SUICIDAL REACTION IN THE SERVICE ENVIRONMENT

Captain A. R. K. MITCHELL
M.B., Ch.B., M.R.C.P. (Edin.), D.P.M., R.A.M.C.

Late Command Psychiatrist, Northern Command

Introduction

ATTEMPTED suicide remains one of the acute psychiatric emergencies in Service medical practice. It is a condition highly charged with emotion and seriously disruptive of the Serviceman’s unit. Faced with an attempted suicide, urgent admission is requested to the nearest military hospital, where psychiatric care is given, or else the case is admitted to the nearest civilian mental hospital. The unit medical officer is under pressure to have the patient or “culprit” removed quickly from the unit, and once in hospital there is often an equal urgency to have the patient disposed of as quickly as possible. This is often paralleled by an equal reluctance to accept the patient back into the unit, once he has been assessed. The object of this article is to show that the suicidal patient under Service conditions need not cause unnecessary panic and also that the prognosis is not as unfavourable as generally imagined. Attempts have been made to discover the factors which contribute to the emergency under the present situations of Service life, and suggestions made as to how the incidence of this disturbing condition can be reduced.

Investigation

Material

The concepts quoted here have been derived from the observation of 61 patients referred to the author after a suicidal reaction in 1961 in Northern Command. Of these 61 cases, 48 were army male other ranks, the remainder comprising W.R.A.C.s, boy soldiers, R.A.F. and naval personnel.

Classification

Suicidal reactions in this series grouped themselves naturally into three types:

Suicidal attempts in which the Serviceman’s behaviour was potentially dangerous to life and in which at first sight it was difficult to assess the degree of determination behind the act.

Suicidal threats in which the Serviceman talked of possible suicide or confessed to having suicidal thoughts or phantasies.

Self-mutilation in which a small group of Servicemen, usually under detention, made a deliberate attempt to injure themselves as a primitive method to escape from an immediate intolerable situation.
Incidence

Males: 3.9 per thousand (expected 3.5 per thousand).
Females: 9.8 per thousand (expected 1.7 per thousand).
Age: Mean = 21.17 years.
   Majority under 25 years.
Marital states: proportionately more of the patients were married.
Time of year: March/April and November/December.
Length of service: majority under one year of service, occurring most commonly at six months’ service.

Personality types: Inadequate 58 per cent.
   Psychopathic 18.8 per cent.
   No disorder 12.5 per cent.

Mental reaction: Impulsive = 40 per cent.
   Depressive = 32 per cent.

Professed reason: Dislike of the army = 31 per cent.
   To escape disciplinary action = 25 per cent.
   True psychopathology = 10 per cent.

Method used: Aspirin compounds = 42 per cent.
   Swallowing of Brasso = 10 per cent.
   Self-inflicted wounds = 10 per cent.

Discussion

Aetiology

Suicidal reactions are to be expected in two groups generally: the immature, inadequate type who responds to all stress in a non-specific way, and in the older obsessional personality with associated depressive features. Stengel and Cook (1958) regard suicide in immature personalities either as a cry for help or as a symbolic trial; once the attempt is made there is relief of tension, the patient is quiet and cooperative. Death could be the result of the attempt, but when they find themselves still alive, there is the feeling that fate cannot be totally against them, that a solution will be found somehow. This was certainly seen in our cases. Few, if any, were sorry the attempt had failed; most were glad to be still alive, and certainly showed less tension and drive than must have been present before the act. On the other hand, the depressed obsessional and the endogenous depressives made much more serious attempts, and in the presence of continuing depression still expressed the wish to be dead.

The inadequate psychopathic personality reacts explosively to stressful situations, in which the suicidal reaction is seen as an aggressive act, directed against himself or against the community which he feels has wronged him. In this series the psychopathic personality did act impulsively, and often used the suicidal reaction, consciously or unconsciously, to put pressure on his unit, his medical officer and the hospital staff, in order to obtain some gain, usually discharge from the Service. Persons of this type are liable to threaten to commit suicide in the future, but results show that this threat is rarely, if ever, carried out.

Suicidal reactions are seen to be characteristic in the Services of the younger person, who is having difficulty in adjusting to the demands of a new and potentially
stressful environment, while in civilian life this reaction appears to be characteristic more of the older age group, with increasing frequency of bodily illness, and social isolation (Mayer-Gross et al. 1960).

Suicidal reactions appear to be commoner in married personnel and it has been suggested that this is due to the specific stresses that Service life places on a marriage, particularly the threat of separation, either due to lack of married quarters, especially in overseas commands, or due to the posting of the Serviceman abroad where the family cannot join him for personal or Service reasons.

There does not appear to be as direct a relationship between suicidal reactions and Service discipline, as is often suggested. In this series suicidal attempts were more common where discipline was slack, and associated with poor unit morale or identification, but also where discipline was strict, but applied in an impersonal, inhumane way.

In the small group of cases seen in the guardroom, the commonest aetiological factor was disciplinary trouble. It is in this situation that suicidal reactions can be explosive, potentially dangerous and epidemic. In this series, we had a group of six cases in quick succession in March and April, and the cause was traced back to the one man, an “old soldier” type, who was encouraging and “instructing” the younger more unstable prisoners in the time-honoured way of “getting out of difficulties via the psychiatrist.” Materials most likely to be at hand were used, viz. Brasso, aspirins collected for headaches, superficial cutting of wrists by razors or blades, etc.

A small proportion of those who disliked the Army were disgruntled because they had not been employed in the particular duties “promised” to them when they originally inquired at the recruiting office. On the other hand, most of them were found to be unsuited for the particular job on testing by the personnel selection officer.

In female cases Dalton (1961) has already shown the relationship between unstable behaviour, including attempted suicide, and the premenstrual and menstrual periods. No information on the menstrual state of the female cases was available in this retrospective series.

Management

A fairly standard method of dealing with these cases became apparent. They were seen as soon as possible by the psychiatrist on referral by the unit medical officer. No cases were accepted directly from an adjutant or commanding officer, but always through the medical officer of the unit concerned. If possible the preliminary assessment was made on an out-patient basis and if the psychiatrist was satisfied the patient was sent back to his unit at once, for review usually in one month’s time.

The remainder were admitted for further assessment and presented no special problem in management, except as already pointed out, in the case of depressive states in older obsessional personalities (Pozner 1961). Following discharge from hospital for those retained in the Service, a regular follow-up on an out-patient basis was arranged. Certain cases benefited from retention in the United Kingdom, until domestic problems could be adequately dealt with through S.A.A.F.A. and other welfare organizations if necessary.

Ease of access to psychiatric opinion is essential in the management of these cases but automatic hospital admission is to be deprecated, because once a case is accepted
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into hospital it is implied that the Serviceman is suffering from an illness, and it is then more difficult to get units to accept the Serviceman back into active duty afterwards. Offenkrantz (1957) in America has already proved the value of a strict disciplinary approach in the management of such cases. His policy is to tell the soldier that only he can stop himself from committing suicide if he really intends to do it and informs him that if he succeeds it will be regarded as a sane act and will therefore allow no material benefits to his family as a result of his death. He also points out that an unsuccessful suicide will mean a possible court martial. Offenkrantz also tries to avoid hospital admission and has proved that such firm handling does pay dividends in this kind of case.

Prognosis

Whether immature or inadequate personalities can be retained for further service depends on a full assessment of the precipitating and causal factors in the light of the Serviceman's personality difficulties. With sympathetic handling by the unit, and attempts, where possible, to alter situational stresses, a favourable result can be expected in about 60 per cent of cases. Psychopathic personalities and immature personalities with a large aggregate of psychopathic traits do not do well and are better discharged from the Service.

Depressive states in the older Serviceman initially carry a very poor prognosis, in that the attempt is usually severe and determined. They require very careful handling and the full resources of psychiatric treatment, but with the removal of the depressive state and reorientation of the patient, these cases have a good prognosis and are a considerable asset to the parent unit. They do, however, require careful follow-up to ensure that a further relapse is not occurring.

Prevention

General measures:
(a) Careful screening at recruiting centres to make sure that the recruit is really good material, and is not merely enlisting to escape from civilian responsibilities and problems.
(b) Fitting, as far as possible, the man into the job for which he is most suited, and ensuring that he is fully occupied. Boredom and frustration are dangerous.

At unit level:
(a) More extensive and intelligent use of existing welfare services, to catch a problem in the early stages and so prevent the development of a potentially suicidal case.
(b) Closer supervision in the early days of the young recruit, ensuring full occupation with sensible tasks. Facilities for discussion of simple problems, such as homesickness, etc.
(c) Better co-operation between the welfare officer and the medical officer in order to distinguish the medical from the social problem, which in turn may well become a medical emergency if help is not offered early enough.
(d) A positive effort to establish good morale in the unit, a common loyalty to Regiment, Corps, etc., in both officers and men, the breaking down of artificial barriers of "them" and "us."
(e) Closer supervision in the guardroom of young impressionable soldiers who may well become indoctrinated by the "old soldier." Supervision of drugs, cleaning materials and razor blades in soldiers under detention.

Medical officer:
(a) Special care in distribution of aspirin compounds and barbiturates to young immature patients, but also the older obsessional N.C.O.
(b) A greater participation in management of suicidal reactions by the medical officer in the unit, under close advice from the area psychiatrist to avoid the "depositing" of the soldiers in hospital, which, as has been already stated, implies patient status and psychiatric disorder.
(c) Great caution in dealing with the senior N.C.O. who may very well be depressed, but does not disclose the gravity of his symptoms to the medical officer, in a perverted sense of devotion to duty, or to avoid discrimination against possible promotion.

Conclusion
Suicidal reactions in Service conditions are seen to be wasteful of potential manpower, and detrimental to unit morale. They are characteristic of the young immature patient, the psychopathic personality and the older obsessional with depressive illnesses. The prognosis for retention in the immature depends on the degree of adjustment to stress already made, and is therefore variable; in the psychopathic the prognosis is poor, and in the older obsessional, although initially very bad, these patients ultimately make a good recovery. Many cases could be averted in the early stages by firm, sympathetic and non-emotional management at unit level. If hospitalization is necessary, these patients need not present any particular difficulties. Unit medical officers should be aware of the relationships of depressive states to suicidal reactions, but should also be aware that this relationship is not so marked as in civilian practice, except in the older obsessional patient. They should also be aware of the element of moral blackmail in suicidal reactions, and be prepared to withstand this pressure by a rational, informed approach under guidance from local psychiatric opinion.

REFERENCES