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LETTER TO THE EDITOR

Violent suicide attempts: socio-demographics, clinical profile, cultural repeaters?

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To the editor: There are several factors which play a role in choosing the method of committing suicide: age, gender, clinical diagnosis, accessibility, sociocultural acceptability, lethal capacity of the method and mimicry of other behaviour. Thus, great socio-geographical and cultural differences appear [2]. For example, it is easy to acquire firearms in the United States, yet this is not so in Europe. The strict regulations concerning the possession of firearms in Spain have meant that this violent method, which was indeed common at the beginning of the century, is used less now than throwing oneself off a building or bridge or hanging. It has been reported that the methods used by women are generally more passive and less violent, self-poisoning (WHO/EURO Multicentre Study on Parasuicide [1]) being the most common method. In rural areas with less development, non-pharmacologic or violent methods are used more frequently.

Information taken from the Epidemiological Survey of Suicide Attempts in Osuna Hospital, a rural area in Seville, Spain, revealed that the mean frequency of non-pharmacologic (violent) methods over the last two years was 18.5% (46 attempters). The most commonly used methods were swallowing caustic substances (12 patients, 26.3%); throwing themselves (12 patients, 26.3%); hanging (ten patients, 21.6%); cutting (ten patients, 21.6%); and being hit by a train (two patients, 4.2%). The descriptive profile of the violent parasuicide person is a middle-aged person (male-to-female ratio 1.4:1) with a previous psychiatric history and attempts, no self-criticism after the attempt and using accessible methods. The spectrum of ICD-10 diagnoses [3] were adjustment, neurotic and somatoform disorders, schizophrenia and other psychoses, depression, and mental organic disorders. No specific nosologic category predominated.

In comparison with a randomized group of 92 attempters who used pharmacologic methods (χ^2, Kruskal-Wallis and analysis of variance tests), there were no significant differences found concerning gender, age group, chronic somatic diseases, impulsiveness or ICD-10 diagnostic group. Therefore, the basic socio-demographic variables considered, as well as the psychological/psychopathological variables (impulsiveness trait and clinical diagnosis), did not determine the choice of method; however, there did seem to be an association with such variables as repetition of the attempt ($P < 0.01$) or the absence of self-criticism afterwards ($P < 0.0001$). This points to the fact that in our area, the use of violent methods is not so affected, as traditionally thought, by such factors as age and gender [1, 2], or so related to the clinical diagnosis (for example, the use of violent methods in schizophrenic, major depressive or severe patients); the presence of previous attempts was however essential. The patients used such violent methods on the second or third attempt to assure their death, regardless of their age, gender or psychiatric diagnosis. This coincided with the patients' persistence of suicidal thoughts.

It is possible that the importance of socio-demographic and clinical factors in the choice of method of suicide has been overestimated; indeed,

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according to our results, the choice of method largely depends on sociocultural patterns, accessibility and failure of methods used in previous attempts.

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