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The Reasons People Give for Taking Overdoses

By J. H. J. BANCROFT, A. M. SKRIMSHIRE and S. SIMKIN

Summary. This study investigates the reasons people give for taking overdoses of drugs. A representative sample of 128 subjects were interviewed immediately after their recovery from an overdose. During the interview they were given alternative reasons for taking overdoses and asked to choose any that applied to them. Spontaneous comments about suicidal intent were also recorded.

Of the subjects, 44 per cent indicated that they had wanted to die. On the basis of their choices 33 per cent were 'seeking help', 42 per cent 'escaping from the situation', 52 per cent 'obtaining relief from a terrible state of mind' and 19 per cent 'trying to influence someone'.

The association between these various reasons and other expected effects or feelings associated with the act were examined by means of multidimensional scaling analysis. In addition, the characteristics of those expressing suicidal intent and other reasons were studied, together with such consequences as toxic effects and psychiatric after-care. The possibility is discussed that a large proportion of those indicating suicidal intent do so either to gain social acceptability for their act or to influence helping agencies.

Introduction

Self-poisoning is a deliberate act which has assumed epidemic proportions. In Oxford the incidence has quadrupled in ten years (Bancroft, Skrimshire, Reynolds, Simkin and Smith, 1975). Nearly 900 cases are seen in the casualty department in one year and approximately 80 per cent of these are admitted to the medical wards before returning home. There are three important reasons for understanding why people take overdoses. First, in order to introduce a rational plan of prevention; for example, to what extent is this behaviour a 'cry for help' which could be prevented by providing more accessible or more appropriate help? Secondly, understanding the particular act may influence the type of help we offer after the act; if, for example, an overdose is seen primarily as a desperate method of communicating distress from one person to another, help might focus more on the communication problems between those two persons. Thirdly, the effect the act has on 'significant others' may influence the likelihood of the act being repeated. It may be that more attention should be given to the meaning of the act as understood by the patient and the 'significant others'. Psychiatrists tend to pay relatively little attention to this aspect tending to concentrate on the problems preceding the overdose in judging the help that is required.

The important differences other than death, between suicide and the majority of self-poisoning and self-injuring acts is now well accepted (Ovenstone and Kreitman, 1974). The need to distinguish between them has led to avoidance of the term 'attempted suicide' by many workers. Kessel (1965) introduced a merely descriptive term—'self-poisoning', while Kreitman and his colleagues (Kreitman, Philip, Greer and Bagley, 1969) have introduced 'parasuicide', a term which implies that the behaviour is something akin to suicide but not the same thing. Birtchnell and Alarcon (1971) described this relationship as follows:

> 'The attempt is more an enactment of dying which carries with it the discharge of some of the emotion appropriate to the actual event.'

The 'appeal' effect of the act has been stressed

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by many writers, e.g. Stengel (1960) and has been incorporated into the 'cry for help' explanation which is now widely accepted. Other writers have stressed the hostility involved (e.g. Moss and Hamilton, 1956; Whitlock and Shapiro, 1967). The interruption of consciousness as distinct from cessation or death has been emphasized by Shneidman (1963).

These views have been largely impressionistic, and there has been a lack of any systematic investigation. Studies by Birtchnell and Alarcon (1971) and by Beck, Schuyler and Hermann (1974) have been exceptions.

This dearth probably reflects the conceptual and methodological difficulties involved. We are concerned with an individual and seemingly deliberate act—an overdose of tablets, rather than an illness, a mental state or a personality trait. No doubt such acts are associated with considerable emotion, but they are too complex and too coordinated to be explained on the basis of disorganized or disrupted behaviour. The determinants of such an act may be as varied as specific genetic predisposition, mediating affective states and the individual's conditioning history. Most of these factors, or at least their relevance to causal explanation, are inaccessible. Even if they were not, it is only a theoretical possibility that they would be *sufficient* to explain the act. There is another level of explanation which involves either the anticipated consequences of the act (i.e. 'If I take an overdose, the result may be . . .') or the act's considered appropriateness in a given situation (i.e. 'the thing to do in such a situation is to take an overdose'). Peters (1958) would include this under the heading of 'reasons for acting'. The relationship between this level of explanation and the earlier causal explanation is complex, and it is discussed more fully by Peters (1958). Such 'reasons for acting', however, can be manifested in the verbal behaviour of the individual and are thus relatively accessible.

This study, which is the first in a series aimed at increasing our understanding of this behaviour, examines such 'reasons for acting'. There are obvious difficulties in interpreting such evidence, as it is likely in many cases that the patient's account will be largely determined by his need to justify or excuse his behaviour (Scott and Lyman, 1968). Nevertheless, this is the most directly relevant evidence and deserves careful and systematic consideration.

The objectives of this study are therefore as follows:

(a) To replicate the study carried out by Birtchnell and Alarcon (1971) in which the patient was asked to choose reasons, effects and associated feelings from given alternatives. In this study further alternatives have been added.

(b) To examine the association between the chosen alternatives, i.e. are there particular groupings of chosen alternatives which would warrant further study.

(c) To examine the association between those chosen alternatives and other circumstantial evidence, such as the events immediately preceding the overdose, the nature of the overdose and its toxic effects, and the consequent help provided.

Method

The evidence presented here was obtained as part of a wider interview study of self-poisoning and self-injury. Full details of the interview procedure will be reported separately, but a brief description will be provided here.

The interview lasted between 1¼ and 1¾ hours and was carried out as soon as possible after the patient's recovery from the overdose, and preceding the normal clinical psychiatric assessment. The interview was postponed whilst there was any evidence of drug-induced impairment of attention, but it was difficult to exclude potential and more long-term pharmacological effects of the overdose on the subject's mood.

The interviewer started by asking for an account of what led up to admission to hospital, whether there were any precipitating events (i.e. 'final straw') and what other problems in the patient's view had contributed to the crisis. This 'open ended' section was followed by a series of factual questions about marriage, family, domestic circumstances, employment, financial and legal problems, physical and mental health, social isolation, previous episodes of self-poisoning, help sought before the recent overdose, attitudes towards various types of helping agency, and the circumstances of the overdose. Direct questions about 'reasons' for the overdose were almost the last of the interview.

Most of the interview was semi-structured, with standardized lead questions followed as necessary by clarifying probe questions. The questions concerning

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'reasons' for the overdose were the only structured ones in the interview. They are given below.

The three interviewers were female members of the research team, two social workers, one a psychiatrist. They had been trained in the interview procedure by means of a series of tape-recorded pilot interviews in order to achieve reasonable similarity of approach. With a few exceptions the extent to which specific items of information were recorded was similar for the three interviewers, making major interviewer effects on the data unlikely. There were some differences in relation to the data obtained, which will be presented in the results.

The interviewers explained to the patient that they were members of a research team, but indicated that they would pass on relevant information to the clinical team. In this way neither the patient nor the interviewer needed to feel that the interview was irrelevant to the patient's management.

The relevant part of the interview was as follows:

(1) *Feelings*

Interviewers: 'I would like to ask you some questions about how you were feeling *at the time* you actually . . . (took the pills). I am going to show you a list of five different feelings and ask you if you felt any of these *at the time*. You may have felt more than one, or none of them.'

The patient was then shown a list as follows:

(a) worried about the future
(b) angry with someone
(c) feeling lonely or unwanted
(d) sorry or ashamed of something
(e) feeling you had failed in life

Each item was read out by the interviewer before the patient made his choice.

(2) *Reasons*

Interviewer: 'There are various reasons why people . . . (take overdoses). I have a list of four common reasons. *Looking back now* on what happened to you, which of these reasons do you think apply to you? You . . . (took the pills) because you wanted to:

(a) seek help from someone
(b) escape for a while from an impossible situation
(c) get relief from a terrible state of mind
(d) try to influence some particular person or get them to change their mind.'

(3) *Expected effects*

Interviewer: 'Now I would like to ask you what *at the time* you thought the effect of . . . (taking the pills) would be on other people. Let me again show you a list and see if any of them apply to you. Did you feel that by (taking the pills) you would:

(a) show how much you loved someone
(b) make things easier for others
(c) make people sorry for the way they have treated you
(d) frighten or get your own back on someone.'

(4) *Wish to die*

After a further series of questions about the overdose and precautions for or against discovery, the following question was asked:

'At the time that you (took the tablets) did you really want to die or was it that you didn't mind whether you lived or died?'

Answers were categorized as either 'didn't want to die', 'didn't mind', 'really wanted to die', 'other'.

In addition to the answers to these direct questions, any comment earlier in the interview about wanting to die or not wanting to die was recorded as 'spontaneous comment'.

The various 'feelings' and 'expected effects' offered to the subject were the same as those used by Birtchnell and Alarcon (1971).

Subjects

The 143 subjects represented a 50 per cent random sample of all cases of self-poisoning or self-injury referred to the study from a defined study area. Six patients refused to be interviewed, and in nine other cases interviews were unobtainable or incomplete, usually because the patient was untraceable or too ill and confused. One hundred and twenty-eight subjects were successfully interviewed, 89 women and 39 men. Data on some individual items were missing or unclassifiable for several of these. (Unless otherwise stated, the base of each percentage shown is the number with complete information.)

Results

The wish to die

The numbers who spontaneously commented that they wanted to die at the time of the attempt are shown at Table I. The number who indicated a wish to die on direct questioning are shown in Table II. The differences between men and women in the case of 'spontaneous comments' was statistically 'significant' at the 5 per cent level.

Of the 125 with complete information, 29 (23 per cent, 11 men, 18 women) indicated they wanted to die both spontaneously and on direct

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TABLE I

Spontaneous comments about dying

		Death not intended	Death not mentioned	Wanted to die	Unsure or confused	Total = 100%
Men	No.	4	18	17	0	39
	%	10	46	44	0	100
Women	No.	14	51	21	3	89
	%	16	57	24	3	100
Total	No.	18	69	38	3	128
	%	14	54	30	2	100

TABLE II

Answer to direct questions about wanting to die

		Wanted to die	Did not mind whether lived or died	Did not want to die	Total = 100%
Men	No.	17	15	7	39
	%	44	38·5	18	100
Women	No.	29	26	29	88*
	%	33	29·5	33	100
Total	No.	46	41	36	127
	%	36	32	28	100

* Four cases were unclassifiable.

questioning. Nine (7 per cent, 6 men and 3 women) indicated 'wish to die' spontaneously but on direct questioning 'didn't mind'; and 17 (14 per cent, 6 men, 11 women) made no spontaneous comment but 'wanted to die' on direct questioning. Thus, combining spontaneous comments and answers to direct questions, 55 (44 per cent) at some stage in the interview indicated that they wanted to die.

Other reasons for the act

The numbers choosing the 'reasons' are shown in Table III. More than one reason could be chosen. Thirteen subjects (10·5 per cent of

TABLE III

Choice of reasons other than 'wish to die'

		Seek help	Escape situation	Relief from state of mind	Influence someone	None of these	Base = 100%
Men	No.	11	15	18	6	9	39
	%	28	38·5	46	15	23	100
Women	No.	30	38	48	18	13	86
	%	35	44	55	21	15	100
Total	No.	41	53	66	24	22	125
	%	33	42	52	19	18	100

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those answering all items; 15 per cent men, 8 per cent women) said they wanted to die and chose no other reason.

Feelings at time of attempt

The feelings chosen are shown in Table IV. Nine per cent chose none of the feelings suggested.

Expected effects

The proportions chosen are shown in Table V; 42 per cent chose none of these effects.

Effects of interviewer on choice of reasons, feelings and effects

Although the questions about reasons, feelings and effects were the most structured part of the interview, it was anticipated that the patient's choice would be influenced to some extent by how they perceived the interviewer, particularly where a choice might imply social acceptability or desirability. The proportions choosing each of the reasons, feelings and effects for each of the three interviewers were therefore examined. There were statistically significant differences between interviewers in the proportions choosing 'help' as a reason and 'make easy for others' as an effect. Choice of 'lonely' and 'relief from state of mind' also showed differences significant at the 10 per cent level. The remainder (including 'wish to die') showed no significant differences.

The association between reasons, feelings and effects

We were interested in whether the choice of 'wish to die' would be predictably associated

TABLE IV

Choice of 'feelings at time of attempt'

		Worried	Angry	Lonely	Sorry	Failed	None of these	No. of cases with information
Men	No.	19	13	26	13	24	2	39
	%	49	33	67	33	61·5	5	100
Women	No.	40	28	48	22	42	9	89
	%	45	31·5	54	25	47	10	100
Total	No.	59	41	74	35	66	11	128
	%	46	32	58	27	52	9	100

TABLE V

Choice of 'expected effects of attempt'

		Show someone how much you love them	Make things easier for others	Make people sorry	Frighten or get your own back	None of these	No. of cases with information
Men	No.	10	15	2	2	15	39
	%	26	38·5	5	5	38·5	100
Women	No.	15	18	17	5	37	85
	%	18	21	20	6	43·5	100
Total	No.	25	33	19	7	52	124
	%	20	27	15	6	42	100

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with the choice of other reasons, feelings or effects within the same individual, and whether particular groups of alternatives emerged associated with e.g. seeking help or influencing someone. If such groups were recognizable and replicable, it might be possible in later studies to distinguish those associated with high suicide risk or severe depression from those determined more by the need to make an impact on significant others or to gain social acceptability for the act. For this purpose we required a non-parametric method of multivariate analysis. Multidimensional scaling analysis (Shephard, Romney and Nerlove, 1973) was therefore carried out using Goodman and Kruskal's (1954) gamma coefficient as a measure of proximity between items. The gamma coefficient is a measure of association between two categorized variables whose categories can be ordered. 'Gamma tells us how much more probable it is to get like than unlike orders in the two classifications, when two individuals are chosen at random from the population' (Goodman and Kruskal, 1954). The gamma values for each individual association are shown in Table VI. Several groupings emerged; the description of these and of the relationships between them provides a convenient summary of the associations among the individual items:

Group A1—worried about the future, sorry or ashamed of something, failed in life, relief from state of mind.

Group A2—angry with someone, seek help, escape from impossible situation, feeling lonely or unwanted.

TABLE VI

Association of reasons, feelings and effects

(Goodman and Kruskal's Gamma coefficients)

		Worried	Sorry	Failed	Relief, mind	Angry	Help	Escape situation	Lonely	Influence	Make sorry	Frighten	Show love	Make easy	Wish to die
A1	Worried														
	Sorry	·42													
	Failed	·57	+												
	Relief, mind	+	·44	+											
A2	Angry	·42	·37		·38										
	Help	·62	·44	+	+	·45									
	Escape situation	·40		+	+		·52								
	Lonely		·39	·46	·44	·50	·54								
B	Influence	−		−	+		+	+	·61						
	Make sorry		−	−·48		+	+	+	+	·65					
	Frighten	+	−	−	−					·52	·79				
	Show love			−	+		+	+	+	·57	+	+			
C	Make easy	+		+	+					−			·44		
	Wish to die	+		+		−·26	−	−·31	+		−		+	·53	

Gamma significant at 10 per cent level recorded in full.

Gamma ≥ 0·10 but not significant represented by sign.

Gamma > 0·10 left blank.

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Group B—influence someone, make others sorry, frighten or get your own back on someone, show how much you love someone.

Group C—make things easy for others, wanted to die.

Group A1 and A2 are closely related, though Group A1 is near to C and A2 nearer to B.

'Feeling lonely or unwanted' is closely related to both Groups A2 and B. 'Show how much you love someone' is closely related to both Groups B and C.

This analysis was carried out separately for men and women and also for the two principal interviewers. The patterns of relationship remained relatively constant, with no significant associations falling outside the pattern as a whole. Group A1 is both self-referring and 'depressive' in content. Group B is 'other-referring'. Group A2 comes between the two, being both 'self-referring' and 'other-referring' and without depressive content. It is of interest that 'wish to die' is only weakly associated with the 'depressive' grouping (A1), is negatively associated with 'anger' and 'escape', and is most strongly associated with 'make easy for others' and 'show how much you love someone' both 'effects' which are likely to be aimed at gaining social acceptability. This suggests that 'wish to die' was commonly used by this group to gain social acceptability.

When the characteristics of those choosing Group A1, A2, B or C motives were examined, there was some evidence that those choosing exclusively from Group A1 were characterized by previous and subsequent attempts, a history of psychiatric treatment, and no current relationship. Those choosing Group B, on the other hand, were more often first attempters, with current and problematic relationships. Further attempts to replicate these 'patterns' and the association with mental state and patient characteristics would be worthwhile.

Characteristics of those 'wanting to die'

Association between characteristics of patients, circumstances of the act and motives are shown in Table VII. In the following comments only those associations that were significant at either the 5 per cent or 10 per cent level are mentioned, unless otherwise stated.

It was predicted that those 'wanting to die' would be more like the 'suicide' population than the 'parasuicide' population. The two most obvious differences between these two groups are in sex and age; the suicide population is predominantly male and elderly, the parasuicide population predominantly female and young. Significantly more men than women said *spontaneously* that they wanted to die. The difference between them in the answers to direct questioning was not statistically significant. Among the 13 who 'only wanted to die' (i.e. chose no other reason) men are relatively highly represented (15 per cent of men, 8 per cent of women). Noticeably higher proportions of women said they did *not* want to die. There is thus limited evidence to support the prediction that 'wanting to die' is more likely among males.

The association between 'wanting to die' and age is more complex. A high proportion (42 per cent) of the very young (i.e. 16–20 years) said in answer to the *direct* question that they did *not* want to die. This conforms with the prediction. In contrast a relatively high proportion of those aged 36 and over made the same comment *spontaneously* (see Discussion).

There was a positive association between 'wanting to die' and both accommodation problems and needing help with money or material goods.

There was a negative association between 'wanting to die' and 'wanting someone to talk to before the attempt', and no relationship with 'contact with helping agencies' prior to the attempt. There was no clear association between 'wanting to die' and evidence of premeditation. A high proportion of those who *spontaneously* said they wanted to die made the attempt out of doors, but of those who said they wanted to die on direct questioning 25·6 per cent made the attempt in front of someone, and in a further 32·6 per cent there was someone in the building at the time, e.g. in another room. On the other hand 50 per cent of those who only wanted to die did not expect anyone within six hours of the attempt, compared with 8 per cent of the rest of the sample.* It is thus likely that those who

* $Z = 1{\cdot}71$, $p < 0{\cdot}05$ in a one-tail test associated with Kendall's tau B.

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TABLE VII

Characteristics associated with the wish to die and choice of other reasons (response as % of persons having each characteristic)

	n = 100% approx. †	Wish to die		Other reasons			
		Spontaneous comment	Direct question	Seek help	Escape situation	Relief from state of mind	Influence someone
Age groups:							
16–20	26	27	35	46	46	38·5	35 } §§
21–35	59	35	38	29	41	53	12 } §§
36 and over	40	24	34	30	42·5	60	20 } §§
Previous attempt in past year	34	41	38	56§§	44	56	26·5
Marriage:							
Couple living together	52	26	34	23	36·5	50	13·5
Couple living apart	17	41	53	35	35	65	23·5
Problem in non-marital relationship	33	35	38	39	51·5	56	33§§
Accommodation problems	39	34	50**	44	28§	46	18
Money or work problems	40	30	40	37·5	25§§	55	12·5
Events in past week:							
A row (mostly in past 2 days)	58	32	42	19§§	38	51	22
Event not involving a key person	25	19	24	52§§	44	58	12
Previous psychiatric treatment:							
None	60	24	31	30	43	43 } §	22
Out-/Day-patient only	20	35	35	35	40	70 } §	20
In-patient	45	35	44	36	42	58 } §	16
No accessible confidant	52	38·5	43*	35	33§	52	15
No relative or friend outside household contacted in past week	19	25	47	42	26	58	5
Contact with GP or psychiatrist in past week	55	30	37·5	34·5	42	54·5	13
Attempt to make contacts for help before the attempt	87	33	38	36	46	60§§	23
Type of help wanted:							
Someone to talk to	59	23	27	47·5§§	54§	63§§	29§§
Money or material goods	12	50	75**	25	33	25§	17
Attempt said to be unpremeditated	36	24	38	14	22	53	8
Attempt made out of doors	12	67*	42	33	42	50	17
No one expected within 6 hours	14	57	64	14	36	36	0

** $p < 0{\cdot}05$, * $0{\cdot}10 > p > 0{\cdot}05$ (Kendall's tau B).

§§ $p < 0{\cdot}05$, § $0{\cdot}10 > p > 0{\cdot}05$ (chi squared).

† The base of the % in any one row is the number of persons known to have the relevant characteristics who also responded to the motivation items. This number varied by 2 or 3 cases for some items.

were prepared to take more risk were more likely to choose only 'wish to die' as a reason.

Characteristics associated with other reasons (see Table VII)

The choice of 'help' as a reason was made more often by those who had made a previous attempt in the past year. There was also a positive association with events occurring in the week before the overdose *not* involving a key person (e.g. accidents, loss of job) and impending events (e.g. court cases). There was a negative association between 'help' and a 'row' preceding the overdose.

Not surprisingly those indicating earlier in the interview that they wanted to help chose

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'help' more often, but the association between choosing 'help' and attempting to get help before the overdose was slight. There were negative associations between 'escape from an impossible situation' and the presence of accommodation, employment and financial problems and relative social isolation (i.e. no contact with any relative or friend outside the household in the past week). These rather surprising negative associations suggest that the concept of 'escape' in this context may be used more to describe escape from people than from situations.

The choice of 'relief from a state of mind' was positively associated with attempting to get help before the overdose and also with previous psychiatric treatment.

'Influence someone' was more likely to be chosen by those under 21 and by those whose overdose had been preceded by problems in a non-marital relationship. These two associations are probably related and reflect the threatened break-up of an adolescent relationship where the overdose is often clearly and explicitly an attempt to 'win back' the other person.

Association between motives and medical effects of poisoning

There was no positive association between wanting to die and the use of any particular class of drug in the overdose.

Those who were unconscious at some stage during admission were more likely to indicate that they wanted to die. Of those 'wanting to die' 58 per cent were unconscious compared with 25 per cent of those who 'didn't mind' and 17 per cent of those who 'did not want to die'.

The association between motives and psychiatric aftercare

Seventy per cent of those who said they wanted to die and 70 per cent of those who said they didn't mind were referred to psychiatric care of some kind on discharge, compared with 50 per cent of those who said they did not want to die.

There were no significant associations between other reasons and psychiatric disposal, except that people choosing 'relief from state of mind' were more likely to be given further psychiatric care, no doubt a further example of the association previously mentioned.

Discussion

This study is a preliminary exploration of an extremely complex area. Our main source of information about 'reasons' is from the patient's account. The problem in interpreting such evidence lies in distinguishing between a 'valid' motivational account, an account which is designed to produce the intended effect on 'significant others' (e.g. to make them feel guilty or sympathetic), and an account which is aimed mainly at presenting a socially acceptable front to the person carrying out the interview.

When compared with the earlier study of Birtchnell and Alarcon, these findings are strikingly similar. In their study 46 per cent chose 'wish to die', 37 per cent 'not to die'. These are slightly higher proportions than in this study, but this may reflect differences in the intermediate category; in their study it was 'uncertain', in our study 'didn't mind', which may be a better way of indicating ambivalence and hence more likely to be chosen by some patients. When spontaneous comments are included, our proportion 'wanting to die' becomes very similar at 44 per cent. In addition, the male : female ratio for 'wanting to die' is almost identical in the two studies.

A high and identical proportion (92 per cent) chose at least one of the 'feelings' in both studies. The proportions for each feeling in the other study were as follows: 'worried' 40 per cent; 'angry' 30 per cent; 'lonely' 53 per cent; 'sorry' 26 per cent; 'failed' 32 per cent; all remarkably similar to ours (see Table IV).

For the 'expected effects', a higher proportion in our study (42 per cent compared with 33 per cent) chose none, and not surprisingly the level of agreement was less for those who did choose an 'effect'. The proportions in the other study were: 'show love' 35 per cent; 'make easy' 12 per cent; 'frighten' 10 per cent (for comparison see Table V). Nevertheless the degree of similarity between the two studies suggests a consistency between different populations of self-poisoners that is worth pursuing. If this method of inquiry is to be used, however, more

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consideration should be given to 'interviewer' effects, in particular to differences between 'doctor'-type and 'layman'-type interviewers, and also to possible variations in the meaning to the subjects of concepts used. These results suggest, for example, that 'lonely' may be used differently by men and women in this context, whereas 'escape' may be more relevant to relationships than to situations.

An alternative to this type of inquiry is the content analysis of the accounts given spontaneously by patients following overdoses, to identify patterns of accounting which may be related to motivation. Further research using this approach is currently in progress.

There are a number of pointers in these results suggesting that 'wish to die' is used by a proportion of patients as a means of gaining social acceptability after the event. The association with other 'socially acceptable' motives has already been mentioned. There is also a surprising negative association between 'wish to die' and 'escape from an impossible situation'. Whilst logically these should be closely associated, the motive of 'temporary escape' may be regarded as less acceptable socially. In a recent study of nurses' and doctors' attitudes to self-poisoning, 'wish to die' was the most acceptable motive, particularly for doctors, who discriminated against other more 'manipulative' motives (Ramon, Bancroft and Skrimshire, 1975).

The 'wish to die' motive, when it does not indicate suicidal intent, may also be used to facilitate an appeal for help to professional agencies, and indeed considerable risk may be taken to enhance this effect. This may be reflected in the association between 'wish to die' and the presence of practical problems such as accommodation or financial problems. The 'suicidal message' in such cases may be aimed at the helping agencies. The effect of the same message when aimed at 'significant others' such as the spouse might be different. These are questions which warrant further research.

The acceptability of the 'wish to die' motive may also vary with age and subcultural factors. It is noticeable that it is in the middle age range that patients are most likely to express *spontaneously* a 'wish to die'. Perhaps the stigma attached to suicidal motives is greater for the older age group than for the population in general (c.f. Birtchnell and Alarcon, 1971). The under-20s, on the other hand, are more likely to choose 'unacceptable' motives such as 'to influence someone'; it is possible that different criteria of acceptability influence their accounts.

One other hypothesis suggested by these findings deserves comment; this relates to possible differences between 'first timers' and 'repeaters'. The tendency for the former to choose Group B motives (i.e. other-referring) and the latter to choose Group A1 (i.e. self-referring) has already been mentioned. 'Seeking help' was chosen more often by those who had made a previous attempt in the past year, and less often in cases where a row preceded the overdose. Other findings in the interview study (in preparation) show that 'rows' more commonly precede first attempts. First attempts, it seems, are often precipitated by emotional crises in close relationships, and such acts may be best understood as attempts to influence the other person or express anger. The practical consequences of the first overdose, such as contact with the hospital and professional agencies, are perhaps of little relevance in determining that first episode. Once those consequences have been experienced, however, they may increase the likelihood of the overdose being repeated in order to reproduce those consequences. This would explain the association between the choice of 'seeking help' as a reason and previous attempts.

At this stage in the research we can do little more than generate hypotheses for further testing. A number have been presented in this paper and work is in progress to explore them further.

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J. H. J. Bancroft, M.D., M.R.C.P., F.R.C.Psych., *Clinical Reader in Psychiatry*,

A. M. Skrimshire, M.A.(Oxon.), Dip.Stat., *Research Officer*,

S. Simkin, B.A., *Research Assistant*,

Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford OX3 7JX

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