EMERGENCIES IN GENERAL PRACTICE

ATTEMPTED SUICIDE

BY

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A patient's suicidal attempt commonly takes both his relatives and his doctor by surprise. In this emergency the doctor's first duty is to conserve the patient's life, by administering whatever first aid is necessary for the injuries sustained, and by arranging without delay for the patient's further physical and psychological care and treatment. This duty takes precedence, of course, over any detailed investigation of the causes and circumstances of the attempt. Where possible, immediate admission to the mental observation ward of a general hospital is the ideal arrangement. Even if the individual has not sustained serious hurt and the situation appears less urgent to his relatives, it is usually advisable to insist that he goes into hospital. The most skilled medical and surgical care is available there for the treatment of injuries: also a breathing space is obtained, during which the situation may be calmly assessed by everyone concerned. The patient should always be kept under observation for at least a few days. He must be safeguarded from further self-injury, his relaxation and sleep must be ensured by sedatives, a detailed assessment of his mental and physical state must be made, the relatives interviewed, and both the individual and the social aspects of the situation fully considered. Usually a proper decision about his future can be taken within two weeks.

All this calls for such a specialized investigation that the help of a psychiatrist should be enlisted as soon as possible, whether or not the patient has been admitted to a general hospital. Where the practitioner is unsupported by a general hospital or psychiatric advice, he will have to rely more on his first estimation of the seriousness of the attempt (see below) in deciding whether or not to arrange prompt admission to a mental hospital. Mental hospital admission is most often required for those suffering from depressive, schizophrenic and paranoid psychoses, and more often for those past middle age than for younger individuals. It is necessary for most of those aged 60 years or over. If the individual's progress cannot be adequately watched and safeguarded at home, mental hospital or other in-patient care is essential. Admission to a mental hospital should not, however, be made the rule: of those who are admitted initially for a short period to a general hospital, about one-half may be discharged home reasonably safely. Those who go to a mental hospital will usually do so as voluntary patients. Psychiatric out-patient treatment is required for many others.

To discharge from observation an individual who has attempted suicide, just as soon as he is physically fit, is malpractice. Sometimes the patient is asked first to promise that he will not attempt suicide again. This promise, if given, is usually valueless. It may reassure the doctor but it does nothing to safeguard the patient, who can no more control his self-destructive impulses than the sufferer from an acute appendicitis his pain.

How Serious was the Attempt?

The determination behind a suicidal attempt may be very difficult to measure and cannot be judged by any one criterion. It is not profitable to draw a sharp distinction between real suicidal attempts and suicidal gestures. It is better to err on the safe side, which is to consider a gesture a real attempt and to treat it as such. After middle life suicidal gestures are uncommon; in old age they are exceptional.

If the individual has injured himself seriously, or has jumped from a height, or has attempted to hang or drown or shoot himself, there can be little doubt that he intended to take his life. The more bizarre the method used, the more likely is it that the individual is seriously mentally ill. Those who have chosen a solitary place, and those who have used more than one method, are likely to have been in earnest.

That the attempt was feeble in execution does not, however, necessarily mean that the intention was feeble. If the individual has not taken a gross overdose of drugs, or has attempted gassing with the windows open, or has made only a few superficial cuts on his wrists or throat, it is sometimes immediately concluded that he was not serious. But a psychotic patient may make a poor attempt: his agitation or retardation may cloud his judgment and render his hands impotent.

It is of great importance to find out if the individual who has made the attempt has recently appeared nervously ill. If he has not appeared to be ill, especially if he is of chronically unstable temperament, and if the act has been an obvious response to some quarrel or frustration and is described by the actor as done on the spur of the moment, then one may usually conclude that the immediate danger has passed, particularly if the actor himself has become calm again. But there are exceptions here too: the young schizophrenic, hardly recognized to be unwell, may act with great impulsiveness.

Unfortunately one cannot accept at its face value the patient's own estimation of his act, but one must correlate his statement with the rest of the evidence. Not infrequently a suicidal individual denies his suicidal intentions after the act, out of fear of police action or the reproaches of relatives, or to get another opportunity to complete the act. On the other hand, an admission of suicidal intent is usually to be believed. A farewell letter is usually of serious import, and its contents may throw light on the motives which prompted the attempt. Inquiry should always be made whether or not the individual left any communication, since such letters are often suppressed or quickly destroyed by relatives.

The most difficult cases to assess are often those in which the suicidal attempt has been made at home and the method has been barbiturate poisoning. The individual may assert that all he wanted was a long sleep. This statement should not be readily accepted. Some suicidal individuals will deny vehemently that suicide was their intention. The story may be given that the drugs were at the bedside, that the patient took two perhaps, then two more, and when drowsy more still. Such an accident, leading to prolonged and deep unconsciousness, is rare. The story, which relatives are only too glad to accept, is usually a cloak for a suicidal attempt.

Attempts made when the individual is under the influence of alcohol are also difficult to assess. While it is true that certain suicidal attempts are made under the influence of alcohol which would not have been made in a state of sobriety, alcohol may release a serious suicidal trend; it may also interfere with its consummation. It may be very difficult in these cases to know how prolonged was the oblivion sought. Perhaps two-thirds of such attempts are to be judged serious.

That the attempt was dramatic does not necessarily mean that it was not serious. A serious attempt may be dressed up for and executed publicly. The sufferer from a depressive psychosis may wish to demonstrate to others the extent of his wickedness and his self-punishment: while the aggressive psychopath, venting a murderous spite upon himself, may at the same time court a posthumous publicity by which relatives will suffer.

More men than women commit suicide, and men more often use active and violent methods. These generalizations, though true, hardly help one with the individual case.

Could it Have Been Prevented?

After such a distressing emergency has arisen, one is prompted to ask, could it have been foreseen and forestalled? While it is perhaps doubtful if the really determined individual can often be deviated from his intention, it must be admitted that preventable suicides do occur. They occur because either the doctor or the relatives or both feel sure that, knowing the patient to have been a decent and trustworthy person, a suicidal attempt was not to be expected. But suicide is no respecter of persons.

Almost any nervous or mental illness, at any age, may lead to a suicidal attempt. Suicide is thought of particularly in relation to depressive psychoses, but it is a mistake to consider it as limited to them. It may be a symptom of any psychosis where there is emotional disturbance. It cannot be ruled out in neurotic reactions. It may be the panic response to a sudden crisis of disablement or bereavement, for example, or to a threat of loss of liberty or reputation, or to the self-discovery of homosexual trends. It is the typically exaggerated response to frustration of that large group of temperamentally unstable people which includes the psychopaths and a certain number of epileptics and mental defectives.

The emphasis must be on the early diagnosis of nervous and mental instability, and on treatment and protection at the earliest possible stage. If the risk of suicide is thought of, it is much more likely to be recognized. To appreciate, even approximately, the degree of risk one must get to know the patient well, must give him time to speak freely about his problems, and must exercise great delicacy in questioning when trying to sense the dangers of his situation. At a single interview it is usually possible to give the depressed patient a feeling of confidence that he is understood; and if he has admitted to despondency he may then be asked if he has had any morbid thoughts or at any time felt discouraged or even hopeless about his future or the outcome of his illness. He must be gently assisted, never forced, to reveal further his emotional state. Any disclosure of suicidal thoughts should be taken seriously. When a patient has spoken of suicidal thoughts it is advisable always to reassure him that these are usual symptoms of a depressive illness, that they are not evidence of sinfulness, and that they will disappear as the illness lifts.

On physical examination scars on the neck and across the fronts of the wrists, which might indicate a previous suicidal attempt, should be noted. There are other features of the patient's history and symptomatology which will point to a particular need for vigilance.

Warning Signs

One still often hears it said that those who talk of suicide to other people do not commit it. This is a false and dangerous belief. At least one-third of those who attempt suicide have threatened suicide. Such threats should therefore never be ignored but should be evaluated carefully in the setting of the type of abnormal reaction and all the individual circumstances. Suicidal threats are not only warnings often of an impending attempt, but cries for help.

If a history of a suicidal attempt in a previous illness is obtained it increases the risk in the present illness. In the case of the manic-depressive, the fact that previous depressions have not been associated with a suicidal attempt may give one a feeling of greater security about the risk in the present illness, but it does not exclude this risk. Neither does one suicidal attempt in a depressive illness eliminate the possibility of further attempts in that illness.

A family history of suicide is significant, and there may be a family mode of committing suicide. A living person may come to identify himself with someone who is dead. If he becomes depressed he may wish to rejoin that person: and if he says so, this is usually to be construed as a suicidal threat. If the individual identified with has himself committed suicide, the risk of a duplicate suicide is materially increased.

There is some evidence also that the history of a "broken home" in childhood is correlated with an increased suicidal risk.

Depression and insomnia are the usual symptomatic precursors of a suicidal attempt. All depressions carry a suicidal risk, whether they have clear precipitants—for example, bereavement, financial ruin—or come out of the blue. The risk is often greatest in the early stages of the illness, and again in convalescence. This unexpected and almost paradoxical risk in convalescence is often forgotten. Depressions associated with retardation are less dangerous than tense, agitated depressions. Any individual past middle-life, who presents a picture of persistent anxiety and who has not previously had neurotic symptoms, should be suspected of suffering from an early involutional melancholia and precautions against suicide should be taken without delay. Particularly dangerous are those who blame themselves, who express feelings of intense shame and guilt and failure, and who say that their continued existence would be burdensome for those they love. The obviously very depressed individual who denies having had thoughts of suicide should on principle be disbelieved: he may be determined to be unhindered. Those who say that they are too cowardly to carry out the act may do it successfully.

Insomnia, Fear, and Loneliness

In general the greater the concern about insomnia, the greater the suicidal risk. The patient may assert that he is certain that lack of sleep is doing irreparable damage to his brain. Though he may sleep for some hours, he may declare that he has not slept at all; if one just dismisses the statement as untrue, one will miss its significance as a danger signal. The psychotically depressed individual often wakens at an early hour of the morning, and is most ill then. A suicidal attempt is often prefaced by a sleepless night.

Severe hypochondriasis in a depressive setting is also a significant complaint, particularly if it is focused on a single organ or part of the body and is accompanied by a phobia of disabling or fatal disease—for example, tuberculosis, heart disease, cancer. The fear of insanity is very common, often associated with intense feelings of tension and head pains, so that the patient feels that something is about to snap in his head. Venereophobia also, accompanied by depression and agitation, must be viewed very seriously. The individual's feelings of great guilt and contamination may urge him to attempt suicide even before the result of a blood test becomes available. Perhaps the most potent fear of all is the dread of the unknown.

Of all the reality fears which may precipitate serious suicidal attempts, the prospect of entering a mental hospital is one of the most noteworthy. The period during which arrangements are being made for a depressed patient to

enter a mental hospital, if the patient has got to know what is planned, is a period of real danger, during which he must not be left unattended.

In a depression, fears of losing control and of hurting or killing others, and actual attacks upon others, particularly if this behaviour is foreign to the person's usual disposition, are serious warning signs. This aggression may at any time be turned by the individual against himself. If the depressed individual goes unexpectedly on a journey, or wanders away with mind clouded (a fugue), he is suicidal.

Feelings of loneliness and of being unwanted are common harbingers of suicidal attempts, particularly in older people.

While none of these several symptoms is found exclusively in the suicidal patient, the presence of any of them will indicate the need for extra caution, and their concentration is always ominous.

Next article on Emergencies in General Practice.—"Obstructed Labour," by Mr. J. Peel.

MUSIC IN MEDICINE

Galen advised playing music to cure snake bite, Pythagoras thought music good for depression, and more recently a dentist claimed that he needed less gas for his anaesthesia if he played Debussy's "Clair de Lune" or "The Moonlight Sonata" on the gramophone at the same time. These were a few of the examples quoted by Mr. FRANK HOWES, music critic of *The Times*, in the third Cantor Lecture given to the Royal Society of Arts on February 21. Mr. Howes is a member of the council for music in mental hospitals, which for the past ten years has tried to make systematic provision of music for psychiatric in-patients, and has sponsored investigations, particularly by the late Dr. Mitchell at Warlingham Park Hospital, into the therapeutic value of music. In one experiment soothing music was played to disturbed patients at bedtime, instead of giving them sedatives, but the only result was a fight. In another, when the last two movements of Vaughan Williams's F minor symphony were played to a group of neurotic patients, the effect was to bring into the open their hostility to psychiatrists, which was freely expressed.

Dr. Cunningham Dax at Netherne Hospital had played music to patients and then made them paint their response. Their pictures showed either elation (after Mahler's adagietto) or depression—after Mendelssohn's "Midsummer Night's Dream." Thirteen out of seventeen pictures were of violence, robbery, murder, and a Chopin nocturne provoked a suicide. Bach and Mozart were probably tranquillizing. But the hope of a musical pharmacopoeia was dashed by the inconstancy of the effects. Results were so often unexpected, or varied with the individual. With some, music provoked an emotional explosion and release which was beneficial; in a few others, epilepsy; and yet others remained indifferent to it. But there are different types of listener, susceptible of classification like other personality attributes. We all listen in various ways, but predominantly in one way characteristic of us. A simple classification, went on Mr. Howes, was Vernon Lea's, into Sicilians (those susceptible to the sheer power of sound, sensuous euphony), dionysiacs (those who respond to the emotion), and apollonians (the intellectual–technical approach). Only the second group was likely to be therapeutically approachable. Mr. Howes's own estimate of music in hospital was modest and commonsensical. An American authority, Dr. S. Licht, in his *Music in Medicine* (1946) thought the music played should be bad music, an endless succession of old-time favourites, but Mr. Howes believed that in-patients were a cross-section of the public with the same musical tastes, and needed something not too long or complicated, but not too well known either. Music for them could be a part of occupational therapy and an entertainment. It might make some temporarily less introspective, in a few it might awaken a new and lasting interest, but above all it was a communal activity, and brought solitary people into contact with their fellows. Those who played had in addition the satisfaction of exercising a skill and of creating something. Beyond that it was difficult to say. Plato in his *Republic* laid great stress on music as an element of education, because rhythm and euphony entered into the inner recesses of the soul and made a man a well-ordered person—an idea which was very foreign to us to-day. We were more accustomed to the thought that music speeded industrial production, or human performance, and Mr. Howes quoted an odd experiment from 1911, when 46 mile-long bicycle races were ridden, 23 to music and 23 in silence. The average speed of the control group was 17.9 m.p.h., and that of the musically stimulated 19.6. To sum up in a sentence, music is certainly hygienic, even if not therapeutic.

Reports of Societies

DEFECTS IN MODERN TREATMENT OF LEPROSY

The introduction of the sulphones for the treatment of leprosy a few years ago aroused world-wide interest and great hopes for the eventual eradication of the disease. But to-day opinion, if no less hopeful, is certainly becoming more critical. Speaking on March 2 before the Edinburgh Branch of the Royal Society of Tropical Medicine, the director of the newly established East African Leprosy Research Centre, Dr. JAMES ROSS INNES, roundly declared: "The modern treatment of leprosy based on the sulphone group of drugs is unsatisfactory." He realized, he said, that many would think this statement outrageous, when they recalled the few lepers who ever came within sight of cure during the chaulmoogra era; but it was high time leprologists expressed their dissatisfactions as a preparation for further advance.

Limitations of the Sulphones

Broadly speaking, the sulphones brought clinical arrest and bacterial negativity to a high percentage (70 to 80) of active cases of leprosy, the relapse rate was low, and relapses were easily reversed. Dosage was moderate, drug reactions were infrequent, and the annual cost was low. Useful adjuvant drugs were also available, such as isoniazid, thiosemicarbazone, A.C.T.H. and cortisone, streptomycin, chlorpromazine, and vitamin B_{12}. Drug resistance to the sulphones proper was practically unknown. In fact the whole therapeutic picture seemed rosy. "We ought to be able to 'plug away' with the sulphones and clear leprosy from the face of the earth." But, said Dr. Innes, after experience of the sulphones on a large scale it was by no means certain that this would be so.

For one thing, it took far too long to achieve bacterial cure in lepromatous cases. A failure rate with the sulphones of 20 to 25% in various countries indicated their inadequacy. Instead of achieving bacterial negativity in six months to a year, which would be a useful period in controlling the spread of the disease and a fair one to expect, they took three to five years or more. It was true that when widely and carefully applied in an endemic country the sulphones achieved great things, but their slowness and imperfection