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Motives for Suicide Attempts—the Views of the Patients

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This study was designed to investigate the motives patients give for attempting suicide and the associations between these motives and diagnosis, various psychiatric features, suicidal intent and socio-demographic characteristics. The Motives for Parasuicide Questionnaire (MPQ), comprising 14 suggested motives, was presented to 53 patients at a psychiatric ward that specialized in suicide attempters. Escape motives were very common, whereas interpersonal motives were rare. Patients with substance abuse, anxiety, or personality disorders more often chose communicating motives and mentioned higher numbers of motives than those with mood or adjustment disorders. Hopelessness was positively associated with a stated wish to die and with escape motives, and negatively correlated to communicating/unclear motives. Suicidal intent was related to some motives. The psychiatric disorder or mental state seems to be more important than socio-demographic characteristics for the choice of motives. Further studies are required to investigate the associations between psychiatric features and motives, as well as the clinical usefulness of such assessments.

Keywords hopelessness, motives, psychiatric disorder, suicidal intent, suicide attempt

Suicide attempters are a group of subjects at great risk of making new attempts, or even completing suicide. In fact, a previous suicide attempt is one of the strongest factors predictive of future suicidal behavior known today

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(Barraclough, 1987; Leon, Friedman, Sweeney, Brown & Mann, 1990; Retterstøl & Mehlum, 2001; van Egmond & Diekstra, 1989). Among suicide attempters, a number of risk factors for future suicide or suicide attempts have been identified, including various socio-demographic and psychiatric features of the patients and the nature of the current suicide attempt (Sakinofsky, 2000). Patients' subjective motives for attempting suicide have also been reported to have a value in predicting future suicidal behavior (Hjelmeland, 1996; Hjelmeland et al., 1998; Kotila & Lönnqvist, 1989; Soukas, Suominen, Isometsä, Ostamo, & Lönnqvist, 2001). However, the views of the patients have not been as extensively investigated as, for example, sex, age, suicidal intent or psychiatric disorders.

To our knowledge, only a few previous studies have been designed primarily to investigate the views of the patients concerning the motives for attempted suicide. Some of these studies were descriptive (Bancroft, Skrimshire & Simkin, 1976; Bancroft et al., 1979; Michel, Valach & Waeber, 1994; Williams, 1986), and a couple were designed to determine the predictive value of motives given by suicide attempters (Hjelmeland, 1996; Hjelmeland et al., 1998). In most previous studies only a limited number of variables were combined with the motives. Hjelmeland and co-workers (1998) found that various motives assessed by the Motives for Parasuicide Questionnaire (MPQ) and suicidal intent rated by means of the Suicidal Intent Scale (SIS) had some value in predicting repetition of the suicide attempt, but suggested a combination of motives with other variables in order to increase the predictive value. This piece of advice is probably important for descriptive studies as well, in order to provide a more complete picture of the patient characteristics. In the present study we therefore investigated a number of clinical rating scales of importance for suicidal behavior along with

socio-demographic data, diagnosis and occurrence of previous suicide attempts in addition to the assessment of the motives.

The clinical rating scales employed in this study measure suicidal intent, hopelessness, general psychopathology and depressive symptoms. A high suicidal intent at an index suicide attempt has been stated to predict future death by suicide (Sakinofsky, 2000), whereas a low suicidal intent on the same occasion has been reported to be predictive of non-fatal repetition (Hjelmeland et al., 1998; Kerkhof et al., 1998; Pierce, 1984; Öjehagen, Danielsson & Träskman-Bendz, 1992).

Hopelessness has been found to be predictive of future suicidal behavior in some studies (Beck, Steer, Kovacs, & Garrison, 1985; Beck, Brown, Berchick, Stewart & Steer, 1990; Fawcett et al., 1987), but in others not (Niméus, Träskman-Bendz & Alsén, 1997). Since the subjects in this study were admitted to in-patient treatment at a psychiatric ward (following their suicide attempt) where a research program concerning different aspects of suicidal behavior was running, a large number of assessments were conducted. This gave us the opportunity to include variables such as general psychopathology and depressive symptoms. We considered these ratings to be of interest as they could be seen as complements to diagnosis in describing the psychiatric features of the patients, as well as factors of possible importance for suicidal behavior per se. It is well known that there is an association between depression and suicidal behavior (Lönnqvist, 2000). Other psychiatric disorders, such as schizophrenia and personality disorders, have also been suggested to be important factors in such patients' suicidal behavior (De Hert & Peuskens, 2000; Linehan, Rizvi, Welch & Page, 2000).

The goals of the study were twofold:

1. To survey what kind of motives patients give for attempting suicide.

2. To investigate whether and how the type and number of motives mentioned were related to socio-demographic data and clinical characteristics known to be of importance for suicidal behavior.

METHOD

Sample

The sample consists of 53 suicide attempters admitted to a psychiatric ward specialized for such patients. Out of all suicide attempters investigated at the Medical Emergency Intensive Unit (MEIU) at the Lund University Hospital, 50–60% are referred to this psychiatric ward, and the others to psychiatric outpatient treatment (Niméus, Alsén & Träskman-Bendz, 2000a). The patients in this study constitute 41% of all suicide attempters who participated in suicide prevention research at the specialized psychiatric ward between 1992 and 1999 (N = 128). The research program included an investigation by a social worker, but the particular investigation concerning the patients' motives was not always performed due to lack of time and change of social workers. Thus there was no systematic selection of patients included in this study. Our sample was found to be representative of patients treated at the psychiatric ward following a suicide attempt concerning distribution of diagnoses, age, gender, number of previous suicide attempts and scores on the clinical rating scales used in this study.

Procedures

Definitions. A suicide attempt was defined as 'a situation in which a person has performed an actually or seemingly life-threatening behavior with the intent of jeopardizing his life, or to give the

appearance of such an intent, but which has not resulted in death' (Beck et al., 1972).

Repeaters were defined as patients who had made at least one previous suicide attempt, and they constituted 37% of the patients.

Social Investigation. An investigation of social characteristics was carried out within 14 days after admission. A social worker conducted a semi-structured interview with the patient in order to investigate present socio-demographic characteristics, motives for the suicide attempt and previous suicidal behavior.

As a part of the social investigation the patient filled out a self-report form on suggested motives for the suicide attempt: the Motives for Parasuicide Questionnaire (MPQ; see below). The social worker was always present as a support and to answer eventual questions about the form.

Assessment of Motives. In the present study the Motives for Parasuicide Questionnaire, the MPQ, was employed. This self-report form was especially designed for the European Parasuicide Study Interview Schedule (EPSIS) (Kerkhof, Bernasco, Bille-Brahe, Platt & Schmidtke, 1993) according to the work of Bancroft and co-workers (1976). The EPSIS, in turn, is an instrument constructed for the Repetition Prediction Project of the WHO/EURO Multicentre Study on Parasuicide (Stiles et al., 1993). The MPQ consists of 14 suggested motives, to which the patients give answers on a three-point (0–2) scale: no, minor or major influence (Table 2).

Psychiatric Diagnosis. The patients were diagnosed according to DSM-III-R, Axis I and II (American Psychiatric Association, 1987) by two independent psychiatrists, and in case of disagreement there was a consensus procedure.

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Hopelessness. The patients' sense of hopelessness was rated at the psychiatric ward by means of Beck's Hopelessness Scale (HS), which is a self-rating scale consisting of 20 items (Beck, Weissman, Lester & Trexler, 1974a). When constructing this scale in the early seventies, Beck and co-workers gathered items both from a test on future attitudes and from empirically well-known pessimistic statements from psychiatric patients. Maximum score is 20 points.

General Psychopathology and Depressive Symptoms. Psychiatric symptoms were assessed using the Comprehensive Psychopathological Rating Scale (CPRS) (Åsberg, Perris, Schalling & Sedvall, 1978). Depressive symptoms were measured by means of the Montgomery-Åsberg Depression Rating Scale (MADRS), which consists of 10 items extracted from the CPRS. Maximum score is 40 points (Montgomery & Åsberg, 1979). The evaluation was performed by the psychiatrist at the ward.

Severity of Suicidal Intent. The patients' suicidal intent was investigated at a Medical Emergency Intensive Unit (MEIU) by means of the Suicidal Intent Scale (SIS). This scale consists of 15 items; 8 of them dealing with objective circumstances of the suicide attempt and 7 concerning the patient's own attitudes and feelings toward the attempt. In the present study we included these two subscales as individual variables (SISobj and SISsubj), in addition to the total score. Maximum total score is 30 points (Beck, Herman, & Schuyler, 1974b).

Ethical Approval. The study was approved by the Research Ethics Committee of the Medical Faculty at the University of Lund. The patients gave informed written consent to participate in the study.

Statistics

The statistical calculations were performed in SPSS (Statistical Package for the Social Sciences), version 10.0 (Norusis, 1995). The Chi-square test was used to analyze differences in proportions of patients. Comparisons between subgroups were carried out with non-parametric tests, Mann-Whitney U-test or Kruskal-Wallis test. Spearman's rho was used for analyzing non-parametric bivariate correlations. Results were considered significant when $p < .05$.

The motives were analyzed by means of a factor analysis to identify underlying patterns in the responses, thereby reducing the number of items to a more manageable set of measures. Thirteen of the fourteen motives were subjected to a principal component factor analysis with Varimax rotation. The item "I wanted to die" was not included in the analysis since it was considered to differ in logical content from all other items, being the only item directly expressing a wish to die. The motive "I wanted to make things easier for others" did not load sufficiently into any of the factors, and was thus excluded when a second factor analysis was carried out.

The internal dropout in the remaining 12 items was dealt with by pair-wise exclusion. A four-factor solution was chosen on basis of eigenvalues (>1), explained variance and logical content. A factor value was then calculated for each factor and respondent, by adding together the answers to the items within each factor. (The response "no influence" was given the value 0, "minor influence" = 1 and "major influence" = 2.)

RESULTS

Patient Characteristics

An overview of the patient characteristics is shown in Table 1. Out of the 53

TABLE 1. Socio-demographic and Clinical Characteristics in 53 Patients Admitted to a Psychiatric Ward Following a Suicide Attempt

	n (%)
Men/women	25 (47)/28 (53)
Age (M ± SD)	36 ± 13
Married/cohabiting	19 (36)
Divorced/widowed	7 (13)
Never married	27 (51)
Employed/studying	35 (66)
Unemployed/empl. training	14 (26)
Disability pension	2 (4)
Old age pension	2 (4)
Children	30 (57)
Major depression	14 (26)
Dysthymia	2 (4)
Depression NOS	5 (9)
Adjustment disorder	14 (26)
Anxiety disorder	3 (6)
Substance use disorder	3 (6)
Others	5 (9)
Axis II disorder (only)	7 (13)
Repeaters	18 (34)

patients, 25 (47%) were men and 28 were women. Patient characteristics did not differ significantly between men and women. The median age of the sample was 31 years, range 18–67.

Approximately half of the patients had never been married and more than 10% were divorced/widowed, whereas some 35% were married/cohabiting.

About half of the patients were ordinarily employed and another 15% were students.

The most common diagnoses were major depression (n = 14) and adjustment disorder (n = 14). For the purpose of statistical calculations, the diagnoses were organized into three main categories. Major depression, dysthymia and unspecified depression were put together, labelled “mood disorders” (n = 21). The same was performed with anxiety disorders, substance use disorders, other diagnoses and those who only had an axis II diagnosis, labelled “others” (n = 18). Adjustment

disorder remained a category of its own (n = 14).

Some patients had more than one DSM III-R axis I diagnosis; 12 patients (22%) had two axis I diagnoses and one patient had three. Seven patients (13%) had an axis II diagnosis only, whereas 20 patients (38%) had an axis II diagnosis in addition to their axis I diagnosis/diagnoses. Forty-two percent (n = 8) of the patients with mood disorder also had an axis II disorder, and the corresponding figure for those with an adjustment disorder was 29% (n = 4). Within the diagnostic subgroup of “others” 44% (n = 8) showed axis II disorder comorbidity, whereas 39% of them (n = 7) had an axis II disorder only. Taken together, 83% (n = 15) within the subgroup “others” had an axis II disorder. In all, 51% of the patient sample had an axis II diagnosis.

The median SIS score in this sample (n = 50) was 18, range 1–26, and men had higher scores than women (19.7 ± 4.5 vs. 14.3 ± 5.7, M ± SD; p < .001). The median CPRS score was 20.25, range 3.00–46.50 (n = 50), and on the MADRS the median score was 8.8, range 0.5–21.5 (n = 50). The median HS score was 9, range 1–19 (n = 44). There were no significant sex differences in the latter ratings.

Patients with adjustment disorder had lower scores on the HS than did patients with mood disorder or other diagnoses (6.2 ± 4.3 vs. 11.5 ± 5.2 and 10.4 ± 5.2, respectively, M ± SD; p < .05). Those with an adjustment disorder also had lower scores on the CPRS than patients in the other two diagnostic subgroups (adjustment disorder: 6.2 ± 4.3 vs. mood disorder: 11.5 ± 5.2 and others: 10.4 ± 5.2, M ± SD; p < .05).

Motives for Attempted Suicide

The motives are listed in order of frequency of affirmative answers in Table 2.

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TABLE 2. Affirmative Answers Given by Suicide Attempters to a List of Suggested Motives for Attempted Suicide

Motive	Minor + major influence (%)	Major influence (%)
I wanted to get away from an unacceptable situation	94	89
The situation was so unbearable that I could not think of any other alternative	93	85
My thoughts were so unbearable; I could not endure them any longer (N = 52)	88	67
I wanted to die (N = 52)	81	69
It seemed that I lost control over myself, and I do not know why I did it	67	31
I wanted to get help from someone (N = 51)	57	33
I wanted to make things easier for others (N = 52)	56	19
I wanted others to know how desperate I felt	42	21
I wanted to sleep for a while (N = 52)	31	25
I wanted to know if someone really cared about me (N = 51)	22	8
I wanted to show someone how much I loved him/her	15	4
I wanted to persuade someone to change his/her mind (N = 51)	14	8
I wanted others to pay for the way they treated me (N = 51)	12	2
I wanted to make someone feel guilty (N = 51)	12	4

When nothing else is given, N = 53.

The motive most often noted (answers 'minor' and 'major influence' taken together) was "I wanted to get away from an unacceptable situation" and almost as common as that was the item "The situation was so unbearable that I could not think of any other alternative." The third most common motive was "My thoughts were so unbearable, I could not endure them any longer," which, just like the two most common ones, is a non-communicating, escape-oriented motive. About eight out of ten patients mentioned the item "I wanted to die," making this the fourth most frequent one. The motive "It seemed that I lost control over myself, and I do not know why I did it" came in fifth, mentioned by approximately two thirds of the patients. The two motives with the highest rates of affirmative answers were also those most often stated to have had a

major influence. "I wanted to die" was the third most common motive with major influence, and "My thoughts were so unbearable, I could not endure them any longer" was number four.

The least common motives were "I wanted to make someone feel guilty," "I wanted others to pay for the way they treated me" and "I wanted to persuade someone to change his/her mind," that is communicating items of a punishing or manipulating nature.

Types of Motives in Relation to Socio-Demographic Data and Clinical Characteristics

As described in statistics, a factor analysis was conducted, resulting in a

four-factor solution. These factors together explained 71% of the total variance. After inspection of the item content, the factors were labelled: "punishment/manipulation factor" ($\alpha = .89$), "communicating and unclear motives" ($\alpha = .74$), "escape factor" ($\alpha = .56$) and "seeking attention factor" ($\alpha = .65$). The item content and loadings in each factor are shown in Table 3. The motives "I wanted to die" and "I wanted to make things easier for others" were individually investigated in relation to patient characteristics since they were not included in any factor.

An overview of the correlations between the motive factors, the two individual motives and clinical rating scales is shown in Table 4.

The Punishment/Manipulation Factor. This factor consists of the three items: "I wanted to make someone feel guilty," "I wanted others to pay for the way they treated me" and "I wanted to persuade someone to change his/her mind," that is, the least common motives. Maximum score was 6 points. The mean factor value in the sample was 0.5 ± 1.3 . None of the patients with an adjustment disorder chose any of the items in the punishment/ manipulation factor. The diagnostic subgroup "others" (axis II disorders, anxiety disorders, substance abuse, etc.) scored higher in this factor than did the other two subgroups (1.2 ± 2.0 vs. 0 ± 0 and 0.24 ± 0.62 , respectively, $M \pm SD$; $p < .05$). The significant difference was between the adjustment disorder group and the subgroup of "others."

There was no correlation between this factor and the total SIS score, but when considering only the SIS items dealing with the objective circumstances of the suicide attempt, there was a negative correlation with the punishment/manipulation factor ($r = -.30$, $p < .05$). This means that patients who gave more punishing or manipulating motives for their suicide attempt scored lower on the SIS items

concerning the objective circumstances of the attempt (such as precautions taken to prevent being discovered and planning of the act) than did patients with relatively lower punishment/manipulation factor scores.

The Factor of Communicating and Unclear Motives. The items in this factor are: "I wanted to get help from somebody," "I wanted others to know how desperate I felt," "I wanted to sleep for a while" and "It seemed I lost control over myself, and I do not know why I did it." The mean factor value in the sample was 3.0 ± 2.5 and since the factor consists of four items, the maximum score was 8 points.

Three variables were associated with this factor, namely: diagnosis, suicidal intent and hopelessness. Patients within the diagnostic subgroup "others" had higher factor values than those within the adjustment disorder and mood disorder subgroups (4.1 ± 2.2 vs. 2.5 ± 2.8 and 2.4 ± 2.3 , respectively, $M \pm SD$; $p < .05$). The total SIS score was negatively correlated to the factor of unclear and communicating motives ($r = -.56$; $p < .01$), and so was the total HS score ($r = -.31$; $p < .05$), that is, the more perceived influence by unclear and communicating motives the lower the suicidal intent and hopelessness scores. (There was no correlation between SIS scores and HS scores.)

The Escape Factor. This factor is made up of three items: "My thoughts were so unbearable; I could not endure them any longer," "The situation was so unbearable that I could not think of any other alternative" and "I wanted to get away from an unacceptable situation," with a maximum factor value of 6 points. The mean factor value in the sample was 5.1 ± 1.3 . The escape factor was positively correlated to hopelessness ($r = .34$; $p < .05$), that is, the higher score on the HS, the higher value in the escape factor.

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TABLE 3. Rotated Component Matrix, Showing the Items and Their Loadings in the Factors

Item	F1	F2	F3	F4
I wanted others to pay for the way they treated me	0.93			
I wanted to make someone feel guilty	0.91			
I wanted to persuade someone to change his/her mind	0.84			
I wanted to sleep for a while		0.77		
I wanted to get help from somebody		0.74		
I wanted others to know how desperate I felt		0.63		
I lost control over myself; I do not know why I did it		0.62		
My thoughts were so unbearable; I couldn't endure them			0.81	
The situation was unbearable; couldn't think of alternative			0.71	
I wanted to get away from an unacceptable situation			0.65	
I wanted to show someone how much I loved him/her				0.90
I wanted to know if someone really cared about me				0.75

F1: Punishment/manipulation factor, F2: Factor of communicating and unclear motives, F3: Escape factor, F4: Seeking attention factor.

Patients with adjustment disorder differed from the two other diagnostic subgroups taken together, in that the former had lower factor values than the two latter (4.8 ± 1.1 vs. 5.3 ± 1.4 , $M \pm SD$; $p < .05$).

The Seeking Attention Factor. This factor comprises two items: "I wanted to show someone how much I loved him/her" and "I wanted to know if someone really cared about me," with a maximum factor value of 4 points. The mean factor value in the sample was 0.47 ± 0.91 .

This factor was not significantly related to any socio-demographic data or any clinical characteristics. However, the total SIS score tended to be negatively correlated to the seeking attention factor ($r = -.27$, $p = .057$), that is, the higher the factor value, the lower the suicidal intent.

An Expressed Wish to Die. The item "I wanted to die" was the fourth most common motive given an affirmative answer and the third most frequent one stated to have had major influence.

There was a positive correlation between this item and the total HS score ($r = .33$, $p < .05$), that is, the more moti-

vated by a wish to die, the higher the hopelessness score. The motive "I wanted to die" was also positively associated with the score on the subjective items on the SIS ($r = .32$, $p < .05$).

Patients within the diagnostic subgroups "mood disorder" and "others" gave affirmative answers to this item more often than patients with adjustment disorder (81% and 94% vs. 57%, respectively; $p < .05$).

"I Wanted to Make Things Easier For Others". This item was positively related to the total MADRS score ($r = 0.56$, 0.56 , $p < .01$), that is, the more depressive symptoms, the more influence this item was stated to have. There was also a positive association with the total CPRS score ($r = .41$, $p < .01$).

Number of Motives Chosen

The mean number of affirmative answers to the suggested motives (i.e. the number of motives of 'minor influence' plus those of 'major influence') was 6.6 ± 2.4 (range 2-13), and the mean

TABLE 4. Correlations Between Motive Factors, Individual Motives and Suicidal Intent (Total Score, Objective and Subjective Items), General Psychopathology, Depressive Symptoms and Hopelessness

Rating scale	Punishment/Manipulation Factor (F1)	Communicating and Unclear Motives (F2)	Escape Factor (F3)	Seeking Attention Factor (F4)	Wanting to Die	Wanting to Make Things Easier for Others
SIS	r = -.26	r = -.56**	r = -.10	r = -.27	r = .24	r = .04
SIS _{obj}	r = -.30*	r = -.41**	r = -.20	r = -.22	r = .07	r = .07
SIS _{subj}	r = -.18	r = .45**	r = -.04	r = -.26	r = .32*	r = .08
CPRS	r = -.04	r = .01	r = .25	r = -.06	r = .06	r = .41**
MADRS	r = -.05	r = .03	r = .15	r = -.06	r = .06	r = .56**
HS	r = -.21	r = -.31*	r = .34*	r = -.19	r = .33*	r = .06

Spearman's rho: *p < .05, **p < .01.

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number of motives given the answer 'major influence' was 4.5 ± 1.9 (range 0-9).

The number of motives (minor plus major) given by each respondent was related to two variables: diagnosis and suicidal intent. Patients in the diagnostic subgroup "others" noted more motives (8.0 ± 2.6 , $M \pm SD$) than patients with mood disorder (6.1 ± 2.2 , $M \pm SD$; $p < .05$) and adjustment disorder (5.6 ± 1.6 , $M \pm SD$; $p < .01$). There was a negative correlation between the number of motives and SIS score, that is, the more motives given, the lower the suicidal intent.

DISCUSSION

Representativity of the Sample

Our sample was found to be representative of all research patients treated at the specialized psychiatric ward following a suicide attempt during the period 1992-1999.

Follow-up of suicide rates of suicide attempters admitted to the Lund University Hospital indicates that those who have been treated as in-patients at the specialized psychiatric ward, such as those in the present study, represent a high-risk group of suicide attempters. At a 5-year follow-up of suicide attempters referred to a psychiatric ward, 13 % had committed suicide (Johnsson-Fridell, Öjehagen, & Träskman-Bendz 1996) compared to 4.7% of all suicide attempters admitted to the MEIU (Niméus, Alsén & Träskman-Bendz 2000b). We do not know whether the present results hold for suicide attempters in general.

A sample of 53 patients is a rather small one, which cannot always be divided into as many subgroups as one would have preferred, since that would create groups too small for statistical calculations. This is the case for the diagnoses, which had to be

forced into three categories, creating the rather heterogeneous group of "others" (substance abuse, axis II disorder only, anxiety disorders, eating disorders, etc.). Therefore some associations may have been missed.

Even though we performed a factor analysis in order to reduce the number of variables, we still cannot exclude the possibility of some significances by chance.

Main Findings

Non-communicating motives, especially those expressing a wish to escape from an unbearable situation or a terrible state of mind, were the most common ones. The motive "I wanted to die" was among the four most frequently chosen motives, stated by the majority of the patients. A stated wish to die at an index suicide attempt has been identified as a predictor for future death by suicide (Hjelmeland, 1996; Soukas et al., 2001), indicating that such statements should be taken seriously. Communicating (interpersonal) motives, in contrast to non-communicating ones, were only given by a minority of the patients in this study. This finding is consistent with results of other studies where the MPQ or similar questionnaires have been used to assess the patients' views on motives for attempted suicide (Bancroft et al., 1979; Michel et al., 1994; Williams, 1986).

Why do suicide attempters so seldom report interpersonal motives? This question is especially interesting since interpersonal problems frequently were stated as important for the suicide attempt by the patients in this sample (Skogman & Öjehagen, in press) - a contrast also reported by Michel and co-workers (1994). It seems that interpersonal motives are less socially acceptable than a true wish to die. It has, for instance, been found that the attitudes toward suicide attempters

among medical staff (including psychiatrists) depended on what motive the patient was believed to have had: If the motive was perceived as a sincere intent to die, the patient was met with more compassion than if it was presumed to be a wish to create a reaction from the surroundings (Hawton, Marsack & Fagg 1981; Ramon, Bancroft & Skrimshire 1975). It is possible that patients are cautious to gain social acceptance for their suicide attempt, and therefore avoid mentioning manipulating or attention-seeking motives.

Concerning the parallel with the frequent occurrence of interpersonal problems, it is of course possible for interpersonal problems to cause a suicide attempt, while the motive is to escape from the situation, a non-communicative reason. In other words, it may be that communicating motives were seldom mentioned because they really were less influential.

The patients in this sample who did mention punishing or manipulating motives more often belonged to the diagnostic subgroup "others." It is possible that patients with psychiatric disorders such as personality disorder (which was very common in this subgroup) are less sensitive to the norms of society concerning what motives are unacceptable, and thus would be less willing to admit to punishing or manipulating motives. Another possibility is that these patients more often have severe problems in their communication and relations with significant others, and that a suicide attempt is a way of communicating their feelings. It has been stated that the suicides of patients with a borderline personality disorder often are triggered by a separation from a significant other, and that they often take place in a mood of fury, mingled with despair (Wasserman, 2001). Suicides in substance abusers are often preceded by a loss in a close relationship (Murphy, 2000).

Patients within the diagnostic subgroup "others" also differed from patients

with mood disorder or adjustment disorder in that they scored higher in the factor of communicating and unclear motives. The content of this factor is somewhat difficult to logically comprehend, since it is made up of what seems to be two types of motives: two communicating, help-seeking items and two non-communicating items of a rather diffuse nature, whereof one may reflect an impulsivity of the act ("I lost control, and I do not know why I did it") and the other one a wish to escape ("I wanted to sleep for a while"). There is thus no obvious common denominator, but one conceivable explanation is that the suicide attempt for these patients is a "passive" outreach for help, which is carried out in an uncontrolled or impulsive way, and by which the attempter escapes responsibility by relying on others to find a solution. This explanation would make the negative association between suicidal intent and the factor of communicating and unclear motives logical, and concerning the high factor scores among "others" it might once again reflect a dysfunction in the communication with significant others.

The fact that patients in the subgroup "others" mentioned higher numbers of motives than other patients may indicate an inability of these patients to be precise about their reasons for attempting suicide. Whatever the explanation, it is clear that they mentioned communicating motives in addition to non-communicating ones, rather than instead of.

Hopelessness was positively associated with the escape factor and with the motive "I wanted to die," whereas it was negatively correlated to the factor of communicating and unclear motives. These findings are similar to the results from a study where Williams (1986) found escape motives to be the most central ones to high-hopelessness suicide attempters, whereas low-hopelessness suicide attempters focused on interpersonal (communicating) motives.

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Suicidal intent was, in addition to its relation with communicating and unclear motives, associated with the punishment/manipulation factor: The score on the SIS items concerning objective circumstances of the suicide attempt was negatively correlated to this factor score, while the total SIS score showed no such association. This means that patients who mentioned punishing or manipulating motives carried out their attempts in a way that they were more likely to survive, whereas their experienced (subjective) suicidal intent was not lower. As already mentioned, those in the diagnostic subgroup "others" gave this type of motive more often than other patients, but no association between diagnosis and suicidal intent was found.

None of the motive factors were related to any socio-demographic data or to the occurrence of previous suicide attempts. The differences between men and women concerning suicidal behavior have been discussed in several studies (Canetto, 1997; Canetto & Sakinofsky, 1998; Hawton, 2000). When we investigated the problems stated by the patients in this sample, we found that men and women mentioned different types of problems, women being more centered on relationship problems and mental illness, whereas men more often referred to socio-economical problems (Skogman & Öjehagen, in press). In this sample men scored higher on the SIS than did women, suggesting that there might have been a

higher proportion of "unsuccessful suicides" among men than among women. One might thus have expected to find some differences between the sexes concerning the report of motives, but none were found. As can be seen above, the motive factors were instead related to diagnosis and other psychiatric features and suicidal intent, that is the psychiatric disorder or mental state seems to be more important than socio-demographic features for the choice of motives.

One must be careful when making interpretations of the results in this study. Hopelessness was self-rated, just like the motives. Hence, an association between a certain type of motive and hopelessness only indicates that those two ratings are related and possibly even measure the same dimension of suicidality. Concerning suicidal intent, one might have proposed that patients who give motives positively associated with SIS score were at greater risk for future suicide. Such a suggestion is highly speculative, and follow-up studies are needed in order to confirm or disprove it. Studies of larger samples are needed in order to further investigate the relations between motives given by suicide attempters and the various psychiatric features associated with them, such as hopelessness, psychiatric diagnosis and suicidal intent. Follow-up studies are required in order to investigate the possible clinical use of motive assessment.

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