SUICIDE ATTEMPTS, THE WAY OF COMMITTING THEM AND, SOCIO-DEMOGRAPHIC CHARACTERISTICS DURING 2003 IN PATIENTS TREATED IN THE CLINICAL CENTER, NIS

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The behavior characterized by enmity towards one's own being, where urges for auto-destructive aggression overcome the instincts for self-preservation is seen only in the human species. In order to understand fully such an act we must recognize the complex dynamics of intra-psychic occurrences, sometimes initiated years before the tragic event. The nature of these auto-destructive events is most often impulsive. On the other hand, parasuicide is any auto-destructive behavior without a fatal outcome. From a clinical point of view, this is less a syndrome within an already present psychopathology and more a way of coping with an unbearable crisis and an expression of person's psychological breakdown.

In recent years, in our country, we have noticed an increase in parasuicidal behavior, mostly among younger and middle-aged population. The most common form of this behavior is the self-administration of medicaments and poisonous substances (corrosive agents and pesticides), and they are all initially treated at Toxicology department of Endocrinology Clinic. Regular psychiatric consultations at this Clinic enabled us to follow this phenomenon, with purpose of establishing psychopathological and social factors leading to this kind of behavior. We presented data from year 2003 concerning suicidal patients treated at Department of Toxicology at Institute for Mental Health in order to highlight the key characteristics of this phenomenon in our community. *Acta Medica Medianae 2005; 44(1):25–29.*

Key words: *suicide attempt, socio-demographic characteristics, way of committing suicides*

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Introduction

The specific quality of psychic life is given to human beings alone. Their ability to produce an awareness of their existence, awareness of their needs, desires, as well as of limitations, constraints and obstacles preventing their fulfillment, at the same time offers the opportunity for intentional negation of that very awareness and discontinuation of conscious perception of events around them as well as within themselves.

The behavior characterized by enmity towards one's own being, where urges for auto destructive aggression overcome the instincts for self-preservation is seen only in the human species. In order to fully understand such an act we must recognize the complex dynamics of intra-psychic occurrences, sometimes initiated years before the tragic event.

Is conscious auto-destruction a sign of triumph of will and power signifying our mastery over self-preservation instincts themselves or is it a sign of utter defeat, of a complete psychological breakdown caused by a long-standing conscious or unconscious conflict and an implosion of vital and aggressive energy?

Parasuicide

Suicide is an intentional termination of one's own life, while parasuicide is any auto-destructive behavior without fatal outcome. There are two types within this category: auto-destructive behavior and suicide attempt, depending on the level of being aware of the urge for termination of one's own life (2).

In auto-destructive behavior, the idea of death is usually distant from the consciousness and can be manifested through various activities: hazardous exploration of one's own limits, or search for new ones, fatalistic submission to destiny, failure to protect oneself in dangerous situations, anger directed towards oneself and other people and release of tension through self punishment.

Auto-destructive actions are most often impulsive. Tension, fear, and hopelessness build up continuously until they are released on an impulse without any forethought, planning or conscious control.

The fact that this behavior was not fatal, although directed against one's own well being shows that the urge for self-destruction is intertwined with an urge for self- preservation and that these actions are actually an appeal for help. These actions are outward representations of the unbearable suffering occurring within, and reveal vague hope for help and understanding. Most of the survivors describe this condition of confusion and fear, of vague and unconnected thoughts, loss of hope, where suicide is seen as the only resolution (3).

In cases of suicide attempts, the idea of death gradually becomes an obsession. Thoughts of suicide develop into suicidal tendencies, producing an inclination for finding resolutions through termination of one's own life. The verbal announcement of these intentions is an obvious sign of suicidal risk and must always be taken seriously. The verbal announcement of intentions is a kind of an opening for the final act. Initially, the act may take the form of a non-lethal self-injury, or of more severe actions where there is a very thin line between life and death which presents an ultimate appeal for help. Endangering of one's own life develops into suicide attempt at the point when the struggle between vital and auto-destructive tendencies is already resolved in favor of destruction and when life is preserved only by accident.

Suicide process characteristics

The real help is possible only for those who have just started along the pathway of self-destruction. Recognizing the persons that hide within them the struggle between life and death at early stages presents a daunting task. We should take special notice of persons susceptible to suicidal risk:

1) Psychiatric patients (psychoses, depressions, personality disorders, addictions)

2) Somatic patients (pain, bodily damage and dysfunction, disfigurement)

3) Persons in long-standing crises (hopelessness)

4) Lonely people, without religious convictions

We should also watch out for personality's predisposition towards for suicide and for the existence of depressive auto-destructive responses in unfavorable circumstances (4).

Person of this type does not have a basis upon which to build a dominant positive image of himself as someone who is worthy of love and attention and therefore he is unable to find within himself positive sources of energy required for the resolution of the problem. Acute or chronic conditions lead to maladaptive crises which cannot resolve positively. These persons show depressive attitude in life, a pronounced need for dependence, attachment and being praised, ambivalence, and the feeling of guilt because of unacceptable aggressive tendencies towards important objects. Existing psychological resources are perceived as depleted and consequently auto-destructive tendencies become stronger than self-preservation instinct (5).

The act of self-destruction is only the final outcome of a complex suicidal process initiated long before the act itself. The influence of heritage, in the form of the predisposition towards depression, is emphasized, especially in cases of unfavorable conditions of early development that strengthened negative psychological mechanisms thus leading to accumulation of negative life experiences that will eventually reduce self-respect, confidence and exhaust capacities for adaptation. The set of unfavorable and constraining circumstances along with lack of emotional and social support is usually the agent that initiates the suicidal crisis, the internal fight between destructive-aggressive and positive-vital forces of the personality. Many internal and external factors will influence the final decision, and when the aggressive tendencies win, unable to find their way out, they will be redirected within and released through self-destruction. The study and understanding of this phenomenon is of great importance for it enables us to predict suicidal behavior and thus offer the means of prevention.

Prevention

Primary prevention includes non-medical measures conducted by the society as a part of its care for an individual and creation of a favorable family, occupational and socio-economic conditions which will facilitate the resolution of problems and overcoming of psychological crises.

Tertiary prevention deals with an immediate saving of life of a poisoned or injured person and treatment of the consequences of the suicidal act. This phase is done right on the spot of the attempted suicide and then in hospitals, depending on the type of the injury.

The most frequent area of our work is the secondary prevention and it includes treatment of persons exposed to this kind of risk demonstrating suicidal tendencies: psychiatric patients, depressive patients, addicts, all persons in some kind of crisis who don't see any other way out. The help is offered by professionals (psychiatrists, psychologists, medical doctors of other specialties) but also by other individuals who come in contact with these persons (6).

Special attention should be paid to persons with history of attempted suicide, regardless of the motives. Forty percents of the survivors repeat the auto-destructive behavior in the year following the first attempt.

About 45% of suicidal persons seek professional medical help in the period of two months before the attempt, half of them turning to a psychiatrist. The announcement of suicide or altered risky behavior are sufficient signals that this person is at risk and that prevention measures must be implemented.

Today, we have multidisciplinary teams treating suicidal persons: physical safety and saving of lives, psychological-psychiatric evaluation and therapy of the condition that led to the suicidal behavior. The psychiatrist is a part of this team and his role is crucial for the further course. His task is to make an evaluation of the psychological condition, current suicidal risk, and propose the measures for further psychiatric treatment. The objectification of this condition is made

easier through application of clinical-psychological tests that measure the degree of suicidal risk. The reliability of these estimations is disputable because they are based on general indicators. Instruments designed for more specific categories like depressive, relapse and schizophrenic patients, have greater value in this respect. Professional literature mentions Pierce Suicide Attempt scale (1981) and Motto (1985) as clinical methods for risk evaluation because they take into account the outer circumstances of the act and psychiatric evaluation. Today, we usually use Poldinger questionnaire "Suicidal estimates". The evaluation scales cannot substitute for psychiatric interview, clinical evaluation and establishment of the relationship of trust between a suicidal person and the physician which is a prerequisite for further prevention and therapy. After somatic treatment, in cases where this is warranted by high suicidal risk and estimated condition, we should continue the treatment by hospitalization in a psychiatric institution. Voluntary hospitalization is usually rejected by the patient and his family, deeming the stigmatization of a being in a psychiatric institution a more serious problem than the risk of suicide. Enforced hospitalization is done in extreme cases due to various ethical dilemmas. This procedure is indicated for serious psychotic conditions (agitation, impulsiveness, impaired voluntary control of behavior, being overwhelmed by psychotic experiences), major depression with agitation and pronounced sense of guilt and need for self-punishment, in cases of relapses and intensification of the crisis because of the unresolved conflicts in patient's surroundings (7,8).

Most of the people with suicidal tendencies require continuity of the treatment in outpatient psychiatric clinics and includes psychotherapeutic and medicament treatment as well as work with family members. Pharmacotherapy mitigates or removes depression symptoms, as well as symptoms of neurotic and psychotic conditions and thereby reduces the patient's suffering. Work with family members should enable the patient to reintegrate into his social environment, as well as help them better understand what happened and defuse antagonistic relationships and thereby create a favorable family atmosphere for overcoming the crisis. A certain degree of discrete supervision and caution is in order, during the first days after the release from hospital. Nevertheless, the patient, the doctor, and the family share the risk of another attempt. Very often, this causes fear and the sense of failed responsibility, and sometimes aggressiveness, condemnation and rejection of the suicidal patient. Family members and other concerned parties who were involved in the conflict that triggered suicidal behavior intuitively understand and feel the aggressive charge of the suicidal act. They know that the patient is trying to punish them by his behavior, imposing on them the burden of guilt for their actions and attitudes. Very often, due to this kind of interplay, the emotional atmosphere in the family becomes very tense and fraught with mutual accusations and rejections, paving the path towards a new suicidal act.

Our Experiences

Our experiences are based on our cooperation with the team of doctors from the Toxicology Department of Endocrinology Clinic in Nis. The psychiatrist is a part of the team and makes psychiatric evaluation of suicidal behavior. The first contact between suicidal person and the psychiatrist is very important not only for the evaluation but also for the initiation of psycho-therapeutic relationship. The psychological condition of the patient most often at that point corresponds to the state of shock, general stupor, and emotional emptiness and sometimes apathy. The patient has difficulties to put his experiences into words. Often, he withdraws to silence, he is confused and feels helpless, unconsciously trying to block the memories of his experiences and prevent the renewal of the psychological catastrophe. The psychiatrist actively approaches with the purpose of offering the patient support and orientation in the current situation. He begins with neutral questions, concerning patient's particulars, and then proceeds with inquiries about some insignificant symptom or some other neutral subject, opening the space for the patient to establish the contact by himself and find the bearing towards present time. The psychiatrist must not insist on the painful subject, the suicidal act itself or its causes, and the patient will understand the message that the psychiatrist has the patience and understanding of the experienced mental anguish and pain, and will do nothing to aggravate them. Starting with innocuous subjects presents a valve for built-up inner tension of the patient and brings him to the realization that the contact with the outside world can still offer some hope. The psychiatrist facilitates the initial integration after the shock mostly by his readiness to listen carefully and give clear information. He also investigates depressive symptoms, and stimulates vital forces that need support in the present.

The cooperation between psychiatrists and toxicologists included interventions in most of the patients treated at Toxicology department of Endocrinology Clinic.

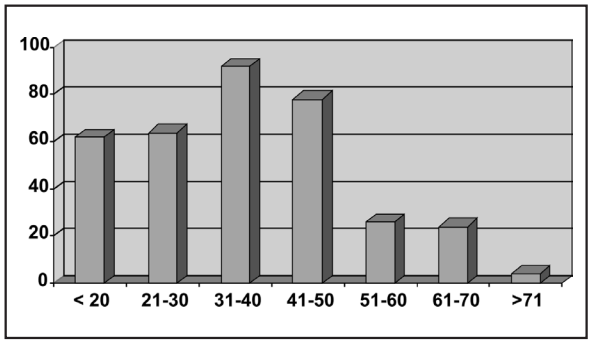
The socio-demographic structure is shown in Table 1.

Table 1. Suicide attempts – Toxicology 2003

Male	136 (39%)
Female	214 (61%)
Village	132 (37%)
City	218 (63%)
Unemployed	170 (48%)
Employed	138 (39%)
Retired	42 (13%)
Medicament	252 (72%)
Poison	98 (28%)
Death outcome	20(6%)
Total	**350**

The age structure shows that the greatest number is young or middle-aged. There is a substantial number of persons18-20 years of age, while patients younger than 18 are treated at the Pediatrics Clinic.

The age structure of the people treated ad the Toxicology department is shown in Graph 1.



Graph 1. The age structure-Toxicology 2003

The data found in professional literature reveal that only 15% of these patients seek further psychiatric help after the internist's treatment has been finished. We can assume that the first contact with the psychiatrist was not encouraging and that the mechanisms of suppression and negation were dominant and suicide tendencies still present. Pathological mechanism has a tendency of resistance and repeating itself, so 40% of these patients have another attempted suicide in the following period.

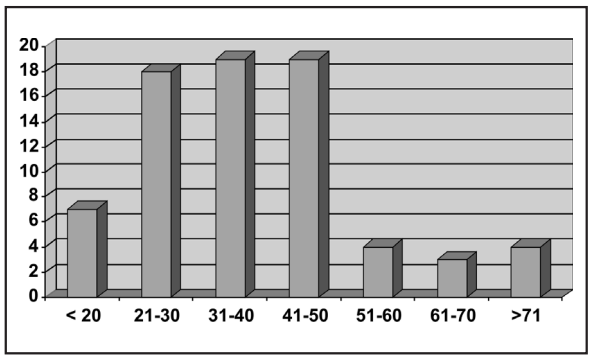
The data concerning treatment of suicidal persons at the Institute for Mental Health show that the number of persons seeking psychiatric help is five times smaller after the attempted suicide.

Socio-demographic data concerning suicidal persons treated at The Institute for Mental Health are shown in Table 2.

Table 2. Suicide attempt-Mental Health Clinic 2003

Male	17 (24%)
Female	54 (76%)
Village	24 (34%)
City	47 (66%)
Unemployed	38 (54%)
Employed	15 (21%)
Retired	18 (25%)
Depressive disorder	11 (15%)
Psychotic disorder	7 (10%)
Reactive condition	53(75%)
Total	71

The age structure in Graph 2 shows the greatest number of middle-aged persons.



Graph 2. The age structure-Mental Health Clinic 2003

Discussion

The increase in suicide in younger persons opens many questions about possible individual and social factors that influence this condition (9,10). Are we dealing with an increase in number of psychological disorders, a greater number of biologically vulnerable people, or is this the case of an unfavorable, suicidal atmosphere in the social environment which does not provide enough support and help at the time of crisis, so that the personal hopelessness of any affected person is just a reflection of an unfavorable social environment. We need a more detailed analysis of different parameters: biological, psychological and social in order to reach a scientifically supported conclusion or at least a valid hypothesis (11).

Pessimistic evaluations of the current preventive measures point to the fact that there is no efficient system which can reduce the suicide rate. Centers for suicide prevention, tele-appeal services, have not contributed to the reduction of this rate. There is no difference between hospital and outpatient clinic treatment after the first attempt. Neither multidisciplinary programs nor various psychotherapeutic methods proved to be efficient. There is no visible causal relationship between the improvement of clinical symptoms, improvement of social circumstances and the number of repeated suicide attempts.

Regardless of these statements, the activity of professionals and society in prevention of these phenomena is of the extreme importance.

Through comprehensive treatment and follow-up of persons at risk, especially of those with the history of attempted suicide, we can better investigate this ever-present phenomenon. By studying this phenomenon in the light of social factors we can recognize pathological social mechanisms that contribute to the development of suicidal behavior and by doing so open the possibility for social prevention of suicide.

References

1. Kaličanin P, Stožinić S. Stres, zdravlje-bolest. Beograd: "Obeležja"; 2001.
2. Angst J, Angst F, Stassen HH. Suicide risk in patients with major depressive disorder. J. Clinical Psychiatry 1999; (suppl 2): 57-62.
3. Kaličanin P. Psihijatrija. Beograd: Velerta; 1997.
4. Lecubier Y. Risk factors for suicide attempts: Epidemiological evidence. La salpetriere, Paris 1998; (2): 18-20.
5. Wiltsey Sh. Word use in the poetry of suicidal and non-suicidal poets. Psychosomatic Medicineus 2001; 63, (4): 156-62.
6. Goldney RD. The privilege and responsibility of suicide prevention. Crisis 2000; 1819: 8-15.
7. Nicholas LM. Managing the Suicidal Patient. Clinical Cornerstone 2001; 3(3): 47-57.
8. Angst J, Angst F, Stassen HH. Suicide risk in patients with major depressive disorder. J Clinical Psychiatry 1999; (suppl 2): 57-62.
9. Alen JZ, Alter R. Suicide in Teenagers. Assessment, Management and Prevention. JAMA 2001; 286 (24): 56-62.
10. Grbesa G, Milosavljevic Lj, Mrkaic A. Epidemiological-Demographic characteristic of suicide attempts in adolescents treated at the Institute for Mental Health in Niš in period of 1999-2003 Acta Medica Medianae 2004; 43(3): 23-7.
11. Kishi Y. Suicidal ideation Among patients with acute life-threatening physical illness. Psychosomatics 2001; (42): 5-12.

POKUŠAJ SUICIDA, SOCIODEMOGRAFSKE KARAKTERISTIKE I NAČIN IZVRŠENJA U 2003. KOD BOLESNIKA LEČENIH U KLINIČKOM CENTRU, NIŠ

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Ponašanje pri kome se čovek okreće protiv sebe, i gde agresivni porivi nadvladaju životne, javlja se samo u ljudskoj vrsti. Razumevanje ovakvog akta znači upoznavanje složene dinamike intrapsihičkih događanja, nekada pokrenutih godinama pre tragičnog postupka. Autodestruktivni postupci su najčešće impulsivni. Parasuicid je svako autodestruktivno ponašanje nefatalnog ishoda. Sa kliničke tačke gledišta, ovo je sve manje sindrom u okviru već prisutne psihopatologije i sve više način rešavanja nepodnošljive krize i izraz sloma ličnosti.

Poslednjih godina, u našoj sredini, uočljiv je sve veći broj parasuicidalnog ponašanja i to među osobama mlađe i srednje životne dobi. Najčešći oblik je trovanje lekovima i otrovima (korozivim sredstvima i pesticidima), a mesto prvog zbrinjavanja ovih osoba je Odeljenje za toksikologiju Endokrinološke klinike. Redovni konsultativni psihijatrijski pregledi na Klinici za endokrinologiju i toksikologiju, omogućili su da pratimo ovu pojavu, s ciljem da uočimo psihopatološke i socijalne faktore koji su predisponirali takvo ponašanje. Predstavili smo podatke iz 2003. godine o lečenim suicidantima na Odeljenju za toksikologiju i na Klinici za zaštitu mentalnog zdravlja da bismo uočili osnovne karakteristike ove pojave u našoj sredini. *Acta Medica Medianae 2005; 44 (1):25–29.*

***Ključne reči**: pokušaj suicida, sociodemografske karakteristike, način izvršenja*