

STUDY ON RISK FACTORS AND CLINICAL PROFILE OF PATIENTS PRESENTING TO A TERTIARY CARE HOSPITAL WITH DELIBERATE SELF-HARM: A CROSSECTIONAL STUDY WITH BECK'S SUICIDE INTENT SCALE ASSESSMENT

Dr. Sukhmani¹, Dr. Poonam Bharti², Dr. Prinka Arora³, Dr. Aman Bharti⁴

¹ PG Student, MMIMSR, Mullana, Haryana, India – kaursukhmani.1997@gmail.com

² Professor and Head of the Department, Department of Psychiatry, Mullana, Haryana, India – poonambharti109@gmail.com

³ Associate Professor, Mullana, Haryana, India – arora.prinka786@gmail.com

⁴ Associate Professor, GGS Medical College and Hospital, Faridkot, Punjab, India – dramanbharti@gmail.com

Corresponding Author:

Name: Dr. Shivakumar Rayanad

Designation: Senior Resident

Institution: MMIMSR, Mullana, Haryana, India

Email ID: scrayanad@gmail.com

ABSTRACT:

Background: Deliberate self-harm is a serious public health problem with high morbidity, replications and an increased risk of suicide. It is crucial to assess suicidal intent to identify highrisk individuals and inform clinical management.

Objectives: To assess socio-demographic details, clinical profile, psychiatric comorbidities, psychosocial risk factors, substance misuse history, suicidal ideation and treatment outcomes in the patients presenting with deliberate self-harm in tertiary care teaching hospital.

Methods: An Analytical Cross-sectional study was conducted in the Department of Psychiatry in Tertiary care Teaching Hospital in the time frame January to July 2025. A total of 200 adults with DSH were sampled consecutively. The data was collected with the help of a structured proforma and Beck's Suicide Intent Scale was used to assess suicidal intent. Data were analyzed statistically using SPSS version 27.0 and the level of significance was set at $p < 0.05$.

Results: The majority of participants were aged 18–30 years (54.0%), female (52.0%), unmarried (68.0%), and from rural areas (84.0%). Liquid poison ingestion was the most common method of DSH (66.0%). Previous suicide attempts were reported by 54.0% of participants, and psychosocial stressors were present in 52.0%. Adjustment disorder (18.0%) and depression (12.0%) were the most common psychiatric diagnoses, while substance use was reported by 50.5% of participants. The mean BSIS score was 13.8 ± 4.9 . Moderate suicidal intent was observed in 49.0% of participants and high suicidal intent in 24.0%. Higher suicidal intent was significantly associated with hanging ($p < 0.001$), previous suicide attempts ($p < 0.001$), psychiatric diagnosis ($p = 0.005$), and treatment outcomes ($p = 0.012$).

Conclusion: Lethal method of self-harm, psychiatric comorbidities and previous suicide attempts were significantly associated with suicidal intent in patients with DSH. Regular evaluation with BSIS can help with risk stratification and help guide interventions to prevent suicide.

Keywords: Deliberate self-harm; Suicidal intent; Beck Suicide Intent Scale; Psychosocial stressors; Substance use.

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INTRODUCTION

Self-harm behavior, known as deliberate self-harm (DSH), poses a huge public health burden and serves as a crucial determinant of future suicidal acts. Based on reports from the World Health Organization (WHO), the estimated number of deaths resulting from

suicide globally every year stands at over 720,000, while prior suicide attempts represent one of the most significant risk factors for future suicide [1]. Acts of self-harm are characterized by a considerable morbidity both physically and psychologically, with future repetitions likely [1, 2].

DSH is multifaceted, and its occurrence is largely dependent on the interaction of various psychiatric, psychological, social, and environmental factors [2]. Psychiatric illnesses constitute major contributors to self-harm and suicidal ideations, where cases of depressive disorders, bipolar disorder, personality disorders, and substance abuse disorders have been noted among patients [2, 3]. Self-injury is associated with psychosocial stressors, including conflicts in families, problems with interpersonal relationships, financial stress, and other stressful life events [4]. Previous studies have also reported associations between psychiatric morbidity, adverse life events, and the severity of suicidal intent among individuals presenting with self-harm [3, 4].

Evaluation of suicidal intent is a key aspect of evaluating patients who present with deliberate self-harm behaviors. Proper identification of intent can aid in determining an elevated likelihood of subsequent suicidal behavior [3]. One common test that is employed for assessing suicidal intent is the Beck's Suicide Intent Scale (BSIS). The scale evaluates both objective factors and subjective motives and expectations relating to the suicide attempt. Several researchers have discovered that there is a positive correlation between high BSIS scores, psychiatric disorders, self-harm behavior, and the future risk of suicide [3, 5].

Although previous studies have described the epidemiological and clinical characteristics of self-harm, relatively few comprehensive studies from Indian tertiary care settings have examined suicidal intent alongside psychiatric comorbidities, psychosocial stressors, substance use patterns, and treatment outcomes within a single clinical population. A better understanding of these relationships may facilitate identification of high-risk individuals and inform targeted preventive and therapeutic interventions.

The current study was conducted to analyze the sociodemographic data, clinical profile, psychiatric co-morbidities, psychosocial risks, pattern of substance abuse, scores on the Beck Suicide Intent Scale, and treatment outcome of deliberate self-harm cases in a tertiary care teaching hospital.

MATERIALS AND METHODS

Study Design and Study Site

This analytical cross sectional study was done in the department of Psychiatry, a tertiary care teaching hospital from 1 January to 31 July 2025. The study compared the sociodemographic profile, clinical characteristics, psychiatric comorbidities, psychosocial risk factors, pattern of substance use,

suicidal intent, and treatment outcomes of patients presenting with deliberate self-harm (DSH).

Operational Definition

Any self-destructive behavior, whether or not the person intended to die, such as self-poisoning or self-injury, that required medical or psychiatric evaluation was considered a deliberate self-harm (DSH) incident [6].

Participants of the Study

DSH patients were screened for eligibility in the adult population (age ≥ 18 years) during the study period. Consecutive patients who were clinically stable and provided written informed consent were enrolled in the study.

Accidental poisoning or injury, severe cognitive impairment and/or intellectual disability, severe medical or neurological illness that prevented psychiatric assessment, refusal to provide written informed consent were the exclusion criteria.

Sampling Size and Sampling Method

The absolute precision was taken as 7%, the prevalence as 50%, and the level of confidence as 95% and the sample size was calculated using Cochran's formula ($n = Z^2pq/d^2$). A sample size of 196 was the minimum required sample size and 200 was included. A sampling method called consecutive sampling was used until the desired sample size was met.

Data Collection

Structured proforma was filled with the sociodemographic characteristics, information about the self-harm episode, the method of DSH, psychiatric diagnosis, psychosocial stressors, previous suicide attempts, medical comorbidities, and treatment outcome.

Clinical evaluation and mental status examination were performed by consultant psychiatrists, who recommended psychiatric diagnoses based on the diagnostic criteria they used.

Beck's Suicide Intent Scale (BSIS) Scoring

The BSIS, a clinician administered scale used to assess both objective circumstances of the act of self-harm and the individual's subjective expectations and motivations, was used to determine suicidal intent. Assessments were conducted following the medical stabilisation process, usually within 24 - 72 hours of presentation.

The suicidal intent was classified as low (scores of 0–10), moderate (scores of 11–19), and high (scores ≥ 20) level of suicidal intent. The continuous and categorical scores were analysed [7, 8].

Statistical Analysis

The data were entered in the Microsoft Excel 2007 file and analysed using IBM SPSS Statistics version 27.0. The data for continuous variables were summarized as

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mean $\pm$ SD or median (interquartile range) according to the data type, and categorical variables as frequencies and percentages.

Chi-square test or Fisher's exact test was used to evaluate the associations between categorical variables. Independent-samples t-test or one-way analysis of variance (ANOVA), as appropriate, was used to compare the mean BSIS scores. Spearman's rank correlation coefficient was used to determine correlation among the continuous variables. The p value was determined to be statistically significant when <0.05 for two-tailed.

Ethical Considerations

The study has been approved by the Institutional Ethics Committee. Informed consent was obtained in writing from all participants before the enrolment. The study ensured confidentiality and participants were free to participate in the study without impacting their access to medical care.

RESULTS:

In total, 200 participants with deliberate self-harm were involved in the current study. The highest proportion of the participants (54.0%) fell in the age range of 18-30 years, followed by 31-40 years (22.5%), 41-50 years (15.0%), and 51-60 years (8.5%). There were more female participants (52.0%) than male participants (48.0%). The majority of the participants (68.0%) were unmarried, and 32.0% of the participants were married. Regarding education level, the most common was secondary school (37.0%), followed by high school (30.5%), graduation (17.5%), primary school (9.0%), and no formal education (6.0%). There were more employed participants (54.0%) compared to the number of unemployed participants (46.0%). With respect to the socioeconomic status of the participants, most were lower (60.0%), followed by middle (32.5%) and upper (7.5%). The majority of participants resided in rural areas (84.0%), whereas 16.0% were from urban areas (Table 1, Figure 1).

Table 1: Sociodemographic Characteristics of Participants Presenting with Deliberate SelfHarm (N = 200)

Variable	Category	Frequency	Percentage (%)
Age Group (years)	18–30 years	108	54.0
	31–40 years	45	22.5
	41–50 years	30	15.0

Gender	51–60 years	17	8.5
	Total	200	100.0
	Male	96	48.0
	Female	104	52.0

Marital Status	Unmarried	136	68.0
	Married	64	32.0
	Total	200	100.0
Educational Status	Uneducated	12	6.0
	Primary School	18	9.0
	Secondary School	74	37.0
	High School	61	30.5
	Graduate	35	17.5
	Total	200	100.0
Occupational Status	Employed	108	54.0
	Unemployed	92	46.0
	Total	200	100.0
Socioeconomic Status	Lower	120	60.0
	Middle	65	32.5
	Upper	15	7.5

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	Total	200	100.0
Place of Residence	Rural	168	84.0
	Urban	32	16.0
	Total	200	100.0

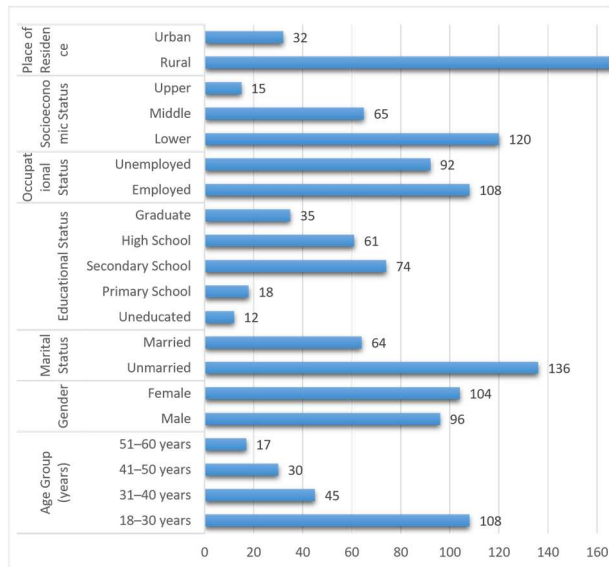


Figure 1: Sociodemographic Characteristics of Participants

The clinical features of the participants have been summarized in Table 2 and Figure 2. The most prevalent mode of self-injury was through liquid poison consumption in 132 (66.0%) participants. This was followed by self-harm using multiple tablets in 30 (15.0%) participants, hanging in 23 (11.5%) participants, and self-cutting in 15 (7.5%) participants. Previous suicide attempts were observed in 108 (54.0%) participants, while 92 (46.0%) participants did not report any previous attempt at taking their life. Of all the participants, 104 (52.0%) participants suffered from psychosocial stress, while none were evident in 96 (48.0%) participants. Medical comorbidities were identified in 51 participants

(25.5%), whereas 149 participants (74.5%) had no documented medical comorbidity.

Table 2: Clinical Profile and Methods of Deliberate Self-Harm Among Participants

Variable	Category	Frequency	Percentage (%)
Method of Deliberate Self-Harm	Liquid poison ingestion	132	66.0
	Multiple tablet overdose	30	15.0
	Hanging	23	11.5
	Self-cutting	15	7.5
	Total	200	100.0
Previous Suicide Attempt	Present	108	54.0
	Absent	92	46.0
	Total	200	100.0
Presence of Psychosocial Stressor	Yes	104	52.0
	No	96	48.0
	Total	200	100.0
Medical Comorbidities	Present	51	25.5
	Absent	149	74.5
	Total	200	100.0

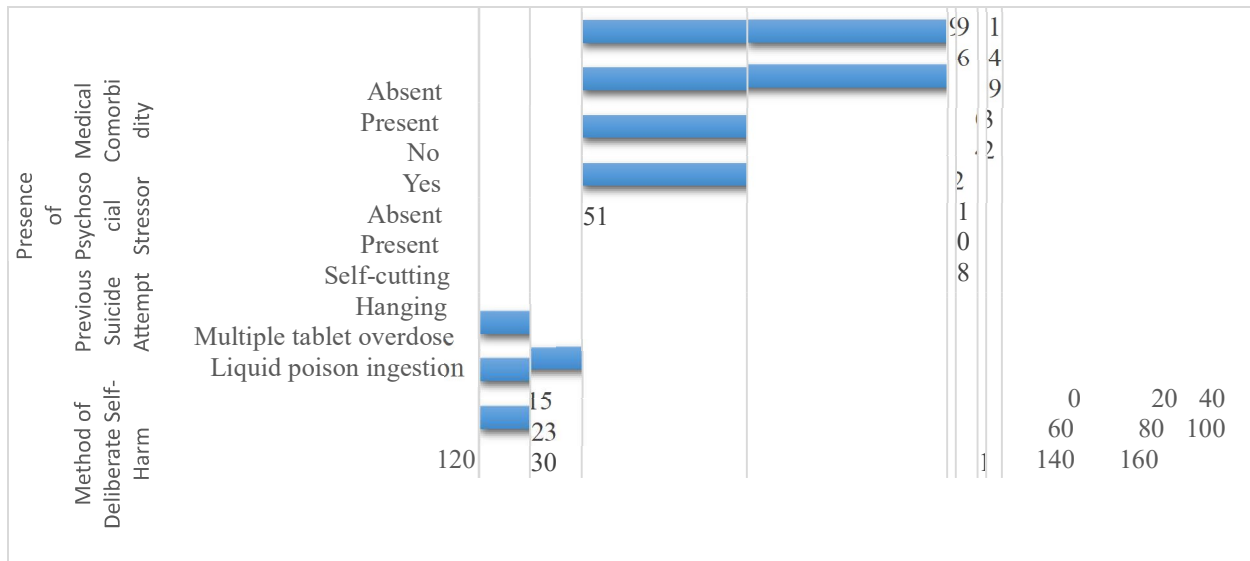


Figure 2: Clinical Profile and Methods of Deliberate Self-Harm

The distribution of psychiatric diagnoses, psychosocial risk factors, substance use, and triggering events is shown in Table 3 and Figure 3. More than half of the participants (53.0%) had no identifiable psychiatric illness. Among those with psychiatric comorbidity, adjustment disorder was the most common diagnosis (18.0%), followed by depression (12.0%), acute stress reaction (5.0%), borderline personality disorder (4.0%), anxiety disorder (4.0%), panic disorder (2.5%), and dysthymia (1.5%). Among the 104 participants reporting psychosocial stressors, family conflict was the most frequently reported stressor (60.6%), followed by financial stress (22.1%), relationship problems (17.0%), academic stress (14.0%), occupational stress (10.0%), and chronic illness (7.5%).

Table 3: Psychiatric Comorbidities, Psychosocial Risk Factors, Substance Abuse, and Triggering Events Among Participants

Variable	Category	Frequency	Percentage (%)
Psychiatric Diagnosis	DSH without psychiatric illness	106	53.0
	Adjustment disorder	36	18.0
	Depression	24	12.0
	Acute stress reaction	10	5.0
	Borderline Personality Disorder	8	4.0

(60.6%), followed by financial problems (22.1%), spousal conflict (6.7%), somatic illness (5.8%), and relationship issues (4.8%). Substance abuse was present in 101 participants (50.5%), while 99 participants (49.5%) reported no substance use. Among participants with substance abuse, alcohol alone was the most common pattern (33.7%), followed by alcohol and tobacco use (19.8%), multiple substance use (16.8%), tobacco alone (11.9%), opium/opioid use (9.9%), and cannabis use (7.9%). Regarding triggering events, family disputes were reported most frequently (30.5%), followed by financial stress (21.0%), relationship problems (17.0%), academic stress (14.0%), occupational stress (10.0%), and chronic illness (7.5%).

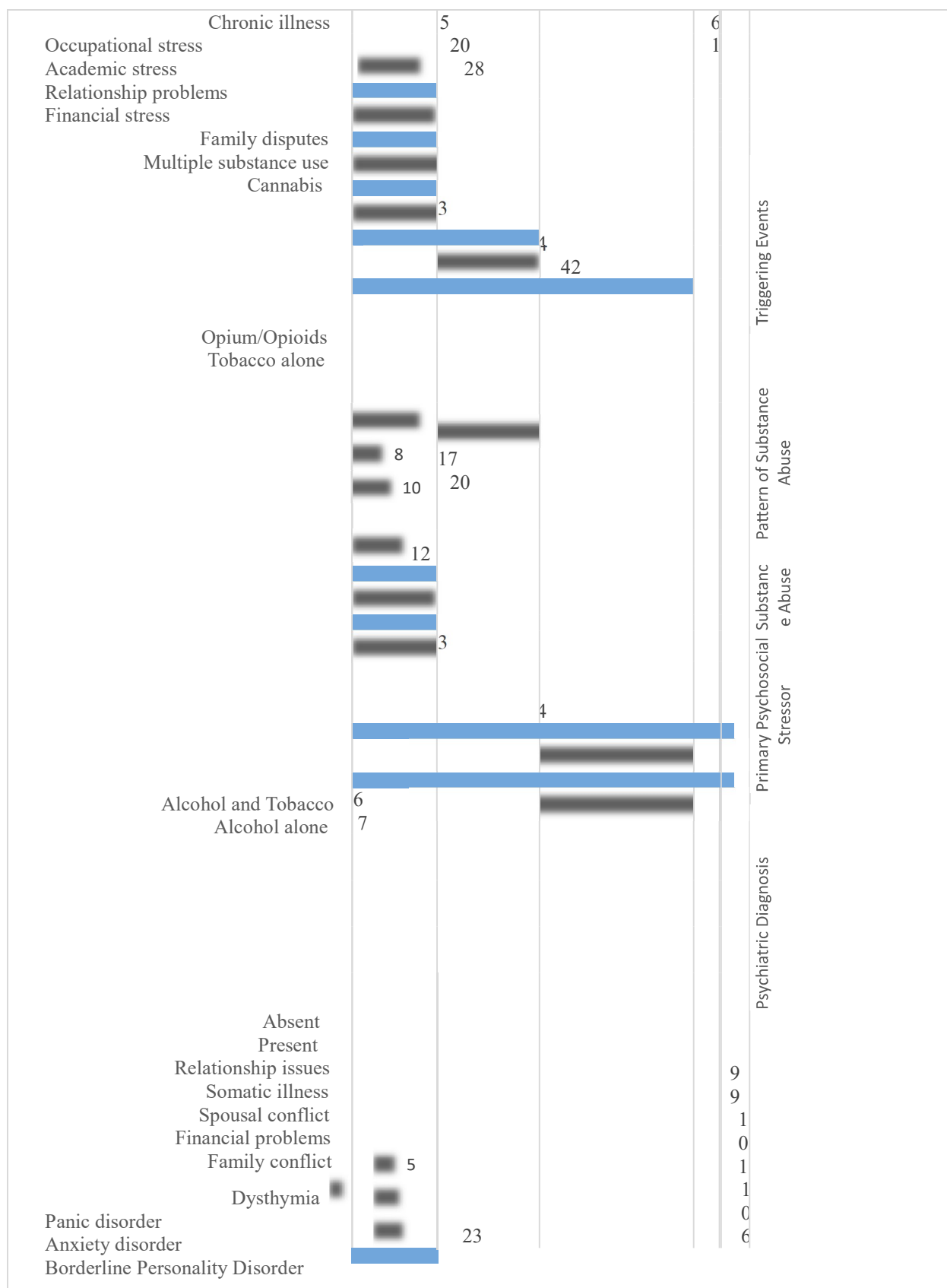
	Anxiety disorder	8	4.0
	Panic disorder	5	2.5
	Dysthymia	3	1.5
	Total	200	100.0
Primary Psychosocial Stressor	Family conflict	63	60.6
	Financial problems	23	22.1
	Spousal conflict	7	6.7
	Somatic illness	6	5.8
	Relationship issues	5	4.8

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	Relationship issues	5	4.8
	Total	104	100.0
Substance Abuse	Present	101	50.5
	Absent	99	49.5
	Total	200	100.0
	Alcohol alone	34	33.7

Pattern of Substance Abuse	Alcohol and Tobacco	20	19.8
	Tobacco alone	12	11.9
	Opium/Opoids	10	9.9
	Cannabis	8	7.9

	Multiple substance use	17	16.8
	Total	101	100.0
Triggering Events	Family disputes	61	30.5
	Financial stress	42	21.0
	Relationship problems	34	17.0
	Academic stress	28	14.0
	Occupational stress	20	10.0
	Chronic illness	15	7.5
	Total	200	100.0



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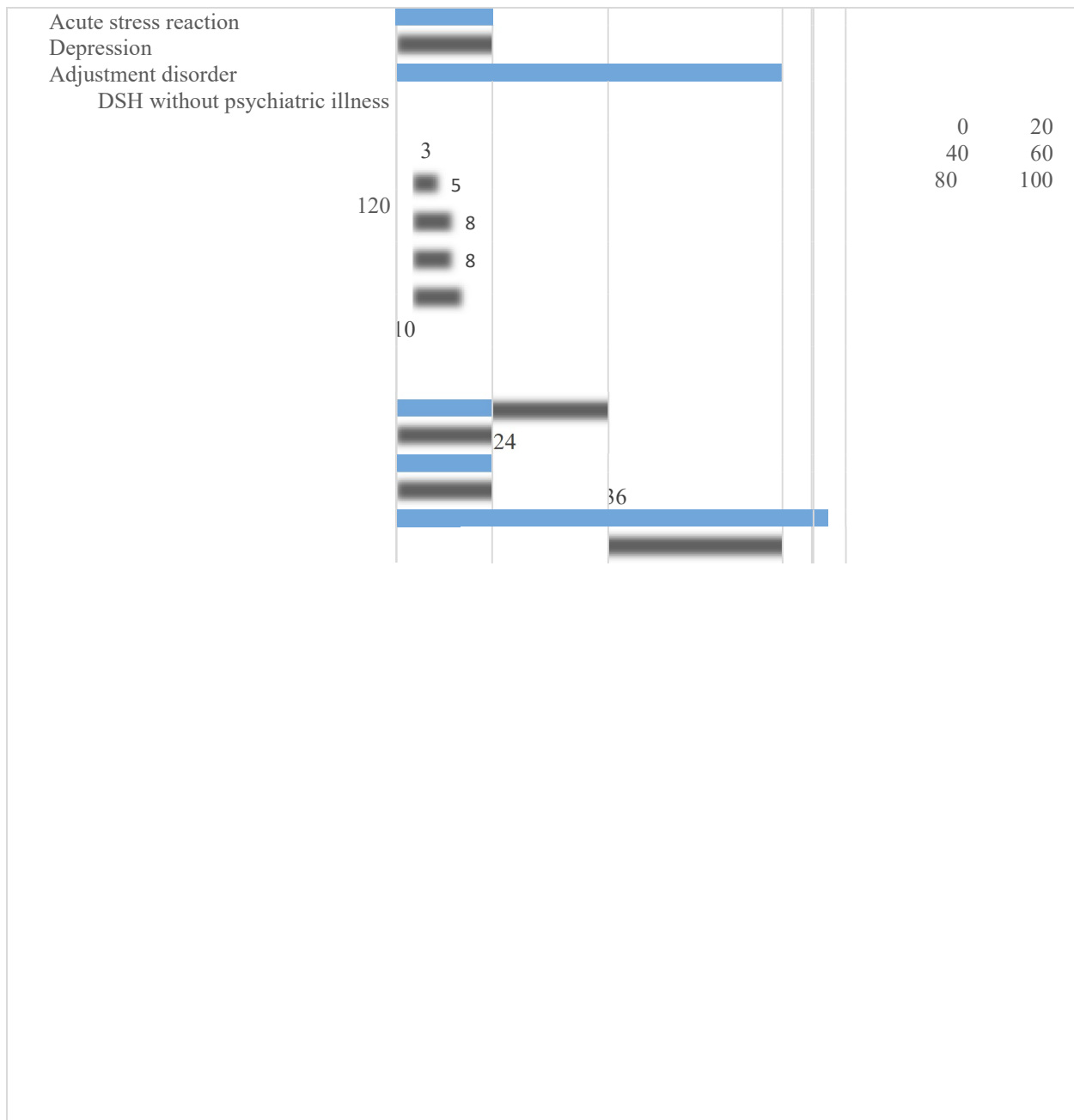


Figure 3: Psychiatric Comorbidities, Psychosocial Risk Factors, Substance Abuse, and Triggering Events

Distributions of BSIS categories and scores are provided in Table 4. The category of moderate suicidal intent was the most prevalent one, with 98 cases (49.0%) recorded. High suicidal intent occurred in 48 cases (24.0%), and there were 54 cases (27.0%) who had low suicidal intent. Overall BSIS score of the participants of this research is 13.8 ± 4.9 (Table 4).

Table 4: Beck's Suicide Intent Scale (BSIS) Categories and Scores Among Participants (N = 200)

Variable	Category	Frequency	Percentage (%)
BSIS Category	Low Intent (0–10)	54	27.0

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	Moderate Intent (11–19)	98	49.0
	High Intent (20–30)	48	24.0
	Total	200	100.0
Overall BSIS Score	Mean ± SD	13.8 ± 4.9	—

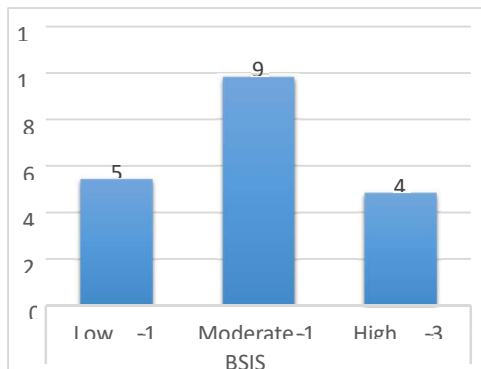


Figure 4: Beck's Suicide Intent Scale (BSIS) Categories

Table 5 gives the relationship between BSIS categorization and some clinical variables. There was a significant relationship between suicidality intent categorization and the mode of self-poisoning ($p=0.010$). In those patients who committed hanging attempts, 78.3% were categorized as high suicide intent while only 16.7%, 13.3%, and 26.7% were found among patients who had attempted poisoning with liquid poison, multiple tablet ingestion, and self-cutting, respectively. There was a significant relationship between previous suicide attempt history and BSIS category ($p<0.001$). Of the group with a history of previous suicide attempts, 38.9% were classified under high suicide intent while 6.5% of the other group had high suicide intent.

The association between psychiatric diagnosis and BSIS category was $p=0.005$. Participants with a borderline personality disorder had high suicidal intent in 75.0%, while the same existed in 66.7%, 60.0%, 50.0%, and 50.0% of participants with dysthymia, panic disorder, depression, and anxiety disorders, respectively. On the other hand, the incidence of high suicidal intent in participants without a psychiatric diagnosis was 11.3%. Treatment outcome differed significantly between various BSIS categories ($p=0.012$). While improvement/discharge rates were 88.9%, 75.5%, and 54.2% in participants with low, moderate, and high suicidal intent, referral for

psychiatric follow-up was 7.4%, 16.3%, and 29.2% in those same participants, respectively. Psychiatric admission remained at 0.0%, 6.1%, and 12.5% among participants with low, moderate, and high suicidal intent, respectively (Table 5).

Table 5: Association of Beck's Suicide Intent Scale (BSIS) Categories with Clinical Variables (N = 200)

Variable	Category	Low Intent (0–10) n (%)	Moderate Intent (11–19) n (%)	High Intent (20–30) n (%)	p-value
Method of DSH	Liquid poisoning	36 (27.3)	74 (56.1)	22 (16.7)	0.010
	Multiple tablet	9 (30.0)	17 (56.7)	4 (13.3)	
	Hanging	1 (4.3)	4 (17.4)	18 (78.3)	
	Self-cutting	8 (53.3)	3 (20.0)	4 (26.7)	
Previous Suicide Attempt	Present	14 (13.0)	52 (48.1)	42 (38.9)	<0.001
	Absent	40 (43.5)	46 (50.0)	6 (6.5)	
Psychiatric Diagnosis	DSH without psychiatric illness	44 (41.5)	50 (47.2)	12 (11.3)	0.005
	Adjustment disorder	5 (13.9)	23 (63.9)	8 (22.2)	
	Depression	3 (12.5)	9 (37.5)	12 (50.0)	
	Acute stress reaction	1 (10.0)	5 (50.0)	4 (40.0)	

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	Borderline Personality Disorder	0 (0.0)	2 (25.0)	6 (75.0)	
	Anxiety disorder	0 (0.0)	4 (50.0)	4 (50.0)	
	Panic disorder	0 (0.0)	2 (40.0)	3 (60.0)	
	Dysthymia	1 (33.3)	0 (0.0)	2 (66.7)	
Treatm ent Outco me	Improved and discharged	48 (88.9)	74 (75.5)	26 (54.2)	0.012
	Referred for psychiatric follow-up	4 (7.4)	16 (16.3)	14 (29.2)	
	Admitted for continued psychiatric care	0 (0.0)	6 (6.1)	6 (12.5)	

Left Against Medical Advice (LAMA)	1 (1.9)	2 (2.0)	1 (2.1)
Mortality	1 (1.9)	0 (0.0)	1 (2.1)

Modalities of treatments and results achieved among participants are described in Table 6. The most prevalent treatment modality was counseling or psychoeducation, utilized for 82 patients (41.0%). Counseling together with pharmacotherapy was used for 64 patients (32.0%) while pharmacotherapy alone was used in the case of 28 patients (14.0%). Psychiatric admission was necessary for 18 patients (9.0%) while intensive care treatment was prescribed to 8 patients (4.0%). In terms of the treatment results, improvement and discharge from the hospital was observed for 148 patients (74.0%). Further consultations of the psychiatrist were recommended for 34 patients (17.0%). 12 patients (6.0%) had to be admitted for further psychiatric treatment while four patients (2.0%) left against medical advice and mortality cases were observed among 2 patients (1.0%).

Table 6: Treatment Modalities and Outcomes Among Participants (N = 200)

Variabl e	Category	Freque ncy	Percent age (%)
Treatm ent Modali ty	Counselling/Psychoe ducation	82	41.0
	Pharmacotherapy	28	14.0
	Counselling + Pharmacotherapy	64	32.0
	Psychiatric Admission	18	9.0
	Intensive Care Management	8	4.0
	Total	200	100.0

Treatm ent Outco me	Improved and discharged	148	74.0
	Referred for psychiatric follow-up	34	17.0
	Admitted for continued psychiatric care	12	6.0
	Left Against Medical Advice (LAMA)	4	2.0
	Mortality	2	1.0
	Total	200	100.0

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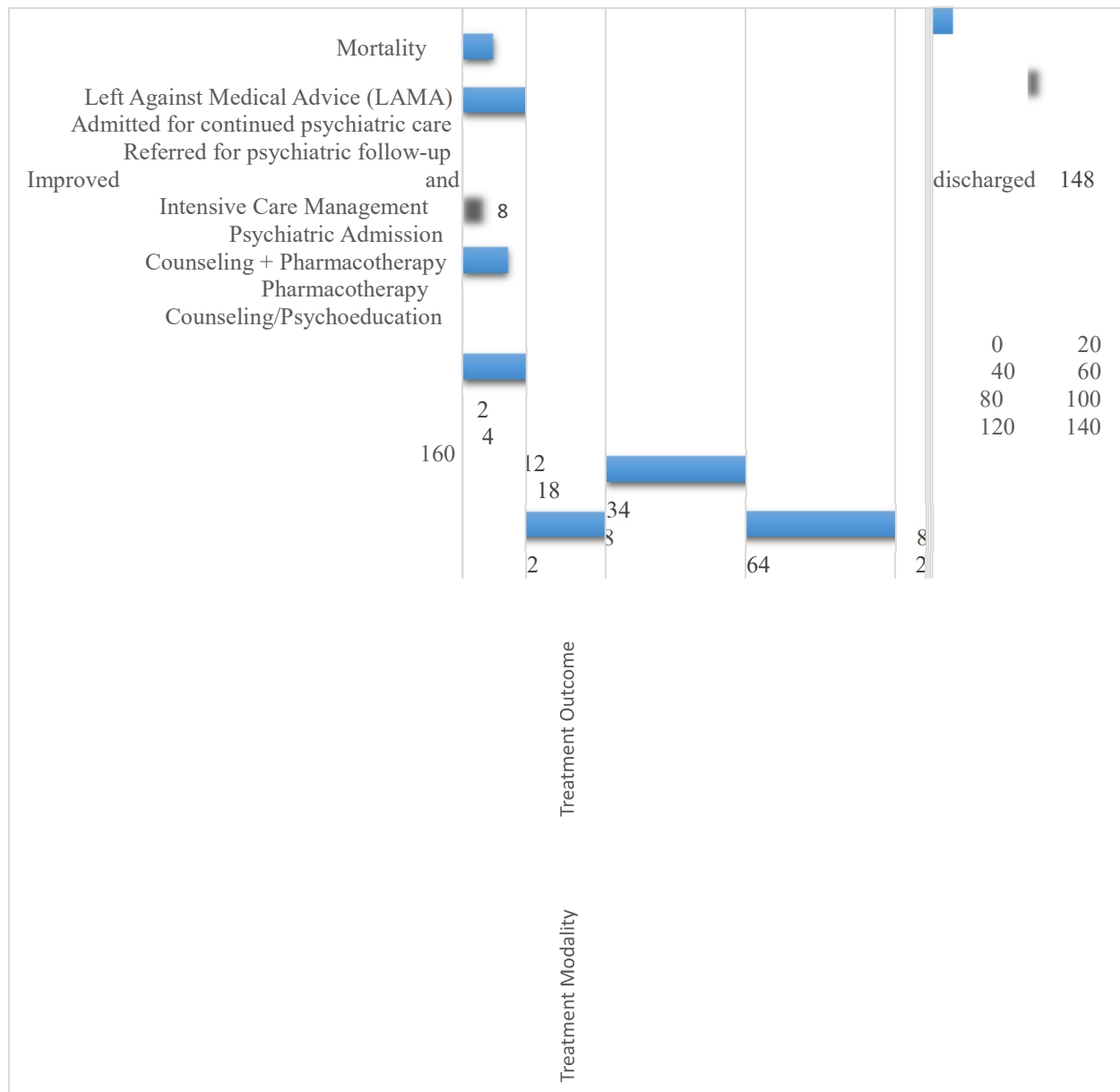


Figure 5: Treatment Modalities and Outcomes

Comparison of the mean scores for BSIS based on the mode of deliberate self-harm and psychiatric diagnosis are given in Table 7. The mean scores for BSIS varied significantly based on the mode of deliberate self-harm ($p < 0.001$). The group of participants who used the hanging method of selfharm obtained the highest mean score (21.6 ± 2.8), followed by liquid poisoning ingestion (11.2 ± 1.4), multiple tablet ingestion (9.8 ± 1.3), and self-cutting (6.8 ± 1.0). Significant differences were observed in the mean scores for BSIS based on the psychiatric diagnosis ($p = 0.025$). The mean scores for BSIS were the highest among

participants diagnosed with depression (18.9 ± 2.7), borderline personality disorder (16.5 ± 2.1), dysthymia (15.2 ± 2.0), panic disorder (14.7 ± 1.9), anxiety disorder (13.8 ± 1.7), acute stress reaction (12.4 ± 1.8), and adjustment disorder (11.3 ± 1.6).

The group of participants that had no psychiatric illness obtained the lowest mean score (8.5 ± 1.1).

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Table 7: Comparison of Mean BSIS Scores According to Method of Deliberate Self-Harm and Psychiatric Diagnosis (N = 200)

Variable	Category	Frequency	Mean BSIS Score $\pm$ SD	p-value
Method of DSH	Liquid poison ingestion	132	11.2 $\pm$ 1.4	<0.001
	Multiple tablet overdose	30	9.8 $\pm$ 1.3	
	Hanging	23	21.6 $\pm$ 2.8	
	Self-cutting	15	6.8 $\pm$ 1.0	
Psychiatric Diagnoses	DSH without psychiatric illness	106	8.5 $\pm$ 1.1	0.025
	Adjustment disorder	36	11.3 $\pm$ 1.6	
	Depression	24	18.9 $\pm$ 2.7	
	Acute stress reaction	10	12.4 $\pm$ 1.8	
	Anxiety disorder	8	13.8 $\pm$ 1.7	
	Borderline Personality Disorder	8	16.5 $\pm$ 2.1	
	Panic disorder	5	14.7 $\pm$ 1.9	
	Dysthymia	3	15.2 $\pm$ 2.0	

DISCUSSION

A cross sectional study of 200 consecutive patients with a diagnosis of DSH at a tertiary care teaching hospital was done to assess some of the sociodemographic and clinical factors, psychiatric comorbidities, psychosocial stressors, substance use patterns and treatment outcomes in patients with DSH, as well as their suicidal intent measured by the BSIS.

Comparison with Sociodemographic Characteristics

The majority of participants (54.0%) were between the ages of 18 and 30 years which is consistent with what has been reported in Indian studies by Singh et al. and Bhowmick et al. which reported a predominance of young adults in DSH presentations [1, 2]. This can be related to increased impulsivity, restricted coping capacity and the stressors of early adulthood. There was slightly more females (52.0%) as opposed to males, which is consistent with the observations of Mashru et al., who found 51.3% females in their similar population from India [3].

The percentage of unmarried participants (68.0%) is similar to that reported by Mashru et al. which is (68.4%) and is due to the youth age group [3]. The lower income and social status (60.0%) was also observed, consistent with findings from rural Sri Lanka that lower household asset scores are a risk factor for DSH alone [4]. The majority of the patients were living in rural areas (84.0%) which is similar to north-eastern India, where 75.8% of the patients were rural residents which could be related to accessibility of pesticides in rural areas and limited access to mental health facilities [2].

The Clinical Profile and Characteristics of Deliberate Self-Harm.

Ingestion of liquids was the most frequent form of suicide (66.0%) with multiple tablets, hanging and self-cutting following at 15.0%, 11.5% and 7.5% respectively. This is similar to Mashru et al. which reported a rate of 65.8% of liquid poison and to the high pesticide ingestion reported in different parts of the north-east India which reflects the easy availability of the agricultural chemicals to rural people [2, 3]. 54.0% of participants had a history of at least one previous suicide attempt, a comparable figure to that reported by Mashru et al. and clinically significant as previous attempts at self-harm are one of the most important risk factors for future suicide attempts [3, 5]. 52.0% of participants had psychosocial stressors, and 25.5% had medical comorbidities.

Psychiatric Comorbidities and Psychosocial Factors

Only 53.0% of those who participated identified with any psychiatric ailment. In those that were diagnosed, the most prevalent condition was adjustment disorders (18.0%), followed by depressive disorders (12.0%), acute stress reaction (5.0%), borderline personality disorder (BPD) (4.0%), anxiety disorder (4.0%), panic disorders (2.5 %) and dysthymia (1.5 %). These ratios are very similar to the proportions found by Mashru et al. (adjustment disorder 17.1%, depression 11.4%) [3]. Relatively low prevalence of depressive disorder in

Indian series could be due to difficulties in the diagnosis in busy emergency departments or due to a true difference in prevalence of situational DSH amongst Indian populations. Previous studies by Yaqoob and Ahsan indicated that suicidal intent scores were significantly predicted by mood and personality disorders among self harm patients, which is in agreement with the present study [6].

Family conflict (60.6%) was the most common primary psychosocial stressor, while financial difficulties (22.1%) was the second most common. This is very similar to the distribution reported by Mashru et al. (family conflict 60.6%, financial difficulties 22.2%) and was also supported by Singh et al. who found that family and social issues were the two most frequent antecedent events during two study periods separated by ten years [1, 3]. Other triggering events that had the greatest prevalence were family disputes (30.5%) and financial distress (21.0%), highlighting the importance of interpersonal and socioeconomic stressors in the precipitating events for DSH.

The Use of Substances and Triggering Events

50.5% of participants reported substance use, which was similar to the 50.25% reported by Mashru et al. [3]. The most prevalent patterns of drug use were alcohol alone (33.7%), combined alcohol and tobacco (19.8%), multiple substance use (16.8%), tobacco alone (11.9%), opioids (9.9%), and cannabis (7.9%). There is a strong association between alcohol use and suicide attempt: Stephenson and Edwards reported that alcohol dependence significantly increased the risk of a suicide attempt even when restricting to those with suicidal ideation in a nationally representative sample of the United States [7]. In the South Asian context, Fernando et al. found that the problematic use of alcohol in the household was an independent risk factor for DSH in young people living in rural areas of Sri Lanka (IRR 1.23, 95% CI 1.04–1.45) [4].

Suicidal Intent and Beck Suicide Intent Scale Findings

The overall mean BSIS was 13.8 ± 4.9 and 49.0% were in the moderate intent category, 27.0% were low intent and 24.0% were high intent. The median value of Method of DSH was significantly associated with BSIS category ($p = 0.010$). The mean score for participants using hanging was 21.6 ± 2.8 (78.3% were high intent), which was higher than the scores for the liquid poison (16.7% high intent), tablet overdose (13.3% high intent) and self-cutter groups (26.7% high intent). This gradient is in line with the relationship that has been established between the lethality of the method and suicidal intent, as shown in the validation

study by Harriss and Hawton of the Suicide Intent Scale [8].

Prior suicide attempt was significantly associated with BSIS category ($p < 0.001$), with a higher rate of high intent attempts among those with prior attempts (38.9%) than among those without prior attempts (6.5%). In a large multicentre prospective study, Hawton et al. have again found that repeated self harm was associated with a significantly higher risk of suicide, independent of the other factors included [5]. BSIS category was also significantly associated with psychiatric diagnosis ($p = 0.005$). The highest proportion of participants with BPD was in the high intent category (75.0%), and the lowest was in the without psychiatric diagnosis category (11.3%), with dysthymia (66.7%) and panic disorder (60.0%) having the next lowest rates. The highest proportion was in the high intent category (75.0%), while the lowest was in the without psychiatric diagnosis category (11.3%), with dysthymia (66.7%) and panic disorder (60.0%) having the next lowest rates. Similarly, the mean BSIS scores were significantly higher in the depressive disorder (18.9 ± 2.7) and BPD (16.5 ± 2.1) groups than in the NDD group (8.5 ± 1.1). The results are consistent with those of Yaqoob and Ahsan, who found that mood and personality disorders have significantly increased risk for suicidal intent [6].

Treatment Outcomes

The most used treatment modality was counselling/psychoeducation (41.0%) followed by combined counselling and pharmacotherapy (32.0%), pharmacotherapy alone (14.0%), psychiatric admission (9.0%) and intensive care management (4.0%). Overall, 74.0% improved and were discharged, 17.0% were referred for outpatient psychiatric care, 6.0% for continued inpatient psychiatric treatment, 2.0% left against medical advice and 1.0% died. The treatment outcome was significantly related to BSIS category ($p = 0.012$): the rate of psychiatric admission was associated and increased in tandem with the decrease of rate of discharge (low, moderate, and high intent: 0.0%, 6.1%, and 12.5%, respectively). The findings in this study are consistent with the clinical usefulness of the BSIS for treatment disposition and treatment planning as recommended by the expert consensus on treatment recommendations for patients with high suicidal intent from the Southeast Asian region [9].

Strengths and Limitations

Advantages are consecutive sampling, calculated sample size adequate, diagnoses confirmed by psychiatrist and the use of a validated clinician administered instrument (BSIS) to provide standardised risk stratification. The cross sectional

design restricts causal inferences. It is limited to a single centre and lacks generalisability. The use of clinical judgment instead of formal interviews for diagnosing some less common disorders could have contributed to less precise diagnoses, while the lack of prospective follow-up restricted the ability to draw conclusions about long-term outcomes.

Clinical Implications

All presentations of DSH, even those without a formal psychiatric diagnosis, should be systematically psychiatric assessed because of the high prevalence of acute situational distress. The BSIS can be used routinely to objectively stratify risks and directly to guide triage and disposition. Those who had attempted suicide, opt for a high-lethality method or had a diagnosis of BPD or depressive disorder should be followed closely in psychiatry and receive special suicide prevention measures. At the community level, upstream interventions with the aim of decreasing family conflict, financial hardship and alcohol misuse can have a meaningful impact on DSH incidence.

CONCLUSION

Deliberate self-harm was predominantly observed among young adults from rural and lower socioeconomic backgrounds, with liquid poison ingestion being the most common method. Family conflict, financial stress, substance use, and psychiatric comorbidities emerged as important factors associated with self-harm. Most participants demonstrated moderate suicidal intent, while higher suicidal intent was significantly associated with previous suicide attempts, psychiatric disorders, and more lethal methods of self-harm.

The findings underscore the need for comprehensive psychiatric evaluation of all patients presenting with deliberate self-harm. Routine assessment using Beck's Suicide Intent Scale may aid in identifying individuals at heightened risk and facilitate timely, targeted interventions to prevent recurrent self-harm and future suicidal behaviour.

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