BROKEN HOMES AMONG ATTEMPTED SUICIDES AND PSYCHIATRIC OUT-PATIENTS: A COMPARATIVE STUDY

By

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MANY investigators have pointed out the social and psychological meanings of broken homes and their effects on individuals' behaviour. Goldfarb (3) stressed the importance of normal parental relationships both in ego formation and in the transfer of ego functions from parent to child. Thompson (16) maintains that the loss of a familiar perceptual framework may be as equally important as the loss of a love-object. Bowlby (2) points out that love deprivation and superficial relationships frequently lead to maladjustment and delinquency. Kardiner (4) emphasizes the importance of the social and cultural values of tender emotion as the basis of social cohesion and culture. Several research workers have found high incidences of broken homes among schizophrenics (Pollack *et al.*, 10; Lidz, 5; Oltman *et al.*, 8) and among neurotics (Madow and Hardy, 6; McGregor, 7). Other research workers have been concerned with the incidence of broken homes among individuals who attempt suicide (Palmer, 9; Reitman, 11; Sainsbury, 12; Batchelor and Napier, 1; Stengel and Cook, 14; Walton, 18; Teichner, 15; Toolan, 17; Simon, 13). However, the majority of the latter group of studies have lacked comparative control groups. The present study investigates several factors of social disorganization which distinguish a group of attempted suicides with a history of broken homes from a group of psychiatric out-patients who have not attempted suicide but have a history of broken homes. All comparisons will be between attempted suicides and psychiatric out-patients from broken homes.

I. RESEARCH SETTING AND METHODS

A sample of 91 attempted suicides consecutively admitted to the Edinburgh Royal Infirmary from November 1st, 1961 to March 1st, 1962 comprised the experimental group. Cases of attempted suicide admitted to the Royal Infirmary receive the appropriate resuscitation and a psychiatric evaluation. The few patients who need further in-patient psychiatric care are then transferred elsewhere; most, however, are discharged home from the hospital.

The sample represented 64% of the total admissions for attempted suicide during this time interval.[1] The definition of an attempted suicide was established as any act of self-injury performed with the intent of taking one's life. Verbal threats and cases where the intent was unclear, e.g., when a person was found in a gas-filled room and it could not be established whether it was "accidental" coal gas poisoning or an attempted suicide, were excluded from the sample. A matched sample of 91 psychiatric out-patients who had not attempted suicide and who were attending the Psychiatric Out-Patient Clinic of the Edinburgh Royal Infirmary or Jordanburn Nerve Hospital, during the same time interval as the attempted suicides, was obtained. This sample was matched with the attempted suicides by sex, age groups and occupational groupings.

[1] The majority of the 36 per cent admissions who were excluded were cases where the intention of suicide was not explicit. A minority were excluded because they were not detained long enough to be interviewed.

https://doi.org/10.1192/bjp.108.457.772 Published online by Cambridge University Press

Diagnosis and previous psychiatric treatment were not controlled factors. The rationale underlying the selection of the control sample of psychiatric out-patients was the assumption that the attempted suicides were also emotionally disturbed prior to the attempt. Psychiatric out-patients were utilized rather than in-patients because the use of in-patients as controls would have introduced the variable of the severity of illness. It will be realized that the experimental group patients are also unlike the in-patients of a psychiatric hospital in this respect. One facet of this study was to seek factors that might explain why some individuals appeal for help by attempting suicide and obtain hospital admission by these means while other individuals seek help by attending a psychiatric out-patient clinic.

The attempted suicides and out-patients were interviewed upon admission by the author, using a questionnaire composed of both structured and unstructured questions. Information obtained in the interview situation was checked with information elicited by the psychiatrist and with available data in past medical records. No refusals were encountered among the out-patients, but there were three unco-operative patients among the attempted suicides.

II. Findings

1. *Background and Social Factors*

A broken home was defined as the absence or loss of one or both parents, by death or by separation due to marital disharmony, for periods of six months or more before the patient reached the age of fifteen years.[2]

Table I shows the incidence of broken homes in the experimental and control groups.

Table I

Attempted Suicides and Psychiatric Out-patients by Home Environment

Home Environment	Attempted Suicides		Psychiatric Out-patients		Total
	N	%	*N*	%	
Raised by both parents ...	53	*58*	68	*75*	121
Broken home	38	*42*	23	*25*	61
Totals ...	91	*100*	91	*100*	182

$\chi^2 = 5{\cdot}548$; $p < {\cdot}02$; 1 d.f.

Table II

Attempted Suicides and Psychiatric Out-patients with Broken Homes by Parent Absent

Parent Absent	Attempted Suicides Broken Home		Psychiatric Out-patients Broken Home		Total
	N	%	*N*	%	
Father	14	*37*	11	*48*	25
Mother	4	*10*	3	*13*	7
Both parents	20*	*53*	9**	*39*	29
Totals ...	38	*100*	23	*100*	61

* 9 of these were in an orphanage.
** 1 of these was in an orphanage.

[2] Separation or absence of either parent during periods of war was not included in our definition of a broken home.

https://doi.org/10.1192/bjp.108.457.772 Published online by Cambridge University Press

The table points out that fewer attempted suicides, 53 (58%), were raised by both parents compared to 68 (75%) of the control group of psychiatric out-patients. This relationship was statistically significant at the ·02 level.

Table II indicates which parent was absent in the broken homes of the two groups.

The majority of the attempted suicides, 20 (53%), lacked the presence of both parents. Nine of these patients were confined to an orphanage, which implies they experienced complete parental deprivation during their childhood. Fourteen (37%) of the attempted suicides were deprived of a father figure, whereas only 4 (10%) lacked a mother figure. The findings are somewhat different among the psychiatric out-patients. Among this group the majority, 11 (48%), experienced the loss or absence of a father. Nine (39%) missed both parents; however, only one of the nine lived in an orphanage. Again, as among the attempted suicides, 3 (13%) were deprived of a mother figure.

No age difference was found when the attempted suicides were compared to the psychiatric out-patients from broken homes. However, age distinguished the attempted suicides who came from broken homes from those who did not come from broken homes. Table III shows these findings.[3]

TABLE III

Attempted Suicides with Broken Homes and No Broken Homes by Age

Age of Patient	Attempted Suicides No Broken Home		Attempted Suicides Broken Home		Total
	N	%	*N*	%	
14–30	16	*30*	22	*58*	38
31 and over	37	*70*	16	*42*	53
Totals ...	53	*100*	38	*100*	91

$\chi^2 = 6{\cdot}985$; $p < {\cdot}01$; 1 d.f.

This table demonstrates a preponderance of older patients among the attempted suicides who did not experience a broken home and a predominance of younger patients among the attempted suicides who came from broken homes. Table IV gives the breakdown of marital status among the attempted suicides and out-patients.

TABLE IV

Attempted Suicides and Psychiatric Out-patients by Marital Status

Marital Status	Attempted Suicides					Psychiatric Out-patients				Total
	No Broken Home		Broken Home		Total	No Broken Home		Broken Home		
	N	%	*N*	%		*N*	%	*N*	%	
Single or common law	12	*23*	15	*39*	27	23	*34*	5	*22*	28
Married ...	25	*47*	14	*37*	39	39	*57*	16	*70*	55
Separated, Divorced or Widowed ...	16	*30*	9	*24*	25	6	*9*	2	*9*	8
Totals ...	53	*100*	38	*100*	91	68	*100*	23	*100*	91

[3] Age was combined into categories 14–30 and 31 and over, as there was a peak number of admissions falling in the age group under 30, after which the number of attempted suicides decreased with increasing age.

https://doi.org/10.1192/bjp.108.457.772 Published online by Cambridge University Press

The important findings in Table IV are (i) there are about three times the number of separated, divorced and widowed patients among the attempted suicides than among the out-patients, regardless of their parental background, and (ii) it is apparent that fewer attempted suicides are married compared to the out-patients, regardless of their parental background. We will now focus on several factors of social disorganization found to distinguish the experimental and control groups.

2. *Factors of Social Disorganization*

(i) *Household Stability*

Here we are concerned with prolonged absence(s) and/or death(s) in patients' families in the year prior to the patients' admission. Table V presents data regarding the factor of household stability.

TABLE V

Attempted Suicides and Psychiatric Out-patients with Broken Homes by Household Stability

Household Stability	Attempted Suicides Broken Home		Psychiatric Out-patients Broken Home		Total
	N	%	*N*	%	
Absence and/or death of family member(s) ...	25	*66*	5	*22*	30
No change(s)	13	*34*	18	*78*	31
Totals ...	38	*100*	23	*100*	61

$\chi^2 = 11{\cdot}123$; $p < {\cdot}001$; 1 d.f.

It is noted that of the attempted suicides, 25 (66%) experienced the absence and/or death of a family member in the year prior to admission, whereas only 5 (22%) of the control group had such an experience. When we examine the attempted suicide group again in Table VI, we find that more individuals who attempted suicide had both the experience of a broken home and the absence and/or death of a family member in contrast to the individuals who attempted suicide, but did not come from broken homes.

TABLE VI

Attempted Suicides with Broken Homes and No Broken Homes by Household Stability

Household Stability	Attempted Suicides No Broken Home		Broken Home		
	N	%	*N*	%	
Absence and/or death of family member(s) ...	22	*42*	25	*66*	47
No change(s)	31	*58*	13	*34*	44
Totals ...	53	*100*	38	*100*	91

$\chi^2 = 5{\cdot}224$; $p < {\cdot}05$; 1 d.f.

(ii) *Employment Status*

We look at the factor of employment status in Table VII. Fifteen (43%) of the breadwinners of the attempted suicides were unemployed compared to only 4 (17%) unemployment among the control group. The degree of unemployment among the attempted suicides is most striking when compared to 3·76% unemployment for the population of Edinburgh during the same time interval.[4]

[4] The Ministry of Labour in the city of Edinburgh reports an unemployment figure of 17,852 for the city between November 1961 and February 1962 in a population of 474,062.

https://doi.org/10.1192/bjp.108.457.772 Published online by Cambridge University Press

TABLE VII

Attempted Suicides and Psychiatric Out-patients with Broken Homes by Head of Household's Employment Status

Head of Household's Employment Status	Attempted Suicides Broken Home		Psychiatric Out-patients Broken Home		Total
	N	%	*N*	%	
Employed	20	*57*	19	*83*	39
Unemployed	15	*43*	4	*17*	19
Totals ...	35*	*100*	23	*100*	58

$\chi^2 = 3{\cdot}011$; $p < {\cdot}10$; 1 d.f. (using Yates correction for small numbers)
* 2 deceased and 1 retired were excluded from analysis.

The frequency of job changes was not a significant factor distinguishing the attempted suicides and out-patients. Of the fifteen (43%) unemployed breadwinners of the attempted suicides from broken homes, 12 were unemployed for less than six months and 3 for six months or more prior to the suicide Among the 4 (17%) unemployed breadwinners among the out-patients, 3 were unemployed for less than six months and 1 for six months or more prior to coming to the out-patient clinic.

(iii) *Residential Mobility*

Table VIII shows the degree of residential mobility in the experimental and control groups. The table indicates that 18 (47%) of the attempted suicide group had changed residences one or more times in the year prior to admission in contrast to 5 (22%) of the control group who changed residences.

TABLE VIII

Attempted Suicides and Psychiatric Out-patients with Broken Homes by Residential Mobility

Residential Changes of Patient	Attempted Suicides Broken Home		Psychiatric Out-patients Broken Home		Total
	N	%	*N*	%	
None	20	*53*	18	*78*	38
One or more	18	*47*	5	*22*	23
Totals ...	38	*100*	23	*100*	61

$\chi^2 = 4{\cdot}006$; $p < {\cdot}05$; 1 d.f.

Another factor, the length of time at current address, gives further substance to the findings regarding residential mobility. These data are presented in Table IX.

TABLE IX

Attempted Suicides and Psychiatric Out-patients with Broken Homes by Length of Time at Current Address

Length of Time at Current Address	Attempted Suicides Broken Home		Psychiatric Out-patients Broken Home		Total
	N	%	*N*	%	
Under 5 years	26	*68*	10	*43*	36
5 years and over	12	*32*	13	*57*	25
Totals ...	38	*100*	23	*100*	61

$\chi^2 = 3{\cdot}685$; $p < {\cdot}10$; 1 d.f.

Not only did the attempted suicide group experience more residential mobility than the controls, but Table IX points out that more attempted suicides, 26 (68%), lived at their current address under five years. This indicates previous residential mobility. The comparative stability of the controls is exhibited by the fact that 10 (43%) lived at their current address under five years.

(iv) *Marital Disharmony*

Table X presents two interesting findings regarding marital disharmony.

TABLE X

*Attempted Suicides and Psychiatric Out-patients with Broken Homes and No Broken Homes by Marital Disharmony**

Marital Disharmony	Attempted Suicides No Broken Home		Psychiatric Out-patients No Broken Home		Total	Attempted Suicides Broken Home		Psychiatric Out-patients Broken Home		Total
	N	%	*N*	%		*N*	%	*N*	%	
Yes	32	*86*	14	*33*	46	17	*94*	15	*88*	32
No	5	*14*	29	*67*	34	1	*6*	2	*12*	3
Totals ...	37	*100*	43	*100*	80	18	*100*	17	*100*	35

$\chi^2 = 23{\cdot}667$; $p < {\cdot}001$; 1 d.f.

* Patients who were single, cohabiting or widowed were excluded from analysis.

The left side of the table presents the data regarding marital disharmony among the attempted suicides and out-patients who did not come from broken homes. It is shown that 32 (86%) of the attempted suicides experienced marital disharmony in their family of procreation at the time of the suicide attempt compared to 14 (33%) out-patients who experienced marital disharmony. The right side of the table shows the findings relevant to marital disharmony among the experimental and control groups who came from broken homes. It is evident that there is an extremely high degree of marital disharmony among both groups.

We will now discuss the relevance and applicability of the findings presented in the previous tables to the study of broken homes and factors of social disorganization.

III. DISCUSSION

The general finding of a high incidence of broken homes among attempted suicide is not new and other research workers have presented varying figures to support this finding. In the present study we found that 42% of the attempted suicide group came from broken homes. This figure would only add to the numerous statistics reported on the incidence of broken homes among attempted suicides had a control group not existed. Among our control group of psychiatric out-patients who had not attempted suicide the rate of broken homes was found to be 24%. When we compare the experimental subjects and controls we find the incidence of broken homes is high, but not alarmingly so. In this study it was found that a broken home becomes causally significant only when other indications of social disorganization were also found.

The finding that more attempted suicides lacked both parental figures in their earlier years, and the fact that half of those missing both parents were in an orphanage, together give the impression that this group suffered a greater degree of parental deprivation than the psychiatric out-patients. The majority

of the latter group had at least one parent present during their childhood, a greater proportion lacking a father figure.

It was found that a larger proportion of the attempted suicides with no experience of a broken home were older, while there was an opposite trend among the attempted suicides who came from broken homes. More attempted suicides than out-patients were separated, divorced or widowed regardless of their parental home background.

Household stability was the first of the four factors of social disorganization we considered contrasting attempted suicide and out-patients. Nearly five times as many attempted suicides experienced the absence and/or death of a family member or members in the year prior to their admission than did the out-patients. This suggests that the repeating of a traumatic experience similar to that experienced in their childhood may have contributed to the suicide attempt. The majority of out-patients did not re-experience this event in the year prior to their admission. This finding was emphasized in Table VI, where it was shown that 66% of the attempted suicides from broken homes but only 42% of those from "normal" homes experienced a traumatic experience in their family prior to admission. What then may account for the attempt to take one's life in the latter group? The ensuing three factors may shed further light on this question.

Almost four times as many attempted suicides compared to the out-patients came from households where the breadwinner was unemployed. The majority of the unemployed breadwinners among the attempted suicides were unemployed for less than six months and there was no indication that unemployment was due to the illness which led to the suicide attempt. Thus, attempted suicides who started life in "abnormal" family circumstances and who currently experienced disruption in the family situation were further confronted with economic problems.

The third factor of social disorganization considered was residential mobility. Three times more of the attempted suicides than the out-patients changed their residences one or more times in the year prior to admission. More of the attempted suicides moved to a "worse" residential area and/or to housing with a "low" person/room density, whereas more of the out-patients who changed residences improved their housing situations. The findings regarding the length of time at current address add further substance to the factor of residential mobility. Over twice as many (26) attempted suicides compared to the out-patients (10) had lived at their current address under five years. This indicates that the attempted suicides had undertaken previous residential changes.

Perhaps the most important finding was that regarding marital disharmony. Attempted suicides and out-patients from broken homes both experienced an exceptionally high degree of marital disharmony, 94% and 88% respectively. More important, is the fact that 86% of the attempted suicides without a history of broken homes experienced marital disharmony compared to 33% of the out-patients.

This study emphasizes the fact that individuals who undergo factors of gross social disorganization, regardless of their parental home background, are more likely to attempt suicide. Parental home background is important, but its influence is enhanced by factors of household stability, employment, residential mobility and marital disharmony, which act in conjunction with parental deprivation. More attention needs to be given to these facets of sociological investigation utilizing comparable control groups.

SUMMARY

1. A group of attempted suicides (91) and a control group of psychiatric out-patients (91) who had not attempted suicide were matched for sex, age groups and occupational groupings.

2. This study investigated four main factors of social disorganization which distinguished both groups with reference to their parental background.

3. The factors of (*a*) household stability, (*b*) employment status of the breadwinner, (*c*) residential mobility and length of time at current address, and (*d*) marital disharmony were found to be more prevalent among attempted suicides from broken homes than among psychiatric out-patients from broken homes.

ACKNOWLEDGMENTS

I am grateful to Dr. J. K. Slater for his permission to publish these findings from Ward 3. I wish to acknowledge the full co-operation and helpfulness of the staffs of Ward 3 of the Edinburgh Royal Infirmary the Jordanburn Nerve Hospital and the Psychiatric Out-patient Clinic of the Royal Infirmary. I am grateful to Mr. Wallace McCulloch, psychiatric social worker, for his advice and reading of the manuscript.

BIBLIOGRAPHY

1. BATCHELOR, I. R. C. and NAPIER, M. B. (1953). *Brit. J. Delinq.*, **4.**
2. BOWLBY, J. (1953). *Child Care and the Growth of Love.* London: Penguin Books.
3. GOLDFARB, WM. (1955). "Emotional and intellectual consequences of psychologic deprivation in infancy: a revaluation", in *Psychopathology of Childhood* (Hoch and Zubin, Eds). London: Grune & Stratton.
4. KARDINER, ABRAM (1954). "Social stress and deprivation", in *Beyond the germ theory* (I. Galdston Ed.). New York: Health Education Council.
5. LIDZ, R. W. and LIDZ, T. (1949). *Am. J. Psychiat.*, **106,** 332.
6. MADOW, L. and HARDY, S. E. (1947). *Am. J. Orthopsychiat.*, **17,** 521.
7. MCGREGOR, H. G. (1944). *J. Neurol. Neurosurg. Psychiat.*, **7,** 21.
8. OLTMAN, J. E., MCGARRY, J. J. and FRIEDMAN, S. (1952). *Am. J. Psychiat.*, **108,** 685.
9. PALMER, D. M. (1941). *J. Nerv. & Ment. Dis.*, **93,** 421.
10. POLLACK, H. M. *et al.* (1939). Hereditary and Environmental Factors in the Causation of Manic-Depressive Psychoses and Dementia Praecox. New York: State Hospitals Press.
11. REITMAN, F. (1942). *J. Ment. Sci.*, **88,** 580.
12. SAINSBURY, PETER (1955). Suicide in London. Chapman & Hall Ltd.
13. SIMON, W. (1950). *J. Nerv. & Ment. Dis.*, **111,** 451.
14. STENGEL, E. and COOK, N. (1958). Attempted Suicide: Its Social Significance and Effects, Maudsley Monograph No. 4. London: Oxford University Press.
15. TEICHER, J. D. (1947). *J. Nerv. & Ment. Dis.*, **105,** 283.
16. THOMPSON, WM. R. (1955). Early environment—its importance for later behaviour, in Psychopathology of Childhood (Hoch and Zubin, Eds.). London: Grune & Stratton.
17. TOOLAN, JAMES M. (1962). *Am. J. Psychiat.*, **118,** 8, 719.
18. WALTON, H. J. (1958). *J. Ment. Sci.*, **104.**

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