# ASSESSMENT OF SUICIDAL INTENT IN A SAMPLE OF INPATIENTS FOLLOWING A RECENT SUICIDE ATTEMPT

ABSTRACT: primary and secondary suicide prevention has always been one of the most important challenges facing the mental health profession. Of the numerous variables associated with suicidal behaviour, suicidal *intent* is one of the most highly investigated topics in clinical studies, but its actual importance has not yet been determined. OBJECTIVE: we present the preliminary results on suicidal intent before and after an attempted suicide (AS) in a sample of patients admitted to hospital following a recent AS. Special attention was focused on investigating any correlations between suicidal intent and 1) repeater/non-repeater status; 2) lethality of the method used. METHOD: The data refer to 92 consecutive suicidological consultations conducted at the Suicidology Unit of the Department of Psychiatry (Padova University). Assessment consisted of: 1) psychiatric assessment with formulation of a DSM-IV diagnosis; 2) collection of the main sociodemographic, anamnestic and suicidological data with the "WHO/Euro multicentre study on parasuicide" monitoring form; 3) assessment of suicidal intent by means of two scales: the Intent Score Scale (ISS) and the Suicide Assessment Scale (SAS). RESULTS: the two subpopulations, represented by repeaters and non-repeaters, did not differ by type of method used for the deliberate self-harm, by degree of suicidal intent assessed by the ISS (before attempting suicide), or by level of subjective belief about the outcome of the parasuicide. Conversely, the level of residual suicidality (in particular, the persistence of suicidal ideation and alteration of affect and mood, as assessed by SAS), was significantly higher in the repeater population. There was no correlation between lethality of method and level of suicidal intent in our sample.

Key words: suicidal intent, repeaters, method

## *INTRODUCTION*

Every suicidal episode, particularly when it has a fatal or almost fatal outcome, poses the age-old question of whether and how this type of behaviour can be predicted. Unfortunately, no research has yet yielded any evidence that suicide can really be predicted, not even among the so-called high-risk populations (Goldney, 2000).

Although it is impossible to accurately identify who will engage in suicide, a number of clinical variables statistically correlated with suicide do exist. Beck (1989) maintained that a high level of *hopelessness* was associated with suicide in psychiatric patients; other important clinical characteristics include the expression of suicidal ideation, presence of a psychiatric disorder (particularly depression and schizophrenia) or an invalidating physical disease, abuse of alcohol or other substances, social isolation and availability of methods for carrying out suicide (Appelby, 1992).

While these variables undoubtedly have important heuristic value, their low specificity and the relative rarity of the suicide phenomenon invalidate the predictive value for individual patients and their particular clinical situations. The same applies, to a lesser degree, to the ability to predict repeated suicidal behaviour (Goldney, 2000).

Clearly, assessing the potential for suicidal behaviour or its repetition is always an evaluation of the *risk* of such behaviour happening, but does not produce any certain conclusions. It is also undeniable that progression from sporadic death thoughts to a more persistent desire for self-destruction, or from imprecise suicidal plans to detailed schemes including choice of method and place, are indication of an

alarming *crescendo* soliciting an (often dramatically urgent) decision from the clinician (Wasserman, 2001).

Analysis of the numerous studies that have, over the years, sought to identify the variables most highly associated with (fatal and non-fatal) suicidal repetition, simply leads to the conclusion that the factors preceding repetition are extremely heterogeneous and non-specific (Sakinofsky, 2000).

Suicidal intent is one of the most highly investigated of these factors, but its actual importance has not yet been univocally acknowledged.

Intent can be defined as subjective, personal motivation which may be explicitly or implicitly communicated. Explicit communication is the type provided by a subject not only in response to a direct question on the purpose of the behaviour, but also refers to previous communications, expectations of death, awareness of the lethality of the behaviour, attitude to death and reaction to being saved (*explicit or subjective intent*). Implicit communication is, instead, based on objective behavioural markers such as the timing of the attempt, isolation, precautions taken to avoid discovery, the search for help, final preparations with respect to death, the presence of farewell messages, the lethality of the method used, level of premeditation and planning, and previous suicide attempts (*implicit or objective intent*) (Beck and Lester, 1976).

As highlighted in numerous studies, method lethality and degree of suicidal intent are factors to bear in mind in assessing attempted suicides since they are significantly associated with an increased risk of repetition and/or completion of the act (Suokas et al, 1991; Suominen et al, 2004). However, the methods used to quantify lethality often have low sensitivity (vague division into high/low lethality) or are indirect (based on type of hospital ward to which the patients are admitted).

The level of suicidal intent associated with a parasuicide could, instead, be a more useful indication of a person's desire to die, since not all subjects are fully aware of the real lethality of a method.

In the literature, level of intent associated with non-fatal self-destructive behaviour is almost always described as rather low (Hawton et al, 1982; Power et al, 1985; Kingsbury, 1993). However, the values obtained in studies adopting specific scales, as the Suicidal Intent Scale (SIS; Beck, Schuyler and Herman, 1974) are very heterogeneous owing to the different ways in which the various studies interpret the terms designating non-fatal suicidal behaviour (Hjelmeland, 2000).

High suicidal intent as a long-term risk factor for deliberate self-harm has been the subject of numerous research works which have again produced discordant results (Beck, 1989; Suokas et al, 2001, Suominen et al, 2004).

Undoubtedly, however, the combined presence of high suicidal intent and a psychiatric disorder prompt immediate psychosocial intervention, often entailing admission to a psychiatric inpatient facility.

It is acknowledged, for example, that suicide is the main cause of premature death among *schizophrenics* (Black et al., 1992). Caldwell and Gottesman (1990), in a review on deliberate self-harm among schizophrenics, concluded that 13% of these patients die as a result of suicide. It is also common knowledge that fatal or non-fatal suicidal behaviour is a frequent finding in *mood disorders*, particularly in persons suffering from major depression and bipolar disorder, with death rates for suicide reaching 15% in both cases. More precisely:

1) depression, not necessarily major depression, but a state such as brief, recurrent depression or combined depression, influences suicidal intent (van Praag et al., 1997; Pezawas et al., 2002)
2) the violence of the method used is not correlated with the strength of the suicidal intent (van Praag et al., 1999; Haw et al., 2003).

Lastly, if we consider the sphere of *personality disorders*, the data available in the literature report that at least one third of subjects committing suicide (31-62%) and up to 77% of those attempting suicide presented a personality disorder (Henriksson et al., 1993; Lesage et al., 1994; Cheng et al., 1997; Foster et al., 1999; Suominen et al., 1996; Ferreira de Castro et al., 1998).

Focusing more specifically on suicidal intent and the lethality of the method used, there do not appear to be any significant differences between subjects with or without personality disorders (Casey, 1989; Corbitt et al., 1996; Suominen et al., 2000).

A final comment is also warranted on the relationship between *gender* and suicidal intent.

On the basis of well-known epidemiological differences between male and female suicidal behaviour (males commit suicide more than females, while the opposite is true of non-fatal self-destructive behaviour), it could be supposed that male attempters are characterized by higher suicidal intent than females. In truth, however, few studies have been conducted on level of intent (O'Brien et al., 1987; Nielsen et al., 1993; Strosahl et al., 1992; Beautrais et al., 1996; Canetto et al., 1998; Hjelmeland, 2000). Not even differences in choice of more (for males) or less (for females) violent methods seem to be explained by a difference in suicidal intent (Denning et al., 2000).

## ***AIMS OF THE STUDY***

Since it is clear from the above that assessment of suicidal intent is an essential, but still controversial, stage in the clinical process of determining suicide risk, it was decided to investigate level of suicidal intent expressed by suicidal subjects with whom the Suicidology Unit of the Department of Psychiatry of Padova University usually comes into contact.

Special attention was addressed to the correlation between this variable and the status of repeater/non-repeater - well-known to be a fundamental condition in determining suicide risk - and type of method used to carry out the attempted suicide.

It also seemed appropriate to extend the investigation to any correlations between level of suicidal intent and certain aspects of a subject's clinical history (e.g. history of outpatient care, compliance with treatment, presence of family or sentimental problems etc.).

Lastly, suicide mortality was assessed in subjects belonging to the test sample.

## ***MATERIALS AND METHODS***

### *Population*

The data refer to 92 suicidological consultations consecutively conducted by the Suicidology Unit of the Department of Psychiatry (Padova University) on the same number of subjects admitted to various inpatient wards (medicine, surgery, psychiatry) at the Azienda Ospedaliera of Padova from 2001 to 2004.

Suicide mortality was drawn from the death registers provided by Padova Department of Public Health.

*Assessment procedure*

The method of collecting pertinent information to be used for subjects in the test sample was organized as follows:

1) psychiatric assessment with formulation of a preliminary DSM-IV diagnosis.
2) collection of main sociodemographic and anamnestic details and any history of suicidal behaviour, using the "WHO/Euro multicenter study on parasuicide" monitoring form (Platt et al., 1992).
3) assessment of suicidal intent by means of two scales: the Intent Score Scale (ISS; Pierce, 1977) and the Suicide Assessment Scale (SAS; Stanley et al., 1986).

The ISS is a modified version of Beck's Suicidal Intent Scale (1974) that evaluates level of suicidal intent in a parasuicide, bearing in mind the environmental circumstances in which the episode took place, the parasuicide's assessment of the episode, and medical assessment of somatic outcome. According to the overall score, level of suicidal intent may be classified as low (0-3), moderate (4-10) and high (over 10). The ISS also measures degree of lethality of the attempted suicide.

The SAS is a scale composed of 20 items assessed on a 5-point scale, designed to measure changes in suicidal intent through exploration of the following areas: a) *ideation and suicidal behaviour* (from items 16 to 20); b) *affect/mood* (items 1,2,9,12,13); c) *somatic conditions* (items 3,8,10); d) *emotive reactivity* (items 4,5,14); e) *control and adjustment* (items 6,7,11,15). The methods used for the parasuicide were classified as *soft* (e.g. drug overdosing, superficial cutting of body surfaces and, generally, all methods belonging to group 2 of the monitoring form); and *hard* (e.g. ingestion of caustic substances, jumping from high places, hanging, etc. and, in general, all methods belonging to group 1 of the monitoring form).

*Data analysis*

Data were processed using the statistical tests in the SPSS statistical package, in particular:

- Chi Square Test
- Wilcoxon Two-Sample Test
- Kruskal-Wallis Test

## ***RESULTS***

The test sample was composed of 41 males (44.6%) and 51 females (55.4%), aged between 19 and 93 years (mean age=44.6, SD=16.9). Most of the respondents were Italian nationals (94.6%; n=87), residing in Padova (58.4%; n=52).

Of the total, 45.1% had never been married (n=41), while 37.4% were married (1st marriage), 7.7% (n=7) separated, 2.2% (n=2) divorced and 6.6% (n=6) widowed. As regards household composition, 28.6% (n=26) lived with their parents, 26.4% (n=24) with a partner and children, 14.3% (n=13) alone, 11% (n=10) with a partner and without children, 7.7% (n=7) in an institution, 4.4% (n=4) alone with their children, and 4.4% (n=4) with other relatives or friends.

Educational level was low (up to compulsory schooling) in 58% of cases (n=53), intermediate (senior high school) in 36.4% (n=33) and high (university degree) in 5.6% (n=5).

Of the subjects, 39.6% had an occupation (n=36), 13.2% (n=12) were unemployed at the time of the interview, and 46.2% were not seeking employment (n=42). Considering earned income, 31.8% of respondents (n=28) reported having no income, 35.2% (n=31) had a low, 30.7% (n=27) had an intermediate and 2.3% (n=2) had a high income.

The study also investigated religious belonging; analysis of the data revealed that 76.9% of subjects reported being Roman Catholic (n=70), 4.4% (n=4) Muslim, 1.1% (n=1) Protestant and 15.4% (n=14) did not profess any religious creed.

Analysis of clinical variables indicated that 56.5% of patients had no history of deliberate self-harm (n=52), 20.7% had attempted suicide in the 12 months prior to the consultation (n=19) and 19.6% (n=18) had made an attempt over 12 months beforehand. In the test population, therefore, 43.5% of subjects belonged to the repeater category (n=40) and 56.5% to the non-repeater one.

Of all the cases, 84.8% were not taking any form of psychotropic medication (n=78).

Psychopathologically, the patients were divided into three diagnostic categories based on dimensional rather than categorial criteria: mood disorders, personality disorders and psychoses. 52.2% (n=48) were in the first category, 37% (n=34) in the second and 10.9% (n=10) in the third.

On analysis of the scores achieved on the suicidal intent scales (previous and persistent), ISS scores indicated that 56.5% (n=52) of patients presented a high level of intent (ISS>10), 34.8% (n=32) a moderate level (ISS 4-10) and 6.5% (n=6) a low one (ISS 0-3). Conversely, SAS scores placed the majority of subjects (90%; n=81) in the high risk category (score >39), with a mean score of 54.6.

Comparison of the three ISS categories and the sample's sociodemographic and clinical variables did not reveal any statistical significance. Further, no statistically significant correlation was observed between repeater status and level of intent prior to the suicidal behaviour, while a tendency towards significance emerged on comparison of the ISS categories and marital status of the test subjects. Frequency distribution indicated the presence of higher suicidal intent in people with no stable interpersonal relationship (those never married and the widowed/divorced; $\chi 2=8.83$; df=4; $p<.06$). This finding was also confirmed on analysis of the correlation between SAS and marital status, which yielded a higher mean score in the aforementioned categories ($\chi 2=5.71$; df=2; $p<.057$).

By contrast, there was a significant correlation between Pierce's categories and the identified diagnostic groups ($\chi 2=14.7$; df=4; $p<.002$). In particular, in subjects presenting mood disorders, 71.7% (n=33) exhibited high suicidal intent, 21.7% (n=10) a moderate level and 6.6% (n=3) a low level. Of the subjects with a personality disorder, 58.8% (n=20) presented an intermediate score and 32.3% (n=11) a high one. Lastly, patients diagnosed with a psychotic disorder presented a high level of previous suicidal intent in 80% of cases (n=8).

Statistical significance was also found on comparing ISS with subjective belief about the outcome of the suicidal episode ($\chi 2=36.9$; df=2; $p<.0001$). Obviously, the subjects most convinced of the fatal outcome of their behaviour all came under the moderate (13.7%) and high (86.3%) categories on

Pierce's scale, whereas those displaying some uncertainty as to the outcome of their action came under the moderate category in 63.9% (n=23), under the high one in 22.2% (n=8) and under the low one in 13.9% (n=5) of cases.

Similar results to the ones just reported were found on comparing the SAS scale with the clinical variables indicated above. Interestingly, a significant relationship emerged between mean SAS score and subjective belief about the outcome of the parasuicide. Subjects who reported being certain of the fatal outcome of their behaviour generally achieved higher SAS scores than those who were uncertain ($\chi2$=6.5; df=1; p<.01). However, the latter exhibited mean scores placing them in the high risk category (score >39).

Repeater status was also positively associated with higher SAS values ($\chi2$=4.3; df=1; p<.03). This correlation was also identified for the *ideation/suicidal behaviour* ($\chi2$=9.2; df=1; p<.002) and *affect/mood* subscales ($\chi2$=4.3; df=1; p<.03).

Conversely, the relationship between SAS and the diagnostic categories adopted in this study were not significant.

Statistical analysis using repeater status as the independent variable indicated a lack of correlation between history of previous suicide attempts and sociodemographic variables, previous psychotropic medication and subjective belief about the outcome of the attempted suicide.

Partial significance was, instead, found with the hospital ward requesting the consultation: 53.6% (n=22) of repeaters were admitted to a psychiatric ward, whereas the majority of those attempting suicide for the first time were admitted to a medical or surgical ward (67.4% vs 32.6%) ($\chi2$=4.8; df=2; p<.08).

The diagnostic groups into which the test subjects were divided presented a significant correlation with the variable "repetition of the behaviour", revealing that 64.7% of subjects with a personality disorder had already attempted suicide in the past (n=22), while 68.8% (n=33) of those with a mood disorder and 70% (n=7) of those with some form of psychosis belonged to the so-called *first attempters* category ($\chi2$=9.7; df=2; p<.009).

Repeaters reported previous outpatient psychiatric care in 89.7% of cases ($\chi2$=23.8; df=1; p<.0001) and previous psychiatric inpatient care in 73.2% of cases ($\chi2$=26.6; df=1; p<.0001).

The results of statistical analysis on suicidal method (*soft/hard*) pointed to an important gender component, since 73.2% (n=30) of males in the sample chose a *hard* method. No particular preference for type of method was, instead, found among the females (50% *hard* and 50% *soft*) ($\chi2$=5.0; df=1; p<.02). The remaining sociodemographic variables did not prove to be significantly associated with parasuicidal method.

There was, instead, a statistically significant correlation with the ward requesting the consultation: 85.4% of subjects who had used a *hard* method were admitted to a surgical ward, while 67.6% of those who had adopted a *soft* method were subsequently admitted to a psychiatric ward ($\chi2$=20.9; df=2; p<.0001).

An interesting finding which may, in some respects, appear difficult to interpret, is the correlation between the presence of family and/or sentimental problems and preference for a *soft* rather than a *hard* method (73%; n=27) ($\chi2$=6.8; df=1; p<.009).

Another finding worth noting, which is also close to statistical significance, is the fact that 70.6% (n=24) of subjects with no history of psychiatric outpatient care attempted suicide using a *hard* method and, conversely, 73% of those who opted for a *soft* method (n=27) had already received outpatient treatment ($\chi 2=3.3$; df=1; $p<.06$).

Moreover, among patients who had attempted suicide on other occasions, an association was revealed between method used in the index episode and the one previously adopted. More specifically, the choice of a *soft* method was reused by 77.3% (n=17) of those who had already used a *soft* method in the past, and a *hard* method was chosen by 84.2% (n=16) of subjects who had adopted this type of method beforehand ($\chi 2=15.4$; df=1; $p<.0001$).

Finally, it should be emphasized that suicide method did not seem to be correlated in any way with type of diagnosis, with repeater status, but above all with degree of suicidal intent indicated by the ISS and SAS scales.

Examination of the death certificates provided by the Department of Public Health of the Municipality of Padova indicated that, from the start of the study to the time of writing this paper, only one test subject died as a result of another attempted suicide. Seven patients were reassessed for a parasuicide, but none of them were readmitted to hospital.

## *DISCUSSION*

On analysis of the data presented above, we will seek to outline the main sociodemographic and clinical characteristics of the patient population referred to the Suicidology Unit of the Department of Psychiatry of Padova University Hospital Complex.

The results of this study are, however, a preliminary draft of the available data and are subject to several biases related to small sample size, lack of follow-up and lack of an instrument for determining diagnoses. Accordingly, they warrant confirmation by subsequent studies.

Over half of the subjects in the sample were females, with a mean age of 45 years. They were not generally married or were at their first marriage, still living at home with their parents or with a partner. The sample's educational level was rather low and many subjects were unemployed at the time of contact with the healthcare facility. Consequently, these patients had a very low mean income. These data are in keeping with the ones reported in the literature.

Clinically speaking, there was a slight prevalence of *first-attempters* among the patients referred for suicidological consultation, characterized by the presence of a mood or schizophrenic spectrum disorder, while the diagnosis of personality disorder was most frequent among repeaters.

Closer examination of level of suicidal intent within the test sample revealed that 63.9% of subjects were uncertain about the fatal outcome of the parasuicide, confirming that ambivalence is a condition commonly found among suicide attempters ($p<.0001$). It is not, however, clear whether the significance of this finding is distorted by the difference in importance attributed to the three ISS subscales, with subjects tending to emphasize level of intent. To remove this bias it would be appropriate to consider not only Pierce's global score, but also the individual subscales.

In addition, a high level (ISS> 10) of suicidal intent was observed in subjects with a diagnosis of mood disorder (71.7%) and psychosis (80%), whereas the majority of patients with a personality disorder (58.8%) presented a moderate level of intent (ISS 4-10) (p<.002).

The study data also exhibited a tendency towards statistical significance in the relationship between suicidal intent and marital status. Subjects who had never been married, or who were widowed, separated or divorced, presented higher levels of suicidal intent than those who were married (p<.06) and, as shown by the SAS, tended to keep the level up for longer (p<.057). This finding seems to support the hypothesis that the lack of stable interpersonal bonds represents a risk factor for suicidal behaviour.

The information yielded by the other scale (the SAS) suggests greater persistence of suicidal intent in parasuicides who felt certain of a fatal outcome (p<.01). These patients still presented suicidal thoughts (p<.01) and impaired affect (p<.03), as indicated by two of the five SAS subscales.

Once again, to obtain clinical information that may help determine suicide risk, it is essential to thoroughly explore subjective belief about the outcome of deliberate self-harm, irrespective of actual outcome or the lethality of the method used, as we will explain in more detail below.

In the knowledge that repetition of deliberate self-harm is an important risk factor for subsequent parasuicides, we compared two subpopulations from our sample (repeaters and non-repeaters) in order to single out hypothetical differences, paying particular attention to level of suicidal intent.

No significant differences in sociodemographic variables emerged between the two groups of patients. Conversely, our results corroborate the observation that repetition of deliberate self-harm is more characteristic of subjects diagnosed with a personality disorder (p<.009).

Close examination of the data on the origin of suicidological referrals for repeaters suggests that most were admitted to a psychiatric ward (a value of p<.08 was borderline). This choice was probably dictated by the fact that the Psychiatric Services were generally acquainted with these people (through previous inpatient or outpatient care; p>.0001 for both). Hence, even when a *hard* method was used - since no physical harm occurred in the majority of cases (p<.001) - the tendency was to refer repeaters to the environment most suited to re-establishing links with the healthcare provider treating them prior to the episode.

Subjects who attempt suicide on more than one occasion have a higher probability of presenting a family history of suicide compared to those assessed after a first attempt (p<.04).

Interestingly, the two test subpopulations did not differ in terms of method used for the attempt, level of suicidal intent identified on the ISS (prior to the episode) and level of subjective belief about the outcome of the parasuicide.

The two groups did, instead, exhibit a difference in terms of residual suicidality (as identified by the SAS), understood in particular to be persistent suicidal ideation and altered affect and mood, even after the parasuicide. Suicidality was higher in the repeater subsample (p<.03 for total SAS scores; p<.002 for the “suicidal ideation subscale”; p<.03 for the “affect/mood” subscale).

These findings rather faithfully reflect previous reports in the literature on repeaters. More specifically, they confirm the higher frequency of personality disorder diagnoses and the higher probability of previous or recent contact with a therapeutic facility (outpatient or hospital). However, these subjects

did not differ from non-repeaters in terms of previous suicidal intent and choice of a particular method in an index episode. We can thus conclude that, although there was a higher frequency of parasuicides among patients with personality disorder, clinical characteristics at the time of the parasuicide did not differ from those of patients characterized by other diagnoses (Suominen et al., 2000).

Lastly, persistence among repeaters of a higher level of suicidality after a parasuicide may also serve as confirmation that patients with personality disorder are at higher risk of repetition, and may be interpreted as an expression of these subjects' greater impermeability to admission to and treatment provided by a hospital facility.

Another objective of this research was to examine and determine any correlation between the parasuicidal method chosen by the test subjects and level of suicidal intent. This analysis proved negative since no significant relationship was observed in terms of subjective certainty about suicidal outcome, or ISS (previous intent), or SAS (persistent intent). This finding confirms reports in the literature and corroborates the findings of Haw et al (2003) who affirmed that apparent lethality was a potential confounding factor in the assessment of a patient's real desire to die. This seems a crucial factor in clinical practice since it cannot be assumed that the lethality of a parasuicidal method necessarily reflects level of suicidal intent. This observation also explains why residual level of intent (SAS) after the parasuicide does not correlate with the choice of method.

Conversely, statistical analysis yields a significant correlation between choice of a *hard* method and being male: a finding well-established in the literature. However, females do not seem to show any preference for type of method. It is a widespread belief, even among mental health professionals, that women's more common adoption of *soft* methods reflects a lower level of suicidal intent (Rich et al., 1988). Various studies have, instead, demonstrated that there is no substantial *gender* difference with respect to suicidal intent (Beautrais et al., 1996; Canetto et al., 1998; Denning et al., 2000) and our study is in line with these surveys.

An interesting finding, but which may appear rather contradictory, is the statistically significant correlation ($p<.009$) between the presence of family and/or sentimental problems and preference for *soft* methods, whereas the absence of such problems seems to prompt the choice of *hard* methods. It could be hypothesized that such subjects opt for deliberate self-harm as a *cry-for-help*, and thus avoid very violent or painful methods.

This theory will have to be confirmed in the future, but in studying the relationship between stressful life events and impulsiveness in suicide attempters, Weyrauch (2001) has already reported that, in repeaters, ambivalence about the outcome of deliberate self-harm increased in subjects presenting family and/or interpersonal problems.

A final noteworthy aspect, in keeping with other similar studies reported in the literature, is the tendency among repeaters to use the same parasuicidal method adopted in the past. Not only has the method been observed to belong to the same *soft/hard* subgroup, but the majority of subjects actually adopts exactly the same method used in the past ($p<.0001$).

It can thus be inferred that choice of method is correlated primarily to its availability and, secondly, to the patient's "familiarity" with the method, suggesting that the subject lays importance on having a certain degree of "control" over their action.

## *CONCLUSIONS*

The preliminary description of the main sociodemographic and clinical characteristics of the suicidal population assessed by the Suicidology Unit of the Department of Psychiatry of Padova is substantially in keeping with the principal findings of modern suicidology.

In particular, it may be appropriate for anyone evaluating these subjects to bear in mind that the lethality of the method employed cannot be used to determine level of suicidal intent and risk (as is, instead, often the case). This would underestimate the intention to die of someone using a *soft* method through lack of knowledge about the chosen means. Likewise, false perceptions also need to be eradicated, such as the belief that males are more at risk than the female population because they often use violent methods, or that repeaters, who present a personality disorder in the majority of cases, more frequently perform "manipulative" acts.

In the literature, high level suicidal intent as a long-term risk factor for deliberate self-harm, has been the subject of numerous studies that have produced contrasting results (Beck et al., 1989; Suokas et al., 2001; Haw et al., 2003). Nonetheless, it appears that among patients with high suicidal intent there is a very high rate of false positives for subsequent suicidal behaviour (Haw et al., 2003).

Hence, as isolated risk factors, suicidal intent or lethality seem to be of limited clinical service; rather, consideration should encompass the whole array of risk factors, including subjective perception of the lethality of the method used.

To conclude, the study of suicidal intent is the first step in understanding the meaning that these people attribute to their behaviour. To date, this aspect has been studied at population level with the aid of quantitative methods; but if we wish to understand the real significance of this behaviour, we must address the phenomenon at a more individual level.

What is needed, alongside quantitative methods, is a qualitative approach based, for example, on the search for the meaning of the various phenomena rooted in the psychic world of the individual human being.

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