Should we not Deliberate more on Impulsivity?

Sir,

The spate of suicides in students from Maharashtra has escalated the concern that was experienced earlier in the cases of suicides of farmers and brides. All suicides are not necessarily the direct result of a categorical psychiatric morbidity. Common Mental Health Problems or desperate social situations may prompt a demoralized individual to attempt suicide. We require much more than just categorical diagnoses for effective clinical management. Impulsivity, for instance, requires attention. It is important because it leads to unexpected and sudden acts of self-harm often provoked by trivia.

Impulsivity—human behavior without adequate forethought—is characteristic of disorders like bipolar disorder, substance abuse disorder, attention deficit disorder, and impulse control disorder.[1] The recent rise in the incidence of suicides among the youth and high-risk behaviours like reckless driving and substance abuse highlight the need for the study of impulsivity. Proneness to accidents and violent eruptions of anger by patients also have impulsivity as the core feature. In India, this concept is not well studied, and there is no indigenous tool to measure impulsivity.

The Barratt Impulsiveness Scale 11 (BIS–11) measures attentional, motor, and nonplanning impulsiveness addressing the biological, social-interpersonal, and cognitive-emotional dimensions of impulsivity. BIS-11 is an internally consistent measure of impulsiveness and has clinical utility among various patient populations.[2] It has been translated in Hindi and was used in one of the Indian studies.[3]

We compared impulsivity among patients and controls in psychiatric clinics. The data were collected from two sources, a general hospital Psychiatry OPD (SD) and a private psychiatry clinic (VP). We used translation and back translation and consensus methods to use BIS-11A in Marathi. BIS was administered in Marathi or English by the clinician according to the literacy of the patients. Raw scores of impulsivity in the psychiatric outpatients were compared with those without any Axis I disorders.

We found significantly higher impulsivity score among patients, both in institute and private practice setting ($P=0.00004$) by Mann-Whitney independent rank sum test ($N=49$). Attentional, motor, and nonplanning impulsiveness were all significantly more among patients than controls. Nonplanning impulsivity was much more among patients than controls ($P=0.0001$) compared to attentional and motor impulsivity ($P=0.003$ and $P=0.002$, respectively). Nonplanning impulsiveness includes impulsivity in self-control and cognitive complexity. We know that most psychiatric disorders alter self-control and the ability to pursue complex tasks contributing to symptoms and disability.

Researchers have de-emphasized categorical psychiatric diagnoses in favor of social-cultural contexts.[4] Impulsive suicides are probably more frequent among...
Asians. We suggest that impulsivity be routinely measured in clinical practice in view of its preventive and therapeutic implications. However, considering social contexts and cultural meaning is essential for such attempts to be effective and useful.[5]

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