Can we solve the alcoholic problems before they come?

E. Bernspäng

In this brief talk I will not in any way discourage the work that is done in way of research and care in order to help those who are already alcoholics. But we know through bitter experience that in most cases the help comes too late, if it does not come before the person is addicted to alcohol.

My burden is therefore to raise the question whether we in the International Association for Suicide Prevention or in this congress could do something that would prevent people from becoming alcoholics.

Recently scientists gave an alarming report concerning the dangers of tobacco. The immediate result was that thousands of people gave up smoking and manufacturers put in a lot of research in order to make the cigarettes less dangerous.

We have seen the suffering due to alcohol. We know the national financial losses, crimes, imprisonments, mental disturbances, heartbreaking divorces and indescribable agony because of alcohol. We have seen mothers' agony because their sons were alcohollics And we know of these thousands of children who will never be privileged to meet ife. with mental health and happiness because their homes were ruined by alcohol. We have seen how alcoholism leads to suicide.

I know that a hundred years ago the alcoholic situation was terrible in northern Europe. That time a religious awakening gave the solution and I am not sure that anything lese radical will h elp us today.

But efforts inspired by love to mankind have never been fruitless. Therefore I believe that something can be done.

May I suggest that we work out a report or start a more continuous propaganda, possibly in co-operation with WHO. What we write let it be scientifically sound and true, and yet let us write in a clear and popular language so that we reach the man in the street and our boys and girls in school. Let us appeal not only to the intellect of people but also to will and emotion.

And I believe it would be profitable if our reactions are in a healthy way alarming. For we know that the alcoholic situation is alarming.

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The Evaluation of suicidal potential

E. Cohen

Our clinical and research instrument for the evaluation of suicidal potential is composed of 22 questions worded so that if the answer is «Yes», it falls into a high risk category; if «No», a low risk category. A coded score for each high risk factor gives an indication

of suicidal risk for each patient. The patients were scored for the 22 factors on the basis of information obtained from the patients themselves, relatives, friends, and from hospital and clinic charts and records. A 5 to 8 year follow-up study of the patients identified those who later committed suicide or made subsequent suicidal attempts. Those who subsequently attempted or committed suicide were labelled the «S» group; those who did not we called the «N» group. Each of the 22 factors were then ranked in the order of their predictability of suicidal behaviour based on the relationship of the «S» to the «N» group.

In ranking the factors on the basis of their predictability of subsequent suicidal behaviour both alcoholism and drug addiction were among the highest ranking factors. Of the 193 total patient group studied, 59 persons were known to have had a problem with alcoholism. The data I am about to present refers only to this alcoholic group. The following is a list of the factors in order of their predictability of suicidal behaviour for the alcoholic group proceeding from high to low degree of predictability:

1. poor physical health. – 2. history of previous suicide attempt. – 3. loss of coherence or consciousness as result of the suicidal attempt. – 4. method of attempted suicide: ingestion, shooting, jumping from high places. – 5. 45 years of age or over. – 6. history of broken home before the age of 16 years. – 7. drug addiction. – 8. race. – 9. living alone. – 10. history of delinquency. – 11. previous psychiatric hospitalization.

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Drug automatism – a problem of particular interest in alcoholics and narcomania cases

B. Jansson

In a previous work on attempted suicide (*Jansson* 1962) I pointed out the importance of drug automatism. *Ettlinger & Flordh* (1955) considered «serial consumption» to be a contributory factor in not less than 27.8 per cent of their cases, and I classified 25.4 per cent of my 476 cases as drug automatism cases. Classification is, of course, difficult, but information was often gathered from relatives and other people that the patient had consumed the tablets gradually and without seeking seclusion.

Automatism cases differed from the true suicidal attemtps in not less than 49.2 per cent belonging to the group of cerebral lesion cases as compared to only 24.5 per cent among other cases. The vast majority of these cases were alcoholics and narcomania cases. Of the whole material 21.7 per cent was classified as alcoholics. It can be assumed that cerebral lesion increases the tendency to pathological pharmacological reactions so that these patients more easily get into a confusional state.

In a follow-up study (catamnestic period 1 year) it was found that the incidence of recidivation was greatest in the cerebro-lesional group, 17.0 per cent as compared with 9.4 per cent in the rest of the material. Recurrence rate for automatism cases did not deviate from the rest, though. I think it is important, in many cases, to give also automatism cases in-patient psychiatric treatment when they happen to get into contact with a hospital on account of an over-dosage of tablets. The incidence of successful suicides within 1 year was very low (1.3 per cent), and it is tempting to connect this with the high over-all figure for inpatient treatment in my material (53.6 per cent within 1 year after the attempted suicide). Of course, patients should be warned against serial consumption and instructed never to have more than 1 tablet at hand at a time.