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Original Research Article

EVALUATION OF PATTERN OF CASES OF DELIBERATE SELF-HARM: AN INSTITUTIONAL BASED STUDY

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ABSTRACT

Background: Deliberate self-harm is an important public health problem and a frequent cause of emergency hospital visits, especially among young individuals. It includes a wide range of self-injurious behaviors carried out with the intention of causing self-harm, irrespective of the degree of suicidal intent. The pattern of deliberate self-harm varies according to sociodemographic profile, psychosocial stressors, cultural factors, and availability of means. Understanding the profile and pattern of such cases presenting to a tertiary care hospital is essential for early identification, risk assessment, and development of preventive strategies.
Aim: To evaluate pattern of cases of deliberate self-harm.
Materials and Methods: This hospital-based cross-sectional study was conducted over a period of one year among 90 participants presenting with deliberate self-harm at Department of Forensic Medicine & Toxicology, Autonomous State Medical College Allied Pt. Ram Prasad Bismil Memorial Hospital, Shahjahanpur, (UP), India. Data were collected using a predesigned, structured, and pretested proforma after medical stabilization of the participants. Information regarding sociodemographic characteristics, clinical profile, previous history of self-harm, psychiatric illness, substance use, nature and method of self-harm, precipitating factors, time, place of act, and associated psychosocial variables was obtained through interview and hospital records.
Results: The majority of participants belonged to the 18–27 years age group (37.78%), followed by 28–37 years (26.67%). Females (55.56%) slightly outnumbered males (44.44%). Most participants were unmarried (51.11%), belonged to nuclear families (64.44%), and were from rural areas (62.22%). A previous history of deliberate self-harm was present in 20.00%, while 26.67% had past psychiatric illness and 33.33% had substance use. Most acts were impulsive (68.89%) and occurred at home (77.78%), commonly during the evening (35.56%). Poisoning (51.11%) was the most common method, followed by self-inflicted cut injury (15.56%) and drug overdose (13.33%). The major precipitating factors were interpersonal conflict with spouse/partner (22.22%) and family conflict other than spouse (20.00%). A statistically significant association was observed between sex and method of self-harm ($p = 0.028$) and between marital status and method of self-harm ($p = 0.041$).
Conclusion: Deliberate self-harm was most commonly seen among young adults and females, with poisoning being the predominant method. Interpersonal and family-related conflicts were the leading precipitating factors, and most acts were impulsive in nature. These findings emphasize the importance of early psychosocial assessment, psychiatric evaluation, and targeted preventive interventions in tertiary care settings.
Keywords: Deliberate self-harm; Poisoning; Psychosocial factors; Tertiary care hospital; Cross-sectional study.

INTRODUCTION

Deliberate self-harm is an important and growing public health concern that affects individuals, families, health systems, and society at large. It encompasses a broad range of behaviors in which a person intentionally causes harm to himself or herself, irrespective of the immediate level of suicidal intent. In clinical practice, deliberate self-harm includes acts such as self-poisoning, medication overdose, self-cutting, hanging attempts, burns, and other self-injurious methods that bring patients to emergency and hospital services. These behaviors are clinically significant not only because of the immediate risk to life and physical health, but also because they indicate severe psychological distress and are strongly associated with future repetition, psychiatric morbidity, and suicide risk. In many low- and middle-income countries, deliberate self-harm continues to remain under-recognized despite its substantial burden on emergency care and mental health services.[1] The global significance of self-harm lies in its close relationship with suicide and its contribution to avoidable mortality and morbidity. Suicide remains one of the leading causes of death among young people worldwide, and non-fatal self-harm occurs much more frequently than completed suicide. For every suicide death, there are many more attempts and episodes of self-harm that require urgent medical attention, follow-up care, and psychosocial support. In addition to the direct health burden, deliberate self-harm is associated with stigma, social disruption, loss of productivity, family distress, and long-term vulnerability to recurrence. Because many people who engage in self-harm first come into contact with the health system through emergency departments and tertiary care hospitals, hospital-based studies play a major role in identifying patterns of presentation and opportunities for prevention.[2]

The causes of deliberate self-harm are complex and multifactorial. Biological vulnerability, psychiatric illness, substance use, personality traits, family conflict, relationship stress, financial hardship, chronic illness, academic pressure, and adverse social circumstances may all interact in different combinations. In many instances, self-harm occurs during periods of acute emotional crisis, especially when coping skills are limited and access to means is easy. Young people are particularly vulnerable because adolescence and early adulthood are periods marked by identity formation, emotional lability, educational and occupational transitions, and increased sensitivity to interpersonal stress. At the same time, family environments, social expectations, digital influences, and exposure to violence or abuse can shape the risk of self-harm in important ways. Understanding these determinants is essential for both clinical assessment and public health planning.[3]

The pattern of deliberate self-harm varies across regions according to culture, gender norms, socioeconomic conditions, and method availability. In many South Asian settings, self-poisoning remains a frequent method because pesticides, household chemicals, and medications are often easily accessible within the home. Elsewhere, self-cutting and other forms of self-injury may be more common. The choice of method is influenced by impulsivity, intent, social modelling, and immediate availability rather than by a single fixed factor. This makes local epidemiological data extremely important. A method that is common in one region may be less frequent in another, and prevention strategies must therefore be adapted to the local context. Studies from emergency departments and tertiary care hospitals are particularly useful because they capture medically significant episodes and highlight the methods that place the greatest burden on acute care services.[4]

Hospital-based evaluation of deliberate self-harm is also important because it allows simultaneous assessment of medical severity, psychosocial context, and psychiatric needs. The emergency department is often the first point of contact, and the quality of care delivered at this stage can influence both immediate outcome and future risk. Patients may present with poisoning, trauma, respiratory compromise, altered sensorium, burns, or other serious medical consequences that require rapid stabilization. However, beyond the physical emergency, every act of self-harm also requires a careful exploration of intent, precipitating factors, prior attempts, family support, and mental health status. Contemporary models of care increasingly emphasize that management should not end with medical treatment alone, but should include psychiatric assessment, safety planning, and referral for ongoing support. Another important dimension of deliberate self-harm is its economic and service burden. Episodes of self-harm frequently require ambulance transport, emergency evaluation, toxicology-related treatment, intensive monitoring, ward admission, and specialist consultation. In resource-constrained settings, this imposes a substantial burden both on tertiary hospitals and on the families of affected individuals. The financial cost becomes even more significant when repeated attempts, prolonged admissions, or intensive care support are required. Therefore, studying the pattern of cases in a tertiary care setting is relevant not only for understanding the psychosocial profile of affected patients, but also for appreciating the implications for hospital workload, treatment pathways, and preventive service planning. Such data can help administrators and clinicians allocate resources more effectively for emergency care, liaison psychiatry, and community-based follow-up.[5] Recent literature has further highlighted the need to understand deliberate self-harm in the context of social change, mental health transitions, and emerging stressors. Pandemic-related disruption, isolation, financial insecurity, and reduced access to routine support systems have drawn renewed attention to self-harm as a marker of crisis. At the same time, research

among adolescents and young adults has shown that self-harm is linked with a wider ecosystem of psychosocial vulnerability, including abuse, depressive symptoms, conflict, and poor coping. These findings reinforce the idea that deliberate self-harm should not be viewed as a single diagnosis, but rather as a behavioral outcome arising from multiple interacting vulnerabilities. A hospital-based clinical profile can therefore provide valuable insight into the demographic groups most affected, the common methods employed, and the immediate triggers that may be amenable to intervention.[6]

MATERIALS AND METHODS

This study was designed as a hospital-based cross-sectional study conducted over a period of one year among 90 participants presenting with deliberate self-harm at Department of Forensic Medicine & Toxicology, Autonomous State Medical College Allied Pt. Ram Prasad Bismil Memorial Hospital, Shahjahanpur, (UP), India. The study population included patients admitted or evaluated in the relevant departments of the hospital following an episode of deliberate self-harm. All eligible participants who fulfilled the selection criteria were included in the study. The study was undertaken to assess the pattern, profile, and characteristics of cases of deliberate self-harm.

The study included patients of either sex who presented with a history of deliberate self-harm and were willing to participate in the study. Patients who were medically unstable and unable to provide relevant information at the time of assessment, those with severe cognitive impairment, those who could not be interviewed even after stabilization, and those who refused consent were excluded from the study. In cases where the patient was unable to provide adequate history initially, relevant information was obtained later after stabilization and, when required, corroborated with attendants or available medical records.

Data were collected using a predesigned, structured, and pretested proforma. Detailed information was obtained regarding sociodemographic variables such as age, sex, marital status, religion, educational status, occupation, socioeconomic status, family type, and place of residence. Clinical and event-related parameters were also recorded in detail, including previous history of deliberate self-harm, past psychiatric illness, family history of psychiatric illness, history of substance use, presence of chronic medical illness, and any ongoing treatment history. Information related to the self-harm episode was documented, including mode of deliberate self-harm, substance or method used, place of act, time of act, source and availability of the harmful agent, whether the act was impulsive or planned, presence of suicide note, history of prior warning or communication of intent, and presence of any precipitating event.

Psychosocial and situational factors associated with deliberate self-harm were assessed during interview. These included interpersonal conflicts, family disputes, marital disharmony, academic stress, occupational stress, financial problems, chronic illness, bereavement, social isolation, substance intoxication at the time of the act, and other identifiable stressors. Clinical examination findings and relevant treatment details available from hospital records were reviewed. The severity and immediate outcome of the episode were also noted in terms of need for emergency intervention, hospitalization, intensive care requirement, referral for psychiatric evaluation, and final disposition from the hospital.

A thorough psychiatric assessment was performed for each participant after medical stabilization. Mental status examination was carried out, and the presence of psychiatric comorbidity was recorded wherever identifiable based on clinical evaluation by the treating team. The intention behind the act, level of suicidal intent as elicited during interview, and insight into the act were also explored. Wherever necessary, information from caregivers and case sheets was used to improve reliability of the collected data.

The primary outcome measures of the study were the pattern and distribution of deliberate self-harm cases according to sociodemographic profile, method adopted, precipitating factors, and associated clinical and psychosocial variables. Secondary measures included the proportion of cases with prior self-harm attempts, psychiatric illness, substance use, and the immediate hospital outcome following the episode.

All collected data were entered into Microsoft Excel and analyzed using Statistical Package for the Social Sciences (SPSS) software version 27.0. Descriptive statistics were used to summarize the data. Categorical variables were expressed as frequencies and percentages, while continuous variables were presented as mean and standard deviation or median and interquartile range, wherever appropriate. Associations between categorical variables were analyzed using the chi-square test or Fisher's exact test as applicable. For continuous variables, independent sample t-test or Mann–Whitney U test was applied depending on data distribution. A p-value of less than 0.05 was considered statistically significant.

RESULTS

Sociodemographic profile (Table 1)

The age-wise distribution of participants showed that the majority belonged to the 18–27 years age group (37.78%), followed by those aged 28–37 years (26.67%), indicating that deliberate self-harm was most prevalent among young adults. A smaller proportion was observed in the 38–47 years (15.56%) and ≥48 years (11.11%) age groups, while adolescents below 18 years constituted 8.89% of the study population. With regard to sex distribution, females (55.56%) slightly outnumbered males (44.44%), suggesting a marginal female predominance in the study sample. In terms of marital

status, more than half of the participants were unmarried (51.11%), followed by married individuals (42.22%), while a smaller proportion belonged to the widowed/separated/divorced group (6.67%). The religious distribution revealed that the majority were Hindus (80.00%), followed by Muslims (13.33%), with Christians (4.44%) and others (2.22%) forming a minority. Educational status indicated that most participants had secondary level education (33.33%), followed by higher secondary education (22.22%), while 17.78% had primary education and 15.56% were graduates or above. A notable proportion (11.11%) were illiterate. Occupationally, homemakers (24.44%) formed the largest group, followed by skilled/unskilled workers (22.22%) and students (20.00%), indicating that both domestic and working populations were affected. Unemployed individuals accounted for 15.56%, while farmers and professionals constituted smaller proportions. The majority of participants belonged to nuclear families (64.44%), and most were from rural areas (62.22%), highlighting the predominance of cases from rural settings and nuclear family structures.

Clinical and self-harm related characteristics (Table 2)

Regarding clinical profile, 20.00% of participants had a previous history of deliberate self-harm, while the majority (80.00%) did not report any prior attempts. A past history of psychiatric illness was present in 26.67% of participants, and 13.33% reported a family history of psychiatric illness. Substance use was noted in 33.33% of cases, indicating a significant association between substance use and self-harm behavior. Chronic medical illnesses were present in 17.78% of participants. The nature of the act revealed that a majority of self-harm episodes were impulsive (68.89%), while 31.11% were planned, suggesting that most acts occurred without prior extensive planning. Only 15.56% of participants had communicated their intent prior to the act, and a suicide note was present in a very small proportion (4.44%), indicating that most acts were not premeditated or formally expressed. The temporal distribution showed that the highest number of incidents occurred during the evening (35.56%), followed by night (28.89%), while fewer incidents occurred in the morning and afternoon. The place of occurrence was predominantly home (77.78%), with fewer cases occurring in workplaces/educational institutions (8.89%) or public places (13.33%), suggesting that the home environment plays a major role in such acts.

Pattern of methods used for deliberate self-harm (Table 3)

The most commonly employed method of deliberate self-harm was poisoning (51.11%), which included pesticide ingestion, household chemicals, and medication overdose. This was followed by self-inflicted cut injuries (15.56%) and drug overdose (13.33%). More lethal or violent methods such as hanging (11.11%), burns (4.44%), and drowning/other methods (4.44%) were less commonly observed.

Precipitating factors. [Table 4]

The most frequently identified precipitating factor was interpersonal conflict with spouse or partner (22.22%), followed closely by family conflicts other than spouse (20.00%), indicating that interpersonal and familial issues were major contributors. Other notable factors included financial problems (13.33%) and academic stress (11.11%), highlighting the role of economic and educational pressures. Occupational stress (8.89%) and substance intoxication-related events (8.89%) were also observed as contributing factors. Less common causes included chronic illness/pain (5.56%), social isolation (6.67%), and bereavement (3.33%).

Association between variables and pattern of self-harm. [Table 5]

A statistically significant association was observed between sex and the method of deliberate self-harm ($p = 0.028$). Among males, equal proportions used poisoning/drug overdose (50.00%) and violent methods (50.00%), whereas females predominantly used poisoning or drug overdose (76.00%) compared to violent methods (24.00%). Similarly, marital status showed a statistically significant association ($p = 0.041$) with the method of self-harm. Participants who were married, widowed, separated, or divorced more frequently used poisoning or drug overdose (77.27%) compared to violent methods (22.73%), whereas unmarried individuals had a relatively higher proportion of violent methods (47.83%). However, no statistically significant association was found between the method of self-harm and previous history of self-harm ($p = 0.529$) or past psychiatric illness ($p = 0.248$). Although participants with psychiatric illness showed a higher proportion of poisoning/drug overdose (75.00%), this difference was not statistically significant.

Table 1: Sociodemographic profile of study participants (N = 90)

Variable	Category	Frequency (n)	Percentage (%)
Age group (years)	<18	8	8.89
	18–27	34	37.78
	28–37	24	26.67
	38–47	14	15.56
	≥48	10	11.11
Sex	Male	40	44.44
	Female	50	55.56
Marital status	Unmarried	46	51.11
	Married	38	42.22
	Widowed/Separated/Divorced	6	6.67

Religion	Hindu	72	80.00
	Muslim	12	13.33
	Christian	4	4.44
	Others	2	2.22
Education	Illiterate	10	11.11
	Primary	16	17.78
	Secondary	30	33.33
	Higher secondary	20	22.22
	Graduate and above	14	15.56
Occupation	Student	18	20.00
	Homemaker	22	24.44
	Unemployed	14	15.56
	Skilled/Unskilled worker	20	22.22
	Farmer	10	11.11
	Professional/Clerical	6	6.67
Family type	Nuclear	58	64.44
	Joint	32	35.56
Residence	Rural	56	62.22
	Urban	34	37.78

Table 2: Clinical and self-harm related characteristics of participants (N = 90)

Variable	Category	Frequency (n)	Percentage (%)
Previous history of deliberate self-harm	Yes	18	20.00
	No	72	80.00
Past psychiatric illness	Yes	24	26.67
	No	66	73.33
Family history of psychiatric illness	Yes	12	13.33
	No	78	86.67
Substance use	Yes	30	33.33
	No	60	66.67
Chronic medical illness	Yes	16	17.78
	No	74	82.22
Nature of act	Impulsive	62	68.89
	Planned	28	31.11
Prior communication of intent	Yes	14	15.56
	No	76	84.44
Suicide note present	Yes	4	4.44
	No	86	95.56
Time of act	Morning	14	15.56
	Afternoon	18	20.00
	Evening	32	35.56
	Night	26	28.89
Place of act	Home	70	77.78
	Workplace/Educational institution	8	8.89
	Public place/Others	12	13.33

Table 3: Pattern of deliberate self-harm methods used (N = 90)

Method of deliberate self-harm	Frequency (n)	Percentage (%)
Poisoning (pesticide/household/medication overdose)	46	51.11
Drug overdose	12	13.33
Hanging attempt	10	11.11
Self-inflicted cut injury	14	15.56
Burns	4	4.44
Drowning/Other methods	4	4.44
Total	**90**	**100.00**

Table 4: Identified precipitating factors among participants (N = 90)

Precipitating factor	Frequency (n)	Percentage (%)
Interpersonal conflict with spouse/partner	20	22.22
Family conflict other than spouse	18	20.00
Academic stress	10	11.11
Financial problems	12	13.33
Occupational stress	8	8.89
Substance intoxication-related quarrel/event	8	8.89
Chronic illness/pain	5	5.56
Bereavement/loss	3	3.33
Social isolation/other stressors	6	6.67
Total	**90**	**100.00**

Table 5: Association of selected variables with pattern of deliberate self-harm

Variable	Category	Poisoning/Drug overdose n (%)	Violent methods* n (%)	Total (n)	p value
Sex	**Male**	20 (50.00)	20 (50.00)	40	0.028
	Female	38 (76.00)	12 (24.00)	50	
Marital status	**Unmarried**	24 (52.17)	22 (47.83)	46	0.041
	Married/Widowed/Separated/Divorced	34 (77.27)	10 (22.73)	44	
Previous history of self-harm	**Yes**	10 (55.56)	8 (44.44)	18	0.529
	No	48 (66.67)	24 (33.33)	72	
Past psychiatric illness	Yes	18 (75.00)	6 (25.00)	24	0.248
	No	40 (60.61)	26 (39.39)	66	

DISCUSSION

In the present study, the largest proportion of deliberate self-harm cases occurred in young adults, with 37.78% in the 18–27 years group and 26.67% in the 28–37 years group, while females constituted 55.56% of the sample. This pattern is comparable to the study by Devassy et al. (2020), in which 60.50% of cases were aged 18–30 years and 54.30% were females. The similarity between the two studies supports the view that early adult life is a particularly vulnerable period for self-harm, likely because it is marked by emotional instability, interpersonal strain, academic or occupational pressures, and adjustment difficulties. The close female predominance in both studies also suggests that women may be more likely to present to hospitals after non-fatal self-harm, particularly with less violent methods.[7] With respect to broader sociodemographic features, 51.11% of our participants were unmarried, 24.44% were homemakers, 20.00% were students, 64.44% belonged to nuclear families, 62.22% were from rural areas, and 80.00% were Hindus. A somewhat similar profile was reported by Singh et al. (2013) from West Bengal, where 57.10% were unmarried, 43.60% were students, 28.80% were housewives, 53.80% belonged to nuclear families, 94.90% were from rural backgrounds, and 86.50% were Hindus. Compared with that study, our sample had a lower rural proportion and a smaller student subgroup, but the overall pattern still indicates that self-harm is concentrated among socially active young people living within family settings, especially in semi-urban or rural sociocultural contexts.8 In relation to psychiatric and clinical background, our study found that 20.00% had a previous history of deliberate self-harm, 26.67% had a past psychiatric illness, and 13.33% had a family history of psychiatric illness. These proportions are lower than those reported by Das et al. (2008), who found that 48.20% of patients had a diagnosable Axis I or Axis II psychiatric disorder at assessment, with depression accounting for 30.70%, while about 17.00% had engaged in self-harm after consuming alcohol. The lower psychiatric morbidity in our study may reflect differences in case definition, timing of psychiatric evaluation, or under recognition of milder psychiatric syndromes in emergency settings. Nevertheless, both studies emphasize that a clinically relevant minority of patients have identifiable psychiatric vulnerability, while a large proportion may act under acute psychosocial stress without a formal diagnosis.[9] The present study showed that 68.89% of acts were impulsive, only 31.11% were planned, 15.56% had prior communication of intent, and just 4.44% left a suicide note. These findings are comparable to those of Halder et al. (2016), who reported that the majority of attempts were impulsive, with available summaries indicating 72.00% impulsive attempts; their study also found that suicidal behavior was more frequent among younger female patients, with 72.00% females, 69.00% single individuals, and 42.00% students. The similarity in impulsive behavior across studies suggests that many episodes of self-harm arise during acute emotional crises rather than through prolonged suicidal planning, which has important implications for crisis intervention, family counseling, and early psychosocial support.[10]

In our series, the acts occurred most often during the evening (35.56%) and night (28.89%), together accounting for 64.45% of all episodes, and the home was the most common place of occurrence (77.78%). This closely resembles the findings of Nongpiur et al. (2018) from Meghalaya, where the home was also the most common setting, 48.00% of attempts occurred during the 6 PM–6 AM period, and no suicide note was left by any participant. The concordance between the two studies suggests that self-harm frequently occurs in private domestic environments during times of relative isolation, when supervision is lower and access to means is easier, reinforcing the need for household-level preventive strategies and family awareness.[11] Regarding the method used, poisoning was the most common in our study (51.11%), and when combined with drug overdose (13.33%), self-poisoning accounted for 64.44% of all attempts. This is consistent with the classic Indian study by Latha et al. (1996), in which organophosphorus poisoning accounted for 67.00% of attempts and drug overdose for 29.00%. Although the exact distribution of agents differs across regions and time periods, both studies demonstrate the continuing dominance of ingestion-based methods in the Indian context, probably because pesticides, household chemicals, and medicines are relatively accessible and can be used impulsively during acute stress.[12] In the present study, the leading precipitating factors were interpersonal conflict with spouse/partner (22.22%) and family conflict other than spouse (20.00%),

together comprising 42.22% of cases; other contributors included financial problems (13.33%) and academic stress (11.11%). These findings are very similar to those of Tekkalaki et al. (2017), who reported that interpersonal conflicts with family members accounted for 47.00%, conflicts with spouse for 22.00%, and broken emotional relationships for 18.00% of cases. The close resemblance suggests that relational distress remains one of the most immediate triggers for self-harm, often overpowering protective factors and leading to impulsive action before conflict can be resolved or support can be mobilized.[13] Our analytical findings showed a significant association between sex and method of self-harm (p = 0.028), with 76.00% of females using poisoning/drug overdose compared with 50.00% of males, and also a significant association between marital status and method (p = 0.041), as 77.27% of married/widowed/separated/divorced participants used poisoning/drug overdose compared with 52.17% of unmarried participants. Although Ismail et al. (2022) did not report the same inferential comparisons, their sample similarly showed a predominance of females (80.00%), rural residents (65.00%), married individuals (56.70%), and self-poisoning as the commonest method. Taken together, these findings suggest that sex and marital context may influence not only the occurrence of self-harm but also the choice of method, with women and married individuals tending toward more readily available ingestion methods.[14] Finally, our study did not find a statistically significant association between method and previous self-harm (p = 0.529) or past psychiatric illness (p = 0.248), even though 75.00% of those with psychiatric illness used poisoning/drug overdose. This mixed pattern is understandable when viewed alongside the prospective study by Benjamin et al. (2018), where poisoning constituted 91.70% of attempts, 44.30% involved pesticides, and the interviewed subgroup was largely composed of women from rural backgrounds, with poisons commonly sourced from home, attempts often occurring at home, and the acts being largely impulsive and related to relationship conflicts. Their findings, like ours, indicate that immediate access to means and acute interpersonal stress may sometimes play a more decisive role in determining the method than psychiatric history alone.[15]

CONCLUSION

The present study concludes that deliberate self-harm was more common among young adults, females, unmarried individuals, and those from rural backgrounds and nuclear families. Poisoning was the most frequently used method, and most acts were impulsive in nature, occurring predominantly at home. Interpersonal and family-related conflicts emerged as the major precipitating factors. The study also found that sex and marital status had a significant association with the pattern of self-harm. These findings highlight the need for early identification of psychosocial stressors, timely psychiatric evaluation, and targeted preventive strategies at both hospital and community levels.

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