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SUICIDE AMONG PSYCHIATRIC PATIENTS IN ILORIN

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ABSTRACT

Objectives: To once again, draw attention to suicide in Nigeria. Two, to demonstrate that where a disorder is few and far in between, psychological autopsy through interview of key informant(s) could be quite revealing. Finally, since no study on suicide has been documented in the study area or its environment, this study is expected to provide baseline data for future works.

Method: All patients attending a newly established psychiatric unit in Ilorin, Nigeria were actively followed up. Patients who defaulted for six consecutive appointments were traced. Where there was tentative evidence of suicide, a psychological autopsy was done through interview of a key informant.

Findings: Of the 100 new patients seen over the four-year period, only four were presumed to have committed suicide. It was found that the suicidees were aged between 30 to 65 years, usually lonely, not religious and had expressed strong suicidal ideation/intent within two weeks of committing suicide. Three of the four case vignettes committed suicide at a point they first showed clinical improvement.

Conclusion: It was concluded that increased attention should be paid to the management/ prevention of suicide through more intensive mental health education for patients and the populace at large in order to enhance symptom recognition and search for appropriate medical attention.

KEY WORDS: Suicide, psychiatric patients

INTRODUCTION

Suicide is difficult to predict, and has potential for catastrophic outcome. But more importantly, in most cases, it is preventable[1]. Though some people admit to wanting their lives terminated, others offer little or no overt signs of suicidal ideation. This becomes even worrisome, as about 70% of suicidees had visited a physician in the preceding month without expressing suicidal ideation or strong intent[1].

In Europe, suicide is the second most common cause of death in ages 15-44 years[2]. In Britain it accounts for less than 10 per 100,000 per year. In Hungary 40 per 100,000 per year and in Spain 3.6 per 100,000 per year[3]. In Asia, its lifetime cumulative incidence is 3.6%[4]. In Nigeria, Asuni found that suicide rate was very low[5].

Accurate statistics about suicide are difficult to obtain as data are based on official sources e.g. coroners report which is prone to errors as it is often difficult to differentiate accidental death or murder from suicide. This problem is even more obvious in developing countries as there are no properly documented death register or coroner's report. Some other factors militating against reliable data include, false declaration of cause of death by the family in order to avoid stigma, absence/improper keeping of death register by government agencies. Most Africans belief in the existence of witches and wizards[6]. Except in old age, the cause of death is usually attributed to these forces. It would therefore be an exercise in futility, they claim, to subject the corpse of a family member to autopsy. Also, Islam prescribes that the dead should be buried before sun set. These factors coupled with low literacy rate constitute impediments to performing autopsy among Nigerians especially for the purpose of eliciting cause of death.

In spite of the foregoing obstacles, knowledge and database must be obtained as regards suicide in Nigeria. A way round such a phenomenon is to conduct a psychological autopsy. This is done by interviewing a key informant about the social and psychological features and circumstances surrounding patient's death[7,8,9]. This study therefore, in spite of its limitations, strives to contribute to the body of knowledge on suicide in Nigeria by reporting the preliminary findings of a four-year experience as regards suicide among patients attending a psychiatric unit established in December 1997 in Ilorin.

METHOD

The setting

In 1997, the author was mandated to start a new psychiatric unit as part of the expansion of the psychiatric department. This assignment presented an opportunity to closely monitor and keep

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records all patients in the unit due to the relatively fewer number of patients compared with the two older units. After four years of follow up, all patients that did not present for follow-up, six consecutive months after last appointment, were traced by the author and a research assistant to ascertain reason for default. Only patients that committed suicide were reported in this article. Since the sample size was small, the emphasis was more on qualitative than quantitative data.

The qualitative data (interview of key informants/psychological autopsy) collection in this study could be divided into two: the identification/establishment of rapport and the psychological autopsy proper of the four vignettes (cases 1-4).

Identification/ establishment of rapport

This is a very important and time-consuming stage. Its success determines to a large extent, the quality and usefulness of interview. Therefore, many trips were made before the most willing, yet appropriate, person to volunteer information within the family was identified. In all cases, a lot of reassurance was given and the purpose of the study as a contribution to knowledge, properly articulated before the interview could proceed. In some cases, some other members of the family would want to be present at interview. This was gently discouraged.

Psychological autopsy (interview)

This was conducted in a quiet place with the most reliable and cooperative relative or close associate (colleague at work, member of religious group, a person from the same village). Since a microrecorder could not be used for reason of confidentiality, note taking was solely employed. Ideally, the interviewer should concentrate on interview and someone else takes notes. In this study, a slight modification was made. Both the author (interview) and research assistant took notes in order to ensure that no information was lost.

With the use of a format (appendix 1) as a guide, open ended questions were asked in the following areas: suicidee's identification (name, age, sex, occupation), relationship of interviewee with suicidee, recall about socio-religious life of suicidee when alive, when suicidee was last seen, possible cause of death, instrument/ method of committing suicide, antecedent events/ problems before committing suicide, was strong suicidal ideation expressed? Was a suicide note left behind? e.t.c.. Each interview lasted a minimum of one hour, but could be longer depending on the level of education and how articulate the interviewee was. Immediately after each interview session, the author and the research assistant met for debriefing and to compare notes. Thereafter, the author transcribed the notes onto a transcript paper (Appendix 2). On the right hand margin of the paper used to transcribe the interview are code words e.g. 'inst' meaning instrument used to commit suicide, 'tell' meaning did the suicidee tell someone before committing the suicide, 'note' meaning any suicide note left. These code words (developed by the researcher) and their meanings were written on a sheet of paper called code list. This is to ensure the codes and their meanings were not forgotten or mistaken for other words. Finally, using a logbook (Appendix 3) adapted from previous studies[8,10], a summary of the highlights was done.

All patients enlisted into the study were and are still being carefully followed up for outcome of illness. This will be reported in future communications.

Findings

After the first four years of study, 100 new patients were seen. Of these, eight were found out to have died. Two died of possibly old age, two of road traffic accident and four of suicide. Below are the brief summary reports of the interview with key informants on the four suicidees.

APPENDIX 1

GUIDELINE FOR INTERVIEW OF KEY INFORMANTS

1. Each interview shall hold in a quiet non-distractible place.
2. Only one interviewee shall be allowed.
3. If possible, the entire discussion shall be recorded on audio tape after due explanation of the aims and objectives and obtaining consent.
4. The author will moderate the interview.
5. The interview shall commence proper with greetings, introduction of author and research assistant and the purpose of study
6. Prompting open ended questions shall be asked around the following main areas: patient's identification (to ensure we were discussing the same patient), relationship with patient, recall about socio-religious life of patient when alive, when patient was last seen, possible cause of death, instrument/ method of committing suicide, antecedent events/ problems before committing suicide, was strong suicidal ideation expressed? was a suicide note left behind? et cetera.
7. The interviewee shall again be assured of confidentiality.
8. The interview shall end with a closing remark and expression of appreciation (including incentives) from the interviewer to the interviewee.

APPENDIX 2

Example of Some Coded Transcript from Interview of Mr. I_1, a key informant on Mr. D (i.e. case 4).

Transcript	Code
'Mr D is usually on his own. He has only one friend that I know. He does not seem to relate well with the wife.'	LONELY
'The stepdaughter saw a bottle of gammalin-20 in the bathroom where he was found dead.'	INST
'On two occasions he told me it was better to die than be alive and suffer'. On one occasion, his niece told him somebody died and he shouted, 'those looking for death are alive, while those not looking for it are dying'.	S/IDEAT

APPENDIX 3

Example of Logbook Format

1. *Date*.....
2. *Place*.....
3. *Interview Number*.....

Items	I_1	I_2	I_3	I_4
a. Relationship with suicidee				
b. Social life				
c. Religious life				
d. Possible motivation				
e. Material used				
f. Suicidal ideation				
g. Suicide note				

I_1, I_2, I_3, I_4 represents 1st, 2nd, 3rd, and 4th in-depth interviews of key informants

Case 1

Mr A was a 32 -year old male secondary school leaver who was a Clerk. He was single and lived alone. He was not known to exhibit strong religious tendencies. His parents died about five years ago. He was first diagnosed as a case of paranoid schizophrenia a year before presenting in the clinic. Three years later, he developed depressive illness. The depression came 8 months after he was retrenched on account of ill health. He was said to have drank a poisonous substance (? name). He expressed strong suicidal ideation about a week to committing the act. He however did not leave a suicide note. Patient was buried without an autopsy.

Case 2

Miss B was a 30-year-old female and the second of a set of twins. She was a ward maid and lived alone. She was not known to be very religious. She was diagnosed as a case of severe depression two years prior to committing suicide. About 2 weeks to committing the act she expressed strong suicidal ideation and was on account of that admitted. She was to be monitored closely with a suicidal caution chart opened for her. Within two weeks of admission, she responded well to therapy (counselling and antidepressants) and was no longer having suicidal ideation. The suicidal caution chart was closed and on request from the patient she was allowed, for the first time, to sit outside the ward as usually done by other patients. She absconded from the hospital and went home. While at home, she sent a small child to buy about 700 mls of concentrated sulphuric acid and drank it. She was subsequently rushed to the accident and emergency unit of the hospital where she died 3 hours later. Autopsy report showed perforation of the gastric, jejunal and colonic walls with faecal matter within the peritoneum.

Case 3

Mrs C was a 40-year old senior executive in a government parastatal. She had been married for 10 years but without children. She attended her church regularly. Husband died a month before presentation. She presented with features of acute psychosis (to rule out atypical grief reaction) and was admitted into the psychiatric ward. She settled rapidly and was discharged after 5 days. She kept her appointments religiously and sustained her clinical improvement. On account of these, she was given a longer appointment of one month. Two days after her last visit, she was said to have driven herself to a refuse dump near her house, fastened her seat belt, rolled up the side wind screens, poured petrol into the car and ignited matches. She died almost immediately. A cousin, who went to visit the patient before her death, claimed that patient expressed strong suicidal ideation a day before committing suicide. She was buried without an autopsy.

Case 4

Mr D was a very senior highly educated public servant. He was aged 64 years old. He got married in 1970 but lost his first wife 4 years later. He remarried 11 years after to a widow who also lost her husband some years back. He has had multiple bereavements as he lost his first child in 1995, lost his mother in 1997, his brother (a close confidant) in 1998, his father in 1999 and his first grand child (2 months after delivery), in year 2000. About 6 months after the death of his brother (September 1998), he was diagnosed as a case of mild to moderate depression. He was initially managed on outpatient basis but later admitted when he started expressing strong suicidal ideation. He was discharged two weeks after admission and remained mentally stable for about 4 months and thereafter went into hypomanic phase. He was stabilized after 3 weeks on haloperidol, benzexol and carbamazepine tablets. Eight months after discharge, patient went into depression again and was commenced on sertraline tablets, as he could not tolerate amitriptyline due to excessive weakness. Though patient was married, he was usually if not always, alone in his room. He once described his relationship with his wife thus: *I pity her, poor woman! I think she is getting what she did not bargain for in this marriage.* Also, there seemed to be little social support from his siblings. Most of the social support came from the nieces who had at some time lived with him. He was not a strong believer in the orthodox churches and was a member of one of the mystical societies.

Three weeks before committing suicide, patient expressed suicidal ideation to his only son, the wife and a cousin. This was however not reported to his doctor. Instead, some members of the family were summoned to reprimand him. He was also reminded of how furious he was when his cousin committed suicide in 1986. A week before patient's death, he visited his doctor and claimed he had improved as he was able to go to work and drive out in the evenings. On that account he was to come back for follow up in two weeks. Five days to his appointment, he committed suicide by drinking *Gammalin 20 (a pesticide)* after ensuring that the two doors leading into his room were securely locked. He died while being rushed to the hospital. Autopsy was not done before patient was buried.

DISCUSSIONS

The suicidees reported in this study were aged 30 to 65 years of age, usually lonely, not religious and had expressed strong suicidal ideation/intent within two weeks of committing suicide. Also, three of them committed suicide at a point they first showed significant clinical improvement. These findings are in keeping with those documented in previous studies[1,3,9]. The suicide rate in this study was 4%. Though for a clinic population, it falls within the lower side of the range reported in previous studies by Robin (2-47%)[11], Dopart and Ripley (12-30%)[12], and Barraclough (3-70%)[13], it is rather high when compared with findings in general population[5,14]. All the suicidees were aged 30 to 64 years with a mean of 41.5 years and a standard deviation of 15.6 years. This is comparable to previous finding by McClure that most suicidees are young men[14] and by Tuckman and Youngman to be 45 years or more[15].

Various methods of committing suicide have been documented. These include use of *gammalin 20*, firearm, setting self ablaze among other methods[3,6,9]. In this study, methods of committing suicide include ingestion of *gammalin 20*, ingestion of concentrated sulphuric acid and setting self ablaze. However, in this study, the most violent method (setting self ablaze) was used, incidentally, by a female. Even though, there is regulation against illegal use of acid in Nigeria, the ease with which one of the suicidees bought concentrated sulphuric acid should be a source of concern. It is therefore imperative that laws should be enforced against its sale and purchase by unauthorized persons.

One of the earliest studies on suicide reported that over two-thirds of suicidees expressed suicidal ideation, while more than a third expressed clear suicidal intent [14]. It was also reported that often, the warning had been given to more than one person[14]. All the suicidees in this study expressed suicidal ideation and/or strong suicidal intent within a day to two weeks prior to committing the act. In all but one of the cases that were on admission (Miss B), no caregiver reported the intent/ideation to the managing doctor. Instead, the intent was discussed secretly at family meetings. This will underscore the importance of intensifying mental health education for not only mentally ill patients, but also the relatives/caregivers. This might improve symptom recognition by relatives and consequently assist them in seeking appropriate assistance. Government and non-governmental organizations should also establish more counselling centers. All these measures might in no small way reduce, if not completely prevent, the incidence of suicide.

Unlike in developed countries, where about one-sixth of suicidees would leave a note behind[16], none of the suicidees in this study left one. This might be an attempt to save the family from stigma by ensuring that the cause of death is not detected if a note left behind inadvertently gets into the wrong hands. It could also be an indication of the seriousness of the intent of suicide as the suicidee might not want to be rescued from death which may be possible if the means of committing suicide is known and an antidote is available e.g. an alkaline against sulphuric acid.

Suicide rates have been noted to be low among the married and increased among the divorced, never married to widowers and widows [3]. It has also been noticed to be inversely proportional to degree of religiosity [2]. These factors were demonstrated in this study as all the cases were found to be lonely and not strong adherents of any of the two dominant religions in the area of study i.e. Christianity or Islam. Even though one of the cases was married, he was almost always alone in his room. This finding will suggest the need to promote mental health, and by implication reduce suicide, by encouraging improved family communication and adequate socialization. Some level of religious inclination and social grouping should be encouraged. These measures will go a long way in providing emotional, social and financial supports when required.

The fact that three of the four case vignettes (cases 2-4) committed suicide when they showed the first sign of clinical improvement should remind mental health workers and other caregivers of the need to be very vigilant at this critical period since it is usually at this time patient has enough energy to commit suicide.

CONCLUSION

With this report, I hope once again, attention has been drawn to one of the most stigmatized phenomena in Nigeria or Africa i.e. suicide. Though a large sample would have been desirable, the available small sample has been analyzed through interview of key informants to yield useful information for taking a renewed look at this important highly catastrophic yet, most times preventable phenomenon.

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