THE UNIVERSITY OF CALGARY

ATTEMPTED SUICIDE: A PILOT PROJECT

by

DENISE L. INGRAM

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF SOCIAL WORK

FACULTY OF SOCIAL WELFARE

CALGARY, ALBERTA

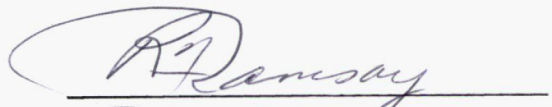
March 1988

ISBN 0-315-42495-8

THE UNIVERSITY OF CALGARY

FACULTY OF GRADUATE STUDIES

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled "Attempted Suicide: A Pilot Project" submitted by Denise Ingram in partial fulfillment of the requirements for the degree of Master of Social Work.



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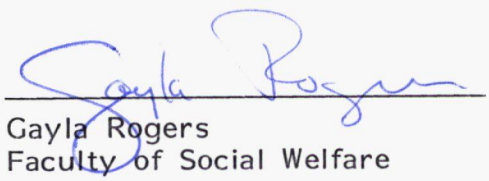

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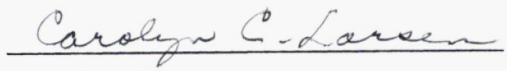

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ABSTRACT

This project was designed to test the feasibility of using a self-administered questionnaire to survey a group of subjects on their experiences with attempted suicide. The project focuses on designing a methodology and testing it in a pilot study within the Suicide Intervention Program of the Canadian Mental Health Association.

A total of fifteen pre-tested questionnaires were distributed to selected subjects who were clients of the Suicide Intervention Program. This distribution followed the mailing of an explanatory letter to the subject and a follow-up phone call from the coordinator of the program. Numerous methodological problems resulted in the data collection period taking approximately eleven months.

The final sample consisted of eight females and seven males. The completed questionnaires provided a variety of information ranging from familial experiences with suicidal behaviors to variances within treatment practices for males versus females. A considerable amount of the obtained information was consistent with existing literature in the area, while other results posed questions for future research in the area of attempted suicide.

Final results of this study indicate that utilizing a self-administered questionnaire could be a feasible way of gathering information on

attempted suicide; however, the methodology used in this study to gather this information is not feasible. Recommendations are made for changes in the methodology in order to increase the overall response rate and to decrease the time required to complete a study of this type.

ACKNOWLEDGEMENTS

The completion of this thesis would not have been possible without the support and assistance of many people. My appreciation and thanks go to my supervisor, Mr. Dick Ramsay, for his patience and direction throughout this thesis.

Special appreciation goes to Mrs. Bev Shea and Mrs. Doreen Neville for going above and beyond their normal duties in helping me to complete my work.

A special thank you to my parents, my sisters and their families, for without their emotional and financial support, the completion of this thesis would not have been possible.

To Mike, Audrey and Bob, thank you for all your help and for always being there to talk to.

Last, but not least, my appreciation and thanks to a number of special people, namely: Irene, Sheila, Diana, Helga, Lori, Mary, Edith, Darleen, Fern, Julia and Michelle, for everything they have done to help me complete this thesis.

DEDICATION

This thesis is dedicated to all those who have contemplated or attempted suicide--with the hope that everyone will soon realize that attempted suicide is a problem that should concern all of us.

TABLE OF CONTENTS

TABLE OF CONTENTS Continued

LIST OF TABLES

LIST OF TABLES Continued

CHAPTER ONE

INTRODUCTION

Attempted suicide is a personal and social problem of considerable concern to society. To more fully understand the extent of this problem, it is first important to understand the extent of the problem of suicide.

Concerned members of society in all provinces of Canada must deal with the issue of suicide and attempted suicide. The provinces and territories of Canada, other than Alberta, as shown in Suicide in Canada (1987), have the following rates of suicide. These are combined rates of males and females and are based on rates of per 100,000 population in 1985: Canada - 12.9, Newfoundland - 4.0, Prince Edward Island - 3.9, Nova Scotia - 12.0, New Brunswick - 12.0, Quebec - 17.1, Ontario - 11.4, Manitoba - 11.9, Saskatchewan - 13.0, British Columbia - 16.0, Yukon Territory - 35.1, Northwest Territories - 25.5. These rates indicate that suicide is a problem of considerable magnitude in the majority of Canada's provinces and territories. Clearly, this is not an isolated issue.

In 1985, the Alberta Attorney-General Department reported that the suicide rate was 16.7 per 100,000; one of the highest provincial rates in Canada. The rate of suicide is a social and health problem of considerable significance in Alberta, which is evident in the rank order of "causes of death." Boldt (1976) found that suicide was ranked as the second leading cause of death between the ages of 15 and 34 years. Only automobile accidents killed more people in this age category. Between the ages of 35-54 years, suicide ranked as the fourth leading

cause of death exceeded only by accidents, cancer and heart disease. When reasonable and appropriate corrections for under-reporting are made, suicide ranks as the leading cause of death between the ages of 15 and 35 years.

In comparison with Europe and the United States, the amount of Canadian research on suicidal behaviors is relatively small (Bagley & Ramsay, 1985). However, there are some significant Canadian contributions to the study of suicide. The most recent contribution is The Report of the National Task Force on Suicide in Canada. Additional Canadian research efforts are identified below.

The problem of attempted suicide has to be understood in the context of completed suicide rates. A Canadian prospective study of non-accidental self-injury conducted in London, Ontario revealed a rate of non-accidental self-injury at 730 per 100,000 population (Whitehead, Johnson & Ferrence, 1973). However, Whitehead et al. also estimated their rate to be inaccurate by at least 100 percent. In this same study, it was shown that when data was collected from a variety of agencies including hospitals, jails, juvenile institutions and physicians, the real rate of attempted suicide in all age categories was found to be at least 70 times the rate of completed suicides, or approximately 1,500 per 100,000. The rate was found to be particularly high in females aged 15-19 years.

Two important American general population studies were completed in the 1970s by Paykel, Myers, Lindenthal and Tanner (1974), and Schwab, Warheit and Holzer (1972). The Paykel study found a suicide attempt to completed suicide ratio of 33:1. The Schwab study found that 15.9 percent of their sample reported some degree of suicidal ideation.

This suicidal ideation and a history of suicide attempts were more frequent in the younger age groups.

A more recent Canadian study by Ramsay and Bagley (1985) found an attempted suicide rate of 2,100 per 100,000 in the city of Calgary which was at least 100 times the rate of suicide in Calgary. This rate is considerably higher than reported in earlier studies and still it was considered to be an underestimate since only adults 18 years and over were surveyed. Based on the Ramsay and Bagley findings, the province of Alberta alone could have in excess of 48,000 attempted suicides and suicides each year.

The extent of these suicidal behavior problems goes far beyond the statistical magnitude. The costs associated with these problems cannot be discounted. The cost of suicide in financial terms includes the lost skills and productivity of the deceased, and the public costs of police investigations, coroner's reports, autopsies, laboratory tests, inquests, the medical costs of ambulances and emergency services, intensive care and hospital services, and physicians and professional care. First and foremost, however, the cost in terms of human suffering must be considered. Rarely does a person attempt or complete suicide in total isolation. Not only does the victim feel the pain of his/her actions, and experience the factors that led to this behavior, but all those associated with him/her, such as family, friends, co-workers and medical personnel, are, in some way and to some degree, affected by the behavior. Although practitioners in the mental health field cannot put a "price tag" on the human suffering of victims and their associates, they can easily identify that the problems of suicide and attempted suicide require serious attention from society.

Role of Social Workers in Attempted Suicide

An area that needs to be addressed concerns the role of social workers in the area of attempted suicide. However, prior to any discussion of the social worker's role, there needs to be an understanding of the purpose and function of social work.

Pincus and Minahan (1973) state that the focus of social work practice is on the interactions between people and systems in the social environment. They provide a definition of social work practice that is based on the linkages and interactions between people and resource systems and the problems faced in the functioning of both individuals and systems. This definition is:

> Social work is concerned with the interactions between people and their social environment which affect the ability of people to accomplish their life tasks, alleviate distress, and realize their aspirations and values. The purpose of social work, therefore, is to (1) enhance the problem-solving and coping capacities of people, (2) link people with systems that provide them with resources, services and opportunities, (3) promote the effective and humane operation of these systems, and (4) contribute to the development and improvement of social policy (p.9).

Pincus and Minahan identify three types of social situations which social work practice addresses. These are:

1. In a social situation, concern with the life tasks confronting people and the resources and conditions which could facilitate their coping with tasks, help them realize their values and aspirations, and alleviate their distress. [Life tasks is a way of describing the demands made upon people by various life situations.]

2. In a social situation, the focus is on people in interaction with their network of resource systems. This means that problems are not viewed as an attribute of people, rather, they are seen as an attribute of their social situation. The question is not who has the problem, but how the elements in the situation (including

> the characteristics of the people involved) are interacting to frustrate people in coping with their tasks.
>
> 3. The relationship between the private troubles of people in a social situation and the public issues which bear on them (pp.9-13).

Pincus and Minahan also state seven functions which the social worker's intervention activities and tasks are designed to accomplish. These are:

> 1. help people enhance and more effectively utilize their own problem-solving and coping capacities;
>
> 2. establish initial linkages between people and resource systems;
>
> 3. facilitate interaction and modify and build new relationships between people and societal resource systems;
>
> 4. facilitate interaction and modify and build relationships between people within resource systems;
>
> 5. contribute to the development and modification of social policy;
>
> 6. dispense material resources; and
>
> 7. serve as agents of social control (p.15).

Meyers (1970) states:

> Social work's special purposes and related individualizing methods have, for good or ill, placed the profession at the fulcrum, the inter-face, between those services and the citizen-client in need. This is then the context of social work practice, the way people live (pp.40-41).

The above provides an outline of the purpose and function of social work. However, the issue of the differences between social work and other professions needs to be addressed. Fischer (1973) discusses this issue as follows:

> There are clearly a variety of differences between the professions engaged in therapeutic practice, in matters of training and education, in interests, spheres of functioning, societal mandates, and so on. Second, and more specifically, social workers operate from a far broader base than the field of psychotherapy - or than other professions - can alone provide. Social workers supply a wide range of services that most psychotherapists do not consider. Moreover, the knowledge base for case-work, and for social work as a whole, is broader than the base used by other professions concerned with clinical practice. At the core of this knowledge base, is a concern with social functioning - the interactions between human beings and their environment. This is a continuing unique feature of both the knowledge base and practice of social workers. Finally, and perhaps most importantly, social workers operate in the context of social work philosophy and values and a particular orientation to people, characteristics unique to social work and to social workers in clinical practice (p.49).

Fischer further states that whatever the source of knowledge, social workers will still be social workers by virtue of their professional affiliation, values, and philosophy, and because their social functioning perspective will likely lead them to engage in a far broader range of interventions than members of other professions. Thus, the goal of the social worker will be to design services to fit the client, as opposed to finding clients to fit the service.

As Meyers (1970) states:

> There is no other profession that is prepared to address the general human needs of people. It is the essential purpose of social work to individualize need and to provide for the growth and development of people in the society with which they transact. The intermediate function of establishing a fit between a person and the source of his functioning, that ecological unit of attention that belongs so uniquely to social work, can be effected through many arrangements and permutations of services and skills in the form of social work practice (p.38).

Turner (1986) refers to the need for a pluralistic conceptual base for social work practitioners. This is somewhat similar to Fischer's (1978) format or framework for eclectic casework practice. Both of these concepts embody the plan that social workers must be flexible and knowledgeable in a wide range of clinical areas in order to best serve the individual needs of the client. This type of approach and the knowledge and skills utilized by the social work practitioner in part distinguishes social work from other professions.

What implications does this have for social workers working with clients who have attempted suicide? As social workers are concerned with the interactions between individuals and their environment, it only follows that they would be concerned with the behavior of attempted suicide, as attempted suicide involves interactions between person/self in a singular sense and person-others or person-environment in a plural sense.

The issue of loss is a central concept in the area of attempted suicide and relates directly to the relationships and systems in which an individual is involved (Durkheim, 1951). Loss is defined in the Coles Concise Dictionary (1979) as: (1) privation, deprivation, forfeiture, (2) failure to win, gain or keep, (3) that which is lost, and (4) damage or injury.

Suicidal persons are either contemplating a loss or have experienced a loss of an interactional experience(s) within their living systems. This loss of a relationship(s) is extremely important to them: they are on the edge of the boundary of all that they have and know. As suicidal persons experience more and more losses, be they perceived or real losses, they move closer and closer to the outside edge of their

personal/environment boundary. That is, as the person experiences the loss of parts of their living system, they are in danger of losing their whole living system. These losses often come about as a result of inadequacies within the interactional experiences of an individual's life system.

As Pincus and Minahan (1973) note, the family used to be the major system for providing people with the resources they needed to cope with their life tasks. However, as society became industrialized, urbanized, and bureaucratized, the family gave up many of its functions. People have become increasingly dependent for help from extrafamilial resource systems such as places of work, schools and units of government. At the same time, these systems have become increasingly complex and difficult to manage.

Pincus and Minahan refer to three types of resources systems:

1. Informal or natural resource systems such as family;

2. Formal resource systems such as membership organizations; and

3. Societal resource systems such as hospitals (pp.4-5).

Many problems may exist within each of these resource systems. Pincus and Minahan propose that in general, informal, formal, and societal resource systems may not provide the resources, services, and opportunities people need because:

1. a needed resource system may not exist or may not provide appropriate help to people who need it;

2. people may not know a resource system exists or may be hesitant to turn to it for help;

3. the policies of the resource system may create new problems for people; or

4. several resource systems may be working at cross-purposes (p.8).

If the individual cannot depend on these systems, they will experience a loss. It is possible, then, to utilize Pincus and Minahan's (1973) social work frame of reference pertaining to types of social situations and resource systems. Social workers can be actively involved within any area of the resource system network. Social workers are equipped with a wide knowledge base and a variety of skills and resources that may best meet the individual needs of the suicidal client. Given that the behavior of attempted suicide is a complex issue, social workers may particularly be well equipped to deal effectively with this behavior and the issues that accompany it.

Rationale and Purpose of Study

Before treatment and/or prevention of suicide can be fully understood, extensive base-line data must be collected and interpreted, and the characteristics and parameters of the problem must be more clearly defined. Often years of research are undertaken to uncover and understand perhaps only one dynamic of any issue. This is evidenced in part by the fact that the study of suicide began at least as early as the beginning of the 1800s and the study of attempted suicide and related behaviors began in the early 1950s (Stengel, 1970). The purpose of this thesis is to offer a contribution to the growing body of knowledge about suicidal behaviors. Its focus is the planning and implementation of a pilot study to test a method of data collection on subjects who have attempted suicide.

Various research studies have been conducted in specific areas of attempted suicide. Examples of these studies include Luckianowicz's (1972) study of suicidal behavior from the standpoint of its function as an attempt to modify the environment to the patient's benefit; Adam's (1981) three-year study to document the clinical management of patients who had attempted suicide; Paykel, Prusoff and Myer's (1975) study of recent life events and their relationship to the patient's attempted suicide; Liberman and Eckman's (1981) study of two therapeutic methods for repeat attempters; Gibbon's (1978) evaluation of a social work service for self-poisoning patients; and, Murphy's (1983) study on suicide attempts in treated opiate addicts. These are a few examples of the types of studies that have been done in the area of attempted suicide. Select groups of subjects have been studied for these purposes. The central focus of data collection has been primarily through the resources and clientele of hospital-based populations. Subjects presenting to emergency departments or admitted to a medical or psychiatric facility following a suicide attempt have been, in the majority of studies, utilized for evaluation and follow-up purposes. As Shneidman (1976) points out, it is often, and perhaps rightly so, that the largest percentage of suicide attempters will seek or require treatment in a medical facility. Thus, in order to obtain the most accurate compilation of the numbers of suicide attempters, the resources of the medical community are utilized.

However, hospital-based populations of subjects are only one source of access to subjects who have attempted suicide. Other sources, such as community agencies, private practitioners, and therapists in private practice, all see subjects who have attempted suicide or who are at risk of doing so. Still others who have attempted suicide do not receive

medical treatment nor do they receive any outside professional help. As yet, we do not have a systematic method of collecting data on the total population of subjects who have attempted suicide. The problem of identifying this population is enormous. However, if identification of this population were possible, a standardized method of examining samples of the population would be required. The need for accurate base-line data is unrefutable. How to obtain this data from the vast numbers of subjects who have attempted suicide is, however, an issue of major importance.

The decision to conduct a pilot study was two-fold. The population under examination had never been studied before and the instrument utilized in the survey methodology was reformulated from an interview instrument used in a general population study, thus, the revised instrument had never been implemented in its entirety. These reasons warranted the use of a pilot study to determine whether a large-scale descriptive study utilizing this survey instrument and methodology was desirable and feasible.

Research Objectives

This is a pilot study of attempted suicide. It has two main objectives:

1. to determine the feasibility of using a survey questionnaire to study a population of subjects who have attempted suicide; and
2. to describe the characteristics, including commonalities and differences, of the sample population.

The following research questions were developed for this study:

1. Is it feasible to use a self-administered questionnaire to collect base-line data on the subject of attempted suicide?
2. Is it possible to conduct a study of attempted suicide ensuring confidentiality and safeguarding against mental and emotional duress?
3. Is it possible to access a large population of subjects who have been identified as having attempted suicide using this methodology?
4. Could a descriptive study of this type be conducted on a larger scale?

Plan for Remainder of Thesis

The remainder of this thesis is divided into four chapters. Chapter Two is a review of the literature on attempted suicide that is considered relevant to this study. This chapter also includes a section on definitions of suicidal behaviors. Chapter Three outlines the methodology of the study, including the areas of difficulty encountered in questionnaire distribution and data collection. Chapter Four evaluates and examines the methodology of the pilot study and presents the data that were collected and interpreted. Chapter Five, the final chapter, outlines the overall conclusions and recommendations for future research using this particular methodology and discusses implications for social work practice.

CHAPTER TWO

REVIEW OF THE LITERATURE

This chapter begins with a brief historical perspective on suicide and attempted suicide and then reviews the literature that was of assistance in designing the project. The latter dealt with the definitions of attempted suicide, the incidence and demographics of attempted suicide, the issue of intent and lethality, and causational factors of attempted suicide. This literature was reviewed as it seemed to cover the spectrum of the issues inherent in any study of attempted suicide. The intent of the literature review is to provide the reader with some understanding of the issues involved in attempted suicide and the kind of information sought in the present study.

Historical Overview

Questions about who commits suicide, how it is done, where it happens and how often it occurs are the most extensively explored research questions if one looks at the entire scope of suicide research. While the earliest treatises were primarily philosophical and moral (Resnik & Hathorne, 1973), statistical compilations began to appear in the Nineteenth century as governments and authorities began to include suicide as one of the accountable indices of their society. The epidemiologists soon became concerned with the tabulation of suicide for each country and for selected geographical areas within each country. When sociology appeared on the scientific scene, sociological studies of suicide began to report its relationship to demographic and ecologic factors. Sociological theory appeared early with Durkheim's masterful evaluation of the

statistics of suicide as a means of illustrating his categories of suicide for society and the consequent relationships with its members. Durkheim's theory was so impressive that it was not actually until the post-World War II period that new sociological viewpoints of suicide began to appear (Resnik & Hathorne, 1973).

In the 1960s and 1970s there was a rapid expansion of existing research. Empirical research focussed on efforts to find causal links between a wide range of independent variables and the dependent variable of suicide. Demographics included many areas such as age, sex, marital status, days of the week and month, national and racial groups, urban and rural differences, economic effects, "religious" influences, the impact of war and so on. These are but a few of the potential correlates that are still being examined in current research studies.

The study in the literature of those who have attempted suicide is far less clear and expansive than the studies in the literature on suicide. The observation that those who committed and those who attempted suicide differed statistically by age and sex was first noted in a small comparative study by Peller, one of the pioneers of epidemiology, in 1932 (Stengel, 1970).

Subjects with a history of attempted suicide have often been used for research into the causes and motives of suicide, the assumption being that they are minor suicides (Stengel, 1970). Therefore, investigations of suicide attempts were purely retrospective and concerned with the same problems as those of suicide. This line of inquiry is perfectly legitimate and necessary, but until recently research workers ignored the differences between suicide and attempted suicide. Studies

into the fate of people who attempt suicide have been carried out only during the last two decades (Stengel, 1970).

As a result of the expansion in the problem of attempted suicide, a major research effort has been directed towards investigation of the characteristics of people who deliberately poison or injure themselves. This began with the work of Stengel and Cook who studied attempted suicide in the London area (Hawton & Catalan, 1982).

There is much information on the characteristics of those who make attempts, where they live, the problems they face, and the important associations between attempted suicide and suicide. There is less understanding of the reasons why the behavior occurs and knowledge is sparse when faced with the question of how best to help people who make attempts. There is virtually no research knowledge when prevention is considered (Hawton & Catalan, 1982).

Definitions

Definition of terms is an important issue in any study of suicidal behaviors. Even using the term "suicidal behaviors" leads to confusion for the reader at times. Terms are not defined clearly in the suicidology literature. There is an abundance of proposed definitions of the meaning and content of terms. In order that some of these difficulties may be outlined, some of the terminology found in the current literature is examined.

The term "suicide" is widely recognized in society but its precise meaning is frequently misunderstood. It is used overinclusively to describe actions ranging from a non-fatal act of self-harm to any self-destructive act resulting in death (Bagley & Ramsay, 1985). The

term "attempted suicide" is also widely recognized but used inaccurately to describe acts of deliberate self-harm which did not have the intention of self-killing. In his book, The Definition of Suicide, Shneidman (1985) discusses the complexity of a full and complete understanding of the terms that are employed in the literature on the topic of suicide and related behaviors. Shneidman states that the term "attempted suicide" should only be used for those events in which there has been a failure of a conscious effort to end one's life. Only those events can be defined as attempted suicides. All others--self-mutilations, excessive dosage of drugs, and other events of this sort--are, properly speaking, "quasi-suicidal attempts," or probably more accurately "non-suicidal attempts."

Morgan, Pocock and Pottle (1975) have utilized the term "deliberate self-harm" in the place of the term parasuicide to describe acts of self-destruction which did not apparently have death as the final outcome of the act. As Goldney (1980) noted, the term "attempted suicide" has been regarded as unsatisfactory by many authors, and as a result, a number of other terms have arisen. Thus, attempted suicide has been regarded as "pseudocide," "acute poisoning," "deliberate self-injury," "non-fatal deliberate self-harm," and "propetia."

The above are just a few examples of the different terms employed in the literature by various authors to describe suicidal behaviors. Diverse classifications have also arisen in an attempt to delineate motivations, intent and seriousness of suicidal acts. Major contributions have come from Shneidman (cited in Goldney, 1980), who provided the concept of "cessation" and its categories "intentioned, subintentioned, unintentioned, and contra-intentioned," and from Kessel (1966) who

rephrased and extended Shneidman's work to "intended cessation, sub-intended cessation, intended interruption, continuation was contra-indicated and intended continuation."

Other contributions to classify suicidal behaviors, mainly derived from clinical observations include those of Dorpat and Boswell (1963) who divided suicide attempts into "gestures," "ambivalent and serious"; Lawson and Mitchell (1972) who regarded patients in their series as either examples of "self-poisoning," "genuine attempted suicide," or "accidental poisoning"; Patel (cited in Goldney, 1980) who described the "exhibitionist," the "pseudocide" and the "malignant or true suicide"; and Osterwalder (cited in Goldney, 1980) who referred to suicide attempts as either a "cry for help," as "obviously ineffective but serious attempts at self-killing," or "as the patient's wanting to make a 'caesura' in their lives."

Kiev (cited in Goldney, 1980) suggested seven profiles of attempted suicide. These are: suicide gesture, acute depressive reaction, anxiety reaction with interpersonal conflict, passive-aggressive and passive-dependent personality disorder, socially isolated, suicidal preoccupation and chronic dysfunctional. Henderson, Hartigan and Davidson (1977), using sophisticated statistical methods, derived three groups in a "typology of parasuicide." The first two were clinically meaningful, being a "depressed alienated group with high life endangerment," and a "group whose act was highly operant, they felt angry with others." However, the third group was not clinically characterized by any of the variables they examined. It is apparent that these terms embody several different concepts often combined. Some refer purely to the semantics of attempted suicide, others to clinical inferences of intent and lethality,

and yet others to diagnostic syndromes. Inevitably, some have assumed a perjorative quality.

All of these terms, among others, have been used to describe, define and categorize the behavior of attempted suicide. It is evident that there is a potential for vast confusion in the clear understanding of these definitions. The terms and their definitions that are supplied below are intended solely for the purposes of this study.

Suicidal Behaviors: This concept includes any behavior that can be construed as a conscious indication of intent to self-injure or self-poison ranging from gestures, threats, and attempts to completed suicides.

Attempted Suicide: This is the central concept of this study. It includes those behaviors which are conscious acts of deliberate self-harm (self-injury or self-poisoning) with death as the intended outcome of this action. The concept is differentiated to include attempted suicide actions that range from low to high intention of death. Other concepts such as parasuicide or pseudo-suicide which have been used by others to define low intent of death as a mimic of suicide will not be used in this study.

Suicide: This concept includes any conscious act of deliberate self-harm, regardless of the level of intent, of which death is the outcome of the action.

Determining the Incidence of Attempted Suicide

In the opening chapter, the estimated numbers of those who attempt suicide were given. Rather than repeat this information, this section deals with the difficulties involved in acquiring accurate statistics on the extent of this problem.

Questions about the exact incidence of attempted suicide in the general population remain unanswered. Granted the difficulties in the reporting and certification of suicide deaths, the problem still lies in determining the extent of the total phenomena of suicidal behaviors. Problems in estimating the frequency of attempted suicide, as this behavior occurs in the community, are multiplied many times over. Some of the major reporting problems occur in the medical system. With psychiatric diagnostic categories prevalent in the medical profession, a person who has attempted suicide may be diagnosed under various criteria such as depression, personality disorder, schizophrenia or any other number of areas. Without access to, and close scrutiny of case notes, the suicidal patient may not be readily identified. However, admittance on a psychiatric unit is but one of several possible dispositions for the suicidal patient. As each patient is assessed as to their medical needs upon presentation at an emergency department, the course of their immediate treatment often lies within the realm of their physical condition. Thus, as Sifneos (1981) reports, another difficulty relating to the unreliability of the statistics of suicide has to do with the medical diagnoses which are being used to label patients who attempt to kill themselves. An individual who ingests barbiturates and develops pneumonia as a result of it, may be listed in the hospital record under "pneumonia," and the suicide attempt which caused it in the first place may not be mentioned. This applies just as well to a surgical diagnosis. For example, "infected lacerated wounds of the throat," which may have resulted from a slashing suicidal intent, may also be lost as far as hospital suicide statistics are concerned.

This is but one aspect of the difficulties of acquiring an accurate report on the total numbers of persons who have attempted suicide. Many people who seriously contemplate or who actually attempt suicide never present to hospital emergency departments. This may lead to questions regarding the seriousness or the degree of intent of the attempt. (These issues will be discussed later in this review.)

Another source of information, as Stengel (1970) reports, is the general practitioner whose cooperation has to be sought. The simplest method of inquiry is a questionnaire. A survey covering hospitals and general practitioners should ascertain most cases of attempted suicide seen by doctors in a certain area. An inquiry of this kind carried out in Sheffeld, England in 1960-1961 revealed that about 20 percent of the suicidal attempts seen by general practitioners had not been sent to hospital (Stengel, 1970). There is an additional number of persons attempting suicide who are not seen by any doctor at the time. Not infrequently, patients admitted to hospital after a suicidal attempt report previous attempts when a doctor had not been contacted. The size of this group is impossible to estimate but it is probably not negligible.

As Hawton & Catalan (1982) have noted, most research concerning the problem of deliberate self-poisoning and self-injury has been based on patients referred to general hospitals, although it is clearly a phenomenon that occurs more widely than this method of detection suggests. This is one of the premises for doing this study. Kennedy and Kreitman (cited in Hawton & Catalan, 1982) found that a survey of general practitioners in Edinburgh indicated that they might be seeing as many as 30 percent more cases than those referred to hospital. A more extensive epidemiological investigation took into account episodes of

self-poisoning and self-injury which occurred in institutions such as psychiatric hospitals, prisons, and nursing homes, and which were not referred to hospitals, as well as cases treated out of hospitals by family doctors (Whitehead, 1973).

There are a number of treatment options open to the suicidal individual. These include private physicians, emergency clinics, private agencies and counsellors, as well as crisis lines and crisis units. Not all of these people, as previously mentioned, will be seen in a hospital emergency room. Clearly, it is not only hospital-based medical and psychiatric services that face the considerable demands in dealing with patients who have injured themselves in an attempt to commit suicide. This problem also affects general practitioners, social services, and many volunteer agencies. In all of these situations, the difficulties of compiling accurate statistics are evident.

This serves as an overview of the possible problems encountered in the determination of accurate statistics on the population of people who attempt suicide. There are, however, findings that appear consistent in the area of demography. The data that follow appear to have the most relevance to the author's study.

Demographics of Attempted Suicide

Age and Sex

One of the most common factors examined in relation to suicide attempts is chronological age of the attempter. The gender is also examined in conjunction with the attempter's age.

Deliberate self-poisoning, defined as a deliberate overdosage of drugs, and self-injury are most common in females. Hawton and Catalan

(1982) found that the number of female attempters to the number of males is usally in the range of 1.5-2.5:1. Hawton and Catalan also report that this behavior occurs most often among younger people. The highest rates for females, for example, were found between the ages of 15-19 years. As many as one in one hundred girls in this age group in the general population are likely to be referred to general hospitals each year after taking overdoses or injuring themselves. The highest rates for males occur a little later, in the age group 25-29, in which more than one out of every two hundred may be referred to hospital after such acts during any one year. In both sexes, they found the rates decline substantially in middle age and are extremely low after the age of 60 years.

Weisman (1974) also reports that regardless of place or time, there is no exception to the observation that suicide attempters tend to be young. Jacobziner (cited in Pfeffer, 1986) states that all ages are represented, occasionally as young as eight years and reach into the elderly.

Marital Status

The situation for marital status is considerably less clear than for age and sex rates. Bancroft (cited in Hawton & Catalan, 1982), reports that particularly high rates for attempted suicide have been found for teenage wives, and single and divorced women aged 24-35 years, and in single men aged 30-40 years. A study on sex, marital status and suicide found that the disparity between being married and being single (or divorced or widowed) is greater for men than women with respect to their attempted suicide rate. The conclusion of this study stated that as

marital roles are presently constituted in our society, marriage is more advantageous to men than to women while being single (widowed, divorced) is more disadvantageous to women.

Other Categories

Although sex, age and marital status are perhaps the most extensively explored demographic areas in attempted suicide, other areas have also been examined. Holding found far higher rates of attempted suicide occurred among those of lower than higher socioeconomic status (cited in Hawton & Catalan, 1982). Hawton and Catalan (1982) found that many people who make attempts, especially men, are unemployed. They also found that the behavior of attempted suicide is more common in urban areas and in areas of relative social deprivation and overcrowding.

More research is required in these and other areas of demographics before conclusive relationships can be determined.

Comparison of Attempted Suicide and Completed Suicide

It is important here, to look at similarities and differences between suicide and attempted suicide. Too often they are classified together. Such classification is inappropriate for several reasons. Hawton and Catalan (1982) cite three reasons for this. First, rates of suicide and attempted suicide have changed independently over recent years. The official suicide rates for both men and women in Britain fell substantially between 1962 and 1976. Secondly, there are marked differences between the characteristics of those who engage in the two forms of behavior.

For example, suicide becomes more common with increasing age, when it more typically involves men; whereas attempted suicide is far more common among young people, when it more typically involves women. Thirdly, suicide often entails violent self-injuries such as hanging and shooting, whereas self-poisoning and less violent self-injuries are the usual method of attempted suicide.

Lester (cited in Hawton & Catalan, 1982), had a somewhat different view of these two behaviors. He felt that suicidal behaviors fall on a continuum and that it was possible to order the different forms of suicidal behavior in terms of lethality or seriousness. (This issue is given further consideration in the following section.) Lester also felt that it was likely that one could extrapolate from investigations of groups falling at different points on the continuum to groups falling elsewhere on the continuum.

Having considered the important differences between attempted suicide and completed suicide, the association between the two behaviors must now be noted. Firstly, a very small but very important proportion of people who make attempts go on to kill themselves (Hawton & Catalan, 1982). Kessel and McCulloch (1966) found that 1.6 percent of the same original group of attempted suicides killed themselves within one year of their initial attempt. Buglass and McCulloch (cited in Hawton & Catalan, 1982) found that 3.3 percent of the same original group killed themselves within three years of their initial attempts. Secondly, a substantial proportion of individuals who kill themselves had made previous attempts (Hawton & Catalan, 1982).

At first, these two statements may appear somewhat ambiguous. However, many authors have clearly shown that a predictor of

subsequent suicide attempts or completed suicide is that of a previous history of suicidal attempts.

Repetition of Attempted Suicide

A major problem of attempted suicide behavior, is that many repeat the behavior. Bancroft and Marsack, (cited in Hawton & Catalan, 1982) state that repeats are likely to occur during the first three months after a previous episode. They go on to say that there are three types of repeaters: the chronic repeater who tends to move from one crisis to another, with self-poisoning or self-injury as a habitual method of coping; the person who has several repeats within a few months, perhaps extending over long periods of stress, such as marital conflict, but then stops for quite a long while; and the 'on-off person' who takes an overdosage at a time of severe crisis and who may occasionally repeat.

The issue of repeat attempters has many implications for prevention and treatment.

Intent and Lethality

An important issue in the area of attempted suicide involves intent. Coles Concise English Dictionary (1979) defines intent as: firmly directed; something intended; a purpose; aim; one's mental attitude at the time of doing an act. Farberow (1961) says that intention involves the concept of motivation. This includes both conscious and unconscious motivation, each of which can contribute significantly to a person's self-destructive tendencies.

Suicidal intent is an important construct in understanding the process that leads some individuals to threaten, attempt, or commit

suicide. However, this concept has received surprisingly little attention as much of the American research effort has been spent on suicidal risk, which is a quite different concept (Wetzel, 1977). For example, two equally suicidal (intent) individuals would have quite different short-term suicidal risks if one were at home alone with a gun and the other were confined on a locked psychiatric unit. Wetzel also states that in order to develop a rational approach to the treatment of suicidal individuals, one needs to be able to assess suicidal intent accurately as well as the variables that increase suicidal intent and those that decrease it. Wetzel further states that suicidal intent is an attitude; thus, it cannot be observed directly. Knowledge of it in others always depends upon inference. In the case of an actual attempt, it is possible to infer suicidal intent both from the individual's statements and their behavior.

However, even though the most direct approach to discovering the patient's intention is naturally to ask him/her what they were trying to do at the time, it is unlikely that they will be entirely truthful about their intentions (Pierce, 1977). Pierce states that subjects may be ashamed of what took place, whether their action was a genuine bid at suicide or whether the action was manipulative; they may minimize any suicidal ideation because they are anxious to leave hospital, or they may be too confused to remember how they felt.

Given the aforementioned difficulties in the determination of intent, scales have been devised to attempt to measure the degree of intent (Beck, Resnik, & Lettieri, 1974). However, the controversy surrounding the question of suicidal intent has spawned a variety of terms such as "suicidal gesture," "abortive suicide," "simulated suicide," "pseudo-suicide," and "sub-intentioned suicide" (Beck, Beck, & Kovacs, 1975).

It is often difficult to understand what a writer means by a "serious suicide attempt" because some authors confound the degree of an individual's intent to kill themselves with the medical consequences of the suicidal act (Beck et al., 1975). Thus, in recent years, a number of efforts have been made to introduce greater clarity and order into the study of suicidal behaviors. A major step in this direction was Stengel and Cook's (cited in Beck et al., 1975) separation of suicidal intent from the physical consequences of the act. The problem of denoting the genuineness or seriousness of an individual's attempt or desire to end their life was handled by conceptualizing intent as a dimension. Thus, patients who gave unmistakable evidence of a determination to end their lives but who suffered little physical damage as a result of the suicidal attempt would be rated high on the intent scale and low on the medical lethality dimension.

Sifneos (1981) states that a physician makes a serious mistake in assessing the physical consequences resulting from a suicidal action as not serious and labelling the act as a "gesture" without carefully inquiring into the intent. By implication an assumption is made that the person is knowledgeable in pharmacology or anatomy, and is cognizant of the exact amount of poison, for example, which is necessary to cause death. It should be remembered, therefore, that the severity of the motive and the person's wish to die are what should be examined, and not only the physical signs (Sifneos, 1981). The physical signs or symptoms are the act of self-destruction and the intent of this action should always be assessed very carefully.

With this knowledge, a study by Beck et al. (1975) indicates that when patients have an accurate conception of the lethality of their

suicidal acts, the resulting degree of danger to their life is proportional to their suicidal intent. The study thus supports the conceptual usefulness of the dimension of intent as a qualifying term in designating attempted suicides and the validity of the Suicidal Intent Scale as a measure of the seriousness of intent, since in the majority of cases the patient inaccurately conceived the lethality of their act.

Clearly, as Stengel and Cook (cited in Beck et al., 1975), pointed out, suicidal intent and lethality must be considered separately. The dimensions of intent and accuracy of conception of the lethality of the act have important implications for the assessment and management of suicidal behaviors. A patient with high intent and accurate conception would generally be at high risk, low intent and accurate conception would be at lowest risk, and high intent and inaccurate conception at intermediate risk.

The final issue to be examined with regards to intent, is that of awareness of the effect of the individual's threats and/or attempts on others. When a person is very much aware of the effect of their threats and/or attempts on others, the manipulative element in their behavior assumes great significance (Farberow & Shneidman, 1961). Farberow and Shneidman state that the more consciously aware the persons are of the effect of their behavior upon other people, the more likely it is that their behavior will represent a nonlethal kind of self-destructive behavior.

This type of intended behavior may have varied consequences for the individual. Any suicidal behavior is often viewed unfavourably by physicians who provide resuscitative care for patients after overdoses (Ramon, Bancroft & Skrimshire, 1975; Patel, 1975; Ghodse, 1978).

Thus, when an individual gives an explanation for an overdose, this may be influenced by the attitudes that person perceives in those around them. Similarly, the explanations given by those involved in a person's care may also be structured by their attitudes to the behavior. For example, physicians (Ramon et al., 1975), and psychiatrists are more favourably disposed towards people whose attempts are seen as being aimed at death, compared with those whose acts are seen as having a manipulative purpose (Hawton & Catalan, 1982).

The view of psychiatrists is very important because during clinical work with overdose patients they are likely to be trying to explain the behavior and their explanations will provide the basis for important decisions concerning subsequent management (Hawton & Catalan, 1982). It is interesting to note that a study done by Bancroft (cited in Hawton & Catalan, 1982) showed that psychiatrists only agreed on suicidal intent for 53 percent of the patients who said they had wanted to die. This difference between self-poisoners themselves and psychiatrists in the attribution of suicidal intent is of considerable interest and may have far reaching implications in the management and treatment of those who attempt suicide.

Causational Factors of Attempted Suicide

There are many potential causational or motivational factors involved in the act of attempted suicide. Some of these areas may be readily identifiable such as a "situation crisis," while others may appear somewhat vague about the nature of their relationship to the feelings of the attempter. This section of the chapter examines some of the potential causational/motivational factors of attempted suicide.

Theoretical Viewpoints

A variety of researchers have presented a collection of reasons/ bases for attempted suicide. Not all researchers agree on these areas. Presented now is a short selection of these varying viewpoints.

Katsching and Steinert (1975) regarded attempted suicide as a strategy for getting out of emotionally troublesome situations. They felt that this strategy is a bodily and risky "cry for help," but also a cry for help with almost certain success as the bodily self-damage forces significant others to show indulgent behavior. Lukianowicz (1972), confirmed his hypothesis that suicidal behavior was an attempt at modifying the environment to the patient's benefit. Farberow and Shneidman (1961) offered their theory on attempted suicide as a "cry for help." These are but three viewpoints among others that may have been selected for presentation. The remainder of this section will present a more detailed look at various components that may or may not play a role in an individual's suicidal behavior.

Depression

Depression is often a critical factor in attempted suicide. Hawton and Catalan (1982) report that many patients who take overdoses have recent psychiatric symptoms which in a sizeable proportion of cases indicate psychiatric disorder. For most of these patients, the disorders are mild and mostly take the form of depression. In addition, the disorder in most cases is relatively transient. It appears that the disorders are usually secondary to the types of difficulty in the patients' lives.

There are various types and classifications of depression. The most commonly accepted standards of these classifications are taken from the Diagnostic and Statistical Manual of Mental Disorders (DSM III) (American Psychiatric Association, 1980). The various forms of depressive illness fall under the category of Affective Disorders in this classification. There are five types of depression although there may be various subtypes under these categories. These main categories are: Bipolar Affective Disorders, Major Depressive Disorders, Neurotic Depression (renamed dysthymic disorder in DSM III), and chronic dysthymic. The final category includes those disorders which are secondary to other diseases. The social worker must be aware of the differences in diagnosis and the correct procedure to follow in the treatment plan. Different categories of depression call for different treatment plans.

Biological/Developmental Factors

Bassuk, Schooner and Gill (1982) felt that suicidal thoughts and behaviors emerge when a developmentally and/or biologically vulnerable individual loses the means of maintaining a sense of inner security and self-worth. The person is then flooded by feelings of utter aloneness, worthlessness, and despair. There is almost always an accompanying rage which is poorly tolerated by a harsh conscience and for multiple reasons become directed at the self. Bassuk et al. (1982) also state that suicide offers relief from inner pain, punishment of the guilty, worthless self, and riddance of tormenting introjects, while allowing the full expression of murderous rage. It may also hold out the promise of merger or union and a retreat from a painful, lonely separateness.

Life Events

From studies of patients who have become suicidal, it has been learned that an early life event felt to be highly associated with later suicidal tendencies was the loss of a love object, parent, or other, at an early age in development. Moss and Hamilton (cited in Resnik & Hathorne, 1973), found this to be true in hospitalized suicidal patients, and Hill; Hall and Price; and Walton (cited in Resnik & Hathorne, 1973) found a significant relationship between suicidal behavior in depressed inpatients and the death of a parent in childhood. This was especially true for depressed women who lost their fathers when aged 10-14 and, to a lesser degree, men and women who lost their mothers in the first ten years of life. Factors of unstable family life with parents divorced or separated for significant periods of time, stormy family experiences, and examples of suicidal behavior by parents, were also found. Schrut (cited in Resnik & Hathorne, 1973) believed that the isolation of the child, poor or no intrafamilial communication, and strongly implanted feelings of guilt were especially important in the suicidal behavior. Paffenberger, King and Wing (cited in Resnik & Hathorne, 1973) speculated on characteristics in youth that predisposed to suicide and accidental death later in life and noted that anxiety and despair characterized their future suicide, while nonchalance predisposed to future accident.

Alcoholism

As Kessel (1966) points out, suicide attempts often take place during a drinking spell, and the disturbance in thinking caused by intoxication distorts both the motive and the planning. Kessel goes on

to say that an overdose of pills is very often taken impulsively, without more than a moment's consideration. When such patients recover consciousness in hospital they often cannot explain why they did it. Some are unsure as to whether they intended to die or to force their plight upon people's notice.

Suicidal Personalities

How are suicidal personalities formed? Why does one person become suicidal and not another? Experience has shown that there is no one suicidal personality; rather there are many syndromes with varying characteristics (Resnik & Hathorne, 1973). Can we describe the necessary, if not sufficient, kinds of development factors and critical experiences which would "produce" a suicidal individual, that is, someone who will develop marked self-destructive tendencies in adulthood given exposure to appropriate events and pressures? A striking aspect of individuals considering suicide is that they do not form a homogenous group. They come from a broad spectrum of different life situations and are not similar in personality. Some are stable people with roots in family and community life, while others lead unstable lives, riddled with failure in most of their interpersonal dealings. All these people, however, share the condition of being in a serious life crisis. Most commonly, their symptoms are those of severe depressive syndrome - sleep disorder, appetite loss, and psychomotor retardation. Often there are disorganized activity states with exaggerated tension, perturbation, and pan-anxiety (American Psychiatric Association, 1980). The crisis may or may not be related to specific life stresses. Such events as divorce, the death of a loved one, financial loss or sudden legal

involvements may trigger suicidal concerns. In a number of people, however, there seems to be no discernible precipitating stress. Rather, there seems to have been a slow, steady loss of the ability to function adaptively.

Suicidal Crisis

In a suicidal crisis there is a radical change in persons' view of themselves and their relationship with others. This often shows itself as an increase in stereotyped perceptions, that is, it is difficult for people in a suicidal crisis to generate new ideas, feelings, or plans without the help from others. A suicidal person is often severely constricted in thinking about personal problems. The individual has so little perspective that the past seems forgotten and the future unimaginable. The view of the present is rigidly confined to a small number of alternative behaviours of which suicide is one.

Suicide Syndrome

In a reanalysis of 137 cases of completed suicide among persons aged 60 or younger in New Orleans, Breed (cited in Resnik & Hathorne, 1973) has sketched a suicide syndrome composed of seven dimensions. The author feels that these seven dimensions, based on the literature available, may also represent the attempted suicide population. These seven dimensions are:

1. failure in a major role;
2. low self-esteem in response to failure;
3. culture trap (strong internal restraints);
4. inflexible behavior;

5. psychopathology;

6. social isolation; and

7. insecure childhood.

This section has been an overview of some of the possible or potential reasons that account for individuals attempting suicide. There are others which have not been mentioned, such as psychiatric illness. This was not an oversight. The literature on this area is both voluminous and contradictory. Further, there is little that focuses on theoretical explanations of attempted suicide. Thus, the author has concluded that the relevance of the material for the study is not significant.

Summary

This literature review has examined various components of attempted suicide. It is evident that even though there is beginning to be a substantial research base on this issue, the information put forth is often contradictory or inconsistent and it does not provide a complete picture. More indepth and extensive research is required to provide an adequate knowledge base to fully understand this issue. This literature review has provided an overview of the types of areas that are being examined and that need further examination, and has shown the type of information sought in the present study.

In the next chapter the methodology utilized in the project will be presented and discussed.

CHAPTER THREE

METHODOLOGY

The purpose of this thesis is to contribute to the knowledge base about attempted suicide. The research involves a pilot study of fifteen adults who have attempted suicide. In this chapter, information on various aspects of the design and methodology is presented.

Setting

The agency utilized in this study is the Canadian Mental Health Association (CMHA). CMHA is a national association with affiliated provincial and regional agencies across Canada. The Calgary agency serves the city of Calgary and the south central region of Alberta. It provides a variety of direct services, residential and social action programs. The program utilized in this study was the Suicide Intervention Program. This is a direct service program to provide counselling and social support services to individuals who have attempted suicide. The program has three major components:

1. Matching of clients and volunteers for the purpose of providing support and direction in daily life situations;
2. Crisis intervention, which provides immediate response to clients on an emergency basis; and,
3. Referral/counselling which provides clients with additional services to meet their individual needs.

The program was staffed by one paid coordinator. All other personnel were volunteers who received training in intervention with suicidal clients. Access to the program was limited by age and type of

referral. Any person eighteen years and over was eligible to receive the services of the program. Thus, all socioeconomic, cultural and religious denominations may be represented in their subject population. All clients in the program are referred through health and social service agencies such as hospitals. or through professionals such as physicians and social workers. Self-referrals are not accepted. Thus, there may be some limitations in the type of subjects referred to the program. Clients were seen both in their own homes and in the offices of CMHA.

Research Design

This is an exploratory, descriptive survey of fifteen adult subjects, aged eighteen years and over, who have attempted suicide within one year prior to this research undertaking. A descriptive method was chosen instead of other methods of research for various reasons. Descriptive research is used in the literal sense of describing situations or events. It is the accumulation of a data base that is solely descriptive--it does not necessarily seek or explain relationships, test hypotheses, make predictions or get at meanings and implications although research aimed at these more powerful purposes may incorporate descriptive methods. The purpose of descriptive research or survey studies is:

1. to collect detailed factual information that describes existing phenomenon;
2. to identify problems that justify current conditions and practices;
3. to make comparisons and evaluations; and
4. to determine what others are doing with similar problems or situations and benefit from their experiences in making future plans and decisions (Issac & Mitchell, 1971).

As one of the objectives of this study is to describe the characteristics of a population of subjects who have attempted suicide, a descriptive survey was considered as best suiting this objective. It was not the intent of this study to generate hypotheses and test relationships between variables.

Sample

The sample for this study was chosen from the population of clients in the Suicide Intervention Program. At the beginning of the study, the program had approximately 50 clients. By the end of the data collection period, the number of clients had risen to about 120. A sample of 30 subjects was to be selected. By the end of the data collection period, however, only 15 were obtained. Had more subjects been available at the beginning of the data collection period, the number of subjects that were able and willing to take part in the study may have been higher. However, even with the increase in subject numbers throughout the data collection period, there did not appear to be any significant increase in the number deemed appropriate to partake in the present study. The sample was a non-probability convenience sample. The major reason for choosing this type of sampling procedure, although it has its limitations, was due to the conditions set down by the agency for inclusion of subjects in the study. Subjects had to be emotionally stable at the time as determined by staff of the program and the anonymity of each subject had to be ensured. Selection of the subjects was made by the coordinator of the Suicide Intervention Program. She selected subjects according to her knowledge of their ability to complete the questionnaire, their present emotional stability and their willingness and availability to

complete the questionnaire. Additional criteria utilized in the selection of subjects was their level of reading and writing comprehension. This criterion was identified in the pre-test. Some subjects possessed a limited comprehension level of the written language. The questionnaire was modified in order to accommodate these subjects as much as possible; however, there remained unavoidable limitations.

The sample selected met the following conditions:

1. subject age was eighteen years or over;
2. subjects had attempted suicide; and
3. subjects had attempted suicide in the past year.

This last condition proved to be an ideal rather than a realistic criterion. The final sample included subjects whose attempt had occurred prior to this one year stated period.

Instrument

The survey instrument was constructed from a number of sources. The main format was adapted from an interview schedule used in a general population study in Alberta entitled, "The Meanings and Experiences of Suicidal Behaviors in an Urban Population" (as reported in Ramsay & Bagley, 1984). In the Ramsay and Bagley study, several sections of the questionnaire incorporated revised research instruments used in previous work. Three of the instruments that dealt with self-esteem (Bagley & Evan-Wong, 1975), suicide probability (Cull & Gill, 1982), and mental health (Bagley, 1980) were utilized in this study. Other instrument questions were based on the author's own research interests and experiences involving work with suicidal clients. The survey instrument contains variables of seven major types:

1. Personal and demographic information. Examples: sex, age, marital status, living arrangements, education, occupation, medical history and religious background.
2. Mental health and suicide probability scales. Example Questions: How often do you feel that in order to punish others you think of suicide? How often do feel so lonely you cannot stand it? How often do you feel that the world is not worth continuing to live in?
3. General life experiences. Example Questions: In the past six months, did any of the following happen to you: Death of spouse? Marital separation? Death of a close family member? Personal injury or physical illness? Loss of job in the family?
4. Familial suicidal history. Examples: Identify family members that have a suicidal history. Identify the type of suicidal behavior involved.
5. Subject's history of most recent attempt. Example Questions: How was the attempt made? Was subject admitted to hospital following attempt? Is the subject receiving counselling at this time? Identification of the reason(s) for the attempt.
6. Subject's history of past suicidal attempts. Examples: The number of the subject's past attempts; The methods the subject used in attempt(s); The subject's reasons for past attempts.
7. Service evaluation. These questions focused on the subject's opinions of the services that they received through CMHA. These results are not included in the thesis as they were to be used only for the host agency's purposes.

The survey instrument was designed as a self-administered questionnaire which required only minimal outside direction. The

questionnaire was utilized rather than an interview schedule or a method of observation. A self-administered questionnaire was used to protect the subject's identity. Administration of the questionnaire was supervised by a volunteer or the coordinator of the program, who was familiar with the subject and who could respond appropriately if the need arose. This procedure was implemented to ensure that if any negative emotional responses were evoked in the subject through the process of completing the questionnaire, a volunteer or staff person would be present. The agency involved accepted this format and agreed to administer the questionnaire according to it. The questionnaire was designed to be completed in approximately one hour, although this depended upon the subject's writing skills and comprehension level.

Procedures for Data Collection

Due to the reformulation of the original interview schedule, changes in the questionnaire and the type of information sought, a pre-test was conducted. Pre-test interviews were arranged by the coordinator of the Suicide Intervention Program. As the original sample was to be 30 subjects, the pre-test consisted of six subjects. At the time of the pre-test interviews, the available subject population was limited; thus, this number seemed appropriate. The pre-test interviews were jointly administered by the author and the coordinator of the program.

The pre-test was conducted using the same procedures as planned in the study. Each subject completed the questionnaire individually without external direction. Following completion of the questionnaire, the results were assessed by the subject, the program coordinator and the author. A list of questions was previously devised to determine the

questionnaire's clarity, understandability, thoroughness and ease of completion. The subjects were encouraged to express any problems encountered with the completion of the questionnaire and were asked for their suggestions regarding format changes, including additions and deletions to the questionnaire. The subjects' input proved invaluable in formulating the appropriate changes in design, wording style, and content of the final questionnaire format.

The pre-test results were analyzed and then discussed with the assistant director of the agency and the coordinator of the program. The subsequent changes to the questionnaire were then presented to the author's supervisor for approval. Additional suggestions for changes were then made and the questionnaire revised. The final revision of the questionnaire was then submitted to the Social Sciences Human Ethics Committee for their approval. Upon receipt of this approval, the survey was implemented.

The types of changes in the questionnaire as a result of the pre-test included, among others, simplification of terms, omission of repetitive questions and clarification of ambiguous statements.

The original procedure for obtaining subject participation in the study was to have the volunteer, who was currently working with that subject, take the questionnaire out to the subject's home on a routine home visit. Instructions were given to the volunteers in order that they be fully aware of their roles in the questionnaire implementation. However, this approach to data collection proved to be an inefficient method of gathering the data. The original procedure for the distribution of the questionnaires had to be revised after receiving little response with this initial procedure. The revision of data collection

procedures included: sending out an explanatory letter to the subjects from the coordinator of the program (see Appendix A), following this letter up with a phone call to the subject from the coordinator, and then having the coordinator arrange a time suitable to the subject to complete the questionnaire at CMHA. Although this revised method of distributing the questionnaires and collecting the data was believed to be more time efficient, the ultimate data collection took eleven months. Approximately six months was spent on the first procedure and five months on the second procedure.

Following completion of the questionnaire, the subjects were instructed to seal the questionnaire inside an envelope provided and to repeat the procedure with the signed consent form (see Appendix B). The completed questionnaires were then returned to the author while the consent forms remained on file at the agency. This procedure was implemented so that anonymity was ensured. The subjects then had the opportunity to discuss any difficulties they had, either in completing the questionnaire or were experiencing as a result of its completion. The coordinator of the program was available to the subjects for this purpose although no problems were reported.

Validity and Reliability

To enhance the validity, that is, to ensure that the questionnaire measures what it was intended to measure (Grinnell, 1985) the following procedures were implemented:

1. Using response categories based on a review of the literature and from a previous study.

2. Using structured responses where possible, specifying behaviors and experiences.
3. Providing a range of possible responses in each category where applicable.
4. Using mutually exclusive categories.
5. Using previously validated scales on self-esteem, suicide probability and mental health.
6. Pre-testing to identify ambiguous questions and response categories.

To enhance the reliability, that is, the extent to which repeated applications would yield consistent results free from bias or error (Grinnell, 1985), the following procedures were implemented:

1. The use of structured responses where possible.
2. The use of clear, unambiguous questions.
3. Careful wording of sensitive questions to allow respondents to give what might be considered a socially unacceptable answer in order to reduce acceptability bias.
4. Guaranteed anonymity to enhance the likelihood of accurate information about a highly sensitive and personal issue.
5. Using exactly the same questionnaire with all subjects.
6. Pre-testing to identify ambiguous questions and instructions.
7. Using previously tested scales on self-esteem, suicide probability and mental health.

Summary

A self-administered questionnaire was designed to survey subjects on their experiences with attempted suicide. Fifteen subjects completed

the questionnaire. The data were collected over a period of eleven months.

In the next chapter, the results of the research design and methodology will be examined and the data that were gathered will be analyzed.

CHAPTER FOUR

RESULTS

The results of the pilot project are presented in this chapter. The first part of the chapter reports on the methodology used in the project by presenting information on its limitation and those difficulties that arose through the process of questionnaire completion. The second part of the chapter analyzes the data received and presents issues for further research.

Methodology and Design Limitations

Study Design

There are numerous limitations inherent in utilizing a survey methodology to collect data from subjects who have attempted suicide. The use of a self-administered questionnaire precludes investigator observation and exploration of subjects' subjective feelings. One of the aims of the questionnaire was to elicit subjective responses from the subjects. The extent of elaboration on the open-ended questions was beyond the control of the author.

Questionnaire Distribution

The procedure for questionnaire distribution presented the major difficulty in the areas of expediency and efficiency in this study. The lack of direct access to the subjects was a major limitation of the study. Access to the subject population and distribution of the questionnaire were dependent on the availability and cooperation of staff persons in the host organization. This method of questionnaire distribution created

lengthy time delays and limited the total number of questionnaires that could be completed. Distribution and completion of the questionnaires was expected to take approximately three months. Instead it took eleven months to obtain fifteen completed questionnaires instead of the expected thirty questionnaires. Direct access to the subject population by the principal investigator must be obtained if this study is to be conducted on a larger scale.

Questionnaire Construction

An initial issue in the questionnaire construction concerned the length of the instrument. Prior to the pretest, the author and program director of the host agency thought that the subjects might find the instrument too lengthy and requiring too much of their time to complete. The results of the pretest and the subsequent pilot study did not validate this concern. Approximately 96 percent of each questionnaire was completed in its entirety although some subjects supplied longer, more detailed answers to some of the open-ended questions than others did.

Question Format

The only difficulties encountered with the completion of questions occurred with the open-ended format. Future use of this questionnaire should replace the open-ended format with a multiple answer format. Although multiple answer selection has its own potential weaknesses such as the possible exclusion of important responses, subjects may find this a less laborious procedure than devising, wording and writing out their own answers. However, the open-ended questions would not be omitted

in their entirety as the subjects will often provide information that is unique to their past and present difficulties and which ultimately gives a more accurate and clearer picture of their life situation.

Question Content

There was not enough specific information elicited on certain questions. This was particularly evident in the section that dealt with the death of the subject's parent(s). The age of the subject at the time of the death was not requested and this information could have been of significance in the determination of predisposing factors for future suicidal behavior. This omission should be corrected if this study is to be conducted on a larger scale.

More questions concerning the subjects' current attitude towards life and methods of coping with stress and further crisis may be of benefit in their overall assessment. In particular, questions designed to evaluate and determine their present feelings about the repetition of suicidal behaviors. This type of information would be geared to making a determination of those currently at risk, however, and this in itself, was not an objective of this study. This type of information may also serve as a useful tool in determining the benefits or current effectiveness of the treatment being received by the subject. However, this again is outside the realm of this study.

Repetitious and ambiguous questions should be omitted. This was most noted in the section on employment. Changes made after the pretest reduced most of the ambiguity, nonetheless, a few minor revisions remain to be made.

Data Analysis

Method of Analysis and Data Presentation Format

Elementary data analysis is utilized in this study for two reasons: (1) the limited size of the study sample; and (2) the method of sample selection.

As indicated by Grinnell (1985), sampling size should be no less than thirty in order to use basic statistical procedures. The sample size in this project was fifteen which rendered the existing sample as unacceptable in meeting this basic criterion. For example, an elementary nonparametric technique such as chi square assumes that the minimum frequency is not less than 5 (Issacs, 1971; Loether, & McTavish, 1974). This is basically impossible for this study with N = 15.

The sample was selected by a non-probability method and is identified as a convenience, accidental, availability or voluntary (Loether & McTavish, 1974) sample. It is well known that non-probability sampling techniques, such as demonstrated in voluntary samples, are not able to estimate the degree of sampling error (Loether & McTavish, 1974). Because of this fact, any statistical relationships that might exist from the sample could not be determined as being representative of a larger population. Random selection is the key to generalizability, and further, necessary for statistical procedures (Fergusen, 1981). In other words, non-probability samples cannot represent the characteristics even from the overall population from which they are drawn (Babbie, 1983).

These are the two central reasons for the elementary data analysis utilized in this study. Advanced statistical analysis was not possible due to the sample size and any results arising from the data could not be generalized to a larger population or used in comparative analysis

with other studies due to the non-probability sample. With the knowledge of non-generalizability to a general population and the limited sample size, the Fisher Exact Probability Test was utilized (Siegel, 1956). The Fisher Exact Probability Test is an extremely useful non-parametric technique for analyzing discrete data (either nominal or ordinal) when the two independent samples are small in size. It is used when the scores from two independent samples all fall into one or the other of two mutually exclusive classes. In other words, every subject in both groups obtains one of the two possible scores. In this project, the Fisher Exact Test was utilized in order to determine any significant differences between the responses of male and female subjects. The purpose of applying this statistical technique to the available data is to identify potential research questions and/or areas for further study.

The following tables present the characteristics of the project sample based on the 15 completed questionnaires. These characteristics are presented in percentage tables. Frequency distributions were utilized to facilitate the comparison between the two subject groups. The total number of subjects is given with each category to provide further clarification for the reader. Where appropriate, the Fisher Exact Test is applied and these results are included, indicating either no significance or the degree of significance between male and female subjects. The Fisher Exact tables are given in absolute numbers. Following each table is a descriptive analysis of the interpreted data and/or potential questions/issues for further research in the area.

Table 1

PERCENTAGE DISTRIBUTIONS OF MALE AND FEMALE SUBJECTS BY AGE AND MARITAL STATUS

Variable	Male %	Female %	Total %
Gender (N = 15)	47	53	100
Age (N = 15)			
18 - 30 years	72	50	60
31 - 40 years	14	38	27
41 - 50 years	14	12	13
	100	100	100
Marital Status (N = 15)			
Married	14	38	27
Single	58	38	47
Divorced	14	12	13
Separated	14	0	7
Other	0	12	6
	100	100	100

Table 1 shows the ratio of female to male subjects was virtually 1:1. The age range varied between these two categories. There was a greater percentage of males in the 18-30 year category. This is contrary to existing research which shows that females represent the younger age category in attempted suicide. A possible relationship to examine further then, is to determine if the age of the attempter is a significant factor in differentiating between male and female attempters. Are we seeing the same proportion of males and females going for help, or is there a difference between these two groups?

Marital status, as shown in Table 1, indicates that a higher percentage of males was single, while a higher percentage of females was married. A possible relationship to test in a further study would be the relationship between marital status and the incidence of attempted suicide. Existing literature indicates that marriage serves as a greater protection from attempted suicide for males than it does for females.

Table 2

GENDER OF SUBJECTS BY AGE AND MARITAL STATUS

Gender	Age and Marital Status		
	Age Under 30 Years	Age Over 30 Years	Total
Female	4	4	8
Male	5	2	7
	9	6	15
	Single	Together	Total
Female	5	3	8
Male	6	1	7
	11	4	15

The above tables were grouped according to age and marital status. The median age for the combination of males and females was 29.6 years, so age thirty was chosen as the division point.

The collapsed categories for marital status were under the headings of single and together. The single category included those subjects who were single, divorced or separated. All other subjects were classified under the marriage category.

Table 2 shows no significant difference according to the Fisher Exact Test.

Table 3

PERCENTAGE DISTRIBUTIONS OF MALE AND FEMALE SUBJECTS BY LIVING ARRANGEMENTS, EDUCATION AND RELIGIOUS AFFILIATION

Variable	Male %	Female %	Total %
Living Arrangements (N = 15)			
With parents	29	0	13
Alone	71	50	60
With Spouse	0	38	20
With Children	0	12	7
	100	100	100
Education (N = 15)			
Less than high school	0	12	7
High school - partial	71	88	80
College	29	0	13
	100	100	100
Religious Affiliation (N = 15)			
Protestant	14	25	20
Catholic	29	25	27
Other	28	0	13
None	29	50	40
	100	100	100
Subject presently part of a religious group (N = 15)			
Yes	14	25	20
No	86	75	80
	100	100	100

Table 3 shows that 60 percent of the subjects lived alone. An issue in attempted suicide concerns isolation. Does isolation affect the sexes in different ways? If so, how does this relate to attempted suicide? As indicated in the literature review, attempted suicide is particularly high in single and divorced women aged 24-35 years, and in single men aged 34-40 years. The occurrence of attempted suicide is far more common where the marital relationship has recently been disrupted through separation (Hawton & Catalan, 1982). However, as shown in Table 3, 38 percent of the females reported that they lived with their spouses. Can women experience marital disruption without separation and still be at risk of attempting suicide? Existing literature indicates that if the man stays in the relationship, this serves as a protection for

him, but if the woman stays in the relationship, this serves as no protection to her.

Eighty percent of the subjects had a partial high school education. Does this indicate that those with a higher level of education are at less risk for attempted suicide than those with less education? Or perhaps, do people with higher education not access public education groups or community agencies? What impact does socio-economic status have on people in relation to suicide attempts? Does attempted suicide cross all of these boundaries and if so, does it cross these boundaries equally?

It is noteworthy that 80 percent of all subjects reported that they did not belong to a religious group or organization. Sociologists have been examining the role of religion in many areas. A future research area may be to examine if those who are a part of a religious group have a lower incidence of attempted suicide than those who are not part of a religious group. Is there a difference between belonging to a religious group versus belonging to a religion? Does the support of a fellowship within a group affect the incidence of attempted suicide?

Table 4

GROUPED SUBJECTS BY GENDER, LIVING ARRANGEMENTS, EDUCATION AND RELIGIOUS AFFILIATION

Gender	Grouped Categories		
	Living Alone	Living With Others	Total
Female	4	4	8
Male	5	2	7
	9	6	15
	Less Than High School Education	More Than High School Education	Total
Female	8	0	8
Male	5	2	7
	13	2	15
	Member of Religious Group	Not Member of Religious Group	Total
Female	2	6	8
Male	1	6	7
	3	12	15

Table 4 was grouped according to living arrangements, education and religious affiliation. The two grouped categories utilized for living arrangements were living alone and living with others. The category of living alone included only those who were living in a solitary environment. The category of living with others included those who lived with their parents, their spouse or their children.

The two categories used to group the area of education were less than high school education and more than high school education. Less than high school education included all subjects who had less than a Grade Twelve education. All others reported a Grade Twelve or higher education.

The two categories used to group the area of religious affiliation were member of religious group and not a member of a religious group.

These two areas are descriptive of the subject's sense of belongingness to a religious group versus identification with a particular religious denomination. Table 4 shows no significant difference according to the Fisher Exact Test.

Table 5

PERCENTAGE DISTRIBUTIONS OF MALE AND FEMALE SUBJECTS BY NUMBER OF BROTHERS, NUMBER OF SISTERS AND PARENTAL STATUS

Variable	Male %	Female %	Total %
Brothers (N = 15)			
1 - 3	72	75	73
4 - 8	14	25	20
0	14	0	7
	100	100	100
Sisters (N = 15)			
1 - 3	57	50	53
4 - 6	14	25	20
0	29	25	27
	100	100	100
Biological Parents (N = 15)			
Mother living	86	100	93
Mother deceased	14	0	7
	100	100	100
Father living	43	63	53
Father deceased	57	37	47
	100	100	100
Parents That Raised Subject (N = 15)			
Living together	14	13	13
Divorced	57	25	40
Separated	0	25	13
Other	29	37	34
	100	100	100

In this study, the numbers indicated a high incidence of the subject's father being deceased. Is there a different impact on the subject if there is the death of the father versus the death of the mother? What, if any, is the relationship between the death of one or both parents and the subject's attempted suicide? A further point that

needs to be examined is the age of the attempter at the time of the parent's death and its relationship to attempted suicide.

An additional point raised is that 53 percent of the subjects reported that their parents were either divorced or separated. Is there a relationship between the marital status of the parents and a subject's attempted suicide? Is the timing of the separation significant or the age of the subject at the time?

Table 6

PERCENTAGE DISTRIBUTIONS OF MALE AND FEMALE SUBJECTS BY OCCUPATION, EMPLOYEMENT STATUS AND SOURCE OF INCOME

Variable	Male %	Female %	Total %
Occupation (N = 15)			
Professional	0	12	8
Skilled Labor	20	12	15
Unskilled Labor	40	25	31
Homemaker	0	38	23
Student	20	0	8
Artist	20	13	15
No data: 2 subjects			
	100	100	100
Employment Status (N = 15)			
Employed	14	37	27
Unemployed	86	63	73
	100	100	100
Length Unemployed (N = 11)			
1 year and under	50	60	56
2 years	25	0	11
Over 2 years	25	40	33
No data: 2 subjects			
	100	100	100
Source of Income (N = 11)			
Unemployment Insurance	75	0	43
Public Assistance	0	67	29
Family Support/Income	25	33	28
No data: 4 subjects			
	100	100	100

The unemployment rates for both males and females are very high in this sample. Males frequently reported unemployment as one of the causational factors for their attempted suicide versus the females who

tended to report relationship problems as their primary difficulty. Does the issue of unemployment affect males more than females in relation to their suicide attempts? Is employment more important to males than interpersonal relationships?

It is of interest to note that almost half of those unemployed reported their present source of income as unemployment insurance. More males reported this as their source of income than females and more females reported income from public assistance and family support than males. A further area to examine would be the chronicity of unemployment and illness (psychiatric) in relation to suicide attempts. Are males less prone to chronic or long-term psychiatric disability than females? Are there social factors involved that bias males versus females in respect to psychiatric disability?

Table 7

GROUPED SUBJECTS BY GENDER AND EMPLOYMENT STATUS

Gender	Grouped Categories		
	Subject Employed	Subject Unemployed	Total
Female	3	5	8
Male	1	6	7
	4	11	15

No significant difference was found in this grouping according to the Fisher Exact Test.

Table 8

PERCENTAGE DISTRIBUTIONS OF MALES AND FEMALE SUBJECTS BY MEDICAL CONDITION, TYPE OF MEDICATION AND PRESCRIBER OF MEDICATION

Variable	Male %	Female %	Total %
Medical Condition Requiring Treatment (N = 15)			
Yes	14	63	40
No	86	37	60
	100	100	100
Subject Taking Medication (N = 15)			
Yes	14	50	33
No	86	50	67
	100	100	100
Medication Prescribed For (N= 5)			
Biological	100	0	20
Psychological	0	100	80
	100	100	100
Prescriber of Medication (N = 5)			
General Physician	100	25	40
Psychiatrist	0	25	20
Both	0	50	40
	100	100	100

Table 8 shows some interesting aspects of the differences in medical care/treatment between males and females. Females far outnumbered the males in both medical conditions requiring treatment and in receiving medication. Yet, when one examines the data further, it shows that all the males were taking medication for biological reasons while all the females were taking medication for psychological reasons. Also, all males reported the medication being prescribed by a general physician while 75 percent of the females indicated that a psychiatrist was involved in the prescription of the medication. Is it more acceptable for females than males to accept psychiatric treatment? Are males treated differently in the prescribing of medications than females? If so, what are the implications of this practice in relation to male suicide attempts? Does this practice affect the method of attempt used by males and

consequently, the level or degree of the lethality of the act? Does this offer any implications for the prevention of suicide?

Table 9

GROUPED SUBJECTS BY GENDER AND MEDICAL CONDITION

Gender	Subject Has Medical Condition	Subject Does Not Have Medical Condition	Total
Female	5	3	8
Male	1	6	7
	6	9	15

No significant difference was found in this grouping according to the Fisher Exact Test.

Table 10

PERCENTAGE DISTRIBUTIONS OF MALE AND FEMALE SUBJECTS BY SUICIDE PROBABILITY, SELF-ESTEEM AND MENTAL HEALTH RATING SCORES

Variable	Male %	Female %	Total %
Suicide Probability Scoring (N = 15)			
Scored 1 - 23	0	0	0
Scored 24 - 46	86	75	80
Scored 47 - 70	14	25	20
	100	100	100
Self Esteem Rating (N = 15)			
1 - 29	0	0	0
30 - 59	57	75	67
60 - 88	43	25	33
	100	100	100
Mental Health Rating (N = 15)			
1 - 39	0	0	0
40 - 78	43	12	27
79 - 116	57	88	73
	100	100	100

Tables 10 and 11 include, in order of presentation, a factorially shortened version of Cull and Gill's (1982) suicide probability scale; a

short measure of Coopersmith's self-esteem scale (Bagley & Evan-Wong, 1975); and, the Middlesex Hospital Questionnaire (Bagley, 1980).

The psychological scales show some interesting differences. A greater percentage of females than males scored higher on the suicide probability scale, while a higher percentage of males scored lower on the self-esteem rating. In addition, more females scored low on the mental health ratings. Do females consistently have a lower overall rate of mental health than males, and if so, is this then a potential predictor for attempted suicide? Does the difference on self-esteem ratings account for the differences between suicide and attempted suicide rates for males and females?

Table 11

GROUPED SUBJECTS BY GENDER AND SUICIDE PROBABILITY SCALES, SELF-ESTEEM SCALES AND MENTAL HEALTH RATING SCALES

Gender	Grouped Categories		
	Medium Score on Suicide Probability	High Score on Suicide Probability	Total
Female	6	2	8
Male	6	1	7
	12	3	15
	Medium Score on Self-Esteem	High Score on Self-Esteem	Total
Female	6	2	8
Male	4	3	7
	10	5	15
	Medium Score on Mental Health Rating	High Score on Mental Health Rating	Total
Female	1	7	8
Male	3	4	7
	4	11	15

No significant difference was shown in any of these scores according to the Fisher Exact Test.

Table 12

PERCENTAGE DISTRIBUTIONS OF MALE AND FEMALE SUBJECTS BY LIFE EXPERIENCES OCCURRING IN THE PAST SIX MONTHS

Variable	Male %	Female %	Total %
* Life Experiences (N = 15)			
Marital separation	14	25	20
Lawsuit/court appearance	14	12	13
Personal injury/illness	0	25	13
Trouble with relatives	43	75	60
Entering or leaving school	14	12	13
Serious injury/illness of family/friend	0	50	27
Change of Residence	29	25	27
Loss of job in family	29	0	13
Searched for job without success	43	37	40
Starting a new job	14	25	20
Renewal of mortgage	0	25	13
Drop in income	57	0	27
Acquiring debts over $15,000	0	12	7

* More than one possible answer

The highest ratings for males in stressful life experiences were: drop in income; searched for job without success; and trouble with relatives. For females they were: trouble with relatives and unsuccessful job searches. Again, this brings up the issue of relationships versus employment for males versus females. Do these two groups differ significantly in their reactions to these two situations and if so, how do these reactions affect the rate of attempted suicide for the sexes? Does this knowledge have implications for prevention of attempted suicide and treatment methodology?

Table 13

PERCENTAGE DISTRIBUTIONS OF MALE AND FEMALE SUBJECTS BY FAMILIAL AND OTHER EXPERIENCES OF SUICIDAL BEHAVIORS

Variable	Male %	Female %	Total %
Family Member with Suicidal Behavior (N = 15)			
Yes	43	50	47
No	57	50	53
	100	100	100
* Type of Suicidal Behavior (N = 7)			
Completed	0	25	14
Attempted	100	100	100
Threatened	0	25	14
* Relationship to Subject (N = 7)			
Mother	67	75	71
Father	0	25	14
Brother	33	0	14
Sister	67	25	43
Other	0	25	14
Knowledge of Anyone Else with Suicidal Behaviors (N = 15)			
Yes	29	50	40
No	71	50	60
	100	100	100
* Relationship to Subject (N = 6)			
Friend	50	67	50
Acquaintance	50	0	17
Other	50	25	33

* More than one possible answer

The males and females in this study were approximately equal with respect to their knowledge of a family member who had exhibited suicidal behavior. Forty-seven percent of these subjects reported knowledge of someone who had attempted suicide. An interesting result was that of those reporting this type of knowledge, 71 percent indicated that it was their mother who had exhibited this behavior. The next highest reported relative was a sister. This was reported by 43 percent of the subjects. Is there a relationship between those who attempt suicide and knowledge of someone else who has attempted suicide? Is there a causal

relationship between a mother or sister's attempt and the subject's attempt?

Table 14

GROUPED SUBJECTS BY GENDER, FAMILIAL EXPERIENCE OF SUICIDAL BEHAVIORS AND KNOWLEDGE OF OTHERS WITH SUICIDAL BEHAVIORS

Gender	Group Categories		
	Family History	No Family History	Total
Female	4	4	8
Male	3	4	7
	7	8	15
	Knowledge of Others	No Knowledge of Others	
Female	4	4	8
Male	2	5	7
	6	9	15

These two collapsed categories are inclusive with respect to knowledge of anyone with a history of suicidal behavior. No significant difference was found according to the Fisher Exact Test.

Table 15

PERCENTAGE DISTRIBUTIONS OF MALE AND FEMALE SUBJECTS BY DATE AND METHOD OF ATTEMPT AND HOSPITAL CONTACT

Variable	Male %	Female %	Total %
Date of Attempt (N = 15)			
in last six months	17	17	17
in last year	83	17	50
in last two years	0	33	17
in last five years	0	33	16
No data: 3 subjects			
	100	100	100
Method Used (N = 15)			
slashing	17	38	29
overdose	33	50	43
hanging	17	0	7
carbon monoxide	0	12	7
firearm	17	0	7
vehicular	16	0	7
No Data: 1 subject			
	100	100	100
Did Subject Present at Emergency Department? (N = 15)			
Yes	86	75	80
No	14	25	20
	100	100	100
Was Subject Admitted to Hospital? (N = 15)			
Yes	57	50	53
No	43	50	47
	100	100	100
Length of Stay on Medical Facility (N = 8)			
less than 1 week	34	0	20
1 - 2 weeks	33	0	20
2 - 3 weeks	33	50	40
longer than 3 weeks	0	50	20
No data: 3 subjects			
	100	100	100

Eighty-three percent of the males reported their attempt occurring in the past year. The females reported a longer period of elapsed time since their most recent attempt. Do females tend to stay in treatment longer than males? Does this length of stay in treatment play a role in the degree of risk for future suicidal behavior?

The most common method of attempt used by both males and females was to take an overdose of drugs. This method was followed for females

by slashing. There was no second method used more than others by males. If one was to separate the methods of attempt into the two categories of high lethality and low lethality, 72 percent of all the attempts would fall under the category of low lethality. Low lethality in this instance referring to slashing and drug overdoses. The males used a wider range of suicidal methods than females. Does the method used in the attempt predispose the subject to future suicide attempts or completed suicide? That is, if the method used in the attempt is of low lethality, does the end result in some way encourage the subject to repeat the attempt in a similar way or to perhaps move on to use a method of attempt with a higher degree of lethality?

A slightly higher percentage of males versus females presented to an emergency department following their attempt. Is there a relationship between the gender of the attempter and presentation at an emergency department? What role does the method of attempt play in this decision? Are males seen as being at more serious risk than females?

As well, a higher percentage of males versus females was admitted to hospital following their attempt. However, what is of interest to note here is that the length of stay in hospital was far longer for females that it was for males. All of the females were in hospital for at least two weeks while only 33 percent of the males reported being in the hospital for two weeks or longer. None of the males was hospitalized for longer than three weeks while 50 percent of the females reported hospital stays of this duration. Is there a discrepancy between the treatment practice procedures used with males versus females? Are males seen as requiring less extensive treatment in hospital than females? Are males seen as having less "serious" problems than females? Or is it more

"socially" acceptable for females to accept extended treatment than it is for males?

Table 16

GROUPED SUBJECTS BY GENDER, DATE OF ATTEMPT, PRESENTATION AT EMERGENCY DEPARTMENTS AND ADMISSION TO HOSPITAL

Gender	Grouped Categories		
	Attempt Less Than One Year Ago	Attempt More Than One Year Ago	Total
Female	2	4	6
Male	6	0	6
	8	4	12
	Subject Presented At Emergency Department	Subject Did Not Present At Emergency Department	Total
Female	6	2	8
Male	6	1	7
	12	3	15
	Subjects Admitted To Hospital	Subject Not Admitted To Hospital	Total
Female	4	4	8
Male	4	3	7
	8	7	15

The date of the subjects' attempt was grouped into the two categories of: attempt occurring less than one year ago and attempt occurring more than one year ago. According to the Fisher Exact Test, significance was found at .05. There was no significance found in the other two groupings of presentation to an emergency department and admission to hospital.

Table 17

PERCENTAGE DISTRIBUTION OF MALE AND FEMALE SUBJECTS BY COUNSELLING SERVICES RECEIVED

Variable	Male %	Female %	Total %
* Provider of Service (N = 9)			
Alberta Mental Health	33	17	22
Pastoral Institute	0	17	11
AADAC	33	17	22
Foothills Hospital	0	33	22
General Hospital	33	0	22
Calgary Family Services	0	17	11
Employer Psychologist	0	17	11
* Professional Providing Service (N = 9)			
Psychiatrist	33	50	44
Psychologist	0	17	11
Social Worker	0	17	11
General Physician	0	33	22
Counsellor (unspecified)	33	17	22
Other	0	17	11
Unknown	33	0	11

* More than one possible answer

In this table, there are two major points of difference between the male and female subjects. First, of those reporting a hospital as a service provider, all the males reported the Calgary General Hospital while all the females reported the Foothills Hospital. When these results first became apparent, the author checked the geographic residence of the subjects. There was no evidence that the selection of hospitals was geographically determined. As the Calgary General Hospital has the forensic unit, the question arises whether this plays a factor in the determination of hospital admission. Are males receiving treatment at the Calgary General due to the forensic facilities? If so, is there a connection between attempted suicide and behaviors that would require the use of a forensic facility?

The second variance between male and female subjects concerns the range of service providers utilized. Female subjects reported a wider

range of contacts, or in this case, service providers than the male subjects. This was true for both institutions and the type of professional providing the service. Do males feel that they are limited to fewer services/professionals than females? If so, what is the basis for this limitation? Does this limited resource base have implications on the rate of attempted suicide for males? Is the wider resource base for females a deterrent against future suicide attempts?

TABLE 18

PERCENTAGE DISTRIBUTIONS OF MALE AND FEMALE SUBJECTS BY HISTORY OF MOST RECENT ATTEMPT

Variable	Male %	Female %	Total %
Was subject undergoing treatment at time of attempt? (N = 15)			
Yes	14	71	43
No	86	29	57
No Data: 1 subject			
	100	100	100
Provider of this service (N = 6)			
Alberta Mental Health	0	40	33
Psychiatrist	100	40	50
General Physician	0	20	17
	100	100	100
* Reasons for most recent attempt (N = 15)			
domestic/marital problems	28	12	20
personal/relationship problems	71	87	80
employment difficulties	43	12	27
recent crisis	0	12	7
financial problems	0	12	7
addiction	14	0	7
* Events that led up to attempt (N = 15)			
unemployment/financial	43	12	27
personal/relationship	43	50	47
domestic/marital	28	75	53
loneliness/helplessness	28	25	27
medical/psychiatric problems	28	25	27
academic/career problems	43	0	20
addictions	28	0	13
experienced a loss	28	25	27
unresolved past crisis	14	25	20
feelings of guilt	14	0	7
court appearance	14	25	20

* More than one possible answer

Overwhelmingly, more females were in treatment at the time of their attempt than the males. Again this poses questions about the differences in treatment/service delivery between males and females. Do males not seek out treatment prior to attempting suicide? If not, what are the reasons for this? Is it still more acceptable for females to receive treatment than males?

Of those who reported that they were in treatment at the time of their attempt, 67 percent were being seen by a medical person. As was noted earlier, taking an overdose of medication was the most common method of attempting suicide for both males and females. It is often found that the drugs used in the overdose were just recently prescribed. Does this suggest implications for our current treatment practices of those that are depressed or exhibiting suicidal ideations?

The reasons given for the subject's most recent attempt were the same categories for both males and females. Their ordering was different and the percentile breakdown was different. Both males and females indicated personal/relationship problems as a major reason. Males reported this 71 percent of the time while females reported it 87 percent of the time. The only other percentage to note is that 43 percent of the males reported employment difficulties as a factor in their attempt compared to 12 percent of the females. It would be important to determine if the stressors are consistently different between males and females. Do males attempt suicide for reasons that are different than those of females? What implications does this have for treatment practices and prevention of attempted suicide? As questioned earlier,

are relationships more or less important to males than the role of employment?

Table 19

GROUPED SUBJECTS BY GENDER AND TREATMENT STATUS AT TIME OF ATTEMPT

Gender	Subjects Receiving Treatment At Time Of Attempt	Subjects Not Receiving Treatment At Time Of Attempt	Total
Female	5	2	7*
Male	1	6	7
Totals	6	8	14

* No data: 1 subject

No significant difference was found according to the Fisher Exact Test.

Table 20

PERCENTAGE DISTRIBUTIONS OF MALE AND FEMALE SUBJECTS BY USE OF ALCOHOL/DRUGS

Variable	Male %	Female %	Total %
Did alcohol/drugs contribute to attempt? (N = 15)			
Yes	29	25	27
No	71	75	73
	100	100	100
Type of substance (N = 4)			
Alcohol alone	50	100	75
Alcohol and drugs	50	0	25
	100	100	100
Does subject have current problem with alcohol/drugs? (N = 15)			
Yes	43	25	33
No	57	75	67
	100	100	100
Has subject received treatments for problem? (N = 5)			
Yes	67	100	80
No	33	0	20
	100	100	100

As shown, the combined total of female and male responses indicated that only 27 percent of subjects used alcohol/drugs in their attempt. In this instance, drugs refer to drugs other than those used for the actual overdose. However, 43 percent of the males and 25 percent of the females indicated that they had a problem with alcohol/drugs. Does the use of alcohol/drugs differ between males and females? Is the use of alcohol/drugs in an attempt different between males and females? All of the females who reported a problem with alcohol/drugs indicated that they had received treatment for the problem while only 67 percent of the males reported receiving treatment. Does the variance in those receiving treatment for alcohol/drug problems reflect in the attempted suicide rates?

Table 21

GROUPED SUBJECTS BY GENDER, USE OF ALCOHOL/DRUGS DURING ATTEMPT AND SUBJECTS HAVING CURRENT PROBLEM WITH ALCOHOL/DRUGS

Gender	Grouped Categories		
	Used Alcohol/ Drugs	Did Not Use Alcohol/Drugs	Total
Female	2	6	8
Male	2	5	7
	4	11	15
	Problem With Alcohol/Drugs	No Problem With Alcohol/Drugs	Total
Female	2	6	8
Male	3	4	7
	5	10	15

No significant difference was found in either of these groupings according to the Fisher Exact Test.

Table 22

PERCENTAGE DISTRIBUTIONS OF MALE AND FEMALE SUBJECTS BY INTENTION OF ATTEMPT

Variable	Male %	Female %	Total %
Purpose of Attempt (N = 15)			
to get attention or revenge	0	0	0
to escape, solve problems	86	50	67
both of the above	14	50	33
	100	100	100
Expectation of Death			
thought death unlikely	0	25	13
thought death possible but not likely	14	25	20
thought death likely or certain	86	50	67
	100	100	100
Understanding of Attempts Lethality			
did less than thought lethal	43	38	40
unaware if action lethal	14	12	13
action equalled or exceeded lethal	43	50	47
	100	100	100
Seriousness of Attempt			
Did not seriously intend to end life	0	12	6
Uncertain about seriousness	14	38	27
Seriously intended to end life	86	50	67
	100	100	100
Attitude towards Living/Dying			
Did not want to die	0	12	6
Wanted to die	43	50	47
Parts of both of the above	57	38	47
	100	100	100
Thoughts on Medical Intervention			
Thought death unlikely with medical intervention	43	43	43
Uncertain whether death could be averted with medical intervention	43	57	50
Certain of death even with medical intervention	14	0	7
No data: 1 subject	100	100	100
Degree of Premeditation			
None, impulsive	29	25	27
Contemplated 3 hours or less	14	12	13
Contemplated more than 3 hours	57	63	60
	100	100	100

Overall, this table shows a stronger death intent in the males and a greater certainty of death than in the females. This may show itself ultimately more in the different rates of suicide between males and

females. Does it also offer implications for further risk of suicide attempts and the degree of lethality and intent in the attempts?

A further point raised when comparing the various responses of the males versus females relates to the subject's awareness of their actions. Although the females indicated a lower degree of intent than the males, some contradiction appears to exist when the data are closely examined. For example, although the males indicated a serious intent to end their lives, 43 percent also indicated that they did less to themselves than they thought was lethal. Can this contradiction be explained as a reluctance on the part of the males to express their true motivation or feelings regarding the attempt? Are there different expectations placed on males versus females in regard to their motivations when they attempt suicide?

Table 23

PERCENTAGE DISTRIBUTIONS OF MALE AND FEMALE SUBJECTS BY SUBJECTS' PERSONAL CONTACTS

Variable	Male %	Female %	Total %
Did subject contact anyone prior to attempt? (N = 15)			
Yes	71	75	73
No	29	25	27
	100	100	100
* Person contacted: (N = 11)			
friend/relative	80	50	64
physician		33	18
counsellor		17	9
emergency/hospital	20	17	18
CMHA		17	9
Crisis Centre		33	18
Response of this person/ agency: (N = 11)			
supportive/caring	20	17	18
upset/angry	20	33	28
phoned family/friends	20	17	18
took subject to hospital	40	33	36
	100	100	100
Does subject have supportive relationships? (N = 15)			
Yes	71	38	53
No	29	62	47
	100	100	100

* More than one possible answer

The males and females were approximately equal with regards to contacting someone prior to their attempt. What is interesting to note is that a combined total of 73 percent of subjects did contact someone prior to their attempt. This is as indicated in the existing literature.

As shown in previous tables, the females reported a wider range of contacts utilized while the males' contacts were rather limited. Do males feel that they have fewer contacts available to them than the females do? Do males, in fact, have a harder time gaining access to contacts that the females utilize? What effect does this have on the rate of male suicide attempts?

A point that almost seems contradictory to the above statements is that males reported having more supportive relationships than females. Do subjects distinguish between supportive relationships such as family or boyfriend/girlfriend and other resource contacts? Do males view supportive relationships differently than females? Does this difference have a role in the higher number of females that attempt suicide versus the number of males? Does this relate to the data previously shown regarding the motivational factors for males and females in attempted suicide?

Table 24

GROUPED SUBJECTS BY GENDER, PERSONAL CONTACTS PRIOR TO ATTEMPT AND SUPPORTIVE RELATIONSHIPS

Gender	Grouped Categories		
	Contact Prior To Attempt	No Contact Prior To Attempt	Total
Female	6	2	8
Male	5	2	7
	11	4	15
	Supportive Relationships	No Supportive Relationships	Total
Female	3	5	8
Male	5	2	7
	8	7	15

Neither of these groupings showed any significance according to the Fisher Exact Test.

Table 25

PERCENTAGE DISTRIBUTIONS OF MALE AND FEMALE SUBJECTS BY SUBJECT'S ACTIONS AT TIME OF ATTEMPT AND REASONS FOR INCOMPLETED SUICIDE

Variable	Male %	Female %	Total %
Did subject write a suicide note? (N = 15)			
Yes	29	38	33
No	71	62	67
	100	100	100
Was subject alone at time of attempt? (N = 15)			
Yes	43	100	73
No	57	0	27
	100	100	100
Did subject take precautions against discovery? (N = 15)			
Yes	57	50	53
No	43	50	47
	100	100	100
* Precautions taken: (N = 8)			
alone/arranged to be alone	50	100	75
took phone off hook		25	13
locked the door	25	50	38
disposed of drug package	25		13
made arrangements to be away		25	13
* What prevented suicide completion? (N = 15)			
ambivalence	29	25	27
overdose/action not lethal	71	25	47
intervention by others	29	13	20
fear of unknown	14	13	13
did not want to hurt others		25	13

* More than one possible answer

A combined total of 67 percent of the subjects did not write a suicide note. All the females reported being alone at the time of their attempt, while only 43 percent of the males reported this. Do females tend to attempt suicide in isolation versus males who may attempt in the presence of another person(s)? What are the reasons for the differences in this behavior pattern? What are the motivational/causational factors involved in this decision? Does the issue of being "rescued" play a role in this behavior pattern?

Approximately an equal number of males and females took precautions against discovery. The females all reported that they were alone or arranged to be alone while only half the males reported this. The central reason for both sexes for the incompleted suicide was that the action was not lethal. Does this offer implications for motivational factors? Or perhaps, does this infer something about the subject's knowledge of degree of lethality? This has been given attention in existing literature under the areas of intent and lethality.

Table 26

GROUPED SUBJECTS BY GENDER, PRESENCE OR ABSENCE OF SUICIDE NOTE, STATUS AT TIME OF ATTEMPT AND PRECAUTIONS TAKEN AGAINST DISCOVERY

Gender	Grouped Categories		
	Suicide Note	No Suicide Note	Total
Female	3	5	8
Male	2	5	7
	5	10	15
	Alone	Not Alone	Total
Female	8	0	8
Male	3	4	7
	11	4	15
	Took Precautions	Did Not Take Precautions	Total
Female	4	4	8
Male	4	3	7
	8	7	15

No significant difference was found in the presence/absence of a suicide note or if precautions were taken against discovery. The subjects' status at the time of the attempt (alone/not alone) was significant at .05 according to the Fisher Exact Test.

Summary

This concludes the information gathered throughout the process of designing and implementing the pilot study. Problems arose due to the lack of direct access to the subjects and due to the methodology used to collect the data. The method of data collection and subsequent return of only fifteen questionnaires precluded the use of sophisticated data analysis. The data collected promoted the formulation of various questions for further research.

The next and final chapter offers conclusions and implications for further research in the area of attempted suicide.

CHAPTER FIVE

CONCLUSIONS AND IMPLICATIONS

A pilot study is, in many ways, a type of experiment. It has within its purpose and methodology the possible expansion of any study. It intends to illustrate the flaws, limitations, strengths and weaknesses of the pilot study and these results are used to determine the feasibility of conducting the study on a larger scale. These factors formed the basis for conducting this particular pilot study on this specific topic.

The purpose of the project was to test the feasibility of conducting a large-scale study utilizing a self-administered questionnaire. The objectives of the project were two-fold:

1. To determine the feasibility of using a survey questionnaire to study a population of subjects who had attempted suicide; and
2. To describe the characteristics, including commonalities and differences of the sampled population.

The research questions developed for the project were:

1. Is it feasible to use a self-administered questionnaire to collect base-line data on the subject of attempted suicide?
2. Is it possible to access a large population of subjects who have been identified as having attempted suicide using this methodology?
3. Is it possible to conduct a study of attempted suicide ensuring the subjects' confidentiality and safeguarding against mental and emotional duress?
4. Could a descriptive study of this type be conducted on a larger scale?

The pilot study yielded the following information:

1. Fifteen questionnaires were completed over an eleven-month time period. During this time frame, the format for questionnaire distribution and data collection was changed in an attempt to improve the number of completed questionnaires and the rate of return of these questionnaires. However, even with the changes, there was little improvement in either of these areas. The original target goal was 30 questionnaires in a time frame of approximately three months.
2. Although the questionnaire was lengthy, there were no negative reports from the subjects regarding this issue. However, the questionnaire could be shortened without altering the type or quality of information requested. This is possible as some of the questions are somewhat repetitive and others proved to be unnecessary as they did not provide the type of information sought. The changes would also include some modification of question construction and the addition of a few questions.
3. Reliance on a third party for questionnaire distribution is not feasible. The control should remain with the author. Access to the subjects is, however, the central problem here. This is a critical issue in completion of a study, be it a pilot project or a full scale study. As each agency that deals with subjects who have attempted suicide will have their own internal policies, it is basically impossible to develop one format to access all the subjects. Each agency/institution would have to be approached on an individual basis, and each would have their own standards/requirements to be met. This would be very time consuming and would require

the resources of many researchers and/or assistants. However, if one wishes to gather base-line data from agencies/institutions other than hospitals, different procedures must be implemented and different criteria met.

4. The concern of the host agency with respect to exposing the subjects to, or causing them to experience emotional duress/upset due to the process of completing the questionnaire was unfounded. None of the subjects reported any emotional duress/upset during or after questionnaire completion. Having the subject complete the questionnaire only when a representative from the host agency was present added to the lengthy time period it took for data collection. The future recommendation would be to omit this aspect and replace this "safe-guard" with alternate measures. There is always the chance that someone will be upset by the process of questionnaire completion, but alternate measures to deal with this situation, if it occurred, would be less time consuming while still ensuring the emotional and psychological well-being of the subject.
5. The data gathered from the subjects remained quite consistent with the research reported in the literature review, although direct comparisons could not be made due to the non-probability sample.
6. Interesting issues which showed levels of significance according to the Fisher Exact Test were date of last attempt and subjects' status at the time of attempt (alone/not alone).

Conclusions

The following conclusions are based on the research questions that were developed for this project.

1. This first point refers to the feasibility of using a self-administered questionnaire to collect base-line data on the subject of attempted suicide. The completed questionnaires showed that using a self-administered questionnaire on attempted suicide is a feasible means of gathering data. The completed questionnaires are rich with information, albeit, subjective information. Subjects, overall, did not appear to have any major difficulties with the questionnaire and most were filled out in their entirety.
2. This second point refers to the issue of ensuring confidentiality and safe-guarding against mental and emotional duress. The conclusion in this study is that it is possible to ensure confidentiality and to provide safe-guards against mental and emotional duress. However, although these criteria were met, they also presented two of the more serious limitations of the study. The issue of confidentiality was extended to the point whereby the author had no direct access to the subjects. This posed a serious limitation. The safe-guards built into the study did what was intended, although they too posed limitations to the study with respect to time management.
3. This third point concerns the possibility of accessing a large population of subjects using this methodology. The only possible conclusion to draw from this study is that this methodology is not a feasible way of accessing a large population of subjects who have attempted suicide. The present methodology is too time consuming with too few returns. Major changes need to be made in the methodological procedures prior to undertaking a further study.
4. This final point refers to conducting a descriptive study of this type on a larger scale. This relates strongly to the third point.

A descriptive study of this type could be conducted on a larger scale, but only with changes to the methodology involving access to the subjects.

Implications for Social Work Practice

With the changes that have been recommended throughout this chapter, this study could be replicated. It is impossible to predict with accuracy whether the changes to the data collection format would change the response rate enought to warrant a full-scale study. Therefore, it is the author's recommendation that after these changes to the format and the questionnaire are made, that another pilot study be conducted to determine whether a full scale study is feasible.

As has been shown, the issue of attempted suicide is a complex one. The role of social workers has been outlined and the value of their services is unrefutable. What implications does this present research have for social workers today? A number of questions were raised regarding various components of attempted suicide. Any of these areas are worth examining by social workers who wish to further expand their own knowledge base and the knowledge base of others. Other than research, social workers may be involved in education. That can mean education of fellow colleagues, the public at large or others who are working in a front-line position.

Finally, social workers can be, and should be, involved in the interventive and treatment aspects with those people who have attempted suicide or who are at risk of doing so. This clinical side of practice is often considered to be the traditional role of social workers, although,

as indicated above, there are various other aspects of attempted suicide in which a social worker may be effective, research being one of these areas.

In order for a social worker to work effectively in any area, they must first be equipped with sufficient knowledge and skills to handle the issue at hand. The knowledge base of suicide and attempted suicide is constantly expanding; thus, it requires diligence on the part of the social worker to stay abreast of this new information in order that they may be the most effective possible in their practice.

The questions raised at the end of each section of data offered many areas for future research. Social workers could be and should be involved in research areas of these kinds. Attempted suicide is an interactional problem, and one that can benefit from the broad knowledge and skill base that social workers possess.

There are much more data needed on the behavior of attempted suicide. Great strides are being made, but as the statistics show, attempted suicide is of major concern in our society today.

Summary

The information gathered from the pilot project led to the conclusion that to replicate this study on a larger scale, without modification to questionnaire distribution and data collection procedures, would not be feasible. If the recommended changes are made, a further pilot study should be conducted before a large scale study is implemented. Even with the proposed changes, implementing this type of study would be a costly and timely undertaking. Additional funding would be necessary to provide for adequate provision of staff and resources. However, taking

into consideration these limitations, collecting base-line data on attempted suicide must remain a priority in the field of mental health. The numbers of suicides that follow after an attempted suicide strongly indicate the need for better understanding and management of the issue of attempted suicide. The emotional, psychological and physical duress experienced by those who attempt suicide is within itself, enough to warrant further research into this area.

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APPENDIX A

canadian mental health association
201, 723 - 14 STREET, N.W
CALGARY, ALBERTA
T2N 2A4
telephone 283-7591

Dear

The Canadian Mental Health Association and Denise L. Ingram, graduate student, Faculty of Social Welfare - University of Calgary, are working together in gathering information that will be of benefit in better assisting people at risk of suicide.

We feel that the best source of information in this endeavour would be people who have recently attempted suicide. Your assistance in completing our questionaire about your attempt, and your feelings at the time of the attempt, would provide invaluable assistance in learning how to better help others in our Suicide Prevention Program.

Again I would like to reiterate the value of this research and state that your confidentiality will be maintained as your name will not be used in any publication of material, but will be held confidential in our office.

Denise or myself will be happy to supply you with a copy of the questionaire at a time and place convenient to you and assist in any way we can in completing the form. If you agree to help with this project please call either Denise or myself. Denise can be reached at the University of Calgary, 220-6711 or you can call me at 283-7591.

Denise and I both look forward to hearing from you at your earliest convenience.

Sincerely,

Carolyn Hoagland

Carolyn Hoagland
Coordinator
Suicide Prevention Program

APPENDIX B

Consent Form

I agree to participate in the follow-up study on attempted suicide. I understand that any initial agreement does not obligate me in any way and that I can withdraw from the study at any time.

I understand that all information will be treated in the strictest of confidence and will contribute to a further understanding of the area of attempted suicide. In the final report of this study, no individual will be identified in any way.

Signed: _____

Dated: _____