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ATTEMPTED SUICIDE AND SUICIDAL GESTURES

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"Die, my dear Doctor, that's the last thing I shall do."
Attr. last words of Viscount Palmerston (1784-1865)

The problem of attempted suicide is attracting much attention because of the great increase in the incidence of these cases in recent years. Anyone who is clinically involved can have no doubt about the increase although, rather surprisingly, the Ministry of Health have no reliable statistics (Ministry of Health, 1967, personal communication). Those statistics which are available have been collected by psychiatrists who have a particular interest in the problem. Kessel (1965) made this the subject of his Milroy Lectures, in which he pointed out that 'the fashion has so developed over the last 20 years that today we regard it almost as commonplace'. Matthew (1966) refers to 'a major epidemic'.

Having realized that approximately one-third of all new psychiatric referrals fell into this category, it was decided to carry out a prospective survey of cases arriving at The General Hospital, Ashton-under-Lyne over a period of one year. A total of 229 cases were dealt with during the year 1 June 1964 to 31 May 1965, an incidence of just over one per thousand of the catchment area population (223,000). The incidence is almost identical to that reported at the Poisoning Centre at Edinburgh. In contrast, Hopkins (1937), who carried out an extensive investigation of all cases of attempted suicide for the whole of Liverpool over a period of four years from 1932 to 1935, could collect only 656 cases, and, even as recently as 10 years ago, Harrington and Cross (1959) were able to collect only 102 cases in a large general hospital in Birmingham over a period of three years.

In order to ascertain whether in fact there had been an increase in the number of cases, a search was made through the hospital records for the sample years 1947, 1949, 1956, 1960, 1962, and 1968, and the results are shown in Table I. As no special record of these cases has been kept in the past, statistics could only be obtained by a search through the records of all types of cases dealt with by the accident and emergency room in the years selected. It will be seen that the number of cases increased by over 30 times in the period from 1947 to 1968.

The problem is a complex one and can be approached in a number of different ways, but the practical aspects of it, in particular possible means of prevention or reduction in the number of cases, must surely be the main consideration. As Kessel (1965) stresses, 'the problem is no longer academic'.

TABLE I
ATTEMPTED SUICIDE IN THE CATCHMENT AREA OF THE HOSPITAL IN VARIOUS SAMPLE YEARS FROM 1947 TO 1968

Year	No. of Cases
1947	10
1949	12
1956	56
1960	109
1962	167
1964/5*	229
1968	333

*1 June, 1964 to 31 May, 1965

RESULTS OF THE SURVEY

The number of patients treated in the year was 216. Eleven patients made two attempts in this period and one made three. Thirty-seven patients (one in eight) had made at least one previous attempt. One patient had made six previous attempts (five by self-poisoning and one by attempted self-strangulation). Females outnumbered males by about five to two and there was a preponderance of young people (Table II).

METHOD USED

Self-poisoning was by far the commonest method (Table III). Hypnotic drugs head the list of substances taken, followed by aspirin and tranquillizers of various kinds. It is notable that only nine patients (less than 1 in 20 of the cases of self-poisoning) took an overdose of drugs used in the treatment of depression. Twenty-four patients took more

TABLE II
AGE DISTRIBUTION OF THE 229 CASES OF ATTEMPTED SUICIDE

Age Group	No. of Cases
10–14	4
15–19	29
20–24	41
25–29	20
30–34	26
35–39	23
40–44	26
45–49	12
50–54	7
55–59	9
60–64	12
65–69	7
70–74	7
75–79	3
80–84	3

TABLE III
METHOD USED

Method	No. of Cases
Self-poisoning	200
Coal gas	15
Cut wrist or wrists	7
Cut throat and wrists	1
Attempted drowning	2
Coal gas plus drugs	2
Cut wrists plus drugs	1
Jump from bedroom window	1

than one drug (one took four, and another five different drugs). Sixteen patients had also drunk alcohol.

In a number of cases it seemed highly improbable that the patient had taken as large an overdose as was claimed, *e.g.*, case 47, a 30-year-old man, claimed to have taken 90 mg. of diazepam and 760 mg. of amylobarbitone but was not even drowsy on admission to hospital.

HOW THE DRUGS WERE OBTAINED. In 119 cases the drug or drugs had been prescribed for the patient by his own doctor and in 10 cases by a hospital department. In 18 cases the drugs had been prescribed for someone else in the household. In 44 cases the drugs had been obtained without a prescription; these were mainly cases of aspirin overdose, and in most cases the drug was already in the house, but in some cases they were bought shortly before the attempt (from a chemist's shop, general store, off-licence, herbalist's or other shop). One patient drank some skin lotion, and another a liquid detergent containing ammonia. In seven cases no reliable information could be obtained about the nature or the source of the drug or drugs taken.

CIRCUMSTANCES OF THE ATTEMPT. Twenty-two patients (almost 1 in 10) actually made the attempt in the presence of one or more persons, and in many other cases there were other people in the house at the time. The following are examples:

Case 14 A 19-year-old girl took an overdose of aspirin in the street in the presence of her boyfriend.

Case 16 A 40-year-old woman took an overdose of barbiturate in front of her husband.

Case 38 A 38-year-old man took an overdose of primidone in an office of the Ministry of Social Security.

Although they were alone when the attempt was made, 49 patients (more than a fifth of the total) told someone about the attempt soon afterwards and thus ensured that they would receive treatment, and four patients actually came up to the Casualty Department themselves. One young man was evidently not prepared to take any chances whatever, as he took his overdose after boarding a bus going to the hospital. The following are further examples:

Case 6 An 18-year-old man took an overdose of barbiturate, made himself vomit, and then went to the police.

Case 22 A 58-year-old man took an overdose when in bed in the morning and then telephoned his general practitioner.

Case 206 A 31-year-old woman took an overdose of aspirin and then gave her young son a note to take to her neighbour, who called an ambulance.

Case 209 A 23-year-old man cut both wrists with a razor blade and then went to his Probation Officer and told him about it.

WAS SUICIDE INTENDED? Judging by the circumstances of the attempt, statements made by the patient and others, and the results of the psychiatric interview, it was thought that in 137 cases there was certainly no intention of suicide, and in a further 39 cases it seemed highly improbable that suicide was intended. In other words, over three-quarters of the alleged suicidal attempts were actually suicidal gestures. (It is well known, of course, that most successful suicides are the result of first attempts.) In only 26 cases did the attempt appear certainly to have been serious, and in a further 17 cases suicide was probably intended. In 10 cases it was impossible to come to a conclusion (mainly patients who took their own discharge before they could be interviewed and about whom insufficient information could be obtained later). The proportion of cases judged to be serious depends, of course, on the stringency or otherwise of the criteria adopted. If one accepted as serious only those cases showing the features of the really

determined suicide bid, such as measures to avoid detection, plugging gaps around windows and doors in attempts by gassing, drinking corrosive liquids or inflicting severe throat or wrist wounds, and so on, the number of cases judged to be serious would have been less than is stated above. Only two patients were known to have left a note, although no specific enquiry was made on this point.

MOTIVE FOR THE GESTURE, IF SUICIDE WAS NOT INTENDED. Writing from Australia, Maddison and Mackey (1966) state the view that 'only a study in depth can begin to unravel the complexity of the patient's motivations, without which proper understanding and treatment are impossible'. This may be absolutely true, but unfortunately a psychiatrist working in a non-teaching hospital of the National Health Service cannot even attempt to carry out a study in depth of the large numbers of cases of attempted suicide with which he is now confronted. Consideration of time alone rules this out (the author has been asked to see as many as seven attempted suicides in one day). The patients are, of course, additional to those referred to the psychiatric clinic in the usual way, and they appear in unpredictable numbers.

In 49 cases (rather more than one in five) the attempts seemed to be a 'cry for help' (Stengel, Cook, and Kreeger, 1958). The following is an example:

Case 57 An 82-year-old woman took an overdose of aspirin and then told her neighbour. She was in failing health, had no relatives, and lived alone.

In 41 cases the attempt was clearly made in retaliation against another person, usually a close relative. The following are examples:

Case 173 A 13-year-old girl took an overdose of aspirin after her parents had forbidden her to continue to see her boy-friend; shortly beforehand she had told her parents that she had been having intercourse with him.

Case 208 A 16-year-old boy took an overdose of codeine tablets after his parents had blamed him for the fact that his friends had driven away his father's car and crashed it.

Marital disharmony was a prominent feature in 56 cases (almost a quarter of the total), the attempt often following immediately after a disagreement:

Case 49 A 21-year-old woman took an overdose of chlordiazepoxide (80 mg.) following a row with her husband. A court hearing for separation was shortly due.

In 15 cases the attempt was clearly aimed at manipulating people with whom the patient was associated:

Case 104 A 26-year-old woman cut her wrist in an attempt to stop her husband associating with another woman; she had taken a small overdose of drugs a few days previously.

Case 9 A 20-year-old man took 25 aspirin tablets in front of his girl-friend who had threatened to leave him. When asked why he took the tablets, he said 'I did it to frighten her'. Analysis in depth does not seem to be necessary in this case.

In 35 cases the gesture appeared to be an attention-seeking manoeuvre. In some cases the motive was completely obscure:

Case 180 A 19-year-old man drank some skin lotion, came up to the Casualty Department himself, refused a stomach washout, and took his own discharge against advice. He was later visited at home but refused to explain his actions or to discuss any problems he may have had. No signs or symptoms of mental illness were elicited.

THE PSYCHIATRIC DIAGNOSIS

It was not possible to come to any definite conclusion about the diagnosis in 17 cases. These were chiefly patients who took their own discharge from the medical ward before they could be seen and about whom insufficient information could be obtained later. The diagnoses in the remaining 199 patients are listed in Table IV. Only a minority of the patients were thought to be suffering from serious mental illness. The 80 patients with personality disorders were chiefly of inadequate or hysterical type. Some of the patients listed as suffering from reactive depression did not in fact have any significant degree of depression by the time they were interviewed, and in these the precipitating stress had been relatively trivial; only a

TABLE IV
THE PSYCHIATRIC DIAGNOSIS

Diagnosis	No. of Cases
Reactive depression	81
Personality disorder	80
No psychiatric abnormality	11
Endogenous depression	10
Schizophrenia	5
Chronic depression	3
Early dementia	3
Paranoid psychosis	2
Chronic anxiety state	2
Manic-depressive psychosis	1
Paraphrenia	1
Not diagnosed	17

minority of patients with reactive depression had been subjected to severe stress, such as a bereavement, by far the commonest causal stress being marital disharmony.

Significant physical disease was present in only 27 cases. With the notable exception of epilepsy (8 cases), these were almost all in the older age groups, and in most of these cases the attempt was judged to be serious or a 'cry for help'. Physical disease was notable by its absence in patients under 45 years of age. (In contrast, a high incidence of organic disease is found in cases of actual suicide. Stewart (1960) analysed 122 cases of suicide in Yorkshire examined from September 1952 to September 1959 and found significant organic disease in 70%.)

Treatment Recommended

No psychiatric treatment seemed to be indicated in 78 cases (a third of the total). Two patients were sent home from the Casualty Department without a psychiatric opinion being asked for, and six patients took their own discharge from the Casualty Department; two of these patients, who had allegedly taken overdoses, refused a stomach washout. Twenty patients took their own discharge from the medical ward against advice shortly after admission.

Seventeen patients were advised to enter the Psychiatric Unit but refused. In-patient psychiatric treatment was arranged for 57 patients; of these, 50 patients were admitted to the general hospital psychiatric unit, and seven to a mental hospital. Compulsory powers were used in only two cases. Thirty-seven patients were discharged from the medical ward but were given an appointment for the psychiatric clinic.

Response to Treatment

Failure by the patient to co-operate in many cases meant that no treatment could be attempted. Of the 37 patients given an appointment to attend the psychiatric clinic, 10 failed to keep their first appointment and eight failed later ones. Seven of the 57 patients admitted for psychiatric treatment took their own discharge against advice within a few days. If one adds to these the patients who took their own discharge from Casualty or the medical ward and those who refused the offer of a psychiatric bed, 60 of the 216 individuals in the series failed to co-operate in treatment. The 10 patients suffering from endogenous depression all responded to treatment and were well on discharge. Response to treatment was poor in 36 patients (two have since had a prefrontal leucotomy without benefit). In many of the other patients only limited results were obtained, particularly in the large group diagnosed as suffering from personality disorders.

Discussion

Why has the incidence of attempted suicide increased so greatly? Durkheim (1897) observed that the suicide rate for each nation remains remarkably constant over a number of years and differs consistently from that of other nations. He concluded that social or cultural influences determine the rate. These influences must also presumably determine the incidence of attempted suicide and of suicidal gestures.

The problem is to determine what social or cultural changes have taken place in this country since the last war to account for the great increase. Since the increase has coincided with the introduction of the National Health Service, and since most cases nowadays are drug overdoses, it is tempting to conclude that free availability of drugs is a major factor. This certainly cannot be the whole answer, however, since 46 of the 200 cases of drug overdose in this series were of aspirin, which was just as freely available before the National Health Service was introduced. The cases of aspirin overdose alone represent an incidence in 1965 over four times as high as that for attempted suicide by all methods in 1947. Drug-taking has undoubtedly increased since the Health Service began. Atkin (1959), in deploring the modern tendency to resort to drugs, aptly refers in the title of his article to the 'Lotos-Eaters' (that people in Greek mythology who, by eating the Lotos plant, forgot all their troubles and responsibilities). If, as Atkin suggests, we have become a nation of Lotos-Eaters, what could be more natural, on meeting a difficulty or problem, than to swallow an extra dose? Drug addiction has also increased to an alarming extent in Great Britain in the last decade or so and is presumably another manifestation of the same process.

In this series, as in others recently reported, adolescents and young adults form the greatest number (as is the case with drug addiction). It must be significant that these individuals have grown up in the 'affluent society' and the Welfare State, which at first sight seems paradoxical. Atkin points out that: 'There is no reason to believe that thwarted love, the pangs of hunger, or the loss of freedom are more poignant or more frequent today than they were in Assyria and Babylonia, Greece and Rome, in the Middle Ages, or during the nineteenth century. Indeed, many stressful factors have diminished in frequency and in intensity'.

Atkin suggests that 'it may be that many of us

really need more, not less stress'. One could reasonably put forward the view that one explanation for the increase in suicidal attempts and gestures might be that present-day social conditions in Great Britain have led some individuals to adopt a philosophy of life which does not countenance the possibility of their being subjected to stresses or reverses of fortune, and when they are the response of such individuals is disproportionate, and suicidal attempts or gestures are made in response to relatively trivial stresses or disappointments. It must be emphasized, of course, that the percentage of individuals who exhibit this type of behaviour pattern is low; their absolute numbers are however such as to present a very serious problem.

In their present numbers, these cases put a severe strain on the hospital and community services, already over-strained for other reasons. This hospital now admits more than twice as many patients annually as in 1947, and the Casualty Department deals with over four times as many. A 30-fold increase in the number of cases of attempted suicide in this period is therefore a very serious matter. Stengel *et al.* (1958) describe attempted suicide as 'one of the most disturbing and costly abnormal behaviour patterns in our society'. Most of these cases involve general practitioners, the ambulance service, the medical and nursing staff of the Casualty Department, and sometimes the police. The cases of self-poisoning have to be washed out in Casualty, and the vast majority are admitted to a medical ward which usually nowadays contains more than its proper number of patients already; skilled medical and nursing attention is then frequently required.

What can be done to reduce the numbers of these cases? Kessel (1965) and Matthew (1966) both stress the need for greater control over the availability of drugs and greater restraint in prescribing. This would certainly help, but can this greater control be achieved in practice? Little success seems to have been met with in attempting to prevent young people from obtaining drugs of addiction, even those covered by the Dangerous Drugs Act. One could make out a strong case for limiting the sale of aspirin and similar drugs to chemists. At the moment it seems that practically anyone can sell them, and aspirin taken in excess is much more dangerous than many drugs which are available on prescription only.

As far as serious attempts are concerned, measures likely to help are those directed to the prevention of social isolation (*e.g.*, in sky-scraper flats on modern housing estates) and poverty, the earlier detection and treatment of mental and physical disease (especially in the case of the elderly) and so on. What, however, can be done to reduce the large number of attempts or gestures made by people free from mental or physical disease, poverty, and social isolation?

Space allows only a brief discussion of the role of the Suicide Act, 1961. It is worth noting that this Act was introduced on the basis of two assumptions: (1) that all persons attempting suicide intend to kill themselves, and (2) that all persons attempting suicide suffer from mental illness. During debates in Parliament, it was pointed out by the protagonists of the Act it was absurd to have a law against suicide, since the individual confidently expects to be dead as a result of his actions. These assumptions are fallacious, as the present survey illustrates. Obviously no person, psychotic or otherwise, who seriously intended suicide, would be deterred by the knowledge that suicide was illegal, but does the same apply to the person who repeatedly indulges in suicidal gestures, and who has no intention of killing himself? Forms of behaviour which are less costly and disturbing to the community carry penalties. It is debatable to what extent the previous legislation acted as a deterrent, but it is interesting that between 1960 and 1962 there was an increase of 50% in the number of cases arriving at this hospital.

In Melbourne and Los Angeles, Suicide Prevention Centres have been set up, based upon the same principle as the Samaritan organization in Britain, *i.e.*, that the would-be suicide will contact them rather than attempt suicide. Some attempts must be prevented in this way, but it is interesting that in fact only 7·8% of the telephone calls received by the Melbourne centre concern suicide (Bartholomew and Kelley, 1963) and the proportion received by the Samaritans is probably similar (Samaritans, 1967, personal communication).

Kessel is surely correct when he refers to the present spate of suicide attempts as a fashion, and, if so, assuming that legal penalties will never be re-introduced even for repeated spurious suicidal gestures, the only preventive measure likely to have much chance of success would seem to be the use of propaganda methods specifically designed to make the practice unfashionable again. This approach is frequently used in other Public Health problems, an example being the use of propaganda methods to lessen the demands of the public on the general practitioner. Admittedly, many suicidal attempts are made impulsively, but why does the impulse to make a suicidal attempt occur so much more frequently now than it did 20 years ago? The previous psychological 'set' of the individual must

presumably determine his reacting to stress in this particular way. In some patients who make repeated attempts, this behavioural response to stress seems to occur eventually almost as a reflex action.

Stengel *et al.* (1958) state that 'the frequency of suicidal attempts as compared with the incidence of suicide appears to depend upon the attitude of the society to the individual; in a hostile society suicide is frequent but attempted suicide is rare'. The implication of this is that if society introduced measures which successfully reduced the incidence of attempted suicide and of suicidal gestures, the rate of actual suicide would increase. There is, however, a fallacy inherent in this line of reasoning, in that it clearly applies only to those individuals who have suicidal intent. It seems highly improbable that individuals who perform suicidal gestures and who have no suicidal intent would be caused to kill themselves if society expressed hostility or disapproval of their behaviour.

Stengel *et al.* state that 'those who attempt and those who commit suicide constitute two different though overlapping populations', but in discussions of this problem the degree of overlap should take second place to the degree of difference between the two. There is, for example, no resemblance whatsoever between the case of the individual suffering from a depressive psychosis who shoots or hangs himself and that of a non-psychotic individual who makes a suicidal gesture which does not carry the slightest risk of death. Similarly, classification of genuine suicidal attempts made by individuals suffering from mental illness and suicidal gestures under the one heading of 'attempted suicide' is surely erroneous and merely confuses the whole issue.

It is paradoxical that so many people nowadays use the suicidal gesture as a means of drawing attention to their difficulties when there are more social agencies to which a person can turn for help than ever existed in the past. Could one reason for this be that, due to insufficient or inefficient publicity methods, few people know of these agencies or how to make use of them?

SUMMARY

A survey is reported of all cases of attempted suicide and suicidal gestures arriving at a general hospital over a period of one year. Attention is drawn to the great increase in the numbers of these cases in recent years and the strain which they place upon the hospital and community services. The need for preventive measures is stressed and some possible ones are discussed.

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