Social class and suicidal behaviour: the associations between social class and the characteristics of deliberate self-harm patients and the treatment they are offered

Abstract
Background Rates of deliberate self-harm (DSH) in the United Kingdom are much higher in lower than upper social class groups. Previous investigations have shown differences in socio-demographic and clinical characteristics of male patients according to social class. In two studies of DSH patients in Edinburgh the extent of provision of psychiatric aftercare was inversely related to social class. These findings have not been investigated in other areas. Method Data collected through the Oxford Monitoring System for Attempted Suicide were used to examine the association between social class and socio-demographic and clinical characteristics in male and female DSH patients who presented to the general hospital in Oxford between mid-1988 and 1996 and to determine whether the previously reported social class differences in provision of psychiatric aftercare were replicated. Results Data on social class were available for 2,828 DSH patients (1,290 males, 1,538 females). In both genders, lower social class group tended to be associated with younger age. In males, the main social class differences were found in under-35-year-olds, in whom lower social class was related to criminal record, violence to others and drug misuse. In females, psychiatric disorders were diagnosed more frequently in the higher social class groups, but only in the under-35 age group. In neither gender was there a significant association between social class and the frequency of offer of psychiatric aftercare following DSH. Conclusions There are considerable variations in socio-demographic and clinical characteristics of both male and female DSH patients in different social classes, especially in younger patients. The reason for the absence of a marked social class gradient in psychiatric aftercare found in this study in contrast to the results from previous investigations may be related to differences in styles of service.

Key words Attempted suicide – Self harm – Social class – Psychiatric treatment – Violence – Substance abuse

Introduction
Increasing attention is being paid to the association between health issues and social disadvantage (Drever and Whitehead 1997). Studies from the USA (Kposowa 2001) and Australia (Taylor et al. 1998) have shown strong inverse associations between suicide rates and socio-economic status in males but not females.

The relationship between social class and suicidal behaviour in the United Kingdom is somewhat complex. While Bulusu and Alderson (1984) commented that there were no social class trends in suicide in England and Wales for the years around 1951–1971, subsequent studies have shown definite social class patterns, although these investigations have been restricted to males. Kreitman et al. (1991) demonstrated higher rates of suicide and undetermined deaths in the lower social class groups in both England and Wales, and Scotland. This relationship was most marked in middle-aged males. For a later period Charlton et al. (1993) found a U-shaped distribution of suicide in males, with highest rates amongst those in social classes I and V. Drever and Bunting (1997) reported an inverse social class gradient in suicide in males for an even more recent period. This was confirmed by Fitzpatrick and Dollamore (1999) using the new National Statistics Socio-economic Classification, which combines social class and socio-economic group. It has been suggested that studies of suicide and social class have been restricted to males because women tend to move in and out of occupations more frequently than men and a woman’s occupation is often not recorded on her death certificate unless she had been employed for most of her life (Kreitman et al. 1991).
The association between social class and non-fatal suicidal behaviour, or deliberate self-harm (DSH; deliberate self-poisoning or self-injury), is much clearer. Rates of DSH are greatly elevated in lower social class groups. For example, in Edinburgh in 1980–82 the relative risk of ‘parasuicide’ in social class V compared with social classes I and II in economically active males was 12.2 and the equivalent relative risk in Oxford during the same period was 8.7 (Platt et al. 1988). In Oxford during 1990–92, DSH rates were again found to be elevated in the lower social class groups of both genders, the relative risk in social classes III–V compared to I and II being 12.3 for males and 8.6 for females (Hawton et al. 1994).

Differences in the characteristics of DSH patients according to their social class were found by Buglass (1976) in Edinburgh. Lower social class was associated with a variety of social problems, including overcrowding, trouble with the law, debt, violent interpersonal relationships and a diagnosis of personality disorder. Depressive disorders were more often diagnosed in patients from higher social class groups.

It has been suggested that the social class of DSH patients may influence treatment decisions, presumably mediated by specific characteristics of patients in different social class groups. In Edinburgh, Buglass (1976) showed that during the period 1968–73 the type and intensity of psychiatric aftercare offered to DSH (‘parasuicide’) patients was inversely related to social class. Compared with patients in social classes I and II (the highest social class groups), patients in the unskilled group (social class V) were far less likely to be offered in-patient psychiatric care, and were more frequently not offered any specific aftercare. This relationship held up within diagnostic groups. On the basis of a similar study of male DSH patients admitted to hospital in Edinburgh in 1981–86, Platt (1991) also showed that psychiatric aftercare was associated with social class, in that there was a clear inverse relationship between social class and the likelihood of psychiatric aftercare being offered. Multivariate statistical analysis indicated that while the main predictor of psychiatric aftercare was psychiatric diagnosis, social class and a number of other factors (e.g. previous DSH, previous psychiatric treatment) were also relevant. The findings of the studies in Edinburgh suggest that social class (and related factors) can have an important influence on decisions about whether psychiatric care is offered to individual DSH patients.

We have undertaken a study based on data collected on DSH patients in Oxford to examine how socio-demographic and clinical factors vary with social class, and to determine whether similar findings regarding the relationship between provision of psychiatric aftercare and social class apply in a different setting. We have included both male and female DSH patients in this investigation and have also examined patterns in younger and older age groups.

Methods

Study population

The sample studied consisted of patients presenting to the general hospital in Oxford following DSH between July 1st 1988 and December 31st 1996. Because of gender differences in usual age of retirement, the study was restricted to males between the ages of 16 and 64 years, and females aged 16–59 years.

The data for the study were obtained through the Oxford Monitoring System for Attempted Suicide (Hawton et al. 1997). This system enables data to be collected on all DSH patients presenting to the general hospital in Oxford. Information on a range of socio-demographic and clinical variables is collected for patients assessed by members of the general hospital psychiatric service. For patients not assessed by the service, limited information is collected from the medical case records. However, as social class would usually not be known for these patients they were excluded from the study.

The general hospital in Oxford is a teaching hospital with a catchment area population of all ages of approximately 450,000. While some DSH patients living at the fringe of the catchment area might present to other hospitals outside the district, especially in an emergency, the extent of cross-boundary presentations is not great.

Social and clinical variables

The standard method of coding social class (summarised in the Appendix) during the study period was used. Patients were allocated to a social class on the basis of their occupation if employed, or their previous occupation if unemployed. Housewives were allocated on the basis of their husband’s occupation and students on the basis of their head of household’s occupation. For the statistical analysis, the social classes were grouped as follows: social classes I and II; III (manual and non-manual); IV and V. Those patients who could not be assigned to one of these categories, either through a lack of information or by their being unclassifiable (e.g. armed forces), were excluded from the analyses.

The subjects included in the study were all those who both received an assessment by a member of the clinical service during the study period and for whom social class was recorded. For individuals who had more than one episode resulting in an assessment during the study period, only the first of these episodes was included in the analyses.

Psychiatric aftercare was recorded as ‘yes’ for any specific type of psychiatric care which was offered to the patient (i.e. in-patient, outpatient or day patient care) and ‘no’ where the patient was simply referred to the care of the general practitioner (although they may of course have provided treatment for mental health problems).

The other social and clinical variables included in the study were: living situation (alone/with others), violence to others, violence received, alcohol misuse, drug misuse (except cannabis), previous DSH episodes, previous psychiatric treatment, psychiatric disorder and personality disorder. It should be noted that most of the assessments of patients in Oxford are conducted by psychiatrically trained nursing staff (with supervision by senior psychiatrists) and that their threshold for recording a diagnosis of psychiatric disorder is fairly high. Thus, the patients recorded as having disorder would mostly be towards the more severe end of the spectrum.

Statistical analyses

χ² analyses (with Yates’ correction) were conducted using SPSS (SPSS 1997). A Bonferroni correction was applied where multiple univariate analyses were conducted on the same sample.