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Motivation in deliberate self-harm

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SUMMARY

Fifty adult patients presenting with deliberate self-harm at the Royal Victoria Hospital were given a choice of nine reasons for their actions. Most chose more than one reason and all but two of the 24 who said that they wished to die chose at least one other motive. There were no trends with respect to sex, past history, or method of deliberate self-harm. These results illustrate the complexity of this condition and show the importance of investigating motives beyond simply the intent to die.

INTRODUCTION

Since Stengel [1] observed that attempted suicides could usefully be distinguished from completed suicides in terms of clinical and demographic characteristics, motivation in attempted suicide has been an area of study. The most studied motive is usually the intent to die, probably because this is of greatest importance in the clinical effort aimed at prevention of future suicide. There is a danger, however, that, if too much emphasis is placed on the intent to die, then other related motives could be under-assessed. In extreme cases the degree to which other motives are important might be simply judged to be inversely proportional to the degree of suicidal intent. This dichotomous thinking is influential in determining the attitudes of professionals to individuals who have attempted suicide. Studying attitudes towards self-poisoning in a general hospital, Ramon et al [2] noted that 'doctors were more accepting of the "wish to die" motive than of the others, and tended to see behaviour as either suicidal or manipulative, being relatively unsympathetic to the latter'. This theory can be harmful to patient management in that it leads to lack of enthusiasm, to a relationship of mistrust and hostility between doctor and patient and to an inability to identify motives other than suicidal intent which are important in management.

Kreitman [3] described five themes which may be seen in attempted suicide: a blind reaction to escape immediately from stress or to relieve tension, attention-seeking, seeking to induce anxiety or guilt in others, testing the benevolence of fate, and true, but frustrated, suicidal intent. He says 'It would be mistaken to think that most patients show only one of the list just enumerated. In most parasuicides the motives are multiple and may be mutually contradictory'. This statement reflects the conclusion of a body of research beginning as early as the 1950s and most recently carried out by a group of researchers in Oxford.[4]

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The purpose of this study is to examine the motives for attempted suicide of patients admitted to the Royal Victoria Hospital, Belfast. It is part of a larger study aimed at the analysis of attempted suicide and social factors.

PATIENTS AND METHODS

One of the authors (GL) was informed of all patients admitted to the Royal Victoria Hospital with a diagnosis of deliberate self-harm. They had presented at the accident and emergency department which has a policy to admit all such cases. The patients had to fulfil the criterion of non-fatal deliberate self-harm,[5] that is, 'a deliberate non-fatal act, whether drug overdosage or poisoning, done in the knowledge that it was potentially harmful and in the case of drug overdosage that the amount taken was excessive'. Individuals had to be at least 16 years old at the time of the act. They were excluded if they were unable to remember the circumstances or reasons behind the act (one demented patient), if they were unco-operative at the time of the study (one), or if they were in hospital at the time of the act (one).

During the period of the study, 65 patients were admitted to the Royal Victoria Hospital fulfilling the study criterion. The 15 who were not studied had either signed themselves out of the Hospital before they could be seen (five), did not otherwise stay long enough to be seen (seven) or had been transferred and could not be traced (three). They did not differ in sex ratio, mean age or method of deliberate self-harm from the study population. No other demographic information was available from this group.

Fifty patients were therefore interviewed by one of us (GL) and the following information was obtained:–

Demographic details.

Method of deliberate self-harm.

The Beck Suicidal Intent Scale.[6]

Patients were shown a series of cards, each of which stated a possible motive. They were asked to select which card, or cards, best described how they felt at the time of the act. The range of motives was:–

(a) To make people understand how desperate you were feeling.
(b) To get relief from a terrible state of mind.
(c) To escape for a while from an impossible situation.
(d) To seek help from someone.
(e) To find out whether or not someone really loved you.
(f) To make people sorry for the way they have treated you;
to frighten or get your own back on someone.
(g) To try to influence some particular person or get them to change their mind.
(h) To show how much you loved someone.
(i) To die.

This method of choice is closely based on earlier work by the Oxford group of researchers. Our results are compared with the findings of this group in earlier studies.

RESULTS

The population consisted of 24 men and 26 women. The mean age was 34·4 years old (SD 13·9). The mean age for men was 37·2 years (SD 16·2), and, for women, 31·8 years (SD 12·0). There was a past history of deliberate self-harm in 19 cases and a past history of treatment by a psychiatrist in 27 cases. Forty-three patients had taken an overdose, three had both taken an overdose and injured themselves by self-cutting, and one had carried out self-cutting alone. One had jumped from a bridge, one ingested bleach and one undertook self-poisoning by domestic gas. Twenty-four patients were seen within 24 hours, a further 15 within 48 hours and the rest after a longer period of time. One was seen after 15, another after 22 days.

Twenty patients were unemployed, five were on invalidity benefit and two were retired. The remainder were either housewives or in employment.

The number of cards chosen is given in Table I. The percentage frequency for each card selected is shown in Table II, together with details of percentage frequencies of other groups studied in the same, or a very similar way.[7, 8, 9, 10] Although the numbers are small, there was no significant correlation between the choice of cards and age, sex, past history of deliberate self-harm or method. The card 'To die' was associated with a significantly higher score on the Beck Suicidal Intent Scale (t test, $p < 0{\cdot}02$).

TABLE I

Number of cards chosen per patient

Cards chosen	*Patients*	*Patients who had already chosen the card 'To die'*
0	1	3
1	8	10
2	18	1
3	8	3
4	8	4
5	4	3
6	3	—

TABLE II

Frequency of alternative motives in this and other studies

Motive	*Number*	*This study* 50	*Bancroft et al (1976)* 128	*Bancroft et al (1979)* 41	*Hawton et al (1983)** 50	*James et al (1985)* 34
Make people understand	22	44%	**	20%	42%	35%
Relief from state of mind	25	50%	52%	44%	42%	70%
Escape from impossible situation	20	40%	42%	32%	42%	44%
Seek help	14	28%	33%	15%	18%	29%
Find out whether loved	10	20%	**	10%	24%	17%
Make people sorry or frighten them	8	16%	15%	10%	32%	12%
Influence, change someone's mind	7	14%	19%	7%	26%	21%
Show love	9	18%	20%	24%	26%	24%
Die	24	48%	44%	**	**	65%

*Study of adolescents. **This motive not presented in the study.

DISCUSSION

With regard to the study population, any conclusions from a hospital sample can be cautiously interpreted only insofar as they apply to the entire population of those who attempt suicide. This study is, however, reasonably representative within this community of the adults who contact hospitals. Almost all patients who attempt suicide and present at the Royal Victoria Hospital accident and emergency department are admitted.

Any study of motivation has to contend with the possibility that what might be declared as a motive is, in fact, simply a justification. In addition, some motives may be falsely declared and others denied — consciously or unconsciously. Furthermore, there is conflicting evidence as to whether motives chosen by patients correspond with assessment of motives produced by psychiatrists or by the patient's close relatives.[8, 9, 10] The uncertainty over validity can be an objection to any study of motivation. This particular method may be criticised because it presents a limited range of alternatives. On the other hand, it reduces observer error, results can be compared across various populations and it appears to be acceptable to patients. Regarding the demographic details of the population, the approximately equal sex ratio and the relatively high mean age are of some interest. It may be that this reflects a trend to a more equal sex ratio and higher mean age of attempted suicides. The Beck Suicidal Intent Scale score corresponds closely to that found in other hospital-based studies in the United Kingdom.

Two studies have been reported from Northern Ireland. Lukianowicz,[11] reporting on 100 consecutive female admissions with attempted suicide in 1962 and 1963 to Holywell Hospital, Antrim, found that in 75 cases there was evidence of gain, while of the other 25 'some subtle gain was probably achieved in these cases also'. Robertson, Savage and Herron [12] reported a number of features in cases of attempted suicide admitted to the Ulster Hospital, Dundonald. They presented their clients with a list of reasons and asked 'Of these reasons which are the strongest?' In reply, 13·2 per cent reported 'A desire to end it all', 22·8 per cent were indifferent, 19·1 per cent reported despair or hopelessness, 17·6 per cent a wish to escape from problems, 11·7 per cent anger or frustration and 12·5 per cent another motive. In their study the intent to die seemed to be incompatible with any other motive. This contradicts much of what has been found elsewhere and is not consistent with clinical experience. It also perpetuates the false dichotomy referred to earlier, that either one intends to die or one has another motive but not both.

The comparison shown in Table II between various studies carried out using very closely related methodology shows a marked consistency in both the percentage frequency of each choice of motive and the rank order of motives, which supports the reliability of this method.

This study supports the conclusion that intent to die is not the most common motive, and that it is the exclusive motive in only a minority of cases. More hostile or manipulative motives are those least often selected. It is possible that this might be because these motives would be judged less socially acceptable and therefore less likely to be chosen on reflection. Similarly, the frequency of the intent to die may be exaggerated. The validity of this method may be strengthened by the fact that there was a statistically significant association between the choice of intent to die and a high score on the Beck Suicidal Intent Scale. It is perhaps surprising that no trend with age was found. It might be expected from clinical experience and from the study reported on adolescents,[9] that more manipulative

motives may be found in a younger age group. This may be due to the exclusion of the under-16-year-old patients. The motive associated with the highest mean age (40·0 years) was 'To try to influence some particular person or get them to change their mind', which is one of the most manipulative choices presented.

Most importantly, this study illustrates the complexity of motivation in attempted suicide. It argues strongly against the analysis of motivation as being either intent to die or some other motive. Enquiry about motivation should not stop at the first answer, and, since the patient might stop anyway unless strongly prompted, there is a case for the presentation of a wide range of alternatives. This is economical of time and in almost every case elicits a response. At the very least, clinicians should be aware of the wide range of alternative motives in deliberate self-harm, which can have an important bearing on the quality of patient management.

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