Living with attempted suicide

A. W. BURKE

M.B., Ch.B., M.R.C.Psych., D.P.M.

Academic Department of Psychiatry, St George's Hospital Medical School, London SW17 0RE

Introduction

Self-destructive behaviour is an increasing problem to workers in all fields of medicine. When attempted suicide occurs this will be an indication of distress and this will be manifest in the patient, persons in his social environment and to medical workers involved in rescue from the attempt itself and treatment of the condition which led to this behaviour. One of the major issues confronting those who have a theoretical interest in suicidal behaviour and those who are confronted with the management problem of such patients, is the definition of the problem. The suicidal patient may harbour ideas of self destruction which may in themselves be incapacitating or, instead, only appear during periods of despair. He may actually carry out a wilful act, clearly indicating to others that he wishes to die, even though up to a third may subsequently deny any such intention. The attempt may be less clear-cut because of an unconscious factor which at the time had been brought about by alcohol or had been induced by psychological stress leading to hysterical behaviour. For some there will be an attraction to dangerous and lethal activities mainly because of low self-esteem, a life-long feeling of despair and the belief that death by chance is a worthwhile alternative (Menninger, 1938).

There is a group of individuals that present major problems to medical services only because of their persistent suicidal behaviour. These comprise a significant proportion of admissions to casualty departments and medical units and might even reach surgical wards following purposeful falls from heights or in the path of moving objects. It will be found that the patient who makes repeated attempts at suicide will do so because of overpowering feelings of despair, frustration and failure. It is unfortunate that the gamble with death, which is implicit in multiple attempted suicide, will not be followed by appropriate management in the great majority of cases. The difficulty which medical and psychiatric workers experience will, in itself, be distressing. In the present paper it is my intention to give an account

of the problems which will be found in the suicidal patient, his social network and finally in the medical community which has been regarded as an alternative support system. In order to complete this account it will be necessary to describe patterns of coping in the patients mentioned as well as in the groups remaining when suicide occurs.

Thinking about suicide

It is not generally recognized that persons who think about suicide but who nevertheless do not attempt to destroy themselves, will experience a great deal of distress. About 16% of the adult population admit to thinking of suicide even though only a few have persistent thoughts of this. The prevalence of this activity increases with age and is greater for those who have not been married and those who have been divorced as compared with the currently married. The distribution of suicidal thoughts in the population is about equal by sex. However, almost 1% of females have frequent thoughts of suicide and this proportion is twice the male rate. The ethnic distribution supports the view that suicidal behaviour is partially determined by socio-cultural factors. The rate for whites is four times greater than for blacks (Schwab, Warheit and Holzer, 1972). A far greater number of people may feel that life is not worth living but will not admit to having ideas of suicide. Workers should be aware of the fact that this population defines more accurately the reservoir of distressed persons likely to attempt suicide and therefore in need of the support of the many services now available. In one study which attempted to identify psychiatric patients likely to attempt suicide it was shown that a half of over 800 patients were given this status only because of their suicidal thoughts. The findings indicated that subsequent suicidal thoughts and acts were similarly distributed among patients who had never attempted suicide and those who had done so (Eisenthal, Farberow and Schneidman, 1966). In each follow-up year about 1% of cases killed themselves.

Cross-cultural data do not support the view that child-rearing practices are of aetiological significance in suicidal behaviour. Nevertheless, clinical practice reveals a characteristic pattern of development among vulnerable individuals and suggests that suicidal thinking may be learned. It is believed that the suicidal patient will have been sensitized by an early separation experience in a disorganized family. In these families parental figures disagree with each other, will show open hostility to each other and also to the child. The developing child will feel unloved and will grow up to hate himself and others. Unfortunately there will be repetitions of traumatic separation experiences in later childhood. The consequence is that such individuals enter adolescence in turmoil. Their efforts at attaining independence are thwarted in part because of conflicts surrounding sexuality and interpersonal relationships but also because of difficulties in disengaging from one or other parent. An obsession with failure is prevalent among them, many openly admit to feeling lost and some will think of death.

When these individuals seek help before attempting suicide the picture they present is one of ambivalence to life, along with feelings of insecurity, desperation and helplessness. The picture in its extreme form is of a chaotic disintegrating patient. It is necessary to provide limits and structures if such individuals are to be helped and prevented from further disintegration and an attempt at suicide. The sharing of despair and of suicidal thinking must be encouraged but only when security has been attained by hospital admission or a restructuring of the social setting. When detailed analyses are carried out, it is found that the developmental period of childhood and adolescence has been interrupted by traumatic events. The result is that the individual will perceive himself as being disadvantaged and therefore less able to deal with emotional problems. He will be hostile and lacking in confidence. However, he will be unable to express this hostility to that person most directly related to him. It is as though there is a hostile dyadic relationship between the suicidal patient and the person whom he loves—'the significant other'.

It is not surprising that workers have been attracted to views expressed by Freud that the aggressive impulse is a significant factor in suicide (Fenichel, 1945). Menninger believed that three components may be identified: the wish to kill someone, the wish to be killed and finally the wish to die. The interplay of these three wishes may be seen in mothers who have recently given birth and are having difficulty in establishing a sense of being worthwhile and competent. There is a risk of killing the child which may be identified along with ideas of worthlessness and suicide. The wish to die is associ-

ated with pleas for rescue and support. This appeal element is an important aspect of the distress experienced by all suicidal persons. The negative view of the self which is an important feature of this distress syndrome is also found in persons who become dependent on hospitals and may be described as suffering from a syndrome of hospital addiction. An example of this is the diabetic young man who, following the death of his mother, finds solace in the medical ward and cannot prevent himself from taking purposeful and self-inflicted overdoses of insulin, in order to gain re-admission. His distress was transmitted to the medical, nursing and social work staff on that ward but only when marital therapy was instituted could his wife appreciate the communication which was implicit in his behaviour. There is a group of epileptic patients that default on their therapy because of similar motives and a smaller group of damaged individuals who cut their wrists and/or take overdoses in an effort to reduce anxiety without any clear intent to kill themselves. When patients present with wrist cutting or related self-mutilating syndromes (for example, burning with cigarette ends, eye enucleation, face and body abrasions) there is evidence of a distortion of body image (dysmorphophobia) which might have come about either from physical illness and hospital admission or sexual trauma through incest or some other traumatic activity. It is perhaps of interest to note that women who have a negative self image most often carry out suicidal behaviour in the period surrounding menstruation. It is also of interest that the group of patients who suffer from anorexia nervosa are characterized by a disturbance of body image, an age of onset at puberty and a relentless and sometimes intractable self-destructive tendency.

The act of attempted suicide

The post-war period has been associated with an epidemic of attempted suicide throughout the Western world. This population makes significant demands on medical beds and represents a fifth of all emergencies to general hospitals. The rate continues to increase and may now be as great as three per thousand population annually. In a recent paper, workers in Cambridge found that junior medical staff were well equipped to assess such patients. Among over 200 patients many could be sent home and perhaps no more than 15% had to see a psychiatrist. When these patients were followed up a year later none had committed suicide (Gardner *et al.*, 1982). This casts substantial doubt on the previous finding of a mortality by suicide of more than 1% in this population. None the less, note should be made of the fact that up to 3% of the adult population have attempted suicide at some time with perhaps three

times as many females as males, fewer older than 30 years of age and twice as many whites as blacks. The population that is married or older than 30 years of age seems to gain protection by virtue of these attributes (Schwab *et al.*, 1972).

The act of attempted suicide necessitates a full appraisal of the distress syndrome which has resulted in this behaviour. When medical intervention has been carried out and the medical emergency has been dealt with, it is important to interview the patient fully. Invariably there is evidence of a loss. This may be real or threatened and the outcome of an interpersonal relationship. It may be due to the death of a loved one or illness in the individual himself. Finally the loss may result from an insult to self esteem consequent on failure or despair. Among adolescents and patients from minority ethnic groups who have emigrated there will be evidence of a dispute which involves a parental figure and this will be an indication of a struggle to gain independence from this figure. Among Europeans it is more likely that the dispute will be with a sexual partner. Many of the cases have been involved in previous disputes and have used a similar method of resolution. This population of patients who make repeated attempts will merit special attention. The compulsion to repeat the behaviour is more an indication of a learned pattern in a desperate individual who lives in a desperate environment. Indeed overcrowding and other indices of social disorganization will be prevalent. Furthermore as many are unsupported and living alone, some have had contact with the police or been in prison, some may be unemployed and others have no purpose in life, the pattern of repeated attempted suicide will be reinforced by the desperate but unmet needs of these individuals.

The aggressive element of attempted suicide may be masked or aggravated by the intake of alcohol. Many patients are depressed but it is of interest that this depression often requires nothing more than brief psychotherapeutic intervention or instead the interviewing of the individual and the significant one. Many may be described as suffering from the anxiety of a situational problem but here there will be need to unmask the aggression and anger of an underlying depressive reaction consequent on the loss of a love object. Stengel (1960) has described multiplicity of motivations among such individuals and the appeal function which he believed to be most important. Workers in Oxford have studied this problem in depth. Their findings indicate that persons taking overdoses will want to influence others to seek help. Although a half admit to wanting to obtain relief from a terrible state of mind, about the same proportion do not want to die. It is of interest that the wish to die was positively associated with social problems (Bancroft, Skrimshire and Simkin, 1976).

Recent data support the postulate that the act of attempted suicide may be transmitted and reinforced by psychological mechanisms (Welz, 1979). There is reason to believe that among the population of persons who attempt suicide there are those who will be carriers of the suicidal tendency. Marriage may be the result of the choice of a similar partner or one who aggravates the behaviour; a suicidal coping style will be acquired by the resulting family and there will be an excess of suicidal acts among these families. It is this group of patients and families for whom therapeutic interventions have been least successful. In this regard it is probable that in this small but significant 'carrier population' suicide has a meaning quite different from other sub-cultural groups.

The effects of communication in attempted suicide

In clinical practice there is overwhelming evidence that the attempted suicide patient is seeking help for his distressing condition. The *prodromal phase* is characterized by a feeling of unrest and with difficulty in coping with normal activity. This may result from problems with the self, from burdening and conflicting interpersonal relationships, from problems with authority which among schoolchildren is an important factor, and finally from the failure to meet responsibilities inherent in a change of status. The recognition of any of these problems will be distressing and such an individual may seek help. More than a half of those who take overdoses would have liked to have had the opportunity to talk with someone and for most this would have been sufficient for crisis prevention. In this regard it is probable that persons who do not offer advice but inevitably lend an ear in the normal course of their work (e.g. hairdressers, bar tenders) satisfy the needs of many who never reach the *stage of crisis*. Those who are in crisis and have attempted suicide will admit to seeking help from an array of professionals. In Oxford Bancroft and co-workers (1977) found that four-fifths of overdose patients had gone to some agency in the month preceding the overdose. The general practitioner was by far the most popular with about three-fifths going to them during that period. Psychiatrists, social workers and the clergy may be similarly distributed with about a fifth going to each group. The act of attempted suicide will be carried out in a setting which highlights the appeal element of this behaviour. It is the significant other to whom the patient makes a final plea but from whom a negative reaction comes. It is inevitable that this 'other' person will be locked into the pathology of suicide and will experience distress not dissimilar to that of the patient. Invariably the crisis which follows the suicidal act results in a psychological reaction in the loved one. His failure to meet the demands of the

patient is followed by sadness, guilt, anxiety and anger. It is as though the act of attempted suicide has brought about an anticipatory grief reaction in the loved one. It is this fear of being responsible for someone's death which results in the attempt to rescue by reconciliation.

When persons repeat attempted suicide there is some indication that the repetition serves the purpose of communicating distress in individuals who because of personality or background factors are not able to communicate by normal channels. A series of repeated attempts may characterize one episode of unrest in such individuals. There are others for whom a single attempt is followed by recurrent dreams of suicide and death but who do not resort to multiple attempts only because of constraints placed on them in treatment facilities or in their social environment. The burden of care for these patients falls entirely on family, friends, sometimes colleagues and finally on persons working in the rescue and support team of social and medical facilities. It is found that in many cases the therapist will resort to hospitalizing the 'patient' in an effort to alleviate his own anxiety and distress. The process of admitting the patient has its dangers and should be avoided whenever possible. It may disrupt the social environment even further by labelling the wrong partner to be sick or mad; it may lead to attempts to rectify distress by medical methods rather than social and psychotherapeutic ones; finally it may increase distress by bringing about loss of status and a greater sense of failure.

Recovery from attempted suicide

Hopelessness is the single most important factor which leads to suicidal behaviour. The aim of intervention should be to reduce this feeling of hopelessness and to bring about some resolution in the conflict which predisposes to it. Hopelessness is found in depression and also in persons who have what are loosely termed personality disorders. These two disorders may co-exist and when this occurs there will be difficulty in disentangling that element of hopelessness which comes from the one and not from the other. It may also be true that the act of attempted suicide may by inducing shame and failure, have the effect of reinforcing feelings of hopelessness.

The recovery phase may appear to be short-lived in the great majority of patients attempting suicide. Nevertheless this will be true for many only when efforts have been made to help the patient with his hopelessness. It is likely that the attempt was planned only in about a half of all cases. The impulsive nature of the attempt in the remainder will in itself seem to be aggressive and irresponsible but this impulsiveness should not be taken as evidence of an absence of

depression. This is particularly true in children and young people among whom obvious symptoms of depression may not be found.

Aggression is an integral feature of attempted suicide. The act may serve the function of manipulating a relationship with a parent or spouse, relative or friend. It may signal feelings of despair in a recently bereaved individual and finally it may be totally self directed as a result of failure to meet the needs of a new status as, for example, following accident, illness or childbirth. Many have a pervasive feeling of loneliness and will project their anger by blaming others. It is unfortunate that these patients are unable to find the security and stability they crave. Instead they enter immature relationships which fail to meet their needs. Many of these patients are dependent personalities who are likely to develop strong attachments to workers in the helping professions.

The aim of hospital admission should be to reduce the burden of distress in the patient and those in his social environment. This may come about only by marital or family intervention with resolution of conflicts or subsequent separation. It may be entirely related to personality deficits necessitating self understanding in a psychotherapeutic community. Finally it may mean the treatment of serious depressive illness by drugs or electro-convulsive therapy. When hospitalization occurs the patient will be perceived by his family and friends as having broken down. A second aim of therapy must therefore be to bring about a return to normal function and to prevent the loss of status implicit in being a mental patient. It could be said that recovery is complete only when family and friends accept the individual back into their midst and when hospital workers have promoted independence to the extent that discharge can take place without a relapse of despair. Unfortunately the risk of suicide itself is greatest among recently discharged mental patients. Furthermore there will be a history of admission to mental hospital in a third of persons who kill themselves.

The lethal outcome of attempted suicide

Here in Britain the official annual rate of suicide is less than 10 per 100,000 population. The true rate may be up to 30% more. The rate is higher in males than females and evidence of isolation and increasing age in the urban unemployed previously suicidal person identifies the high risk group. The extent of the problem is best appreciated from the weekly newspaper reports of suicide. Reporting may heighten feelings of horror in religious and ethnic groups that prohibit suicide. It is uncertain that reporting will increase the likelihood of suicide in the predisposed. None the less it may be true that reporting has increased the general awareness of

suicide and the wish to prevent this calamity. In Los Angeles one in four adults will have known someone who died by suicide. People believe that suicide rarely follows disputes of love, but frequently results from psychological stresses and real loss. Mental illness is given as the cause by two-fifths of blacks but only a fifth of whites (Reynolds, Kalish and Farberow, 1975).

It has been shown that suicide may be predicted in individuals who have a lifelong history of unrest and/or instability consequent on traumatic childhood experiences and unfulfilled interpersonal relationships. Unfortunately, the prediction of suicide has been largely unsuccessful among the high risk group of psychiatric patients. In an eight-year mean follow-up period of one thousand or so index admissions to the University psychiatric unit at Atkinson Morley's Hospital it was found that a verdict of suicide had been recorded in 28 deaths with a related verdict in an equal number. The two groups were similarly distributed demographically and there was little variation in the age distribution of suicide. Two-fifths had previously attempted suicide and a quarter died within 6 months of discharge. The data confirm that evidence of a personality disorder was the single most important predictive factor.

Suicide in the psychiatric setting will evoke high levels of distress in patients, the family of the deceased and the staff themselves. Distress will be complicated by the fact that staff will be held to be responsible. The family will want an explanation. There may be adequate clinical care and yet the Coroner's investigation and the publicity which follows may cast doubt on this. The therapist and team will experience sadness and anger but may not be able to show these feelings. One outcome will be a change in the quality of care for remaining patients.

Among patients sudden loss by suicide is experienced as a repetition of earlier traumatic separations. In the therapeutic community at Atkinson Morley's Hospital it has been found that the first stage of grief following suicide is facilitated by group therapy which deals with the disbelief and anger among patients. In this setting it is undoubtedly true that suicide raises major problems. The ethical issue concerning the right of the patient to die will conflict with the right of the therapist to prevent this death. At an early stage the patients express feelings of hopelessness, sadness and guilt and many will be hostile to staff. For the first time some will admit to suicidal feelings; other have a wish to join this trusted friend or to be reunited with an earlier significant other; some actually attempt suicide at this time.

In the great majority of suicides the distress will be borne entirely by the family and other members of the social environment. It is a horrifying experience

for a child or parent, spouse or friend to discover a lifeless corpse or the unconscious body of someone who has taken an overdose and subsequently dies. Family members will be burdened by a series of events surrounding the death and burial and the investigations of suicide. Society has a horror of suicide and will not be sympathetic. The family must bear stigma and ridicule and must live with the last note if one was written, and the cruel after-effects of the inquest and newspaper reports. There may be attempts to shield young children from the truth but this will only delay the traumatic grief reaction in those remaining. When a child experiences suicide in a parent it will have a profound effect on their view of life and death. There will be a prolonged period of crisis and many will not recover from the event. Eventually the child will blame the remaining parent but may be unable to express this. Suicide in a young person will be a calamity for which the parents will hold themselves responsible. There will be a prolonged phase of denial, during which little effort will be made to obtain help and over-idealization will be necessary. Among parents who have lost a child there will be an ongoing process of blaming each other. The process will be somewhat different when suicide occurs in one's spouse. In this case, however, the findings are that a suicidal pattern has been established as part of a sado-masochistic relationship or one in which the dependency needs of one partner were only being met in a pathological way. The remaining partner will have the problem of being isolated in the social environment previously occupied by them both and will feel great shame in this setting. Many undergo a psychological reaction; some will replace the lost partner with someone almost identical; some will deny the emotional loss; there will be reparation in others. Finally, a small group will have a similar fate and die by suicide.

Conclusion

It will be found that suicidal behaviour occurs in a pathological social network. This will be devoid of warmth and security. Communication may be impaired or even perverse. Aggression is an important element and self-hatred will commonly be found. The members of the network will themselves experience disappointments as repetitions of earlier losses. It is in this way that a life style, in which death is longed for, may be learned and maintained. None the less when people think of suicide, attempt this but live or die, they are appealing for help. Some have access to doctors because of injury or physical disease; others will seek help from general practitioners for less obvious problems of health, whilst the vast majority will seem to be physically well. All will be suffering from emotional difficulties. Few will be

able to be helped by professionals in this field. For the majority there will be constant distress which unfortunately will not be recognized.

In the present paper an account has been given of the manifestations of distress in the syndrome of attempted suicide. The syndrome may be defined as a content of consciousness which results from feelings of hopelessness and which may be associated with an impulse to injure the self. The features are thoughts of suicide which are quite prevalent, overdoses and acts of self-injury which make great demands on medical services, multiple attempts which make even greater demands on social and psychiatric agencies. Finally, there is the uncommon but tragic event of death by suicide.

In order to make a diagnosis of this syndrome it will be necessary to elicit symptoms of hopelessness, together with thoughts of giving up, or of dying or of killing oneself. The act of attempted suicide will be confirmation of these things. The task of the therapist will be to make an accurate appraisal of the factors which contribute to this condition and to bring about meaningful interventions which are designed to reduce distress and to protect life. Among the young it will be important to be aware of the fact that classical features of depression are uncommon whereas impulse-ridden and chaotic forms of behaviour are prevalent. Thus, problems with parents or teachers, running away from home or school, delinquency and abuse of alcohol or drugs may be found. Alternatively there may be evidence of premature sexual relationships which sometimes may be quite unintentioned and the result of incest or rape, early pregnancy from unsatisfactory immature relationships, and problems concerning appearance and maturity with social avoidance and difficulties in making relationships outside the home. Among adults it will be found that the hopelessness which

leads to the syndrome of attempted suicide is preceded by a more obvious loss and is associated with hostility. Doctors should be aware of the fact that this hopelessness may result from a personality disorder and/or depression. Although depression may be a primary condition it is more likely to be secondary to childbirth, bereavement, medical disease, social problems or some other psychiatric disorder. If the distress of attempted suicide is to be alleviated it will be necessary to make appropriate investigations and to treat the relevant condition.

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