Self-Harm Behaviors Among Internal Medicine Outpatients

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Abstract

Beyond suicidal ideation, attempts, and completions, very few epidemiological studies have examined broad types of self-harm behavior, especially in primary care populations. In this study, using a survey methodology and a cross-sectional approach, the authors examined the lifetime prevalence of 22 self-harm behaviors among a sample of 393 consecutive internal medicine outpatients. With regard to results, nearly 20% of the sample reported alcohol abuse, 19% emotionally abusive relationships, 18% sexual promiscuity, 17% the torturing of self with self-defeating thoughts, and 11% suicide attempts. In addition, 8% reported the abuse of prescription medication, 6% making medical situations worse, and 3% the prevention of wounds from healing. These findings indicate that a substantial minority of patients engage in various types of self-harm behaviors—a finding that is clinically relevant to practitioners in these types of settings.

Key Words: Self-harm behavior, Self-Harm Inventory, primary care

Disclosure: The authors disclose no relevant conflicts of interest.

Introduction

In the field of self-harm behavior, there are many published epidemiological studies on suicidal ideation, suicide attempts, and completed suicides. However, there are far fewer epidemiological studies on non-suicidal self-harm behaviors, such as self-cutting and self-burning, with most conducted in inpatient and outpatient psychiatric populations. Indeed, with regard to non-suicidal self-harm behavior among primary care populations, the authors were unable to locate any epidemiological data. In a related study, the authors compared the self-harm behaviors of individuals with borderline personality from two different study sites—an outpatient mental health setting and a primary care setting.[1] However, this behavioral analysis was limited to participants with borderline personality disorder (ie, self-harm behaviors in a general clinical population were not explored). In this study, the authors examined the lifetime prevalence of 22 specific self-harm behaviors among a large and consecutive sample of internal medicine outpatients.

Method

Participants. Participants were men and women, ages 18 years and older, who were being seen at an outpatient primary care clinic for non-emergent medical care. The outpatient clinic is staffed predominantly by residents in the department of internal medicine and is located in a mid-sized, mid-western city. Participants unable to complete a brief survey—ie, those with compromising medical (eg, dementia, pain), intellectual (eg, mental retardation), or psychiatric disorders (eg, psychotic)—were excluded.

In an effort to further characterize the general population at this center, for the year 2008 (the year preceding this study), 64% of the consultations were for women. With regard to age distribution, 30% of the patients were between the ages of 15 and 44 years, 45% were between the ages of 45 and 64 years, and 25% were age 65 or older. Regarding payment status, 8% were self-pay, 49% had government insurance (Medicare/Medicaid), and 43% had private insurance. The

Table 1
Rates of Endorsement for Each Item in the Self-Harm Inventory (N = 393)

SHI Item	% Indicating Yes
Overdosed	6.6
Cut yourself	7.9
Burned yourself	3.3
Hit yourself	7.9
Banged your head	10.5
Abused alcohol	19.9
Driven recklessly	13.5
Scratched yourself	5.9
Prevented wounds from healing	2.8
Made medical situations worse	5.9
Been promiscuous	17.9
Set yourself up in a relationship to be rejected	9.9
Abused prescription medication	8.4
Distanced yourself from God as punishment	11.3
Engaged in emotionally abusive relationships	18.6
Engaged in sexually abusive relationships	5.9
Lost a job on purpose	7.6
Attempted suicide	11.3
Exercised an injury	2.0
Tortured yourself with self-defeating thoughts	16.8
Starved yourself to hurt yourself	4.1
Abused laxatives to hurt yourself	0.5

most common clinical diagnoses during this 12-month period were hypertension (8.7%), hyperlipidemia (6.1%), diabetes (5.4%), allergies (4.7%), and hypothyroidism (2.3%).

For this study, a total of 492 people were invited to participate, of which 419 agreed (85.2% response rate). Of these 419 respondents, 393 completed the Self-Harm Inventory (SHI).2 Of these 393 respondents, 118 were men, 273 were women, and 2 failed to indicate sex. Respondents ranged in age from 18 to 85 years (mean = 48.97, SD = 15.13). Most were white (337; 85.8%); 33 participants were black, 8 Native-American, 2 Hispanic, 3 Asian, and 10 indicated "other" for ethnicity. With regard to educational attainment, most (94.1%) had at least graduated high school, with 27.2% having earned at least a 4-year college degree.

Procedure. During afternoon clinic hours, one of the authors (C.L.) positioned herself in the lobby of the outpatient clinic. She approached consecutive incoming patients on study days and informally assessed exclusion criteria. With potential candidates, she reviewed the focus of the project and invited each to participate. Each participant was then asked to complete a 4-page survey booklet, which took about 10 minutes. Participants were asked to place the completed survey booklets into sealed envelopes and then to place the envelopes into a collection box in the lobby.

The survey booklet unfolded with a demographic query that asked participants about their gender, age, marital status, racial/ethnic origin, and educational level. The authors next explored self-harm behaviors with the SHI,[2] a 22-item, yes/no, self-report measure that explores participants' lifetime histories of self-harm behavior. Each item in the inventory is preceded by the statement, "Have you ever intentionally, or on purpose..." Individual items include "overdosed," "cut yourself on purpose," "burned yourself on purpose," and "hit yourself." Each endorsement is in the pathological direction (Table 1).

These data were collected during April 2009. The institutional review boards of the affiliated community hospital and the university approved the project. The elements of informed consent were provided on the cover page of the survey booklet and completion of the survey booklet was assumed to be implied consent.

Results

The prevalence rates of the various 22 self-harm behaviors in this sample are presented in Table 1. Note that 11% of this sample reported bonafide suicide attempts. In addition, all of the following reported behaviors exceeded 15% in prevalence: abused alcohol (19.9%), engaged in emotionally abusive relationships (18.6%), been promiscuous (17.9%), and tortured self with self-defeating thoughts (16.8%). Approximately 7% to 8% of the sample reported overdoses and cutting self. No single item was left unendorsed.

Discussion

In this sample of patients from a resident-provider clinic, there were fairly high self-reported rates of self-harm behavior. For example, 11% of the sample reported suicide attempts and 1 in 5 participants reported alcohol abuse. From these data, the potential mediating variables that account for these findings are unknown. For example, are these behaviors mediated by low economic status (50% of the patients were on government insurance), character pathology (eg, borderline personality, antisocial personality), alcohol and substance abuse/dependence, and/or other contributors?

As for items that specifically relate to primary care practices, note that 3% of the sample reported preventing wounds from healing, 6% reported making medical situations worse, and 8% reported the abuse of prescription medications. While infrequent, these are still substantial proportions of patients, given the nature of the items endorsed.

Although no comparison data with other types of primary care populations are available, the authors suspect that this sample may harbor more behavioral pathology than other types of community samples, simply because the majority of these patients were seen in a resident-provider clinic (ie, low income, indigent). The authors suspect that privately insured populations might demonstrate a

lower overall profile of self-harm behavior, although such data do not presently exist in the published literature.

This study has several potential limitations, including the use of a self-report methodology and the associated inherent limitations of this approach, the lack of specificity of a number of items on the SHI (eg, lack of definition of promiscuity, lack of diagnostic parameters for alcohol abuse), and nominal understanding of what some items may have actually meant to participants (eg, torturing self with self-defeating thoughts, making medical situations worse). In addition, there are no corroborating diagnoses to determine associations between items and any potential psychopathology. Therefore, conclusions regarding the context of these behaviors cannot be drawn. However, beyond suicide attempts/completions, there are few if any epidemiological studies with regard to self-harm behavior; the sample size is relatively large; and the number of self-harm items explored is broad. In addition, these data likely represent the tip of the proverbial iceberg, as some respondents may have been too embarrassed to report some of these behaviors. These data provide an initial yardstick with regard to the prevalence of self-harm behaviors in an internal medicine outpatient population. ■

References

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