NON SUICIDAL SELF INJURY BY CUTTING IN A CHRONIC ALCOHOLIC: A CASE REPORT

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ABSTRACT
Non-suicidal self-injury (NSSI) is very uncommon and poorly documented in case of children, adult and elderly persons as compared to adolescent population. Not all self-destructive behaviour are recommended as tendency to suicide. So there is need of better understanding regarding the NSSI for prevention of this type of abnormal behaviour. Understanding non-suicidal self-injury (NSSI) across the lifespan requires comprehension of the interaction between developmental periods and self-injury behaviors. We report a case of 26 year male patient with history of chronic alcoholism with violent behavior and attempted cutting down his wrist, with a knife without the intention of causing harm to himself or suicide. This phenomenon was repeated many a times. On repeated follow up to the psychiatry department of our hospital with complete stoppage of alcohol, management of withdrawal and proper counseling, the recurrence of the NSSI has been stopped.

KEY WORDS: NSSI, Alcohol withdrawal, counseling, adolescent.

INTRODUCTION
Non-suicidal self-injury (NSSI) defined as self-injurious behaviour without the intent to die, is a puzzling and poorly understood phenomenon. NSSI usually begins in adolescence, and most commonly takes the form of cutting, burning, or self-hitting. [¹] NSSI is usually a compulsive quality of behaviour, which is usually used by patients to relieve tension, or
alleviate emotional distress or pain. [2] Disturbances in pleasure circuitry or pain regulation in individuals may be a vital cause who self-injure. [3] NSSI is also common in those with emotion-focused and avoidance-focused coping styles. NSSI can best be understood as a morbid self-help effort providing rapid but temporary relief from feelings of depersonalization, guilt, rejection, and boredom as well as hallucinations, sexual preoccupations, and chaotic thoughts. NSSI occurs most often in individuals diagnosed with borderline personality disorder, a disorder characterized by self-destructive behaviour, impulsiveness and emotional liability (APA, 1994). However, several other disorders and syndromes have been associated with this behaviour, including major depression, [4] antisocial personality disorder, [5] dissociative identity disorder, [6] posttraumatic stress disorder, [7] eating disorder, [8] autism, developmental disabilities and Lesch–Nyhan syndrome [9] and alcoholism. [10]

Case Report
A 26 year male patient reported to our OPD, who was an chronic alcoholic taking alcohol since last 2 years on regular basis, every third or fourth day interval and moderate in amount (60-100 ml a day). In between he used to take larger amount (infrequently) and during that time he was becoming violent, aggressive, and quarrelsome towards family members. While being heavily drunk, twice he attempted cutting down his wrist, with a knife. As described by his wife, during that time he was totally unconcerned about the pain and severity of that injury. And he was engaged in that behaviour deliberately and repeatedly as depicted by the injury marks. The situation at that moment became so uncontrollable that the local police was called upon to stop him doing that act. But on asking the patient about the incidence he denied the awareness of the event and also was quite astonished looking at the injury marks. No other cause of self-mutilation was found on detail evaluation like, MDD, lesch nyhan syndrome, ASPD, BPD, dissociative disorders, autism or mental retardation. On examination patient had irritable mood with inappropriate affect. But he was well oriented, alert & conversant. He had normal verbal fluency, auditory comprehension, repetition, reading and numbering. His visual & verbal recognition scores were within normal limit. The general physical examination was unremarkable & neurological examination showed normal cranial nerves, coordination, motor & sensory reflexes. EEG revealed no epileptiform discharges. The withdrawal symptoms were controlled by Chlorodiazepoxide with a tapering dose. Patient had maintained abstinence since last one year and regularly being followed up with proper counselling. No recurrence in self-mutilating behaviour has been observed yet.
DISCUSSION & CONCLUSION

Self-mutilation, the deliberate, non-suicidal destruction of one's own body tissue, occurs in such culturally sanctioned practices as tattooing; body piercing; and healing, spiritual, and order-preserving rituals. As a symptom, it has typically been regarded as a manifestation of borderline behaviour and misidentified as a suicide attempt.

There is lack of data regarding Clinico – epidemiological finding of NSSI in psychiatric illness in which patients harm themselves. Self - injurious behavior may occur as a symptom in various psychiatric diagnoses: such as with mental retardation and patients with antisocial, dissociative and borderline personality disorder.

It has begun to attract mainstream media attention, and many more who suffer from it are expected to seek treatment. Major self-mutilation that requires attention and proper treatment includes infrequent acts such as eye enucleation and castration, commonly associated with psychosis and intoxication. Stereotypic self-mutilation includes head banging and self-biting most often accompanying Tourette’s syndrome and severe mental retardation. Superficial/moderate self-mutilation include compulsive acts such as trichotillomania and skin picking and skin-cutting and burning, which evolve into an axis I syndrome of repetitive impulse.

The higher incidence of self-injury has been reported in patients with dissociative disorders. The present study shows self-destructive behaviour in a patient of chronic alcoholic who is more frequently engage in self-destructive behaviours, use more methods of self-injury, and begin to injure themselves. Results have important implications for understanding the relationship between chronic alcoholic and self-injury and for assessment and treatment of patients with chronic intake of alcohol.

REFERENCES


