PARASUICIDES IN KUALA LUMPUR REASONS FOR THE ATTEMPT

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SYNOPSIS

This study examines the primary reasons for attempting suicide as described by the 271 parasuicidal patients assessed at the Psychiatric Clinic, General Hospital, Kuala Lumpurdirng 1982. The reasons in order of frequency were: marital problems; family problems; boyfriend, girlfriend problems; a medical illness; a psychiatric illness; and others. The types of marriage, family, and love problems experienced by each of the three major Malaysian racial groups are discussed. Indians presented with family problems more frequently than the other racial groups and Indian females were more frequently battered before the suicidal attempt. Suggested treatment measures based on the findings include employing a crisis intervention model for suitable patients, interviewing the patients on the Medical Wards, and involving more Psychiatric Social Workers in their management.

INTRODUCTION

This is the second portion of a descriptive study of 271 parasuicidal patients seen at the General Hospital, Kuala Lumpur (GHKL), Psychiatric Clinic, during the year 1982. Whereas the first portion presented statistics summarizing the patients' age, sex, race, marital status, educational level, occupation, living arrangements, religious involvement, degree of suicidal intent, and method employed, this one focuses primarily on the reasons these patients gave for their suicidal behaviour and concludes with a few suggested treatment measures based on the findings.

MATERIALS AND METHODS

The data presented was compiled from the relevant sections of a fifty-item questionnaire filled in by the author or a Psychiatrist during or immediately following the patient's initial assessment. The data was broken down by sex, race, and marital status to detect any significant differences among these groupings. Some patients cited more than one reason for their suicidal attempt. These patients were asked to choose the one reason they considered had most contributed to their suicidal act and only these "primary reasons" are included in this study. While suicide attempts are frequently multi-causal, involving conscious and unconscious factors (1, 2), this paper discusses only the patient's conscious motivation.

RESULTS

The major precipitating factors leading to the suicide attempts of these 271 patients fell into seven general categories. These categories were: marital problems, comprising 27.7% of the total; family problems 23.6%; girlfriend/boyfriend problems 15.17%; medical illness 9.2%; psychiatric illness 8.5%; accidental 7.4%; and others 8.5% (Table 1).

Table 2 gives a breakdown by sex and race of the reasons for attempt given by the 135 single patients. The seven categories for these patients were: family problems, 34.8%, love problems 30.4%, psychiatric illness 12.6%, accidental 8.2%, medical illness 4.4%, a quarrel with an unrelated person 3%, and others 6.6%. But for single males love problems were cited almost twice as frequently as family problems as the reason for the attempt and the males naming family problems were all Indians. For the single females a family problem was the most frequent reason given for the attempt but this held only for Indians, who implicated family problems more than twice as often as love problems. For female Malays love and family problems were named with equal frequency whereas for Chinese females love problems occurred more often.

The various kinds of love problems and family problems these single patients faced were also examined. Love problems fell into four categories which were in order of frequency: being jilted 42%; being scolded 29.0%; fearing a dissolution of the relationship as the partner refused to propose, had been unfaithful or seemed to have lost interest 27%; and others 2%.

The family problems were classified in terms of who was involved. 51% attempted suicide after being scolded by one or both parents, 25% after a quarrel with a sibling, 11% following a family quarrel involving more than three persons, 4% following a quarrel with a relative, while the remaining 9% of these 47 single patients failed to specify who was involved. The nature of the family problems varied widely among these patients but the most frequently mentioned were : family rejection of the patient's lover, family excessively controlling the patient, quarrels relating to house work, and financial disputes. 34% of these 47 patients were also physically assaulted prior to the suicide attempt. These abused patients were all female, 13 Indian, 2 Chinese, and 1 Malay.

The primary reasons for attempting suicide as related by the 136 married* patients were: marital problems 55.1%, medical illness 14%, family problems 12.5%, accidental 6.6%, psychiatric illness 4.4%, quarrel with an unrelated person 1.5%, and others 5.9% (Table 3). Whereas marital problems were the most frequently mentioned reason by both sexes and all racial groups except Chinese males, family problems were restricted mainly to married Indian and Chinese females.

The major types of marital discord are shown on Table 4. Loss of love, actual or perceived, accounted for 37.3% of the marriage problems. These patients explained that their suicide attempt followed the separation of the spouse, his threatened separation, or the discovery of his mistress. In-law problems, which includes quarreling with one's husband's second wife, constituted 16% of thes cases. A spouse being too controlling or domineering also made up 16.0%, followed by financial problems 9.3%, disagreements over childrens' supervision 5.3%, and others 16%. While loss of love was the most frequent marital complaint for females of all races a spouse being excessively controlling and financial problems affected mainly Indian females. 25% of the female patient's with marital difficulties were physically assaulted by their husbands immediately prior to the attempt. 13 of the 39 Indian females were

TABLE 1
PRIMARY REASONS FOR ATTEMPTED SUICIDES

PRIMARY REASONS	MALE NO.	MALE (%)	FEMALE NO.	FEMALE (%)	TOTAL NO.	TOTAL (%)
Marital Problems	8	(3.0)	67	(24.7)	75	(27.7)
Family Problems	7	(2.6)	57	(21.0)	64	(23.6)
Boyfriend, girlfriend Problems	11	(4.0)	30	(11.1)	41	(15.1)
Medical Illness	7	(2.6)	18	(6.6)	25	(9.2)
Psychiatric Illness	11	(4.0)	12	(4.4)	23	(8.5)
Accidental	8	(3.0)	12	(4.4)	20	(7.4)
Other (Includes 3 Unknown)	8	(3.0)	15	(5.5)	23	(8.5)
TOTAL	60	(22.2)	211	(77.8)	271	(100)

* Married includes 14 patients who were either divorced, separated or widowed.

TABLE 2
PRIMARY REASONS OF ATTEMPTED SUICIDES FOR SINGLE PATIENTS

PRIMARY REASONS	MALAY		INDIAN		CHINESE		TOTAL M/F		TOTAL	
	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	NO.	(%)
Family Problems	—	7 (5.2)	6 (4.4)	26 (19.3)	—	8 (5.9)	6 (4.4)	41 (30.4)	47	(34.8)
Boyfriend, girl friend problems	1 (0.7)	7 (5.2)	5 (3.7)	12 (8.9)	5 (3.7)	11 (8.1)	11 (8.1)	30 (22.2)	41	(30.4)
Psychiatric Illness	—	—	1 (0.7)	4 (3.0)	5 (3.7)	7 (5.2)	6 (4.4)	11 (8.1)	17	(12.6)
Accidental	—	2 (1.5)	4 (3.0)	4 (3.0)	1 (0.7)	—	5 (3.7)	6 (4.4)	11	(8.2)
Medical Illness	1 (0.7)	—	—	2 (1.5)	—	3 (2.2)	1 (0.7)	5 (3.7)	6	(4.4)
Quarrel With Unrelated Person (e.g. workmate)	—	1 (0.7)	—	2 (1.5)	1 (0.7)	—	1 (0.7)	3 (2.2)	4	(3.0)
Other	—	1 (0.7)	—	2 (1.5)	2 (1.5)	1 (0.7)	2 (1.5)	4 (3.0)	6	(4.4)
Unknown	—	—	—	—	3 (2.2)	—	3 (2.2)	—	3	(2.2)
TOTAL	2 (1.5)	18 (13.3)	16 (11.9)	52 (38.5)	17(12.6)	30 (22.2)	35 (26)	100 (74)	135	(100)

TABLE 3
PRIMARY REASONS OF ATTEMPTED SUICIDE FOR MARRIED* PATIENTS

PRIMARY REASONS	MALAY		INDIAN		CHINESE		TOTAL M/F		TOTAL	
	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	NO.	(%)
Marital Problems	1 (0.7)	8 (5.9)	7 (5.1)	39 (28.7)	—	20 (14.7)	8 (5.9)	67 (49.3)	75	(55.1)
Medical Illness	1 (0.7)	1 (0.7)	1 (0.7)	8 (5.9)	4 (2.9)	4 (2.9)	6 (4.4)	13 (9.6)	19	(14.0)
Family Problems	—	—	1 (0.7)	8 (5.9)	—	6 (4.4)	1 (0.7)	16 (11.8)	17	(12.5)
Accidental	—	—	2 (1.5)	5 (3.7)	1 (0.7)	1 (0.7)	3 (2.2)	6 (4.4)	9	(6.6)
Psychiatric Illness	1 (0.7)	1 (0.7)	4 (2.9)	—	—	—	5 (3.7)	1 (0.7)	6	(4.4)
Quarrel with Unrelated Person (e.g. workmate)	—	1 (0.7)	—	1 (0.7)	—	—	—	2 (1.5)	2	(1.5)
Other	—	1 (0.7)	2 (1.5)	1 (0.7)	—	4 (2.9)	2 (1.5)	6 (4.4)	8	(5.9)
TOTAL	3 (2.2)	12 (8.8)	17 (12.5)	64 (47.0)	5 (3.7)	35 (25.7)	25 (18.4)	111 (81.6)	136	(100)

* Married includes 4 divorcees, 4 separated persons, and 5 widows.

TABLE 4
PRIMARY REASONS OF MARITAL PROBLEMS

PRIMARY REASONS	MALAY		INDIAN		CHINESE		TOTAL M/F		TOTAL	
	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	NO.	(%)
Loss or Threatened Loss of Love*	1 (1.3)	3 (4.0)	1 (1.3)	13 (17.3)	—	10 (13.3)	2 (2.7)	26 (34.7)	28	(37.3)
In-law Problems	—	2 (2.7)	2 (2.7)	7 (9.3)	—	1 (1.3)	2 (8.1)	10 (13.3)	12	(16.0)
Spouse too Controlling	—	1 (1.3)	1 (1.3)	9 (12.0)	—	1 (1.3)	1 (1.3)	11 (14.6)	12	(16.0)
Financial Problems	—	—	—	6 (8.0)	—	1 (1.3)	—	7 (9.3)	7	(9.3)
Disagreements Concerning Raising Children	—	—	1 (1.3)	2 (2.7)	—	1 (1.3)	1 (1.3)	3 (4.0)	4	(5.3)
Other or Unknown	—	2 (2.7)	2 (2.7)	2 (2.7)	—	6 (8.0)	2 (2.7)	10 (13.3)	12	(16.0)
TOTAL	* 1 (1.3)	8 (10.7)	79.3	39 (52)	—	20 (26.7)	8 (10.7)	67 (89.3)	75	(100)

* Includes separation, threatened separation, spouse discovered to have lover, and suspicions of spouse's infidelity

beaten, 5 of the 20 Chinese females, and 1 of the 8 Malays. A high proportion of the Indian husbands had been drinking heavily prior to assaulting their wife.

Other findings pertaining to the total group of 271 para-suicidal patients were: 19% had been separated from one or both parents before the age of 5, 16% claimed at least one family member suffered from a mental illness, and 6% said at least one other family member had attempted suicide. That 19% suffered from an early separation experience is surprising and could help to explain why these patients were unable to handle their distress in a more mature fashion.

DISCUSSION

The finding that marital discord, family problems and broken love affairs are frequently the primary reason behind para-suicide has been confirmed in earlier studies (3, 4, 5). But the finding that more Indian females present with family problems and complaints of assault than the other races, and Chinese females present more often with love problems merits further study to determine whether or to what extent these trends might occur in a more representative sample of suicide attempters in Malaysia. As pointed out in the first portion of this study, these findings only reflect patients seen at the G.H.K.L. Psychiatric Clinic and are not necessarily representative of "attempted suicides" in the country at large.

Concerning the treatment of attempted suicide cases several comments are in order based on the findings. First, since the majority of these patients suffer from a "problem-in-living" rather than a mental illness, a crisis intervention model is the usual treatment of choice. Most patients have little idea of what constitutes psychiatric help and are reluctant to engage in more than a few therapy sessions. Crisis intervention is useful, therefore, in that it is short term, realistic in its goals, and offers the patient concrete help (6).

Secondly, within the crisis intervention framework, an individual, couple or family therapy approach may be indicated. While individual counseling is usually appropriate for victims of broken love affairs, and marital counseling the treatment of choice for a marriage misunderstanding, family therapy is useful for victims of family pathology. However as few Psychiatrists or General Practitioners are familiar with both suicidology and family therapy (7), the latter method is rarely employed with these patients. It is recommended that more Asian therapists familiarize themselves with both fields, especially in order to determine the usefulness of family therapy in an Asia setting.

Thirdly, the employment of trained Psychiatric Social Workers to assess and counsel parasuicide patients in the government hospitals should be considered. Newson-Smith's study recently concluded that British Psychiatric Social Workers assess parasuicidal patients as safety and reliably as the Junior Psychiatrists while offering other skills as well (8) and trained Asian Social Workers should also be given this responsibility.

Finally, it is recommended that the initial psychiatric assessment of parasuicide cases be done on the Medical Ward rather than in the Psychiatric Department. This would enable all such cases to be assessed and also eliminate the stigma associated with a visit to a Psychiatric Clinic. Kessel also found that it is advantageous to conduct the patients recusitation and psychiatric management in the same clinical setting (9).

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