

Psycho-Social Assessment of Participants in ICU with Deliberate Self Harm: An Observational Study

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ABSTRACT

Objectives: To assess the socio demographic profile, prevalence of psychiatric disorders, methods employed and significant life events among the participants of deliberate self harm (DSH) admitted in the intensive care unit (ICU) of a tertiary care hospital. **Methods:** After taking approval from the institutional ethics committee and obtaining a written informed consent, forty participants of DSH, admitted in the ICU were recruited for the study. A specially designed semi structured Performa was used to collect the socio-demographic details, DSM- IV-TR criteria was used to identify the mental health disorders, The Explanatory Model Interview Catalogue (EMIC) was used to identify the distress and Presumptive Life Stress Event Scale was used to identify the significant life events among the recruited subjects of DSH. **Results:** The mean age of the study group (n=40) was 29.4 yrs with the females constituting the majority (53.3%). Majority of the subjects were married (50%). Psychiatric disorders were identified among 53.3% of the subjects with depression constituting the major diagnosis. Depression was followed by alcohol dependence and adjustment disorder contributing 10% each. Most common method employed for DSH was poisoning (90%) followed by hanging (6.6%) and slitting of wrist (3.3%). Among half of the subjects, significant contributory life events had occurred within last 6 months with marital conflict being the commonest (13%). **Conclusions:** Psychiatric disorders are very commonly present among the participants of deliberate self-harm. Marriage and gender do not play a significant role in DSH. The life events leading to the deliberate self harm were influenced by the traditional gender roles. Poisoning is the commonest method of DSH.

Keywords: *Psycho-social Assessment, Deliberate Self Harm (DSH)*

The term deliberating self-harm is commonly used to describe a wide range of behaviours and intentions including attempted hanging, impulsive self-poisoning, and superficial cutting in response to intolerable tension. Pattison and Kahan first described 'deliberate self-harm' as a syndrome in 1983 [1]. Other names have also been used to refer to this behavior, including moderate self-mutilation [2], deliberate self-injury, self-wounding [3] and parasuicide [4]. Deliberate self-harm can be defined as the intentional and direct injuring of one's body tissue without suicidal intent [5, 6]. Deliberate self-harm (DSH) is a serious mental health problem in Society [7]. Deliberate self-harm (DSH) is becoming more common [8, 9] and is associated

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with significant risk of suicide [10,11]. One of the predictors for suicide is previous deliberate self-harm [12]. Although suicide is not the intention of self-harm, the relationship between self-harm and suicide is complex, as self-harming behaviour may be potentially life-threatening [13]. As mentioned in W.H.O. (2014) report “The distressing feature of DSH is the high frequency of occurrence of suicide most suicides in the world occur in the South-East Asia Region with India accounting for the highest estimated number of suicides overall in 2012. This report shows 258,075 people committed suicide in India in 2012, with 99,977 women and 158,098 men taking their own lives. India’s suicide rate was 21.1 per 100,000 people, according to the report. This report do not include the suicidal attempts which are about 20 times more common than the completed suicide and is estimated to be around 10 – 20 million per year [14]. In another study The World Health Organization estimates that, as of 2010, 880,000 deaths occur as a result of self-harm [15].

Self-poisoning, the most common form, comprises a substantial part of the work of hospitals and mental health services [16]. It has been estimated that 1.2–5% of all medical admissions to general hospitals are for deliberate self-poisoning (DSP) [17, 18]. Deliberate self-poisoning accounted for 1.2% of one emergency department’s workload [19]. In the UK, DSH is one of the top five causes of acute hospital admissions for both men and women [20], and accounts for 15–20% of the workload of medical units and 10% of emergency departments [21]. People who self-harm are at higher risk of repeated episodes and of suicide [22]. One-third of accident and emergency (A & E) participants who deliberately take an overdose are not admitted to hospital, and this proportion is increasing [23].

DSH is a result of complex interaction between the biological, psychological, and social factors but psycho social factors are very important in cases of DSH. The social circumstances are also important including those who are isolated or living in areas of socioeconomic deprivation have increased rates of suicide and suicide attempters [24]. Frequently, the type of events experienced by younger people is related to relationship difficulties, but in older people it is more likely to be health or bereavement related [25]. Vulnerability factors such as early loss or separation from one or both parents, childhood abuse, unemployment, and the absence of living in a family unit are contributory. Many participants consider that their problems are insolvable and although self-harm is an immediate but not long-term response, they often cannot think of any other way out of their situation at that time [26]. It is more meaningful to understand self-harm in terms of psychosocial theories, self-harm can be viewed as a coping strategy for feelings resulting from inter-personal difficulties and life events. Although self-harm is multifactorial, the combination of feeling helpless, hopeless and trapped or neglected seems to underpin the diverse and complex reasons why people self-harm. As there are many models for understanding self-harm, these have inspired a wide variety of treatment methods. Treating participants who self-injure presents a number of challenges for therapists. Self-injury may cause psychological distress to the patient and his or her loved ones, and can result in physical damage that requires medical treatment or even leads to death. In addition, participants who self-injure may be hospitalized against their will, even though some mental professionals fear this intervention may damage the therapeutic relationship and may not be helpful for these participants [27].

Admission to a psychiatric ward occurs for around 10% of people treated by accident and emergency staff following self harm [28] and this is often to prevent further self harm or attempted suicide [29]. Additionally, inpatient care may also provide a therapeutic

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environment which can help to promote recovery [30]. There are several factors which are responsible for DSH. Some researcher claim gender, some history of drug and alcohol misuse, some psychiatric illness and some stressful life events.

Present study is a trail to explore the socio-demographic factors with deliberating self harm.

Statement of the Problem: Is deliberating self harm associate with psychosocial factors?

Objectives of the study

- Socio-demographic profile of patient admitted to ICU for DSH.
- Prevalence of psychiatric disorder in these participants.
- Significant life event in association with attempt.
- Different methods used in DSH

Hypotheses

H1: Socio-Demographic profile of patient admitted to ICU is more prone to DSH.

H2: Psychiatric disorders prevalence is exist in DSH participants.

H3: Life event of Participants increases the risk of DSH attempt.

H4: The commonest method of DSH is self poisoning.

MATERIALS AND METHODS

This is an observational study was undertaken to study the psycho-social assessment of participants with deliberate self-harm among the participants admitted in intensive care unit of Various Hospitals of Indore District. A total of 40 cases of who attempted DSH and admitted in ICU during study were included in this study. The clearance from institutional ethical committee was obtained before starting the study. An informed and bilingual consent was obtained from each patient. Data was analyzed using descriptive analytical methods.

All the subjects underwent thorough physical examination. After getting voluntary informed consent the data was collected in specially designed semi- structured Performa. The data pertaining to socio-demographic characteristics, clinical features and information regarding the attempts was gathered and recorded. The diagnosis was based on diagnostic criteria of DSM-IV-TR [31a]. History of the patient was recorded in a semi-structured history form. Focus was on psycho-social aspects of attempted suicide. The detail records of attempts and method of those attempts was also recorded. The diagnosis was reviewed as per DSM-IV-TR [31b] checklist. The review of diagnosis involved interview from patient and their care givers. Participants were rated as per Explanatory Model Interview Catalogue (EMIC) guidelines related to suicide attempt by Parker and Weiss [32]. For life events, Presumptive Stressful Life Events Scale (PSLE), Singh et al scale [33] was used. The data thus obtained was compiled and analyzed.

RESULTS

All the suicide survivors participants agreed for this study who were admitted in ICU for DSH and who survived after DSH, all the consecutive thirty participants agreed to participate in the study thus the Overall response rate was 100%. Statistical analysis of socio-demographic data shows particular heading wise that-

I. Socio-demographic profile of patient admitted to ICU for DSH-

H1: Socio-Demographic profile of patient admitted to ICU is more prone to DSH. This hypothesis is not rejected

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Sex and Marital Status-

Sex	Sample	Mean Age (In Years)	Married	Unmarried	Divorced
Male	42.5 %	30.9	47.06 %	35.29 %	17.64 %
Female	57.5 %	27.9	56.57 %	34.78 %	8.65 %

There was a female and male preponderance was 57.5 % and 42.5 % respectively in the study. The mean age was 30.9 years and 27.9 years respectively male and female participants. 52.50 % participants were married, 35 % were unmarried and 12.50 % were divorced. Results revealed that male and female who were married were more prone to DSH in comparison of unmarried male and female, but divorced male are more prone to DSH in comparison of Divorced female.

Education, Employment And Religion-

Education and Employment 48 % of male participants were occupied and rests of all were struggling for the job and 36.84 % of female participants were in job, 15.79 were students and others were unemployed. Majority of the participants were primary educated that is 60%, were those participants who did graduation were 37%, and 3% were illiterate. Majority of the participants belonged to Hindu religion (60%), Buddhist 13 % Muslim 10%, Sikh 8 %, Christen 7 %, Parsi 2%.

II. Prevalence of psychiatric disorder in these participants-

H2: Psychiatric disorders prevalence is exist in DSH participants, this hypothesis is not rejected.

As we found that Psychiatric diagnosis was observed in 73.33 % participants out of which, depression was the major diagnosis seen in 40.91 % followed by alcohol dependence (27.27 %), adjustment disorder (18.18 %) and borderline personality disorder (13.67 %). No psychiatric diagnosis was seen in 26.67 % of the total subjects. Life events related traditional gender roles were seen to be more significantly affecting suicidal attempt. Within the last 6 months 50% of the contributory life events had occurred. Marital conflict (13%) ranked maximum points of age among the contributory life events followed by financial problem and family conflict 12% each, unemployment, job and finance 9%, conflicts in love and academic failure 9% each, 36% of the participants did not reveal any factors. Prior help seeking from close family members was significant in females, while those from friends were more common in males.

Table-01 “Common Psychiatric Diagnosis in DSH participants”

Serial Number	Diagnosis	% of Participants
01	Depression	40.91
02	Alcohol Dependence Syndrome (ADS)	27.27
03	Adjust Disorder	18.18
04	Borderline Personality	13.67

III. Significant life event in association with attempt-

H3: Life event of Participants increases the risk of DSH attempt.

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Result reveal that stress full life event found positively correlates with DSH although it was observed that all participants who were admitted in ICU ,they has poor problem solving attitude toward stressful life event, which lead to deliberating self-harm.

IV. Different methods used in DSH-

H4: The commonest method of DSH is self poisoning, this hypothesis is not rejected.

As we found that most common method of DSH was self poisoning (90 %), followed by hanging (6.6%) and slitting of wrist (3.3%). Poisoning was the most common method used by both genders.

Serial Number	Method use for DSH	Proportion of Sample
01	Self Poisoning	90 %
02	Hanging	6.6 %
03	Slitting of Wrist	3.3 %

Hence this study presents a clear picture of our study i.e.

- I. Socio-demographic profile is responsible for DSH.
- II. Prevalence of psychiatric diagnosis is found significant in DSH patient. Depression is one of common psychiatric diagnosis in participants admitted in ICU for DSH.
- III. Alcohol Dependence was the second big diagnosis in participants of DSH.
- IV. Adjustment disorders and Borderline personality disorder also presented as an independent diagnosis.
- V. Stress full life event found positively correlates with DSH.
- VI. Comments method of DSH was self poisoning.

Discussion and Interpretation-

The main goal of present study was to examine that is deliberating self harm associated with psychosocial factors. Results indicated that psychosocial factors are closely associated with deliberating self harm.

An explanation for these findings may be that important clinical observations were made but usually not recorded properly. Leaving aside the legal inadvisability of this, it seems unlikely that a doctor would ask important questions for treatment purpose and then not record the answers at documentation level.

The more likely explanation is that the recommended assessment was not made as we have found that psychosocial factor is responsible for DSH.

Socio-demographic Data and DHS

There were mixed findings regarding sex differences and deliberating self harm but Sexual difference found an important demographic factor in incident of DSH, as we found that female are more prone to DSH[34,35,36,37,38,39] and mean of the age was 27.9 years But in other studies researchers found contradictory results [40,41,42,43]. In general, studies that gave a descriptive account of the gender of people who self harmed during an admission reported more women than men, however case control studies which conducted a statistical analysis of this data found no significant associations between gender and self harm [44^a,45,46,47,48].

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The results of present study indicate that married females are found more prone to DSH than married Males but other studies suggested that there is no significance difference between married and non-married participants who were admitted in hospital due to DSH [44^b, 49]

While in case of divorced, males are more prone to DSH than female and same results found in case of unmarried male. In many studies Educational status were also recorded as an important demographical factor with the people who were admitted in ICU due to DSH. Studies state that having a high school qualification predicted a suicide attempt during an admission [50] ,But another studies state that those who self harmed during their admission were significantly.

More likely to have no educational qualifications (81% vs 47%), however were not less likely to be in employment [44^c]. Occupational stress also found with those who self harmed during their admission in ICU, in present study.

Majority of participants who were admitted in ICU due to DSH, were belongs from Hindu Community in present study, an explanation of this finding may be that the hospital is situated at Hindu dominating area but there is a need to investigate this factor under control trail.

Psychiatric Diagnosis and DSH

People with DSH who present to hospital have a high rate of psychiatric co-morbidity: major depression, 8–62%; dysthymia, 3–35%; substance misuse or dependence problems, 10–46%; and schizophrenia, up to one-quarter [51]. Alcohol abuse [52, 53] and Substance misuse, dependence and withdrawal are associated with self-harm [54, 55]. In India suicide attempts are more common in females of whom majorities were Hindus, married, and the suicide rate is three times higher in rural areas than the overall national rate. Majorities were staying in a nuclear family and they were unemployed [56].

As per results psychiatric co-morbidity and stress full life events were found in the participants of Deliberating Self Harm [57, 58] but recommended assessments were not made in the large majority of cases. They didn't refer to psychiatric ward or psychiatric unit for further assessment. How important is this? We do not know for certain whether discharged participants do worse than those admitted .However, the increasing number of participants being discharged straight from the ICU, means that mistakes are more likely to occur in the form of second episode of deliberating self harm [59].

The most common method was found self poisoning in our research which is supported by earlier researches data [60, 61, 62] as incidents correlated with psychosocial factors. These incidents positively found correlated with psychopathology, past suicidal behaviours, hopelessness, MDD, Isolation, and suicidal ideation [63, 64, 65, 66]. So it is highly recommended that psychiatric assessment should be done on mandatory level of all participants of DSH in ICU for preventing other episode.

Life event and DSH

In present study, we found that Life event also associated with DSH. The findings from the majority of studies suggest that there is an association between Life event and self harm [67, 68, 69].

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Method used in DSH

Self Poisoning was identified as the most commonly used method in present study. 90 % of participants use this method but Cutting was found most commonly used method in other studies [70,71,72,73,74]

CONCLUSION

Early identification of symptoms and timely intervention is one of the best preventive measures on self-harm and suicidal behaviors. Overall it seems that the physical treatments have limited impact on self-harm behaviour. This may be because, whilst psychological factors may have a biological signature, pharmacological treatments do not directly address the many psycho-social reasons why people self-harm. Whilst traditional psychiatry tends to rely heavily on these interventions, because of their limited impact, the search for adequate treatment methods has widened to include psychological and social interventions. With the help of psychological intervention and screening in such type population we can stop another incident of Deliberating self harm.

CLINICAL IMPLICATIONS

In this study Psychiatric disorders were seen. Therefore they need careful screening for psychiatric symptoms. 40.91 % of DSH participants have depressive affect and range was restricted, therefore immediate treatment was required in the form of psychotherapy and psychopharmacological intervention. Therefore treatment with psychotherapy and psychopharmacological intervention may often be indicated for these participants which would be lifesaving.

The intervention program should be including the Psychoeducation to the participants as well as relatives or care givers of participants because Social Support is an essential tool for Preventing another incidents of DSH. So treatment should not be limited till medication it should be extended with counselling to the participants and their care givers. In this study 50 % DSH participants have Predisposing factors and may need social support after they are discharged from ICU by involving multiple agencies.

LIMITATIONS

This was an observational study and the cases admitted in the ICU may not be representative of the actual population. There may have been a small bias towards participants with somewhat greater psychopathology being included in the study sample. Sample size was small, which indicated sample error statistically. Hence the results of studies cannot be generalized.

Psychiatric disorder was assessed using a structured clinical diagnostic schedule which may have influenced the reporting of symptoms and should be cross checked by the relatives of patient.

REFERENCES

1. Pattison EM, Kahan J. The deliberate self-harm syndrome. *Am J Psychiatr.* 1983;140:867-72.
2. Favazza and Rosenthal (1993), In Gournay, K. & Bowers, L. 2000, "Suicide and self-harm in in-patient psychiatric units: a study of nursing issues in 31 cases", *Journal of Advanced Nursing*, vol. 32, no. 1, pp. 124.

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3. TANTAM, D., & WHITTAKER, J. (1992) Personality disorder and self-wounding. *British Journal of Psychiatry*, 161, 451–464.
4. Ogundipe (1999) In Gournay, K. & Bowers, L.(2000) "Suicide and self-harm in in-patient psychiatric units: a study of nursing issues in 31 cases", *Journal of Advanced Nursing*, vol. 32, no. 1, pp. 124-131.
5. Herpertz (1995) In Beer, D. M., Muthukumaraswamy, A., Khan, A. A., & Musabbir, M. A. Clinical characteristics of participants with self harming behaviour in a low secure mental health unit. *Journal of Psychiatric Intensive Care* 6, 15-21. 2010
6. Muehlenkamp (2005) In Beer, D. M., Muthukumaraswamy, A., Khan, A. A., & Musabbir, M. A. Clinical characteristics of participants with self harming behaviour in a low secure mental health unit. *Journal of Psychiatric Intensive Care* 6, 15-21. 2010
7. Mellon,G. (2008).In Rajput, J ., Awasthi,S., Dwivedi,S.K. (2011).Impact of Yoga on depression. *Shodh Dhara*,16(4),77-83
8. Howton,K., Fagg,J., Simkin,S.,et al (1997).Trends in deliberated self-hram in oxford,1985-1995.Implications for clinical services and the prevention of suicide. *British Journal of Psychiatry*,171,556-560.
9. Kapur,N., House,A., Creed,F.,et al (1998).Management of deliberate self –poisoning in adults in four teaching hospitals: descriptive study, *British Journal of Psychiatry*,316,831-32.
10. Howton,K. & Fagg.J. (1988).Suicide, and other causes of death, following attempted suicide. *British Journal of Psychiatry*,152 ,359-66.
11. Nordentoft,M. & Rubin,P. (1993). Mental Illness and social integration among suicide attempters in copenhagen.*Acta psychiatric Scandinavica*,8,278-85
12. Nordentoft M, Breum LK, Nordestgaard AG, Hunding A, Bjaeldager PAL. (1993).High mortality by natural and unnatural causes: a 10 year follow up study of participants admitted to a poisoning treatment centre after suicide attempts. *BMJ*. 306:1637-41).
13. Farber, S. et al. (2007), "Death and annihilation anxieties in anorexia nervosa, bulimia, and self-mutilation", *Psychoanalytic Psychology* 24 (2): 289–305, doi:10.1037/0736-9735.24.2.289
14. World Health Organization (2014). Suicide prevention (SUPRE). [cited 2014 January 20th] Available from URL: http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/
15. Lozano,R (2012). “Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease study 2010. *Lancet* 380 (9859), 2059-128.doi:10.1016/S0140-6736(12)61728-0.PMID 23245604.
16. Boyce PM, Ellis P, Penrose-Wall J.(2003). Introduction to the Royal Australian and New Zealand College of Psychiatrists clinical practice guideline series. *Australian and New Zealand Journal of Psychiatry*; 37: 637–640.
17. Pond S.(1995). Prescription for poisoning. *Medical Journal of Australia*; 162:174–175.
18. McGrath J. (1989). A survey of deliberate self poisoning. *Medical Journal of Australia*; 150:317–322.
19. Hall AK, Curry C. Changing epidemiology and management of deliberate self poisoning in Christchurch. *New Zealand Medical Journal* 1994; 107:396–399
20. House A, Owens D, Patchett L. Deliberate self harm. *Effective Health Care* 4. York: University of York, NHS Centre for Reviews and Dissemination, 1998; 1–11.

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21. Greaves I, Goodacre S, Grout P. Management of drug overdose in accident and emergency departments in the United Kingdom. *Journal of Accident and Emergency Medicine* 1996; 13:46–48.
22. Owens D, Horrocks J, House A. Fatal and non-fatal repetition of self-harm: systematic review. *British Journal of Psychiatry* 2002; 181:193–199.
23. Ebbage, J., Farr, C., Skinner, F., White, P. (1994). The psychosocial assessment of participants discharged from accident and emergency departments after deliberate self-poisoning. *Journal of the Royal Society of Medicine*, 87, 515
24. Gunnell DJ, Peters TJ, Kammerling RM, Brooks J. Relation between parasuicide, suicide, psychiatric admissions, and socio-economic deprivation. *BMJ*. 1995; 311:226–30.
25. De Vanna M, Paterniti S, Milievich C, Rigamonti R, Sulich A, Faravelli C, et al. Recent life events and attempted suicide. *J Affect Disord*. 1990;18:51–8.
26. Milnes D, Owens D, Blenkinsop P. Problems reported by self-harm participants: Perception, hopelessness, and suicidal intent. *J Psychosom Res*. 2002;53:819–28
27. Huband, N., & Tantam, D. (1999). Clinical management of women who self-wound: A survey of mental health professionals' preferred strategies. *Journal of Mental Health*, 8, 473–487.
28. Gunnell et al., (2004) In Gunnell, D., Hawton, K., Ho, D., Evans, J., O'Connor, S., Potokar, J., Donovan, J., & Kapur, N. 2008, "Hospital admissions for self harm after discharge from psychiatric inpatient care: cohort study", *British Medical Journal*, vol. 337, no. nov18 3, p. a2278.
29. Ziegenbein, M., Anreis, C., Brüggen, B., Ohlmeier, M., & Kropp, S. 2006, "Possible criteria for inpatient psychiatric admissions: which participants are transferred from emergency services to inpatient psychiatric treatment?", *BMC Health Services Research*, vol. 6, no. 1, p. 150.
30. Cutcliffe, J. R., Stevenson, C., Jackson, S., & Smith, P. 2007, "Reconnecting the person with humanity", *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, vol. 28, no. 4, pp. 207-210.
31. Boyce PM, Ellis P, Penrose-Wall J. (2003). Introduction to the Royal Australian and New Zealand College of Psychiatrists clinical practice guideline series. *Australian and New Zealand Journal of Psychiatry* ;37: 637–640.
32. Greydanus DE, Shek D (September 2009), "Deliberate self-harm and suicide in adolescents" *Keio J Med* 58 (3): 144–51, doi:10.2302/kjm.58.144, PMID 19826208
33. Bell M; O'Doherty E, O'Carroll A, McAnaney B, Graber S, McGale B, Hutchinson D, Moran P, Bonner B, O'Hagan D, Arensman E, Reulbach U, Corcoran P, Hawton K (21 January 2010), "Northern Ireland Registry of Deliberate Self-Harm Western Area, Two year report. January 1st 2007–31 December 2008" (PDF), *Health and Social Care in Northern Ireland* (Northern Ireland: CAWT)
34. Ballinger, B. (1971). Minor Self-Injury. *British Journal of Psychiatry* [118], 535-538.
35. Beasley, S. (1999). Deliberate self harm in medium security. *Nursing Management*. 6[8], 29-33.
36. Burrow, S. (1992), "The deliberate self-harming behaviour of participants within a British special hospital", *Journal of Advanced Nursing*, vol. 17, pp. 138-148.
37. Modestin, J. & Kamm, A. 1990, "Parasuicide in psychiatric inpatients: Results of a controlled investigation.", *Acta Psychiatrica Scandinavica*, vol. 81, no. 3, pp. 225-230.
38. Pao, P.-N. 1969, "The syndrome of delicate self-cutting", *British Journal of Medical Psychology*, vol. 42, no. 195, pp. 867-872.

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39. Phillips, R. H. & Alkan, M. 1961, "Some aspects of self-mutilation in the general population of a large psychiatric hospital", *Psychiatric Quarterly*, vol. 35, pp. 421-423.
40. Callias, C. G. & Carpenter, M. D. 1994, "Self-injurious behavior in a state psychiatric hospital", *Hospital & Community Psychiatry*, vol. 45, no. 2, pp. 170-172.
41. Gournay, K. & Bowers, L. 2000, "Suicide and self-harm in in-patient psychiatric units: a study of nursing issues in 31 cases", *Journal of Advanced Nursing*, vol. 32, no. 1, pp. 124-131.
42. Myers, K. & Dunner, D. 1984, "Self and other directed violence on a closed acute care ward", *Psychiatric Quarterly*, vol. 56, pp. 178-188.
43. Sweeny, S. & Zamecnik, K. 1981, "Predictors of self-mutilation in participants with schizophrenia", *American Journal of Psychiatry*, vol. 138, pp. 1086-1089.
44. ^{a,b,c} Beer, D. M., Muthukumaraswamy, A., Khan, A. A., & Musabbir, M. A. (2010). Clinical characteristics of participants with self harming behaviour in a low secure mental health unit. *Journal of Psychiatric Intensive Care* 6, 15-21.
45. Bowers, L., Simpson, A., & Alexander, J. 2003, "Patient-staff conflict: Results of a survey on acute psychiatric wards", *Social Psychiatry & Psychiatric Epidemiology.*, vol. 38, no. 7, pp. 402-408.
46. Callias, C. G. & Carpenter, M. D. 1994, "Self-injurious behavior in a state psychiatric hospital", *Hospital & Community Psychiatry*, vol. 45, no. 2, pp. 170-172.
47. Karson, C. & Bigelow, L. 1987, "Violent behaviour in schizophrenic inpatients", *Journal of Nervous Mental Disorders*, vol. 175, pp. 161-164.
48. Myers, K. & Dunner, D. 1984, "Self and other directed violence on a closed acute care ward", *Psychiatric Quarterly*, vol. 56, pp. 178-188.
49. Hillbrand, M., Krystal, J. H., Sharpe, K. S., & Foster, H. G. 1994, "Clinical predictors of self-mutilation in hospitalised forensic participants", *Journal of Nervous and Mental Disease*, vol. 182(1),pp9-13.
50. Spiebl, H., Hubner-Liebermann, B., & Cording, C. 2002, "Suicidal behaviour of psychiatric in-patients", *Acta Psychiatrica Scandinavica*, vol. 106, pp. 134-138.
51. National Treatment Agency for Substance Misuse (2007). "Drug misuse and dependence – UK guidelines on clinical management" (PDF). United Kingdom: Department of Health.
52. Rossow, I.; Hawton, K.; Ystgaard, M. (2009). "Cannabis Use and Deliberate Self-Harm in Adolescence: A Comparative Analysis of Associations in England and Norway". *Archives of Suicide Research* 13 (4): 340–348. doi:10.1080/13811110903266475.PMID 19813111.
53. Ramdurg S, Goyal S, Goyal P, Sagar R, Sharan P, Socio-demographic profile, clinical factors and mode of attempt in suicide attempters in consultation liaison with psychiatry in a tertiary care centre, *Ind psychiatry J*: 2011: 20(1):11-6.
54. Nock, M., Joiner, T. E., Gordon, K. H., Lloyd-Richardson, E., & Prinstein, M. J. (2006), Non-suicidal self-injury among adolescents: diagnostic correlates and relation to suicide attempts. *Psychiatry Research*. 144(6), 5-72
55. Ramleth, Ruth-Kari & Groholt, Berit & Diep, Lien & Walby, Fredrik & Mehlum, Lars. (2017). The impact of borderline personality disorder and sub-threshold borderline personality disorder on the course of self-reported and clinician-rated depression in self-harming adolescents. *Borderline Personality Disorder and Emotion Dysregulation*. 4.10.1186/s40479-017-0073-5

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56. Ebbag et al. (1994).In Nock, M.,Joiner,T.E., Gordon,K.H., Lloyd-Richardson,E., & Prinstein, M.J. (2006), Non-suicidal self-injury among adolescents: diagnostic correlates and relation to suicide attempts.Psychiatry Research.144(6),5-72
57. Owens DW, Jones SJ. The accident and emergency department management of deliberate self-poisoning. Br J Psychiatry 1988; 152:830-3
58. Ramdurg S, Goyal S, Goyal P, Sagar R, Sharan P, Socio-demographic profile, clinical factors and mode of attempt in suicide attempters in consultation liaison with psychiatry in a tertiary care centre, Ind psychiatry J: 2011: 20(1):11-6.
59. Kapur,N.,House,A.,Creed,F.,et al (1998).Management of deliberate self –poisoning in adults in four teaching hospitals: descriptive study, *British Journal of Psychiatry*,316,831-32.
60. Fishcer,G., Brunner,R., Parzer,P., Klug,K., Durkee,T., Carli,V., Wasserman,D., Vonderlin, E., Resch,F., Kaess,M., (2012).Depressiona, Delibrating self-harm and suicidal behaviour in adolescents engaging in risky and pathological internet use. *Prax Kinerpsyhol kinderpsychiatr*;61(1):16-31
61. Jacobson,C, M.,Muehlenkamp, J,J., Miller, A,L., Turner,J,B.(2008). Psychiatric Impairment among adolescents engaging in different types of deliberating self-harm. *Journal of Clinical Child & Adolescent Psychology*, 37 (2), 363-375.
62. Garrison, C.A., Cheryl,L.A., McKeown., R.E.,Cuffe, S.P., Jackson, K.L., & Waller, J.L. (1993).Nonsuicidal physically self-damaging acts in adolescents. *Journal of child and family studies*,2,339-352
63. Gould,M.,Greenberg,T., Velting,D.M.,Shaffer,D. (2003)Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American academy of Child & Adolescent Psychiatry* ,42,386-405
64. Roaldset, J. O. B. S. Participants' own statements of their future risk for violent and selfharm behaviour: A prospective inpatient and post-discharge follow-up study in an acute psychiatric unit. *Psychiatry Research* 178, 153-159. 2010.
65. Rogers, P., Watt, A., Gray, N. S., MacCulloch, M., & Gournay, K. 2002, "Content of command hallucinations predicts self-harm but not violence in a medium secure unit", *Journal of Forensic Psychiatry.*, vol. 13, no. 2, pp. 251-262.
66. Mannion, A. 2009, "Self-harm in a dangerous and severely personality disordered population", *Journal of Forensic Psychiatry & Psychology*, vol. 20, no. 2, pp. 322-331.
67. Plutchik, R.1995, 'Outward and inward directed aggressiveness: The interaction between violence and suicidality. *Pharmacopsychiatry* 28, 47-57.
68. Swinton, M. & Hopkins, R. 1996, "Violence and Self-injury", *Journal of Forensic Psychiatry*, vol. 7, no. 3, pp. 563-569.
69. Ehmann,T.S.,Smith,G.N.,Yamamoto,A.,McCarthy,N.,Ross,D.,Au,T.,Flynn,S.W.,Alt man,S., & Honer, W.G. 2001, "Violence in treatment resistant psychotic inparticipants", *Journal of Nervous & Mental Disease.*,vol.189 (10),716-21
70. Beasley, S. 1999, 'Deliberate self harm in medium security. *Nursing Management*. 6(8),29-33
71. Brown, S. & Bass, N. 2004, "The psychiatric intensive care unit: patient characteristics, treatment and outcome", *Journal of mental Health*, vol. 13, no. 6, pp.601-609.
72. Burrow, S. 1992, "The deliberate self-harming behaviour of participants within a British special hospital", *Journal of Advanced Nursing*, vol. 17, pp. 138-148.

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73. Low, G., Terry, G., Duggan, C., MacLeod, A., & Power, M. 1997, "Deliberate selfharm among female participants at a special hospital: an incidence study", *Health Trends*, vol. 29, (1),6-9
74. Low, G. J. D. a. D. C. The treatment of deliberate self harm in borderline personality disorder using dialectical behaviour therapy: A pilot study in a high security hospital. *Behavioural and Cognitive Psychotherapy* 29, 85-92. 2001.

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Conflict of Interest

There is no conflict of interest.

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