Suicide

by Sam Bloomberg

For 22 years I have been totally involved – without any assistance whatsoever – in activities related to the prevention of suicide and the disseminating of suicide prevention education.

This paper concerns my counselling experiences in dealing with acutely suicidal persons and the general situation of suicide prevention and education in South Africa, while taking the role of the General Practitioner into consideration.

As statistics and crucial data for attempted and completed suicides are not possible to come by, for a variety of reasons, I cannot quote any reliable figures. However, I can tell you that according to the best available estimates, suicide is **the fastest growing cause of death in South Africa**, and our society has already been severely eroded by the extent of suicidal behaviour.

We have bred a new genetic strain – "**the child suicide**" which has become the third leading cause of death among young people under the age of 20.

A suicidal society sadly breeds suicidal people - we have reached the stage in South Africa where suicide attempts are now both a major health threat and ironically, a way of life.

There has also been a marked increase in suicide amongst the black groups in our country.

South Africa's urban populations are increasing considerably through the migration of populations to the major cities. It is possible therefore that with South Africa's economic progress and rapid expansion suicide may before long present a major social problem to the black people.

An urbanised and industrialised society carries within itself seeds of frustration and destruction. As time goes on therefore, the incidence of suicide amongst the blacks (depending, of course, on the degree of urbanisation attained) may well approximate that existing amongst the whites."

True to these predictions there is now a noticeable increase in black suicides which present a major social problem to the black people. Today the incidence of suicide amongst blacks is fast approaching that of the white population. No section of the population remains unaffected. An interesting observation is that there are entire families which can be identified and known to be at suicide risk.

It is well known that the magnitude of the problem of suicide as affecting our hospitals is that attempted suicide by over-dosage is one of the most prevalent types of case in our casualty service, psychiatric ward and quite a sizable one in medical wards, and intensive care units.

Suicide threats and abortive attempts are no longer a rare event encountered in most General Practices.

While most studies of suicide have been limited to those with seriously disturbed mental states there exists a large group – 75% of the total would-be-suicide population – who do NOT fall into the category of severe mental illness.

These are people who are emotionally "normal" in their daily existence – ordinary people but – on being presented with what they regard as an overwhelming crisis in their lives, their emotional hurt causes a degree of confusion which extends beyond their limits of tolerance and they "fall apart".

These people suffer from neuroses and personality disorders, and portray a suicidal behavioural pattern of being temporarily emotionally disturbed.

The suicidal impulse is of short duration, yet the patient – after having assessed the pros and cons of living and dying – seeks to escape from his problems by opting for suicide – but with appropriate intervention, allows for the balance to be tilted to the side of life.

It is this type of aberrant behaviour of the would-be suicide in social crisis that I have personally dealt with, in both threats and attempts. The majority of people, having received the appropriate intervention and correct form of advice, do survive the crisis and, return to psychological equilibrium, seldom again resorting to suicidal behaviour. With few exceptions nearly all people who threaten suicide simultaneously desperately want to live.

Estimates vary, but I believe that every year some 150 000 South Africans find their lives so painful that they consider suicide as the only means of ending their torment. Because they are so miserable confused and desperately lonely, close on 3 000 people complete the suicide act.

(THE LAST RESORT, Käthe Kollwitz; courtesy of The National Gallery of Art, Washington, D.C.; Rosenwald Collection.)

Implications

It can be predicted that if the recession and mounting political pressures continue resulting in mass unemployment and insecurity, more people will come to lose their zest for living.

It has been estimated that there are at least a quarter of a million suicidally affected persons in South Africa by which I mean people who have a history of at least one suicide attempt during their lives or amongst members of their family.

Suicidal personalities are costing industry and business million of Rands each year through absenteeism, mistakes and accidents. Suicidal people are more crisis and accident prone. The cost to the health services for each suicidal patient treated on antidepressants and sedatives and sleeping pills is staggering.

There is no way to estimate the anguish, misery, sorrow – and sometimes financial worry – of those left behind by a suicide.

Management of the suicidal personality in professional practice

If a doctor is to care for a suicidal patient effectively, his own attitude toward suicide must be identified.

Should people be ALLOWED to commit suicide?

Does suicide serve a valuable purpose by weeding out the weaklings and allowing the strong to survive? Suicide is democratic and plays no favourites. I know of strong people who have committed suicide.

Remember, a confused and troubled person cannot decide what is best for himself. The doctor's attitude towards the problem will either encourage the potential victim to go ahead and destroy himself, or make him understand that his problems can be solved in other ways. This is the watershed of success or failure in terms of the final outcome.

Suicidal patients are not all equally "dangerous" to themselves – they vary in lethal potential.

The development towards suicide takes months – or even years. The patient passes through three stages of pre-suicidal development:

- Consideration of the act. The initial suicidal impulse is reinforced by social isolation.
- Physical preparation for suicide – method and availability of means by which the act will be committed, ie. if a patient says he is going to shoot himself, he presents a higher risk factor.
- The decision to commit suicide – the method to be used determines the degree of risk and the presence or absence of other people may determine whether the would-be suicide can be stopped.

During all stages, appropriate intervention can reverse the outcome. All three stages are characterised by the patient's uncertainty about living or dying.

Many suicidal people have told me that they do not tell their doctor of their suicidal urges because he either avoids asking about it or because his attitude is not always conducive to discussing such matters. If the patients problems appear to be emotional ones, the General Practitioner will usually refer the patient to a psychiatrist.

What the General Practitioner should understand is that the patient is a whole person, therefore the GP's interest should cover not only the medical problems but also psychological problems which the patient has brought to his rooms.

If a doctor is able to recognise immediately that the patient has suicidal tendencies emergency short term psychological support is essential.

Once this has been given, the patient must then be referred to an appropriate specialist. Until such time as the patient is handed over to the specialist, he remains the GP's immediate problem. The GP should alert the patient's family to the potential danger. No suicide threat should be taken idly.

The medical doctor must always be aware of the fact that on discharge from hospital and when the patient seems to be responding and appears to be coping - the patient may have a setback that triggers off the suicidal phase again.

Should the GP feel that he has no moral obligation to prevent suicide, this attitude will be felt by the patient and will often tilt the balance to his patient's self-destruction.

There are many well known professionals who believe that "suicide is a basic human right and should be an option always available to the individual".

I must disagree most strongly with this opinion. Even the most deliberate, objective and well thought out suicide attempt for seemingly rational reasons can be saved with the correct handling.

Major emotional or social problems can be solved by means other than suicide. Most suicide threats or attempts are cries for help. The patient is not really saying "I want to die". He is saying "Help me - I want to go on living. I want to be rescued from my fear and desperation".

The person threatening or attempting suicide is, by his behavioural pattern, communicating to others that he is in emotional difficulties and uses suicide gestures as an expression of his inability to handle his stress and conflict.

The doctor is not responsible for solving the suicidal patient's problems. He should maintain his medical attitude but should assist in motivating the patient and/or his family to ensure that further treatment is received. He should help to boost the will to live – Hope is the medicine that should be freely dispensed.

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The role of the doctor's wife or receptionist in relation to Crisis Management

It is the doctor or his receptionist who frequently is the first professional person that the suicidal person will find the courage to phone.

These important people who are in the front line of suicide prevention, should be compassionate and properly trained and should know their limitations.

They can be of tremendous support in tiding the emotionally troubled patient over his crisis until the doctor is available to take over.

The initial conversation can take the form of a brief therapeutic discussion. The attitude of the wife/receptionist towards a distressed caller is most important. They project the doctor's image.

If a caller is made to feel that he is really being listened to – and that his problem is understood – he relaxes and becomes less hostile or anxious. In this way, the way is paved for the caller to feel confident that the doctor will help him.

Remember that many patients are actually afraid that the doctor will consider them only mentally disturbed. The receptionist or wife must become familiar with the language of the suicidal personality and must interpret this correctly and lead the discussion towards the information needed to establish the urgency of the situation.

From the start of the conversation with the suicidal patient one must evaluate how much time one has to make a decision about the caller.

Terms such as "parasuicide" are beginning to displace the term "attempted suicide", implying that the patient does not truly intend to kill himself and is not really in need of help.

To suggest that parasuicides or people who have not succeeded in their suicide attempt are merely being hysterical is wrong as very often dicing with death can result in miscalculation of some kind, and often death does actually occur.

Therefore the professional should deal with all suicide attempts as genuine cries for help. After all, happy, secure and healty people do not threaten or attempt suicide.

It is important that the doctor should find some person close to the caller who could share the responsibility of dealing with the problem.

It is also important to tell a caller who has already taken an overdose not only that medical treatment will save his life, but also that his emotional problems can be solved.

Helping a suicidal patient against his will

Experience shows that those cases who appear non-cooperative – those who are unpleasant and hostile – do respond and cooperate well if they are handled with firmness, sincerity and coordinated effort.

One's patience does however, get taxed to the utmost when the picture is complicated with alcohol or drug intoxication.

Responsibiliity · when does it end?

- when one has shown real concern
- when one has assessed correctly the patient's reason for calling and, if he is prepared for suicide, that his suicide plan is known.
- when the suicidal person has been stimulated into constructive action.
- when he leaves your consulting room with a hopeful and optimistic attitude.
- when his mind has been changed about suicide or murder.
- when one has suggested, or called into play, other professional people, agencies or community resources.

Telephone conversation versus traditional face to face interviews.

On the basis of the success of the work done at Suicides Anonymous over the past 22 years it must be said that if one listens to a telephone call with the intensity of a piano tuner one can learn to distinguish the voice of a drug addict, alcoholic, depressed, frightened, anxious or physically ill person and assess the degree of risk.

If listening skill is developed and used by a trained person the telephone can be made into an instrument of therapy and analysis.

Instant availability at the time of crisis, together with appropriate intervention and correct course of action, is the very essence of suicide prevention.

There is unfortunately a high degree of failure in the treatment of potential suicide by professional people as they have not yet learnt the art of telephonically detecting the person who is a high suicide risk.

More often than not when an anxious person calls his doctor he is told to phone back later or to make an appointment . . . usually for some days or weeks later. This, of course, is of no help to the emotionally desperate person.

He wants and needs immediate help. If a three minute telephone counselling session were introduced, those in crisis would receive immediate help and the call could be therapeutic enough to restore the will to live.

(SORROW, Vincent van Gogh Collection, Museum of Modern Art, New York.)

Depression causes emotional changes which convince the individual that his feelings of sadness, lowered self regard, hopelessness and failure can never be eased. Although this sense of entrapment does not make sense to an observer, it is actually an extreme intensification of "down" feeling that most people usually experience.

It is also very important to know how to recognise a potential suicide within the first few words of a conversation and then, to know how to speak to such a caller.

More often than not, from the tone of the telephone voice it is clear if the patient is merely being manipulative or likely to commit suicide or if he only needs sensible advice. It is also possible to detect if the caller is physically ill or emotionally disturbed.

The suicidal patient and the successful psychotherapist tune into each other. Failure occurs when the consultant's voice and wrong choice of words are off key.

Sometimes the shock of making the phone call has a cathartic effect. This releases the suicidal impulse and the patient is no longer at risk. He may even deny any suicidal thoughts.

As important as voice identification is the need to establish the circumstances that have led up to the suicide intention; the proposed plan for committing suicide; is there a history of previous suicide attempts (whether serious or not); has the patient recently undergone psychotherapy and if so, with whom?; does the patient live alone or with someone?; the attitude of the spouse/parent; is there anyone to care for the patient immediately?; is there a close relative who could be called upon to help the patient to sort out his problems?

Drug treatment of suicidal patients

Drugs are usually great lifesavers, but in suicide prevention they can be more harmful than helpful. We have heard many stories from would-be suicides of how, initially, they responded to medication and felt internally calmer, but outwardly lost the zest for life because of their state of limbo and became totally dependent on their drugs, and, of course, often used them in their suicide attempts.

The prevention of suicide does not lie in drugs which so often only mask the condition.

In fact, there is an urgent need to limit prescription of drugs to suicidally inclined patients. We all know of the high incidence of suicide by drug overdose, and every effort should be made to combat this.

If a doctor gives sleeping tablets for more than a night or two to a suicidal patient and that patient should take an overdose, it should be seen in the light that the doctor has failed to respond to the patient's real reason for going to him, making the doctor the unintentional accomplice.

One cannot teach suicidal people how to go on living or to come alive again with sleeping tablets.