

A typology of heroin-dependent patients based on their history of self-injurious behaviours

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Abstract

Self-injurious behaviours (SIB) can provide useful criteria for subtyping heroin-dependent patients, since SIB have been related to an opioid system dysfunction and they hinder patient management. The frequency of nine varieties of moderate/superficial SIB during active heroin use was assessed retrospectively in 164 heroin-dependent patients. A principal component analysis of SIB episodes revealed a four-component solution which accounted for 69.3% of the variance. The components were named as follows (percentage of variance explained by each component is enclosed in parentheses): 'SIB with objects' (27.3%), 'SIB by biting/scratching/hair-pulling' (18.2%), 'SIB by hitting' (12.3%), and 'SIB by picking scabs' (11.5%). A cluster analysis using the results of the principal component analysis enabled us to define three types of heroin-dependent patients, labelled: 'low-occurrence SIB cluster' (59.8%), 'high-occurrence scab-picking cluster' (31.7%) and 'high-occurrence hitting and cutting cluster' (8.5%). SIB by hitting was the most discriminatory component among clusters: its frequency was at a minimum in the low-occurrence SIB cluster, and attained a maximum in the high-occurrence hitting and cutting cluster. However, there were no differences among clusters regarding heroin-use variables. Patients from the low-occurrence SIB cluster, compared with those from the other two clusters, reported fewer episodes of SIB or suicide attempts and were diagnosed less frequently with bulimia. Patients from the high-occurrence scab-picking cluster had a very frequent history of these SIB, while the opposite was true in patients from the high-occurrence hitting and cutting cluster. Patients from this cluster probably presented staff members with the main management problems.

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1. Introduction

Self-injurious behaviours (SIB) are self-inflicted, non-accidental injuries lacking in suicidal intent which cause damage to bodily tissue (Claes and Vandereycken, 2007; Favazza and Rosenthal, 1993;

Pattison and Kahan, 1983; Skegg, 2005; Winchel and Stanley, 1991). A wide variety of self-aggressive behaviours, varying considerably in their severity and characteristics, meet the requirements to be considered SIB. Favazza and Rosenthal (1993) have classified SIB into three subtypes: severe self-mutilation; self-lesions carried out in a rhythmic, stereotyped manner; and superficial/moderate SIB. This last type of SIB is the most frequently reported by heroin-dependent patients.

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Although some studies have reported associations between superficial/moderate SIB and substance abuse in community samples (Favaro et al., 2007) and clinical samples composed of patients who presented with substance use disorders (Evren and Evren, 2005; Harned et al., 2006) or other mental disorders (Langbehn and Pfohl, 1993; Zlotnick et al., 1999), to our knowledge, SIB have not been evaluated systematically in samples of heroin-dependent patients. Only Gossop et al. (1975) reported 30 years ago that the frequency of cutting, burning and other unspecified SIB in 56 opioid-dependent patients was 11%. However, more clinical studies are justified because SIB are related to psychological distress, which is a significant risk factor for continued opioid abuse (Flynn et al., 2004; Kosten et al., 1986). Interestingly, SIB could be a consequence or even a cause of functional changes in the opioid system (Herman, 1990; Sandman and Hetrick, 1995; Winchel and Stanley, 1991). In keeping with the former alternative, itching and scratching have been observed after the administration of morphine (Hales, 1980; Ko et al., 2004; Lee et al., 2003; Thomas et al., 1993). This finding suggests that an excessive opioid activity underlies SIB. Such opioid hyperfunction would explain the absence of pain reported by some patients during SIB (Bohus et al., 2000; Claes et al., 2006; Schmahl et al., 2004). According to the latter possibility, SIB could cause an activation of the opioid system and, as a result, mitigate heroin abstinence. The repetitive activation of the opioid system throughout SIB could be a particular kind of addiction in some patients. Whether for reducing an opioid hyperfunction or whether for blocking an SIB-induced opioid activation, the opioid antagonist naltrexone has been used for treating SIB (Roth et al., 1996; Symons et al., 2004).

Patients with superficial/moderate SIB frequently report a history of bulimia and suicide attempts (Claes et al., 2001; Favaro and Santonastaso, 2002; Favazza and Rosenthal, 1993; Matsumoto et al., 2005; Sansone and Levitt, 2002). Heroin-dependent patients in particular also frequently report suicide attempts (Darke and Ross, 2002; Darke et al., 2004, 2005; Frederick et al., 1973; Kokkevi and Stefanis, 1995; Murphy et al., 1983), and have a lifetime diagnosis of bulimia in a non-negligible number of cases (Holderness et al., 1994; Huseman et al., 1990; Katzman et al., 1991; Rodríguez-Llera et al., 2006). The objective of the present study was to establish a classification of heroin-dependent patients according to the frequency of nine varieties of SIB they carry out when they use heroin. In addition, it also aimed to characterise the identified typologies of patients by means of comparing their history of suicide

attempts, bulimia, unintentional heroin-related overdoses and other heroin-use variables. We hypothesised that heroin-dependent patients grouped according to the varieties of SIB would be different regarding their heroin dependence. The classification that we intend to establish could help staff in the prevention and general management of SIB and other potentially dangerous actions. Before elaborating this classification, we described and grouped the superficial/moderate SIB reported by these patients.

2. Method

2.1. Participants

The sample comprised 164 heroin-dependent patients consecutively admitted to a closed and voluntary detoxification unit ($n=71$), a naltrexone maintenance programme ($n=56$) and a day hospital ($n=37$). When they were interviewed, all of the patients were either opioid-abstinent or in hospital to treat opioid withdrawal syndrome. As this study involved data routinely gathered in the course of usual clinical assessment, no separate, specific informed consent was considered necessary by the Research Ethics Committee of Santa Creu i Sant Pau Hospital, who approved the study protocol. The study was carried out in accordance with the principles described in the Declaration of Helsinki.

2.2. Assessment

Episodes of SIB and overdose which had occurred in the course of the patients' heroin dependence were assessed, as well as their life history of bulimia and suicide attempts. SIB were considered to be deliberate, self-inflicted injuries to bodily tissue lacking in suicidal intent. Based on a review of the literature and our own clinical experience (Pérez de los Cobos et al., 1994), we designed a semistructured questionnaire to systematically gather data on episodes of the following nine varieties of superficial/moderate SIB (the abbreviated term chosen to designate each variety in the tables is in italics): *scratching* oneself with fingernails; *cutting* wrist, forearms or other parts of the body with razor blades or knives; *burns* made with cigarettes or other objects; *butting* the head against a wall or other hard surfaces (*head-butting*); *violently hitting extremities* against hard surfaces or furniture; *picking* at small wounds or pimples and causing them to bleed (*picking scabs*); *pulling out hair* from the scalp, eyebrows, eyelashes, pubic area or any part of the body; *carving signs* or words with sharp objects, not tattoos; *biting*

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