COMPARATIVE STUDY OF SELF HARM BEHAVIOR AMONG ADULTS WITH ALCOHOL DEPENDENCE SYNDROME AND DEPRESSIVE DISORDER

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Abstract

Self-harm is a salient component for upcoming risk behaviors in an individual that constitute to considerable jeopardy of the rest of their social and emotional well-being. As per estimate of WHO, globally, life time prevalence of substance use disorder and mood disorder are 10.7% and 9.6% respectively. These are two major psychiatric conditions that are commonly seen in India. Knowledge about vulnerable population for self-harm in these conditions can help us to address their needs and thereby reduce the risk of further self-harm. The objective of this study is to assess the prevalence, socio-demographic details and clinical factors associated with self-harm behavior in patients with alcohol dependence syndrome and those with depression. This was a cross sectional study of 312 patients, 156 of them with Alcohol dependence syndrome and 156 of them with depression diagnosed according to ICD 10 criteria. Study population included patients whose age was above 18 years, without any other co-morbid psychiatric or organic mental disorder. Descriptive analysis was carried out by mean and standard deviation for quantitative variables, frequency and proportion for categorical variables. The association between socio-demographic and clinical parameters and self-harm behavior was assessed by cross tabulation and comparison of percentages. Odds ratio along with 95% CI is presented. Chi square test was used to test statistical significance. Self-harm is directly correlated with the severity of the illness and inversely correlated with age of onset of illness. Early age of onset and severe illness are associated with self-harm behavior. In ADS individuals, marriage can be a risk factor for Self-harm, where as in depression, it is considered to be protective. The study has highlighted the prevalence of self-harm in specific psychiatric conditions, which are most often neglected or under reported. It can thus be concluded that prevalence of self-harm behaviors in both the conditions is equal. There are risk factors specific to the illness , which make an individual vulnerable to self-harm attempts and these population should be monitored vigorously.

Key Words: Self-harm, Non-Suicidal Self Injury (NSSI), Alcohol Dependence Syndrome (ADS), World Health Organization (WHO)


INTRODUCTION
Self-harm is a salient component for upcoming risk behaviors in an individual that constitute to considerable jeopardy of the rest of their social and emotional well-being (Adrian M, E et.al, 2011). Of many methods available commonly seen self-harm types include over dosage with medications, fertilizer or pesticide poisoning and self-injury of hands by cutting themselves.

As per WHO 2014 report, suicide is one of the top 10 leading causes of death contributing to 0.9% of total deaths. According to WHO estimate, a suicide occurs once in every 40 seconds with global rate of one million deaths per year. Self-Harm is a principal marker for predictor of subsequent attempted or completed suicide (Skegg K, 2005). There exists a clear variation in the rates of suicide globally and it can be attributed to study subjects included into the research and also cultural differences. The risk of suicide is in the range of 0.8% - 8.0% in males and 0.3% - 1.9% in females during the first year following self-harm attempt (GibbSJ et.al, 2005 &ChenVC et.al,2011). Vulnerable population to attempt suicide following self-harm include elderly males with more violent self-harm attempts and had a recent psychiatric hospitalization (GibbSJ et.al, 2005 &Vajani M et.al,2007)

Complications of self-harm can vary as the methods differ and it causes harm to the body thereby leading to unintentional death. There can be acute effects due to attempts following poisoning or tablet overdose. Short-term to long-term effects following cutting oneself or self-burning. Almost more than two-third situations, Self-harm behavior is seen in the age group below 30 years (Hawton K et.al,2007) This age group population are more prone to have a range of psychiatric conditions like Affective disorders, personality issues, comorbid substance use, conduct disorders and other psychosocial factors (Vajani M et.al,2007 &Gupta R et.al,2019).

According to the data given by National Health Portal India in 2005, from the report by WHO, 62.5 million individuals were using alcohol with 17.4% (10.6 million population) of them having Alcohol use disorder. Considering the details of global status report on alcohol and health by WHO in 2018, from 2005 to 2016, highest increase in alcohol consumption was noted in South-East Asian areas with an increase of 2.2 liters in India alone. Substance use, especially alcohol, is considered as a significant risk factor for self-harm. It can mostly occur either under intoxication or due to impulsivity. Research shows that among substance dependent individuals, those with young age, who are unmarried or divorced, with high school education and low social class and presence of family history of self-harm, substance use or psychiatric illness are prone for self-harm attempt under stress or intoxication (BakkenK et.al,2007 &PawanRathi at.al,2016).

AIMS AND OBJECTIVES

To study the frequency of self-harm behavior in patients diagnosed with alcohol dependence syndrome and Patients diagnosed with depression.

To study the demographic, clinical and psychosocial variables of patients with self-harm behavior.

To compare these factors among patients diagnosed with alcohol dependence syndrome and depression.

REVIEW OF LITERATURE
Self-harm is a purposeful, non-fatal way of inflicting pain or injury upon oneself, without any intention to die, in ways that are not culturally or socially sanctioned (Herpertz, 1995 & Muehlenkamp, J. J., 2005). Various terminology is used in the literature synonymously to describe self-harm behavior (Isaacson G, Rich CL, 2001). According to ICD-10, Intentional Self-harm includes purposely self-inflicted poisoning or injury or suicidal attempt (X60 - 84).

Non-suicidal self-injury (NSSI), as defined in DSM-V, is the deliberate, self-inflicted destruction of body tissue (e.g., cutting, burning) without suicidal intent and for purposes not socially sanctioned, includes behaviors such as cutting, burning, biting and scratching skin.

Herpertz (1995) - Deliberate Self-Harm is defined as self-poisoning or injury, irrespective of the purpose of the act.

Kreitman (1977) defines Para-suicide as a non-fatal act in which an individual deliberately causes self-injury or ingests a substance in excess of any prescribed or generally recognized therapeutic dose. This term was coined by .

HISTORY:

The origin of Self-harm dates back to primeval period. It was believed to be a ritual in many religions and cultures. Only in late 90s, people began to think certain self-harm attempts are not just a tradition, they have some reason behind that.

Anon (1882) stated in his book - when a young farmer who had attempted to castrate himself had expired, for the first time it was reported in medical journals that – there cannot be the slightest doubt in the mind of any one that the case was throughout one of self-mutilation from insanity.

For the first time, L.E Emerson, in 1913, in his case study The Case of Miss A: a Preliminary Report of a Psychoanalytic Study and Treatment of a Case of Self-Mutilation, used the term self-mutilation and considered it as a substitution for masturbation.

Karl Menninger (1938) refined the concepts of self-mutilation and described it as a non-fatal expression of an attenuated death wish. He had done extensive research between suicide attempters and individuals with self-harm attempt. He named it as Partial Suicide and classified into 6 categories based on mode of attempt.

<table>
<thead>
<tr>
<th>No.</th>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Neurotic</td>
<td>Nail-biters, pickers, extreme hair removal &amp; unnecessary cosmetic surgery.</td>
</tr>
<tr>
<td>2</td>
<td>Religious</td>
<td>Self-flagellants and others</td>
</tr>
<tr>
<td>3</td>
<td>Maturity ceremonies</td>
<td>Hymen removal, circumcision or clitoral alteration.</td>
</tr>
<tr>
<td>4</td>
<td>Psychotic</td>
<td>Genital self-mutilation, eye or ear removal and extreme amputation.</td>
</tr>
<tr>
<td>5</td>
<td>Organic Brain Diseases</td>
<td>Allow repetitive, hand-biting, head-banging, finger-fracturing or eye</td>
</tr>
</tbody>
</table>

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The concept of low lethality (delicate) and high lethality (coarse) self-harm attempts was given by Pao (1969) in his study “The syndrome of delicate cutting”. On one hand, Individuals with low lethal or delicate self-harm attempts were young, with repeated attempts and generally with diagnosis of borderline personality disorder while on the other hand, high lethal or coarse self-harm attempters were mostly older and psychotic.

Walsh and Rosen (1988) in their publication —Self - Mutilation: Theory, Research and Treatment described four classes of self-harm behavior and their corresponding physical damage, psychological state and the social acceptability of the attempt.

Favazza et.al, after reviewing many studies, classified self-mutilation into two categories – Culturally sanctioned and deviant self-mutilation . Culturally sanctioned was again sub-categorized into rituals and practices. Rituals reflect the traditions and beliefs of a society and repeated in the families for generations, whereas practices are historically transient and may also be cosmetic (piercing of earlobes, nose, eyebrows). On the other hand, deviant self-mutilation is equivalent to self-harm.

In his later studies, Favazza and Simeonrevised the classification into four categories of self-harm behavior, which is most frequently used currently.

Stereotypical self-mutilation - which is typically seen in individuals with pervasive developmental disorders (e.g. autism, mental retardation, etc.). It is rhythmical, repeated and doesn’t have affective content.

Serious self-mutilation- which involves serious mutilation of the body organs (e.g. auto-castration or gauging one’s eyes) leading to permanent damage and often seen as a part of severe psychotic illness.

Compulsive self-mutilation- which is characterized by repeated or ritual behavior, which often occurs several times in a day (e.g. pulling out hair, biting nails, scratching)

Impulsive self-mutilation- seen in a person without pervasive developmental disorder or psychotic illness. It is manifested as direct, socially unacceptable damage of tissue, without any intention to die which can occur once or can be repeated.

**BURDEN OF SELF-HARM**

**GLOBAL**

As per World Health Organization (WHO) 2016 report on global health estimates, Self-harm is one of the top 20 leading causes of death worldwide with accounting to 1.4% of total deaths (10.6 per 1, 00,000). Self-harm as a cause of death in South—East Asia contributes to 1.9% of total deaths (13.2 per 100,000 population), which is highest among the other regions under WHO.
The WHO/EURO Multicenter Study on Parasuicide is the first of its kind in comparing the frequency of methods used in attempted suicide internationally (Hjelmeland, H., & Ostamo, 1997). The study involved 15 centers from 13 European countries representing a total of 5 million population. All the parasuicide cases between 1989 and 1993 consulted in the research centers were included into the study. First analysis of the data reported the variation between different centers on the use of insecticides, chemicals, self-cutting and alcohol. And further analyses were on the age, gender and other socio-demographic detail variations in the study groups.

A community based national epidemiological survey was conducted regarding Non-suicidal self-injury in Australia on 12,006 people by Martin G et al in 2016. It was done as a part of Australian epidemiological study of self-injury (ANESSI) and those above 40 years of age were included into the analysis. 24.7% of them had history of NSSI in the past 12 months. Among those (n=78), majority of them were females (61.4%), who were married (58.9%) and had education up to high school (68.7%). In the population, history of NSSI, emotional regulation, impulsivity, psychological distress, Suicidal intent was assessed. It was seen that in older individuals with self-injury, the scores on psychological distress was high (OR 9.41, CI [1.73, 51.24]) and they tend to blame themselves (OR 8.23, CI [2.65, 25.50]). There was no significant difference in the socio-demographic and other parameters in those with self-injury and without self-injury.

A cohort study was conducted in Sri Lanka assessing the risk of suicide and repeat self-harm in rural areas of the country by Duleeka Knipe and colleagues (2019). In this study, 13 hospitals in the rural areas were followed up with self-harm surveillance team as a part of a randomized controlled trial. Total of 2945 patients with self-harm were followed up for duration of 3-5 years as a part of the study. Of the population, higher risk of repeat self-harm was found in men and those aged above 56 years and those who had poisoning as an attempt of self-harm. The study reported that the risk of suicide or repeat self-harm was low in those with low and middle income countries when compared to high income countries. There was 3.1% risk of repeat self-harm and 0.6% of death by suicide at the end of 12 months after presentation to hospital with index self-harm.

INDIAN STUDIES:

According to the latest survey by National Crime Record Bureau (NCRB) on accidental deaths and suicides in India (ADSI) over the decade from 2005-2015, All India average suicide rate was 10.6 per 1 lakh population with highest rate of suicides (43.2) from Puducherry in the year 2014. Considering the suicide rates in individual states, Maharashtra and Tamilnadu were seem to be having high rates continuously in the past 3 years with more than 10,000 suicidal deaths per year (11%-14%). Overall, it was noticed that there was an increasing trend of suicides in that decade by 17.3% (1,33,623 in 2015 from 1, and 13,914 in 2005). However no proper data was available for suicide attempts or self-harm attempts.

A prospective study was done in India by Ramdurg S et al (2011) on socio-demographic and clinical profile in suicide attempters in consultation- liaison psychiatry in AIIMS. Out of total 504 referrals for DSH, Majority of them were males, married, employed and from urban area. On assessment, around four-fifth (82%) individuals were diagnosed to have a psychiatric disorder, common being g emotionally unstable personality traits or disorder (24%) followed by schizophrenia or other psychotic disorders (20%) and affective disorders (19%). The method of the attempt was poisoning (corrosives or insecticides) in more than half of them.
Srivastava S. et al (2005) have done a cross-sectional study on suicidal ideation and attempts in patients with major depression in Varanasi. Patients between 16 and 60 with major depressive disorder were included into the study. 16.6% of them had suicide attempt with 20% of them having family history of psychiatric illness and 30% of them having prior self-harm attempt. In this study, unmarried men, married women, presence of agitation and paranoid symptoms, and severe suicidal ideation were found to be predictors for suicidal attempt in major depressive disorder.

Chakraborthy R et al (2010) conducted research on predictors of suicide attempt among those with depression in Indian sample. In this study, 75 consecutive patients with severe depression as per ICD-10 were included. The prevalence of attempted suicide in current episode was found to be 25.6%. On univariate regression analysis, HAM-D total score, early insomnia, lack of insight, past history of suicide attempt, unmarried factors found to have associated with increase suicide attempts. However, on multivariate analysis only lack of insight and suicide ideation were found to have significant association with suicide attempts.

MATERIALS AND METHODS

Study design: Analytical observational study

Study site The study was conducted in the department of Psychiatry at Chettinad Hospital, and Research Institute, Kelambakkam.

Study population The study population included patients with alcohol dependence syndrome or depression, visiting the psychiatry department. Study duration The data collection for the study was done from November 2017 to November 2018 for a period of 1 year.

Inclusion criteria

• All patients aged between 18-59 years with diagnosis of alcohol dependence syndrome (F10.2) or depressive disorder (F32 and F33), according to ICD-10 23.

• Both Inpatients and outpatients

• Subjects willing to give informed consent.

Exclusion criteria

• Patients with mental retardation & other psychiatric illnesses.

• Patients with mixed diagnosis of alcohol dependence & depression

• Patients unwilling to participate in the study.

Sample size & method The total sample size is 156 subjects per group. All the study subjects were recruited consecutively by convenient sampling, till the sample size is reached.

Study procedure Patients were carefully screened for ICD 10 diagnosis of Alcohol dependence syndrome or Depression and then interviewed using MINI (Mini international neuropsychiatric interview-6. 0) to rule out other psychiatric co-morbidities.

STATISTICAL ANALYSIS

Self-harm and DSHI interpretation were considered as primary outcome variables. Study group (Alcohol dependence syndrome or Depression) was considered as Primary explanatory variable. Age, Gender, Education, Occupation etc., were considered as other explanatory variables. Descriptive analysis was carried out by mean and standard deviation for quantitative variables, frequency and proportion for categorical variables. Non-normally distributed quantitative variables were summarized by median and inter-quartile range (IQR). Data was also represented using appropriate diagrams like bar diagram, pie diagram and box plots. All Quantitative variables were checked for normal distribution within each category of explanatory variable by using visual inspection of histograms and normality Q-Q plots. Shapiro-wilk test was also conducted to assess normal distribution. Shapiro wilk test p value of >0.05 was considered as normal distribution.

DATA ANALYSIS & INTERPRETATION

Table 1 :Description of the Illness characteristics in Alcohol Dependence Patients (N=156)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Mean ± SD</th>
<th>Minimum</th>
<th>Maximum</th>
<th>95% C.I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of onset of dependence</td>
<td>30.85 ± 7.85</td>
<td>16.00</td>
<td>55.00</td>
<td>29.60 - 32.09</td>
</tr>
<tr>
<td>Alcohol Units per day</td>
<td>14.94 ± 5.36</td>
<td>6.00</td>
<td>36.00</td>
<td>14.09 - 15.78</td>
</tr>
<tr>
<td>Years Of Alcohol Use</td>
<td>17.31 ± 8.19</td>
<td>1.50</td>
<td>44.00</td>
<td>16.02 - 18.61</td>
</tr>
</tbody>
</table>

In patients with Alcohol Dependence Syndrome (N=156), the mean age of onset of dependence was found to be 30.85 ± 7.85, with least age being 16 years and maximum 55 years. (95% CI 29.60 - 32.09). The mean of Average alcohol use was 14.94 ± 5.36 Units per day with minimum of 6U/day and maximum of 36U/day (95% CI 14.09 - 15.78). The mean duration of alcohol use (in years) was 17.31 ± 8.19 years with minimum 1.5 years and maximum duration of 44 years. (95% CI 16.02 - 18.61).

Table 2 : Illness characteristics in depressed individuals (N=156)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Mean ± SD</th>
<th>Minimum</th>
<th>Maximum</th>
<th>95% C.I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of onset (years)</td>
<td>33.63 ± 10.68</td>
<td>18.00</td>
<td>60.00</td>
<td>31.95 - 35.32</td>
</tr>
<tr>
<td>Duration of current episode (months)</td>
<td>8.48 ± 10.43</td>
<td>0.50</td>
<td>48.00</td>
<td>6.83 - 10.13</td>
</tr>
</tbody>
</table>

The mean age of onset in depressed individuals was $33.63 \pm 10.68$ years, with minimum age of 18 years and maximum 59 years (95% CI 31.95 to 35.32). The mean duration of current episode was $8.48 \pm 10.43$ months, minimum duration of 0.50 month and maximum 48 months (95% CI 6.83 to 10.13).

### Table 3: Comparison of self-harm with Education in ADS population (N=156)

<table>
<thead>
<tr>
<th>Educational Status</th>
<th>Self-harm</th>
<th>Chi Square Value</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>With SH (N=34)</td>
<td>Without SH (N=122)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>4(11.76%)</td>
<td>14(11.47%)</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>1(0.29%)</td>
<td>14(11.47%)</td>
<td></td>
</tr>
<tr>
<td>middle School</td>
<td>4(11.76%)</td>
<td>15(12.29%)</td>
<td></td>
</tr>
<tr>
<td>High school</td>
<td>18(52.94%)</td>
<td>48(39.34%)</td>
<td></td>
</tr>
<tr>
<td>Post high school diploma or intermediate</td>
<td>5(14.70%)</td>
<td>17(13.93%)</td>
<td>4.006</td>
</tr>
<tr>
<td>Graduate and Post-graduate</td>
<td>2(0.58%)</td>
<td>14(11.47%)</td>
<td></td>
</tr>
</tbody>
</table>

Among the alcohol dependence individuals with self-harm, majority (52.94%) of them had high school education, followed by 14.71% with post high school diploma and 11.76 % each of middle school and illiterates. The difference between education and Self-harm was statistically not significant (p-value – 0.549).

### Table 4: Comparison of self-harm with socio-economic status in Depressed individuals (N=156)

<table>
<thead>
<tr>
<th>Socio-economic status</th>
<th>Self-harm</th>
<th>Chi Square Value</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>With SH (N=31)</td>
<td>Without SH (N=125)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower</td>
<td>5(16.13%)</td>
<td>14(11.20%)</td>
<td></td>
</tr>
<tr>
<td>Upper lower</td>
<td>5(16.13%)</td>
<td>21(16.80%)</td>
<td></td>
</tr>
<tr>
<td>Lower middle</td>
<td>6(19.35%)</td>
<td>34(27.20%)</td>
<td></td>
</tr>
<tr>
<td>Upper middle</td>
<td>10(32.26%)</td>
<td>40(32.00%)</td>
<td></td>
</tr>
<tr>
<td>Upper</td>
<td>5(16.13%)</td>
<td>16(12.80%)</td>
<td></td>
</tr>
</tbody>
</table>

1.303 0.861
Among depressive individuals, in both the groups, most of them belong to Upper middle socio-economic status, followed by lower middle and the rest being relatively less. The difference between socio-economic status and self-harm was not statistically significant. (P-value – 0.861).

### Table 5: Type of self-harm in both the groups (N=65)

<table>
<thead>
<tr>
<th>Type of self-harm</th>
<th>ADS individuals (N=34)</th>
<th>Depressive Individuals (N=31)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hesitation cuts</td>
<td>8 (23.53%)</td>
<td>14 (45.16%)</td>
</tr>
<tr>
<td>Hanging</td>
<td>11 (32.35%)</td>
<td>5 (16.13%)</td>
</tr>
<tr>
<td>Poisoning or Tab overdose</td>
<td>8 (23.53%)</td>
<td>8 (25.81%)</td>
</tr>
<tr>
<td>Banging hand / head to wall</td>
<td>5 (14.70%)</td>
<td>2 (6.45%)</td>
</tr>
<tr>
<td>Cigar burns</td>
<td>3 (8.82%)</td>
<td>0</td>
</tr>
<tr>
<td>Attempt for emolition</td>
<td>0</td>
<td>2 (6.45%)</td>
</tr>
</tbody>
</table>

Among alcohol dependence individuals with self-harm, 11 (32.35%) of them had self-harm attempt by hanging, 8 (23.53%) of them each by hesitation cuts and poisoning or tablet overdose. Depressive individuals with self-harm, most of them attempted hesitation cuts (45.16%), rest by poisoning and hanging. Other types of self-harm attempts seen in the study population were banging head or hand to the wall, cigarette burns, attempting to emolliation.

**FINDINGS**

According to the report by Institute for Health Metrics and Evaluation (IHMC) for the past decade, self-harm is one of the top 20 causes of death accounting for 10.6% of total deaths. It is the 8th common cause for premature deaths in India accounting for 3.2%. Depression and alcohol use are two common psychiatric conditions causing disease burden globally and in low and middle income countries. According to Global Health Estimates (2015), Depression accounts for nearly one-third of the total disability adjusted life years (DALYs) caused by psychiatric conditions. Whereas alcohol accounts for 10% of total DALYs due to psychiatric illnesses. Presence of self-harm in these conditions, increase their disability that might cause in premature death.

Around half of the depressed individuals with self-harm had attempted by cutting self with sharp objects, while next common method was tablet overdose or poisoning seen in one-fourth of the individuals. Considering the total study population, the prevalence of self-harm attempts in those with ADS and depression in our study were 21.79% and 19.87% respectively. There is a variation of prevalence rates of self-harm in depressed individuals. For example, in a study by Al-Habeeb, along with patients with depression, those with bipolar disorder and postpartum disorder were also included. This can cause increase in the actual suicidal attempts, reducing the rates of NSSI in the sample.

In the present study, factors favoring self-harm in ADS individuals were younger age of dependence, married men with more quantity of alcohol and severe dependence of ADS. In depressed individuals, younger onset of
illness, unmarried and unemployed, first episode of depression and high severity of depression are the vulnerable people for self-harm.

CONCLUSION

Self-harm is a serious concern globally, which when not addressed can cause repeated attempts or even a fatal death which can be unintentional. Majority of those with self-harm attempts have an either unrecognized or under reported psychiatric illness which should be taken care of.

The current research is a hospital based cross-sectional study conducted in a tertiary care center with study population of 312 patients as per inclusion criteria. This study was aimed to assess the prevalence of self-harm in patients with alcohol dependence syndrome or with depression and further to evaluate the socio-demographic and clinical parameters associated with self-harm in these individuals.

The scales used in the study were MINI-6.0 for all the patients and HAM-D for the depressed individuals and SADQ for those with alcohol dependence syndrome. Self-harm attempts were assessed by deliberate self-harm inventory.

The study has revealed an equal prevalence of self-harm in those with ADS or depression and that younger age and more severe illness are risk factors for self-harm in both the groups. In ADS individuals, marriage can be a risk factor for Self-harm, whereas in depression, it is considered to be protective.

FUTURE RECOMMENDATIONS

1. There is a necessity to conduct more research in this area to provide better levels of evidences, which can create awareness in health care practitioners as well as policy makers, as considering the role of demographics as viable target for intervention of self-harm, in the long run, can help in reducing the occurrence of self-harm.

2. Further studies which are done longitudinally are required to establish the association among different variables.

3. General health professionals and primary health care practitioners need to be made aware of the prevalence of self-harm in these conditions, which can be brought to notice to a psychiatric consultant for further evaluation and management of the same.

4. Presence of self-harm at different time intervals and at various levels during the illness period can be done to know the actual burden of self-harm at particular phase of illness and to understand an individual’s thought process to self-harm in a vivid manner.

REFERENCES


