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Suicidal Behaviour: An Attempt to Modify the Environment

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The aim of the present investigation is to consider the dynamics and the effects of suicidal attempts in 100 female patients admitted to Holywell Hospital in two consecutive years, 1962 and 1963. (Holywell is a psychiatric hospital of 750 beds situated in the town of Antrim, 17 miles north-west of Belfast. It serves County Antrim, which has a population of about 330,000.)

So far we have been unable to find any previous psychiatric studies on attempted suicide in Northern Ireland. Thus the present paper may partially fill the existing gap. Further, unlike most other articles on attempted suicide, which are concerned with attempted suicide in large cities (e.g. London, Los Angeles, etc.), our paper investigates attempted suicide in a mixed urban and rural population. Although the great majority (86 per cent) of our patients lived in towns, these towns were quite small (10,000 to 20,000 inhabitants), and the old traditions of neighbourliness and kinship (cf. Young and Willmott, 1957), were still very much alive there.

We have deliberately confined our inquiry to those patients only who admitted that they 'really' intended to kill themselves. We have discarded a large number of subjects (86) who denied having had suicidal intentions, or who claimed that they took an overdose of drugs 'by mistake', or caused injuries to themselves 'by accident'. We have also omitted all those subjects who maintained that they 'were not sure' whether they 'really meant' to take their life or not.

By eliminating all doubtful cases we arrived at the present figure of 100 cases of attempted suicide, which represents about 11 per cent of all female admissions to the hospital in 1962 and 1963. About 90 per cent of these patients were admitted from general hospitals after emergency treatment following their attempted suicide and after being assessed by one of our psychiatrists. Only 12 per cent of subjects were admitted directly from their home, and all these patients were re-admissions, already known to us.

Results

(a) *Social factors*

1. *Civil state and occupation.* Of the 100 patients 52 women were married, 6 separated or divorced, and 5 widowed; 37 women were single.

Of the 63 women who were married, divorced or separated, 51 declared their occupation to be that of 'housewife'. The remaining 12 had continued with their premarital occupations (e.g. nursing; working in a factory, etc.).

Of the 37 single women, two-thirds (23) were working immediately prior to their admission; 6 were unemployed for 'some time'; 8 had never worked outside their own homes.

2. *Social class.* Over one-half (55) of our patients belonged to Social Class V; almost one-third (27) to Social Class IV; one-sixth (15) belonged to Class III; 3 women belonged to Social Class II; none to Class I.

This class distribution does not necessarily imply that the members of Social Class I never attempt suicide; it may rather suggest that they are not referred to a psychiatric hospital, but are treated in private nursing homes.

Over four-fifths (82) of our patients came from the two lowest socio-economic classes. But one has to remember that these two classes constitute the bulk of the community; furthermore, belonging to one of them might by itself lead to various stresses, such as living in overcrowded quarters, lack of privacy, lack of amenities, etc.

3. *Place of residence.* More than one-half (56 per cent) of our subjects lived in small, fairly industrial towns; one-third (30 per cent) resided in one larger town with a population of

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about 70,000; only 14 subjects lived in the country, i.e. in villages or farms. Thus 86 per cent of our subjects came from urban areas, and only 14 per cent from rural areas.

4. *Religion.* Almost four-fifths (78 per cent) of our patients were Protestants of various denominations, and only about one-fifth (22 per cent) were Catholics. This proportion is lower than would be expected from the Census of Population of Northern Ireland (c.f. Registrar General, 1961), where Catholics account for about 35 per cent of the population. However in County Antrim Catholics represent only 24·6 per cent of population. Thus the proportion of our Catholic patients seems to closely follow this trend in the general population of County Antrim.

Although one might speculate that the Catholic Church, with its stronger grip on its followers and its uncompromising attitude towards suicide would deter many potential candidates from an attempt on their life, our figures do not seem to uphold such claim.

5. *Residential mobility.* Comparing a group of 91 patients who attempted suicide with a group of matched psychiatric patients who had not attempted suicide, Bruhn (1962) found a prevalence of the following factors in the suicidal group: (a) residential mobility, (b) brief stay at the current address, (c) household instability, and (d) marital dysharmony.

All these factors were very much in evidence in our group as well: (a) residential mobility: 72 per cent of our patients had changed their address within the two years preceding their suicide attempt; (b) 46 per cent of them had lived at the present address for less than 1 year; (c) about 20 per cent of our patients gave a history of a disturbed home life, with temporary separations from their husbands, followed by short-lasting reconciliations, fresh separations, etc.; (d) over half of our married subjects complained of various forms of marital dysharmony, such as husband's alcoholism, meanness, 'unusual' sexual demands, 'short-temper', etc.

(b) *Personal factors*

1. *Age.* There were three peaks in the following age groups of our patients: (a) 22–25 years (33 per cent of all subjects); (b) 34–37 years (27 per cent), and (c) 45–47 years (19 per cent). These three periods of life are roughtly related to early adulthood with its new stresses and responsibilities, to the period of life when the young mothers begin to have various difficulties with their teenage children, and finally, to the involutional period. Together, these three peaks were responsible for four-fifths of all suicide attempts in our group of patients. There was also a mild fourth peak, (d), with 9 per cent of patients in the age group of 62–65, the period of life when two factors—failing health and loneliness (often due to widowhood)—contribute to the number of suicidal attempts.

2. *Number of admissions and of suicidal attempts.* For 68 patients it was their first admission to a psychiatric hospital following attempted suicide. For 11 subjects it was their second admission; for 7 women the third; for 8 their fourth and fifth admissions. One women was admitted 6 times; 3 patients were admitted seven, eight and nine times respectively, two subjects had over ten admissions, although not in connection with an attempted suicide.

The attempted suicide leading to the present admission was the first for 76 patients; for 13 it was their second attempt; for 2 their third, and 9 subjects had made more than three suicidal attempts.

3. *Clinical syndromes.* The majority of our patients (58 per cent) showed symptoms of depression of different types and intensity, although most of them also showed some personality defects. Eleven patients presented a clinical picture of a predominantly schizophrenic nature, 29 showed various serious personality disorders; finally there were 2 depressed patients with signs of a progressive organic dementia.

The proportion of depressed patients in our group agrees with the findings of other workers.

4. *Personality.* The personality of our subjects appeared to be a much more important factor in their suicide attempts and in the frequency of their admissions than was the type of their psychiatric disorder or the severity of their social stresses. Thus the patients with a large number of admissions were mostly young women with a dependent, immature or inadequate type of

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personality, who sought admission to the hospital whenever they faced a stressful situation at home.

Almost four-fifths of our patients showed some features of poorly integrated or defective personality. About one-third showed personality disorders, mostly of the inadequate (9 women), immature (5), hysterical (8) and psychopathic (7) types.

5. *Alcoholism and drug addiction.* We have excluded all cases of a genuinely accidental poisoning in alcoholics and drug addicts who occasionally took an overdose, but without any real suicidal intentions; we left in the present group only those alcoholics and drug addicts who made a deliberate attempt on their lives; there were only 12 alcoholics and 9 drug addicts in the group.

6. *Parental loss.* Almost one-half (47 per cent) of our patients had lost either one or both parents in their childhood. In 31 cases this loss was caused by parental separation, divorce or desertion; in 16 the loss was due to the death either of one parent (in 11 cases) or of both parents (in 5 cases).

Like other authors we formed the impression that parental loss in early childhood resulted either in (a) character (personality) disorder, or (b) a later depression with pronounced suicidal tendencies. Certainly the very high proportion (47 per cent) of parental loss in our suicidal patients must be regarded as an important factor in the disturbed emotional and psychosocial development of our subjects.

7. *Methods used in suicidal attempts.* The most common method in our group of patients was poisoning with drugs (used by 56 subjects), such as barbiturates (34 women), a 'cocktail' of various drugs (9), barbiturates and alcohol (5), antidepressants (5) and aspirin (3 patients).

More aggressive and violent physical methods were used by 28 of our subjects; 14 slashed their wrists; 4 cut their throats; 1 girl poured petrol on her bed and then set fire to it (sustaining burns); 2 patients jumped out of the window; 2 threw themselves over banisters; 3 attempted to strangle themselves; one patient tried to suffocate herself with a polythene bag tied over her head; one woman swallowed three sewing needles. Thus our patients showed no lack of originality and ingenuity in their choice of suicidal methods.

There were 11 women who attempted to poison themselves by commercial gas.

Five subjects attempted to drown themselves; one jumped into a disused well in her orchard, 4 others waded into the sea. All these patients performed their 'dramatic' suicidal gestures in full view of numerous spectators, thus making sure of being rescued at the right time.

(c) *The dynamics of suicidal behaviour*

1. *Precipitating factors.* Most of them appear to have been of an interpersonal nature. They may be divided into several non-homogenous groups: bereavement, 12 cases; quarrels (with husband, boyfriend, parents, children), 21 cases; rejection (by husband, by boyfriend, by parents), 11 cases; desertion (by the loved person), 18 cases; feelings of guilt, 3 cases; fear of pregnancy, 2 cases; fear of cancer, 2 cases; illness in the family, 2 cases; 'frustration', 5 cases; husband's 'abnormal' sexual demands, 2 cases; fear of 'responsibility (when the in-laws wanted to move out and to leave the whole house to the patient and her husband), 1 case. No apparent precipitating factor could be found in 21 cases.

The patients who attempted to take their lives without a discoverable precipitating factor were usually suffering from a more serious psychiatric condition, mostly from depression, and their suicidal attempt has to be viewed as one of the hazards inherent in this illness. None of our patients attempted to kill themselves near the time of the anniversary of their parents' death, a phenomenon reported by Bunch and Barraclough (1971), and in none of our subjects was the attempted suicide a part of a 'double suicide' (cf. Lukianowicz, 1971).

2. '*Gains*'. In all our patients the suicidal attempt has acted as an appeal for help: each patient was admitted to hospital, i.e. removed from her stressful environment, and all endeavours were made to improve this environment and to readjust it to the patient's advantage.

Here are a few examples of such 'gains': reconciliation (with the husband, the boyfriend, the parents, the children) was achieved in 41 cases; getting out of a stressful situation in 18

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cases; 'getting away from it all' in 13 cases; expiation of the neurotic guilt in 3 cases. Altogether some 'gain' was evident in 75 cases.

There was no apparent gain in 25 cases, although some subtle gain was probably achieved in these cases also, at least in the form of the patient's removal from an intolerable situation and receiving sympathy and understanding from all persons involved in her treatment. Furthermore, in many cases the hospital represented rest and some kind of 'holiday' (which many women had not had for years) in the quiet and pleasant countryside, with all possible care and attention to their needs.

Even the hysterical and the psychopathic patients, whose suicidal behaviour seemed quite irrational, probably derived some vicarious gratification or 'gain' from their suicidal behaviour, by becoming the centre of attention and by releasing their tension and aggression.

3. *Follow-up.* A five-year follow-up and a recent survey gave the following picture: of the 100 patients under review 3 died; one, a 19-year-old schizophrenic girl, killed herself at home one year after her second discharge from the hospital, by taking an overdose of tranquillizers. The other two patients died from natural causes.

The remaining 97 patients were alive, and seemed to have made a fairly satisfactory readjustment to their home situation. Of those, 16 had one or two readmissions, but only 7 have made another suicidal attempt, one fatal (the 19-year-old girl above). Thus the results of the patients' first admission to the hospital and our therapeutic endeavours seem to be encouraging.

III. Conclusions

The function of a suicidal attempt as an 'appeal to society for help' has been recognized since Stengel's (1958) classical monograph. Kreitman *et al.* (1970) regarded attempted suicide as a 'language' of 'attempted suicide subculture' conveying the information of distress. From the study of our 100 patients it seems to emerge that some patients employ suicidal behaviour to achieve reconciliation, acceptance, independence, approval for marriage, etc. This function of suicidal behaviour was most often found in patients with a poorly organized personality structure, particularly in subjects with an immature, dependent or inadequate personality.

Summary

A study was made of various types of suicidal behaviour in 100 female admissions to Holywell Hospital in Antrim (Northern Ireland) in 1962 and 1963. The subjects' age, civil state, occupation, social class, religion, place of residence and residential mobility were reviewed. The number of admissions, and of suicidal attempts, as well as the methods employed in suicidal attempts, were considered. The clinical syndromes and the types of personality observed were discussed. The precipitating factors and the apparent 'gains' resulting from the suicidal behaviour were discussed, and the result of a 5-year follow-up was reported.

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