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By- Wold, Carl I.

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An on-going research project at the Los Angeles Suicide Prevention Center is attempting to describe the potential suicide. Comparisons on a rating scale were made among patients who commit suicide and a random sample of case histories from the coroner's office. Approximately 10 syndromes or subgroupings of people who commit suicide have been identified. Of these syndromes, two are discussed in detail. The "Down-and-Out" syndrome includes those whose lives have followed a downhill course and who are at the end of their resources. The "I-Can't-Live-Without-You" group includes passive, dependent people who have suffered a loss of an important person. Neither of these syndromes is notable for previous suicide attempts or particular to men or women. (NS)

SOME SYNDROMES AMONG SUICIDAL PEOPLE: THE PROBLEM OF SUICIDE POTENTIALITY

by Carl I. Wold, Ph.D.

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Some Syndromes Among Suicidal People: The Problem of Suicide Potentiality

by Carl I. Wold, Ph.D.

An on-going research project at the Los Angeles Suicide Prevention Center has as a main purpose the description of our patient population. We want to learn about those people who call the Suicide Prevention Center with a suicide problem and make comparisons with, at least, two other populations: The first is a sub-group of our callers who go on to commit suicide, and the second is a group of people who have committed suicide with information about them available from the Los Angeles County Coroner's Office. Who are these people? Are these suicidal people men or women? What are their ages? Have they made suicide attempts? What has been their contact with mental health professionals? What can we say about their history in marriage, employment, and early life experiences?

The current data under study consist of over 100 descriptive categories, including answers to the questions asked above. Out of case material describing over 26,000 suicidal patients, we have selected a random sample of about 500. A second group is made up of 40 of our patients who have gone on to kill themselves sometime after their contact with the Suicide Prevention Center.

At this point, I wish to emphasize one major purpose of such research and suggest another. Our focus is on learning more about

suicide potentiality. What are the important factors about a person which will help us decide the likelihood of his killing himself? In addition, what can we learn that is useful in preventing suicide?

There has been research in the area of suicide potentality by Drs. Robert Litman, Norman Farberow and Norman Tabachnick in Los Angeles; Drs. Jerome Motto, Earl Cohen and Richard Seiden in the San Francisco Bay area; Dr. Jacob Tuckman in Philadelphia; Dr. Warren Breed in New Orleans; Dr. Alex Pokorny in Houston, and a number of others in this country and elsewhere. In general, the approach has been to study individuals identified as suicidal and, retrospectively, to investigate the personalities and life styles of people who have killed themselves.

At the Los Angeles Center we have developed a suicide potential rating scale which has undergone periodic revision since 1959. In spite of our efforts to include known, relevant variables and weight them appropriately, we remain dissatisfied with the predictiveness of the instrument. Such variables as age and sex, psychological symptoms, environmental or life stress, the proposed plan for suicide, prior suicidal history, and the meaning of the suicidal communication are included. The resulting scale is helpful clinically, but we hope for more. The

factors which have been isolated correlate with suicide potentiality, but do not account for enough of the variance. Those of our patients who commit suicide have been evaluated as high risks by the use of the scale; nevertheless, a large number of suicidal people rated high suicide risks do not kill themselves.

Recently, Dr. Litman has suggested a new approach to the study of suicide lethality. He feels that by identifying clusters of suicidal indicators or sub-groupings of suicidal people, we may be able to sharpen up the predictiveness of lethality indicators. For some time now, it has been clear to researchers in this field that the concept of suicide is a broad one, referring to a variety of different events and describing people with many different personality configurations and life styles. It seems ambitious to hope for the discovery of general principles and specific indicators which apply to the broad range of suicidal people.

We have been aware of certain high-risk sub-groupings. For example, the suicide rate among alcoholics is substantially greater than the rate for the general population. However, researchers in the area of suicide potentiality have used alcoholism as another indicator. In this way, a person's drinking habits are assessed and perhaps weighted along with other

variables. It may be more useful to think of a sub-group of suicidal people, such as alcoholics, separately when deciding suicide potentiality. Viewed this way, other indicators, such as prior suicidal history or age or sex, have special predictiveness for a given sub-group, but not for other sub-groups. For example, repeated unsuccessful attempts at psychotherapy in the history of a person could be a crucial factor in deciding his suicide potentiality if that person is seen as an alcoholic, while it may be of far less importance among other sub-groups.

Following this approach, my colleagues and I at the Suicide Prevention Center in Los Angeles have been trying to isolate and describe relevant sub-groupings of suicidal people. Without reference to a medical model, we refer to these sub-groupings as suicidal syndromes. With these syndromes, we hope to cut across and re-combine standard psychiatric categories and common sociological descriptions. At present, we have about ten of these syndrones, which are undergoing continual redefinition and some seem better than others. The other papers presented today will include more detailed data on a few of these syndromes.

To illustrate some of these points, I will talk about two syndromes and present some data which support such a new approach. I want to make it clear that these syndromes developed

out of our work with suicidal people who were patients at the Los Angeles Center. It remains to be shown how they apply to the population of people who have killed themselves; that is, coroner's cases of suicides. I will present syndrome data on a group of 40 Suicide Prevention Center patients who went on to kill themselves.

One syndrome we refer to as Down-and-Out. These suicidal people are men and women, usually in their 40's or 50's. They are often in poor physical health and use alcohol and/or drugs abusively. Their lives, viewed historically, have followed a downhill course in most areas such as job and marriage. Often they have a history of superfical relationships with other people and may have moved around frequently. Feelings of pride and self-esteem have been acutely damaged. When they come to our attention they have exhausted most of their personal resources and often many community resources as well.

Out of our random sample of about 500 Suicide Prevention Center patients, there were 14 (or 3% of the total) classified as Down-and-Out. In the sample of 40 Suicide Prevention Center suicides, however, there were nine classified as Down-and-Out (or about 23%). But what about lethality indicators for this Down-and-Out syndrome? First, let us consider the question of sex. For our over-all Suicide Prevention Center patient population, two-thirds of these suicidal people are women. Among

those people in the Down-and-Out syndrome, about 36% are women. Yet, among the Suicide Prevention Center suicides classified as Down-and-Out, all of them were men. This suggests that sex as an indicator of suicide potentiality is important when a person has been classified as a member of the Down-and-Out syndrome. I will show later that sex may not be an important indicator for some of the other syndromes.

Another lethality indicator for the Down-and-Out syndrome is a history of prior suicide attempts. The random patient sample, the Down-and-Out syndrome group, and the patient suicides who were classified as Down-and-Out, all showed about the same percentage of prior high-lethal suicide attempts. This suggests that a history of high-lethal suicide attempts among people in the Down-and-Out syndrome is not especially indicative of high suicide potentiality. This is quite different from some other syndromes where an outstanding characteristic of people who kill themselves was a history of multiple, high-lethal suicide attempts.

Another indicator is parental loss before the age of 12. That is, had the patient's parents died, divorced or separated before the patient reached the age of 12. Among our general patient population, 40% had experienced such a parental loss.

Among those in the Down-and-Out syndrome, about the same percentage of people suffered early parental loss. Remarkably, 84% of the sub-group of Down-and-Out people who went on to kill themselves told of an early parental loss.

A second syndrome to consider here we call I-Can't-Live-Without-You. These are both men and women who are suicidal in response to a threat or actual break-up of an intense, symbiotic relationship. The relationship may be with a spouse, homosexual partner, or parent. Often these are people with passive-dependent characters. Their ages range from the 20's through the 60's. The patient feels like part of him has gone when there is a loss of the symbiotic other. He experiences feelings of terror and overwhelming incompleteness. Moreover, he is unable to conceive of anyone ever replacing the lost partner. Frequently, these people have led a fairly stable life in terms of job or residence. About 12% of our general patient population are classified in this syndrome. Of the forty Suicide Prevention Center patient suicides, 20% were classified as I-Can't-Live-Without-You.

In contrast to the Down-and-Out syndrome, sex is not a major lethality indicator among the I-Can't-Live-Without-You group. About 60% of people in the I-Can't-Live-Without-You syndrome are women, and among the sub-group of this syndrome who committed suicide, 50% were women.

It is interesting to consider, for this syndrome, the history of prior suicide attempts. Among our general patient population about 50% have a history of prior suicide attempts and the percentages are about the same for the I-Can't-Live-Without-You syndrome, as well as for the sub-group of that syndrome who went on to kill themselves. However, if we classify those prior attempts as multiple, high-lethal, we find that this occurs among less that 10% of all three of these populations. Yet, among those 40 Suicide Prevention Center suicides as a group, 30% had a history of multiple, high-lethal suicide attempts. Since this high percentage was not present among the I-Can't-Live-Without-You suicides, it suggests that this indicator is of limited usefulness for people in that syndrome.

I want to summarize with some caution and suggestions for new directions. A number of the observations I have made were based on a small group of 40 Suicide Prevention Center patient suicides. When these 40 are distributed among the various syndromes the numbers decrease accordingly. It will be very interesting to see if these observations hold up when the size of the samples is increased. More than this, will it be possible to use these syndrome classifications with a group of people who have committed suicide and who become known through retrospective coroner's investigations?

TABLE 1.

A Random Sample of Patients at the
Los Angeles Suicide Prevention Center

n=485

Age	n	%
≤12	4	1
13-19	53	11
20-29	155	32
30-39	119	24
40-49	63	13
50-59	57	12
60-69	16	3
70+	3	1
Unknown	15	3

Sex	n	%
Men	187	38
Women	296	61
Unknown	2 less 1	

History of Prior Suicide Attempts	n	%
Single, low-lethal	63	15
Single, high-lethal	38	9
Multiple, low-lethal	75	18
Multiple, high-lethal	42	10
None	206	48

Parental Loss Before Patient was 12 Years old		
Suicide	7	2
Parent(s) died (other than suicide)	51	18
Parents separated	57	20
None	171	60
	(Unknown-199)	

TABLE 2.

Patients from the Random Sample (Table 1) who Were Classified in the Down-and-Out Syndrome

n=14

Age	n	%	Sex	n	%
< 12	0	0	Men	9	64
13-19	0	0	Women	5	36
20-29	1	7			
30-39	0	0			
40-49	3	22			
50-59	9	64			
60-69	1	7			
70+	0	0			

History of Prior Suicide Attempts	n	%
Single, low-lethal	1	8
Single, high-lethal	0	0
Multiple, low-lethal	1	8
Multiple, high-lethal	2	17
None	8	67

Parental Loss Before Patient was 12 Years old		
Suicide	0	0
Parent(s) died (other than suicide)	3	38
Parents separated	0	0
None	5	62

(Unknown--6)

TABLE 3.

Patients from the Random Sample (Table 1) who Were Classified in the I-Can't-Live-Without-You Syndrome

n=61

Age	n	%	Sex	n	%
< 12	0	0	Men	22	36
13-19	1	2	Women	39	64
20-29	31	52			
30-39	9	15			
40-49	11	18			
50-59	6	10			
60-69	2	3			
70+	0	0			

History of Prior Suicide Attempts	n	%
Single, low-lethal	12	22
Single, high-lethal	3	6
Multiple, low-lethal	10	18
Multiple, high-lethal	1	2
None	28	52

Parental Loss Before Patient was 12 Years old		
Suicide	0	0
Parent(s) died (other than suicide)	8	23
Parents separated	10	28
None	17	49

(Unknown--26)

TABLE 4.

Patients who Committed Suicide and Who Were Classified in the Down-and-Out Syndrome

n=9

Age	n	%	Sex	n	%
< 12	0	0	Men	9	100
13-19	0	0	Women	0	0
20-29	0	0			
30-39	0	0			
40-49	3	38			
50-59	4	50			
60-69	1	12			
70+	0	0			

History of Prior Suicide Attempts	n	%
Single, low-lethal	1	11
Single, high-lethal	1	11
Multiple, low-lethal	1	11
Multiple, high-lethal	1	11
None	5	56

Parental Loss Before Patient was 12 Years old		
Suicide	1	16
Parent(s) died (other than suicide)	3	52
Parents separated	1	16
None	1	16

(Unknown-3)

TABLE 5.

Patients who Committed Suicide and who Were Classified in the I-Can't-Live-Without-You Syndrome

n=8

Age	n	%	Sex	n	%
< 12	0	0	Men	4	50
13-19	0	0	Women	4	50
20-29	1	12.5			
30-39	1	12.5			
40-49	2	25			
50-59	2	25			
60-69	2	25			
70+	0	0			

History of Prior Suicide Attempts	n	%
Single, low-lethal	1	12.5
Single, high-lethal	1	12.5
Multiple, low-lethal	2	25
Multiple, high-lethal	0	0
None	4	50

Parental Loss Before Patiert was 12 Years old		
Suicide	0	0
Parent(s) died (other than suicide)	2	67
Parents separated	0	0
None	1	33

(Unknown-5)