SUICIDE AND ATTEMPTED SUICIDE

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A major psychiatric problem in general hospitals is constituted by the cases presenting at the casualty department for 'attempted suicide', having taken noxious agents, or with self-inflicted wounds. There has always been a difficulty in deciding whether such attempts at suicide should be considered serious or not. At the Johannesburg General Hospital it has recently been the policy to admit the majority of such cases to the wards for observation and psychiatric assessment, any emergency treatment that is required being given in the casualty department.

The present study was carried out in order to determine the incidence of suicide and attempted suicide in Johannesburg. For 1958 all 'suicidal' admissions to the Johannesburg General Hospital were reviewed and the suicides which took place in the Johannesburg area analysed. Admissions to this hospital are limited to Europeans over the age of 14 years.

(A) Cases of Suicide and Attempted Suicide Admitted to Johannesburg General Hospital

1. *Incidence.* During 1958, 358 admissions were made to the general medical and surgical wards because of attempted

suicide. These admissions were made by 337 patients, of whom 17 died in the hospital and 1 (from the effects of the original poison) a few weeks later after transfer to Tara Hospital. The 319 patients who survived constituted 340 admissions.

2. *Time of admission.* The admissions to hospital took place throughout the day and night. The majority occurred in the evening, with the greatest incidence between 11 and 12 p.m. (Fig. 1).

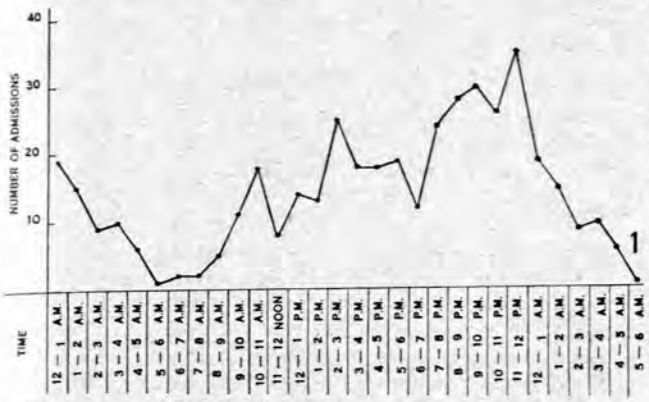

Fig. 1. Admissions (1958) to Johannesburg General Hospital for suicide and attempted suicide, by time of admission.

3. *Distribution over the week.* There was no significant difference in the number of admissions during the different days of the week.

4. *Distribution over the year.* The admissions were more or less evenly distributed over the year.

5. *Age and sex distribution* (Fig. 2). The admissions for attempted suicide included patients in both sexes between the ages of 14 (the minimum age for admission to this hospital) and 78. The females were more numerous than the males. This difference was more marked in the younger age-groups; from 44 years onwards the admissions were more or less equal for the two sexes. The age-group in which admission for attempted suicide were commonest was 19 - 23. In this group the number of females admitted was more than 2·5 times the number of males.

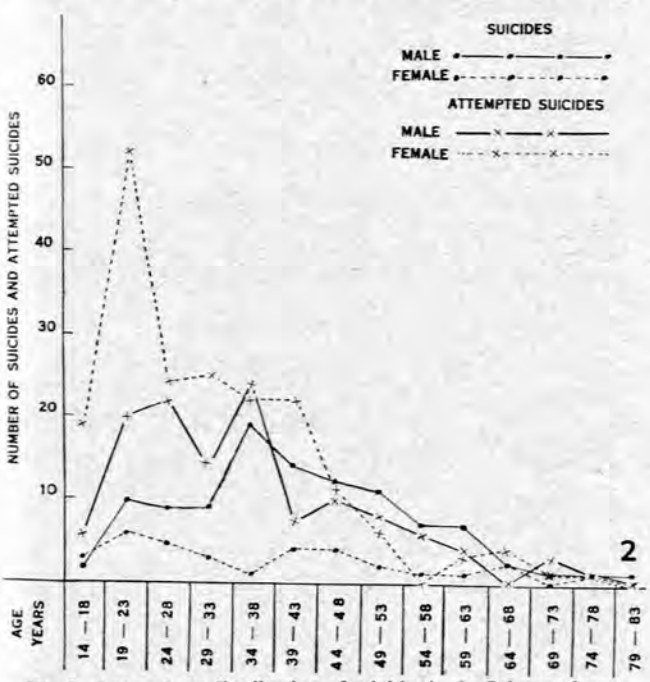

Fig. 2. Age and sex distribution of suicides in the Johannesburg area, and of attempted suicide admitted to Johannesburg General Hospital (1958).

6. *Duration of hospitalization.* The 319 patients who had 358 admissions between them spent 920 days in this hospital, the average number of days per admission being 2·57. This does not include the time which some cases spent in other hospitals after being referred for further psychiatric treatment.

7. *Previous suicidal attempts.* Of the cases admitted to hospital, in 79·6% there was no history of a previous attempt at suicide; 11·0% had a record of 1 previous attempt, 3·13% of 2 previous attempts and 6·27% of more than 2 previous attempts. Some cases were admitted to the hospital for attempted suicide on more than one occasion during 1958—11 on 2 occasions, 2 on 3 occasions, and 1 on 7 occasions.

8. *Methods.* The commonest method of attempting suicide was by ingestion of 'poisons'. This method was used by 82·6% of the cases. The group of poisons most commonly used was the hypnotics (32·9%). The commonest substance used was aspirin (acetylsalicylic acid, 10·5%); noludar (methylprylone) was second (7·34%) and seconal (quinal-barbitone) third (7·09%). At least 79 different substances were ingested by this group of cases. The 'poisons' included almost anything available in a household. The methods used are shown in Table I. The majority of cases (83·7%) only ingested one substance or used a single other method. There were cases, however, who simultaneously 'attempted suicide' by more than one method; 12·5% combined 2 methods and 3·76% combined more than 2 methods.

TABLE I. METHODS USED IN ATTEMPTED SUICIDE (1958)*

Methods	*Male*	*Female*	*Total*	*%*
I. Poisons	115	223	338	82·64
(A) *Hypnotics*	43	92	135	32·91
(i) Barbiturates ..	25	40	65	15·90
1. Seconal (quinal-barbitone) ..	13	16	29	7·09
2. Phenobarbitone	8	14	22	5·38
3. Nembutal (pento-barbitone) ..	1	6	7	1·71
4. Tuinal (amytal + seconal)	2	1	3	0·73
5. Veronal (barbi-tone)	1	1	2	0·49
6. Butobarbitone (soneryl) ..	—	1	1	0·24
7. Amytal (amylo-barbitone) ..	—	1	1	0·24
(ii) Non-barbiturate Hypnotics ..	10	26	36	8·80
1. Noludar (methyl-prylone) ..	8	22	30	7·34
2. Monoureides ..	2	2	4	0·98
3. Glutethimide ..	—	1	1	0·24
4. Paraldehyde ..	—	1	1	0·24

* Fatal cases are excluded from this table. If a patient was admitted to the hospital for attempted suicide on more than one occasion, or if multiple means were used, then each admission or method is separately recorded in the table.

Method	Male	Female	Total	%
(iii) Unidentified 'sleeping tablets'	8	26	34	8·31
(B) *Analgesics*	22	52	74	18·09
1. Aspirin (acetylsalicylic acid)	13	30	43	10·51
2. A.P. Codeine ..	7	11	18	4·40
3. Anadin†	2	2	4	0·98
4. A.P. Caffeine ..	—	2	2	0·49
5. Saridone	—	2	2	0·49
6. Codis	—	2	2	0·49
7. Pethidine	—	1	1	0·24
8. Omnopon	—	1	1	0·24
9. Physeptone ..	—	1	1	0·24
10. Edrisol (aspirin & dexedrine)	—	1	1	0·24
† (Acetophenetidin acetylsalicylic acid and caffeine)				
(C) *Insecticides and Rodent Toxins* ..	15	16	31	7·58
1. 'Ant poison' ..	6	11	17	4·16
2. DDT	3	3	6	1·47
3. 'Rat poison' ..	4	1	5	1·22
4. 'Fly poison' ..	1	1	2	0·49
5. 'Snail pellets' ..	1	—	1	0·24
(D) *Corrosives*	9	11	20	4·89
1. Lysol	4	3	7	1·71
2. Caustic soda ..	2	5	7	1·71
3. Carbolic acid ..	1	1	2	0·49
4. Ammonia ..	1	1	2	0·49
5. Nitric acid ..	—	1	1	0·24
6. Hydrochloric acid	1	—	1	0·24
(E) *Miscellaneous Drugs and Poisons*	24	38	62	15·16
1. 'Chlorodyne' ..	3	2	5	1·22
2. Antihistaminics ..	1	4	5	1·22
3. Sulphonamides ..	1	4	5	1·22
4. Phenytoin	1	3	4	0·98
5. Methyl salicylate ..	2	1	3	0·73
6. Preludin	—	2	2	0·49
7. Quinine	1	1	2	0·49
8. Equanil (meprobamate)	—	1	1	0·24
9. Dexedrine	—	1	1	0·24
10. Ritalin	1	—	1	0·24
11. Chlorpromazine ..	—	1	1	0·24
12. Selenium	1	—	1	0·24
13. Dramamine ..	1	—	1	0·24
14. Ephedrine ..	1	—	1	0·24
15. Iodine	—	1	1	0·24
16. Pot. permanganate	—	1	1	0·24
17. Insulin	—	1	1	0·24
18. Hydrogen peroxide	1	—	1	0·24
19. Tinct. benz. co. ..	1	—	1	0·24
20. Terramycin ..	—	1	1	0·24
21. Mercurochrome ..	—	1	1	0·24
22. Acriflavin ..	—	1	1	0·24
23. Methylene blue ..	—	1	1	0·24
24. Gentian violet ..	1	—	1	0·24
25. Washing soda ..	1	—	1	0·24
26. Methyl alcohol ..	—	1	1	0·24
27. Camphorated oil ..	—	1	1	0·24
28. Croton oil ..	1	—	1	0·24
29. Smelling salts ..	—	1	1	0·24
30. 'Fume tablets' ..	—	1	1	0·24
31. 'Slimming ointment'	—	1	1	0·24
32. 'Bottle of tonic' ..	1	—	1	0·24
33. 'Nerve tonic' ..	1	—	1	0·24
34. Strychnine ..	—	1	1	0·24
35. Alophen	—	1	1	0·24
36. Liquid paraffin ..	—	1	1	0·24
37. 'Nomisol' ..	1	—	1	0·24
38. 'Sanpic'	—	1	1	0·24
39. Naphthalene (moth balls) ..	1	—	1	0·24
40. 'Silvo'	1	—	1	0·24
41. Petrol	—	1	1	0·24
42. Paraffin	1	—	1	0·24
43. Benzine	—	1	1	0·24
(F) *Unidentified 'Tablets'*	3	14	17	4·16
II. Hanging	—	—	—	—
III. Burning	—	1	1	0·24
IV. Gunshot	1	—	1	0·24
1. Head	1	—	1	0·24
2. Chest	—	—	—	—
3. Abdomen	—	—	—	—
V. Gassing	9	5	14	3·42
1. Gas stove	7	5	12	2·93
2. Car exhaust	2	—	2	0·49
VI. Trauma	26	17	43	10·51
1. Jump from height ..	1	1	2	0·49
2. Cut throat	7	2	9	2·20
3. Cut brachial artery ..	1	—	1	0·24
4. Cut wrist	15	11	26	6·36
5. Cut face	—	2	2	0·49
6. Cut foot	1	—	1	0·24
7. Jump in front of moving vehicle ..	1	—	1	0·24
8. Jump from moving vehicle	—	1	1	0·24
VII. Drowning	—	—	—	—
VII. Swallowing Metalic and Related Objects ..	9	2	11	2·69
1. Wire	5	—	5	1·22
2. Pins	3	—	3	0·73
3. Razor blades ..	1	1	2	0·49
4. Glass	—	1	1	0·24
Total (All methods)	161	248	409	100

9. *Disposal of cases* (Table II). Practically all cases were seen by a psychiatrist before discharge from hospital. The majority (41·0%) were sent home; usually they were advised to seek psychiatric aid if they had any further difficulties.

TABLE II. DISPOSAL OF CASES

Disposal	Number (female)	Number (male)	%
1. Home	79	59	40·95
2. R.H.T.	34	18	15·43
3. Psychiatric O.P.D. ..	38	21	17·51
4. Institution for alcoholics	1	3	1·19
5. Tara	18	8	7·72
6. Mental hospital ..	2	3	1·48
7. Refused psychiatric help	5	4	2·67
8. Private doctor	12	8	5·94
9. Absconded	1	2	0·89
10. Social welfare	3	1	1·19
11. Died	6	11	5·04
Total	199	138	100
		337	

Note: 1 case sent to Tara terminated while there from toxic effects of original poison (arsenic).

17·5% were referred to the psychiatric out-patient department. Many patients (15·4%) are recorded as refusing further hospital treatment after they had recovered from the immediate effects of their suicidal attempt; this figure is perhaps slightly erroneous, because some cases signed the R.H.T. (refused hospital treatment) form to protect the doctor when the patient requested discharge, usually for domestic reasons. 26 cases (7·72%) were referred to Tara Hospital for further psychiatric treatment; these were mainly cases with severe depression. Five cases (1·48%) were certified under the Mental Disorders Act and sent to mental hospitals.

(B) Suicides in Johannesburg Area

1. *Incidence*. During 1958 there were 141 suicide verdicts for the Johannesburg area at the Johannesburg Inquest Court; 107 were European, 32 Bantu and 2 Indian.

2. *Distribution over the year*. There was no significant difference between the different months of the year.

3. *Age and sex distribution* (Figs. 2 and 3). The greatest incidence of suicides occurred in the age group 34 - 38. Suicides were commoner in males than in females.

4. *Race* (Fig. 3). Suicide was less common in the Bantu than in the European in spite of the fact that the Bantu population was greater than the European. Suicide was rare in Bantu females; none occurred in Indian females.

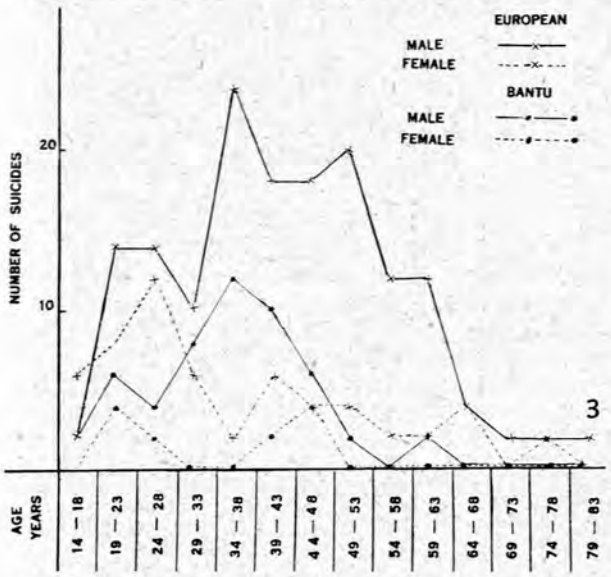

Fig. 3. Age and sex distribution of European and Bantu suicides in the Johannesburg area (1958).

5. *Methods* (Table III). There were significant differences in the methods used by the different races in committing suicide. The 2 Indian suicides were both by poison. In the Bantu the commonest method was by hanging (68·75%); only 1 case died from the effects of a poison, and 1 case shot

TABLE III. METHODS USED IN SUICIDE (1958)

(A) INDIAN

Method	*Male*	*Female*	*Total*	%
I. Poisons	2	—	2	100
1. Barbiturates	1	—	1	50
2. Phenol	1	—	1	50
II. Other methods	—	—	—	—
Total	2	—	2	100

(B) BANTU

Method	*Male*	*Female*	*Total*	%
I. Poisons	—	1	1	3·13
1. Ammonia	—	1	1	3·13
2. Other poisons	—	—	—	—
II. Hanging	20	2	22	68·75
III. Burning (fire)	1	2	3	9·38
IV. Gunshot				
1. Head	1	—	1	3·13
2. Elsewhere	—	—	—	—
V. Gassing				
1. Car exhaust	1	—	1	3·13
2. Other methods	—	—	—	—
VI. Trauma	3	1	4	12·50
1. Jump from height	1	1	2	6·25
2. Cut throat	1	—	1	3·13
3. Stab chest	1	—	1	3·13
VII. Drowning	—	—	—	—
Total	26	6	32	100

(C) EUROPEAN

Method	*Male*	*Female*	*Total*	%
I. Poisons	12	7	19	17·76
1. Arsenic	2	4	6	5·61
2. Barbiturate	4	2	6	5·61
3. Cyanide	3	—	3	2·80
4. Lysol	1	1	2	1·87
5. Parathion	1	—	1	0·93
6. Sodium fluoride	1	—	1	0·93
II. Hanging	9	1	10	9·35
III. Burning	—	—	—	—
IV. Gunshot	25	10	35	32·71
1. Head	21	8	29	27·10
2. Chest	3	1	4	3·74
3. Abdomen	1	1	2	1·87
V. Gassing	21	6	27	25·23
1. Gas stove	12	6	18	16·82
2. Car exhaust	9	—	9	8·41
VI. Trauma	10	4	14	13·10
1. Jump from height	4	4	8	7·48
2. Cut throat	2	—	2	1·87
3. Cut brachial artery	1	—	1	0·93
4. Jump in front of moving train	3	—	3	2·80
VII. Drowning	1	1	2	1·87
Total	78	29	107	100

1 European female used a combination of two methods, viz., gunshot abdomen and head.

himself; 3 cases committed suicide by burning (fire). In Europeans the commonest method was by gunshot wounds (32·7%), especially of the head; gassing (25·2%) and poisons (17·8%) were also common methods. Hanging was not so common as in the Bantu (9·35%). Two Europeans died from suicide by drowning; this method was not used by the other races during 1958.

OTHER COUNTRIES AND TOWNS

1. *Incidence*

It is not surprising that much has been written about suicide and attempted suicide, when one realizes the magnitude of the problem throughout the world.

OTHER PARTS OF THE WORLD

It is difficult to determine the incidence of 'attempted suicide' because no satisfactory statistics are available. Many cases are not admitted to hospital and some are treated in private hospitals. National statistics for the incidence of suicide, however, are available. Table IV shows the suicide rate in certain countries for 1955, as published by WHO.[29, 30] Of these, the countries with the highest incidence are Japan, Austria, Denmark, Switzerland and Finland. The highest incidence of all is recorded for West Berlin. The countries with the lowest rates are Mexico, Eire and Northern Ireland, and Israel (Jews)—in Malta and Gozo no suicides at all are recorded for 1954 and 1955. In South Africa the White suicide rate does not differ much from those of the USA and the UK. The Coloured rate (like the non-White rate in the USA) is much lower.

TABLE IV. COMPARATIVE SUICIDE RATES (WHO) PER 100,000 POPULATION OF EACH SEX (1955 UNLESS OTHERWISE STATED)

Country	*Male*	*Female*
Australia (excluding aboriginals)	15·1	5·4
Austria	33·0	15·0
Belgium	20·0	7·3
Canada	10·7	3·4
Denmark	32·4	14·8
Finland	32·4	8·5
France	24·7	7·8
Germany		
Federal Republic	26·0	13·0
West Berlin	43·6	27·3
Saarland	13·1	6·2
Hungary	28·6	13·1
Ireland	3·7	1·0
Israel (Jews) (1954)	5·2	2·3
Italy	9·8	3·8
Japan	31·6	19·0
Malta and Gozo (1954 & 1955)	—	—
Mauritus	14·4	3·7
Mexico (1954)	1·7	0·5
Netherlands	7·5	4·6
New Zealand (excluding Maoris)	12·9	5·1
Norway	11·7	3·3
Portugal (and adjacent islands)	15·0	3·7
South Africa (1954)		
European	17·6	4·5
Asiatic	12·2	9·3
Coloured	3·8	1·5
Spain	9·1	2·9
Sweden	27·2	8·5
Switzerland	31·4	12·4
United Kingdom		
England and Wales	14·3	8·4
Scotland	9·6	5·9
N. Ireland	5·4	1·3
United States of America		
Total	16·0	4·6
White	17·2	4·9
Non-White	6·1	1·5

In the USA about 16,000 suicides are reported each year.[22] In addition about 100,000 suicidal attempts are believed to occur annually in the USA.[23,4] In San Francisco from November 1956 to September 1957 there were 175 suicides and 197 admissions to the San Francisco City and County Hospital for suicidal attempts.[17]

In England and Wales during 1956 there were 5,262 suicides, the highest ever recorded.[20] During the same period there were 5,387 known attempted suicides.[1] In England and Wales, but not in Scotland, attempted suicide is still a criminal offence, but there were many attempted suicides of which the police had no record. During the calendar year 1957 a total of 44 attempted suicides arrived at Guy's Hospital and York Clinic.[28] Of these cases, together with 11 admitted to York Clinic in 1956 (55 cases in all), only 13 were known to the police.[28] In 1949 72 patients were admitted to the Bethlem Royal Hospital and Maudsley Hospital for attempted suicide.[25] The Glasgow Western Infirmary had 457 admissions for attempted suicide between 1937 and the end of the first quarter of 1953.[12]

The cases of attempted suicide admitted to Groote Schuur Hospital, Cape Town, between January 1947 and May 1950 numbered 252, consisting of 204 Europeans, 46 Coloured and 2 Natives.[27]

In Sweden the annual number of deaths from suicide is about 1,300, which exceeds the number of deaths from street accidents. In 1953 there were 1,332 suicides, of which 195 occurred in Stockholm. Between January 1952 and May 1953 500 suicidal attempts were made by 457 patients admitted to Södersjukhuset, a municipal general hospital in Stockholm.[5]

2. *Time of admission to hospital.* The tendency for the majority of admissions for attempted suicide to occur at night has also been reported by others, e.g. for Guy's Hospital (London),[28] Södersjukhuset (Stockhholm),[5] Cincinnati General Hospital,[19] and Detroit (USA).[10]

3. *Distribution over the year.* In the present series, suicides, and admissions to hospital for attempted suicide, occurred evenly throughout the year. McGeorge[13] (1942) found in a series of 523 attempted suicides in Australia that the favourite season was the summer and the least favoured the spring. McKinlay[14] gave figures for suicide in Scotland for the period 1911 - 1940 and found that the incidence was greater during spring and early summer. Swinscow[26] also found that in Britain the favourite season for committing suicide was clearly from spring to about midsummer.

4. *Distribution over the week.* As in the present series Ettlinger *et al.*,[5] found no difference in distribution over the different days of the week in their Stockholm series of attempted suicide. Donalies,[3] however, reported that Sunday was the commonest day for suicide and attempted suicide in Munich; and Moore,[16] of Boston, and Lendrum,[10] of Detroit, reported high incidences on Sundays and also, for females, on Wednesdays.

TYPES OF SUICIDAL PATIENTS

Suicide is a danger in all types of depressions. This includes manic-depressive psychoses, endogenous depressions, organic depressions, reactive depressions, involutional melancholia, and psychoneurotic depressions. In manic-depressive psychosis, when the patient is severely depressed, psychomotor retardation is common and suicide is rare. In the convalescent

phase, when the retardation is less severe, the patient presents a greater suicidal threat.

Suicide is not uncommon in schizophrenia. It is commoner in the paranoid group than in the others.[7] In these cases the attempts at self-destruction are often brutal and horrifying. The suicidal attempt may be prompted by hallucinations or bizarre delusional ideas.

In the psychoneuroses suicide is rare. It is, however, possible in acute anxiety states when the anxiety reaches panic proportions.[7] In hysterical personalities suicidal attempts are usually attention-seeking devices, in which the patient has no serious intent to terminate life. These persons may use the shock of a suicide gesture to control their environment, to gain attention, to arouse sympathy, to frighten others into submission, or to dramatize themselves.[15] The action often reflects a child fantasy, 'When I am dead you will be sorry'.

The possibility of a rational suicide has been much debated.[18] Rational suicide may be defined as a suicide in a well-integrated, mature person under the burden of a massive, objectively irremediable misfortune, after calm reflection. Many authors feel that any type of suicide is a pathological act, but Oliven[18] considers that judgment on this point may well hinge on the observer's definition of psychic normality and on the cultural setting and background of tradition in which the act occurs. For example, suicide was reportedly the expected normal step in the Imperial Japanese Army after failure to carry out an assigned task, or in the old Prussian Officer Corps after transgression against the honour code. 'Rational' suicides are most frequently to be expected in patients with incurable or severely painful afflictions.

Delirium from any cause may lead to suicide in response to extreme apprehension and confused ideas of persecution, often during a lucid period.[11]

Alcoholism is frequently a feature of suicidal individuals, but it is probably not a direct cause of suicide, with the possible exception of acute alcoholic hallucinosis, in the course of which terrifying hallucinations and ideas of persecution may drive the patient into a suicidal panic.

COMPARISON OF SUICIDE AND ATTEMPTED SUICIDE

The present study shows certain differences between the patients who entered the Johannesburg Hospital for 'attempted suicide' and survived and those who died from suicide. 'Attempted suicide' was commoner in females and the peak incidence occurred in the age-group 19 - 23. Suicide on the other hand was commoner in males and most frequent between 34 and 38. The methods employed in 'attempted suicide' and suicide also differed considerably. Ingestion of 'poisons' was by far the commonest method employed in 'attempting suicide' (82·6%); it was much less common in European suicide (17·8%). The 'poisons' used also differed. Gunshot wounds were common in suicides but uncommon in 'attempted suicide'. Similar differences between suicide and attempted suicide have been found by others.[26]

The existence of differences between suicide and 'attempted suicide' has lead one to wonder what the relationship is. Are all cases of 'attempted suicide' really persons who wished to terminate their lives? Did they fail only because their methods were inadequate and because they were fortunate enough to receive medical aid?

Studies have shown that only a small minority of those who have committed suicide have made a previous suicidal attempt. Sainsbury's figure for North London (1936 - 38) was 9%,[21] and in Stengel and Cook's studies the figure was 13%.[25]

In order to find out how many of those who attempt suicide finally kill themselves, 138 cases of attempted suicide admitted to a London mental observation ward in one year (1946 - 47) were followed up 5 years later; 35 patients were found to be dead, of whom only 1 had killed himself, 18 were in mental hospitals, 5 were untraced, and the rest were out of hospital.[24] In 1949 72 patients were admitted to the Bethlem Royal Hospital and Maudsley Hospital because of attempted suicide; when followed up 3 years later only 2 of them had killed themselves.[25] In Sweden, Dahlgren[2] found that of 230 people who attempted suicide 6% killed themselves in 4 years. Hove[8] followed up 500 attempted suicides treated at the poisoning unit of Bispebjerg Hospital, Copenhagen; after 2 - 3 years 94% of the patients were still alive, 5% had committed suicide, and 1% had died of other causes. It appears that only a small proportion of those who attempt suicide finally kill themselves.

The fact that suicidal deaths are more numerous in males than in females has been attributed by some to the fact that men more often resort to violent methods. In their series, however, Ettlinger *et al.*[5] could not find a correlation between the sex or age distribution and the methods used.

The above evidence suggests that 'suicide' and 'attempted suicide' are two different symptoms of psychological maladjustment, although there is probably a certain amount of overlap in the two conditions.

Many people apparently attempt suicide although they do not wish to die. Lennard-Jones *et al.*[9] recently subdivided apparent suicide actions into 3 classes, viz. (1) the serious class, those who really intended to kill themselves, (2) the doubtful cases, those who tried for death but clung on to life, and (3) spurious suicidal cases those who never meant to kill themselves (the 'pseudocide' group). In 34 consecutive patients in the general wards of a hospital in London they classified 12 of the attempts as serious 9 as doubtful and 13 as spurious.

The 'attempted suicide' group appears to be made up largely of the hysterical personalities who attempt suicide as a form of mental blackmail. In this group fatal accidents are apt to occur. They may for example inadvertently take an overdose of a 'real poison' miscalculate the arrival of someone to turn off the gas stove or lean too far out of the window. Such cases might be called 'unsuccessful attempted suicide' since their aim was attention seeking and not self-destruction. The 'attempted suicide' group also contains people who failed in a genuine suicidal attempt. Failing in a serious suicidal attempt they often deny the true intention; occasionally they maintain that they took poison 'accidentally'.

DIAGNOSIS OF SUICIDAL PATIENT

A major psychiatric emergency is the prevention of suicide and hence it is important to differentiate a suicidal patient from a hysterical personality attempting to seek attention. Contrary to a popular belief that a truly suicidal person 'just goes ahead and does it' it is estimated that as many as 40% talk about their intent beforehand,[6] though in many instances this can only be established through careful enquiry.[25] Such talk may range from melodramatic threats to matter-of-fact statements. The finding of a discarded farewell or other suicidal letter should serve as a warning

symptom and, if the subject is an adult in a state of depression, such notes must be regarded with pessimism, no matter how convincingly the patient explains them away.[18] Suicidal notes are rarely written by hysterical patients. Patients who have recently recovered from a serious depression must be treated with suspicion, for suicide not infrequently occurs at that stage. Potentially dangerous methods should be regarded seriously, and apparently trivial methods are not always to be taken lightly, especially in cases of low intelligence.

Cruel and bizarre methods, such as slitting throat from ear to ear, lying in front of steamroller, igniting self, thrusting red-hot poker down throat,[15, 16] are usually evidence of dangerous psychopathology and are hardly ever 'hysterical'. It is usually in serious psychoses that the swallowing of foreign bodies (glass, nails, etc.) takes place and, even though it may be ineffectual, it cannot be called trivial. Oliven[18] considers multiple means, such as poison plus hanging, or sleeping tablets plus drowning, always to be evidence of a serious attempt. When the patient is questioned about suicidal thoughts, an outburst of anger or indignation or an increase in agitation or self-accusation is significant. Reading about death, despair and doom, and also carelessness about personal appearance in dress and bodily hygiene, especially of recent origin, are indicators of potential suicide.[7]

'Accidental' poisoning may be hard to differentiate from attempted suicide. It is not uncommon for a patient who fails in a genuine suicidal attempt to state that the poison was taken accidentally. There may be psychiatric reasons for the accidental taking of poisons; for example, it may occur while the patient is in a toxic confused state. Some observers feel that in all accidental poisoning an underlying (subconscious or unconscious) suicidal impulse can be found.

In addition to 'accidental' poisons many other so-called traumatic accidents (e.g. car accidents) are really attempts at suicide. It might be advisable for psychiatric opinion to be obtained in all such cases, especially where the patient was the driver of the vehicle.

SUMMARY

1. The 358 attempted-suicide admissions to the Johannesburg General Hospital for 1958, and the 141 suicides which took place in the Johannesburg area during the same period, are reviewed.

2. The problem of suicide and attempted suicide in Johannesburg is similar to that found elsewhere.

3. Evidence is presented to support the hypothesis that 'suicide' and 'attempted suicide' are two different symptoms of psychological maladjustment, although there is probably a certain amount of overlap in the two conditions.

4. The types of suicidal patients are discussed.

5. Certain aspects in the diagnosis of a suicidal patient are discussed.

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