attempt was measured with a 15-item questionnaire.

Beck's Suicide Intent Scale

It is 20-items scale, up to 15-items included in total score in which first 8 items were asked to patient and appropriate response noted by interviewer and 9-15-items wereself-reported by patient after explaining and 16-20-items not included in total score. Response noted on scale 1 to 3 as per severity like for item 6 active preparations for attempt 1-none, 2-minimal to moderate, 3-extensive. Patient's suicide intent was determined from total score as low intent 15-19, medium intent 20-28, and high intent 29+.Suicide characteristic like isolation, timing, presence or absence of suicide note, alleged purpose of attempt, previous attempt, attitude toward living or dying, expectation of fatality of method were also evaluated.

Caregiver's Attitude

The closest and most responsible caregivers who accompanied patients were interviewed about their attitudes towards patient after suicide attempt. We interviewed parents, wife, brother, husband in different patients. Standard caregiver's questionnaire was downloaded from health and medical information for consumer (Australia 2009) and with some modifications appropriate for our patients in local socio-cultural setup a 15-item questioner was prepared. Response of caregiver noted in yes/no. It includes some positive attitudes like 'take it as sign of failure to cope-up', 'feels the need for overprotection', 'feels the need to avoid giving shocking news' and some negative attitudes like 'doesn't take attempt seriously', 'feels anger at relative who attempted suicide', 'doesn't feel the need for treatment/ counselling'.

Data were tabulated, master chart prepared, analysis was done using SPSS 15 and Chi-square test was applied.

III. Results and discussion

Table 1: Demographic Characteristic

Demographic variable	Values	N=50, n(%)
Age	<18 years	4(8)
	18-30 years	33(66)
	>30 years	13(26)
Sex	Female	20(40)
	male	30(60)
Education	Illiterate	4(8)
	primary	28(36)
	Secondary	15(30)
	Graduate	3(6)
occupation	Housewife	17(34)

	Unskilled	19(38)
	Skilled	12(24)
	Study	2(4)
Marital status	Unmarried	16(32)
	Married	34(68)
Family	Nuclear	20(40)
	Joint	30(60)
Monthly income	No	22(44)
	Up to 2500	11(22)
	>2500	17(34)
Psychiatric diagnosis	No	33(66)
	MDD	15(30)
	Alcohol use	1(2)
	OCD	1(2)

As regards to socio-demographic characteristics in our study we found almost all NFDSH patients from Hindu religion [9]. Possible explanation for this finding is that most patients attending our hospital are of Hindu religion. It is only matter of serendipity that there were no patient form any other religion in our sample.

NFDSH more common in males in our study is similar to finding of previous studies [14,15], whereas most studies[9,16,17,18,19] report higher rates in females. This difference is possibly explained by the fact that our study was done during pick of economic recession so loss of job and financial problem affected earning male members of family more or may be due to attitude of family members like not taking treatment for female attempter and try to hide such incidences form society whereas they would more concern and anxious about restoring physical health of male members who attempted NFDSH.We found higher rate of NFDSH among adult age group [1,16,18,20] while some studies [9,17,21] reported rate among adolescent age group is increasing in present scenario because of changing social values, highly competitive education system, higher influence of media culture which places extreme stress on adolescents.We found higher rate of NFDS among married patients is similar to finding of [16,17,20]. This suggests that stable marriage is protective factor for completed suicide. It might be rather predisposing for NFDSH. We found higher rate among unemployed [22]. In our study we noticed that major depressive disorder was common among NFDSH patients is similar to finding of [23-29]. Depressed patients have sad mood, lack of interest they perceive even minor stress as major leading to hopelessness and worthlessness finally suicide attempt. Few studies [25,26,30,31] suggest personality disorders are also risk factors for NFDSH.

After evaluation of Suicide Intent Scale in our study (TABLE 2), we found that 30% patients have attempted to manipulate environment, get attention or revenge and 54% have attempted to escape or solve the problem [9,22]. Some studies [32,33] reported that NFDSH in response to overweening emotional pain explained by that it may be a cry for help or is the only available solution. We found that most have attempted when somebody was in visual or vocal contact (64%), without writing suicide note (92%) and none has attempted where death was probable or certain.

Table 2: Characteristic of NFDHS based on Suicide Intent Scale

Characteristic of attempt	SIS Rating	Specification	N=50
Isolation	1	Somebody present	17(34)
	2	Somebody in visual or vocal contact	32(64)
	3	No one nearby or in visual or vocal contact	1(2)
Timing	1	Intervention is probable	25(50)
	2	Intervention is not likely	25(50)
	3	Intervention highly unlikely	0
Suicide note	1	Absence of note	47(94)
	2	Note written but torn	0
	3	Presence of note	3(6)
Previous attempt	1	None	45(90)
	2	One or two	5(10)
	3	Tree or more	0
Communication of intent before attempt	1	None	36(7)
	2	Equivocal	14(28)
	3	Unequivocal	0
Alleged purpose	1	To manipulate environment, get attention, revenge	15(30)
	2	Component of above and below	8(16)
	3	To escape, surcease, solve problem	27(54)
Expectation of fatality	1	Death was unlikely	12(24)
	2	Death was possible but not probable	38(76)
	3	Death was probable or certain	0
Attitude towards	1	Did not want to die	21(4))

living/ dying	2	Component of above and below	26(5)
	3	Wanted to die	3(6)

Table 3: Method of NFDHS (N=50)

Method of attempt	N (%)
Ingestion	
Insecticide	20(40)
Sedative	14(28)
Acid	13(26)
Analgesic	2(4)
Wrist slashing	1(2)

In our study we found commonest method of NFDSH was self-poisoning (98%) method probably due to easy availability (benzodiazepine required prescription), less painful, less violent, lower fatality rate, less courage required as compared to physical methods. Among self-poisoning methods we found organophosphorus poisoning (40%) was commonest similar to finding of [17,18,34-37]. Our finding differs from some studies which reported benzodiazepine [14,16] and analgesic[15,20,38] medicines overdose was commonest method of NFDSH which could probably due to that their specific circumstances of study.

Among self-poisoning methods suicide intent were medium with median 22 to 23.85.in wrist slashing suicide intent was low.(TABLE 4)

Table 4: Suicide Intent scale score and method of suicide attempt

Method of attempt	**Range of suicide intent**	**Mean (SD)**
Ingestion		
Insecticide	16-32	23.75(4.46)
Sedative	16-28	23(4.095)
Acid	15-35	23.85(6.41)
Analgesic	18-26	22(5.66)
Wrist slashing	17	17

Table 5: Caregivers who were interviewed

Caregiver	**N=50, n(%)**
Mother	14(28)
Parents	13(26)
Husband	11(2
Wife	7(14)
Brother	5(10)

Table 6: Caregiver's attitude

Sr. no	**Caregiver's attitude**	**N=50**
1	Feel shock associated with traumatic incidence	47(94)
2	Feels anger at the relative who attempted suicide	40(80)
3	Feels the need for overprotection	33(66)
4	Feels the need to avoid giving shocking news	28(56)
5	Take it as sign of failure to cope up	25(50)
6	Feel awkwardness when doesn't know how to respond	24(48)
7	Feels that it is a way to get his own way	21(4)
8	Thinks that attempt was to get attention toward him/herself	21(4)
9	Take pity on attempter but doesn't respect	18(36)
10	Feels that he/she will not attempt again	18(36)
11	Doesn't take attempt seriously	14(28)
12	Feel loneliness when others keep their distance	11(2
13	Feel isolation caused by sense of self-imposed shame	10(20)
14	Doesn't feel the need for Rx/counselling	2(4)
15	Feels that attempt was justified	0

Family member who brought patients were interviewed in which 28% were mothers, 26% were parents, 22% husband of patients interviewed.There are very few studies [10-12] available on caregivers response to NFDSH.After evaluation of caregiver's questionnaire, we found that most common response of caregiver was they felt shock associated with such traumatic incidence (94%), is similar to result found by H Raphael et al. [13], probably due to caregiver's thought that such attempt would have led to untimely and unnatural death.Other common caregiver's attitude towards attempters was feeling of anger at relative who attempted suicide (80%). They felt that there were other ways to deal life stress or felt that attempted pull himself and other family member in difficulty.Caregiver felt the need for overprotection (66%), felt the need to

avoid giving shocking news (56%) is possibly due to that they felt that scolding for attempt may lead to repetition of such attempts andin turn they avoid giving shocking news and overprotective to avoid any further stress to attempter.Caregiver takes NFDSH as a sign of failure to cope up (50%) is similar to study by H Raphael et al. [13] which showed parents reported being deeply depressed with feeling of helplessness. None caregiver has reported that attempt was justified as none gave sanction to such behaviour which may lead unnatural death. Caregivers reported that they felt the need for treatment or counselling (96%) as it gives better mental health,helps to learn of appropriate coping strategies and prevent repetition of future attempts.None of demographic characteristics like age, sex, marital status, socioeconomic status and occupation, severity of intent, family type, presence or absence of any psychiatric disorder was correlated with any specific caregivers' attitude. None of deliberate self-harm characteristics was associated with specific caregivers' attitudes.

IV. Conclusion

In our study we found that most common caregivers' responses towards patient of NFDSH were they shock associated with traumatic incidence (94%),anger at the relative who attempted suicide (80%), felt the need for overprotection (66%), felt need to avoid giving shocking news (56%). None has reported that attempt was justified. None of the demographic characteristics like age, sex, marital status, socioeconomic status and occupation, severity of intent, family type, presence or absence of any psychiatric disorder was correlated with any specific caregiver's attitude. Our sample was small and longitudinal study is required to assess correlation between caregiver's attitude and demographic characteristics of NFDSH.

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