Section of Psychiatry

President Professor Denis Hill FRCP

Meeting June 15 1965

Papers

Repeated Acts of Self-poisoning and Self-injury

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During the course of a study of a group of patients who had deliberately poisoned or injured themselves we found many instances where the act was repeated. Such patients have previously been described by Batchelor (1954) and Stengel & Cook (1958). The subject is one of increasing importance, for the fashion of self-poisoning continues to grow. Our data relate to the total incidence of a defined phenomenon in a specific population.

During twelve months from June 1962 the Edinburgh Royal Infirmary admitted 511 people who had poisoned or injured themselves deliberately, intending the act to be harmful, and who survived. Anybody presenting at the hospital having deliberately taken an overdose, however small, or having injured himself, however slightly, was admitted. A separate study (Kessel *et al.* 1964) revealed that we observed more than 90% of all such patients arriving at *any* hospital in Edinburgh. All patients were followed for one year after they entered the series and we know of readmissions during a second year. The whole series and certain follow-up aspects have been presented elsewhere (Kessel 1965, McCulloch 1965).

Of these patients 97 (19%) repeated their acts within one year. Similar figures have been presented by Batchelor (1954), by Stengel & Cook (1958) and by Hove (1953).

Sixty-eight of the 97 patients repeated once only: 20 repeated twice: 7 three times and 2 patients four times during the follow-up year. Altogether the 97 patients had 137 episodes. Eight of these patients (1·6%) killed themselves. A 2% rate was found by Batchelor (1954) in his more selected Edinburgh series. Jansson (1962) and Tuckman & Youngman (1963) reported rates of 1·3% and 1·4% respectively. All these are one year follow-up figures. Ettlinger (1964) reported 3·7% within two years.

More than 85% of our patients were readmitted to hospital when they repeated the act.

Thirty-nine per cent of the original series gave a history of a previous episode. Stengel & Cook (1958) reported a similar prior incidence though Batchelor's (1954) figure of 23% is substantially less. A history of an episode before they entered the survey was found much more often in those who repeated their acts (58%) than in those who did not (34%). Similarly, in the one or two years *subsequent* to our follow-up year, those who had repeated their acts within that year returned to the ward five times more often than the remaining patients (27% compared with 5%). Some people are repeat prone.

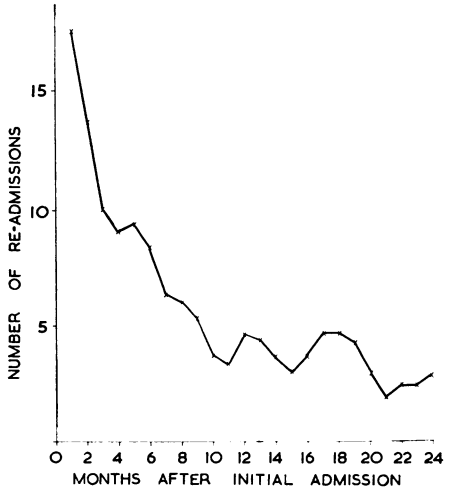

Fig 1 *Self-poisoning and self-injury: frequency and timing of readmissions (three-month moving averages)*

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Timing

Repeat episodes tended to occur shortly after the initial episode (Fig 1), usually within the first two or three months. Only episodes resulting in readmission to the ward have been included. Most of the events of the later period were second or third repeats.

Sex, Age and Civil State

Men and women repeated in equal proportion. Those who were single and, particularly, those whose marriages had ended, were significantly more often represented among the repeaters. A continuing marriage militates against repeating the act.

Table 1

Age of patients who repeated self-poisoning or self-injury

Age	*No. in series*	*Repeaters*
Under 25	144	27 (19%)
25–34	123	31 (25%)
35–44	105	18 (17%)
45–54	73	12 (16%)
55+	66	9 (14%)

The age group 25–34 years yielded a rather excessive proportion of repeaters (Table 1). The eight suicides were older but their ages (31, 37, 41, 41, 50, 53, 56, 59) were less than is typical for suicides. Suicides who have had previous episodes of self-poisoning or self-injury seem to be younger than suicides in general.

Method, Danger to Life and Impulsiveness

In the whole series ten times as many people poisoned themselves as injured themselves but a third of those who injured themselves repeated the act, compared with a fifth of the self-poisoners. No particular poison was associated with later repetition. Most people kept to the same method, poisoning or injury, when they repeated the act (Table 2). Subsequent suicide was not associated with any particular initial method.

Of four categories of danger to life – death, death probable, death unlikely and certain to survive – none was particularly associated with a tendency to repeat. Like Stengel we deduce that no prediction about repetition can be made from examination of the so-called 'seriousness' of what the patient did. The same is true about those who subsequently committed suicide. At the initial episode, half were classed as 'certain to survive'. Repeat acts were sometimes more life endangering than the original episode, sometimes less and sometimes equally so.

Table 2

Comparison of methods used in initial and subsequent episodes, including suicides

	Method at repetition	
Initial method	*Poisoning*	*Injury*
Poisoning	107	13
Injury	4	18

Table 3

Impulsiveness

Initial episode	*No. in series*	*Repeaters*
Impulsive	332	73 (22%)
Premeditated	159	19 (12%)

χ^2 7·11 $P<0.01$

Those whose initial act had been impulsive were more likely to repeat subsequently (Table 3). The initial act was impulsive for 7 of the 8 suicides; we cannot say whether this also applied to their fatal acts.

Diagnosis

Patients were classified at the time of their initial admission, into those with a formal psychiatric illness (mostly neurotic, mostly depressive), those with personality disorders only and those with no psychiatric illness, whose episodes could be classed as situational reactions. The highest proportion of repeaters was found among those with personality disorders, most of whom were psychopaths; they also had the highest proportion of suicides (Table 4). Those with a psychiatric illness had a lower rate of repeating partly because more of them were admitted to hospital and partly because of the better prognosis. The relatively low rate among those with no psychiatric illness may be explained by the amelioration of social circumstances that followed their admission, either spontaneously or as a result of help. However, 15 patients without psychiatric illness did repeat; here the precipitating circumstances precluded our helping them sufficiently even though half of them received psychiatric treatment.

Table 4

Diagnosis and repetition

Diagnosis	*No. in series*	*Repeaters*	*Suicides*
Psychiatric illness	286	47 (16%)	1·4%
Personality abnormality only	100	27 (27%)	4·0%
No psychiatric diagnosis	116	15 (13%)	—

Alcoholics and those who were drug dependent (Table 5) both yielded significantly high numbers of repeaters. Moreover, of the 8 suicides, 4 were alcoholic, 1 was alcoholic and drug dependent, and 2 were drug dependent.

Table 5

Alcoholism and drug dependence

	No. in series	*Repeaters*	χ^2 *(against 'all others')*	*P*
Alcoholic	90	27 (30%)	11·40	<0·001
Drug dependent	26	11 (42%)	13·19	<0·001
All others	395	59 (15%)		

Table 6

Past and current psychiatric treatment

	No. in series	*Repeaters*	*P*
Treatment in the past but not currently	213	58 (27%)	<0·001
No past treatment	293	39 (13%)	
Currently under treatment at initial admission	80	29 (36%)	<0·001
Not under treatment	426	68 (16%)	

A history of psychiatric treatment, at the time of the initial episode or previously, was associated with a high rate of repeat acts (Table 6).

The People who Repeat

Twice a week, on average, we readmit a patient who has been in the ward within the previous twelve months. Batchelor (1954) has suggested that those who act impulsively are manifesting an acute frustration reaction and this aspect we recognize. But our impression is that they do it not so much because they are or feel thwarted as because they are distressed. Some patients repeatedly get distressed beyond what they can bear. Often this occurs when they are drunk. Distress, whether it stems from depression or from intolerable social circumstances, is always present at the time of the act. Suddenly the situation becomes too painful to bear. They have to do something to relieve the situation at any cost or, rather, without counting the cost. Their motive, if they can be said to have had a motive, is no plainer or more definite than that.

Repetition after a premeditated act needs a different explanation. Occasionally, failure to recognize a depression or to treat it adequately results in a repeat act. Sometimes an initial success of the appeal prompted resort to the same device, consciously or unconsciously. More people repeat the act because the appeal fails, because the unbearable situation which besets them is not relieved.

Another group consists of people with that dangerous combination, psychopathic personality and a tendency to cyclothymia. Henderson (1942) wrote: 'Almost the most specific manner in which the psychopathic state shows itself is in the act of suicide.' We would add 'and in acts of self-poisoning and self-injury'.

Prevention

For someone who has deliberately taken an overdose, there is a 20% chance of repeating during the next year; one in 60 will have died by suicide in that time unless we can improve upon present practices. Those most prone to repeat, young adults with poor work records and unstable living circumstances, often with personality disorder, with an emphasis on alcoholism and drug dependence, are not the most promising group of patients to deal with. Because there often seems so little acutely wrong to treat, treatment may go by default. But we can take some steps.

These patients are bad risks with drugs. Drugs should not be prescribed for people who have recently poisoned themselves unless they cannot get at the supply. This precaution should also apply to the tablets of other members of the household. The general practitioner should visit the home and destroy all stocks of medicines there which are not in current use. Most episodes are impulsive. If there are no pills handy the impulse may well pass. People stick to one pattern. We do not think patients would turn to more drastic measures, self-injury or the use of household domestic poisons.

The people whom we fail to protect are the people we do least for. They fall principally into three groups:

(1) In some cases we misappreciated the situation at our necessarily short initial appraisal. Sometimes the whole story did not emerge until later.
(2) Some patients have personality disorders which we lack the resources or knowledge to deal with effectively. But many with personality abnormalities would benefit from prolonged contact with someone, a psychiatric social worker, a mental welfare officer, a health visitor, or, when he is willing, a general practitioner. There need be no great therapeutic aspiration. It is continuing availability of support that is required.
(3) Similar considerations apply with even more force to those who, without much, if any, abnormality themselves, are trapped in an unbearable social situation, for instance with abnormal or excessively difficult relatives. They do not need formal treatment but the apparent resolution of interpersonal disturbances brought about in the ward immediately following the act does not necessarily endure. Bedside reconciliations are often impermanent. When the patient returns home the old animosities reassert themselves. Such patients ought to be followed for about three months after their discharge so that one may opportunely intervene if necessary. After this, if further support is indicated, the health visitor, given access to the psychiatrist, is in a good position to continue.

Once they have been evaluated psychiatrically the subsequent management of many of these patients can be as much a social as a psychiatric matter. But people who poison or injure themselves are brought to *hospitals* and the physician or surgeon calls for psychiatric help. After physical recovery, if admission is needed to remove patients from an explosive domestic situation this will have to be to a psychiatric bed. Asylum is not a word psychiatrists use much nowadays, nor are they keen to bestow it. Yet many of these patients need a temporary refuge.

When out-of-hospital care is required there are many patients for whom a psychiatrist's time is not necessary. It is, however, essential to provide the patient with an alternative way of securing support at the very moment when he feels he must have it. Emergency services must be offered to provide emergency relief. The patient must know that he can get help without having to pay the price of self-poisoning or self-injury.

REFERENCES
Batchelor I R C (1954) *Brit. J. med. Psychol.* **27**, 158
Ettlinger R W (1964) *Acta psychiat. scand.* **40**, 363
Henderson D K (1942) *J. ment. Sci.* **88**, 485
Hove H (1953) *J. Amer. med. Ass.* **152**, 1649
Jansson B (1962) *Acta psychiat. scand.* **38**, 183
Kessel N (1965) *Brit. med. J.* ii, 1265, 1336
Kessel N, McCulloch W, Hendry J, Leslie D, Wallace I & Webster R (1964) *Scot. med. J.* **9**, 333
McCulloch W (1965) MSc Thesis, Edinburgh
Stengel E & Cook N G
(1958) Attempted Suicide. Maudsley Monograph No. 4. London
Tuckman J & Youngman W F (1963) *Publ. Hlth Rep., Wash.* **78**, 585

Initial Assessment of Suicidal Risk [*Abridged*]

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The irrevocable consequences of mistaken judgment colour every aspect of our handling of the suicidal patient, but in none more so than in our first decision, which is whether to treat a new patient as an inpatient or an outpatient. The anxieties for the psychiatrist are increased by the fact that suicide is not a circumscribed entity but a method of reacting to stress which cuts across most of the formal diagnostic categories. Neither are the precipitating conflicts characteristic: they seem to be common to other people of similar age and circumstances (Moss & Hamilton 1956). Thus there can be no simple guide to assessing suicidal risk.

In order to come to an informed decision about the degree of suicidal risk in an initial consultation, and the safety of outpatient treatment, five interrelated aspects of the total situation need to be assessed:

(1) Suicidal motivation.
(2) The intrapsychic balance of power.
(3) The patient's social environment.
(4) Therapeutic facilities.
(5) The degree of rapport between the doctor and the patient.

I have taken for granted the ability to make an accurate formal diagnosis, particularly of psychotic depression in its various manifestations. With the rapid response to physical treatments, many of these patients, who are grave suicidal risks, are being treated as outpatients and so finer decisions are having to be made on cases of borderline manageability.

Suicidal Motivation

Whether the precipitating stresses are due to environmental causes of frustration and unhappiness, or to intrapsychic causes of depression and guilt feelings, the suicidal patient's attempts to resolve the conflict may take a number of forms, including:

(1) *Communicating suicidal feelings*, where the aim is to elicit a response not otherwise forthcoming. They try to convey the seriousness of their distress to people who they feel have not noticed or do not fully understand. As a last resort, by making overt suicidal threats or gestures, they try to force people who do not seem to care, to yield under the threat of being held responsible for their deaths.
(2) *The wish to die*, which follows loss of hope, is felt as the only escape from unbearable torment, death being conceived as a state of peace, or a state of nothingness with affinities to sleep. In another group of patients there is the hope of reunion with a lost loved figure. However, even in those patients driven by an apparently unequivocal wish to die, an unconscious appeal can be discerned when they communicate this wish to a third party (Stengel *et al.* 1958). In 1959 Robins *et al.* reported that 69% of their group of suicides had previously communicated their suicidal ideas, in the majority of instances repeatedly and to many persons, so that one must presume that the failure of an adequate response to these appeals was followed by the abandonment of hope.

A life-saving compromise may be discerned in those patients who are dependent on short periods of oblivion for temporary respite from their