# Characteristic of Self-Harm Behaviour among Psychiatric Patients Visiting Outpatients Prof. HB Saanin Mental Hospital in Padang, Indonesia

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**Submission date:** 22-Jul-2023 03:33PM (UTC+0800)
**Submission ID:** 2134905238
**File name:** atients_Prof._HB_Saanin_Mental_Hospital_in_Padang,_Indonesia.pdf (230.73K)
**Word count:** 4231
**Character count:** 23955

AMJ
ISSN: 0005-2523

ISSN: 0005-2523
Volume 62, Issue 09, November, 2022

# Characteristic of Self-Harm Behaviour among Psychiatric Patients Visiting Outpatients Prof. HB Saanin Mental Hospital in Padang, Indonesia

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**Keywords:**
self-harm; self-injury; borderline personality disorder

**ABSTRACT**

Self-harm is a person's behavior who intentionally injures his body in various ways without any suicidal intent. Self-harm behavior can include slicing the skin with a razor or other sharp object, burning the body, hitting oneself, picking at scars, pulling hair, and consuming toxic substances. People with self-harm behavior are at high risk of committing suicide. Self-harm behavior is an attempt to escape from emotional pain. The purpose of the study was to determine characteristic of self-harm behaviour among psychiatric patients visiting outpatients Prof. HB Saanin Mental Hospital in Padang, Indonesia. The research used a descriptive study with a cross-sectional approach. The research instrument is Self-Harm Inventory (SHI), using a sample of 104 respondents with a consecutive sampling technique. The results showed that most respondents were in the age range of 36-45 years (35.6%), male (55.8%), single (49%) and homemakers (28.8%). More than half of patients had senior high school education (54.8%) and diagnosed with schizophrenia (67.3%). Most respondents are in the category of mild self-harm (78.8%), and the most self-harm behavior method is thoughts of attacking oneself. The study concludes that patients in the clinical population (with mental disorders) have self-harm behavior.



## 1. Introduction

Self-harm is a person's behavior who intentionally injures his body in various ways without any suicidal intent. This term, also called self-injury, deliberate self-harm, self-mutilation or non-suicidal self-harm (NSSI) [1], [2]. According to its form, the severity of self-harm is categorized into mild, moderate, and severe. Mild forms of self-harm include hitting oneself, squeezing wounds, and banging the head, while moderate/severe forms of self-harm include cutting, carving one's skin, burning, and substance abuse [3]. People with self-harm are at high risk of committing suicide [4]. A history of self-harm is the strongest risk factor for suicide. Higher severity, more varied morphology, and longer duration of self-harm were associated with increased suicide risk. The belief that the ability to commit suicide is acquired through self-harm and that past experiences of self-harm may facilitate serious death [5].

Risk factors for self-harm are complex interplay of biological, psychological, and environmental factors. Psychological factors include depression, anxiety, emotional dysregulation, personality disorders and aggression. Environmental factors include exposure to life-threatening events such as sexual abuse, violence, early parental separation, bullying, family/parent conflict, and school problems [6]. Self-harm behaviors are attempts at emotional and social regulation. Perpetrators of self-harm will feel their emotional pain will be reduced by self-harm. This behavior is also an attempt to gain social support or eliminate some undesirable social situation [7]. Victimization of bullying is associated with self-harm. The risk of self-harm was six times higher for "bully-victims", five times higher for victims of bullying, and three times higher for bullies [6].

Self-harm behavior can be found in the general population but often in adolescents and patients with mental disorders. Self-harm begins in early adolescence, usually between the ages of 12 and 14. Meta-analytical studies have reported a 2.9-69.6% lifetime prevalence of self-harm in children and adolescents. [8] a systematic review gives an overview of the prevalence self-harm are 7.5–46.5% in adolescents, 38.9% in university students and 4–23% adults. [9] studies conducted in the united states and the united kingdom found that adults who intentionally self-injure have a suicide rate 30 times higher than the general population. Based on a survey made by yougov omnibus, it was found that more than a third of the population (36.9%) of indonesia had injured themselves. [10] meanwhile, the survey results on violence against indonesian children in 2013 found that 6.06% of adolescents aged 18-24 years injured themselves due to physical violence [11].

Mental disorders closely related to self-harm are borderline personality disorder, depressive disorder, bipolar disorder, schizophrenia, and post-traumatic stress disorder [10], [12]. One-half of patients who attend an emergency department with self-harm will have consumed alcohol as part of the self-harm episode [13]. Self-harm in schizophrenia patients correlate with the presence of delusions, hallucinations and treatment delay. The high frequency of self-harm combined with higher levels of impulsive aggression and depressive symptoms increase the risk for severe suicidal behavior in the future [14], [15]. Risk of self-harm increases in Patients with psychiatric illness who had some physical illnesses such as epilepsy, asthma, eczema and cancers [12].

The aim of self-harm treatment is to eliminate self-injurious behavior, help control impulses to self-harm, and prevent recurrence and remission of comorbid psychiatric conditions. This goal can be achieved if psychological and pharmacological interventions accompany the correct diagnosis. Psychosocial assessment by a mental health physician is a major component of clinical care and is recommended for any episode of self-harm. This in-depth assessment helps clinicians to formulate decisions about continued care and reach informed decisions about the risks of further self-harm. There is also evidence that psychosocial assessment can reduce the risk of further episodes of self-harm [16]. Assessment self-harm should be carried out comprehensively, including information about the present and the past. Self-harm behavior includes type, method, location, precipitating factors, frequency, age, onset, severity, urge to self-harm, hospitalization, and understanding of biopsychosocial risks and protective factors for self-harm [17].

Identifying possible methods used for self-harm is essential. This study aims to identify the characteristic of self-harm behaviour among psychiatric patients visiting outpatients Prof. HB Saanin Mental Hospital in Padang, Indonesia.

## 2. Material and methods

A retrospective descriptive study was conducted to collect information about characteristic of self-harm

ISSN: 0005-2523
Volume 62, Issue 09, November, 2022

behaviour among psychiatric patients visiting outpatients Prof. HB Saanin Mental Hospital in Padang, Indonesia. This study was conducted between September – December 2021. Prof. HB Saanin Mental Hospital is tertiary, government and teaching hospital that is located in Padang, West Sumatera, Indonesia. It is the only one government mental hospital hospital in west Sumatra.

Samples were all patients who visited the outpatient Prof. HB Saanin Mental Hospital and met the inclusion criteria, which were patients aged over 18 years and willing to become respondents by signing informed consent, while the exclusion criteria were patients in a state of restlessness. The number of samples required is a minimum of 80 samples, which were using consecutive sampling.

Variables of this study are psychiatric illness, gender, age, marital status, education, occupation, classification of self-harm, and forms of self-harm. Psychiatric illness is diagnosed by a psychiatrist and is categorized into four categories, namely schizophrenia, depressive disorder, anxiety disorder, bipolar disorder, and borderline personality disorder. Gender in the study was categorized into male and female. Age in this study was categorized into five categories, namely 17-25 years, 26-35 years, 36-45 years, 46-55 years, and 56-65 years. Marital status was categorized into two, namely married, widowed and unmarried. The work in this study is divided into five categoris, which were housewives, entrepreneurs, farmers, retirees, and unemployment. Education was categorized into primary school, junior high school, senior high school, diploma, bachelor and no formal education.

This study used a Self-Harm Inventory (SHI) questionnaire to measures self-harm behaviour. Self-harm Inventory has been validated in Indonesian by [10]. The Self-harm Inventory is a valid and reliable instrument for assessing self-harm behavior in clinical settings. This instrument consists of 22 pretty short items. If the cut-off score > 5 indicates the presence of mild self-harm behavior, while the cut-off score > 11 indicates a psychopathological tendency (threshold personality disorder). This instrument can be used as a screening tool lifetime prevalence, screen for BPD and/or predict past levels of mental health care utilization. (6)

The data processing stage of this research begins with editing, namely, re-checking the entire questionnaire contents and whether the respondent has answered all questions. Then coding, namely classifying respondents' answers that have been planned using numbers, followed by scoring, which gives values with categories and numbers. The next stage is tabulating, namely entering data into a table and counting the number of each frequency. Then the percentage, namely the data, is grouped in tables and analyzed using SPSS version 20. This study met research ethics: the respondent's consent, maintaining confidentiality, and being anonymous.

**3. Result and discussion**

This study obtained a sample of 104 respondents, divided into respondent profiles based on characteristics, forms of self-harm, and diagnosis of mental disorders.

Table 1 shows that of 104 patients, 55.8 % (n = 58) were males, and 44.2% (n = 46) were females. Their ages ranged from 17 to 65 years. About 35.6% (n=37) were in the age group of 36-45 years, followed by aged 26-35 years (24%). Most of the patients were not married 49% (n=51), followed by married 37,5% (n=39). About 28.8% (n = 30) were homemakers, and 24% (n=25) were not working. More than half of patients had senior high school education (54.8%) and at least had had diploma degree (2.9%). More than half of the patients were diagnosed with schizophrenia 70% and followed by depression disorder.

**Table 1.** Characteristics of Psychatric Patients Visiting Outpatients Prof. HB Saanin Mental Hospital

| Characteristics | Total | |
|---|---|---|
| | Frequency | Percentage |
| Age | | |
| 17-25 years | 13 | 12.5 |
| 26-35 years | 25 | 24.0 |
| 36-45 years | 37 | 35.6 |
| 46-55 years | 17 | 16.3 |
| 56-65 years | 8 | 7.7 |
| Gender | | |
| Male | 58 | 55.8 |
| Female | 46 | 44.2 |
| Education | | |
| Primary school | 12 | 11.5 |
| Junior high school | 15 | 14.4 |
| Senior High School | 57 | 54.8 |
| Diploma | 3 | 2.9 |
| Bachelor | 8 | 7.7 |
| No formal education | 9 | 8.7 |
| Occupation | | |
| Student | 8 | 7.7 |
| Homemaker | 30 | 28.8 |
| Civil servants | 4 | 3.8 |
| Entrepreneurs | 29 | 27.9 |
| Farmer | 7 | 6.7 |
| Retired | 1 | 1.0 |
| Unemployemnet | 25 | 24.0 |
| Marital status | | |
| Not married | 51 | 49.0 |
| Married | 39 | 37.5 |
| Widow/widower | 14 | 13.5 |
| Psychiatric Illness | | |
| Depression | 21 | 20.2 |
| Anxiety | 8 | 7.7 |
| Schizophrenia | 70 | 67.3 |
| Threshold personality | 2 | 1.9 |
| Bipolar | 3 | 2.9 |

Based on table 2, it was found that most of the respondents had mild self-harm behavior 78.8%.

**Table 2.** Frequency Distribution of Self-Harm Classification of Psychatric Patients Visiting Outpatients Prof. HB Saanin Mental Hospital

| Self- | *f* | % |
|---|---|---|
| *Self-harm* Mild | 82 | 78.8 |
| Presence of psychopathology | 22 | 21.2 |
| Total | 104 | 100.0 |

Based on table 3, the most self-harming method used by patient are torturing oneself with self-blaming thoughts (38.4%), followed by intentionally making the medical situation worse (30.8%). None of the respondents were engaging in an abusive relationships with their partners sexually.

ISSN: 0005-2523
Volume 62, Issue 09, November, 2022

**Table 3.** Frequency Distribution of Self-Harm Methods of Psychatric Patients Visiting Outpatients Prof. HB Saanin Mental Hospital

| Method of self-harm behavior | f | % |
|---|---|---|
| Overdose | 8 | 7.7 |
| Deliberately cutting | 8 | 7.7 |
| Burning oneself on purpose | 2 | 1.9 |
| Injuring oneself | 22 | 21.2 |
| The intentional banging of the head | 24 | 23.1 |
| Drinking alcohol | 17 | 1.6 |
| Driving carelessly on purpose | 9 | 9 |
| scratching oneself | 7 | 7 |
| Not treating wounds | 17 | 1.6 |
| Making a medical situation worse on purpose, for example, not following medical advice | 32 | 30.8 |
| Not being picky about having sex with anyone/many people | 2 | 1.9 |
| Positioning oneself in an opposing relationship | 4 | 3.8 |
| Misusing prescription medication with the intent of harming oneself | 6 | 6 |
| Dissociating oneself from God as punishment | 6 | 6 |
| Engaging in an abusive relationship with a partner emotionally/psychologically | 4 | 3.8 |
| Engaging in an abusive relationship with a partner sexually | 0 | 0 |
| Quitting work intentionally | 15 | 14.4 |
| Attempting to commit suicide | 18 | 17.3 |
| Injuring oneself by Intentionally | 22 | 21.2 |
| Torturing oneself with self-blaming thoughts (not taking sides) | 40 | 38.4 |
| Making oneself hungry | 24 | 23.1 |
| Forcing yourself to take laxatives to hurt oneself | 1 | 0.09 |

***Discussion***

In this study, more than half of the patients who visited the Prof. HB Saanin Mental Hospital were in the age range of 36-45 years and were male. The results of this study are consistent wirh Yasen's research that most mental patients in Mosul City are in the age range of 20-49 years [18]. Similar results were also obtained by Nindi at the Atma Husada Hospital Samarinda that most patients with mental disorders were in the age range of 26-35 years [19]. The age range of 36-45 years is included in the range of early to middle

adulthood. Adulthood is a time full of problems and emotional tension, a period of social isolation, commitment and dependence, changes in values, and adjustment to a new lifestyle [20].

Adult individuals are required to be able to adapt by using adaptive coping mechanisms. Continuous use of maladaptive coping mechanisms can lead to mental disorders, for example, depression [20]. Self-reported motives for doing self-harm is that wanting to escape or get relief from unbearable feelings. Self-harm is associated with low self-esteem, loss control of impulsivity, hopelessness, and depression. Adults who did self-harm experienced negative life events and problems, such as relationships problem with partners, families and friends [21]. People with self-harm reported that they self-injure as a form of self-directed anger or self-punishment [22].

Most of the respondents are male. This result is in line with Alghadeer's research in Riyad that men experience more mental health problems than women [18]. Similar results were obtained by Muller in the German population showing that men are even more likely to engage in self-harm than women [23]. This result is different with cross-sectional surveys of the general population research in England that self-harm was greatest in female [24]. A study found that men were more likely to get burned, bang themselves, bang their heads against objects, and bang their heads against walls and other objects, and generally risky behavior, such as dangerous driving. Women more frequently exhibit other forms of insidious self-harm than men, such as preventing wound healing, starvation, and abusing laxatives [23]. Men tend to use externalization defense mechanisms, namely in the form of addictive substance abuse, aggression, and antisocial personality disorder. Men also have a common understanding of health, so they are less likely to report their feelings and seek medical help [25].

Most respondents are homemakers, followed by entrepreneurs and unemployemnet. A population-level find unemployed is associated with an elevated risk of both suicide and self-harm [26]. Unemployment can lead to worsening mental health, and people with worse mental health are more likely to be unemployed. People with mental disorders more likely to lose job because miss work due to illness, stigma and social exclusion [27]. Mental disorders such as schizophrenia and depression are closely related to decrease cognitive function and social interaction. Cognitive relates to memory, learning ability, and decision-making, all of which are needed in work. The limitations of social interaction also affect the ability to work in a team [28], [29].

In this study, most of the respondents were unmarried. Research consistently shows that married people tend to have lower rates of mental disorders and higher levels of social support. Family can help individuals deal with stress and improve healthier behaviors, self-esteem that is leading to greater happiness [30]. Unmarried and divorcees had risk of poorer mental well-being, associated with depressive symptoms and low self-esteem [31].

Most of the patients were diagnosed with schizophrenia. Patients diagnosed as having schizophrenia are most at risk for self harm [13]. About 5% of schizophrenia will eventually die by suicide and self-harm is a strong predictor of completed suicide [32]. Self-harm in schizophrenia patients is due to command hallucination, catatonic excitement or associated depression [33]. Emotional dysregulation has been linked theoretically to self-harm and patients with schizophrenia often have high levels of negative affects. They use self-harm to regulate the negative affects [32]. Based on Riskesdas 2018, the estimated prevalence of people who have had Schizophrenia in Indonesia is 1.8 per 1000 population. West Sumatra is in 4th position after DI Yogyakarta, Bali and West Nusa Tenggara [34].

ISSN: 0005-2523
Volume 62, Issue 09, November, 2022

In this study, it was found that most of the respondents experienced mild self-harm, with SHI scores below >5. Most of the patients were diagnosed with schizophrenia and self-harm of schizophrenia patients is caused by command hallucinations [32]. Most of research sample had been given medication such as psychotropic. Treatment of schizophrenia usually consists of psychoeducation, medication, psychosocial interventions, psychotherapy, Transcranial Magnetic Stimulation (TMS) or Electroconvulsive Therapy (ECT) [35].

Most participants engaged in indirect self-harm method, torturing oneself with self-blaming thoughts. This result is in line with research in German which is most of self-harm patients had self-defeating thoughts, follow by "lost a job on purpose" and alcohol abused [23]. This result is different with Zakiullah research in Pakistan, and Vancayseele in Belgium, self-poisoning methods are more widely used [36], [37]. Thoughts of self-blame are actual self-injurious behavior. This behavior may have a long-term negative impact and take longer than the wound to heal [38]. Self-harming behavior is associated with self-critical and punishing thoughts. Self-harm becomes a channel for expressing strength, destruction, and anger that are impossible to express freely and are instead directed at oneself [39].

## 4. Conclusion

The majority of patients with mental disorders have a variety of self-harm behaviors (severity and method). Clinicians need to identify self-harm by paying attention to risk factors and protective factors for these behaviors. This behavior found mostly in schizophrenia patients, so screening and assessment self harm is essential in this group.

Acknowledgments

The authors would like to thank for their kind support during studies

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