Egypt. J. Psychiat. , 1990, **13:** 11-23

Suicidal Intent in Deliberate Self-Harm

E. Hamdi, Yousreya Amin, T. Mattar and M. Howaidi

ABSTRACT

Suicidal intent was measured in a series of 65 consecutive referrals for deliberate self-harm as measured by the Suicide intent Scale (SIS) the majority of cases have a low to moderate intent upon dying. The degree of intent was found to increase with age. Psychosis and deliberate self-injury were associated with high suicidal intent. The medical seriousness, the dangerousness of the method used and the degree of intent were found to correlate significantly with consensual rater opinion of the seriousness of the attempt. Hopelessness and a sense of isolation were significantly more frequent antecedent affects in cases with high intent while anger and frustration were more prevalent in cases with low intent. Other motivational affects like helplessness, feeling of loss, feeling of incompetence, hostility towards oneself and guilt were non-differentiating with regard to the intensity of suicidal intent.

INTRODUCTION

Suicidal intent has been defined as "the actual wish to die" (Power *et al.* 1985) or the sense of purpose inherent in the act (Hawton & Catalan 1987) Scrutinized clinical observations have questioned the notion that all or almost all people who commit suicidal acts are clearly determined to die (Stengel, 1975; Hawton & Catalan, 1987; Dorpat & Boswell, 1963). The acts subsumed under the term of deliberate self-harm differ in the degree and clarity of conscious suicidal intention. Dorpat & Boswell (1963) have classified their in relation to the degree of intent into the suicide gesture group the ambivalent category and the serious act. In their series, the ambivalent category comprised the largest number. This group is vacillating and confused in intent, however they run the risk of death. Stengel (1975) reported that "many acts of deliberate self-harm and quite a few suicides are carried out in an ambivalent mood rather than with a clear and unambiguous determination to end life". Weiss (1957) described this group as showing a kind of "gamble with death".

There is always a need to be able distinguish the cases who had a genuine desire to terminate their lives from those who did not. This is all important of the institution of treatment, the possibility of commitment, and the treatment approach. There are various approaches to quantifying the genuiness or seriousness inherent in the act of deliberate self-harm including the medical seriousness, the method used and the degree of suicide intent. The value of assessing suicidal intent after self-harm has been discussed by several authors (Pallis & Sainsbury, 1976; Stengel, 1975) and a number of methods have been devised for its measurement, (Silver *et al* . 1971; Beck *et al*. 1974; Pierce, 1977). In addition to their use as screening instruments, they may have a predictive value for the fu-

ture risk of suicide (Pierce, 1981; Power *et al* . 1985). The relationship between suicide intent and medical seriousness of the act of deliberate self-harm has been a controverisal issue.In the traditional sense they are closely linked (Luscomb *et al* . 1980, pierce, 1977, pallis & Barraclough 1977; Morgan,1979; Goldney,1981). However, it is important to distinguish between the two concepts (Faberow,1950; Stengel *et al.* 1958). Power *et al.* (1985) state that the relation between both variables is positive but imperfect.According to Birtchnell & Alarcon (1971), Card (1974) and Beck *et al* . (1975) the seriousness of physical consequences is not a reliable measure of the intent to die.

The method empolyed in deliberate self-harm is another measure of seriousness. Violent methods appear to be associated with high suicidal intent (Pierce,1977). In cases of self-poisoning low suicidal intent scores may be associated in some cases with many medical complications (Fox & Weissman,1975). Hawton & Catalan (1987) stress that what matters for assessing seriousness is to what extent the individual was aware of the likely medical consequences of the attempt. The issue is as yet unresolved.

This articel assesses suicidal intent in a polyethnic population residing in U.A.E.(Dubai & Ras El-Khaimah). Intent is first linked to demographic and clinical variables. The assocation between suicide intent on one hand and medical condition of the patient, the method used, and genuineness of the act assessed by consensual opinion of multiple raters on the other hand is traced. Lastly, an attempt is made to correlate between the motivational affects preceding the event and the degree of suicide intent detected in the deliberate act of self-harm.

MATERIAL & METHOD

Subjects were recruited from consecutive referrals of medical admissions for self-poisoning or self-inflicted injury to Rashid Hospital (Dubai) and Saif Hospital (Ras El-Khaimah). A total number of 65 were examined (40 from Rashid Hospital & 25 from Saif Hospital). The presence of an act of deliberate self-harm was recorded if the patient had taken drugs or poisons in excess of therapeutic dosage and the act was not obviously accidental. Patients, e.g. drug addicts, who took an overdose and those who denied making a suicide attempt were not included in the study. A semi-structured interview was used to collect the data.

Subjects were interviewed as early as possible after referral by the physician; in most cases within 1-5 days after the attempt. The interview ranged widely over social, demographic and clinical information with special emphasis on the circumstances of the event of deliberate self-harm. Relatives and other informants were seen in the majority of cases. moreover, interviewing relatives was part of 12he management of many cases.

The suicidal intent scale (SIS) devised by Back *et al* . (1974) was used to assess the suicidal intent. It aims to measure "the intensity of patient's wish to terminate his life". The scale has two sections and consists of 15 items which are rated on a three-point scale (0-2) according to severity and then summed up to give the suicidal intent score The total score ranges from 0 to 30 . The first section includes 8 items and is concerned with the circumstances of the act (isolation, timing, precautions against discovery, seeking help during or after the act, degree of planning, suicide note, communication of intent before the act and purpose of the act). The second section (self-report) includes7 items. It is based on the subject's own reconstruction of his feelings and thoughts at the time of the act (expectation of fatality, conception of lethality, conception of seriousness, ambivalence towards living, conception of the act's reversibility and premeditation). The test was included as a part of the interview and supplemented

by information from relatives whenever needed. Two cases were muddled and under severe emotional stress at the time of time the act that they could not report their subjective feelings. Only the circumstances score was calculated for these subjects.

All cases were interviewed by a psychiatrist who made a preliminary psychiatric diagnosis. In the second phase, the data collected was subjected to detailed evaluation in each case by the three researchers.

Following the immediate review of all the information for each case, the raters assessed the medical seriousness scored from the case files according to the following criteria:1) physical condition on admission (vital signs, medical & neurological examination and emergency laboratory investigations as recorded by the receiving medical officer &2) measures of physical care that the physical condition necessitated on admission and during in-patient care. Special attention was given to the level of consciousness, the use of resuscitation measures, and duration of admission in ICU. The medical seriousness was scored along 4 degrees of severity (absent-mild-moderate & severe).

The seriousness of the method was also evaluated along four degrees of severity. In cases of drug overdose the number, and brand of tablets were considered together with the patient's awareness of their risks. In non-overdose cases the severity of injury and the circumstances of rescue were studied. Both, medical seriousness and seriousness of the method were assessed independently from the assessment of suicidal intent. The scoring was made by in the second phase without reviewing the content of the SIS responses).

A global score of the seriousness of the act was given to each case along a four point scale (absent-mild-moderate& marked). Interrater differences were discussed in order to reach a common consensus. All demographic, circumstantial, and clinical information, excluding (SIS responses), was taken in consideration. The clinical information was used to arrive at a clinical diagnosis according to the criteria of the DSM-III R. Diagnoses were discussed before reaching a common consensus.

Using content analysis a list of affects concomitant with deliberate self-harm was prepared. These affects were expressed in response to the inquiry about the immediate reasons behind the act. The list included feelings of loss (expression of the fear of impending loss or the experiencing of actual loss by death, separation etc), helplessness (feelings associated with living an inescapable situation whether delusional or real), hopelessness, isolation (feeling that nobody is there to help, to care or to love), frustration (blocking of on-going goal directed behaviour), anger, shattered self-esteem (the impending realization of wrongdoing or pain e.g. after discovery of misbehaviour or psychological trauma from a significant object), incompetence or inadequacy (feeling that compared to others they are unable to have a successful role in life e.g. discontinuation of academic carrier,failure of marriage projects etc). self-hatred (expression of hostile feelings toward self), and conscious feelings of guilt. An operational definition was put forward for each criterion. At the end of the review of all informations collected for each subject,raters were requested to screen the presence of each of the associated affects. A common consensus was a prerequisite for the identification of the presence of any particular affect.

In order to explore the relation between suicide intent on one hand and demographic variables, clinical variable and the other measures of seriousness, all our subjects were devided into three groups. The first group includes cases with low intent, the second one the medium intent attempters, and the third the high intent subjects. The cut-off levels were adopted from Pierce (1981). The

low intent cases (n=13 or 21%) are those who had a total score between 0-3; the medium intent cases (n= 25 or 40.3%) scored between 4-10; and the high intent cases (n= 24 or 38.7%) scored 11 or above on the SIS. The frequency of the motivational affects associated with deliberate self-harm in each of the three groups were compared.

RESULTS

The mean total SIS score for the whole sample is 8.9 (SD±5.54); with a range of O to 22. The mean score for circumstances is 2.8 (SD±2.51); with range of 0 to 9 and the mean self-report score is 6.2 (SD±3.99) with a range of 0 to 14. The correlations among the total SIS score and its component parts are shown in table1.

The correlation between self-report and the total score is greater than between circumstances and total score The least correlation is between circumstances and self-report.

The total SIS scores were used to study suicidal intent in relation to demographic and clinical variables. As illustrated in table 2, suicidal intent scores do not vary with sex (mean score for females 8.9± 4.64 and for males 9±7.71; t value 0.07 ;df= 60,n.s.). However, when males are compared to females (fig1) within the same age-group, differences emerge. Adolescent females (13-20 years) have a higher intent than male adolescents (mean score for females 7.3±3.6 and for males 3.3±2.99; t=2.1;df= 25; P<0.05). In the age groups 31-55y (mean score for females 10.6±6.2 and for males 17.6±5.3; t=1.92; df=8; n.s.). When age is studied independent of sex, SIS total scores showed significant increase with age in the three age groups (fig 1) (one way ANOVA, F=8.19; df1=2, df2=58; P<0.01). The 13-20 year group had a mean score of 6.7±3.8; ascending in the 21-30 year group to 9.54 s.d.+5.47, and still higher (14.1±6.57) in the 31-55 year age group. The study of the civil status in relation to suicidal intent (fig 2) revealed that suicidal intent is higher in married females (mean=10.3±5.42) than single ones, (mean=7.9; SD±4.15). The difference is non significant (t=1.59; df=40). In males, marriage seems to have little effect on suicidal intent being almost equal in both groups

TABLE I

Inter-correlations between Suicide Intent Scale total score & its two components,circumstances and self-report (Pearson Correlation Coefficient)

	Circumstances	Self-report	Total score
		n = 63	
Circumstances	1.00	0.40	0.75
Self-report		1.00	0.91
Total score			1.00

Fig 1 - Suicidal Intent in Relation to Sex and Age

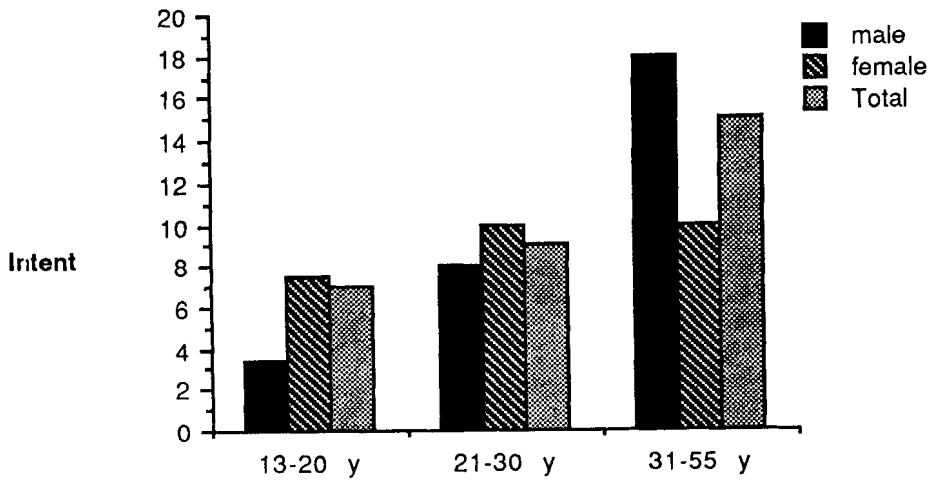

Fig 2 - Suicidal Intent in Relation to Civil Status & Sex

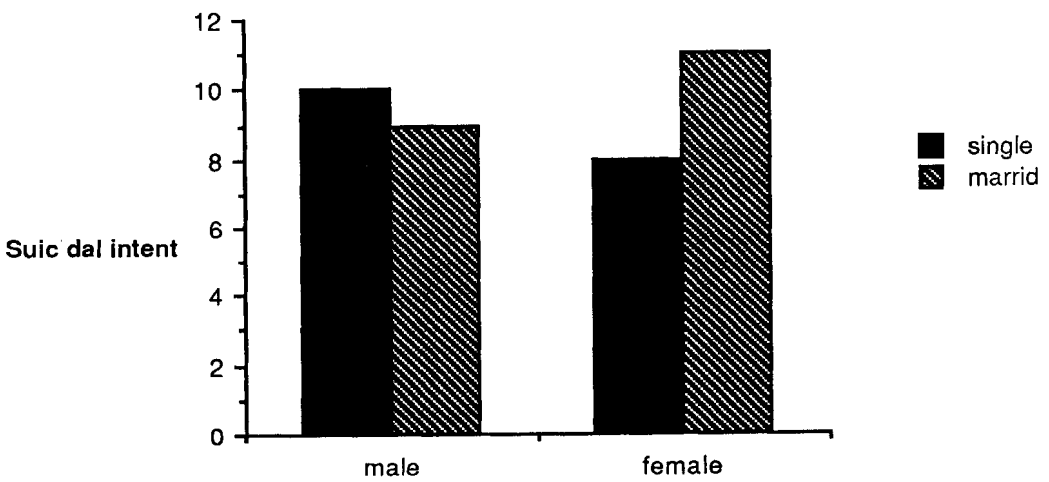

Fig 3- Comparison of Affects

(9.5; SD±7.95 for married subjects and 9.8; ±7.66 for single subjects; t=0.7; df=15; n.s.).

Suicidal intent was lower in the repeaters (mean score 7.7 SD±5.17) compared with the first-ever attempters (mean score 9.5 SD±5.63). The difference is non-significant (t=1.15; df=60). Subjects with deliberate self-injury showed significantly higher suicidal intent (mean=14.8±6.39) than the cases with self poisoning (mean score 8.2±4.9; t=3.41; P<0.01).

The study of suicidal intent in relation to the presence or absence of psychotic behaviour revealed significant differences. Intent is higher in the psychotic group (mean score for psychotic subjects being 14.7±5.12 and in the non psychotic 8.1.±5.03; t =3.64; P<0.001, df=60). Patients who manifest behavioural problems in relating to their environment show lesser suicidal intent (mean=7.9± 4.21) than the subjects without problem behaviour (mean=10.3±6.37). The differences are nonsignificant (t=1.76;df=60).

As illustrated in Table 4, the SIS total scores in the four groups of patients with absent, mild, moderate and severe medical seriousness fall along a continuum with the non-serious group having the scores and the most serious group getting the highest scores. Analysis of variance showed that the F ratio is significant (P<0.01). Similarly the comparison of the mean scores of SIS for the four groups of patients with increasing seriousness of the method used in the act of deliberate self-harm revealed significant differences (F=14.85; df1 3;P<0.01). The study of total SIS scores in relation to the raters' global evaluation of the seriousness of the act revealed highly significant differences (F=17.23, df=3, P<0.01) with those subjects classified as the most serious attempters getting the highest intent scores.

The frequency of the different affects identified by content analysis in the three intent groups are illustrated in Table 4. Feelings of loss, helplessness,

TABLE II

Demographic & Clinical Correlates of Suicide Intent

Sex	Male	Female	2-Tailed t value
	n=17	n=45	& df
Mean score	9 (±7,71)	8.9 (±4.64)	0.07 df 60
Age			
13-20y	3.3	7.3	2.1 *
S.D.	(±2.99)	(±3.64)	df 25
21-30y	7.9	10.4	1.06
S.D.	(±6.18)	(±5.08)	df 22
>30y i	17.6	10.6	1.92
S.D.	(±5.32)	(±6.19)	df 8
Civil Status			
Single	n=9	n=27	
Mean	9.8	7.9	0.94
S.D.	(±7.66)	(±4.15)	df 34
Married	n=8	n=15	0.27
Mean	9.5	10.3	df 21
S.D.	(±7.95)	(±5.42)	
Employment			
Employed	n=12	n=32	
Mean	9.6	9.2	0.30
S.D.	(±6.92)	(±4.7)	df 11
Unemployed	n=5	n=13	
Mean	9.2	7.8	0.27
S.D.	(±9.09)	(±4.47)	df 4
Order	first-ever	repeaters	
	n=45	n=17	
Mean	9.5	7.7	1.15
S.D.	(±5.63)	(±5.17)	df 60

TABLE II (CONT.)

Method	self-poison	self-injury	
	n=54	n=8	
Mean	8.2	14.8	3.41**
S.D.	(±4.90)	(±6.39)	df 60
Psychosis	-ve	+ve	
	n=53	n=9	
Mean	8.1	14.7	3.64***
S.D.	(±5.03)	(±5.12)	df 60
Problem Behaviour	-ve	+ve	
	n=34	n=28	
Mean	10.3	7.9	1.76
S.D.	(±6.37)	(±4.21)	df 60

*P<0.05 **P<0.01 ***P<0.001

TABLE III

Comparison of Affects Associated with Deliberate Self-harm in Low Intent, Medium Intent and High Intent.

Affect	low Intent	Medinm In-	High Intent	Chi-squarre
	n=13	tent n=25	n=24	x 2
loss	2(15.4%)	7 (28%)	5(20.8%)	0.89
Helplessness	7(53.8%)	9 (36%)	14(58.3%)	2.64
Hopelessness	1(7.7%)	5 (20%)	16(66.7%)	17.20*
Isolation	6(46.2%)	6 (24%)	15(62.5%)	7.43**
Frustration	8(61.5)	17 (68%)	11(45.8%)	2.55
Anger	10(76.9%)	13 (52%)	8(33.3%)	6.48**
Self-esteem	4(30.8%)	14 (56%)	12 (50%)	2.22
Inadequacy	5(38.5%)	3 (12%)	5(20.8%)	3.61
Self-hatred	1(7.7%)	2 (8%)	2(8.3%)	0.0049
Guilt		2 (8%)	2(8.3%)	0.0016

*P<0,001 **P<0.05

TABLE IV

Suicide Intent in Relation to Medical Seriousness,Seriousness of Method & Global Rater Evaluation.

	N	Mean	± S.D.	Significance
Medical seriousness				
Absent	35	7.3	(5.37)	df1 3
Mild	20	9.5	(3.99)	df2 58
Moderate	5	14.6	(4.67)	df3 61
Severe	2	19.5	(3.54)	F=6.87*
Seriousness of method				
Absent	20	5.9	(5.02)	df1 3
Mild	25	8.2	(3.73)	df2 58
Moderate	14	13.2	(4.08)	df3 61
Severe	3	19.7	(2.52)	F=14.85*
Rater global opinion				
Absent	30	5.6	(4.29)	df1 3
Mild	20	10.4	(3.55)	df2 58
Moderate	10	14.6	(4.93)	df3 61
Severe	2	18.5	(2.12)	F=17.23*

*P<0.01

frustration, incompetence, hostility directed towards self and guilt were found to be non-differentiating. However, hopelessness was significantly higher in the high intent subjects; manifesting in 16 (66%) of cases while in the low intent group it was evident in one case (7.7%) only. In the medium intent group, the frequency was intermediate (manifesting in 5 cases (20%). The differences are significant (x2=17.2;P<0.001).Anger presents an opposite trend being highest in the low intent group (76.9%) and lowest in the high intent cases (33.3%). In the medium intent group, anger was evident in 52% of the subjects (x2=6.48;P<0.05). Feeling of isolation are highest in the high intent group (62.5%) and in the low and medium intent groups the frequency is respectively 46.2% and 24% the differences were significant (x2=7.43; P<0.05). Following the trend of anger, frustration feelings were high

in the low intent and medium intent groups; they were present in 61.5% and 68% of the cases respectively. In the high intent group, they were evident in 45.8% of the cases (x2=2.55; n.s.). On the other hand, feelings of shattered self-esteem were higher in the high and medium intent groups; they were present in 50% and 56% respectively of the two groups and in 30.8% of the cases. In the low intent group. The differences are *non significant* (x2=2.22;n.s.).

DISCUSSION

Suicide intent does not relate significantly to sex, but it increases with age. The trend is more evident for males than females. Married subjects from both sexes tend to have higher suicide intent than single subjects. Such a finding is particularly present in females. The frequent self-harm and high suicide intent among young females (in adolescence and young adulthood) compared to males may be interpreted by the earlier maturation of female subjects. it may be also explained by the greater restrictions imposed on female activities in the Emirates Oriental Islamic society. Male adolescents are having more freedom and more outlets to neutralize their frustration. Antisocial and drug addiction figure in the list of outlets. The finding that subjects with problem behaviour have a lower suicide intent compared to attempters without problem behaviour may give support to our suggestions. Marriage and employment for female subjects was found to be associated with a higher suicide intent (n.s) in females. This finding may suggest that the more the individual engages in responsible life roles e.g. marriage,employment the more serious the intent becomes. Similarly to our finding Dorpat and Boswell (1963) have reported that intent increases with age. Following the same trend, Goldney (1981) has found that lethality of deliberate self-harm increases with age. Moreover, rates of suicide were found to increase with age, though the in women is often 10 years earlier than men (Sainsbury, 1986). Self-harm in the young is often connected with interpersonal problems (Whitlock & Schapira, 1967). However, the motives and causes of suicide may vary with age. Deliberate self-harm aiming at influencing the environment might be less serious than the acts associated with hopelessness.

Suicide intent is significantly high in psychotic subjects, Psychosis seems to break the relation with reality and exacerbates feelings of alienation. The subject in a state of divorce from interpersonal relationships becomes more vulnerable to self-destructive drives. Many authors have pointed to the important role played by social isolation in suicide (Sainsbury 1955:Durkheim, 1857; Gibbs, 1967). Social isolation was described under different terms; it is highlighted in the anomic and egoistic suicide of Durkheim and the theory of status incongruity of Gibbs. Recently, Sainsbury (1986) has pointed that "alienation and loss of social regulation (anomie) emerge as conditions that predispose to suicide".

The comparison of suicidal intent in first-ever attempters and repeaters seem to be in accord with Pierce (1984)'s report where multiple repeaters showed a non significant fall in their intent scores.

Suicide intent was found to correlate significantly with the seriousness of the medical condition on admission as well as with the seriousness of the method used. The level of significance was highest for the correlation between the rater's global evaluation of the act excluding responses to SIS.This finding may point to the complexity of the phenomenon of acts of deliberate self-harm with many variables interacting to exert a pathoplastic effect. Though the value of the use of SIS was evident, the wholistic clinical evaluation need not to be overlooked.

Authors have tried to identify patterns of suicidal behaviour (Dorpat& Boswell, 1963). In the classification of suicidal behaviour into suicidal gesture, ambivalent acts and serious attempts, motivating affects and cognitions are crucial. In the current study, affects like feelings of loss, helplessness, inadequacy or incompetence,self-hatred and guilt were commonly identified in cases with high, medium and low intent.They may act like contributory factors. However,high intent was significantly associated with feelings of hopelessness and isolation. Beck *et al* . (1975b) suggest that hopelessness might be the main symptom preceding suicide. Among subjects with deliberate self-harm it has been shown that the extent of suicide intent is significantly correlated with hopelessness, irrespective of the level of depression (Minkoff *et al* . 1973: Beck *et al.* 1975b. Dyer & Kreitman,1984). The motivational affects of acts with medium and low intent included anger and frustration. The different profile may reflect the causes underlying the act with divorce from the social and interpersonal life the first group and a desperate attempt to relate to the external world in a new way in the second group. Shattered self-esteem showed a more manifest trend in the groups with high and medium intent.

The administration of the SIS has demonstrated that not all cases are consciously aware of the decision of self-harm. Sometimes though, the decision may be building up unconsciously, and the act fulfilled with a high intent. The self-report section being based on subjective reconstruction of judgements and feelings at the time of the act are liable to be exaggerated . Attempters of deliberate self-harm have the tendency to magnify their intentions; the impact of the behaviour and its effectiveness will be enhanced if the act is perceived as a serious one (Hawton & Catalan, 1987). By saying that wanted to die the attempter may be enhancing the social acceptability of his behaviour. In the current study, the correlation between objective scores (evaluation circumstantial dangerousness) and subjective scores (self-report) is low (0.40). Such finding may explain the modification introduced by Pierce (1981) in SIS where six of subjective items of the self-report section were modified and reduced.

In our series, cases with deliberate self-harm like previous reports (Goldney, 1981) , were found to experience both suicidal and non-suicidal wishes. The study sample represented a mixture of people who might have been successful without rapid and intense medical care and subjects who were impulsive attempters. Focussed assessment(SIS) as well as detailed evaluation of the circumstances of the act may help to identify serious attempters.Moreover, the global assessment may help to eliminate the halo effect produced by the tendency to exaggerate the seriousness of the ac

REFERENCES

Beck, A. T. Schuyler, D.& Herman, J (1974) Development of suicidal intent scales. In *The Prediction of Suicide* (ed, A ,T. Beck, H. L. P. Resnilk &D. J. Lettieri). Charles Press: Maryland.

Beck, A. T., Beck, R. and Kovacs, M, (1975) Classification of suicidal behaviours:I Quantifying intent and medical lethality. *Am. J. P.* , **132:** 285-7.

Beck, A. T., Kovacs, M., and Weissman, A. (1975) Hopelessness and suicidal behaviour: An overview. *Journal of the American Medical Association,* **234:** 1146-9.

Beck, A. T.Steer, R. A., Kovacs, M. and Garrison, B. (1985) Hopelessness eventual suicide: A 10 year prospective study of patients hospitalized with suicidal ideation. *Am. J. Psychiat.* , **145:** 559-63.

Birtchnell, J. and Alarcon, J. (1971) Depression & attempted suicide: A study of 91 cases seen in a causality department *Brit. J. Psychiat.,* **118:** 289-

296.
Card, J. (1974) Lethality of suicidal methods and suicide risk. Two distinct concepts. *Omega,* **5:** 37-45.
Dorpat, T. L. and Boswell, J. W. (1963) An evaluation of suicide intent in suicide attempts. *Comprehension Psychiatry,* **4:** 117-125.
Dyer, J. A. T. and Kreitmen, N. (1984) Hopelessness, depression and suicidal intent in parasuicide *Brit. J. Psychiat.,* **144:** 127-33.
Faberow, N. L. (1950) Personality patterns of suicidal mental hospital patients. *General Psychology Monographs,* **42:** 3-79.
Fox, K. & Weissman, M (1975) Suicide attempts and drugs: Contradiction between method and intent. *Social Psychiatry* , **10:** 31-8.
Gibbs, J. (1967) *Suicide.* New York: The Macmillan Company.
Goldney, R. D. (1981) Attempted suicide in young women:correlates of lethality*: Brit J. Psychiat.,* **139:** 382-90.
Hawton, K. and Catanlan, J. (1987) *Attempted Suicide A Practical Guide to its Nature and Management.* (2nd edition) Oxford- New York: Oxford University Press.
Luscomb, R. L., Clum, G. A. and Patsiokas, A. T. (1980) Mediating factors in the relationship between life stress & suicide attempting. *Journal of Nervous and mental Diseases,* **168:** 644-50.
Minkoff, K., Bergman. E., Beck, A. T. and Beck, R. (1973) Hopelessness, depression and attempted suicide *Am. J. Psychiat.,* **130:** 455-9
Pallis, D. J. and Sainsbury, P. (1976) The value of assessing intent in attempted suicide. *Psychological Medicine,* **6:** 487- 492.
Pierce, D. W. (1977) Suicidal intent in self-injury. *Brit J. Psychat.* , **130:** 377-385.
Pierce, D. (1984) Suicidal intent and repeated self-harm. *Psychological Medicine,* **14:** 655-9.
Power, K. G., Cooke, D. L. and Brooks, D. N. (1985) Life stress medical lethality and suicidal intent. *Brit. J.Pschiat.,* **147:** 655-9.
Power K. G. and Barraclough, B. M. (1977) Seriousness of suicide attempt and future risk of suicide: A comment on Card's paper. *Omega,* **8:** 141-9.
Sainsbury, P. (1955) Suicide in London. *Maudsley Monograph.* London: Chapman & Hall
Sainsbury, P. (1986) The epidemiology of suicide. In: *Suicide* (ed. A. Roy), London: Williams&Wilkins
Silver, M. A. , Bohnert, M., Beck, A.T. and Marcu, D. (1971) Relation of depression of attempted suicide and seriousness of intent. *Archives of General Psychiatry,* **25:** 573-76.
Stengel.E, Cook, N. and Kreeger, I. S. (1958) Attempted suicide :Its social significance and effects. *Maudsely Monograph* **4.** London: Chapman & Hall.
Stengel, E. (1975) *Suicide& Attempted. Suicide.* Great Britain: Penguin Books.
Weiss, J. M. A. (1975) The gamble with death in attempted suicide. *Psychiat. J. Study Interpers.Proc.,* **20:** 17-25.

AUTHORS

Emad Hamdi, M. D. (Psychiat.), M.Sc.(P.M&N), Assistant Professor of Psychiatry, Cairo Univesitry.
Yousereya Amin, M. D. (Psychiat.), M.Sc. (P.M&N), Assistant Professor of Psychiatry, Suez Canal Univesity
Talaat Mattar, M.Sc., Specialist, Saif Hospital (Ras El-Khaimah)
M. Howaidi, PhD. , Psychology

ABSTAIT

La Tentative de Suicide dans l'Essai Délibré de se Blesser

La tentative de suicide est mesurée dans une serie de 65 malades consécutifs référés pour un essai délibré de se blesser. Le "SIS" (Suicide Intent Scale) a montré que le voeux de mort a la plupart des cas, varie de bas á moderé. On a trouvé que le degré de tentative de suicide s'élève avec l'âge. La psychose et l'essai délibré de se blesser sont associés avec l'élévation de la tentative de suicide. La sériosité médical, le danger de la méthode utulisée, et le degré de tentative ont été correlés significativement avec le consensuel de l'opinion estimateur à l'égard des sèrieux de l'essai. Le désespoir et le sentiment d'isolement ont été significativement plus fréquents comme des évents antécédents pour les cas qui ont une tentative élevée, par contre la colére et la frustration ont été plus répandues dans les cas qui ont une tentative réduite qui motivent comme les sentiments de perte, les sentiments d'incompétence, d'hostilité à l'égard de soi méme, et de culpabilité n'ont pas été différenciateurs à l'égard de l'ntensité de la tentative de suicide.

الموجز

رغبة الانتحار في حالات تعمد إيذاء الذات

تمت هذه الدراسة على ٦٥ حالة من حالات تعمد إيذاء النفس، وبتطبيق مقاييس نية الإنتحار وجد أن نية الموت في معظم الحالات كانت موجودة بدرجة بسيطة إلى متوسطة، وتبين أن النية تزداد مع تقدم العمر، كما تبين أن الذهان وإيذاء النفس يكونان مصاحبين بنية الإنتحار الشديدة، ووضحت العلاقة بين جدية محاولة الإنتحار وخطورة الوسيلة المستخدمة والنية، ولوحظ أن اليأس والشعور بالوحدة هما الشعوران الغالبان المسبقان في حالات نية الإنتحارالشديدة، وفي حين أن الغضب والإحباط أكثر تواترا في حالات نية الإنتحار البسيطة. ووضح أن الدوافع الوجدانية مثل قلة الحيلة، الشعور بالضياع، الشعور بعدم الكفاءة، العدوان على الذات والشعور بالذنب كلها مشاعر غير مميزة بالنسبة لشدة نية الإنتحار.