

A study on personality disorders among cases of deliberate self-harm

M D Shahanawaz Zafar^{1*}, Upendra Paswan²

¹Senior Resident, ²Professor & HOD, Department of Psychiatry, Darbhanga Medical College and Hospital, Darbhanga, Bihar, INDIA.

Email: zafarshahanawaz8@gmail.com

Abstract

Background: Previous Indian studies have found that persons who attempt suicide had lower incidence of psychiatric and personality disorders than those who die by suicide. To understand more about the types of psychiatric and personality issues that people with deliberate self-harm have and how common they are. **Method** Total 50 DSH patients who presented Darbhanga Medical College and Hospital, were assessed using a structured clinical interview and a standardised instrument. During the period of January, 2019 to November 2020. **Results:** Affective disorder was present in 38 patients (76%). A Depressive episode was present in male cases 68.4% & Female cases were 71.0%. Substance use disorders (alcohol) present in 16(32.0%) cases. Substance use disorders (Drug) users was present 30(60%) cases. Neurotic, stress, somatoform disorders was found 19(38%) cases. Eating disorder was observed 14(28%) cases. & Schizophrenia cases was found 7(14%) respectively. **Conclusion:** In DSH patients, psychiatric and personality disorders, as well as their comorbidity, are common. This has significant assessment and management consequences.

Keywords: personality disorders.

*Address for Correspondence:

Dr M D Shahanawaz Zafar, Senior Resident, ²Professor & HOD, Department of Psychiatry, Darbhanga Medical College and Hospital, Darbhanga, Bihar, INDIA.

Email: zafarshahanawaz8@gmail.com

Received Date: 13/11/2021 Revised Date: 12/12/2021 Accepted Date: 19/01/2022

This work is licensed under a [Creative Commons Attribution-NonCommercial 4.0 International License](https://creativecommons.org/licenses/by-nc/4.0/). 

Access this article online

Quick Response Code:	Website: www.medpulse.in
	DOI: https://doi.org/10.26611/1072121

the second most common diagnosis (after adjustment disorders) in 18% of male and 15% of female suicide attempters, according to data from the World Health Organization/EURO Multicentre Study on Suicidal Behaviour.⁵ Furthermore, personality disorders frequently coexist with other mental diseases, complicating therapy and increasing the risk of suicide.²

METHODS

All DSH patients who presented to the hospital and were medically fit to be questioned on recruiting days, which covered both weekdays and weekends to ensure the patient sample was dispersed throughout the week, were considered for inclusion in the possible sample. The general hospital psychiatric service evaluates the majority of DSH patients that present to Darbhanga Medical College & Hospital's general hospital. However, attempts were made to attract people who had not previously been visited by the service, usually after a mental evaluation. If the patient was discharged before they could be contacted, a phone call was made to follow up. Using data from the Monitoring System for Attempted Suicide, which collects information on all

INTRODUCTION

Personality disorders are long-term, rigid, and persistent patterns of behaviour and inner experience that diverge significantly from cultural standards and produce significant distress or impairment in numerous aspects of an individual's functioning.¹ Personality disorders (particularly cluster B) have been linked to a higher incidence of suicidal ideation, attempted and completed suicide, and self-mutilation in studies.^{2,3} According to a review of psychiatric autopsy investigations, up to 57 percent of people who died by suicide had personality abnormalities.⁴ Neurotic and personality disorders were

DSH patients presenting at Darbhanga Medical College & hospital.

Measurement of tools

Interview Schedule

The WHO/Euro Multicentre Study on Parasuicide^[6] was utilised to administer the programme. The following topics of inquiry are included in the schedule: demographics, present and previous DSH episodes, life events, social support, interaction with health experts, and physical and mental health.

Personality Assessment Schedule:

Tyrer and colleagues used the self-report version of the Personality Assessment Schedule (PAS),⁹ which was modified according to ICD-10 criteria. Tyrer *et al* method's was used to categorise the ratings within each personality area, with a rating of seven or more indicating personality disorder and a rating of 4-6 trait accentuation. At the follow-up interview, the PAS was completed (see below). This enabled us to examine personality at a time

when psychiatric disorders were less likely to be present.^[10]

ICD-10 Diagnostic Schedule:

The duration and nature of current and prior psychiatric symptoms were recorded using a systematic interview schedule established by our group and based only on ICD-10 research diagnostic criteria ^[7,8] The diagnosis was based on the patient's self-report of symptoms in the weeks leading up to the DSH index episode, as well as the patient's behaviour during the interview. Patients were asked screening questions for each condition group. When one or more of the screening questions were answered affirmatively, the entire set of research criteria for the specific diagnosis as indicated in ICD-10 was presented. The research interviewers were taught by a physician psychiatric researcher with extensive experience in diagnostic interviewing, as well as another researcher with similar experience.

RESULTS

Table 1: Demographic characteristics among study population

Variable	Frequency	Percentage	
Age	20-30 years	29	58.0
	31-40 years	11	22.0
	41-50 years	06	12.0
	>50 years	04	08.0
Sex	Male	19	38.0
	Female	31	62.0
Employment status	Employed	10	20.0
	Unemployed	06	12.0
	House wife	16	32.0
	Student	06	12.0
	Unskilled worker	12	24.0
	Method of deliberate self harm	Self poisoning	42
	Self injury	08	16.0
Previously deliberate self harm	Yes	27	54.0
	No	23	46.0
Previous psychiatric treatment at time of deliberate self harm	Yes	18	35.0
	No	32	64.0

Total 50 patients including in the study, Maximum no of the patients were belongs to 20-30 years of age group, i.e. 29(58.0%). Next commonest age group was 31-40 years, patients consisted 11(22.0%). Female cases were predominately higher than male cases,

Table 2: Psychiatric disorder according to ICD10

Psychiatric disorder	Male(n=19)		Female(n=31)	
	No	Percentage	No	Percentage
Affective disorders (n=38)	Bipolar(F-31)	0	2	6.5
	Depressive episode(F32)	13	22	71.0
	Dysthymia(F34)	0	1	3.22
Substance use disorders (alcohol)(n=16)	Alcohol harmful use(F10.1)	4	2	6.5
	Alcohol dependence((F10.2)	8	2	6.5
Substance use disorders(Drug)(n=30)	Drug harmful use(F11.1-19.1)	4	9	29.0
	Drug Dependence((F11.2-19.2)	5	12	38.7
	Anxiety disorder(F40-41)	3	10	32.2

	Obsessive compulsive disorder(F42)	2	10.5	1	3.2
Neurotic, stress, somatoform disorders(n=19)	Stress disorder((F34.1)	0	0	4	12.9
	Adjustment Disorder((F43.2)	0	0	4	12.9
	Dissociative disorder((F44)	2	10.5	0	0
	Somatoform disorder(F45)	1	5.3	5	16.1
Eating disorder (n=14)	Anorexia nervosa(F50.0-50.1)	0	0	2	6.5
	Bulimia nervosa((50.2-50.3)	2	10.5	6	19.4
	Unspecified eating disorder(F50.8-50.9)	0	0	4	12.9
Schizophrenia(n=7)	Paranoid schizophrenia((F20.0)	1	5.3	1	3.2
	Schizoaffective depressive type(F25.1)	0	0	4	12.9
	Other nonorganic psychoses(F28.0)	1	5.3	0	0

Affective disorder was present in 38 patients (76%). A Depressive episode was present in male cases 68.4% & Female cases were 71.0%. Substance use disorders (alcohol) present in 16(32.0%) cases. Substance use disorders (Drug) users was present 30(60%) cases. Neurotic, stress, somatoform disorders was found 19(38%) cases. Eating disorder was observed 14(28%) cases. & Schizophrenia cases was found 7(14%) respectively.

DISCUSSION

We discovered a high prevalence of both psychiatric (84.0 percent) and personality (41.2 percent) disorders in a representative sample of DSH patients presenting to a general hospital in Darbhanga Medical College, with the most common psychiatric disorders being depression, substance use, and anxiety disorders.

The rates of psychiatric disorder discovered in this study are significantly greater than those reported in prior UK studies that employed systematic screening tools.^[11] The rates and profile of psychiatric disorders in this study are more similar to those reported in UK studies of completed suicides.¹² One possible explanation for the disparity between the findings of this study and those from the 1970s is a change in the DSH population's characteristics over time. It is also likely that the implementation of a standardised diagnostic routine led to the over-diagnosis of mental diseases among susceptible people. However, given the level of reported historical psychiatric disease, such an effect, if present, would be minor. Suominen *et al*¹³. also reported discrepancies between the frequency of psychiatric diagnoses in DSH patients based on research interviews and those made in routine clinical consultations. In comparison to usual consultations, they discovered considerably greater incidence of depression, alcohol dependence/abuse, and comorbidity of psychiatric diseases following research interviews. They came to the conclusion that this discovery had significant consequences for clinical practise. Furthermore, recent studies from other countries have found comparable rates

of psychiatric disorders in DSH patients to those found in this study, Barnes, and Kennedy-Ennis *et al*, 1989, 85 percent ; Suominen, Henriksson, and Suokas-Suominen *et al*, 1996, 98 percent. Nearly half of our sample had several psychiatric diseases, which is consistent with the findings of Suominen *et al.*,¹³

The number of DSH patients having a personality disorder in this study (45.9 percent) is comparable to that discovered in previous investigations by Ferreira de Castro, Cunha, and Pimenta (Ferreira de Castro *et al*, 1998, 50.6 percent).¹⁴ In various investigations of DSH patients, borderline personality disorder was found to be the most common personality disorder.¹⁵ Recurrent threats or acts of self-harm are one of its diagnostic features.

This study found no significant gender differences in the prevalence and severity of depressive disorders, the prevalence of anxiety disorders, or the frequency of psychiatric and/or personality disorder comorbidity. There were, however, significant gender disparities in prevalence of alcohol dependence or hazardous use, as well as eating disorders.¹⁶

CONCLUSION

Psychiatric and personality disorders, as well as their comorbidity, are common among DSH patients. This has substantial implications for assessment and management. The high rates of psychiatric morbidity discovered in this study imply that DSH patients' assessments should include comprehensive screening for psychiatric symptoms. This has ramifications for employee training. The high incidence of depressed symptoms and the huge number of patients with severe depressive episodes begs the question of whether affective disorders are under-recognized and under-treated in DSH patients. While psychosocial therapies are regarded to be appropriate for the majority of patients.

REFERENCES

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. Text revision. Washington, DC: APA; 2000.
2. Linehan MM, Rivzi SL, Welch SS, Page B. Psychiatric aspects of suicidal behaviour: personality disorders. In: Hawton K, Van Heeringen K, editors. The international handbook of suicide and attempted suicide. Chichester, UK: John Wiley & Sons; 2000. pp. 147–178.
3. Pompili M, Ruberto A, Girardi P, Tatarelli R. Suicidality in DSM-IV cluster B personality disorders: an overview. *Ann Ist Super Sanita* 2004; 40:475–483. A review of literature published from 1980 to 2004 on the subject of suicidality in borderline, narcissistic and antisocial personality disorders, and other co-morbid disorders.
4. Isometsa ET. Psychological autopsy studies: a review. *Eur Psychiatry* 2001; 16:379–384.
5. Schmidtke A, Bille-Brahe U, De Leo D, *et al.* Sociodemographic characteristics of suicide attempters in Europe: combined results of the monitoring part of the WHO/EURO Multicentre Study on Suicidal Behaviour. In: Schmidtke A, Bille-Brahe U, De Leo D, Kerkhof A, editors. Suicidal behaviour in Europe: results from the WHO/EURO Multicentre Study on Suicidal Behaviour. Goettingen, Germany: Hogrefe & Huber; 2004. pp. 29–43.
6. Kerkhof, A., Bernasco, W., Bille-Brahe, U., *et al* (1989) WHO/EU Multicentre Study on Parasuicide: European Parasuicide Study Interview Schedule (EPS/S). Leiden: Leiden University, Department of Clinical, Health and Personality Psychology.
7. World Health Organization (1993) The ICD–10 Classification of Mental and Behavioural Disorders; Diagnostic Criteria for Research. Geneva: WHO.
8. Hawton, K. Simkin, S., Malmberg, A., *et al* (1998) Suicide and Stress in Farmers. London: The Stationery Office.
9. Tyrer, P., Alexander, J. & Ferguson, B. (1988) Personality Assessment Schedule (PAS). In Personality Disorder: Diagnosis, Management and Course (ed. Tyrer, P.), pp. 140–167.
10. Zimmerman, M. (1994) Diagnosing personality disorders: a review of issues and research methods. *Archives of General Psychiatry*, 51, 225–245.
11. Newson-Smith, J. & Hirsch, S. (1979) Psychiatric symptoms in self-poisoning patients. *Psychological Medicine*, 9, 493–500.
12. Barraclough, B., Bunch, J., Nelson, B., *et al* (1974) A hundred cases of suicide: clinical aspects. *British Journal of Psychiatry*, 125, 355–373.
13. Suominen, K., Isometsa, E., Henriksson, M., *et al* (1999) Consultation versus research diagnoses of mental disorders among suicide attempters. *Nordic Journal of Psychiatry*, 53, 253–256.
14. Ferreira de Castro, E., Cunha, M., Pimenta, F., *et al* (1998) Parasuicide and mental disorders. *Acta Psychiatrica Scandinavica*, 97, 25–31.
15. Ennis, J., Barnes, R. A., Kennedy, S., *et al* (1989) Depression in self-harm patients. *British Journal of Psychiatry*, 154, 41–47.
16. Hawton, K. & Fagg, J. (1988) Suicide, and other causes of death, following attempted suicide. *British Journal of Psychiatry*, 152, 359–366.