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Comparison of non-suicidal self-injurious behavior and suicide attempts in patients admitted to a psychiatric crisis unit

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ABSTRACT

The aim of the current study was to examine differences in personality, coping skills, and select psychopathology symptoms in psychiatric patients with and without non-suicidal self-injury and/or suicide attempts. We collected data in a sample of 128 psychiatric patients by means of self-report questionnaires measuring self-harm, psychological symptoms, personality and coping skills. Results support a continuum of self-harm such that patients with both non-suicidal self-injury and suicide attempts exhibit significantly greater levels of psychopathology and lower levels of adaptive personality traits and coping skills. The findings point to the clinical importance of making a distinction between non-suicidal self-injury and suicide attempts, and offers additional variables to consider outside of intent when appraising suicide risk.

1. Introduction

Non-suicidal self-injury (NSSI) is any socially unaccepted behavior involving deliberate and direct injury to one's own body surface *without suicidal intent* (Claes & Vandereycken, 2007a). It is estimated that 4.3–20% of adult psychiatric inpatients engage in NSSI and these percentages increase to 40% for adolescent psychiatric inpatients (Klonsky & Muehlenkamp, 2007). Suicide attempts are defined as self-injurious behaviors with intent to die and it has been estimated that approximately 4.6% of individuals have made at least one suicide attempt (Nock & Kessler, 2006). Researchers have noted a high co-occurrence between NSSI and suicide attempts (Jacobson & Gould, 2007) leading some to question the need to differentiate the behaviors. Many argue that self-injuring patients with suicidal intent clearly differ from those without such intent (Nock & Kessler, 2006), with the former being more likely to have potentially lethal injuries and greater psychopathology (Joiner, 2005).

Important differences have been identified between persons reporting NSSI and/or suicide attempts in regards to depressed mood, hopelessness, psychological distress, reasons for living, aggressive symptoms, and functions served by the behavior (Brown, Comtois, & Linehan, 2002; Klonsky, 2007; Muehlenkamp & Gutierrez, 2004, 2007; Nock & Kazdin, 2002, 2006; Whitlock & Knox, 2007; Whitlock, Muehlenkamp, & Eckenrode, 2008). Significant limitations to these studies are that many used non-clinical populations of adolescents and they failed to examine whether there are clinically meaningful differences in actual coping skills and personality characteristics.

Both suicide attempts and NSSI have been associated with impulsiveness and borderline personality disorder (Andover, Pepper, Ryabchenko, Orrico, & Gibb, 2005; Brown et al., 2002; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). Persons with suicide attempts have also scored significantly higher than controls on personality characteristics of neuroticism, harm avoidance, and lower on extraversion (Brezo, Paris, & Turecki, 2006; Calati et al., 2008). Similarly, within a sample of eating disordered patients with(out) NSSI, Claes et al. (2004) found higher levels of neuroticism and lower levels of extraversion among patients with NSSI. While these are valuable results, the studies indicating differences between NSSI and suicide attempt groups are based on predominantly higher functioning, non-clinical, adolescent populations and those with adults are largely restricted to examining BPD features.

The same is true in regards to coping skills. While there is a larger body of literature documenting that persons with suicide attempts have less adaptive problem-solving skills (Speckens &

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Hawton, 2005), there is only one known study examining specific coping skills in NSSI (Andover, Pepper, & Gibb, 2007) and the sample included relatively high functioning college students. It is important for research to identify whether meaningful differences in core personality traits and coping skills exist between these self-harming groups within psychiatric adult populations to further inform clinical practice.

The purpose of the current study was to compare four groups of psychiatric patients with(out) NSSI and suicide attempts (SA) on personality traits, coping strategies, and clinical symptoms. It was hypothesized that patients without NSSI or SA would show less psychopathology, more adaptive and active coping strategies, and higher levels of extraversion and conscientiousness than the other groups. Furthermore, we expected that patients with both NSSI and SA would show the highest levels of psychopathology and neuroticism, less adaptive coping strategies, and the lowest levels of extraversion and conscientiousness among the self-harm groups.

2. Method

2.1. Participants and procedures

Participants were recruited from 200 admissions to an inpatient psychiatric crisis unit in Belgium between September 2006 and June 2007. The crisis unit is part of a university general hospital and admits patients who are referred by psychiatrists working in the first aid unit of the hospital or, by psychiatrists treating psychiatric outpatients. Patients admitted to the crisis unit suffer from severe psychopathology and are a danger to themselves or others, and/or are unable to remain at home due to severe crisis in the family situation (e.g., partner violence, child–parent problems). All patients admitted to the inpatient psychiatric crisis unit (maximum duration of stay is 14 days) were invited to participate in the study shortly after the crisis situation was alleviated (approximately 5–6 days). All patients were provided with an envelope holding informed consent documents and questionnaires. Patients willing to participate provided written informed consent and completed the questionnaires individually within their hospital rooms. The documents were returned to the researcher in a sealed envelope via their individual therapist who had no access to participant responses. In total 128 patients (64% of all presenting patients) with a mean age of 35.62 (SD = 13.04) completed the study, of whom 25% ($N = 32$) were male. De-identified DSM-IV Axis I diagnoses (APA, 1994), as listed in the patients' charts, were provided to the researcher by a staff psychologist (see Table 1). Participants were not provided any direct compensation but were given a short report of the results prepared by the researcher and given to the treating therapist. The study procedures were approved by the ethical committee of the University of the first author.

2.2. Instruments

To assess the presence/absence of NSSI and SA two YES/NO questions were used: (1) have you ever injured yourself without the intent to die? and (2) have you ever injured yourself with the intent to die? Both questions were cross-validated by means of a related questionnaire (e.g., SIQ-TR, SIS; see below). Participants completed official Dutch reliable/valid translations of all English based instruments and the internal consistency estimates for the Dutch translated scales are included in the scale descriptions.

To assess NSSI we used the *Self-Injury Questionnaire-Treatment Related* (SIQ-TR; Dutch version: Claes & Vandereycken, 2007b), which consists of five items asking participants to indicate whether they had engaged in one or more behaviors: severe scratching, bruising, cutting, burning, or biting. For each behavior endorsed, participants were asked to report the recency and frequency of their self-injury. Patients who mentioned at least one type of NSSI were assigned to the NSSI group, whereas patients reporting no form of NSSI were assigned to the noNSSI group. Data supporting the validity and reliability of this scale are available (Claes & Vandereycken, 2007b).

The 10 item ($\alpha = 0.93$) *Suicidal Ideation Scale* (SIS; Rudd, 1989) was used to assess the severity of suicidal ideation and cross-validate reports of suicide attempts (item 4). Each item is scored from

Table 1
Number and percentage of the DSM-IV primary Axis I diagnoses ($N = 128$) of total and the four patient groups.

Axis I code	Axis I diagnosis	Group 1 noNSSI/noSA, $N = 58$		Group 2 NSSI only, $N = 26$		Group 3 SA only, $N = 23$		Group 4 NSSI + SA, $N = 21$		Total group, $N = 128$	
		N	%	*N*	%	*N*	%	*N*	%	*N*	%
292.9	Substance-related disorder NOS			1	3.8					1	0.8
293.81	Psychotic disorder due to general medical condition, with delusions			1	3.8					1	0.8
296.2x	Major depressive disorder, single episode	6	10. 3	2	7.7					8	
296.3x	Major depressive disorder, recurrent	10	17.1	1	3.8	9	39.0	7	33.3	27	
296.80	Bipolar disorder NOS	6	10.3	1	3.8	1	4.3			8	6.2
298.9	Psychotic disorder NOS	1	1.7	2	7.7					3	2.3
300.00	Anxiety disorder NOS			1	3.8			1	4.8	2	1.6
300.02	Generalized anxiety disorder	1	1.7							1	0.8
300.22	Agoraphobia without history of panic disorder	1	1.7							1	0.8
300.3	Obsessive–Compulsive disorder	1	1.7							1	0.8
300.4	Dysthymic disorder					1	4.3			1	0.8
305.00	Alcohol abuse	1	1.7	1	3.8					2	1.6
305.40	Sedative, hypnotic or anxiolytic abuse	1	1.7							1	0.8
307.50	Eating disorder NOS	1	1.7	2	7.7					3	2.3
309.0	Adjustment disorder with depressed mood	12	20.7	8	30.8	8	34.8	6	28.6	34	26.6
309.24	Adjustment disorder with anxiety	3	5.2							3	2.3
309.28	Adjustment Disorder With mixed anxiety and depressed mood	5	8.6	2	7.7	1	4.3			8	6.2
309.3	Adjustment disorder with disturbance of conduct			1	3.8					1	0.8
309.4	Adjustment disorder with mixed disturbance of emotions and conduct			1	3.8	2	8.7	1	4.8	4	3.1
309.81	Posttraumatic stress disorder	1	1.7					1	4.8	2	1.6
309.9	Adjustment disorder unspecified	2	3.4					1	4.8	3	2.3
311	Depressive disorder NOS	1	1.7					2	9.5	3	2.3
799.9	Diagnosis or condition deferred on Axis I or on Axis II	3	5.2	1	3.8	1	4.3	2	9.5	7	
V61.1	Partner relational problem	2	3.4	1	3.8					3	2.3