UPDATE ARTICLE

Management Of Suicide In General Practice – A Practical Approach

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Abstract

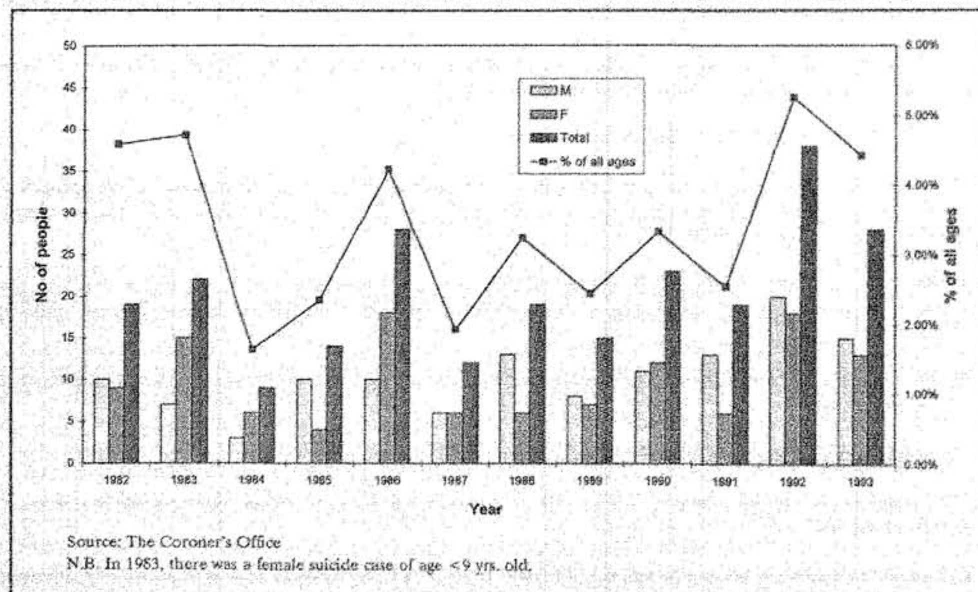
General practitioners often come into contact with patients with suicidal thoughts and behaviour. An understanding of the etiologies and a proper psychosocial assessment are essential in the management of such patients. Suitable treatment and appropriate referral can be quite rewarding.

Key words: Suicide, parasuicide, assessment, management, general practice

Introduction

In Hong Kong, under the category of injury and poisoning, suicide forms only the 4th most common adult mortality disease group (5.7%), compared with malignant neoplasms (30%), circulatory diseases (29%) and respiratory diseases (17.5%). According to entity, suicide actually ranks 7th, compared to malignant neoplasms, heart diseases, cerebrovascular diseases, pneumonia, renal disease, injury[1]. But when it occurs, suicide can be quite sensational, especially if it occurs in the younger age group such as secondary school students. Though there was a surge in absolute numbers in 1992, statistics (**Figure 1**) do not suggest that there is any significant increase in the number or sex preference of confirmed suicides in this age group in recent years, compared to the total number of suicides in Hong Kong.

Figure 1: Suicide of Adolescence (10-19 years of age) in Hong Kong



Source: The Coroner's Office
N.B. In 1983, there was a female suicide case of age <9 yrs. old.

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What is more important to general practitioners is that many suicidal patients consult their doctors shortly prior to their death, and give subtle clue to their intentions[2]. Unfortunately, they often go undetected, especially in busy clinics in Hong Kong. On the other hand, doctors cannot be over-reactive to suicidal ideas expressed by their patients and send all of them to the Accident and Emergency Departments. Not only may this result in the breaking of the doctor-patient relationship; it may cause unnecessary admissions to psychiatric units.

Because of the stigma attached to psychiatric disorders, general practitioners may be in a better provision to offer help and support to suicidal patients, provided they have adequate knowledge about suicidal behaviour and have the necessary support from specialists.

Suicide and Parasuicide

Suicidal behaviour can be divided into two types, that of suicide (those who die of suicide attempts) and parasuicide (those who self-injure themselves without dying). The latter is also called deliberate self-harm e.g. those who overdose themselves or who slash their hands ('delicate wrist cutting'). Studies overseas and in Hong Kong[3-6] showed unique characteristics for both suicide and parasuicide (see **Table 1**), but this classification is only arbitrary because of the possibility of accidental death.

It appears therefore that single, elderly, retired male depressive patients (or alcoholics) form the group most at-risk of suicides. Furthermore, parasuicidal persons do not aim primarily at killing themselves, but have a primary motive of either a blind reaction in seeking immediate relief from a stressful situation, a cry for help, an expression of aggression to make others feel guilty or even a trial by ordeal.

Table 1: Comparison between Parasuicide and Suicide

	PARASUICIDE	SUICIDE
Sex	F > M	M > F
Age group	Usually <45	>45
Marital status	Highest in divorced & single	same + widowed
Social class	More in lower classes	upper classes
Urban/rural	More in cities	same
Employment	Association with unemployment	same + retirement
Effects of war	?	lower in wartime
Seasonal variation	Nil	peak in spring
Broken home in childhood	Common	same
Physical illness esp. chronic/painful ones	No association	clear association
Personality disorders	Common	?
Psychiatric disorders	Situation reaction Depression, alcoholism	Depression & alcoholism

Causes of Suicide

From a practical point of view, suicidal behaviour can occur in either mentally ill patients or in persons who are only temperamentally unstable (i.e. those immature, egocentric, anxious, dependent, hostile, impulsive with interpersonal problems).

For those who are genuinely mentally ill, they can further be classified into either sane or insane groups. For the former, they usually suffer from adjustment disorder, situation reaction, panic disorder, non-psychotic depressive disorder, etc. For the latter, the most common disorders are affective psychosis, schizophrenia and paranoid disorder. For both groups, there are often co-existing alcoholism, drug abuse and/or personality disorder.

Methods Used in Suicidal Behaviour

In Hong Kong, the most common method for suicide is that of 'jumping from height'. Hanging is another common method especially for the older age group while drug overdose occurs more in the females. Statistical analysis points to more females committing suicide at home than males. A significant minority also communicate their intention to others, either verbally or with a suicide note.

Assessment of Suicide

As a precaution, there should be proper suicidal assessment of each and every patient who is upset or who seems depressed, even if the suicidal intention is not explicit. Proper assessment should consist of at least the following:

1. The Attempted Suicide

Both the antecedents and the circumstances in which the suicidal behaviour occur should be analyzed as regard to the genuineness of the attempt and the precipitating causes of such an event. The doctor should note especially any precautions taken against discover, any preparatory acts (procure means, suicidal note, etc.) and also the method used whether it is violent or lethal. The consequences of the suicide (the responses from others, whether the patient's purposes are achieved, etc.) should also be noted.

2. Assessment of the Suicidal Intention

Seldom does a person jump into a suicidal act without going through the various stages of suicidal intention (see **Table 2**). By asking the appropriate questions, a general practitioner is able to assess the real severity of an imminent suicidal threat.

Table 2: Severity of Suicidal Tendency[7]

1.	Minimal	Disinterested in daily hobbies
2.	Slight	Occasional thoughts of death e.g. "I would be better off dead"
3.	Mild	Frequent thoughts of death or occasional thoughts of suicide
4.	Moderate	Often thinks of suicide or occasional thought of suicidal method
5.	Severe	Often thinks of suicide with plan(s) or suicide gesture of the communicative type
6.	Extreme	Has made preparations for a potentially serious attempt
7.	Very extreme	Suicidal attempt with intent to die (physically or even medically)

3. Assessment of Psycho-social Factors

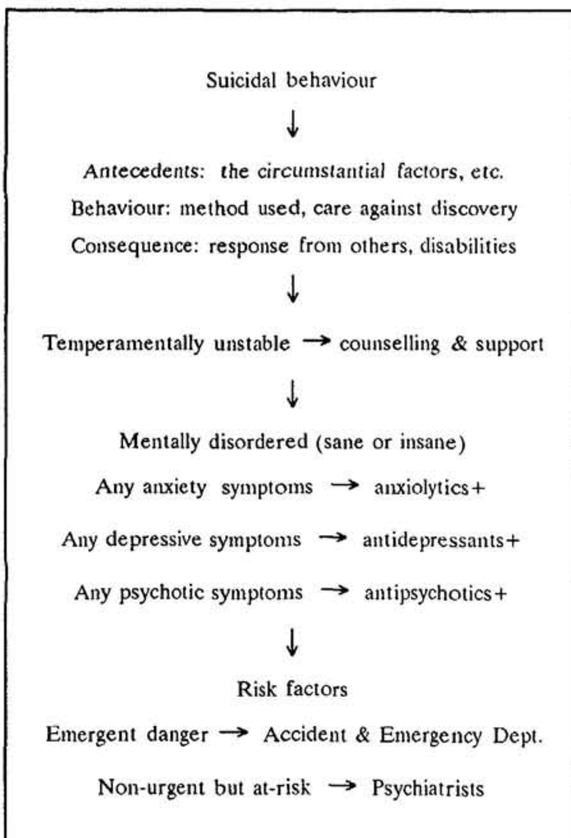
Circumstances also often affect a person's chance of committing suicide, and an appropriate evaluation of the patient's personal and social environment is important in determining the chance of dying as well as the need of voluntary or even compulsory admission. The personal factors include both the personal characteristics (age, sex, marital status) and the personal assets (intelligence, physical health). The social factors should include living condition and support, family relationships, employment and significant life events (bereavement, separation and other losses, dramatic changes in life style, etc.).

The doctor should also ask for any previous history of mental illness (esp. alcoholism, affective disorder), suicidal attempts in the patient and other family members.

Management of Suicide

For the general practitioner, a simple scheme is listed in **Figure 2.** If the risk of genuine suicide is low, the doctor is more comfortable to treat the patient with psychological support and the appropriate drug therapy. Proper recognition and treatment of depression[8] and anxiety disorders is very useful; but for the more serious patients (e.g. psychotic patient) or those at high suicide risk, prompt referral is necessary.

Figure 2: Scheme in the Management of Suicidal Behaviour



1. Definitive Treatment

Supportive psychotherapy includes attentive listening, practical advice, reassurance and explanation. Occasionally, an interested practitioner can employ the Balint type of brief psychotherapy to help the patient. Sometimes, a busy doctor can delegate part of the psychotherapy (e.g. attentive listening) to the paramedical professionals or the relatives of the patient.

As regard psychotropic medications, the choice of drugs (usually anxiolytics and/or antidepressants) depends on the symptomatology. Care should be paid to the possibility of overdose by a suicidal patient. Therefore, the medications chosen should be as safe as possible and the total number of drugs should not be too many. However, medications must be given for an adequate time and at an adequate dosage. The more recently developed medications are preferable (e.g. the non-benzodiazepine anxiolytics); and the newer anti-depressants are more preferable than the tricyclics. Those with serotonin reuptake inhibition are also most interesting, as some studies do suggest that 'suicidality' is associated with deficiency of serotonin in the brain. Lastly, the doctor should beware of co-existing 'depressogenic' medications e.g. some anti-psychotic drugs, antihypertensives, oral contraceptives, etc.

Psycho-social care should also be looked into by the general practitioner who should not aim at bearing all the burden alone. The doctor should call on the support of relatives or significant persons to the patient. Occasionally, he may have to provide family support, marital and relational therapy to these persons as well. Information should also be given as regard to social resources (e.g. the Family Services of the Social Welfare Department or other non-government organisations) and emergency hot-lines (e.g. the Samaritans).

2. Referral for Those of the High-Risk Group

For those patients with imminent danger to self or others, prompt referral to the Accident

and Emergency Department is needed for hospitalisation. Usually, the doctor should persuade the patient to go voluntarily, but sometimes (especially for a frankly psychotic or a very tricky patient), physical or chemical restraint may be needed.

If the patient is not in imminent danger but beyond the capacity of the general practitioner to manage e.g. the psychotics and the hysterical, appropriate referral to the psychiatric out-patient departments should be arranged.

3. Prevention of Recidivism

About 75% of suicide attempters have improved social and mental conditions afterwards, largely because of the responses from relatives and friends. However, about 25% repeat the act in one year's time, and 1-2% die within the first two years. Some of the predictors of repeated suicide are listed below (**Table 3**).

Table 3: Predictors of Repeated Suicide

1. Previous attempt
2. Previous psychiatric treatment
3. Obvious psychopathy
4. Alcoholism
5. *Socially isolated*

Ethical and Legal Issues

Firstly, it is the issue of 'medical confidentiality'. The most commonly encountered dilemma for a general practitioner is whether to inform the relatives of the suicidal wishes of the patient.

Secondly, should doctor treat his suicidal patient against his/her will (e.g. by referring the patient to hospital for in-patient care), as this may break the doctor-patient relationship.

Last but not the least, there is the issue of possible 'medical negligence'. In the U.K., physicians are charged with the responsibility for assessment of deliberate self-harm patients and deciding whom should be referred to the psychiatrists. Failure to assess such patients may be considered as one form of medical negligence. In the U.S., psychiatrists are generally requested to have documentary evidence of thorough assessment of suicidal patients.

Conclusion

Suicide is a fairly complicated human behaviour. There can never be a guarantee of success in its treatment and prevention. Despite the best detection and provision, some suicide cases still occur despite treatment by the most experienced psychiatrists or suicidologists. However, general practitioners can play an important role in the prevention of some of the potential cases. An understanding of some of the psychopathology and management techniques (**Table 4**) could provide some protection against negligence, and can sometimes be very professionally rewarding. ■

Table 4: The Suicidal Patient[9]

Assessment	Behaviour	Management
Temperamentally unstable	Taken overdose Slashed wrists, etc. Issued threats	A&E Dept. &/or admission Assess significance, but do not dismiss lightly. May need short admission. Assess significance. If no depressive illness, tell those in attendance to watch overnight and contact you the next working day.
Mentally ill	Taken overdose Slashed wrists, etc. Issued threats	Admit via A&E Dept. Admit to psychiatric unit. Take very seriously. May be possible to start anti-depressants and monitor at home, but, if severely depressed, urgent psychiatric opinion &/or admission indicated.

(From: Moulds *et al*, 1993. Emergencies in General Practice. Ch. 15)

(Continued on page 58)

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CUMULATIVE HIV/AIDS STATISTICS IN HONG KONG

Updated 30 November, 1994

		TOTAL	(AIDS)
SEX	Male	472	(119)
	Female	41	(8)
ETHNICITY	Chinese	340	(88)
	Non-Chinese	173	(39)
TRANSMISSION ROUTES	Homo/Bisexual	189	(67)
	Heterosexual	206	(39)
	IVDU	11	(2)
	Blood/Blood Products Recipients	66	(12)
	Perinatal	1	(1)
	Undetermined	40	(6)
	TOTAL	**513**	**(127)**

Enquiries may be directed to the AIDS Counselling and Health Education Service (Telephone: 2780 8622)