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The management of attempted suicide – reflections of a physician*

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THREE ASPECTS OF attempted suicide will be considered in this paper:

I. The old adage "prevention is better than cure" is as true in this subject as in many others.

II. Patients with this complaint are deserving of optimal medical care.

III. The presentation of an attempted suicide to the Emergency and Accident Department is a dual emergency, firstly medical, and secondly, just as important, a psychosocial emergency.

I. PREVENTION OF ATTEMPTED SUICIDE

This can be two-fold, firstly prevention in terms of a higher mode of medical care, and secondly changing the techniques of attempted suicide by making common means of suicide more difficult to perform.

1. MEDICAL PREVENTION

A. The diagnosis of hidden depression[3]

Not all patients presenting with suicidal attempts are depressed. Patients presenting with the following three complaints often have some psychological or social pathology which is within the power of the doctor to treat:

(i) *Frequent attenders* – These patients repeatedly visit the doctors' surgery, often more than once a month with relatively trivial complaints, often of a variety of symptoms, and usually complaints for which no organic basis can be found.

(ii) *Insomnia* – Patients presenting to the physician with insomnia often have some underlying social or emotional problem and sometimes an underlying depressive syndrome. A careful history of the type of insomnia and all the things that they think about whilst they are lying awake at night may often give a clue.

(iii) *Headache* – Headache is an extremely common complaint for which there may be no clear organic cause. Often a careful family and social history will give rise to some clue as to the cause of the headache.

B. Drug-induced depressive illness

The following drugs may predispose to depressive illness and when symptoms are present, drugs should be changed whenever possible: alpha methyl dopa, reserpine, L dopa, the contraceptive pill, and steroid preparations.

C. Puerpural depression

This diagnosis should always be borne in mind during the puerpurium and if in doubt the patient can be referred for a psychiatric assessment.

* (Based on a presentation at a seminar on Attempted Suicide, University of Malaya Medical Centre – 7.4.76)

D. **High risk groups**[3]

(i) *Prolonged illness* – Patients who have a prolonged medical condition, particularly those for which there is no definitive cure, and often exacerbated by chronic pain, may develop insidiously a depressive syndrome which responds to anti-depressant therapy.

(ii) Patients who are dependent upon alcohol or other drugs.

(iii) University students.

(iv) Doctors and their wives.

(v) Impulsive character disorders.

(vi) Repetitive self-damagers.

The latter two groups will most often be looked after by our psychiatric colleagues. It is important to remember that, at a time when the student intake to our universities is rapidly expanding, we should expect the incidence of adjustment and emotional problems to increase. We also have to remember that doctors and their wives may suffer from inadequate medical care particularly if the doctor feels that there is stigma attached to an "emotional" disorder, or they may suffer from the problem of too much care.

E. **Epidemiological clues**

Whilst the following factors have been found to be true in western society, there is some evidence from Singapore[2] that the pattern of suicidal attempts, particularly in the manner in which the attempt was made, is growing more similar to the pattern of suicidal attempts made in the West. No distinction is made between the type of persons likely to succeed in their suicide and those who do not want to succeed and who are only making a suicidal gesture.

(i) Older women

(ii) Persons living alone

(iii) History of suicidal attempts

(iv) Unmarried people.

There is an extremely good correlation with successful suicide for the groups of people who are living alone and who have a history of a previous suicidal attempt.

N.B. SIXTY FIVE TO SEVENTY FIVE PER CENT OF PATIENTS WHO HAVE EITHER COMMITTED SUICIDE, OR ELSE PERFORMED A SUICIDAL ATTEMPT HAVE SEEN (IN THE WEST) A DOCTOR IN THE PREVIOUS ONE MONTH PRIOR TO THE SUICIDAL ATTEMPT.[3]

It therefore has to be said that as a profession we are manifestly unsuccessful in predicting those patients who are in need of urgent psychiatric or supportive therapy.

2. PHYSICAL PREVENTION

It has been shown on many occasions that the mode of suicidal attempt reflects the availability of materials to perform the suicidal attempt. Thus the removal of carbon monoxide from the gas supplied to domestic gas cookers in Europe speedily reduced the attempted suicide by this mode.

(i) Drugs are not locked up. If we consider the manner in which we keep tablets in our own homes, often lying around in bathroom cupboards or shelves, with our education and knowledge of disease, how much more likely are members of the general public to keep their tablets so that they may be readily taken either accidently or deliberately.

(ii) Drugs looking like sweets. It is now accepted that the production of tablets with bright colours looking like sweets is a cause for increased accidental ingestion of tablets by children. This is often compounded by well meaning parents who, when having to give medicine to their children, ask the child to have a "sweetie".

(iii) Poisonous substances kept in low cupboards. The ready availability of weed-killers and insecticides accounts for the fact that this remains a common form of presentation of a suicidal attempt in this country. It is particularly dangerous to keep these on the floor or in low cupboards where they can be easily obtained by children. The situation is made worse when the poisonous substances are stored in bottles labelled "Cocacola" or "Seven-up".

(iv) Over-prescribing. I regret that I am unable to join in the general condemnation of the medical profession for over-prescribing of mild tranquillisers. There is no doubt that the use of these drugs has transformed the care of many millions of patients throughout the world. In addition to that, the increasing incidence of suicidal attempts with such drugs as nitrazepan, chlordiazepozide and diazepan is beneficial in that death associated with the ingestion of these drugs is rare. Where the medical professional is at fault, how-

ever, is in the failure to realise that the prescription of transquillisers cannot be a substitute for a careful family and personal history which may give the clue to the psychosocial problem precipitating the emotional illness. In this regard the present system used in some of the clinics in this country when a patient is seen by different doctors at each visit should be condemned. It is only by the development of a doctor-patient relationship that the patient will confide to the doctor those things which are precipitating the symptoms[1].

II. OUR ATTITUDE TO THE SUICIDAL ATTEMPTS

As doctors, we have to admit that we are no more perfect than our lay-colleagues and if we are honest with ourselves we will admit that there are times in which we consider suicidal patients as a rather tedious form of patient to look after. If we compare our attitude to the management of patient with septicaemic shock and compare that with our attitude to the management of a patient who has twice taken a drug overdosage, can we honestly say that we feel that they both are equally deserving of our medical attention?

How many times in casualty or accident departments throughout the world have I heard the sentiment expressed that a washout in a conscious patient is a very good thing as it is an effective punishment for the attempted suicide and a disincentive to the patient to do the same thing again. Bearing in mind these thoughts which certainly I have had from time to time in my professional career we should remember the following points:

(i) Suicide in Great Britain is the cause of one-third of the total number od deaths in University students[3].

(ii) Ten per cent of all deaths for the age group 25 – 34 are caused by suicides[3].

(iii) Most reports of recurring suicidal attempts are only in the order of up to 4% of patients and the greatest recorded one is 15%[2].

(iv) Only 16% of 112 cases of suicide in Singapore had a history of previous admission to a mental hospital[5]. This suggests that the majority of suicides are not related to severe or irreversible mental illness.

It is therefore clear that the majority of suicides occur in young people and that the chances of severe recurring illness are remote. It should also be clear that the successful treatment of these patients should be as professionally satisfying as the successful treatment of any other patient.

III. EMERGENCY CARE

We are all familiar with questions to be asked by doctors faced with the medical emergency of a drug overdosage or ingestion of toxic materials[4]. They are as follows:

(i) What are the general supportive measures needed in the care of this medical emergency?

(ii) What drug was taken, when was it taken, and how successfully?

(iii) Is a stomach washout indicated or not?

(iv) Is there any antidote for this substance?

(v) Can we successfully increase the elimination of this substance from the body?

I believe that at the same time as these questions are being asked and answered there should be a parallel treatment of the psychosocial emergency.

(i) Why was this substance ingested?

(ii) If it followed a quarrel why was there a quarrel and was it a once only affair or was it part of a prolonged family disagreement?

(iii) What are the social, family, emotional, or personality problems which have precipitated this suicidal gesture?

I believe that the plan of management of the psychosocial emergency should be as follows:

(i) We should always give explanations to the patient in a sympathetic and humane manner explaining to them why they need injections, stomach washout, etc. It is not always easy to know whether a patient is fully conscious or just rather drowsy. In addition, it is often not known whether the patient understands the language which is spoken in the emergency room, and we must remember that in Malaysia many people can understand a language which is being spoken even though they cannot speak this language themselves.

(ii) We must avoid making any comments which, if heard and understood by the patient, will reinforce in the patient their pre-existing conviction that the world may be against them.

(iii) We must avoid reporting the suicidal attempt to the police within the patients hearing. Surely this only increase the fears of patients by helping them to realise that they have compounded their problems by committing an offence. This may make the patient even more determined to take his own life.

(iv) We must alleviate extra problems – The result of the attempted suicide may be to further disrupt social and family relationships, e.g. if a husband and wife quarrel, the husband may go off to get drunk. At the same time the wife may swallow an overdose of tablets. This may lead to a young family uncared for, as the night progresses. In addition, speedy contact with the patient's employer informing him that the patient has been taken ill, but that she should be well enough to return to work over a certain period of time, may be enough to persuade the employer to keep her job open for her. This may, in itself, help to alleviate some of the patient's worries.

(v) Relatives of patients admitted with attempted suicide should be kept behind after a patient has been resuscitated in the Emergency and Accident Department to enable the physician to interview the relatives to obtain the important family and social history that will often give a clue as to why the patient has attempted suicide.

(vi) We must create a peaceful atmosphere. Accident departments are usually noisy, hectic and unrestful. I believe that it is vital that, even if the patient is in the Accident and Emergency Department for only a few minutes, if conscious, the hustle and bustle should cease, and the doctor should have the opportunity to talk to the patient in quiet. The doctor can then assess the patient's view of their problems, arrive at a psychosocial diagnosis, and reassure the patient that, whilst they are in hospital, everything will be done to help them through the difficulties and problems which are the causes (and also possible results) of their suicidal attempt.

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