Understanding Suicidality: Suicide risk, sex differences and views of suicide attempters

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Problems of Importance for Suicide Attempts—the Patients' Views

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This study was designed to investigate suicide attempters' views on problems underlying their suicidal behavior. A questionnaire comprising 17 problems was presented to 54 non-consecutive patients (men/women = 25/29, mean age 36 ± 14 years) admitted to a specialized psychiatric ward following an attempt. (In the large majority of cases the method was self-poisoning. 37% had previously attempted suicide.) The most common problem was 'feelings of loneliness,' followed by 'mental illness or psychiatric symptoms.' Men more often experienced socio-economical problems, whereas women more often mentioned psychiatric problems and interpersonal relation difficulties. Patients diagnosed with adjustment disorder more often experienced recent/current problems in relationships than those with other disorders. High numbers of problems mentioned were related to being "never married/single," having a poor social network and many depressive symptoms. In addition to psychiatric problems, interpersonal problems were in focus to most patients. The importance of listening to the patients' own views on their problems after a suicide attempt is discussed.

Keywords EPSIS, sex differences, patients' views, problems, suicide attempters

Suicide attempters are 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 (Barraclough, 1987; van Egmond & Diekstra, 1989; Leon, Friedman, Sweeney, Brown & Mann, 1990). In order to improve prevention of suicidal behavior it is therefore important to increase the understanding of these patients.

Communication problems between health care professionals and suicidal patients have been perceived as commonly occurring and suggested to cause some difficulties in the treatment. Patients who are

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not sure that they will be understood and accepted are likely to keep their suicidal thoughts to themselves (Michel, Valach & Waeber, 1994). In order to form a working alliance, which is necessary for treatment success (Horvath & Symonds, 1991), it is important for the patient to be understood, and for the therapist to know how the patient reasons. Investigating the patients' own views on their suicidal behavior and related problems seems to be a key factor to the understanding of both the individual patient and of suicide attempters as a group.

A thorough assessment of suicide attempters is recommended to take place as soon as possible after an attempt. In this assessment, problems faced by the patient are listed as one of the factors that should be covered. Among other important patient characteristics to be assessed are suicidal intent, social situation, psychiatric disorder and previous suicide attempts (Hawton, 2000). Further, it has been stated in a sample of suicide attempters that these experienced far weaker social supportive networks than both healthy controls and samples of physically ill patients (Magne Ingvar, Öjehagen & Träskman-Bendz, 1992), making social network a variable of interest to this study. Structured questionnaires may facilitate these investigations. Concerning problem identification, such a questionnaire has been included in the European Parasuicide Study Interview Schedule, (EPSIS) designed for the WHO/EURO Multicentre Study on Parasuicide (Kerkhof, Bernasco, Bille-Brahe, Platt & Schmidtke, 1993).

In the present study, the EPSIS problem questionnaire was included among other investigations at a psychiatric ward specialized for suicide attempters, at Lund University Hospital of Sweden. Since a research program concerning different aspects of suicidal behavior was running at this ward, several assessments were conducted with the patients in the present sample. The data collection and assessments were thus not uniquely chosen for this study, giving us the opportunity to include such variables as depressive symptoms, whereas some information that might also have been interesting was unavailable.

As far as we know, little has been done to investigate whether there are any relationships between the problems experienced by the patients and other patient characteristics such as psychiatric diagnosis, depressive symptoms, suicidal intent and social network.

The aims of the present study were twofold: First to make a survey on what kind of problems suicide attempters find important for attempting suicide, and secondly to investigate whether and how the type and number of problems mentioned was related to socio-demographic data, social network and clinical characteristics known to be of importance for suicidal behavior.

METHOD

Sample

The sample consists of 54 patients admitted to a psychiatric ward following a suicide attempt. Among suicide attempters investigated at the Medical Emergency Inpatient Unit at the Lund University Hospital, 50–60% are referred to this psychiatric ward, which is specialized for suicide attempters, and the rest to psychiatric outpatient treatment (Niméus, Alsén & Träskman-Bendz, 2000a).

Admission to inpatient treatment was based on several evaluations, including the seriousness of the suicide attempt and the estimated need for treatment and support. The patients in this study constitute 42% 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 problem assessment 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 specialized psychiatric ward following an attempted suicide concerning distribution of psychiatric 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 persons who had made at least one previous suicide attempt.

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, social network, problems perceived by the patient and occurrence of previous suicidal behavior.

In order to facilitate statistical calculations the patients were divided into three age groups, with approximately one third of the total number in each group: 18–26 years (n = 16), 27–40 years (n = 19) and 41–67 years (n = 19). The division was also made with the thought that patients in each group would represent different stages of life. Employed and studying patients were put together in one subgroup and the rest in a second subgroup in order to create two main categories of occupational status. The rationale for putting employed and studying subjects together was that we considered these two occupations equal from the activity and health aspect.

As a part of the social investigation, the patient filled out the EPSIS questionnaire concerning problems of importance for the suicide attempt and the self-rating scale concerning their social network, Interview Schedule for Social Interaction (ISSI; see below). The social worker was always present as a support and to answer to eventual questions about the forms.

Problem Assessment. The EPSIS was designed to be a part of the Repetition Prediction Project of the WHO/EURO Multicentre Study on Parasuicide (Kerkhof et al., 1993). The problem questionnaire was formulated especially for the EPSIS. We used the Nordic extended version comprising 17 different problems (Table 2), with permission of the WHO/EURO Multicentre Study on Parasuicide. The answers could be 'none,' 'some' or 'great,' referring to the degree of importance that the patient felt each suggested problem had for the suicide attempt. Patients were asked to leave out problems that were not applicable to their situation (for example not to answer anything to 'problems with your children' if one did not have children).

Social Network. The social network was assessed using an abbreviated Swedish version of the Interview Schedule for Social Interaction, ISSI (Henderson, Duncan-Jones, Byrne & Scott, 1980; Undén & Orth-Gomér, 1989). This version is a self-rating scale, which measures social integration and attachment. Social integration is a complex concept including relations in which interest is shared, relations that give reassurance of personal worth, and alliances that give possibility for both instrumental and other types of support in difficult situations. Attachment refers to the need of deep emotional

relations (Undén & Orth-Gomér, 1989). The ISSI measures the quality and quantity of the social network and consists of four sub-scales: availability of social integration (AVSI), availability of attachment (AVAT), adequacy of social integration (ADSI), and adequacy of attachment (ADAT). Maximum score is 30 points, designating an optimal social interaction. The reliability and validity have been tested in Australia and Sweden and were found to be satisfactory (Henderson et al., 1980; Undén & Orth-Gomér, 1984).

Severity of Suicidal Intent. The patients' suicidal intent was investigated at the Medical Emergency Inpatient 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 attitudes and feelings toward the attempt. Maximum score is 30 points (Beck, Herman & Schuyler, 1974).

Depressive Symptoms. In order to measure depressive symptoms, the Montgomery-Åsberg Depression Rating Scale (MADRS) was used. This scale consists of 10 items extracted from the Comprehensive Psychopathological Rating Scale. Maximum score is 40 points (Montgomery & Åsberg, 1979). The evaluation was performed by the psychiatrist at the ward.

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.

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 = 22). 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).

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.

A stepwise regression analysis with marital status, social network and depressive symptoms (MADRS) as independent variables and the number of problems of 'great importance' (expressed as a "problem ratio" see below) as dependent variable was performed.

For the purpose of investigating eventual associations between the number of problems mentioned by each respondent and socio-demographic data, clinical characteristics and social network, an individual "problem ratio" was calculated. This was done in order to correct for the fact that the maximal number of possible problems was not the same for all patients. Each patient's number of problems was divided with his/her maximal number of possible problems (e.g. 5/16 or 5/17), resulting in a figure between 0 and 1. This figure will be referred to as the problem ratio. A problem ratio concerning only the number of problems of 'great importance' was also

calculated, and will be referred to as the problem great ratio.

The problems 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 seventeen problems were subjected to a principal component factor analysis with Varimax rotation. The least common problems (items with less than 20% affirmative answers; 'criminality,' 'fear of physical illness or infection' and 'physical illness or disability') were excluded from the factor analysis. One item ('problems with your children') was excluded since 42% of the patients could not answer it. The internal dropout in the remaining 13 items was dealt with by pair-wise exclusion before the factor analysis was carried out. 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 responses to the items within each factor. (The response 'no importance' was given the value 0, 'some importance' = 1 1 and 'great importance' = 2.) In this calculation the missing values were replaced with the answer 'no importance' ($= 0$). Since patients were asked to leave out items not applicable to their situation, that is problems they could not have, a replacement with zeros was considered suitable.

Results were considered significant when $p < .05$.

RESULTS

Patient Characteristics

An overview of the patient characteristics, separated by sex, is shown in Table 1. These patient characteristics did not differ significantly between men and women, except for suicidal intent, which was higher among men than among women (19.7 ± 4.5 vs. 14.3 ± 5.6, $M \pm SD$; $p < .001$).

Some patients were diagnosed with more than one DSM III-R axis I disorder; 12 patients (22%) suffered from two axis I disorders and one patient from three. Seven patients (13%) were given an axis II diagnosis only, whereas 21 patients (39%) suffered from an axis II disorder in addition to their axis I disorder(s). In all, 52% were diagnosed with an axis II disorder.

Problems of Importance for the Suicide Attempt

The problems are listed in Table 2 in order of frequency, also showing sex differences. 'Feelings of loneliness' was the problem most frequently mentioned, as well as the most common problem said to be of 'great importance.' The second most frequent problem was 'mental illness or psychiatric symptoms.'

The problem of unemployment was mentioned by 12 patients (23%). Among these, nine were actually unemployed, one was in vocational rehabilitation and two were employed. A majority of the unemployed patients actually did consider their unemployment to be a problem of importance (75%), and many of them thought it to be of great importance (42%).

Problems Differing Between the Sexes. The item 'problems with your children' was recognized by 45% of the patients who had children ($n = 31$) and was more often mentioned by women than by men. The proportions of patients who had children did not differ significantly between the sexes (60% of men vs. 55% of women). Women also mentioned the items 'mental illness or psychiatric symptoms' and 'feelings of loneliness' more often than did men. The item 'financial problems' was on the contrary more often mentioned by men than by women, just as was 'recent

TABLE 1. **Patient Characteristics, Also Separated by Sex. Significant Differences Between the Sexes are Shown**

	Total sample n (%)	Men (n = 25) n (%)	Women (n = 29) n (%)
Married/cohabiting	19 (35)	9 (36)	10 (35)
Divorced/widowed	8 (15)	4 (16)	4 (14)
Never married/single	27 (50)	12 (48)	15 (52)
Employed/studying	36 (67)	15 (60)	21 (72)
Unemployed/vocational rehab.	14 (26)	9 (36)	5 (17)
Disability pension	2 (4)	0 (0)	2 (7)
Old age pension	2 (4)	1 (4)	1 (3)
Children	31 (57)	15 (60)	16 (55)
Major depression	15 (28)	5 (20)	10 (35)
Dysthymia	2 (4)	0 (0)	2 (7)
Depression NOS	5 (9)	5 (20)	0 (0)
Adjustment disorder	14 (26)	7 (28)	7 (24)
Anxiety disorder	3 (6)	2 (8)	1 (3)
Substance use disorder	3 (6)	2 (8)	1 (3)
Others	5 (9)	0 (0)	5 (17)
Axis II disorder (only)	7 (13)	4 (16)	3 (10)
Repeaters	19 (37)	7 (28)	12 (42)
	M ± SD	M ± SD	M ± SD
Age	36 ± 14	38 ± 13	35 ± 14
SIS	16.7 ± 5.8	19.7 ± 4.5***	14.3 ± 5.6
ISSI	14.0 ± 8.4	14.1 ± 7.9	14.0 ± 9.0
MADRS	8.7 ± 5.0	7.2 ± 4.4	10.0 ± 5.1

Mann-Whitney U-test measuring sex differences in clinical rating scales: *p < .05, **p < .01, ***p < .001. The Chi-square test was used to investigate sex differences in socio-demographics, but none were found.

or current change in life situation' and 'unemployment.'

Number of Problems

The mean number of problems mentioned by each respondent (i.e. the number of problems of 'some importance' plus problems of 'great importance') was 6.3 ± 2.8 (range 1–13), and the corresponding number for problems of great importance was 3.1 ± 2.0 (range 0–9). When calculating these figures, no respect was given to the fact that the maximum number of problems was less than 17 for patients who did not have children or a partner.

The problem ratio and the problem great ratio (described in Statistics) differed between the marital status subgroups, in that they were higher among the never married/single patients than among the married/cohabiting ones (0.45 ± 0.18 vs. 0.32 ± 0.14, M ± SD; $p < .05$ and 0.23 ± 0.13 vs. 0.13 ± 0.09, M ± SD; $p < .01$). Both problem ratios, respectively, were intermediate among the divorced/widowed and did not significantly differ from the other two subgroups.

ISSI score was negatively correlated to the problem ratio, as well as to the problem great ratio ($r = -.45$, $p = .001$ and $r = -.35$; $p < .05$, respectively), that is the poorer the social network, the more problems mentioned. Further it was found that depressive symptoms (MADRS score) were positively correlated to the problem great ratio ($r = .35$; $p < .05$), that is the more depressive symptoms, the higher the number of problems of great importance. No other significant relations were found

TABLE 2. **Affirmative Answers Given by Suicide Attempters to a List of Possible Problems as Causes of Attempted Suicide. Significant Sex Differences are Shown**

Item	Total sample		Men		Women	
	Affirmative answers[1] %	Great importance %	Affirmative answers %	Great importance %	Affirmative answers %	Great importance %
Feelings of loneliness	76	54	56	36	93**	69*
Mental illness or psychiatric symptoms	70	37	52	24	86**	48
Problems in creating or maintaining friendships and social relations	56	26	52	24	59	28
Problems with your partner (N = 47)	55	30	50	18	60	40
Problems concerning work/ work place/school (N = 53)	51	23	60	28	43	18
Rejection by a lover (N = 50)	48	28	46	29	50	27
Problems with your parents (N = 53)	47	21	40	20	54	21
Recent/current change in life situation	46	28	64	44	31*	14*
Problems with your children (N = 31)	45	19	20	0	69**	38**
Financial problems	44	24	64	44	28**	7**
Housing problems (N = 53)	28	2	38	4	21	0
Addiction (to alcohol, drugs, medication, gambling etc.)	28	7	24	8	31	7
Problems in making friends at work or at school (N = 53)	23	6	12	4	32	7
Unemployment (N = 53)	23	11	40	24	7**	0**
Physical illness or disability (N = 52)	17	10	17	8	18	11
Fear of physical illness or infection (N = 53)	10	4	4	0	14	7
Criminality (N = 53)	0	0	0	0	0	0

[1]"Affirmative answers" refers to those who answered "some importance" plus those who answered "great importance." When nothing else is given, N = 54. Chi-square test measuring sex differences: $*p < .05$, $**p < .01$.

between the problem ratios and any other socio-demographic data or clinical characteristics.

A stepwise regression analysis with marital status, social network and depressive symptoms (MADRS) as independent variables and the problem great ratio as the dependent variable was performed, as shown in Table 3. The problem great ratio was related to these variables with an explained variance of 25%.

Problem Factors in Relation to Socio-demographic Data, Clinical Characteristics and Social Network

As described in statistics, a factor analysis was conducted, resulting in a four-factor solution. These factors explained 59% of the total variance. After inspection of the item content, the factors were labelled: "Psychiatric problems and inter-personal relation difficulties," "Recent/current problems in relationships," "Socio-economical

TABLE 3. **Stepwise Regression Analysis Investigating the Relationship Between Marital Status, Social Network, Depressive Symptoms and the Mean Number of Problems of Great Importance (problem great ratio)**

Independent Variables	Beta Coefficient	R Square Change	F Change	Sig. F Change
Marital status[1]	.331	.124	6.531	.014
Social network	−.342	.108	6.298	.016
Depressive symptoms	.264	.069	4.368	.042

[1]Married/cohabiting = 1, divorced/widowed = 2, never married/single = 3.

problems" and "Problems at workplace/school." The item content and loadings in each factor are shown in Table 4.

An overview of the correlations between the problems factors and clinical rating scales is shown in Table 5.

Psychiatric Problems and Interpersonal Relation Difficulties. This factor consists of the five items 'problems with your parents,' 'feelings of loneliness,' 'problems in creating or maintaining friendships and social relations,' 'mental illness or psychiatric symptoms' and 'addiction' (to alcohol, drugs, gambling, etc). The factor value was thus a figure ranging from 0 to 10 for each patient. The mean factor value in the sample (N = 54) was 4.2 ± 2.6.

Women had higher factor values than men (4.9 ± 2.4 vs. 3.4 ± 2.6, M ± SD; $p < .05$), that is women more often felt that psychiatric problems and interpersonal relationship difficulties had a major influence on their suicide attempts. Patients in the diagnostic subgroup "others" had higher factor values than those diagnosed with adjustment disorder (5.2 ± 2.5 vs. 2.6 ± 1.6, M ± SD; $p < .01$). The factor values among those suffering from mood disorders were intermediate and did not significantly differ from the other two diagnostic subgroups.

Further it was found that ISSI score was negatively related to this factor score, and that the SIS score was positively related to it, that is the poorer the social network, or the lower the suicidal intent, the more psychiatric problems and interpersonal relationship difficulties. (There was no significant correlation between SIS score and ISSI score.)

TABLE 4. **Rotated Component Matrix, Showing the Items and Their Loadings in the Factors**

Item	F1	F2	F3	F4
Feelings of loneliness	0.789			
Mental illness/psychiatric symptoms	0.691			
Addiction	0.611			
Problems creating/maintaining friendships	0.566			
Problems with your parents	0.516	0.464		
Rejection by a lover		0.823		
Problems with your partner		0.709		
Recent/current change in life situation		0.686		
Unemployment			0.788	
Financial problems			0.719	
Housing problems			0.710	
Problems concerning work/school				0.784
Problems making friends at work/school				0.588

TABLE 5. **Problem Factors in Relation to Suicidal Intent, Depressive Symptoms and Social Support**

Problem factor	SIS	MADRS	ISSI
Psychiatric problems and relational difficulties	r = −.29*	r = .38**	r = −.41**
Recent/current problems in relationships	r = .05	r = −.04	r = −.20
Socio-economical problems	r = .21	r = .02	r = −.06
Problems at workplace/school	r = −.21	r = −.03	r = −.23

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

Recent/Current Problems in Relationships. This factor consists of the three items 'problems with your partner,' 'rejection by a lover' and 'recent/current change in life situation,' the factor value ranging from 0 to 6. The mean factor value in the sample (N = 54) was 2.2 ± 1.9.

The only statistically significant finding in relation to this factor was that patients diagnosed with adjustment disorder had higher factor values than did patients with mood disorder and "others" taken together (3.1 ± 1.9 vs. 1.9 ± 1.9, M ± SD; $p < .05$).

Socio-Economical Problems. This factor consists of the three items 'unemployment,' 'housing problems' and 'financial problems,' the factor value being a figure 0–6. The mean factor value in the sample (N = 54) was 1.3 ± 1.5.

Men had higher factor values than women (2.1 ± 1.7 vs. 0.62 ± 0.90, M ± SD; $p < .001$), that is men more often felt that socio-economical problems were important for their suicide attempt than did women.

The factor values differed between the age groups in that 27–40-year-olds had higher values than 41–67-year-olds (2.1 ± 1.7 vs. 0.74 ± 1.4, M ± SD; $p < .01$).

Problems at Workplace/School. This factor consists of the items 'problems in making friends at work or at school' and 'problems concerning work/workplace/school,' the factor value ranging from 0 to 4. The mean factor value in the sample (N = 54) was 1.0 ± 1.1. The 18–27-year-olds scored higher in this factor than the 41–67-year-olds (1.4 ± 1.3 vs. 0.53 ± 0.77, M ± SD; $p < .05$). The 27–40-year-olds were intermediate in this aspect.

DISCUSSION

Representativeness 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.

Among patients in this study the mean score on the ISSI was 14.0 ± 8.4, which is similar to that of 15.6 ± 7.3 obtained in a sample of suicide attempters admitted to the same specialized psychiatric ward during the period 1987–1989 (Magne-Ingvar et al., 1992). Among healthy controls a considerably higher mean ISSI score has been reported, namely one of 23.9 ± 5.2 points (Cederblad & Höök, 1991). There is no known clinical threshold value of the ISSI.

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 high-risk patients. At a 5-year follow-up of patients referred to a psychiatric ward, 13% had committed suicide (Johnsson-Fridell, Öjehagen &

Träskman-Berdz, 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 54 patients is a rather small one, which cannot always be divided into as many subgroups as one would have preferred, since that would have created too small groups 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.). Some associations may therefore 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 significance by chance.

Main Findings

The most common problem mentioned was 'feelings of loneliness,' closely followed by 'mental illness or psychiatric symptoms.' The type of problems mentioned differed between the sexes. Patients suffering from adjustment disorder had higher factor values in the factor of recent/current problems in relationships than did patients with other psychiatric disorders, and had lower factor values in the factor of psychiatric problems and interpersonal relation difficulties than patients within the diagnostic subgroup "others." Finally, the number of problems of great importance mentioned by each patient, expressed as a problem ratio, was related to being "never married/single," having a weak social network and having many depressive symptoms.

That 'feelings of loneliness,' closely followed by 'mental illness/psychiatric symptoms' were the most frequently mentioned problems is consistent with results of an EPSIS study conducted in Bern, in which a list of 10 of the 17 problems was presented to a sample of 66 suicide attempters (in- and out-patients). The third and fourth most common problems mentioned in our study ('problems in creating or maintaining friendships and social relations' and 'problems with your partner') were also common among patients in the other study (Michel et al., 1994).

One of the main findings was that the types of problems mentioned differed between men and women. Men more often mentioned the problem of unemployment and had higher factor values concerning the factor of socio-economical problems than did women. Although not reaching statistical significance, a higher proportion of men than of women were unemployed, which partially might explain the above-mentioned findings. Women, on the other hand, had higher factor values than men concerning psychiatric problems and interpersonal relationship difficulties and more often mentioned the individual items 'feelings of loneliness,' 'mental illness or psychiatric symptoms' and 'problems with children.' A partial explanation to why women more often than men mentioned problems with their children may be that women probably more often were in custody of their children. Another reason could be that women perhaps experience an unsatisfactory relationship with their children as more painful than men do.

Why did the women in this sample seem to be more concerned about psychiatric/mental problems than did the men? One reason could be that the women were more depressed than the men. This is however questionable, since mood disorders were equally distributed between the sexes, and since the MADRS scores showed no significant sex differences. Perhaps the question ought to be posed the other way around, that is, why did men less often

report problems concerning their mental health and relations, and instead focus on problems of a practical nature, referring to outer circumstances and events? This could reflect that it may be more difficult for men to recognize and to talk about their feelings. For instance, epidemiological data indicate that the consultation rate and help seeking by men in the general population is lower than for women, especially in the case of emotional problems and depressive symptoms. There is empirical evidence that the lower help seeking rate of men cannot be explained by a better health but must be attributed to a discrepancy of need and help seeking behavior (Möller-Leimkühler, 2000). Another contributing reason may be that men perhaps are more fragile to changes in life situation. Furthermore, the importance of culturally influenced conceptions of femininity and masculinity has been discussed in relation to suicidal behavior. Dahlen and Canetto (1996) observed that persons who become suicidal in response to a relationship loss are perceived as more feminine than persons who become suicidal in response to an achievement failure. It is possible that the subjects were influenced by gender related ideas concerning what would be suitable/acceptable explanations for their suicidal behavior.

Patients diagnosed with adjustment disorder differed in some aspects from patients with other disorders. As may be expected, they more often stated problems in the factor 'recent or current problems in relationships,' and had lower values in the factor 'psychiatric problems and interpersonal relation difficulties' than those with other diagnoses. To these patients, recent or current relationship problems seem to be the focus, rather than intra-personal problems. Involving family members or other "significant others" in the treatment of suicidal patients has been recommended in several studies (Magne-Ingvar & Öjehagen, 1999; Olsson & Wasserman, 1991). This may be especially important to patients suffering from adjustment disorder.

Being "never married/single," experiencing a weak social network and having many depressive symptoms were related to higher numbers of problems of great importance. Marital status, social network and depressive symptoms were entered as independent variables in the stepwise regression, since we hypothesized that patients with lower ISSI scores, higher MADRS scores and a single status would mention more problems than others. However, it may be the other way around, that is that the many problems caused the depression or made it impossible to create or stay in a relationship.

Concerning the correlation between ISSI score and the number of problems mentioned one has to take into account that both of these measures are self-rated. This means that they may partially express the same thing.

The patients' statements of the problems underlying their suicide attempts naturally cannot be regarded as an objective truth, and problems other than those stated should of course not be forgotten. What then is the use of assessing the patients' own views? As argued in the introduction of this article, it is important for the patient to be understood, and for the therapist to know how the patient reasons, in order to form the working alliance necessary for treatment success (Horvath & Symonds, 1991). Further, the efficacy of treating suicidal behavior "indirectly" by treatment of psychiatric disorders has been questioned: It has been suggested that directly targeting suicidal phenomena, including suicidal ideation, might prove to be more efficient (Linehan, 1998). Moreover, the patients' experiences of their problems may form a basis to improve their problem solving capacity. Problem solving has in many studies been found to be impaired in suicide attempters (Williams & Pollock, 2000).

Further research is however needed in order to conclude to what extent assessing the patients' views could be helpful in treatment and prediction of future suicidal behavior, which is beyond the scope of this study.

REFERENCES

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders.* (3rd Edn., revised). Washington D.C.

Barraclough, B. (1987). *Suicide: Clinical and epidemiological studies.* London: Croom Helm.

Beck, A.T., Davis, J.H., Frederick, C.J., Perlin, S., Pokorny, A., Schulman, R., Seiden, R., & Wittlin, B. (1972). Classification and nomenclature. In H.L.P. Resnick, & B. Hathorne (Eds.), *Suicide prevention in the seventies.* Washington DC: Government Printing Office.

Beck, A.T., Herman, I., & Schuyler, D. (1974). Development of suicidal intent scales. In A.T. Beck, H.P.L. Resnick, & D.J. Lettieri (Eds.), *The prediction of suicide* (pp. 45–48). Bowie, Maryland: Charles Press.

Cederblad, M., & Höök, B. (1991). Östgötastudien No 1. Rädda Barnen (Save the Children).

Dahlen, E.R., & Canetto, S.S. (1996, April). *The role of gender and context in attitudes toward nonfatal suicidal behaviour.* Paper presented at the meeting of the American Association of Suicidology, St. Louis, MO.

van Egmond, M., & Diekstra, R.F.W. (1989). The predictability of suicidal behavior. The results of a meta-analysis of published studies. In R.F.W. Diekstra, R. Maris, S. Platt, A. Schmidke, & G. Sonnek (Eds.), *Suicide and prevention. The role of attitude and imitation.* Amsterdam: E.J. Brill.

Hawton, K. (2000). General hospital management of suicide attempters. In K. Hawton, & K. van Heeringen (Eds.), *The international handbook of suicide and attempted suicide* (pp. 519–537). Chichester: John Wiley & Sons, Ltd.

Henderson, S., Duncan-Jones, P., Byrne, D.G., & Scott, R. (1980). Measuring social relationships: The interview schedule for social interaction. *Psychological Medicine, 10,* 723–734.

Horvath, A.O., & Symonds, B.D. (1991). Relation between working alliance and outcome: A meta-analysis. *Journal of Consulting Psychology, 38,* 138–149.

Johnsson Fridell, E., Öjehagen, A., & Träskman-Bendz, L. (1996). A 5-year follow-up study of suicide attempts. *Acta Psychiatrica Scandinavica, 93,* 151–57.

Kerkhof, A.J.M., Bernasco, W., Bille-Brahe, U., Platt, S., & Schmidtke, A. (1993). European parasuicide study interview schedule (EPSIS I). WHO Regional Office for Europe, Copenhagen.

Leon, A.C., Friedman, R.A., Sweeney, J.A., Brown, R.P., & Mann, J.J. (1990). Statistical issues in the identification of risk factors for suicidal behaviour: The application survival analysis. *Psychiatry Research, 31,* 99–108.

Linehan, M.M. (1998). Behavioral treatments of suicidal behaviours: Definitional obfuscation and treatment outcomes. *Annals of the New York Academy of Science,* 302–328.

Magne-Ingvar, U., & Öjehagen, A. (1999). Significant others of suicide attempters: Their views at the time of the acute psychiatric consultation. *Social Psychiatry and Psychiatric Epidemiology, 34,* 73–79.

Magne-Ingvar, U., Öjehagen, A., & Träskman-Bendz, L. (1992). The social network of people who attempt suicide. *Acta Psychiatrica Scandinavica, 86,* 153–158.

Michel, K., Valach, L., & Waeber, V. (1994). Understanding deliberate self-harm: The patients' views. *Crisis, 15(4),* 172–178.

Montgomery, S.A., & Åsberg, M. (1979). A new depression scale designed to be sensitive to change. *British Journal of Psychiatry, 134,* 382–389.

Möller-Leimkühler, A.M. (2000). Men and depression: Gender-related help-seeking behaviour. *Fortschritte der Neurologie, Psychiatrie, 68(11),* 489–495.

Niméus, A., Alsén, M., & Träskman-Bendz, L. (2000a). The suicide assessment scale: An instrument assessing suicide risk of suicide attempters. *European Psychiatry, 15,* 1–7.

Niméus, A., Alsén, M., Träskman-Bendz, L. (2000b). High suicidal intent scores indicate future

suicide. Accepted for publication in *Archives of Suicide Research*.

Norusis, M.J. (1995). SPSS 10.0 for Windows. Spss Inc., Chicago, USA.

Olsson, M., & Wasserman, D. (1991). The family–buffer or risk factor in parasuicide? In T. Bjerke, & T.C. Stiles (Eds.), *Suicide attempts in the Nordic countries: Epidemiology and treatment* (pp. 121–129). Trondheim: Tapir forlag.

Undén, A.L., & Orth-Gomér, K. (1984). Social support and health, report No 2. Development of a survey method to measure social support in population studies. Stress Research Report No 178, Stockholm.

Undén, A.L., & Orth-Gomér, K. (1989). Development of a social support instrument for use in population surveys. *Social Sciences and Medicine, 29*, 1387–1392.

Williams, J.M.G., & Pollock, L.R. (2000). The psychology of suicidal behaviour. In K. Hawton, & K. van Heeringen (Eds.), *The international handbook of suicide and attempted suicide* (pp. 79–93). Chichester: John Wiley & Sons.