
PERSONALITY PROFILE AMONG PATIENTS WITH DELIBERATE SELF HARM IN TERTIARY CARE HOSPITAL: A CROSS SECTIONAL STUDY

By

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Dissertation submitted to the

**SRI DEVARAJ URS ACADEMY OF HIGHER EDUCATION AND
RESEARCH CENTRE, TAMAKA, KOLAR**

In partial fulfillment of the requirements for the degree of

DOCTOR OF MEDICINE (M.D.)

IN

PSYCHIATRY

Under the guidance of

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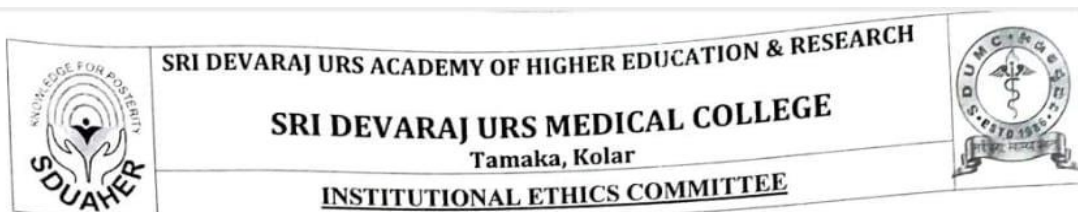
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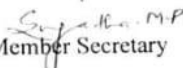
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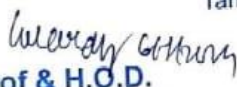
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ABSTRACT

Background

Deliberate self-harm (DSH) refers to an intentional act of causing physical injury to oneself without wanting to die. DSH subjects with any personality disorder have more suicide attempts than those without personality disorder. A psychosocial assessment is an important area to assess DSH. It is important to further explore and better understand the correlates of self-harming behaviours and their outcomes. Although several studies have been conducted on identifying the socioeconomic factors for deliberate self-harm on adolescent populations and their personality disorders, only limited studies are available on general population.

Objectives:

To determine the personality profile among patients with deliberate self-harm (DSH) and to study the relationship between socio- demographic factors and deliberate self-harm (DSH).

Methodology

The participants in this analytical cross-sectional study were 193 adult individuals who had a history of DSH and who visited the psychiatric department of RL Jalappa hospital in Kolar between September 2022 and December 2023. The researcher conducted a comprehensive investigation into

DSH, gathering detailed accounts from patients and a trusted informant through in-depth interviews. Subsequently, these case studies were deliberated with the psychiatrist in the department. The diagnosis of personality profiles in patients who engage in DSH was determined according to the recommendations provided by the ICD-10 and DSM-V, and the IPDE questionnaire was utilized. Responses were documented and scoring was conducted according to the answers provided.

Results

The mean age of 193 research subjects was 31.46 ± 9.75 years. Among these samples, 51.3% were female and the occurrence of co-morbidities was noticed among 24.9%. About 70.5% belonged to lower income status, and 68.4% were unmarried. Among the respondents, 51.8% were employed and the remaining 48.2% were unemployed. Around 84.9% came from rural areas while 32.6% completed high school education. Among the study participants, 95.3% belongs to Hindu religion.

Among 193 research patients, 57.5% attempted deliberate self-harm without any psychiatric illness while 42.5% attempted deliberate self-harm with the presence of psychiatric illness. Among them 53.4% had a previous history of suicide attempts. Nearly 51.3% have self-reported the presence of stress and the most common reason for this stress was family issues. The most common method of suicide attempts was liquid poison (65.8%), followed by Multiple

tablets (14.5%). Among the study participants, substance abuse was noticed among 50.25%. The most common substance abuse was alcohol use in the present study.

The most common personality trait in the present study was borderline (24.9%) and it was followed by dependent (21.8%) and impulsive (14%). Cluster B (50.8%) was the most common personality cluster in the present study. Cluster C was noticed among 34.2% of the samples and the remaining 15% was Cluster A group of personality. The factors influencing the personality profile among patients with deliberate self-harm were younger age (18 to 30 years), female gender, lower education (school education), lower income status, unmarried, unemployment, history of suicidal attempts especially with more than 2 attempts, stress, substance abuse, and use of liquid poison for self-harm (p value less than 0.05).

Conclusion:

Our results are in line with those of other researchers who have found that mental health issues increase the likelihood of suicidal thoughts and behaviours. The assessment of personality traits among DSH patients necessitates additional research in this area using larger numbers of participants.

Keywords: Deliberate self-harm, Personality Disorder, Suicide, self-poisoning, socioeconomic factors, International Personality Disorder Examination.

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ABBREVIATIONS

S. No	Abbreviation	Explanation
1	DSH	Deliberate self-harm
2	SDG	Sustainable Development Goals
3	DSP	Deliberate self-poisoning
4	NSSI	Non-Suicidal Self-Injury
5	SA	Suicide Attempt
6	PD	Personality Disorder
7	ICD	International Classification of Disease
8	BPD	Borderline Personality Disorder
9	IPDE	International Personality Disorder Examination
10	WHO	World Health Organization

11	NS-DSH	Non-Suicidal Deliberate Self-Harm
12	S-DSH	Suicidal Deliberate Self-Harm
13	DSM	Diagnostic and Statistical Manual of Mental Disorders
14	SH	Self-Harm
15	ASSR	Age-standardised Suicide Rate
16	LMIC	Low- and Middle-Income Countries
17	PT	Personality Trait

INTRODUCTION

INTRODUCTION

About 1.5 percent of all fatalities occur as a result of acts of suicide every year.

¹ In order to better stratify risk and prioritize measures for those at greatest risk, it is necessary to recognize determinants linked with committing suicide. ² The foremost recognized indicator for suicide is a history of suicidal thoughts or attempts. The suicide rate is substantially greater among people who have tried suicide before than among those who have not previously done so. ³ Furthermore, research has shown that suicidal ideation is a predictor of a wide range of negative outcomes, such as poor physical health, mental illness, issues with relationships, injury to others, and increased use of medical services. ³⁻⁵

When a person intentionally hurts themselves physically without intending to end their own life, this is called deliberate self-harm (DSH). ⁶ A deliberate overdoses of drugs, self-harming behaviours like as slicing with objects that are sharp, scratching, or striking oneself are prevalent among DSH. Reducing caloric intake and engaging in other "risk-taking" behaviours like speeding and hazardous sexual practices are also possible. ⁷ Many people who hurt themselves employ a combination of techniques. Even though they hurt just little to moderately, these actions are usually satisfying. While some people engage in self-harm frequently, others do it less frequently. Even if intentional self-harm does not always have a fatal purpose, it can nonetheless result in

death.⁶ The reasons for intentional self-injury have been the subject of multiple theoretical frameworks.⁸

How an individual responds under pressure is highly dependent on their personality.⁹ Individuals with personality disorders often struggle in various areas of life, such as their relationships, social functioning, and work. This is because these diseases are characterized by unbalanced emotional behaviours and skewed perceptions of the real world.¹⁰ Personality disorders are characterized by persistent, dysfunctional ways of thinking, feeling, and behaving. There is an increased likelihood of suicide thoughts, actions, and outcomes, as well as self-mutilation, in people with personality disorders and those who also suffer from other mental health issues.¹¹

Suicide attempts are higher among DSH patients with personality disorders overall compared to those without such disorders.¹² A lot of people who self-harm say they're feeling really worried, scared, furious, or tense right before they do it, and then they feel better afterward, which makes them want to do it again.¹³

People in India who struggle with self-harm or risky behaviours have received scant support from loved ones, neighbours, and the government. Adolescents' actions in areas such as violence, substance misuse, self-harm, and socio-psychological disorders are shaped by their backgrounds in society and culture.^{14,15} Adolescent and child self-harm has been on the rise in India due to

the country's high economic disparity. Additionally, cultural and social standards shape changes in behaviour among adolescents and children in India, which in turn defines their health and wellness.¹⁶

When evaluating DSH, a psychosocial examination is crucial. Additional research into the causes and consequences of self-harming behaviours is necessary. Few research has examined the general population to determine the socioeconomic characteristics associated with intentional self-harm among adolescents with personality disorders, while there have been numerous studies focusing on this topic in this subset of the population. The present research set out to determine the demographic and personality traits shared by people with a history of intentional self-harm, as well as the variables that may have contributed to this behaviour.

OBJECTIVES



OBJECTIVES

1. To determine the personality profile among patients with deliberate self-harm (DSH).
2. To study the relationship between socio- demographic factors and deliberate self-harm (DSH).

REVIEW OF LITERATURE



REVIEW OF LITERATURE

Suicide

An important problem in public health around the world is the act of suicide. Every year, 703,000 individuals lose their lives via committing suicide. More people die from committed suicide than from breast cancer, malaria, HIV/AIDS, or any other cause in the world, including war and homicide. The act of suicide accounted for more than one percent of all fatalities in 2019.¹⁷ In 2019, the world's suicide rate, adjusted for age, was 9.0 per 100,000 people. The suicide rate ranged from about two per 100,000 people in certain nations to more than eighty per 100,000 people in others (Figure 1).

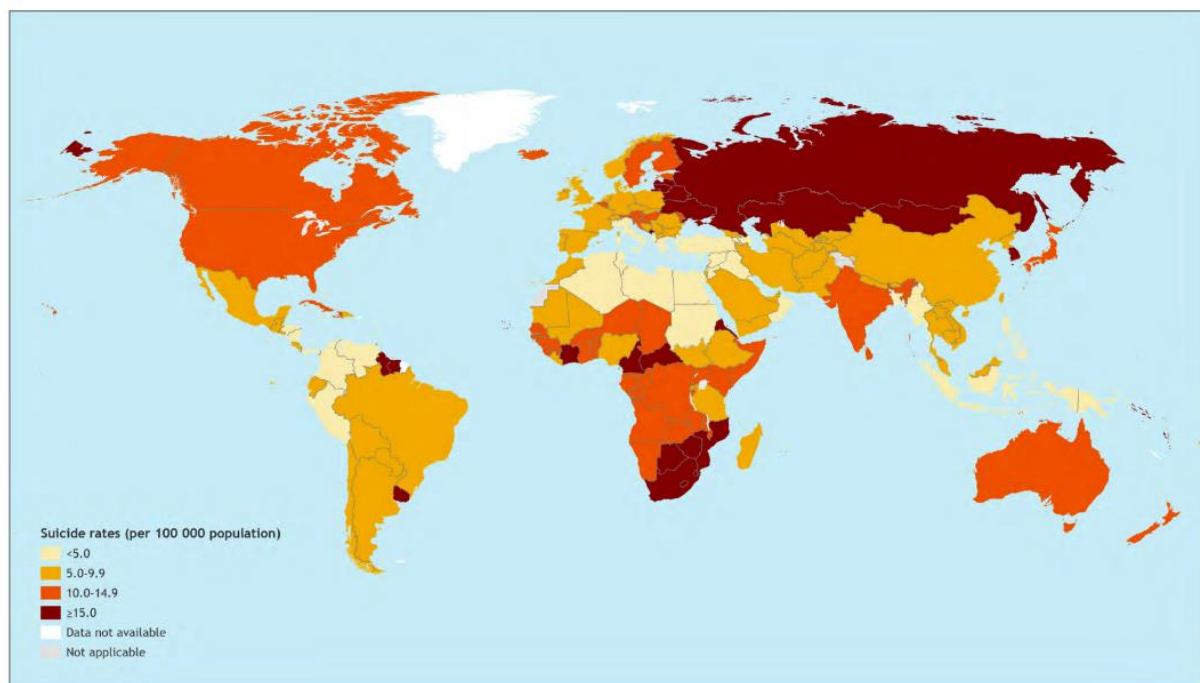


Figure 1: AASR of both sexes in 2019.

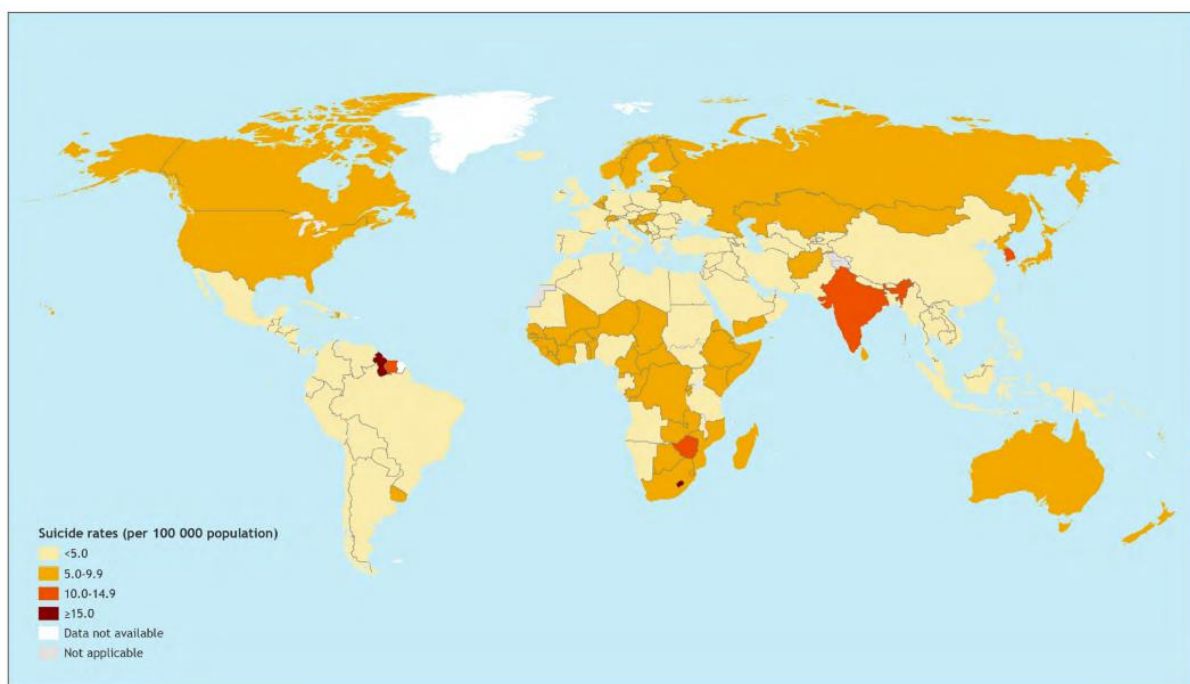


Figure 2: ASSR of females in 2019.

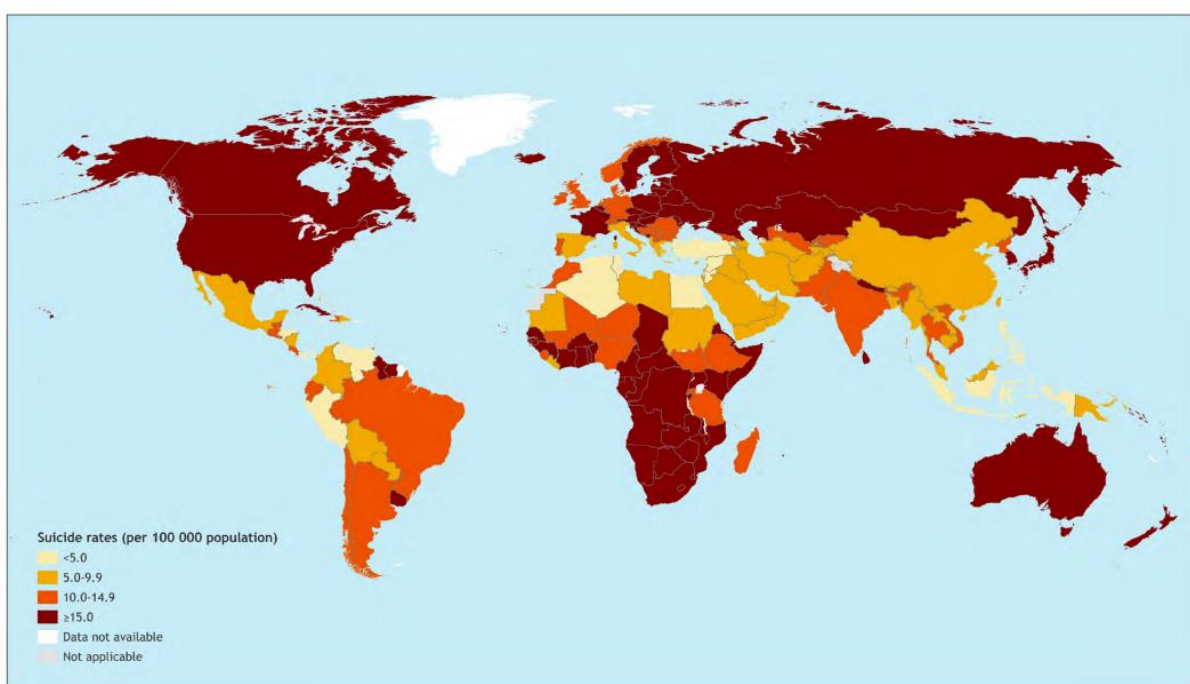


Figure 3: ASSR of males in 2019.

Suicide rates among men (12.6 per lakh) were greater than those among females (5.4 per lakh) when adjusted for age on a worldwide scale. Compared to men, girls had rates above 10 per lakh in the most developed nations, while men had rates above forty-five per lakh.¹⁷

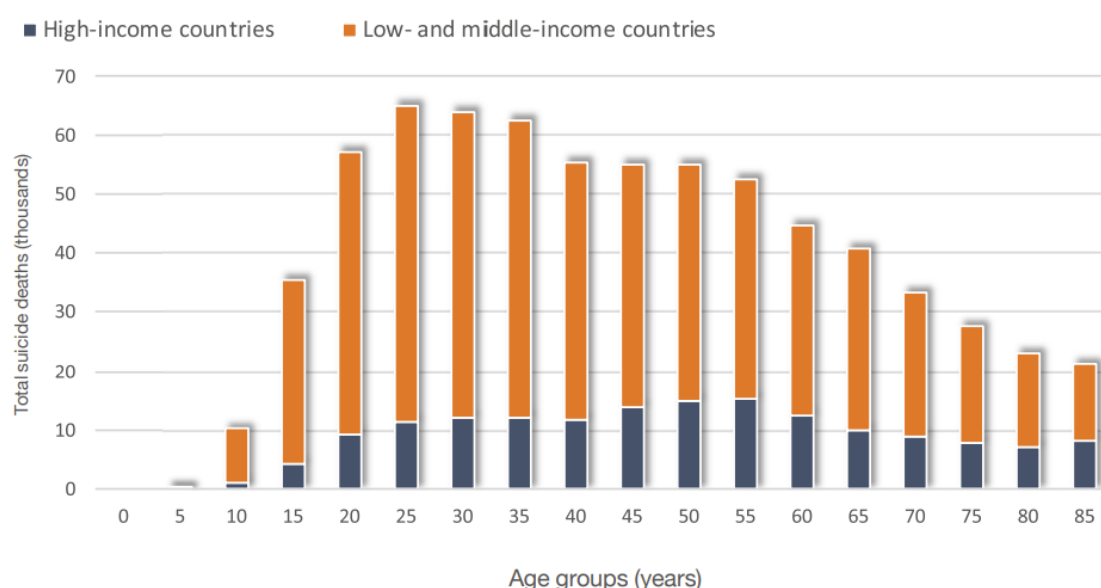


Figure 4: Global suicides, by age and country income level in 2019.

The bulk of the global populace resides in LMICs, which also happen to be the countries with the highest number of deaths from suicide (77%). This data is shown in Figure 4. Over half of all suicides (58%) happened in those less than 50 years old. Nearly 90% of the world's teenagers reside in low- and middle-income nations, where the majority of suicides among adolescents occurred (88%).¹⁷

Figure 5 shows that among males and females aged 15–29, suicide ranked fourth in terms of cause of death, behind road injuries, TB, and domestic

violence. Among people of this age, committing suicide ranked third for men and fourth for females.

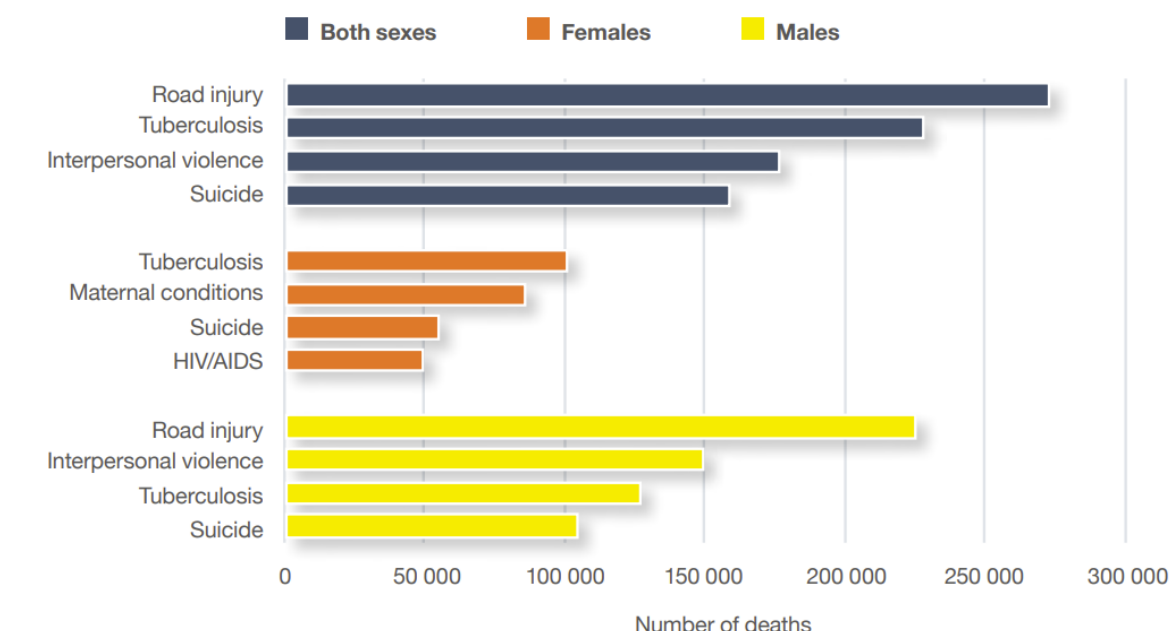


Figure 5 : Global top four causes of death among ages between 15 and 29 years in 2019.

Figure 10 shows that the ASSR fell by 36% worldwide between 2000 and 2019, with regional drops of 17% in the Eastern Mediterranean, 47% in Europe, and 49% in the Western Pacific. At the same span of time, the only location to see an increase in ASSR was the Americas, where they reached 17%. When broken down by age group, the worldwide rate fell as well.¹⁷

Regarding the SDGs, to meet the worldwide goal of a decrease in suicides of one third by 2030 that nations have pledged, there needs to be an acceleration of the decline in the suicide death rate.

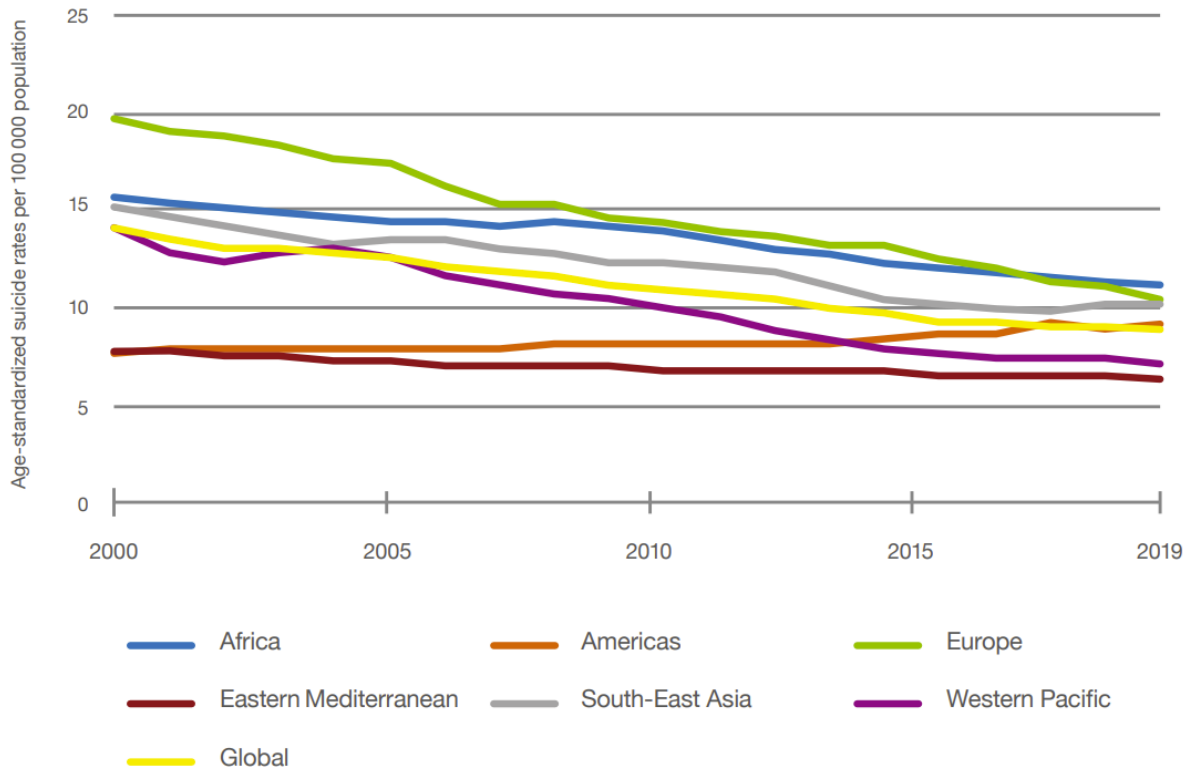


Figure 6: ASSR over time by WHO regions, both sexes

Many people in rural agricultural regions of LMICs poison themselves with pesticides, accounting for an estimated 20% of all deaths by suicide worldwide. Hanging and weapons are also typical ways people take their own lives.

Numerous individuals who are suicidal or have attempted suicide do not seek treatment because they are ashamed of the stigma associated with mental illness and suicide. Death by suicide is a big public health concern, but few people recognize it as such, and many cultures frown upon discussing the subject publicly, therefore efforts to prevent suicide have lagged behind.¹⁷

Deliberate Self Harm

Deliberate self-harm (DSH) is defined as, “intentional self-poisoning or self-injury irrespective of the type of motive or the extent of suicidal intent, is one important predictor of completed suicide.”¹⁸

The costs of DSH, which includes DSP and intentional self-injury, are high, and there is a substantial correlation between DSH and future suicide attempts.¹⁹

NSSI is a comparable word that describes self-injury that does not have suicidal intent.⁸ The DSM includes NSSI as an indicator for further investigation, and its definition is more commonly used in the American subcontinent. Because of this, there are now varying opinions on the subject, which makes it hard to compare statistics from different countries. In the Indian context, there are similar issues with defining and evaluating.²⁰

Epidemiology

The development of DSH, which is a risk element that influences SAs and is more prevalent in adolescents and young people, is an important public health problem.²⁰

India has experienced swift sociocultural transformations over the past few decades because of the revolution that has been technology. This leads to the convenient accessibility of social networking sites and the web for young

individuals via smartphones, thereby exposing them to violent content and generating peer pressure that adversely impacts their mental well-being.²⁰

DSH is observed in several different ages and social and economic categories within society, at varying levels.^{21,22} Nevertheless, it is more prevalent among the adolescent demographic. Moreover, the aetiology and magnitude of self-inflicted damage among teenagers varied within and within nations, as well as across various socio-economic contexts.^{23,24}

Although there are various types of self-imposed harm, such as carving, scratching, branding, marking, picking or pulling skin or hair, burning, cutting, biting, hitting, or excessive body piercing, that may not result in severe health consequences, there are other forms that are inherently hazardous and can lead to significant injuries and fatalities.²¹

Problem statement

The data collected from 40 LMICs revealed that the average 12-month prevalence of self-harm behaviours among teenagers was 17.2%. Girls had a greater overall prevalence of SAs and a larger proportion of SAs with a plan. Additionally, both the incidence of SAs and the percentage of SAs with plans for suicide worsened with age.³

According to Patel et al., the probability of dying by committing suicide at the age of 15 in India is approximately 1.3%. The risk of suicide is significantly

higher, ranging from 50 to 100 instances, within the first year following a self-harm event.²⁵

A study conducted in India examined 1571 young adults and teenagers from 19 schools and institutions. The study revealed that the prevalence of NSSI was 33.8%. The study revealed a prevalence rate of 40.7% for any type of self-injury. Approximately 18.5% of patients indicated any intention to commit suicide.²⁶ According to a comparable study, 31.2% of students in higher education reported engaging in NSSI in the year prior to the study, with an average age of onset at 15.9 years.²⁷

Risk factors for DSH^{28–31}

Psychosocial environmental factors, population-specific traits, and the interplay between these and other determinants all contribute to the prevalence of indicators of risk for self-inflicted damage.³²

Static risk factors

- Female gender
- Certain ethnic minorities
- Sexual and gender minorities
- Childhood maltreatment
- Biological processes (although medications could alter this factor)

Dynamic risk factors

- Bullying (victimization and perpetration)
- Internet addiction/high level of internet use
- Certain youth subcultures (eg, goth, emo)
- Impulsivity
- Loneliness
- School absenteeism
- High family conflict
- Low parental monitoring
- Low maternal support and warmth
- Parental alcohol abuse
- Parental adversity
- Substance use
- Emotional dysregulation
- Sleep problems

Figure 7: Risk factors for Non suicidal self-injury.

Many different things can put someone at risk for self-harm. Protective variables, which are not only the opposite of determinants but are also stated alongside them, have received less attention yet are no less crucial. The clinical and psychological variables that distinguish suicidal ideation from self-harm are shown in Table 1.

<i>Factors</i>	<i>Suicide/failed suicide</i>	<i>Deliberate self harm</i>
Age	Can be present in all ages	Adolescents (aged 15– 24) and young females are more vulnerable
Gender	Both male and female	More in female
Marital status	–	Higher in divorced and separated
	–	Childhood maltreatment, higher in separated/divorced parents
Childhood experiences	–	Higher risk in a homosexual man
Sexual orientation	Heterosexual	–
Illness	Depressive episode	Neurotic spectrum like anxiety
Intentionality	To end life and to relieve from pain	To drain pent-up emotions
Lethality	Can be high to medium	Medium to low
Methods	Significantly harmful like the use of pesticides, shooting, hanging	Less harmful
Frequency	Usually single mode	Usually multiple
Stressful situation	May not be significant	Significant
Past history	Maybe present	Usually present
Presence of suicide/serious attempt in family	Maybe present	Less likely
Presence of personality traits/disorder	Less likely	More likely
Planning	Most of the time planned and prepared for the act	Usually impulsive

Table 1: Psychosocial and clinical factor to differentiate between self-harm and suicide.

Personality Disorders

People who exhibit unusual patterns of thought, emotion, behaviour, or interpersonal interaction are recognized during routine clinical treatment. This out-of-the-ordinary behaviour is hallmark of PDs.

Individuals with PDs are said to have "a pervasive pattern of thought, feeling and behaviour that characterize an individual's unique lifestyle and mode of adaptation, which deviates markedly from the expectations of the individual's culture." This description has changed slightly over the years, but broadly stands. Having such traits undoubtedly makes life more difficult for the bearer. Some PDs manifest in early adulthood or youth, whereas others cause impairment or discomfort and seem to be stable throughout time.³³

English physicist Sir Francis Galton (1882–1911) is credited with the precursor to the modern effort to ascertain the structure of human personality. The underlying premise of his lexical approach to character traits was that the language of a community will reflect the values held by its members.³⁴

Many others picked up where this one left off, and the lexical concept is still the bedrock of modern methods for describing aspects of personality.³⁵

PDs are medical diagnoses that are derived from symptoms that are reported by the individual, by others in their immediate environment, or by researchers in

controlled laboratory settings. Because of this, the present diagnostic tools do not have ideal validity and reliability.³⁶

Personality pathology

Studies describing personality pathology have mostly relied on four viewpoints to form our current understanding of abnormal characters.³³

1. The clinical image, which is the total of all the observed or reported clinical symptoms, is the first point of view. Clinical organized assessment regarding categories is based on this viewpoint.
2. In the alternative view, the brain's cognitive, emotional, and impulse regulation mechanisms are examined to identify any underlying disordered personality characteristics or functional limits.
3. The third view is concerned with the biological processes and activities of the brain; this view has profited greatly from the fast advancement of brain scanning methods.³⁷
4. Current approaches to these phenomena are based on whole-genome correlation research, which brings us to our fourth point of view.³⁸

Classification of personality disorders

Disorder	Characteristics in brief
Paranoid	Excessive sensitivity to setbacks, unforgiveness of insults, recurrent suspicions without justification regarding the sexual fidelity of the spouse or sexual partner, and a combative and tenacious sense of personal rights.
Schizoid	Withdrawal from affectional, social, and other contacts, preference for fantasy, solitary activities, and introspection. Limited capacity to express feelings and to experience pleasure.
Dissocial	Disregard for social obligations, callous unconcern for the feelings of others. Gross disparity between behaviour and prevailing social norms. Behaviour not readily modifiable by adverse experience, including punishment. Low tolerance to frustration; low threshold for discharge of aggression, including violence; tendency to blame others, all leading to conflict with society.
Emotionally unstable	A tendency to act impulsively and without consideration of the consequences; unpredictable and capricious mood. Liability to outbursts of emotion and incapacity to control the behavioural explosions. Tendency to quarrelsome behaviour and to conflicts with others. Two types are distinguished: the impulsive type with emotional instability and lack of impulse control; and the borderline type, with added disturbances in self-image, aims, and internal preferences, chronic feelings of emptiness, intense and unstable interpersonal relationships, and a tendency to self-destructive behaviour, including suicide gestures and attempts.
Histrionic	Shallow and labile affectivity, self-dramatization, theatricality, exaggerated expression of emotions, suggestibility, egocentricity, self-indulgence, lack of consideration for others, easily hurt feelings, and continuous seeking for appreciation, excitement, and attention.
Anankastic	Feelings of doubt, perfectionism, excessive conscientiousness, checking and preoccupation with details, stubbornness, caution, and rigidity. There may be insistent and unwelcome thoughts or impulses that do not attain the severity of an obsessive-compulsive disorder.
Anxious [avoidant]	Feelings of tension and apprehension, insecurity and inferiority. A continuous yearning to be liked and accepted, hypersensitivity to rejection and criticism with restricted personal attachments, and a tendency to avoid certain activities by habitual exaggeration of the potential dangers or risks in everyday situations.

Dependent	Pervasive passive reliance on other people to make one's major and minor life decisions, great fear of abandonment, feelings of helplessness and incompetence, passive compliance with the wishes of elders and others, and a weak response to the demands of daily life. Lack of vigour may show itself in the intellectual or emotional spheres; often a tendency to transfer responsibility to others.
Other specific	Eccentric, 'haltlose' type, immature, narcissistic, passive-aggressive, psychoneurotic.
Unspecified	Diffuse symptoms, not fully qualifying for specific PD, but with the general criterion fulfilled.

Table 2: Personality disorders in the ICD-10

A definitive diagnosis of PD is a challenge for specialized psychiatry since it is a function that depends on the passage of time. The current clinical situation must be understood in perspective and against a backdrop of the someone's distinctive developmental past events, which requires a patient history that covers the life viewpoint.

When gathering information about the individual's medical history, it is normal practice to begin with details about the present issue and the individual's current living environment. The hazards of violence and suicide require consideration. At the right times, you should fill out the medical records piecemeal.

Problem statement

Individuals with PDs make up over 25% of inpatient mental health admissions and 20% of emergency department visits; the overall prevalence of PDs is around 7.8% of the entire population.^{39,40} In mental health and primary care settings, BPD is the most common personality disorder.⁴¹

The International personality disorder examination (IPDE)

The International personality disorder examination (IPDE) was developed within the Joint Program for the DSM of the WHO and US ADAMHA.⁴² Global clinical research relies on standardized diagnostic assessment instruments, which is why their development and standardization was the primary goal.⁴³

One method for evaluating PDs in the ICD-10 and DSM IV categorization systems is the IPDE, which is a semi-structured questionnaire by investigator. The IPDE offers two manuals for the evaluation of PDs: one based on the DSM IV criteria and the other on the ICD-10 criteria. Although they are distinct, these two systems of classification do overlap.⁴⁴ The terminology and criteria for diagnosis are different.

ICD-10 has “anankastic, anxious and dissocial instead of obsessive compulsive, avoidant and antisocial personality disorders respectively.”⁴³

Also, narcissistic personality disorder isn't part of the emotionally unstable PD subcategories in ICD-10; borderline and impulsive are. There are 67 items in the IPDE ICD-10 manual. The screening survey is also a part of it; it has 59 items and patients have to mark them as true or untrue.⁴²

Relevant articles

1. In 2023, Tay et al. performed a cross-sectional study on 40 inpatients to investigate the relationship between the intensity of suicide attempt and maladaptive PTs in individuals who SH.⁴⁵ The majority of the patients (n = 33, 89.19%) were initial consumers of DSP, and about 64.86 percent of those patients were for the first time self-harming individuals overall. A little over two-thirds (n = 24), or 64.86 percent, intended to take their own lives. Adjustment disorder was the most prevalent diagnosis, with 21 cases (56.76%). Nearly every individual tested positive for a maladaptive PT, and nearly all those people (n = 33, or 89.19%) had multiple PTs. Inpatients with DSH were shown to frequently exhibit maladaptive PTs, and the intensity of suicidal intent was positively associated with dissocial characteristics, according to their findings.
2. By 2010, 70 Australian women with a diagnosis of borderline personality disorder had participated in a RCT by Maddock et al., which aimed to identify the causes of DSH occurrences.¹⁹ They also contrasted the explanations provided for S-DSH and NS-DSH incidents. There was an elevated risk of S-DSH (adjusted odds ratio 12.07) in the group which utilized techniques including DSP, jumping, or stabbing compared to the reference group, which entailed external skin harm without the need for rescue contact. There was no statistically significant aggregation of

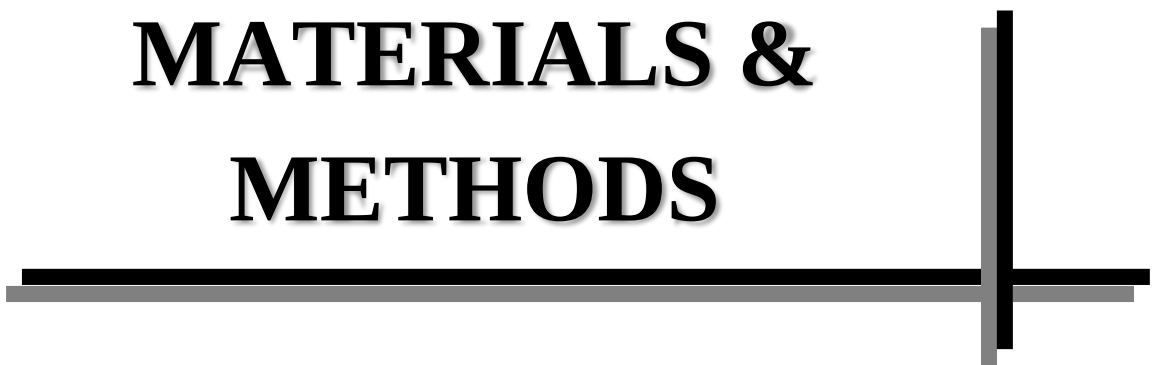
causes, although the likelihood of an S-DSH event increased as the DSH event's efficacy decreased in resolving the causes of the event. Their research led them to the conclusion that S-DSH events should be suspected in clinical settings involving patients with borderline PD who seek assistance or remedial attention, who use methods other than superficial external skin damage, or who report not being able to effectively resolve the reasons for the DSH event. Subject features or the precise cause of the DSH event failed to differentiate between S-DSH and NS-DSH events.

3. From 2013 through 2015, 398 consecutive teenage psychiatric patients presented at General Hospital in Singapore. Lauw et al. retrieved socioeconomic and medical information from these records in a retrospective assessment.⁶ Among the teenagers they studied, 3.1% participated in some form of DSH. The majority of DSH cases were classified as cutting. It was three times more common for females than for males to participate in DSH. Female gender, mental disorders, alcohol usage, and forensic background were all positively correlated with DSH.
4. From 114 suicidal patients admitted to general hospitals in Helsinki, Finland, Suominen et al. compared the clinical features of suicidal attempters with and without PTs.¹² Cluster A included four subjects, Cluster B included thirty-four, and Cluster C included eight individuals

with personality disorders as defined by DSM-III-R. Clinical features and treatment outcomes were compared between these individuals and sixty-five suicide attempters who did not suffer from PDs. Clinical features at the moment of trying to commit suicide may not differ between persons with PDs and those without, they found, even though suicidal behaviour is more persistent among people with PDs.

5. A study was carried out by Haw et al. to ascertain the kind and frequency of mental and PDs in 150 individuals who intentionally hurt themselves.⁴⁶ A total of 138 individuals (92.0%) were found to have a diagnosable mental health problem, with 46.7% experiencing co-occurring mental health disorders. At 72.0%, affective disorder was the most prevalent diagnosis. A total of 45.9% of patients questioned during the follow-up interview were found to have a PD. Among those who were diagnosed, 44.1% had both a mental illness and a PD.

MATERIALS & METHODS



MATERIALS AND METHODS

STUDY DESIGN:

In this analytical cross-sectional study, persons who had a history of DSH were investigated.

STUDY AREA:

The participants in the research were individuals who had a history of DSH who visited the psychiatric department of RL Jalappa hospital in Kolar. This hospital is a teaching hospital of Sri Devaraj Urs Medical College.

STUDY PERIOD AND DURATION:

Over the course of one year and four months, the study period turned out to be between September 2022 and December 2023.

STUDY POPULATION:

Everyone admitted to the RL Jalappa hospital's psychiatry department with a diagnosis of DSH between September 2022 and December 2023. In addition, we incorporated individuals who were referred to the Psychiatry department from another department.

SAMPLE SIZE CALCULATION

In a one-year cross-sectional study, 525 individuals with mental illnesses at a tertiary hospital had their PTs assessed by Saini et al. They found that 56.3% of

patients had symptoms of the PD.⁴⁷ We determined the sample size using the following formula:

$$N = 3.84 * p * q / d^2,$$

where p is the prevalence rate, q is the complement of p, and d is the precision (with a 7% absolute error) needed to draw the conclusion.” At least 193 people had to take part in the study for it to be valid.

INCLUSION CRITERIA:

- From the age range of 18 to 60 years old, individuals who had DSH attempted to get treatment.
- Patients who give consent for screening questionnaire.

EXCLUSION CRITERIA:

- Inability to understand the interview questions is a common symptom among people with significant intellectual disabilities and mental disorders.
- Individuals with serious neurological and physical illnesses.
- Individuals who were previously identified with PD.

SAMPLING METHOD:

All sequential patients diagnosed with DSH from September 2022 to December 2023 and admitted to the psychiatric department of RL Jalappa hospital,

affiliated with Sri Devaraj Urs Academy of Higher Education and Research Tamaka, Kolar, received treatment for their condition.

DATA COLLECTION PROCEDURE

The researcher conducted a comprehensive investigation into DSH, gathering detailed accounts from patients and a trusted informant through in-depth interviews. Subsequently, these case studies were deliberated with the psychiatrist in the department. The diagnosis of personality profiles in patients who engage in DSH was determined according to the recommendations provided by the ICD-10 and DSM-V, and the IPDE questionnaire was utilized. Responses were documented and scoring was conducted according to the answers provided.

STUDY TOOLS

International Personality Disorder Examination (IPDE) Screening Questionnaire

This is a self-administered questionnaire used to evaluate PDs. The patient provides a response of either True or False to each question and can finish these questions within a time frame of 10-15 minutes. The clinician can efficiently assess the survey answers and promptly identify patients with PD. Patients who scored positively for a specific number of criteria for any PD were classified as having a personality disorder.^{42,43}

ETHICAL CONSIDERATION

In terms of ethics, the Institutional Ethics Committee granted its approval. The researchers ensured that the privacy and confidentiality of the participants were upheld throughout the study by exclusively utilizing the collected data for the intended purposes.

DATA ANALYSIS

- After collecting the data, it was entered into Excel and subsequently run through IBM's statistical software, SPSS 23.0.
- To describe the data using descriptive statistics for discrete variables, we used percentage analysis and frequency analysis. We used the mean, median, and standard deviation for the continuous variables.
- To characterize the data in inferential statistics, we used the Chi-square test or Fisher's exact test to look for statistically significant differences in the two groups' discrete variables.
- All statistical methods used a significance level of 0.05 as their cutoff.

RESULTS



RESULTS

Table 3: Age composition of research subjects.

Age in years	
Mean	31.46
Std. Deviation	9.754
Range	43
Minimum	18
Maximum	60

The mean age of research subjects was 31.46 ± 9.75 years. The minimum age of the patients was 18 years, and the maximum age of the study participants was 60 years.

Table 4: Gender composition of research subjects.

Gender	Frequency	Percent
Female	99	51.3
Male	94	48.7
Total	193	100

Among the study participants, 51.3% were female and the remaining 48.7% were males.

Figure 8: Gender composition of research subjects.

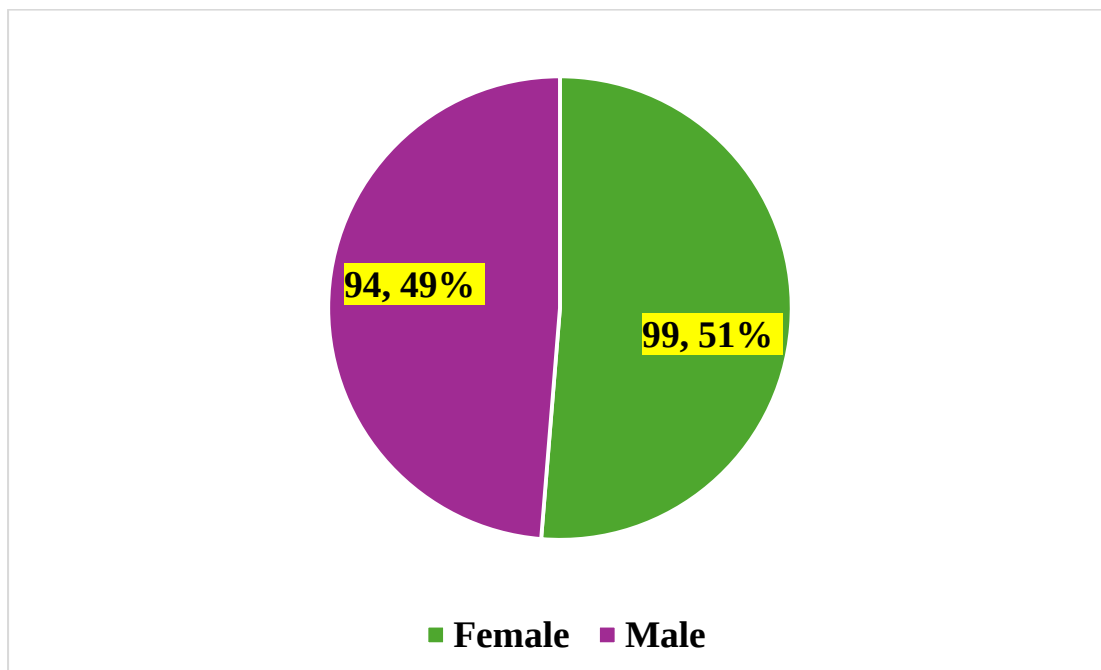


Table 5: Social class allocation of participants in studies.

Socio economic status	Frequency	Percent
Lower	136	70.47
Middle	57	29.53
Total	193	100

Among the study participants, 70.5% belonged to lower income status and the remaining 29.5% belonged to middle income status.

Figure 9: Social class allocation of participants in studies.

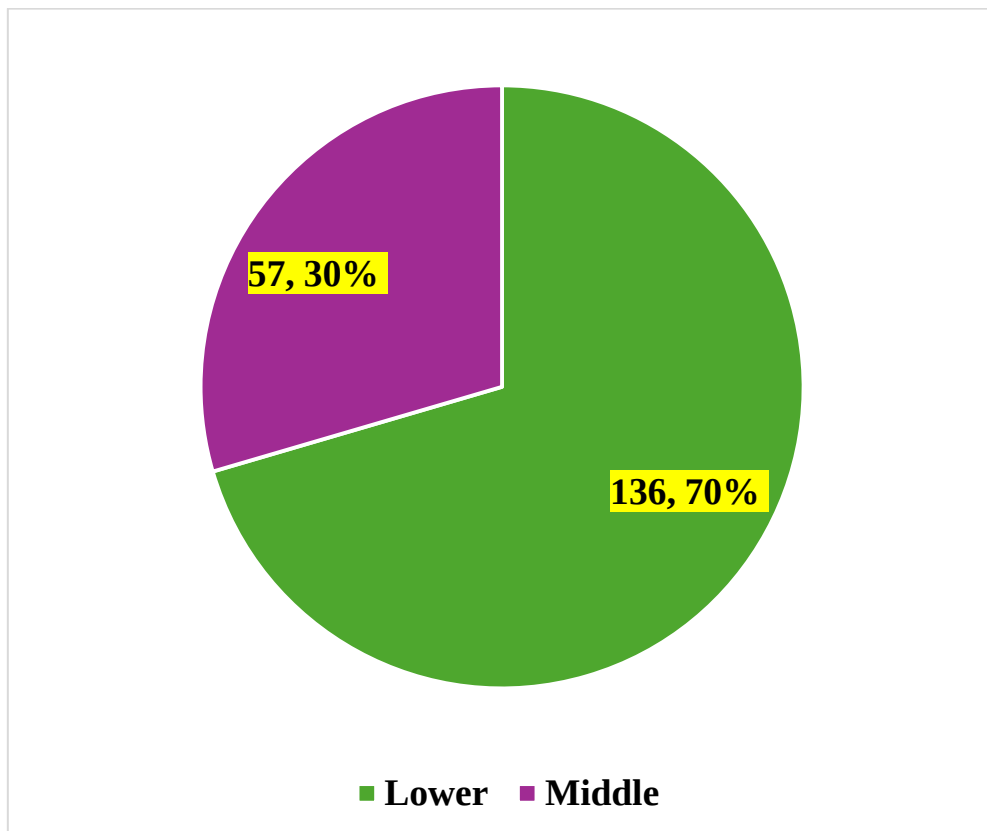


Table 6: Marital status proportion among those participating in the study.

Marital status	Frequency	Percent
Married	61	31.61
Unmarried	132	68.39
Total	193	100

Among the study participants, 31.6% were married and the remaining 68.4% were unmarried.

Figure 10: Marital status proportion among those participating in the study.

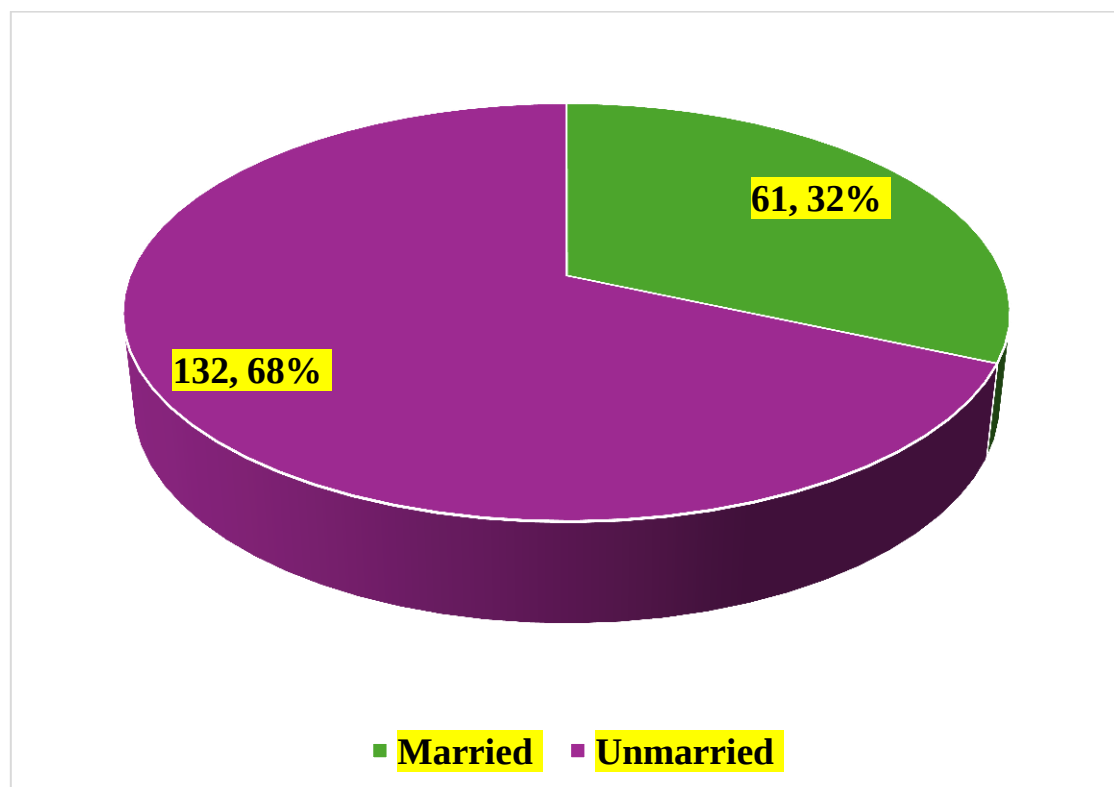


Table 7: The research's respondent allocation according to their occupation.

Occupational status	Frequency	Percent
Employed	100	51.81
Unemployed	93	48.19
Total	193	100

Among the study participants, 51.8% were employed and the remaining 48.2% were unemployed.

Figure 11: The research's respondent allocation according to their occupation.

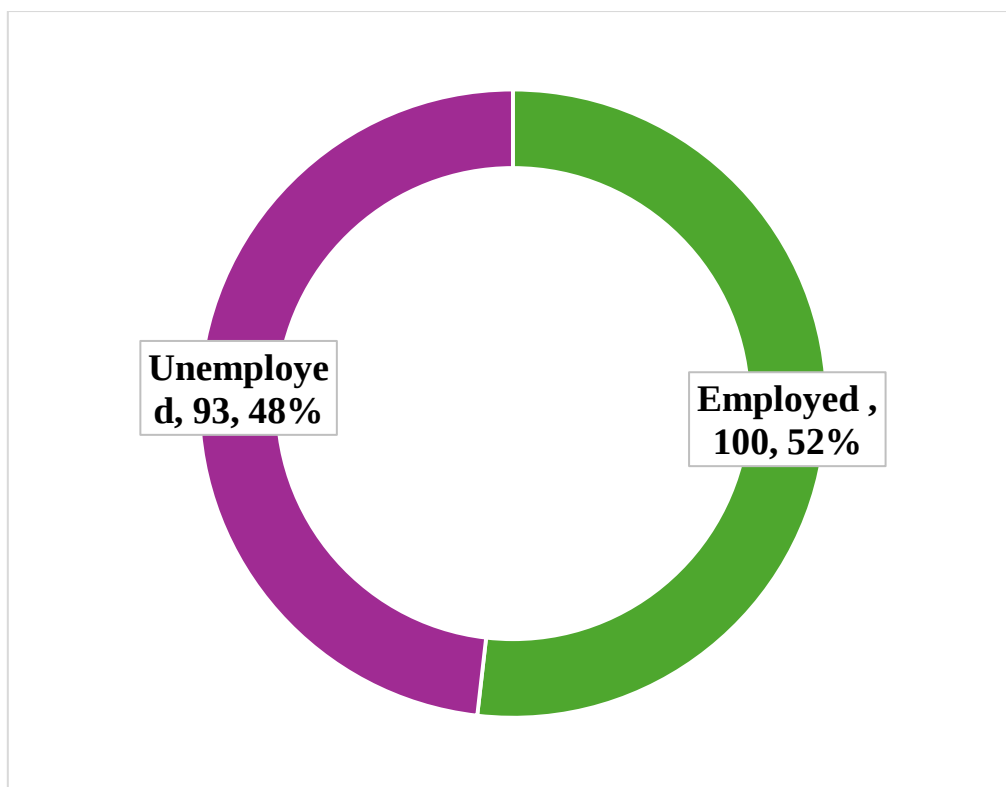


Table 8: Geographical placement of research subjects.

Place of residence	Frequency	Percent
Rural	164	84.97
Urban	29	15.03
Total	193	100

Among the study participants, 84.9% came from rural areas and the remaining 15.1% came from urban areas.

Figure 12: Geographical placement of research subjects.

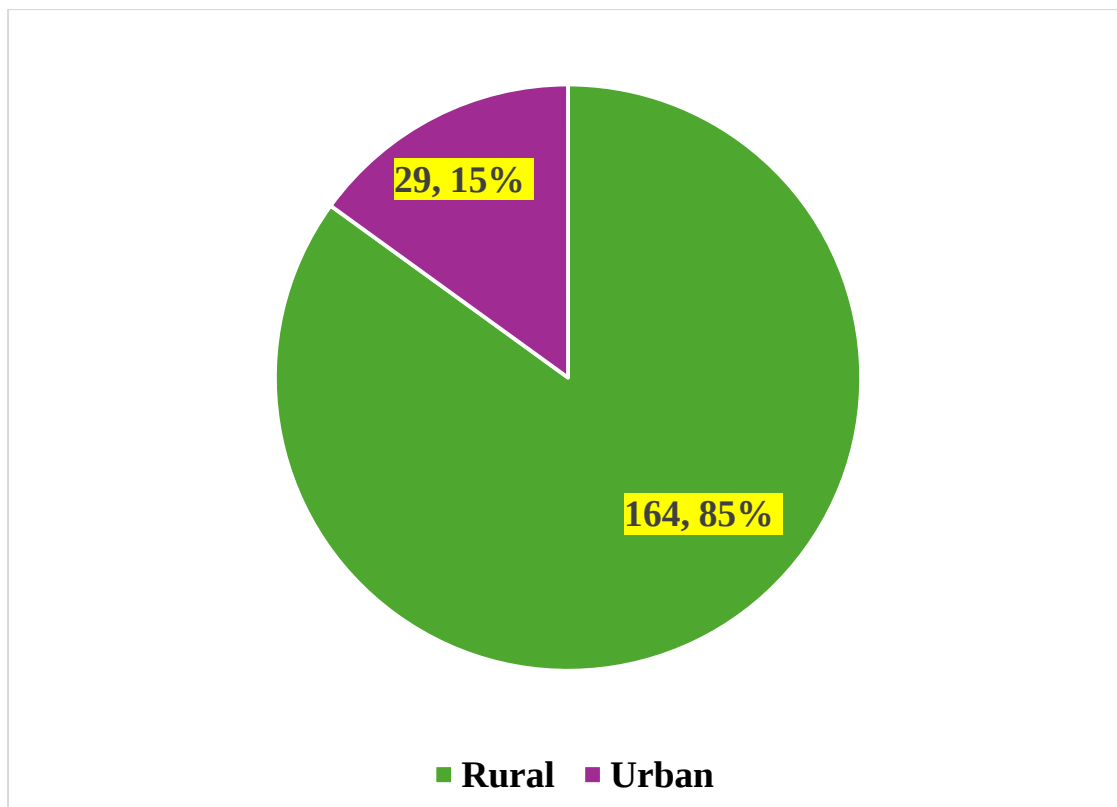


Table 9: A summary of the research subjects according to their degree of education.

Educational status	Frequency	Percent
Graduate	38	19.69
High school	63	32.64
Primary school	12	6.22
Secondary school	70	36.27
Uneducated	10	5.18
Total	193	100

Among the study participants, 36.27% has completed secondary school education while 32.6% has completed high school education. Only 5.1% of the samples were uneducated.

Figure 13: A summary of the research subjects according to their degree of education.

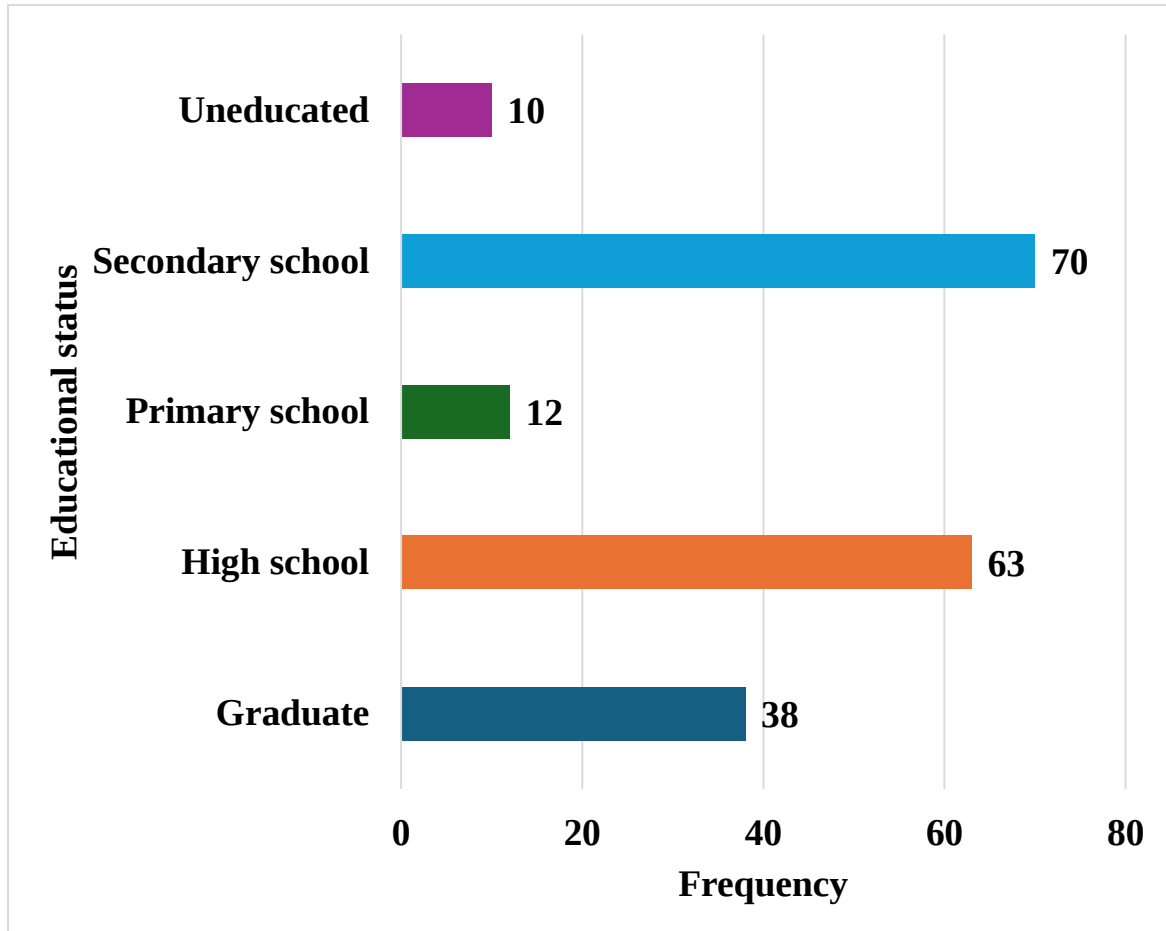


Table 10: Psychiatric diagnosis of enrolled patients as per ICD 10.

Diagnosis	Frequency	Percent
DSH	111	57.5
DSH, Acute Stress Reaction	10	5.2
DSH, Adjustment disorders	33	17.1
DSH, Anxiety disorder	3	1.6
DSH, Depression	22	11.4
DSH, Dysthymia	5	2.6
DSH, Grief reaction	3	1.6
DSH, Panic disorder	6	3.1
Total	193	100

Among the study participants, 57.5% has attempted deliberate self-harm without any psychiatric illness while 42.5% has attempted deliberate self-harm with the presence of psychiatric illness. The most prevalent psychiatric illness was adjustment disorders (17.1%) followed by depression (11.4%) and acute stress reaction. (5.2%)

Table 11: Study participants were distributed according to their history of suicidal thoughts and attempts.

Previous history of suicide attempts	Frequency	Percent
Yes	103	53.4
No	90	46.6
Total	193	100.0

Among the study participants, 53.4% had previous history of suicide attempts. and the remaining 46.6% did not have previous history of suicide attempts.

Figure 14: Study participants were distributed according to their history of suicidal thoughts and attempts.

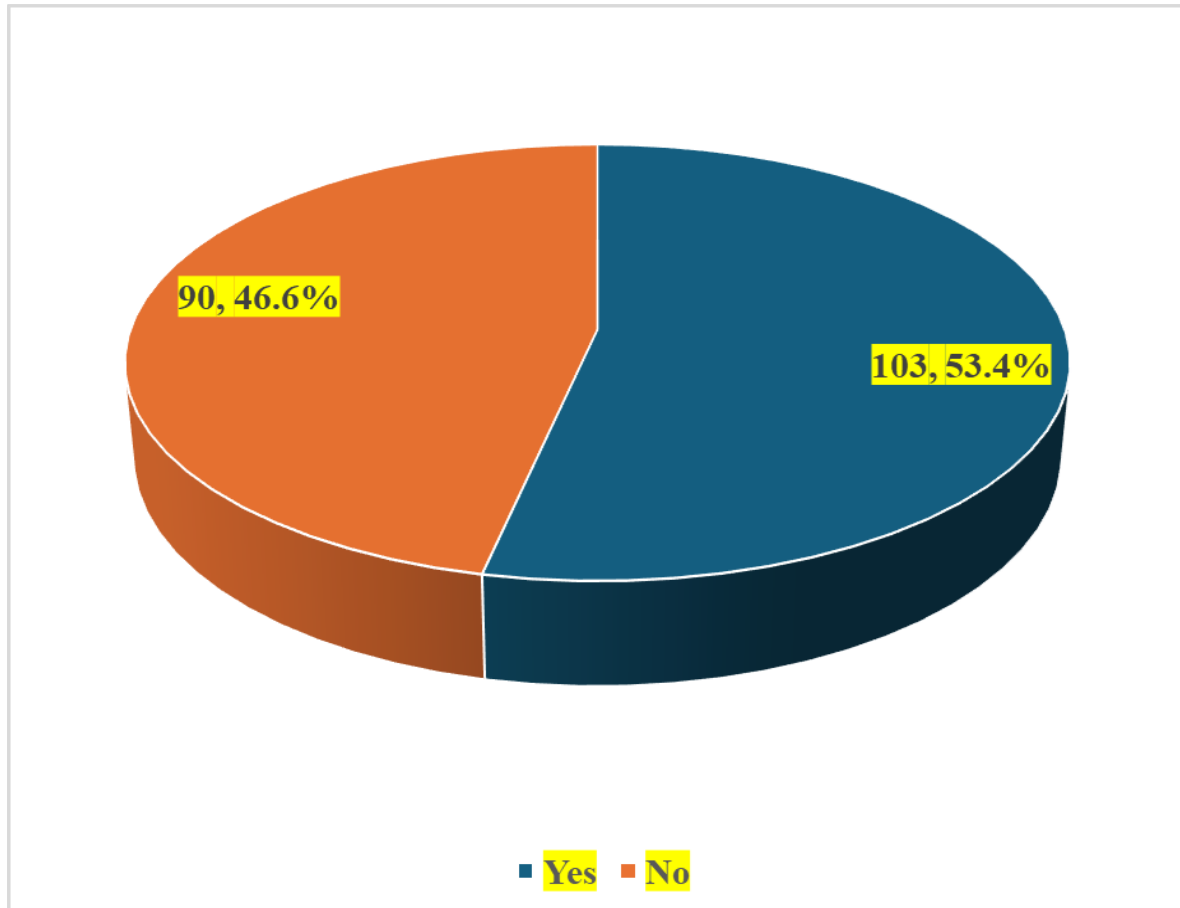


Table 12: Categorization of study subjects according to the presence of stress.

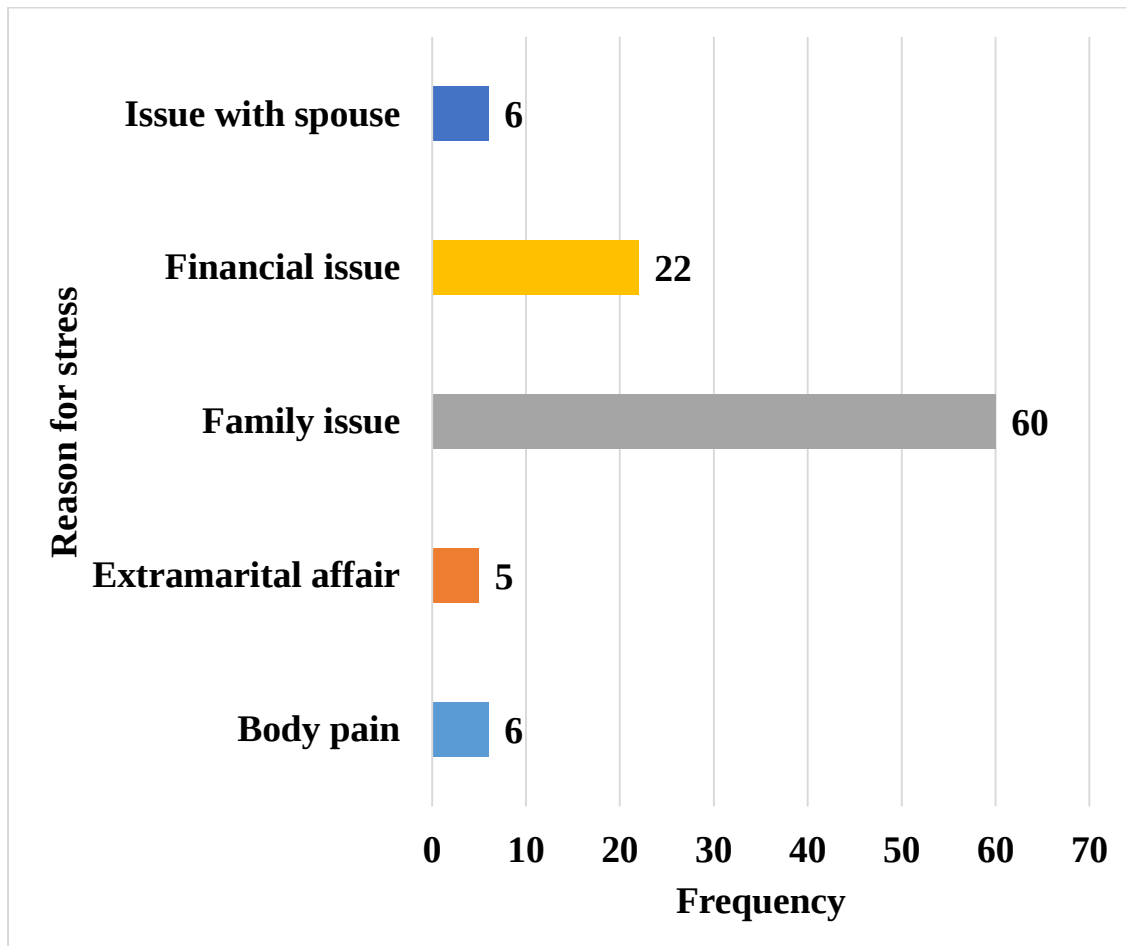
Stressor	Frequency	Percent
Yes	99	51.3
No	94	48.7
Total	193	100.0

Among the study participants, 51.3% has self-reported the presence of stress and the remaining 48.7% did not report stress.

Table 13: The study respondents were categorized according to the reason for their stress.

Reason for stress	Frequency	Percent
Body pain	6	6.1
Extramarital affair	5	5.1
Family issue	60	60.6
Financial issue	22	22.2
Issue with spouse	6	6.1
Total	99	100.0

Figure 15: The study respondents were categorized according to the reason for their stress.



Among the study participants who reported the presence of stress, 60.6% has self-reported family issue and 22.2% has reported financial issue.

Table 14: The study respondents are categorized according to their birth order.

Birth order	Frequency	Percent
1	75	38.9
2	82	42.5
3	22	11.4
4	12	6.2
5	1	0.5
6	1	0.5
Total	193	100

Among the study participants, 42.5% were born second in their family and 38.9% were born first in their family.

Table 15: Classification of the subjects of study according to family type.

Type of Family	Frequency	Percent
Joint family	39	20.2
Nuclear	154	79.8
Total	193	100.0

Among the study participants, 79.8% belongs to nuclear family and the remaining 20.2% belongs to joint family.

Figure 16: Classification of the subjects of study according to family type.

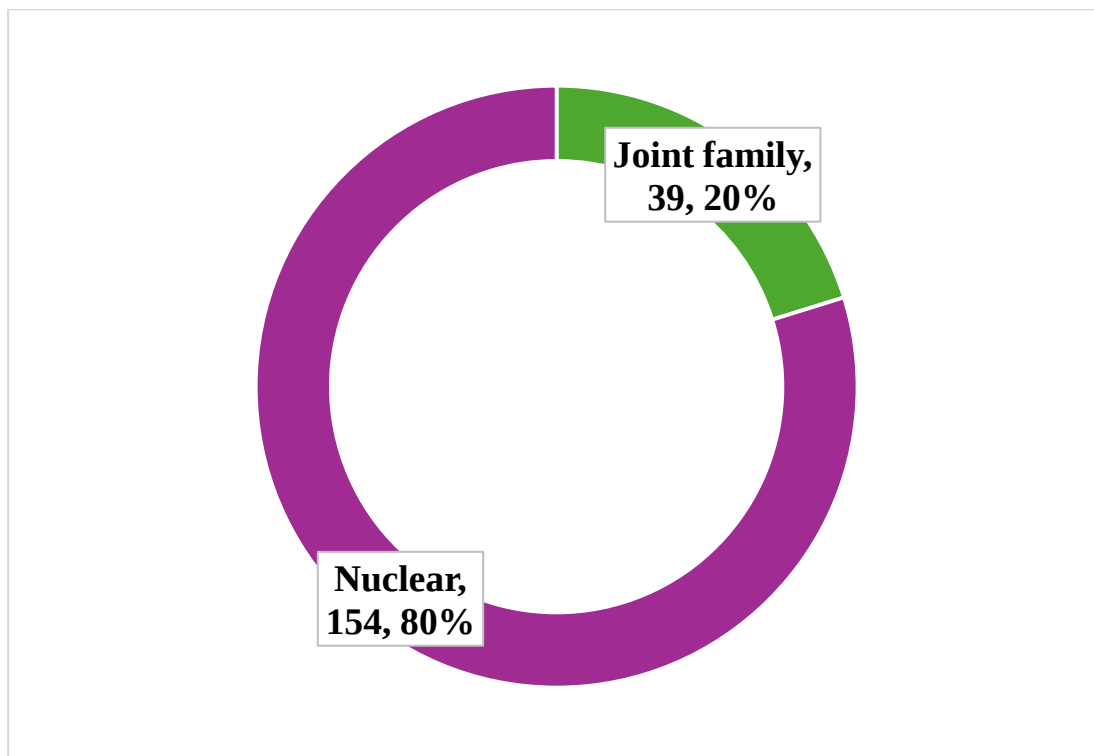


Table 16: Categorization of those who participated according to their religious affiliation.

Religion	Frequency	Percent
Hindu	184	95.3
Muslim	9	4.7
Total	193	100.0

Among the study participants, 95.3% belongs to Hindu religion and the remaining 4.7% belongs to Muslim religion.

Figure 17: Categorization of those who participated according to their religious affiliation.

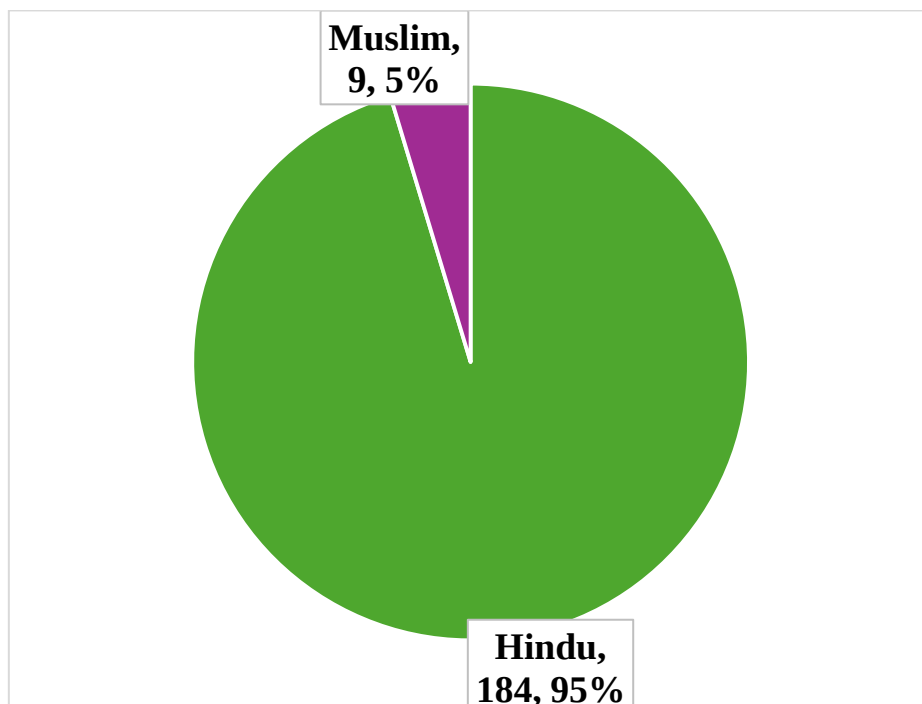


Table 17: The categorization of participants in the study according to the substances they are using.

Substance Abuse	Frequency	Percent
Alcohol & Arecanut	4	2.1
Alcohol, Smoking, Tobacco	6	3.1
Alcohol, & Tobacco	15	7.8
Alcohol & Smoking	18	9.3
Alcohol alone	32	16.5
Smoking alone	8	4.1
Tobacco alone	14	7.3
No	96	49.7
Total	193	100.0

Among the study participants, substance abuse was noticed among 50.25% and the remaining 49.7% did not have any substance abuse habits. The most common substance abuse was alcohol use in the present study.

Table 18: Categorization of those who participated according to the presence of substance misuse.

Substance abuse	Frequency	Percent
Yes	97	50.26
No	96	49.74
Total	193	100.0

Figure 18: Categorization of those who participated according to the presence of substance misuse.

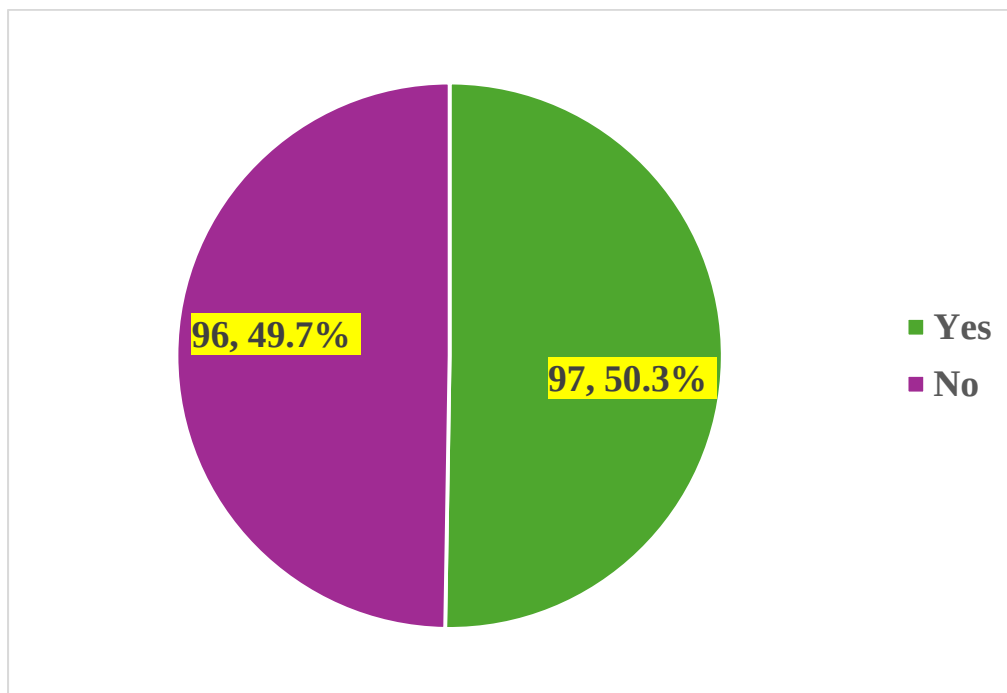


Table 19: The categorizing of study subjects according to the existence of comorbidity.

Presence of Comorbidity	Frequency	Percent
Yes	48	24.87
No	145	75.13
Total	193	100.0

Figure 19: The categorizing of study subjects according to the existence of comorbidity.

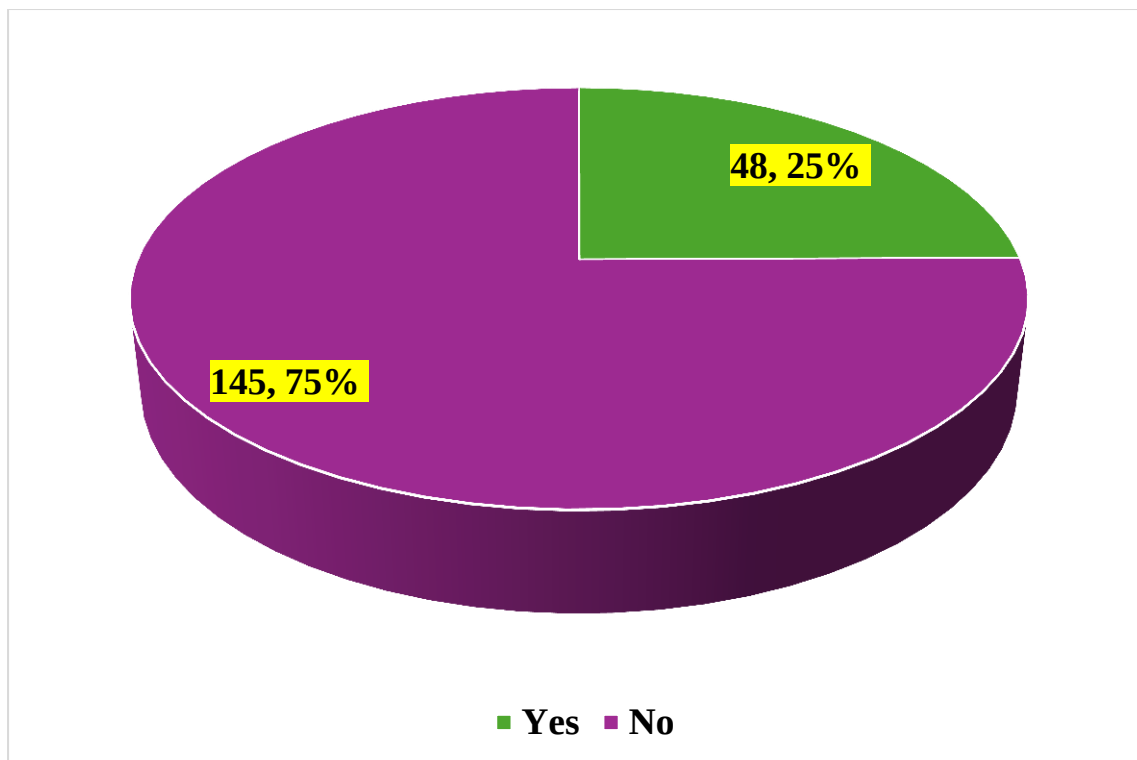


Table 20: The categorization of the study subjects according to their coexisting medical conditions.

Co-Morbidity	Frequency	Percent
Anaemia	1	0.5
Asthma	1	0.5
Diabetes Mellitus	11	5.7
Diabetes Mellitus, Respiratory failure	2	1.0
Hypertension	17	8.8
Hypertension, Diabetes Mellitus, Thyroid disorder	2	1.0
Seizure	12	6.2
Thyroid disorder	2	1.0
No	145	75.1
Total	193	100.0

Among the study participants, the occurrence of co-morbidities was noticed among 24.9% and the remaining 75.1% did not have any co-morbidities. The most common co-morbidity was hypertension in present study.

Table 21: Classifying the research subjects according to suicide method.

Method of Suicide	Frequency	Percent
Hanging	24	12.4
Liquid Poison	126	65.8
Multiple Tablets	28	14.5
Self-cut	15	7.8
Total	193	100.0

The most common method of suicide attempts was liquid poison (65.8%), followed by Multiple tablets (14.5%). Hanging method was practised by 12.4% of the participants and only 7.8% of samples practised self-cut as a method of suicide.

Figure 20: Classifying the research subjects according to suicide method.

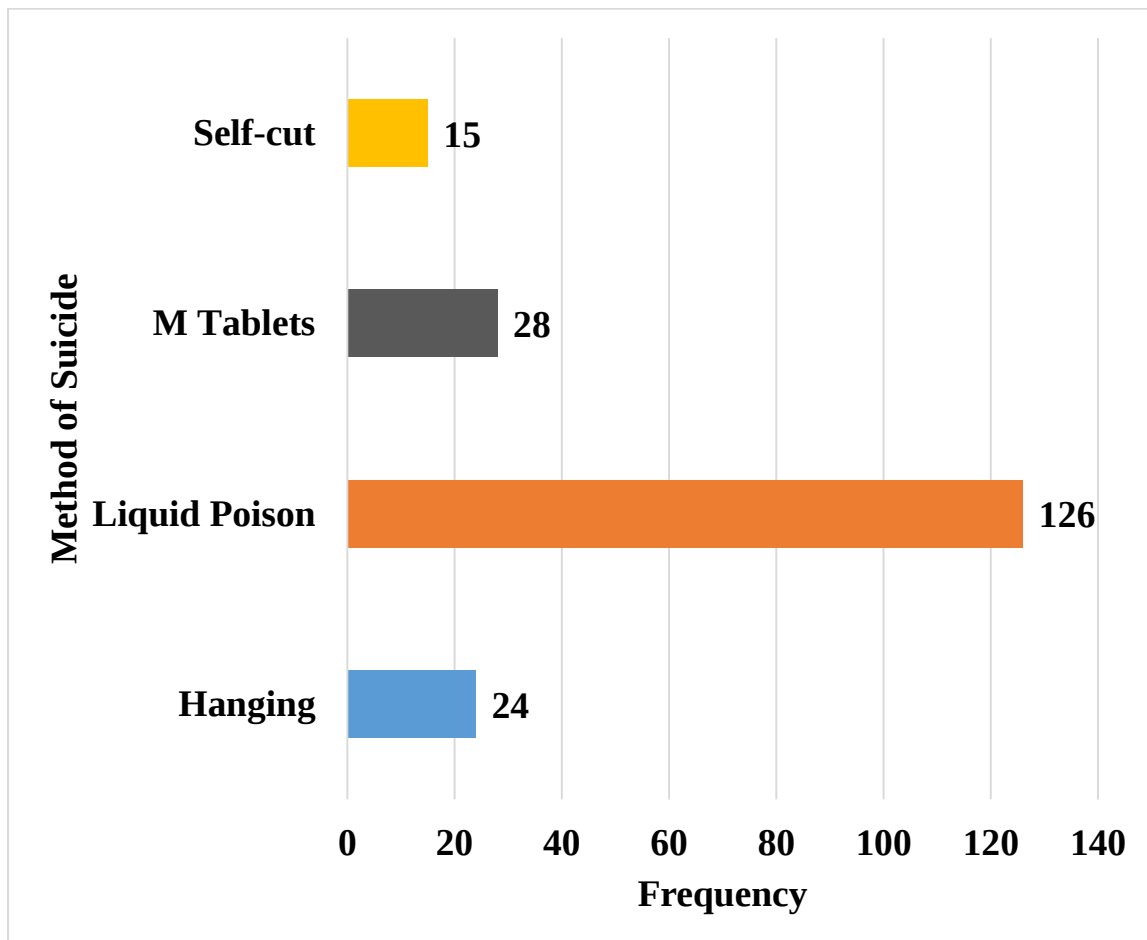


Table 22: The categorization of those who participated according to their personality trait distribution.

Personality Trait	Frequency	Percent
Anankastic	6	3.1
Anxious	18	9.3
Borderline	48	24.9
Dependent	42	21.8
Dissocial	9	4.7
Histrionic	14	7.3
Impulsive	27	14
Paranoid	13	6.7
Schizoid	16	8.3
Total	193	100

The most common personality trait in the present study was borderline (24.9%) based on the International Personality Disorder Examination (IPDE) Screening Questionnaire. It was followed by dependent (21.8%) and impulsive (14%).

Table 23: The study participants were categorized according to the sort of clusters they belonged to.

Clusters	Frequency	Percent
Cluster A	29	15.0
Cluster B	98	50.8
Cluster C	66	34.2
Total	193	100.0

Cluster B (50.8%) was the most common personality clusters in the present study. Cluster C was noticed among 34.2% of the samples and the remaining 15% was Cluster A group of personality.

Figure 21: The study participants were categorized according to the sort of clusters they belonged to.

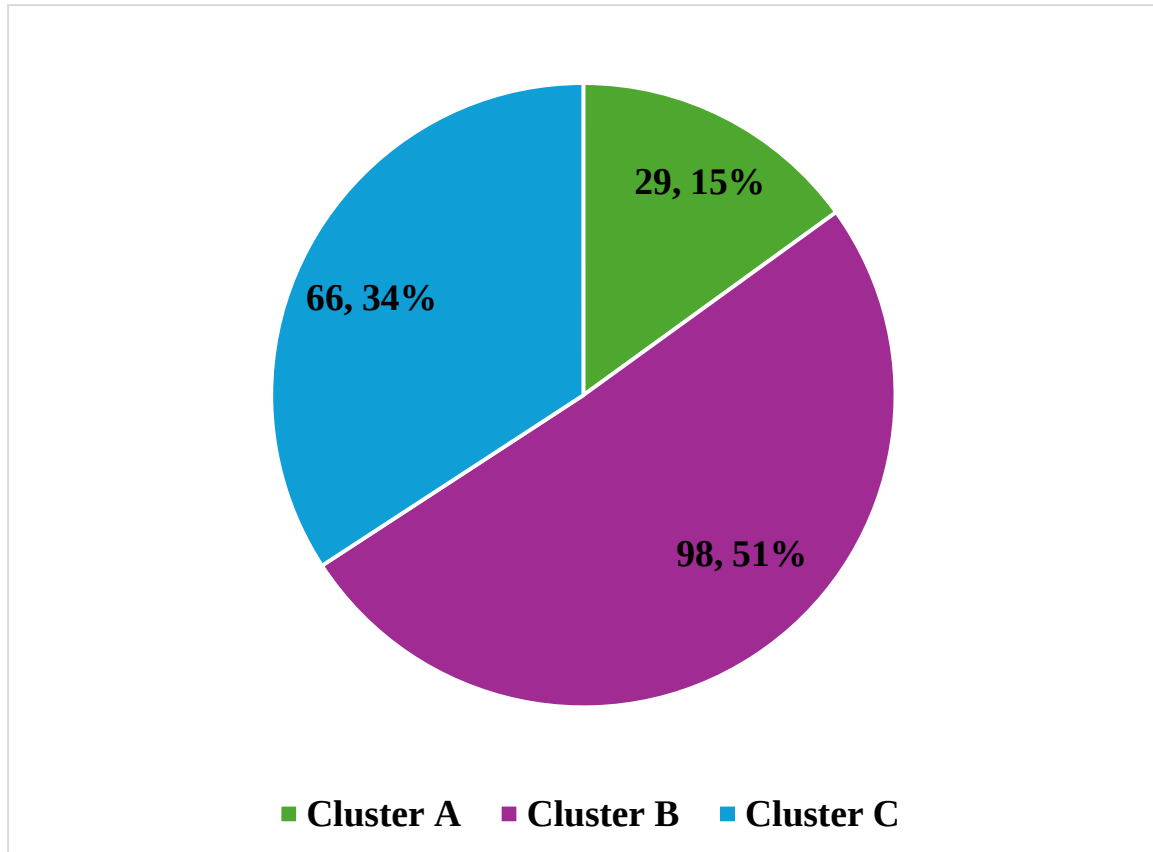


Table 24: Relationship between age group and personality profile among patients with deliberate self-harm.

Clusters	Age Group						Total	
	18 - 30		31- 45		56 - 60			
	n	%	n	%	n	%	n	%
Cluster A	9	6.87	13	33.33	7.00	30.43	29	15.03
Cluster B	78	59.54	9	23.08	11.00	47.83	98	50.78
Cluster C	44	33.59	17	43.59	5.00	21.74	66	34.20
Total	131	100	39	100	23.00	100.00	193	100

Chi square value = 28.111, P value = 0.0001

Individuals with Cluster B trait (50.7%) presented with more DSH in comparison to other cluster groups. Among them, younger age group of 18 to 30 years (59.5%) had higher number of DSH in comparison to other two groups. But in other two cluster groups, age group of 31 to 45 years had higher number of DSH in comparison to other age groups. These differences in proportion between the cluster groups were statistically significant by chi-square test with the p value of 0.0001.

Table 25: Relationship between gender and personality profile among patients with deliberate self-harm.

Clusters	Gender				Total	
	Female		Male			
	n	%	n	%	n	%
Cluster A	12	12.12	17	18.09	29	15.03
Cluster B	60	60.61	38	40.43	98	50.78
Cluster C	27	27.27	39	41.49	66	34.20
Total	99	100	94	100	193	100

Chi square value = 7.858, P value = 0.0197

Individuals with Cluster B trait (50.7%) presented with more DSH in comparison to other cluster groups. Among them, female (60.6%) had higher number of DSH in comparison to male (40.4%). But in other two groups, male had higher number of DSH in comparison to male. These differences in proportion between the cluster groups were statistically significant by chi-square test with the p value of 0.0197.

Table 26: Relationship between Educational status and personality profile among patients with deliberate self-harm.

Clusters	Educational status						Total	
	Uneducated		School education		Graduated			
	n	%	n	%	n	%	n	%
Cluster A	3	30.00	17	11.72	9	23.68	29	15.03
Cluster B	4	40.00	82	56.55	12	31.58	98	50.78
Cluster C	3	30.00	46	31.72	17	44.74	66	34.20
Total	10	100	145	100	38	100.00	193	100

Chi square value = 9.924, P value = 0.041

Among Cluster B trait, those who completed school education (56.5%) had higher number of DSH in comparison to other two educational status groups. But in cluster A group, those who are uneducated (30%) had higher number of DSH in comparison to other two educational status groups. In cluster C group, those who are graduated (44.7%) had higher number of DSH in comparison to other two educational status groups. These differences in proportion between the cluster groups were statistically significant by chi-square test with the p value of 0.041.

Table 27: Relationship between socio-economic status and personality profile among patients with deliberate self-harm.

Clusters	Socio economic status				Total	
	Lower Income		Middle Income			
	n	%	n	%	n	%
Cluster A	15	11.03	14	24.56	29	15.03
Cluster B	78	57.35	20	35.09	98	50.78
Cluster C	43	31.62	23	40.35	66	34.20
Total	136	100	57	100	193	100

Chi square value = 9.712, P value = 0.007

Individuals with Cluster B trait (50.7%) presented with more DSH in comparison to other cluster groups. Among them, lower income groups (57.35%) had higher number of DSH in comparison to middle income groups (35.09%). But in other two cluster groups, middle income groups had higher number of DSH in comparison to lower income groups. These differences in proportion between the cluster groups were statistically significant by chi-square test with the p value of 0.007.

Table 28: Relationship between marital status and personality profile among patients with deliberate self-harm.

Clusters	Marital status				Total	
	Unmarried		Married			
	n	%	n	%	n	%
Cluster A	17	12.88	12	19.67	29	15.03
Cluster B	79	59.85	19	31.15	98	50.78
Cluster C	36	27.27	30	49.18	66	34.20
Total	132	100	61	100	193	100

Chi square value = 13.904, P value = 0.001

Individuals with Cluster B trait (50.7%) presented with more DSH in comparison to other cluster groups. Among them, unmarried groups (59.85%) had higher number of DSH in comparison to married groups (31.15%). But in other two cluster groups, married groups had higher number of DSH in comparison to unmarried groups. These differences in proportion between the cluster groups were statistically significant by chi-square test with the p value of 0.001.

Table 29: Relationship between occupational status and personality profile among patients with deliberate self-harm.

Clusters	Occupational status				Total	
	Unemployed		Employed			
	n	%	n	%	n	%
Cluster A	12	12.90	17	17.00	29	15.03
Cluster B	56	60.22	42	42.00	98	50.78
Cluster C	25	26.88	41	41.00	66	34.20
Total	93	100	100	100	193	100

Chi square value = 6.495, P value = 0.038

Individuals with Cluster B trait (50.7%) presented with more DSH in comparison to other cluster groups. Among them, unemployed groups (60.2%) had higher number of DSH in comparison to employed groups (42%). But in other two cluster groups, employed groups had higher number of DSH in comparison to unemployed groups. These differences in proportion between the cluster groups were statistically significant by chi-square test with the p value of 0.038.

Table 30: Relationship between place of residence and personality profile among patients with deliberate self-harm.

Clusters	Place of residence				Total	
	Rural		Urban			
	n	%	n	%	n	%
Cluster A	23	14.02	6	20.69	29	15.03
Cluster B	84	51.22	14	48.28	98	50.78
Cluster C	57	34.76	9	31.03	66	34.20
Total	164	100	29	100	193	100

Chi square value = 0.870, P value = 0.647

Among Cluster B trait, those participants from rural areas (51.2%) had higher number of DSH in comparison to those participants from urban areas. But in cluster A group, those participants from urban areas (20.69%) had higher number of DSH in comparison to those participants from rural areas. In cluster C group, those participants from rural areas (34.7%) had higher number of DSH in comparison to those participants from urban areas. These differences in proportion between the cluster groups were not statistically significant by chi-square test with the p value of 0.647.

Table 31: Relationship between previous history of Suicidal attempts and personality profile among patients with deliberate self-harm.

Clusters	Previous history of Suicidal attempts				Total	
	Yes		No			
	n	%	n	%	n	%
Cluster A	11	11.00	18	19.35	29	15.03
Cluster B	59	59.00	39	41.94	98	50.78
Cluster C	30	30.00	36	38.71	66	34.20
Total	100	100	93	100	193	100

Chi square value = 6.070, P value = 0.048

Individuals with Cluster B trait (50.7%) presented with more DSH in comparison to other cluster groups. Among them, those who had history of suicidal attempts (59%) had higher number of DSH in comparison to those who did not had history (41.9%). But in other two cluster groups, those who did not had history of suicidal attempts had higher number of DSH in comparison to those who had history of suicidal attempts. These differences in proportion between the cluster groups were statistically significant by chi-square test with the p value of 0.048.

Table 32: Relationship between number of suicidal attempts and personality profile among patients with deliberate self-harm.

Clusters	Number of suicidal attempts						Total	
	Nil		Less than 3		Three or more			
	n	%	n	%	n	%	n	%
Cluster A	16	17.78	11	18.33	2	4.65	29	15.03
Cluster B	38	42.22	29	48.33	31	72.09	98	50.78
Cluster C	36	40.00	20	33.33	10	23.26	66	34.20
Total	90	100	60	100	43	100	193	100

Chi square value = 11.59 , P value = 0.02

Among Cluster B trait, those had history of 3 or more suicidal attempts (72.09%) had higher number of DSH in comparison to other two groups. But in cluster A group, those who had history of less than 3 suicidal attempts (18.33%) had higher number of DSH in comparison to other two attempt groups. In cluster C group, those who had nil suicidal attempts (40%) had higher number of DSH in comparison to other two attempt groups. These differences in proportion between the cluster groups were statistically significant by chi-square test with the p value of 0.017.

Table 33: Relationship between history of Stressor and personality profile among patients with deliberate self-harm.

Clusters	History of Stressor				Total	
	Yes		No			
	n	%	n	%	n	%
Cluster A	12	12.12	17	18.09	29	15.03
Cluster B	63	63.64	35	37.23	98	50.78
Cluster C	24	24.24	42	44.68	66	34.20
Total	99	100	94	100	193	100

Chi square value = 13.650, P value = 0.001

Individuals with Cluster B trait (50.7%) presented with more DSH in comparison to other cluster groups. Among them, those who had history of stress (63.64%) had higher number of DSH in comparison to those who did not had history (37.23%). But in other two cluster groups, those who did not had history of stress had higher number of DSH in comparison to those who had history of stress. These differences in proportion between the cluster groups were statistically significant by chi-square test with the p value of 0.001.

Table 34: Relationship between birth order and personality profile among patients with deliberate self-harm.

Clusters	Birth order				Total	
	≤ 2		> 2			
	n	%	n	%	n	%
Cluster A	23	14.65	6	16.67	29	15.03
Cluster B	83	52.87	15	41.67	98	50.78
Cluster C	51	32.48	15	41.67	66	34.20
Total	157	100	36	100	193	100

Chi square value = 5.807, P value = 0.831

Individuals with Cluster B trait (50.7%) presented with more DSH in comparison to other cluster groups. Among them, those who had birth order of ≤ 2 (52.8%) had higher number of DSH in comparison to those who had birth order of > 2 (41.67%). But in other two cluster groups, those who had birth order of > 2 had higher number of DSH in comparison to those who had birth order of ≤ 2 . These differences in proportion between the cluster groups were not statistically significant by chi-square test with the p value of 0.831.

Table 35: Relationship between type of family and personality profile among patients with deliberate self-harm.

Clusters	Type of Family				Total	
	Joint Family		Nuclear Family			
	n	%	n	%	n	%
Cluster A	6	15.38	23	14.94	29	15.03
Cluster B	18	46.15	80	51.95	98	50.78
Cluster C	15	38.46	51	33.12	66	34.20
Total	39	100	154	100	193	100

Chi square value = 0.470, P value = 0.791

Individuals with Cluster B trait (50.7%) presented with more DSH in comparison to other cluster groups. Among them, nuclear family (51.9%) had higher number of DSH in comparison to joint family (46.1%). But in other two cluster groups, joint family had higher number of DSH in comparison to nuclear family. These differences in proportion between the cluster groups were not statistically significant by chi-square test with the p value of 0.791.

Table 36: Relationship between religion and personality profile among patients with deliberate self-harm.

Clusters	Religion				Total	
	Hindu		Muslim			
	n	%	n	%	n	%
Cluster A	29	15.76	0	0.00	29	15.03
Cluster B	94	51.09	4	44.44	98	50.78
Cluster C	61	33.15	5	55.56	66	34.20
Total	184	100	9	100	193	100

Chi square value = 2.752, P value = 0.243

Among Cluster A and B trait, Hindu had higher number of DSH in comparison to those participants from Muslim religion. In cluster C group, those participants from Muslim religion (55.6%) had higher number of DSH in comparison to those participants from Hindu religion. These differences in proportion between the cluster groups were not statistically significant by chi-square test with the p value of 0.243.

Table 37: Relationship between presence of Co-morbidities and personality profile among patients with deliberate self-harm.

Clusters	Presence of Co-morbidities				Total	
	Yes		No			
	n	%	n	%	n	%
Cluster A	11	22.92	18	12.41	29	15.03
Cluster B	24	50.00	74	51.03	98	50.78
Cluster C	13	27.08	53	36.55	66	34.20
Total	48	100	145	100	193	100

Chi square value = 3.160, P value = 0.165

Among Cluster B and C trait, those participants with co-morbidities had lower number of DSH in comparison to those participants without co-morbidities. In cluster A group, those participants with co-morbidities (22.9%) had higher number of DSH in comparison to those participants without co-morbidities. These differences in proportion between the cluster groups were not statistically significant by chi-square test with the p value of 0.165.

Table 38: Relationship between substance abuse and personality profile among patients with deliberate self-harm.

Clusters	Substance abuse				Total	
	Yes		No			
	n	%	n	%	n	%
Cluster A	11	11.34	18	18.75	29	15.03
Cluster B	61	62.89	37	38.54	98	50.78
Cluster C	25	25.77	41	42.71	66	34.20
Total	97	100	96	100	193	100

Chi square value = 11.441, P value = 0.003

Individuals with Cluster B trait (50.7%) presented with more DSH in comparison to other cluster groups. Among them, those participants with substance abuse (62.8%) had a higher number of DSH in comparison to those participants without substance abuse (38.5%). But in other two cluster groups, those participants without substance abuse had higher number of DSH in comparison to those participants with substance abuse. These differences in proportion between the cluster groups were statistically significant by chi-square test with the p value of 0.003.

Table 39: Relationship between method of suicide and personality profile among patients with deliberate self-harm.

Clusters	Method of Suicide							
	Hanging		Liquid Poison		M tablets		Self-cut	
	n	%	n	%	n	%	n	%
Cluster A	3	12.50	16	12.70	8	28.57	2	13.33
Cluster B	9	37.50	72	57.14	13	46.43	4	26.67
Cluster C	12	50.00	38	30.16	7	25.00	9	60.00
Total	24	100	126	100	28	100	15	100

Chi square value = 13.899, P value = 0.030

Among Cluster B trait, those who consumed liquid poison (56.14%) had higher number of DSH in comparison to other two suicide method groups. But in cluster A group, those consumed M tablets (28.57%) had higher number of DSH in comparison to other two suicide method groups. In cluster C group, those who made self-cut method of suicide (60%) had higher number of DSH in comparison to other two suicide method groups. These differences in proportion between the cluster groups were statistically significant by chi-square test with the p value of 0.030.

DISCUSSION



DISCUSSION

Multiple studies have been undertaken to investigate the socioeconomic factors associated with DSH in teenage populations and their personality disorders. However, there is a scarcity of research on the general population in this regard. This study is an analytical cross-sectional study that included 193 adult patients with a history of DSH who visited the teaching medical centre in Kolar. The diagnosis of personality profiles in patients who engage in DSH was determined based on the guidelines outlined in the ICD-10 and the DSM-V. The assessment tool used was the International Personality Disorder Examination (IPDE) questionnaire.

Psychiatric Disorders

Out of the 193 research participants, 57.5% engaged in DSH even though they did not have any psychiatry disorder, while 42.5% engaged in DSH had co-morbid psychiatry disorder. A subsequent investigation found that 46.7% of people who attempted suicide had a personality disorder.⁴⁸ Mental health issues affected over 57% of those who participated in the research by Jain et al.⁴⁹ One case-control study on DSH participants found that among those who tried to kill themselves, 11.6% had a alcohol dependence; the most common psychiatry disorder, however, was adjustment disorders.⁵⁰ Of the people who took their own lives, 37 % had a diagnosable mental illness. According to the research

conducted by Manoranjitham et al., the two most prevalent categories were alcohol dependence of about 16% as well as adjustment disorders of about 15%.

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Table 40: Comparison of prevalence of psychiatric disorders among patients with DSH

Author	Prevalence of psychiatric disorders
Present study	57.5 %
Sharma et al ⁴⁸	46.7 %
Unni and Mani ⁵²	59.7 %
Jain et al ⁴⁹	57 %
Latha et al ⁵³	93 %
Manoranjitham et al. ⁵¹	37 %

The most prevalent psychiatric illness was adjustment disorders (17.1%) followed by depression (11.4%) as second and acute stress reaction (5.2%) as the third. In India, researchers Latha et al. studied 73 people who had attempted suicide.⁵³ A mental diagnosis could be made in 63 out of the 73 suicide attempters, or 93% at that point of the time. Diagnosis of mood disorders was the norm. Suicide attempts occurred in 42% of instances involving dysthymic

illnesses, severe depressive disorder in 22% of cases, and alcohol misuse in 11% of cases.

Depression was the most common mental illness in the study conducted by Kar et al., accounting for 29% of the cases.⁵⁴ Researchers Unni and Mani analysed data from 154 people who reported attempting suicide between 1988 and 1991.⁵² There was a total of 59.74% depression, 9.74% substance misuse, and 9.74% psychosis, according to their findings Jain et al. found that among the psychiatric disorders, depression was the most common, affecting 37.5% of the participants.⁴⁹

In the present study, the most common personality trait in the present study was borderline (24.9%) and it was followed by dependent (21.8%) and impulsive (14%). Cluster B (50.8%) was the most common personality cluster in the present study. Cluster C was noticed among 34.2% of the samples and the remaining 15% was Cluster A group of personality. Several studies have found that between 7 and 50% of Indian suicide attempters suffer from a personality condition.^{53,55,56} A schizoid personality, borderline PD, or antisocial personality disorder was the most prevalent diagnosis.⁵⁶ Anankastic and histrionic personality disorder were found to be the diagnoses that are most prevalent among the participants in a study of personality disorders.⁵⁵

Features of suicide attempt

Particularly noteworthy is the fact that attempted suicide has been shown as a predictor of subsequent suicide attempts.⁵⁷ Research confirms this, showing that nearly one-fifth of those who take their own lives had attempted suicide before.⁵⁸ A total of 51.8% of the DSH patients in this study had attempted suicide before. One sixteenth of the suicide samples had a history of suicidal ideation or behaviour, according to Ahmed Khan et al.⁵⁹

Nearly 51.3% of the DSH patients have self-reported the presence of stress and the most common reason for this stress was family issues followed by financial problems. The most prevalent causes of attempted suicide include problems in interpersonal relationships, financial difficulties, and the demands of school.^{48,50,59} Because of its sociocentric nature, Indian culture places a premium on human connections. So, it should come as no surprise that males are more likely to take their own lives as a result of interpersonal strife than marital strife.⁶⁰

The most common method of suicide attempts was liquid poison (65.8%), followed by Multiple tablets (14.5%). More impulsive behaviour leads to suicide attempts, which may suggest a lack of forethought. Latha et al. conducted a study in India on 73 individuals who had attempted suicide.⁵³ 67% (49 out of 73) of participants used a variety of herbicides and insecticides to intentionally poison themselves. The second most prevalent method of suicide

attempts was the use of medications with a substantial toxicity risk, accounting for 29% of the total.

The study conducted by Banerjee et al. found that the most frequently performed form of suicide was poisoning with pesticides.⁶⁰ The study conducted by Ahmed Khan et al. found that the most common form of suicide was hanging (40%) followed by poisoning (34%), primarily with pesticides and sometimes with pharmaceuticals.⁵⁹ Researchers in India and other rural parts of low-income countries have shown that the most common method of suicide and attempted suicide is the ingestion of pesticides, particularly the easily accessible agricultural pesticides in rural communities.^{48,50,60,61}

Among the study participants, substance abuse was noticed among 50.25% and the remaining 49.75% did not have any substance abuse habits. The most common substance abuse was alcohol use in the present study. The study conducted by Latha et al. also found that 27% of the participants consumed alcohol.⁵³ Twenty youths (ranging in age from twelve to nineteen) who had committed suicide and a control group of matched-pairs were examined psychologically by Shafii et al., and it was found that seventy percent of the participants had abused drugs or alcohol.⁶² Substance misuse was prevalent in 9.74% of those who attempted suicide, according to Unni and Mani.⁵² An examination of 18% of the suicide samples by Ahmed Khan et al. revealed the presence of substance misuse.⁵⁹

In India, Lingeswaran surveyed 40 people who had survived a suicide attempt.

⁶³ One hundred percent of those who attempted suicide had experienced psychosocial pressures in the time leading up to it. It was most often diagnosed as an adjustment disorder or acute stress condition. Twelve percent of the sample exhibited unstable emotions and lack of humour. As a means of suicide, pesticide consumption accounted for 45 percent of all cases.

Socioeconomic factors influencing the personality profile of DSH.

The factors influencing the personality profile among the present study patients with deliberate self-harm were younger age (18 to 30 years), female gender, lower education (school education), lower income status, unmarried, unemployment, history of suicidal attempts especially with more than 2 attempts, stress, substance abuse, and use of liquid poison for self-harm (p value less than 0.05).

Age

The mean age of 193 research subjects was 31.46 ± 9.75 years. In this study, higher number of DSH was observed among the younger age group of 18 to 35 years. This result was in line with what the National Crime Records Bureau found: that 34.4 percent of all suicides occurred in the 15–29 age bracket. ⁶⁴ The global suicide rate is moving away from being disproportionately high among the elderly and toward the younger generation.

Gender

Among the study samples in the present study, 51.3% were female and the remaining 48.7% were males. Similarly, the majority of DSH attempters were females (60.6%), which is consistent with the results seen in the studies by Kar et al., Bhugra and Desai, and Lingeswaran. Males (40.4%) also had a lower number of DSH.^{63,65,66} Sociocultural factors may explain why more women in India commit suicide. Women in India may be more likely to take their own lives due to the societal and familial pressures that come with arranged weddings, which can keep them in abusive relationships. Suicidal thoughts and actions may be triggered by a toxic family environment, underlying personality disorders, or mental disease.⁶⁷ Brides who are young may also be driven to suicide by the stresses associated with dowry demands.⁶⁸

Marital status

Marriage does not appear to be a robust buffer against suicidal ideation and behaviour in underdeveloped nations.⁶⁹ In the contemporary conditions, approximately 68.4% of DSH patients were not married. In this study, the number of DSH was larger in the unmarried group (59.85%) than in the married group (31.15%). In an Indian study by Sarkar et al., the number of DSH was highest among single women who were not married (79%). The 52% DSH rate among singles in the Indian study by Sharma et al. was consistent with this

finding. According to Sudhir et al., most of the people who attempted suicide were unmarried.⁷⁰

Educational status

Around 32.6% completed high school education in the current settings. The current study shows those who completed school education (56.5%) had higher number of DSH in comparison to higher educational status and uneducated groups. Student suicides increased from 5.5% of all cases in 2010 to 6.2% in 2013, according to a similar data published by the National Crime Records Bureau.⁶⁴ Those with lower IQs are two to three times more likely to take their own lives. People who score lower on IQ tests may not be as competitive in the labour market, which could explain why they end up with lesser income and social standing. They might also have trouble handling pressure effectively.⁷¹ Lastly, they may be more prone to a mental condition due to neurodevelopmental abnormalities.⁷²

Socioeconomic and employment status

About 70.5% of the respondents belonged to lower income status and 48.2% were unemployed. In the present study lower income groups (57.35%) had higher number of DSH in comparison to middle income groups (35.09%) and also unemployed groups (60.2%) had higher number of DSH in comparison to employed groups (42%). Among Indian suicide attempters, 46% were jobless, according to one study.⁵⁰ While 12% of patients were jobless, more than half

had jobs in a different study.⁵³ There is consensus that unemployment and socioeconomic status are major contributors to the cause of suicide. The rate of unemployment does not directly cause suicide, but it does make the already economically and mentally susceptible feel even more despairing, which in turn increases their risk of suicide.²⁸

Comparison of risk factors with similar articles

One hundred Indians who had attempted suicide were the subjects of a study by Sahoo et al. in 2018.²⁸ Suicide attempters were disproportionately young women, students, and those from lower-middle class metropolitan backgrounds. Nearly 70% of those who attempted suicide had a diagnosable mental health condition. After some sort of triggering event, over three quarters of the suicide attempts occurred. Factors such as personality features, perceived humiliations, peer-interpersonal issues, and higher family disputes were found to relate to suicide attempts. Our study observations agree with these results.

In India, Lingeswaran surveyed 40 people who had survived a suicide attempt.⁶³ The survivors of suicide attempts were disproportionately young, female (1.1:1), countryside, educated low-income (67.5%), singled (90%), nuclear (95%), and Hindu (87.5%). Our study findings align with these findings.

Latha et al conducted a study in India among 73 suicide attempters.⁵³ Suicide attempters were more likely to be male, have not completed high school, be

unemployed (within the last five years), and belong to nuclear households if they were younger (16–24 years old).

Unni and Mani conducted a study among 154 suicidal attempters registered between 1988 and 1991, were recruited for an analysis.⁵² Forty percent of those people were staying at home (housewife). With an educational standing below the tenth Standard, most of them were between the ages of 16 and 45.

Mohanty et al conducted a study in which 588 suicide victims were autopsied.⁷³ Almost equally, men and women were hit hard. Those between the ages of 21 and 30 made up the bulk of the victims. There were two main methods of suicide, accounting for 63% of all cases: hanging and poisoning. The victims were mostly married people from rural areas who were in good mental health. The majority of victims (48% of the total) were from low-income backgrounds. In most cases, the victims were less educated or illiterate people. It was not possible to detect suicidal ideation or alcohol consumption in the majority of patients. The two most common causes of suicide, according to the data, were financial stress (37%) and marital discord (35%).

There is a significant public health concern with committing suicide, and it is mainly preventable.⁷⁴ India, like many other low- and middle-income nations, needs public health initiatives to reduce the suicide rate. Counselling and curative psychiatric services can help people cope with their problems and avoid suicide attempts, but they won't lower the suicide rate as a whole.

Poverty, economic inequality, and a lack of social justice are other root causes of human misery; the medicalization of societal and personal distress must end. In order to lower suicide rates in the population, we need population-based initiatives that go beyond limited disciplinary viewpoints.⁵¹

CONCLUSION

CONCLUSION

The purpose of this research was to find out the relationship between the socioeconomic factors, and patients those who attempted DSH. Based on the study findings, nearly 42.5% of the study respondents attempted deliberate self-harm with the presence of psychiatric disorders and it was quite high in the current settings. Adjustment disorders (17.1%) were the most prevalent psychiatric illness, followed by depression (11.4%). The most prevalent personality cluster in the current study was Cluster B (50.8%). In this study, patients with the following socioeconomic factors were more likely to attempt deliberate self-harm: younger age (18 to 30 years), female gender, lower education (school education), lower income status, unmarried, unemployment, history of suicidal attempts especially with more than 2 attempts, stress, substance abuse, and use of liquid poison for self-harm.

LIMITATIONS

LIMITATION

- The information not covered include the historical context of bullying, experiences of loneliness and anxiety, the timing and duration of suicide attempts, variables that contribute to suicidal behaviour, the type of the attempts, communication of suicidal intentions, the potential for harm, the level of risk involved, and factors that may help prevent suicide.
- Having a comparison group, such as individuals who engage in non-suicidal deliberate self-harm (DSH), would yield more informative results.
- The relevance of these findings to the wider community is questionable because this study was conducted only within a hospital setting and was cross-sectional in nature.
- This study was conducted with smaller sample size. To assess the personality profile of those who attempt suicide, more research with bigger samples is needed in this area to validate our study findings.

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ANNEXURE

ANNEXURE 1:

IPDE ICD-10 module screening questionnaire

Directions-

1. The purpose of this questionnaire is to learn what type of person you have been during the past five years.
2. Please do not skip any items. If you are not sure of an answer, select the one TRUE or FALSE-which is more likely to be correct. There is no time limit, but do not spend too much time thinking about the answer to any single statement.
3. When the answer is TRUE, circle the letter T. When the answer is FALSE, circle the letter F.

1. I usually get fun and enjoyment out of life. T F
2. I don't react well when someone offends me. T F
3. I'm not fussy about little details. T F
4. I can't decide what kind of person I want to be. T F
5. I show my feelings for everyone to see. T F
6. I let others make my big decisions for me. T F
7. I usually feel tense or nervous. T F
8. I almost never get angry about anything. T F
9. I go to extremes to try to keep people from leaving me. T F
10. I'm a very cautious person. T F
11. I've never been arrested. T F
12. People think I'm cold and detached. T F
13. I get into very intense relationships that don't last. T F
14. Most people are fair and honest with me. T F
15. I find it hard to disagree with people if I depend on them a lot. T F
16. I feel awkward or out of place in social situations. T F
17. I'm too easily influenced by what goes on around me. T F
18. I usually feel bad when I hurt or mistreat someone. T F
19. I argue or fight when people try to stop me from doing what I want. T F
20. At times I've refused to hold a job, even when I was expected to. T F
21. When I'm praised or criticized, I don't show others my reaction. T F
22. I've held grudges against people for years. T F
23. I spend too much time trying to do things perfectly. T F
24. People often make fun of me behind my back. T F
25. I've never threatened suicide or injured myself on purpose. T F
26. My feelings are like the weather; they're always changing. T F
27. I fight for my rights even when it annoys people. T F
28. I like to dress so I stand out in a crowd. T F
29. I will lie or con someone if it serves my purpose. T F
30. I don't stick with a plan if I don't get results right away. T F

31. I have little or no desire to have sex with anyone. T F
32. People think I'm too strict about rules and regulations. T F
33. I usually feel uncomfortable or helpless when I'm alone. T F
34. I won't get involved with people until I'm certain they like me. T F
35. I would rather not be the center of attention. T F
36. I think my spouse (or lover) may be unfaithful to me. T F
37. Sometimes I get angry, I break or smash things. T F
38. I've had close friendships that lasted a long time. T F
39. I worry a lot that people may not like me. T F
40. I often feel "empty" inside. T F
41. I work m hard I don't have time left for anything else. T F
42. I worry about being left alone and having to care for myself. T F
43. A lot of things seem dangerous to me that don't bother most people. T F
44. I have a reputation for being a flirt. T F
45. I don't ask favors from people I depend on a lot. T F
46. I lose my temper and get into physical fights. T F
47. I prefer activities that I can do by myself. T F
48. People think I'm too stiff or formal. T F
49. I often seek advice or reassurance about everyday decisions. T F
50. I keep to myself even when there are other people around. T F
51. It's hard for me to stay out of trouble. T F
52. I'm convinced there's a conspiracy behind many things in the world. T F
53. I'm very moody. T F
54. It's hard for me to get used to a new way of doing things. T F
55. Most people think I'm a strange person. T F
56. I take chances and do reckless things. T F
57. Everyone needs a friend or two to be happy. T F
58. I'm more interested in my own thoughts than what goes on around me. T F
59. I usually try to get people to do things my way. T F

1. Circle the item numbers not followed by F, if they were answered True.
2. Circle the remaining item numbers (those followed by F), if they were answered False.
3. If three or more items from a disorder are circled, the subject has failed the screen for that disorder, and should be interviewed. Clinicians and investigators may wish to adopt lower or higher screening standards, depending on the nature of the sample, and the relative importance to them of errors of sensitivity (false negative cases) vs. specificity (false-positive cases). The screen should not be used to make a diagnosis or to calculate a dimensional score for a personality disorder.

IPDE ICD10 module screening questionnaire scoring summary –

- F60.0 Paranoid: 2 14F 22 24 27 36 52
- F60.1 Schizoid: 1F 8 12 21 31 46 55 57F 58
- F60.2 Dissocial: 11F 18F 20 29 38F 47 51
- F60.30 Impulsive: 19 30 37 53 56
- F60.31 Borderline: 4 9 13 25F 40
- F60.4 Histrionic: 5 17 26 28 35F 44
- F60.5 Anankastic: 3F 10 23 32 41 48 54 59
- F60.6 Anxious: 7 16 34 39 43 50
- F60.7 Dependent: 6 15 33 42 45 49

ANNEXURE 2:

SOCIO-DEMOGRAPHIC QUESTIONNAIRE AND CLINICAL PERFORMA

- UHID No:
- DOA.....
- Ward..... SES..... Rural/Urban.....
- Diagnosis.....
- Name..... Education..... Age.....
- Gender : male / female
- Marital status : married / unmarried
- Employed/Unemployed
- Address/Mobile phone number/Email.....
- Presenting Complaint:
- Family history of personality disorder : yes / no

- Previous suicide attempt : yes / no
- No. of attempts : 1 / 2 / 3 / 4 / 5 or more
- Nature of attempt:
- Mode of suicide :
- History of stressors prior to the suicidal attempt : yes / no

Duration Onset:

1. Background: Rural/urban
2. Family H/o DSH/mental illness Yes/No If yes, please specify
3. Birth order
4. CHILDHOOD: Delayed Milestones/phobias/bed wetting/ thumb sucking/ nail biting/ fire setting/ temper tantrums/ Any other significant information.
5. Education: Illiterate/ Primary/ Upto 10TH class/ upto 12th std/Graduate
6. Occupation/Trade: Professional/Semi professional/ Skilled worker/ Unskilled worker/ Unemployed/ Others.
7. Income (Specify amount/ month)
8. Marital status: Unmarried/ Marriage Intact/ Not Living Together/ Divorced/ Widowed
9. Nuclear family/joint family

10. Religion: Hindu/Muslim/Christian/ Other

11. Habits: Yes/No Quantity:

- OTHER MEDICAL/PSYCHIATRIC ILLNESS:

ANNEXURE-3:

- NAME:
- AGE:
- GENDER:
- DATE:

ANNEXURE – 4 :

- The diagnostic and statistical manual of mental disorders categorizes the Personality Disorder (PD) into three clusters : cluster A (odd/ eccentric cluster) – schizoid , paranoid , schizotypal PD ; cluster B (dramatic / emotional / impulsive) – borderline , narcissistic , antisocial , histrionic PD ; cluster C (anxious / fearful) – avoidant , dependent , obsessive – compulsive PD .

ANNEXURE 5 :

PATIENT INFORMATION SHEET

STUDY TITLE: PERSONALITY PROFILE AMONG PATIENTS WITH DELIBERATE SELF HARM IN TERTIARY CARE HOSPITAL: A CROSS SECTIONAL STUDY

STUDY SITE: R.L. JALAPPA HOSPITAL AND RESEARCH CENTRE, TAMAKA, KOLAR

The main aim of the study is to identify the personality profile among patients with deliberate self harm. You are requested to participate in a study conducted by the department of Psychiatry as a part of dissertation. This study will be done on patients with DSH between age group of 18-60 years in that patients who give consent for screening questionnaire.

This study is approved by the institutional ethical committee. The information collected will be used only for dissertation and publication. There is no compulsion to agree to participate. You are requested to sign/thumb impression only if you voluntarily agree to participate in the study. All information collected from you will be kept confidential and will not be disclosed to any outsider. Your identity will not be revealed. You will not receive any monetary benefits to participate in this research.

This informed consent document is intended to give you a general background of study. Please read the following information carefully and discuss with your family members. You can ask your queries related to study at any time during the study.

If you are willing to participate in the study you will be asked to sign an informed consent form by which you are acknowledging that you wish to participate in the study and entire procedure will be explained to you by the study doctor. You are free to withdraw your consent to participate in the study any time without explanation and this will not change your future care.

Left Thumb Impression/Signature of the Patient Left Thumb Impression/Signature of the Witness
signature of the investigator

For any further clarification you can contact the study investigator:

Dr. STUTI J. MASHRU

Mobile no. 7874069680

E-mail id : stutimashru@gmail.com

ರೋಗಿಯ ಮಾಹಿತಿ ಹಾಳೆ

ಅಧ್ಯಯನದ ಶೀರ್ಷಿಕೆ: ತೃತೀಯ ಆರೈಕೆ ಆಸ್ಪತ್ರೆಯಲ್ಲಿ ಉದ್ದೇಶಪೂರ್ವಕವಾಗಿ ಸ್ವಯಂ-ಹಾನಿ ಮಾಡಿಕೊಳ್ಳುವ ರೋಗಿಗಳಲ್ಲಿನ ವ್ಯಕ್ತಿತ್ವದ ಪ್ರೊಫೈಲ್: ಒಂದು ಅಡ್ಡ ವಿಭಾಗದ ಅಧ್ಯಯನ

ಅಧ್ಯಯನ ತಾಣ: ಆರ್.ಎಲ್.ಜಾಲಪ್ಪ ಆಸ್ಪತ್ರೆ ಮತ್ತು ಸಂಶೋಧನಾ ಕೇಂದ್ರ, ತಮಕ, ಕೋಲಾರ

ಉದ್ದೇಶಪೂರ್ವಕವಾಗಿ ಸ್ವಯಂ ಹಾನಿಗೊಳಗಾದ ರೋಗಿಗಳಲ್ಲಿ ವ್ಯಕ್ತಿತ್ವದ ಪ್ರೊಫೈಲ್ ಅನ್ನು ಗುರುತಿಸುವುದು ಅಧ್ಯಯನದ ಮುಖ್ಯ ಗುರಿಯಾಗಿದೆ. ಪ್ರಬಂಧದ ಭಾಗವಾಗಿ ಮನೋವೈದ್ಯಶಾಸ್ತ್ರ ವಿಭಾಗವು ನಡೆಸಿದ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಿಮ್ಮನ್ನು ವಿನಂತಿಸಲಾಗಿದೆ. ಸ್ಟ್ರೀನಿಂಗ್ ಪ್ರಶ್ನಾವಳಿಗೆ ಒಪ್ಪಿಗೆ ನೀಡುವ ರೋಗಿಗಳಲ್ಲಿ 18-60 ವರ್ಷ ವಯಸ್ಸಿನ ನಡುವೆ ಉದ್ದೇಶಪೂರ್ವಕವಾಗಿ ಸ್ವಯಂ-ಹಾನಿ ಮಾಡಿಕೊಳ್ಳುವ ರೋಗಿಗಳ ಮೇಲೆ ಈ ಅಧ್ಯಯನವನ್ನು ಮಾಡಲಾಗುತ್ತದೆ. ಈ ಅಧ್ಯಯನವನ್ನು ಸಾಂಸ್ಥಿಕ ನೈತಿಕ ಸಮಿತಿಯು ಅನುಮೋದಿಸಿದೆ.

ಸಂಗ್ರಹಿಸಿದ ಮಾಹಿತಿಯನ್ನು ಪ್ರಬಂಧ ಮತ್ತು ಪ್ರಕಟಣೆಗೆ ಮಾತ್ರ ಬಳಸಲಾಗುತ್ತದೆ. ಭಾಗವಹಿಸಲು ಒಪ್ಪಿಕೊಳ್ಳಲು ಯಾವುದೇ ಒತ್ತಾಯವಿಲ್ಲ. ನೀವು ಸ್ವಯಂಪ್ರೇರಣೆಯಿಂದ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಒಪ್ಪಿದರೆ ಮಾತ್ರ ಸಹಿ/ಹೆಚ್ಚರಳಿನ ಗುರುತು ಹಾಕಲು ನಿಮ್ಮನ್ನು ವಿನಂತಿಸಲಾಗಿದೆ.

ನಿಮ್ಮಿಂದ ಸಂಗ್ರಹಿಸಲಾದ ಎಲ್ಲಾ ಮಾಹಿತಿಯನ್ನು ಗೌಪ್ಯವಾಗಿ ಇರಿಸಲಾಗುತ್ತದೆ ಮತ್ತು ಯಾವುದೇ ಹೊರಗಿನವರಿಗೆ ಬಹಿರಂಗಪಡಿಸಲಾಗುವುದಿಲ್ಲ. ನಿಮ್ಮ ಗುರುತನ್ನು ಬಹಿರಂಗಪಡಿಸಲಾಗುವುದಿಲ್ಲ. ಈ ಸಂಶೋಧನೆಯಲ್ಲಿ ಭಾಗವಹಿಸಲು ನೀವು ಯಾವುದೇ ಹಣಕಾಸಿನ ಪ್ರಯೋಜನಗಳನ್ನು ಸ್ವೀಕರಿಸುವುದಿಲ್ಲ. ಈ ತಿಳುವಳಿಕೆಯುಳ್ಳ ಸಮ್ಮತಿಯ ದಾಖಲೆ ನಿಮಗೆ ಸಾಮಾನ್ಯ ಅಧ್ಯಯನದ ಹಿನ್ನೆಲೆಯನ್ನು ನೀಡಲು ಉದ್ದೇಶಿಸಲಾಗಿದೆ. ದಯವಿಟ್ಟು ಕೆಳಗಿನ ಮಾಹಿತಿಯನ್ನು ಎಚ್ಚರಿಕೆಯಿಂದ ಓದಿ ಮತ್ತು ನಿಮ್ಮ ಕುಟುಂಬ ಸದಸ್ಯರೊಂದಿಗೆ ಚರ್ಚಿಸಿ.

ಅಧ್ಯಯನದ ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ಅಧ್ಯಯನಕ್ಕೆ ಸಂಬಂಧಿಸಿದ ನಿಮ್ಮ ಪ್ರಶ್ನೆಗಳನ್ನು ನೀವು ಕೇಳಬಹುದು.
ನೀವು ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಸಿದ್ಧರಿದ್ದರೆ, ತಿಳುವಳಿಕೆಯುಳ್ಳ ಸಮ್ಮತಿಯ ನಮೂನೆಗೆ ಸಹಿ ಹಾಕಲು
ನಿಮ್ಮನ್ನು ಕೇಳಲಾಗುತ್ತದೆ ಮತ್ತು ಅದರ ಮೂಲಕ ನೀವು ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಬಯಸುತ್ತೀರಿ ಎಂದು
ಒಪ್ಪಿಕೊಳ್ಳುತ್ತೀರಿ ಮತ್ತು ಸಂಪೂರ್ಣ ಕಾರ್ಯವಿಧಾನವನ್ನು ಅಧ್ಯಯನ ವೈದ್ಯರು ನಿಮಗೆ ವಿವರಿಸುತ್ತಾರೆ.
ವಿವರಣೆಯಿಲ್ಲದೆ ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಿಮ್ಮ ಸಮ್ಮತಿಯನ್ನು ಹಿಂಪಡೆಯಲು
ನೀವು ಸ್ವತಂತ್ರರಾಗಿದ್ದೀರಿ ಮತ್ತು ಇದು ನಿಮ್ಮ ಭವಿಷ್ಯದ ಕಾಳಜಿಯನ್ನು ಬದಲಾಯಿಸುವುದಿಲ್ಲ.

ಎಡ ಹೆಬ್ಬರಳಿನ ಅನಿಸಿಕೆ/ರೋಗಿಯ ಸಹಿ ಎಡ ಹೆಬ್ಬರಳಿನ ಅನಿಸಿಕೆ/ಸಾಕ್ಷಿಯ ಸಹಿ ಎಡ ಹೆಬ್ಬರಳಿನ

ಅನಿಸಿಕೆ/ಸಾಕ್ಷಿಯ ಸಹಿ

ಡಾ. ಸ್ತುತಿ ಜೆ. ಮಾಶ್ರು

ಮೊಬೈಲ್ ನಂ. 7874069680

ಇ-ಮೇಲ್ ಐಡಿ : stutimashru@gmail.com

ANNEXURE – 6

INFORMED CONSENT FORM

STUDY TITLE: PERSONALITY PROFILE AMONG PATIENTS WITH DELIBERATE SELF HARM IN TERTIARY CARE HOSPITAL: A CROSS SECTIONAL STUDY

The main aim of the study is to identify the personality profile among patients with deliberate self harm. You are requested to participate in a study conducted by the department of Psychiatry as a part of dissertation. This study will be done on patients with DSH between age group of 18-60 years in that patients who give consent for screening questionnaire.

This study is approved by the institutional ethical committee. The information collected will be used only for dissertation and publication. There is no compulsion to agree to participate. You are requested to sign/thumb impression only if you voluntarily agree to participate in the study.

All information collected from you will be kept confidential and will not be disclosed to any outsider. Your identity will not be revealed. You are free to withdraw your consent to participate in the study any time without explanation and this will not change your future care.

Consent form for Literate:

I have read the above information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily for me/my son/daughter/brother/sister/husband/wife to participate as a participant in this study.

Name of Participant_____

Date_____

Signature of the participant_____

For Illiterate:

Name of witness _____ AND Thumb print of the participant

Signature of witness _____

Relationship of witness to participant_____

Date _____

ಮಾಹಿತಿ ನೀಡಿದ ಒಪ್ಪಿಗೆ ನಮೂನೆ

ಅಧ್ಯಯನದ ಶೀರ್ಷಿಕೆ: ತೃತೀಯ ಆರೈಕೆ ಆಸ್ಪತ್ರೆಯಲ್ಲಿ ಉದ್ದೇಶಪೂರ್ವಕವಾಗಿ ಸ್ವಯಂ-ಹಾನಿ ಮಾಡಿಕೊಳ್ಳುವ

ರೋಗಿಗಳಲ್ಲಿನ ವ್ಯಕ್ತಿತ್ವದ ಪ್ರೊಫೈಲ್: ಒಂದು ಅಡ್ಡ ವಿಭಾಗದ ಅಧ್ಯಯನ

ಉದ್ದೇಶಪೂರ್ವಕವಾಗಿ ಸ್ವಯಂ ಹಾನಿಗೊಳಗಾದ ರೋಗಿಗಳಲ್ಲಿ ವ್ಯಕ್ತಿತ್ವದ ಪ್ರೊಫೈಲ್ ಅನ್ನು ಗುರುತಿಸುವುದು

ಅಧ್ಯಯನದ ಮುಖ್ಯ ಗುರಿಯಾಗಿದೆ. ಪ್ರಬಂಧದ ಭಾಗವಾಗಿ ಮನೋವೈದ್ಯಶಾಸ್ತ್ರ ವಿಭಾಗವು ನಡೆಸಿದ

ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಿಮ್ಮನ್ನು ವಿನಂತಿಸಲಾಗಿದೆ. ಸ್ಟ್ರೀನಿಂಗ್ ಪ್ರಶ್ನಾವಳಿಗೆ ಒಪ್ಪಿಗೆ ನೀಡುವ

ರೋಗಿಗಳಲ್ಲಿ 18-60 ವರ್ಷ ವಯಸ್ಸಿನ ನಡುವೆ ಉದ್ದೇಶಪೂರ್ವಕವಾಗಿ ಸ್ವಯಂ-ಹಾನಿ ಮಾಡಿಕೊಳ್ಳುವ ರೋಗಿಗಳ

ಮೇಲೆ ಈ ಅಧ್ಯಯನವನ್ನು ಮಾಡಲಾಗುತ್ತದೆ.

ಈ ಅಧ್ಯಯನವನ್ನು ಸಾಂಸ್ಥಿಕ ನೈತಿಕ ಸಮಿತಿಯು ಅನುಮೋದಿಸಿದೆ. ಸಂಗ್ರಹಿಸಿದ ಮಾಹಿತಿಯನ್ನು ಪ್ರಬಂಧ ಮತ್ತು

ಪ್ರಕಟಣೆಗೆ ಮಾತ್ರ ಬಳಸಲಾಗುತ್ತದೆ. ಭಾಗವಹಿಸಲು ಒಪ್ಪಿಕೊಳ್ಳಲು ಯಾವುದೇ ಒತ್ತಾಯವಿಲ್ಲ.

ನೀವು ಸ್ವಯಂಪ್ರೇರಣೆಯಿಂದ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಒಪ್ಪಿದರೆ ಮಾತ್ರ ಸಹಿ/ಹೆಬ್ಬರಳಿನ ಗುರುತು ಹಾಕಲು

ನಿಮ್ಮನ್ನು ವಿನಂತಿಸಲಾಗಿದೆ.

ನಿಮ್ಮಿಂದ ಸಂಗ್ರಹಿಸಿದ ಎಲ್ಲಾ ಮಾಹಿತಿಯನ್ನು ಗೌಪ್ಯವಾಗಿ ಇರಿಸಲಾಗುತ್ತದೆ ಮತ್ತು ಯಾವುದೇ ಹೊರಗಿನವರಿಗೆ

ಬಹಿರಂಗಪಡಿಸಲಾಗುವುದಿಲ್ಲ. ನಿಮ್ಮ ಗುರುತನ್ನು ಬಹಿರಂಗಪಡಿಸಲಾಗುವುದಿಲ್ಲ. ವಿವರಣೆಯಿಲ್ಲದೆ ಯಾವುದೇ

ಸಮಯದಲ್ಲಿ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಿಮ್ಮ ಸಮ್ಮತಿಯನ್ನು ಹಿಂಪಡೆಯಲು ನೀವು ಸ್ವತಂತ್ರರಾಗಿದ್ದೀರಿ

ಮತ್ತು ಇದು ನಿಮ್ಮ ಭವಿಷ್ಯದ ಕಾಳಜಿಯನ್ನು ಬದಲಾಯಿಸುವುದಿಲ್ಲ.

ಸಾಕ್ಷರರಿಗೆ ಸಮ್ಮತಿ ನಮೂನೆ:

ನಾನು ಮೇಲಿನ ಮಾಹಿತಿಯನ್ನು ಓದಿದ್ದೇನೆ ಅಥವಾ ಅದನ್ನು ನನಗೆ ಓದಿದ್ದೇನೆ. ಅದರ ಬಗ್ಗೆ ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳಲು ನನಗೆ ಅವಕಾಶವಿದೆ ಮತ್ತು ನಾನು ಕೇಳಿದ ಯಾವುದೇ ಪ್ರಶ್ನೆಗಳಿಗೆ ನನ್ನ ತೃಪ್ತಿಗೆ ಉತ್ತರಿಸಲಾಗಿದೆ. ನಾನು/ನನ್ನ ಮಗ/ಮಗಳು/ಸಹೋದರ/ಸಹೋದರಿ/ಗಂಡ/ಹೆಂಡತಿ ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಾನು ಸ್ವಯಂಪ್ರೇರಣೆಯಿಂದ ಸಮ್ಮತಿಸುತ್ತೇನೆ.

ಭಾಗವಹಿಸುವವರ ಹೆಸರು _____

ದಿನಾಂಕ _____

ಭಾಗವಹಿಸುವವರ ಸಹಿ _____

ಅನಕ್ಷರಸ್ಥರಿಗೆ:

ಸಾಕ್ಷಿಯ ಹೆಸರು _____ ಮತ್ತು ಭಾಗವಹಿಸುವವರ ಹೆಬ್ಬರಳು

ಸಾಕ್ಷಿಯ ಸಹಿ _____

ಭಾಗವಹಿಸುವವರಿಗೆ ಸಾಕ್ಷಿಯ ಸಂಬಂಧ _____

ದಿನಾಂಕ _____

Statement by the researcher/person taking consent:

I have accurately read out the information sheet to the patient and reliable relative of the potential participant, and to the best of my ability made sure that the person understands that the following will be done: I confirm that the subject was given an opportunity to ask questions about the study, and all the questions asked have been answered correctly and to the best of my ability. I confirm that the individual has not been forced into giving consent, and the consent has been given freely and voluntarily.

Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____

PLACE OF STUDY: R. L. JALAPPA HOSPITAL AND RESEARCH INSTITUTE,
TAMAKA, KOLAR.

PRINCIPAL INVESTIGATOR : Dr. STUTI J. MASHRU

ಒಪ್ಪಿಗೆಯನ್ನು ತೆಗೆದುಕೊಳ್ಳುವ ಸಂಶೋಧಕ/ವ್ಯಕ್ತಿಯ ಹೇಳಿಕೆ:

ನಾನು ರೋಗಿಯ ಮತ್ತು ಸಂಭಾವ್ಯ ಭಾಗವಹಿಸುವವರ ವಿಶ್ವಾಸಾರ್ಹ ಸಂಬಂಧಿಗೆ ಮಾಹಿತಿ ಹಾಳೆಯನ್ನು ನಿಖರವಾಗಿ ಓದಿದ್ದೇನೆ ಮತ್ತು ನನ್ನ ಸಾಮರ್ಥ್ಯದ ಅತ್ಯುತ್ತಮವಾಗಿ ಈ ಕೆಳಗಿನವುಗಳನ್ನು ಮಾಡಲಾಗುತ್ತದೆ ಎಂದು ವ್ಯಕ್ತಿಯು ಅರ್ಥಮಾಡಿಕೊಂಡಿದ್ದಾನೆ ಎಂದು ಖಚಿತಪಡಿಸಿಕೊಂಡಿದ್ದೇನೆ: ವಿಷಯವನ್ನು ಕೇಳಲು ಅವಕಾಶವನ್ನು ನೀಡಲಾಗಿದೆ ಎಂದು ನಾನು ಖಚಿತಪಡಿಸುತ್ತೇನೆ ಅಧ್ಯಯನದ ಕುರಿತಾದ ಪ್ರಶ್ನೆಗಳು ಮತ್ತು ಕೇಳಲಾದ ಎಲ್ಲಾ ಪ್ರಶ್ನೆಗಳಿಗೆ ಸರಿಯಾಗಿ ಮತ್ತು ನನ್ನ ಸಾಮರ್ಥ್ಯಕ್ಕೆ ತಕ್ಕಂತೆ ಉತ್ತರಿಸಲಾಗಿದೆ. ಸಮ್ಮತಿಯನ್ನು ನೀಡುವಂತೆ ವ್ಯಕ್ತಿಯನ್ನು ಬಲವಂತಪಡಿಸಲಾಗಿಲ್ಲ ಮತ್ತು ಒಪ್ಪಿಗೆಯನ್ನು ಮುಕ್ತವಾಗಿ ಮತ್ತು ಸ್ವಯಂಪ್ರೇರಣೆಯಿಂದ ನೀಡಲಾಗಿದೆ ಎಂದು ನಾನು ದೃಢೀಕರಿಸುತ್ತೇನೆ.

ಒಪ್ಪಿಗೆಯನ್ನು ತೆಗೆದುಕೊಳ್ಳುವ ಸಂಶೋಧಕರ/ವ್ಯಕ್ತಿಯ ಹೆಸರು_____

ಸಂಶೋಧಕರ/ಸಮ್ಮತಿಯನ್ನು ತೆಗೆದುಕೊಳ್ಳುವ ವ್ಯಕ್ತಿಯ ಸಹಿ_____

ದಿನಾಂಕ _____

ಅಧ್ಯಯನದ ಸ್ಥಳ: ಆರ್.ಎಲ್.ಜಾಲಪ್ಪ ಆಸ್ಪತ್ರೆ ಮತ್ತು ಸಂಶೋಧನಾ ಸಂಸ್ಥೆ, ತಮಕ, ಕೋಲಾರ.

ಪ್ರಧಾನ ತನಿಖಾಧಿಕಾರಿ : ಡಾ. ಸ್ತುತಿ ಜಿ. ಮಾಶು

ANNEXURE 7 :

KEY TO MASTER CHART

GENDER	M- Male F-Female
SES	Socio Economic Status Lower Middle
MARITAL H.	Marital History UM-Unmarried M-Married
RURAL/URBAN	Background – Rural / Urban
DIAGNOSIS	DSH – Deliberate Self Harm
METHOD	Method of DSH
PREVIOUS ATTEMPT H.	Previous Attempt of DSH History N – NO Y – YES Y-1 = previously 1 time attempted Y (2) = previously 2 times attempted Y (3) = previously 3 times attempted Y (4) = previously 4 times attempted Y (5) = previously 5 times attempted
STRESSOR	STRESSOR – Stress prior to DSH attempt YES NO
CHILDHOOD H.	CHILDHOOD HISTROY NO
FAMILY H.	Family History Nuclear Family Joint Family
RESULT	<u>Result of Personality</u>

CLUSTERS	Personality Disorder Clusters Cluster A - schizoid , paranoid Cluster B – impulsive , borderline , histrionic , dissocial Cluster C – anxious , dependent , anankastic
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MASTER CHART

AGE	GENDER	EDUCATION	SES	MARITAL H.	EMPLOYMENT	RURAL/URBAN	DIAGNOSIS	METHOD	PREVIOUS ATTEMPT H.	STRESSOR	STRESS REASONS	CHILDHOOD H.	BIRTH ORDER	FAMILY H.	RELIGION	HABITS	HABIT	MEDICAL ILLNESS	MEDICAL ILLNESS	RESULT	CLUSTERS
20	Male	High school	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	N	Yes	Family issue	No	2	Joint family	Hindu	alcohol	Yes	No	No	impulsive	Cluster B
21	Male	Secondary school	lower	Unmarried	Employed	Rural	DSH, depression	Multiple tablets	Y-1	No	No	No	3	Nuclear	Hindu	no	no	No	No	borderline	Cluster B
38	Male	Primary school	lower	Married	Employed	Rural	DSH, adjustment disorder	Hanging	Y (2)	Yes	Financial issue	No	4	Joint family	Hindu	alcohol,smoking	Yes	No	No	anxious	Cluster C
25	Female	Secondary school	Lower	Married	Unemployed	Urban	DSH, adjustment disorder	liquid poison	Y (2)	No	Family issue	No	1	Nuclear	Hindu	no	no	No	No	dependent	Cluster C
45	Male	Primary school	Lower	Married	Employed	Rural	DSH	self cut	N	Yes	Financial issue	No	1	Joint family	Hindu	no	no	No	No	schizoid	Cluster A
21	Male	Secondary school	Lower	Unmarried	Employed	Rural	DSH	liquid poison	Y-1	Yes	Financial issue	No	3	Nuclear	Hindu	smoking	Yes	No	No	impulsive	Cluster B
38	Male	High school	Middle	Married	Employed	Rural	DSH	liquid poison	N	No	Family issue	No	2	Joint family	Hindu	tobacco	Yes	No	No	impulsive	Cluster B
29	Female	Secondary school	Middle	Unmarried	Employed	Rural	DSH, dysthymia	Multiple tablets	Y (2)	Yes	Family issue	No	2	Joint family	Hindu	no	no	No	No	dependent	Cluster C
31	Female	Primary school	Middle	Married	Unemployed	Rural	DSH	liquid poison	Y (2)	No	Family issue	No	2	Nuclear	muslim	alcohol,arecanut	Yes	No	No	borderline	Cluster B
27	Female	High school	Middle	Married	Unemployed	Rural	DSH	liquid poison	NO	No	No	No	4	Nuclear	Hindu	smoking	Yes	No	No	anxious	Cluster C
23	Male	Secondary school	Lower	Unmarried	Employed	Rural	DSH, adjustment disorder	Multiple tablets	NO	Yes	Financial issue	No	4	Nuclear	Hindu	no	no	No	No	impulsive	Cluster B
50	Male	High school	Lower	Married	Employed	Rural	DSH	liquid poison	Y(3)	No	Family issue	No	2	Nuclear	Hindu	alcohol,tobacco	Yes	No	No	impulsive	Cluster B
20	Male	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH	self cut	N	Yes	Financial issue	No	4	Nuclear	Hindu	no	no	No	No	impulsive	Cluster B
26	Male	Graduate	Lower	Unmarried	Employed	Rural	DSH	liquid poison	Y-2	No	No	No	3	Nuclear	Hindu	no	no	No	No	anxious	Cluster C
22	Male	High school	Lower	Married	Employed	Rural	DSH	Hanging	Y-2	No	No	No	4	Nuclear	Hindu	no	no	No	No	anxious	Cluster C
32	Male	Primary school	Lower	Married	Employed	Rural	DSH	Hanging	Y-1	No	No	No	2	Nuclear	muslim	alcohol,smoking	Yes	No	No	histrionic	Cluster B
55	Male	Secondary school	Lower	Unmarried	Employed	Rural	DSH, depression	liquid poison	Y-1	Yes	Family issue	No	2	Nuclear	Hindu	no	no	No	No	borderline	Cluster B
30	Male	Secondary school	Lower	Married	Employed	Rural	DSH, depression	liquid poison	Y-2	No	Family issue	No	6	Nuclear	Hindu	no	no	No	No	dependent	Cluster C
38	Female	Secondary school	Lower	Married	Employed	Rural	DSH, adjustment disorder	Hanging	N	Yes	Extramarital affair	No	2	Nuclear	Hindu	no	no	No	No	borderline	Cluster B
40	Male	High school	Lower	Unmarried	Employed	Rural	DSH	liquid poison	N	Yes	body pain	No	1	Nuclear	Hindu	no	no	No	No	paranoid	Cluster A
35	Male	High school	Lower	Married	Employed	Rural	DSH, adjustment disorder	liquid poison	Y-1	Yes	Family issue	No	2	Nuclear	Hindu	smoking	Yes	No	No	dependent	Cluster C
52	Female	Secondary school	Middle	Married	Unemployed	Rural	DSH, adjustment disorder	self cut	Y-2	No	No	No	2	Nuclear	muslim	alcohol,smoking	Yes	No	No	anankastic	Cluster C
21	Male	Graduate	Middle	Unmarried	Employed	Rural	DSH	liquid poison	N	Yes	Financial issue	No	2	Nuclear	Hindu	no	no	seizure	Yes	borderline	Cluster B
30	Female	High school	Lower	Married	Unemployed	Rural	DSH, depression	Hanging	Y-1	No	Family issue	No	3	Nuclear	Hindu	alcohol,arecanut	Yes	seizure	Yes	dependent	Cluster C
30	Female	High school	Lower	Married	Unemployed	Rural	DSH, depression	liquid poison	N	Yes	Financial issue	No	3	Joint family	muslim	no	no	No	No	histrionic	Cluster B
37	Female	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH	Multiple tablets	N	Yes	Financial issue	No	3	Nuclear	Hindu	no	no	No	No	paranoid	Cluster A
34	Female	High school	Middle	Married	Unemployed	Rural	DSH, dysthymia	liquid poison	Y (5)	Yes	Family issue	No	1	Nuclear	Hindu	no	no	No	No	anankastic	Cluster C
60	Male	Secondary school	Lower	Married	Employed	Rural	DSH	self cut	y(2)	No	Family issue	No	2	Nuclear	Hindu	alcohol	Yes	No	No	dependent	Cluster C
28	Male	Graduate	Middle	Unmarried	Employed	Rural	DSH, adjustment disorder	Hanging	y(2)	Yes	Family issue	No	5	Joint family	Hindu	no	no	No	No	borderline	Cluster B
18	Male	Secondary school	Middle	Unmarried	Unemployed	Rural	DSH	self cut	N	No	No	No	1	Nuclear	Hindu	smoking	Yes	No	No	dissocial	Cluster B
20	Female	High school	Lower	Unmarried	Unemployed	Rural	DSH, adjustment disorder	liquid poison	N	Yes	Financial issue	No	2	Nuclear	Hindu	no	no	No	No	anankastic	Cluster C
28	Male	Graduate	Lower	Married	Employed	Rural	DSH	liquid poison	Y-2	No	Family issue	No	1	Nuclear	Hindu	alcohol	Yes	No	No	impulsive	Cluster B
29	Male	High school	Lower	Unmarried	Unemployed	Rural	DSH	self cut	Y-1	No	Financial issue	No	1	Nuclear	Hindu	alcohol	Yes	No	No	borderline	Cluster B
30	Male	Secondary school	Lower	Unmarried	Employed	Rural	DSH	liquid poison	Y-1	No	No	No	3	Joint family	Hindu	no	no	No	No	anxious	Cluster C
40	Male	High school	Lower	Married	Employed	Rural	DSH, depression	liquid poison	N	No	No	No	1	Nuclear	Hindu	no	no	No	No	dependent	Cluster C
24	Male	Graduate	Lower	Unmarried	Employed	Rural	DSH, adjustment disorder	Multiple tablets	Y(2)	No	No	No	2	Joint family	Hindu	alcohol	Yes	seizure	Yes	borderline	Cluster B
25	Female	High school	Middle	Married	Unemployed	Rural	DSH	liquid poison	N	Yes	Family issue	No	1	Nuclear	Hindu	no	no	seizure	Yes	paranoid	Cluster A
30	Male	Secondary school	Middle	Unmarried	Employed	Rural	DSH, adjustment disorder	liquid poison	N	Yes	Family issue	No	2	Joint family	Hindu	alcohol,smoking,tobacco	Yes	No	No	anxious	Cluster C
35	Female	High school	Lower	Married	Unemployed	Rural	DSH	Multiple tablets	Y(2)	Yes	Extramarital affair	No	4	Nuclear	Hindu	no	no	No	No	dependent	Cluster C

AGE	GENDER	EDUCATION	SES	MARITAL H.	EMPLOYMENT	RURAL/URBAN	DIAGNOSIS	METHOD	PREVIOUS ATTEMPT H.	STRESSOR	STRESS REASONS	CHILDHOOD H.	BIRTH ORDER	FAMILY H.	RELIGION	HABITS	HABIT	MEDICAL ILLNESS	MEDICAL ILLNESS	RESULT	CLUSTERS
22	Male	Graduate	Lower	Unmarried	Unemployed	Urban	DSH, depression	liquid poison	N	No	Financial issue	No	1	Nuclear	Hindu	tobacco	Yes	No	No	dependent	Cluster C
30	Female	High school	Lower	Married	Unemployed	Rural	DSH	liquid poison	N	Yes	Family issue	No	2	Nuclear	Hindu	no	no	No	No	impulsive	Cluster B
28	Male	Primary school	Middle	Married	Employed	Rural	DSH	liquid poison	Y-2	Yes	Family issue	No	1	Nuclear	Hindu	alcohol,tobacco	Yes	No	No	anxious	Cluster C
19	Female	Secondary school	Middle	Unmarried	Unemployed	Rural	DSH, acute stress reaction	Multiple tablets	Y-1	No	No	No	2	Nuclear	Hindu	no	no	No	No	borderline	Cluster B
29	Male	High school	Lower	Married	Employed	Rural	DSH	liquid poison	Y-1	Yes	Family issue	No	2	Nuclear	Hindu	alcohol	Yes	No	No	schizoid	Cluster A
31	Male	Graduate	Lower	Married	Employed	Rural	DSH, acute stress reaction	liquid poison	N	No	Financial issue	No	2	Joint family	Hindu	no	no	HTN	Yes	paranoid	Cluster A
61	Male	High school	Middle	Unmarried	Employed	Rural	DSH	Multiple tablets	Y (1)	Yes	Financial issue	No	1	Nuclear	Hindu	alcohol,smoking	Yes	DM	Yes	histrionic	Cluster B
19	Female	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	N	Yes	Family issue	No	2	Nuclear	Hindu	no	no	No	No	impulsive	Cluster B
35	Male	Secondary school	Lower	Married	Unemployed	Rural	DSH	self cut	Y (2)	No	Financial issue	No	1	Nuclear	Hindu	alcohol,tobacco	Yes	DM	Yes	paranoid	Cluster A
22	Female	High school	Middle	Unmarried	Employed	Rural	DSH, depression	liquid poison	N	Yes	Family issue	No	2	Nuclear	Hindu	alcohol	Yes	No	No	impulsive	Cluster B
28	Male	High school	Middle	Unmarried	Employed	Rural	DSH,depression	liquid poison	Y-1	No	Family issue	No	2	Nuclear	Hindu	no	no	No	No	dependent	Cluster C
44	Male	Secondary school	Lower	Married	Employed	Rural	DSH	Multiple tablets	Y-1	Yes	Family issue	No	3	Joint family	Hindu	alcohol	Yes	No	No	dependent	Cluster C
36	Male	High school	lower	Married	Employed	Rural	DSH, depression	liquid poison	N	No	Family issue	No	1	Nuclear	Hindu	alcohol	Yes	No	No	impulsive	Cluster B
32	Male	Secondary school	lower	Unmarried	Employed	Rural	DSH	liquid poison	N	Yes	Financial issue	No	1	Nuclear	Hindu	no	no	No	No	histrionic	Cluster B
32	Female	Graduate	Middle	Married	Employed	Rural	DSH	Multiple tablets	Y (4)	No	Financial issue	No	1	Nuclear	Hindu	no	no	No	No	impulsive	Cluster B
21	Male	High school	Lower	Unmarried	Unemployed	Rural	DSH, depression	self cut	N	No	Family issue	No	2	Nuclear	Hindu	alcohol	Yes	No	No	dependent	Cluster C
23	Female	High school	Lower	Unmarried	Unemployed	Rural	DSH, anxiety disorder	Multiple tablets	Y-2	Yes	Family issue	No	2	Joint family	Hindu	no	no	No	No	borderline	Cluster B
30	Female	Secondary school	Lower	Married	Unemployed	Rural	DSH, depression	liquid poison	N	No	Financial issue	No	3	Joint family	muslim	alcohol,smoking	Yes	No	No	dependent	Cluster C
20	Female	High school	Lower	Married	Unemployed	Rural	DSH	Multiple tablets	Y-2	Yes	body pain	No	2	Joint family	Hindu	no	no	No	No	schizoid	Cluster A
28	Female	Primary school	Lower	Unmarried	Unemployed	Rural	DSH	Multiple tablets	Y-1	No	Financial issue	No	4	Joint family	muslim	no	no	No	No	borderline	Cluster B
32	Male	High school	Lower	Married	Employed	Rural	DSH, grief reaction	liquid poison	Y-1	No	Financial issue	No	2	Joint family	Hindu	no	no	No	No	dependent	Cluster C
28	Male	Secondary school	Middle	Unmarried	Employed	Rural	DSH	liquid poison	N	No	No	No	4	Nuclear	Hindu	alcohol,tobacco	Yes	No	No	paranoid	Cluster A
28	Female	Graduate	Lower	Married	Unemployed	Rural	DSH	self cut	Y-1	Yes	Financial issue	No	2	Nuclear	Hindu	no	no	No	No	borderline	Cluster B
35	Male	High school	Middle	Married	Unemployed	Rural	DSH	liquid poison	N	No	No	No	4	Joint family	Hindu	no	no	No	No	histrionic	Cluster B
19	Male	Graduate	Lower	Unmarried	Unemployed	Rural	DSH, adjustment disorder	Multiple tablets	Y(5)	Yes	Family issue	No	2	Nuclear	Hindu	alcohol,tobacco	Yes	No	No	impulsive	Cluster B
30	Female	High school	Middle	Married	Employed	Rural	DSH	liquid poison	N	Yes	Family issue	No	3	Nuclear	Hindu	no	no	DM	Yes	paranoid	Cluster A
28	Male	High school	Lower	Unmarried	Employed	Rural	DSH	Hanging	y(1)	Yes	Family issue	No	1	Nuclear	Hindu	alcohol,arecanut	Yes	No	No	borderline	Cluster B
31	Female	High school	Lower	Married	Unemployed	Rural	DSH	Hanging	N	No	No	No	2	Nuclear	Hindu	no	no	asthma	Yes	dependent	Cluster C
28	Male	High school	Middle	Unmarried	Unemployed	Rural	DSH, depression	liquid poison	Y-1	Yes	Family issue	No	3	Joint family	Hindu	alcohol	Yes	No	No	dependent	Cluster C
28	Female	High school	Lower	Married	Unemployed	Rural	DSH, adjustment disorder	Multiple tablets	Y-2	No	Family issue	No	2	Nuclear	Hindu	no	no	HTN	Yes	anxious	Cluster C
35	Female	Graduate	Lower	Married	Unemployed	Rural	DSH	liquid poison	Y-1	No	Financial issue	No	2	Nuclear	Hindu	alcohol,tobacco	Yes	No	No	schizoid	Cluster A
32	Female	High school	Middle	Unmarried	Employed	Rural	DSH, anxiety disorder	Multiple tablets	N	Yes	Family issue	No	1	Nuclear	Hindu	no	no	No	No	histrionic	Cluster B
39	Male	uneducated	Middle	Married	Employed	Rural	DSH	liquid poison	N	No	No	No	1	Nuclear	muslim	no	no	No	No	dependent	Cluster C
22	Female	Graduate	Lower	Unmarried	Unemployed	Rural	DSH, adjustment disorder	liquid poison	Y-1	No	No	No	1	Joint family	Hindu	no	no	No	No	borderline	Cluster B
19	Female	High school	Middle	Unmarried	Unemployed	Rural	DSH, depression	Multiple tablets	Y-2	Yes	Family issue	No	1	Nuclear	Hindu	tobacco	Yes	No	No	impulsive	Cluster B
24	Female	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH, adjustment disorder	liquid poison	N	Yes	Family issue	No	2	Nuclear	Hindu	no	no	No	No	dependent	Cluster C
32	Male	High school	Lower	Unmarried	Employed	Rural	DSH	Multiple tablets	Y(1)	Yes	Family issue	No	2	Nuclear	Hindu	tobacco	Yes	HTN	Yes	paranoid	Cluster A
26	Female	Secondary school	Middle	Unmarried	Employed	Rural	DSH, acute stress reaction	liquid poison	N	No	Family issue	No	1	Nuclear	Hindu	no	no	seizure	Yes	histrionic	Cluster B
29	Male	Graduate	Lower	Married	Employed	Rural	DSH	liquid poison	Y-1	No	No	No	1	Nuclear	Hindu	no	no	No	No	schizoid	Cluster A
26	Female	Primary school	Lower	Married	Unemployed	Rural	DSH	liquid poison	Y-2	Yes	Family issue	No	2	Joint family	Hindu	alcohol,tobacco	Yes	seizure	Yes	anxious	Cluster C

AGE	GENDER	EDUCATION	SES	MARITAL H.	EMPLOYMENT	RURAL/URBAN	DIAGNOSIS	METHOD	PREVIOUS ATTEMPT H.	STRESSOR	STRESS REASONS	CHILDHOOD H.	BIRTH ORDER	FAMILY H.	RELIGION	HABITS	HABIT	MEDICAL ILLNESS	MEDICAL ILLNESS	RESULT	CLUSTERS
35	Female	High school	Middle	Unmarried	Unemployed	Rural	DSH, anxiety disorder	Multiple tablets	Y-1	No	Family issue	No	2	Nuclear	Hindu	no	no	thyroid disorder	Yes	borderline	Cluster B
24	Female	Graduate	Lower	Unmarried	Unemployed	Rural	DSH, adjustment disorder	liquid poison	N	Yes	body pain	No	2	Nuclear	Hindu	tobacco	Yes	No	No	anankastic	Cluster C
30	Female	High school	Middle	Married	Employed	Urban	DSH, acute stress reaction	Multiple tablets	Y(3)	Yes	Family issue	No	3	Nuclear	Hindu	no	no	DM,respiratory failure	Yes	borderline	Cluster B
26	Female	Graduate	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	N	No	Financial issue	No	2	Nuclear	Hindu	no	no	No	No	anxious	Cluster C
35	Male	Secondary school	Middle	Married	Employed	Rural	DSH	Multiple tablets	Y-1	No	Family issue	No	1	Nuclear	Hindu	no	no	No	No	dependent	Cluster C
46	Male	Secondary school	Lower	Unmarried	Employed	Rural	DSH	liquid poison	Y-2	Yes	Family issue	No	2	Nuclear	Hindu	alcohol,tobacco	Yes	No	No	borderline	Cluster B
30	Male	Secondary school	Lower	Unmarried	Employed	Rural	DSH, dysthymia	liquid poison	N	No	No	No	2	Joint family	Hindu	alcohol,smoking,tobacco	Yes	No	No	histrionic	Cluster B
21	Female	Secondary school	Middle	Married	Unemployed	Rural	DSH	Multiple tablets	N	Yes	Family issue	No	1	Nuclear	Hindu	no	no	No	No	dependent	Cluster C
28	Male	High school	Middle	Unmarried	Unemployed	Rural	DSH	Multiple tablets	Y-1	No	Family issue	No	1	Nuclear	Hindu	alcohol	Yes	No	No	impulsive	Cluster B
42	Male	uneducated	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	Y-1	Yes	Family issue	No	2	Joint family	Hindu	alcohol,tobacco	Yes	seizure	Yes	schizoid	Cluster A
45	Male	Primary school	Lower	Married	Employed	Rural	DSH, adjustment disorder	liquid poison	N	Yes	Family issue	No	1	Nuclear	Hindu	alcohol, smoking	Yes	HTN	Yes	histrionic	Cluster B
30	Female	High school	Middle	Unmarried	Employed	Rural	DSH	Hanging	N	No	No	No	1	Nuclear	Hindu	no	no	No	No	borderline	Cluster B
29	Male	Graduate	Lower	Unmarried	Unemployed	Rural	DSH, depression	liquid poison	Y(3)	No	Family issue	No	2	Joint family	muslim	alcohol,arecanut	Yes	No	No	dependent	Cluster C
50	Female	Primary school	Lower	Married	Unemployed	Rural	DSH	liquid poison	N	Yes	Family issue	No	2	Joint family	Hindu	tobacco	Yes	No	No	anxious	Cluster C
30	Male	uneducated	Lower	Married	Employed	Rural	DSH, adjustment disorder	liquid poison	Y-1	No	No	No	2	Nuclear	Hindu	alcohol, smoking	Yes	HTN	Yes	borderline	Cluster B
28	Female	Secondary school	Middle	Unmarried	Employed	Rural	DSH, adjustment disorder	Hanging	Y-1	Yes	Family issue	No	1	Nuclear	muslim	no	no	HTN,DM,thyroid disorder	Yes	dependent	Cluster C
30	Female	High school	Middle	Unmarried	Unemployed	Urban	DSH, acute stress reaction	Hanging	N	No	No	No	1	Nuclear	Hindu	no	no	No	No	schizoid	Cluster A
38	Male	Secondary school	Lower	Married	Employed	Rural	DSH	liquid poison	Y-2	Yes	Family issue	No	1	Nuclear	Hindu	alcohol, smoking	Yes	No	No	paranoid	Cluster A
45	Male	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	Y-1	No	No	No	2	Nuclear	Hindu	alcohol	Yes	No	No	impulsive	Cluster B
30	Male	Secondary school	Lower	Married	Unemployed	Rural	DSH	liquid poison	N	No	No	No	1	Nuclear	Hindu	alcohol, smoking	Yes	No	No	dissocial	Cluster B
27	Female	High school	Middle	Unmarried	Unemployed	Rural	DSH	liquid poison	N	No	No	No	1	Nuclear	Hindu	no	no	No	No	borderline	Cluster B
38	Male	Graduate	Lower	Unmarried	Employed	Rural	DSH	liquid poison	Y-1	Yes	Family issue	No	4	Nuclear	Hindu	alcohol	Yes	No	No	histrionic	Cluster B
25	Male	Graduate	Middle	Unmarried	Employed	Rural	DSH, acute stress reaction	Hanging	Y-1	Yes	Family issue	No	1	Nuclear	Hindu	alcohol, smoking	Yes	seizure	Yes	dependent	Cluster C
28	Male	Secondary school	lower	Unmarried	Employed	Rural	DSH	liquid poison	N	No	Family issue	No	3	Joint family	Hindu	alcohol, smoking	Yes	No	No	paranoid	Cluster A
30	Male	Graduate	Lower	Married	Employed	Rural	DSH, adjustment disorder	liquid poison	Y-2	Yes	Family issue	No	1	Nuclear	Hindu	alcohol,tobacco	Yes	No	No	histrionic	Cluster B
20	Female	High school	Middle	Unmarried	Unemployed	Rural	DSH, adjustment disorder	liquid poison	N	Yes	Family issue	No	1	Nuclear	Hindu	no	no	No	No	borderline	Cluster B
27	Female	Secondary school	Middle	Unmarried	Unemployed	Rural	DSH, adjustment disorder	liquid poison	N	No	Family issue	No	1	Nuclear	Hindu	no	no	No	No	anxious	Cluster C
40	Male	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH	Hanging	Y(2)	Yes	Family issue	No	1	Joint family	Hindu	alcohol	Yes	No	No	dependent	Cluster C
18	Female	High school	Lower	Married	Unemployed	Rural	DSH, acute stress reaction	Hanging	N	Yes	Family issue	No	2	Joint family	Hindu	no	no	No	No	dependent	Cluster C
22	Male	High school	Middle	Unmarried	Employed	Rural	DSH	liquid poison	Y(3)	No	Family issue	No	2	Nuclear	Hindu	tobacco	Yes	No	No	schizoid	Cluster A
26	Male	High school	Middle	Unmarried	Employed	Rural	DSH	liquid poison	N	No	No	No	1	Nuclear	Hindu	alcohol, smoking	Yes	No	No	borderline	Cluster B
22	Female	High school	Lower	Unmarried	Unemployed	Rural	DSH	Hanging	Y-1	Yes	Issue with spouse	No	1	Nuclear	Hindu	no	no	No	No	dependent	Cluster C
55	Male	uneducated	Lower	Married	Employed	Rural	DSH, acute stress reaction	Hanging	Y-1	Yes	Family issue	No	1	Nuclear	Hindu	no	no	No	No	dependent	Cluster C
30	Male	Graduate	Lower	Unmarried	Unemployed	Rural	DSH, adjustment disorder	liquid poison	Y-1	No	Family issue	No	2	Nuclear	Hindu	alcohol,smoking,tobacco	Yes	No	No	borderline	Cluster B

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45	Female	Secondary school	Middle	Unmarried	Unemployed	Rural	DSH	liquid poison	Y-2	Yes	Family issue	No	2	Joint family	Hindu	tobacco	Yes	HTN	Yes	borderline	Cluster B
38	Female	Graduate	Middle	Unmarried	Employed	Rural	DSH, depression	liquid poison	N	Yes	Issue with spouse	No	1	Nuclear	Hindu	no	no	anemia	Yes	anankastic	Cluster C
30	Female	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH, adjustment disorder	liquid poison	Y-2	No	Issue with spouse	No	1	Nuclear	Hindu	no	no	No	No	borderline	Cluster B
28	Female	High school	Lower	Married	Unemployed	Rural	DSH	liquid poison	N	Yes	Family issue	No	1	Nuclear	Hindu	no	no	No	No	dependent	Cluster C
38	Female	High school	Lower	Unmarried	Unemployed	Rural	DSH, acute stress reaction	liquid poison	N	No	body pain	No	2	Nuclear	Hindu	no	no	No	No	schizoid	Cluster A
24	Male	Graduate	Middle	Unmarried	Employed	Rural	DSH	liquid poison	N	Yes	Issue with spouse	No	2	Nuclear	Hindu	alcohol,tobacco	Yes	No	No	histrionic	Cluster B
60	Female	uneducated	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	N	No	No	No	1	Nuclear	Hindu	tobacco	Yes	No	No	impulsive	Cluster B
50	Male	Secondary school	Lower	Unmarried	Employed	Rural	DSH	liquid poison	Y-1	No	Family issue	No	2	Nuclear	Hindu	alcohol, smoking	Yes	HTN	Yes	paranoid	Cluster A
32	Female	Graduate	Middle	Married	Employed	Urban	DSH, adjustment disorder	liquid poison	N	Yes	Issue with spouse	No	1	Nuclear	Hindu	tobacco	Yes	DM	Yes	dependent	Cluster C
32	Male	Graduate	Lower	Unmarried	Employed	Rural	DSH	Hanging	N	Yes	Extramarital affair	No	2	Nuclear	Hindu	alcohol, smoking	Yes	No	No	dissocial	Cluster B
38	Female	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	Y-1	No	Family issue	No	2	Nuclear	Hindu	no	no	No	No	dependent	Cluster C
25	Female	High school	Lower	Unmarried	Unemployed	Urban	DSH	liquid poison	N	Yes	Family issue	No	2	Nuclear	Hindu	no	no	No	No	borderline	Cluster B
22	Male	Secondary school	Middle	Unmarried	Employed	Rural	DSH, adjustment disorder	liquid poison	N	No	Family issue	No	3	Nuclear	Hindu	alcohol,tobacco	Yes	No	No	anxious	Cluster C
34	Female	Graduate	Middle	Married	Employed	Urban	DSH	Hanging	N	Yes	Issue with spouse	No	2	Nuclear	Hindu	smoking	Yes	DM	Yes	borderline	Cluster B
46	Male	High school	Lower	Unmarried	Employed	Rural	DSH	liquid poison	N	No	No	No	2	Nuclear	Hindu	no	no	No	No	dependent	Cluster C
26	Male	Secondary school	Lower	Unmarried	Employed	Rural	DSH	Hanging	N	Yes	Family issue	No	2	Nuclear	Hindu	alcohol, smoking	Yes	No	No	schizoid	Cluster A
22	Male	High school	Middle	Unmarried	Unemployed	Rural	DSH	Hanging	N	Yes	Family issue	No	1	Nuclear	Hindu	no	no	No	No	anankastic	Cluster C
57	Male	Secondary school	Middle	Unmarried	Unemployed	Urban	DSH	liquid poison	Y-1	No	Family issue	No	1	Joint family	Hindu	no	no	No	No	borderline	Cluster B
35	Female	Secondary school	Lower	Married	Employed	Urban	DSH, depression	liquid poison	N	Yes	Family issue	No	2	Nuclear	Hindu	smoking	Yes	HTN	Yes	anxious	Cluster C
55	Male	Primary school	Lower	Unmarried	Unemployed	Urban	DSH	liquid poison	N	Yes	Family issue	No	1	Joint family	Hindu	no	no	No	No	dependent	Cluster C
60	Female	Secondary school	Lower	Unmarried	Unemployed	Urban	DSH, acute stress reaction	liquid poison	N	No	Family issue	No	1	Joint family	Hindu	no	no	No	No	dissocial	Cluster B
20	Male	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH	Multiple tablets	Y-1	Yes	Family issue	No	2	Nuclear	Hindu	tobacco	Yes	No	No	borderline	Cluster B
25	Female	Secondary school	Lower	Married	Unemployed	Rural	DSH	Hanging	N	Yes	Family issue	No	2	Nuclear	Hindu	no	no	DM	Yes	borderline	Cluster B
22	Male	High school	Lower	Unmarried	Employed	Rural	DSH	liquid poison	N	No	Family issue	No	2	Nuclear	Hindu	no	no	HTN	Yes	borderline	Cluster B
38	Female	Graduate	Middle	Married	Employed	Urban	DSH, adjustment disorder	liquid poison	N	Yes	Family issue	No	1	Nuclear	Hindu	alcohol, smoking	Yes	No	No	anxious	Cluster C
23	Male	Secondary school	Lower	Unmarried	Employed	Urban	DSH	self cut	Y (2)	No	No	No	1	Nuclear	Hindu	alcohol	Yes	No	No	impulsive	Cluster B
25	Male	uneducated	Middle	Unmarried	Unemployed	Urban	DSH	Hanging	N	No	No	No	1	Nuclear	Hindu	no	no	No	No	paranoid	Cluster A
22	Male	Secondary school	Lower	Unmarried	Unemployed	Urban	DSH, grief reaction	liquid poison	Y-1	Yes	Family issue	No	2	Nuclear	Hindu	no	no	HTN	Yes	schizoid	Cluster A
23	Female	Secondary school	Middle	Unmarried	Employed	Urban	DSH	liquid poison	N	Yes	Family issue	No	1	Nuclear	Hindu	no	no	DM	Yes	borderline	Cluster B
43	Male	Graduate	Lower	Married	Employed	Rural	DSH	liquid poison	Y-1	Yes	Family issue	No	1	Nuclear	Hindu	no	no	No	No	histrionic	Cluster B
43	Male	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH, dysthymia	liquid poison	N	No	No	No	4	Nuclear	Hindu	alcohol,tobacco	Yes	No	No	dissocial	Cluster B
33	Female	High school	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	N	No	No	No	1	Nuclear	Hindu	alcohol,smoking,tobacco	Yes	HTN	Yes	dependent	Cluster C
29	Male	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH, adjustment disorder	Multiple tablets	Y (2)	Yes	Family issue	No	3	Nuclear	Hindu	no	no	No	No	borderline	Cluster B
32	Female	Graduate	Middle	Unmarried	Employed	Urban	DSH	liquid poison	N	Yes	body pain	No	1	Nuclear	Hindu	alcohol	Yes	No	No	borderline	Cluster B
22	Male	High school	Lower	Married	Employed	Urban	DSH, adjustment disorder	liquid poison	Y-1	No	No	No	1	Nuclear	Hindu	alcohol,tobacco	Yes	DM	Yes	impulsive	Cluster B
19	Female	Secondary school	Lower	Unmarried	Employed	Urban	DSH, panic disorder	liquid poison	N	No	No	No	2	Nuclear	Hindu	alcohol, smoking	Yes	No	No	borderline	Cluster B
30	Male	High school	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	N	Yes	Family issue	No	3	Nuclear	Hindu	no	no	No	No	schizoid	Cluster A
38	Female	Secondary school	Middle	Unmarried	Unemployed	Urban	DSH	liquid poison	y(1)	No	No	No	2	Joint family	Hindu	alcohol	Yes	HTN	Yes	dependent	Cluster C
19	Male	Secondary school	Lower	Unmarried	Employed	Rural	DSH	Hanging	N	Yes	Extramarital affair	No	1	Nuclear	Hindu	no	no	DM	Yes	borderline	Cluster B
34	Female	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH, depression	Multiple tablets	N	No	Family issue	No	2	Nuclear	Hindu	alcohol, smoking	Yes	No	No	impulsive	Cluster B

AGE	GENDER	EDUCATION	SES	MARITAL H.	EMPLOYMENT	RURAL/URBAN	DIAGNOSIS	METHOD	PREVIOUS ATTEMPT H.	STRESSOR	STRESS REASONS	CHILDHOOD H.	BIRTH ORDER	FAMILY H.	RELIGION	HABITS	HABIT	MEDICAL ILLNESS	MEDICAL ILLNESS	RESULT	CLUSTERS
20	Male	High school	Lower	Unmarried	Employed	Rural	DSH	liquid poison	Y(3)	Yes	Family issue	No	3	Nuclear	Hindu	no	no	No	No	dissocial	Cluster B
28	Female	Secondary school	Lower	Married	Employed	Rural	DSH	liquid poison	N	Yes	Family issue	No	2	Joint family	Hindu	smoking	Yes	No	No	borderline	Cluster B
25	Male	uneducated	Middle	Unmarried	Employed	Rural	DSH, adjustment disorder	liquid poison	N	No	No	No	1	Nuclear	Hindu	alcohol	Yes	DM	Yes	dependent	Cluster C
26	Female	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	N	No	No	No	3	Nuclear	Hindu	no	no	HTN	Yes	borderline	Cluster B
21	Male	Secondary school	Middle	Unmarried	Unemployed	Rural	DSH	liquid poison	Y-1	Yes	Family issue	No	2	Nuclear	Hindu	alcohol	Yes	No	No	impulsive	Cluster B
35	Male	Graduate	Lower	Unmarried	Employed	Rural	DSH	liquid poison	N	No	Family issue	No	2	Nuclear	Hindu	no	no	No	No	borderline	Cluster B
45	Male	Graduate	Lower	Unmarried	Employed	Rural	DSH	liquid poison	N	No	No	No	3	Nuclear	Hindu	no	no	No	No	anxious	Cluster C
25	Male	Primary school	Lower	Unmarried	Employed	Rural	DSH, adjustment disorder	liquid poison	N	No	No	No	2	Nuclear	Hindu	alcohol	Yes	No	No	dependent	Cluster C
22	Male	Secondary school	Lower	Unmarried	Employed	Rural	DSH	liquid poison	N	Yes	Family issue	No	2	Nuclear	Hindu	no	no	No	No	impulsive	Cluster B
35	Male	Secondary school	Middle	Unmarried	Unemployed	Rural	DSH	liquid poison	Y-1	Yes	body pain	No	2	Nuclear	Hindu	tobacco	Yes	HTN	Yes	borderline	Cluster B
41	Female	High school	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	N	No	No	No	1	Nuclear	Hindu	alcohol	Yes	seizure	Yes	schizoid	Cluster A
35	Female	uneducated	Middle	Unmarried	Unemployed	Urban	DSH	liquid poison	N	No	No	No	1	Nuclear	Hindu	no	no	No	No	paranoid	Cluster A
20	Female	Secondary school	Lower	Unmarried	Unemployed	Urban	DSH	Multiple tablets	N	Yes	Family issue	No	2	Nuclear	Hindu	no	no	seizure	Yes	borderline	Cluster B
26	Female	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH, adjustment disorder	Multiple tablets	Y (2)	Yes	Family issue	No	1	Nuclear	Hindu	alcohol,smoking,tobacco	Yes	thyroid disorder	Yes	impulsive	Cluster B
19	Female	Graduate	Lower	Unmarried	Employed	Rural	DSH	liquid poison	N	No	Extramarital affair	No	1	Nuclear	Hindu	no	no	No	No	dependent	Cluster C
32	Female	Graduate	Lower	Unmarried	Employed	Urban	DSH, grief reaction	liquid poison	N	No	No	No	2	Nuclear	Hindu	no	no	DM,respiratory failure	Yes	schizoid	Cluster A
26	Female	Graduate	Lower	Unmarried	Employed	Urban	DSH	self cut	Y-1	Yes	Family issue	No	2	Joint family	Hindu	smoking	Yes	No	No	histrionic	Cluster B
21	Female	Secondary school	Lower	Unmarried	Employed	Rural	DSH, adjustment disorder	liquid poison	N	Yes	Family issue	No	2	Nuclear	Hindu	no	no	No	No	borderline	Cluster B
22	Female	Graduate	Lower	Unmarried	Employed	Rural	DSH, dysthymia	liquid poison	N	No	No	No	1	Joint family	Hindu	no	no	No	No	borderline	Cluster B
42	Female	Graduate	Lower	Unmarried	Unemployed	Rural	DSH	self cut	N	No	No	No	1	Joint family	Hindu	alcohol,tobacco	Yes	No	No	schizoid	Cluster A
23	Female	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	Y (2)	Yes	Family issue	No	1	Nuclear	Hindu	no	no	No	No	dissocial	Cluster B
24	Female	Secondary school	Lower	Unmarried	Unemployed	Urban	DSH	liquid poison	N	Yes	Family issue	No	2	Nuclear	Hindu	alcohol	Yes	No	No	dependent	Cluster C
24	Female	High school	Lower	Unmarried	Unemployed	Rural	DSH, depression	liquid poison	N	No	Family issue	No	1	Nuclear	Hindu	tobacco	Yes	seizure	Yes	borderline	Cluster B
27	Female	High school	Lower	Unmarried	Employed	Rural	DSH	liquid poison	Y-1	Yes	Family issue	No	1	Nuclear	Hindu	alcohol	Yes	HTN	Yes	impulsive	Cluster B
56	Female	High school	Lower	Unmarried	Employed	Rural	DSH, panic disorder	liquid poison	Y	Yes	Family issue	No	4	Nuclear	Hindu	no	no	No	No	anxious	Cluster C
24	Female	High school	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	y(1)	No	Family issue	No	1	Nuclear	Hindu	no	no	No	No	impulsive	Cluster B
32	Female	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	Y	Yes	Family issue	No	3	Nuclear	Hindu	alcohol	Yes	No	No	dependent	Cluster C
44	Female	Graduate	Lower	Unmarried	Employed	Urban	DSH, depression	liquid poison	Y	Yes	Family issue	No	1	Nuclear	Hindu	no	no	HTN	Yes	borderline	Cluster B
30	Female	uneducated	Lower	Unmarried	Employed	Urban	DSH, panic disorder	liquid poison	Y(3)	Yes	Family issue	No	1	Nuclear	Hindu	alcohol	Yes	HTN,DM,thyroid disorder	Yes	dissocial	Cluster B
60	Female	High school	Lower	Unmarried	Unemployed	Rural	DSH	self cut	Y	No	Family issue	No	2	Nuclear	Hindu	no	no	No	No	dependent	Cluster C
32	Female	Secondary school	Lower	Unmarried	Unemployed	Rural	DSH	liquid poison	Y	No	No	No	2	Nuclear	Hindu	alcohol	Yes	No	No	borderline	Cluster B
47	Female	Graduate	Middle	Unmarried	Employed	Rural	DSH, depression	liquid poison	Y-1	No	No	No	3	Nuclear	Hindu	alcohol	Yes	No	No	impulsive	Cluster B
37	Female	High school	Lower	Unmarried	Employed	Rural	DSH, adjustment disorder	self cut	Y	Yes	Family issue	No	1	Nuclear	Hindu	alcohol,smoking,tobacco	Yes	No	No	dependent	Cluster C
23	Female	Graduate	Lower	Unmarried	Unemployed	Rural	DSH, panic disorder	liquid poison	Y	Yes	Family issue	No	2	Nuclear	Hindu	no	no	No	No	dissocial	Cluster B
41	Female	uneducated	Lower	Unmarried	Unemployed	Rural	DSH	Hanging	Y (1)	No	Family issue	No	2	Nuclear	Hindu	alcohol	Yes	No	No	dependent	Cluster C
39	Female	Secondary school	Lower	Unmarried	Employed	Urban	DSH, panic disorder	liquid poison	Y	No	No	No	3	Nuclear	Hindu	alcohol	Yes	seizure	Yes	schizoid	Cluster A
45	Female	Secondary school	Lower	Unmarried	Employed	Rural	DSH, panic disorder	liquid poison	Y	Yes	Family issue	No	2	Joint family	Hindu	alcohol	Yes	No	No	borderline	Cluster B
42	Female	Primary school	Lower	Unmarried	Employed	Rural	DSH	liquid poison	Y	No	No	No	1	Nuclear	Hindu	no	no	No	No	impulsive	Cluster B
36	Female	High school	Lower	Unmarried	Unemployed	Rural	DSH	self cut	Y (2)	No	No	No	1	Joint family	Hindu	alcohol	Yes	HTN	Yes	borderline	Cluster B
40	Female	Secondary school	Lower	Unmarried	Employed	Urban	DSH, depression	liquid poison	Y	Yes	Family issue	No	2	Nuclear	Hindu	tobacco	Yes	DM	Yes	anxious	Cluster C