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Suicide in Avon

Life stress, alcohol misuse and use of services

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Background Suicide rates among young men are rising. Further information about their contacts with services and possible associated stressful life events is necessary.

Method The sample consisted of all cases where the coroner in the County of Avon had given an inquest verdict of suicide over a 20-month period, together with those who were categorised as suicide by a panel of psychiatrists even though they had received open or accidental inquest verdicts. The coroner's dossiers and hospital notes were examined and the relevant general practitioners interviewed.

Results Interpersonal stress in the last 72 hours was much higher in younger suicides. Young male suicides were also much less likely than others to seek help. Levels of alcohol misuse were no higher in younger than older suicides.

Conclusions Various subgroups of suicide behave differently in the way they seek and utilise help. The implications of these findings for suicide prevention and service strategy are discussed.

Recently concern has been expressed about the increase in suicide rates among young males (Lowry *et al*, 1990; Hawton, 1992). The present paper describes the differential way in which life stresses and contact with services apply in young compared with older suicides. We hypothesised that younger suicides would be less likely to be in contact with potential helping services and be more likely to experience life stresses than older suicides. Alcohol may be one causal factor in the rise of young male suicides (Marttunen *et al*, 1991), so we also looked at the extent to which this was a problem compared with older suicides.

METHOD

During the period March 1990 to November 1991, Her Majesty's Coroner's data for the County of Avon (population 932 674) were perused. A note was made of those instances in which a verdict of suicide, open or accidental death was returned on residents in Avon. Summaries of all open verdicts, and verdicts of death by accident and misadventure, where the mode of death was similar to that used in suicides, were presented to a panel of three consultant psychiatrists. If a majority of the panel felt that the verdict was suicide, then the death was included in the study. Younger suicides were taken as those aged less than 35 years.

The general practitioner (GP) relevant to each patient was interviewed (by C. A. V.). Details were noted, with reference to the GP's notes, concerning any clinical contacts which the patient had made in the previous year, and of psychological symptoms, life stresses and clinical management, including the use of psychotropic medication.

Information was also obtained from psychiatric and general medical hospital records for each patient. Avon Social Services and the Avon Council on Alcoholism and Drugs (ACAD) provided details as to when clinical contact had been made with them. Information about life events was recorded from all the above sources and coded according to the Interview for Recent Life Events (Paykel, 1987). Specific attention was paid to the evaluation of interpersonal life stresses in the 72 hours before suicide, as these have been suggested as being particularly important (Hoberman & Garfinkel, 1988).

Diagnoses derived from psychiatric case notes were assigned according to DSM–III–R criteria (American Psychiatric Association, 1987). Otherwise, Family History Research Diagnostic Criteria (FH–RDC) were used (Andreasen *et al*, 1977).

RESULTS

The series (n=144) consisted of 83 people who received suicide verdicts, and 61 of the 91 who had received either open or accidental verdicts and were considered by the panel to be suicides. In five cases the GP notes were not found (in three of these cases, information was available from hospital records).

The age range was 17–85 years, with a mean age of 43 (s.d.=18). Of the younger suicides, 49/56 (88%) were male compared with 62/88 (70%) of the older suicides.

Contact with services

Of all the females, 24/33 (73%) had ever seen a psychiatrist, compared with 46/111 (41%) of the males (χ^2=9.97, d.f.=1, P=0.002). Of those less than 35 years of age, 5/7 (71%) of the females and 16/49 (33%) of the males had ever seen a psychiatrist (χ^2=2.49, d.f.=1, P=0.128).

With regard to the four-week period before death, 7/56 (13%) of the younger suicides and 24/88 (27%) of the older suicides had had contact with mental health services (χ^2=4.42, d.f.=1, P=0.036). Fifteen of the 56 (27%) suicides under 35 years of age and 53/88 (60%) of the suicides 35 years and older had seen any kind of health professional in the same time period (χ^2=15.36, d.f.=1, P<0.001). Table 1 gives details of all contacts of the series with potential helping agencies, including health and social services and ACAD.

Life stress

There was no significant difference in the proportions of those under 35 years of age (32/56, 55%) and those 35 years of age and over (42/88, 48%) experiencing any stressful life event in the 13 weeks before death (χ^2=0.37, d.f.=1, P=0.47). The different age

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Table I Service contacts, interpersonal stresses and alcoholism before death

	Age ⩽34 years	Age ⩾35 years	χ^2, d.f.=1
Male			
n	49	62	
In contact with services four weeks before death	11 (22%)	32 (52%)	9.81, *P*=0.002
Interpersonal stress in the 72 hours before death	12 (24%)	5 (8%)	4.50, *P*=0.034
FH–RDC or DSM–III–R alcoholism	8 (16%)	17 (27%)	1.35, *P*=0.246
Female			
n	7	26	
In contact with services four weeks before death	4 (57%)	21 (81%)	1.54, *P*=0.215
Interpersonal stress in the 72 hours before death	3 (43%)	2 (8%)	*
FH–RDC or DSM–III–R alcoholism	1 (14%)	2 (8%)	*

*χ^2 values not calculated because of small numbers.

groups were not distinguished by the experience of particular life events in the 13 weeks before death according to the categories: work/education, finance, health, interpersonal events (a combined category comprising courtship and cohabitation, and family and social, to allow comparison with other studies), bereavement, migration and legal.

The most common category of event in the 13 weeks prior to death was interpersonal events; the proportions of persons under and over 35 years experiencing such an event (18/56, 32%, and 18/88, 20%, respectively) did not differ significantly (χ^2=2.49, d.f.=1, *P*=0.1). Fifteen of the 49 (31%) young men and 3/7 (43%) of the young women had experienced such an event.

However, when interpersonal stresses in the 72 hours before death were considered, significant subgroup differences were found. More of the younger suicides, 15/56 (27%), had experienced such an interpersonal stress, compared with 7/88 (8%) of the older suicides (χ^2=7.98, d.f.=1, *P*=0.005).

The following vignette taken from the Coroner's dossiers vividly illustrates the rapid escalation of interpersonal crises that appeared common in many of the young males immediately before suicide occurred.

> The deceased was 23 years old and living with his girlfriend. He returned home smelling of drink and there was a row; during the course of this the girlfriend was hit accidentally. The deceased ran from the house after saying, "I love you, for God's sake, I would never lay a finger on you – you know that". Shortly afterwards he hanged himself in a street nearby. There had been no previous contact with psychiatric services.

Of the younger suicides, 8/56 had been unemployed for 12 months or less and 8/56 for over a year: a total of 29%. Of the older suicides, 15/88 had been unemployed for 12 months or less and 10/88 for over a year (a total of 28%). There was no difference between the age groups in the proportions unemployed (χ^2=0, d.f.=1, *P*=1).

Alcoholism

Nine of the 56 (16%) suicides under 35 years of age and 19/88 (22%) aged 35 and over (χ^2=0.666, d.f.=1, *P*=0.41) met either FH–RDC or DSM–III–R criteria for alcoholism. In the whole series there were only an additional two young male suicides who met criteria for substance misuse and not alcoholism.

DISCUSSION

We have previously reported on the lack of contact that young suicides have with their GPs (Vassilas & Morgan, 1993). Young men were the least likely to visit their GP or to have seen a psychiatrist, and neither did they appear to seek help through alternative sources, in the present study. When all contacts are considered together, 80% of the young men in the present series had no contact with any agency in the four weeks before death. This contrasted markedly with the range of 19–48% in other groups.

Any analysis of life events which is not based on interviews is open to criticism. In the present study, the use of the coroner's and medical records, as well as interviews with GPs, enabled the timing of events to be assessed, thereby excluding those which might be secondary to psychiatric illness in any individual.

The present study has highlighted how common interpersonal stress in the 72 hours prior to death is among younger suicides. In the younger age group there appears to be a temporal relationship between interpersonal problems and suicide shortly afterward, giving the impression that many of these suicides were impulsive.

The overall rate of 19% for alcoholism in the present study was far higher than the 1.5% found in a study in the same area using a similar methodology 30 years ago (Seager & Flood, 1965). Contrary to expectations, we have not found alcoholism to be particularly associated with younger male suicides compared with other groups.

The present findings have important service implications because they focus on the differential needs of subgroups within the overall population of suicides. Young males appear to be especially vulnerable, because in a quarter of them the 72-hour interpersonal stress factor seems important, yet as a group they make contact with services least often. We have reported elsewhere significant problems in young male suicides concerning unemployment, substance misuse, repeated deliberate self-harm, and the need for better management of antidepressant medication (Vassilas, 1994).

In view of the greater willingness of older suicides to seek help, educational programmes aimed at improved recognition and treatment of potential suicides within traditional health settings might be particularly effective. With regard to younger suicides, a significant element of impulsivity, in a setting of rapid and late escalation of crisis, suggests that early intervention and prophylactic support might be a valuable component in service delivery, given their reluctance to seek help. GPs may well have a preventive role (Appleby *et al*, 1996). We need to take into account where young men can best be contacted, for instance, community centres and statutory and voluntary services dealing with alcohol misuse, and evaluate how educational programmes and helping strategies might best work in those environments. New approaches are needed, both to ascertain what help young men see as relevant to their needs, as well as to determine the best way of delivering it to them.

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CLINICAL IMPLICATIONS

- Young males who commit suicide behave in very different ways to other suicides.
- Impulsivity and recent interpersonal stress appear to be particular features of young male suicides. In terms of prevention these pose particular challenges.
- In seeking to prevent suicide among young males, new strategies need to be sought in order to make contact with this group.

LIMITATIONS

- Information about substance misuse and life stress is incomplete because this was not a full autopsy study in which relatives, colleagues and friends are interviewed.
- A controlled comparison needs to be made with young men who have not committed suicide. The study does not directly address aetiological issues.
- The numbers of females (particularly young females) involved in the study was small, making it difficult to draw conclusions about this group.

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