In the Federal Republic of Germany, the institutions, pathological concepts, and therapeutic methods involved in psychiatry have been subjected to growing criticism, are often challenged, and are occasionally evaluated as being reactionary or misanthropic. The reasons for this attack are the brutal realities still existing in part in psychiatric institutions and also the differing views of man and of his meaning and purpose in life. Other significant contributing factors are the great importance widely attached to health today and the general belief in the ability of modern medicine to restore health with relatively little difficulty, the term health being defined by the World Health Organization as bodily, mental, and social wellbeing. Medical science has definitely contributed to this utopia; in any event, it has posed no opposition. It is time to indicate the limits of medical ability and to point out the fact that all the expense involved, the great number of personnel, the many technical aids and modern hospitals cannot absolutely guarantee health and can by no means ensure happiness. This also holds true for psychiatry. No therapeutic principles, whether they be psychotherapeutical, sociotherapeutic, psychopharmacological, or having to do with follow-up care, can offer a guarantee for happiness. In the end analysis, these are only a bit of assistance against the powers of fate.

Such limitations are also set for measures used in suicide prevention. These measures are likewise subjected to widely differing public assessments. Some authors even go so far as to deny the legitimacy of efforts to prevent suicide (1,2). The basis of this criticism is the argument that man in a free society has the right to lead his life as he sees fit and to freely decide in favor of death when faced with a situation he finds unbearable. No one has the right to stand in his way after he has made this decision. Suicide must be tolerated as an act of self-determination. The attempt to apply the label of a psychiatric diagnosis would be a total misinterpretation of reality. Such opinions must be countered with several cold facts of reality. Over 95% of all patients who have survived a suicide attempt are happy to
be living, at least at first. Approximately 80% of these do not make a second attempt. They live on, at least. Whether they are happy or not is another matter. The majority of those who later repeat the suicide attempt are in fact suffering from mental disorders. However, it is also noted that the overwhelming majority of those without significant psychological disturbances, even at the time of the first suicide attempt, accept the fact of their survival (3, 6, 7). These points of view are so convincing that hardly a doubt remains about not only our right, but our obligation to try to prevent suicide and save people who have poisoned or wounded themselves. If there is agreement on these points and acceptance of the fact that suicide prophylaxis is an integral part of humane medical care in a humane society, the focus must be more vigorously placed on the need for much more intensive measures than have been undertaken thus far. This is because the number of people that die in suicide attempts has been growing steadily.

Currently, the death toll from suicide in the German Federal Republic is 14,000 yearly. This number has increased, although due to intensive medical measures many more poisoned patients can be saved today. This suicide rate has increased despite the existence of hot lines and other counseling centers in practically every middle-sized town, and despite the emergence of many crisis intervention centers.

In view of these facts it may be argued that suicide prevention is practically impossible and that factors contributing to suicide cannot be adequately dealt with. Numerous observations and research findings, however, contradict this argument. They prove that it is possible to convince many potential suicide victims that self-destruction is by no means the only solution to a seemingly hopeless problem (3—5, 9—12).

Suicide prophylaxis is therefore not a utopia, but a feasible measure that can and must be exercised in a humane society. The prerequisite for this is the awareness of those groups and individuals that are especially in danger of committing suicide. Only the most important of the many available facts on this can be presented here, in particular those that primarily involve the physician. It is a known fact that many people who successfully carry out a suicide attempt have sought out the help of a doctor in the last few days or weeks prior to their death (9, 11). It would certainly have been possible in many cases to recognize this imminent threat. The physician, however, is presented with a situation which is by no means easy to diagnose. Practically every disturbance having psychological bearing can produce suicidal tendencies. Whether or not a suicide attempt is actually carried out is not only contingent on the type and severity of the psychological disturbance, but also on factors in the social environment of the patient (8).
Fleeting thoughts of suicide are extremely common. There are very few adults who have not considered suicide at least once or entertained brief thoughts of suicide at a crucial moment. To what extent the individual is actually endangered is sometimes a difficult question to answer due to the important interaction between personal factors and the social environment. Moreover, the patient cannot always be expected to express his thoughts of suicide in the general practice. More often he will complain primarily of physical problems or make vague allusions to his intentions. The underlying conflicts are often not brought out spontaneously, but come to light only after directed probing by the doctor.

Many patients are not even aware that they are endangered at the time of their visit to the doctor. We know for a fact that in many cases the thought of suicide emerges within minutes or a few hours and is then carried out immediately. During this brief period, no further alternative to suicide is considered and help is no longer sought out (3,9). It is therefore mandatory that potential suicide tendencies be recognized before the patient has a chance to develop concrete plans or even before he is aware of the threat himself. Several pointers on diagnosis and explanations on exploratory techniques should assist in recognizing the threat of suicide, despite these difficulties.

Every depression, whether disguised or immediately recognizable, can mean a potential suicide threat, regardless of its etiology. Even in endogenous depression, which almost always involves thoughts of suicide, social and psychological factors can drive the patient to implementing his plans. Patients with endogenous depressions are particularly endangered when their depressions are especially severe, when they no longer feel sheltered in the family, when family members do not react adequately to the illness, and in patients coming from broken homes. In reactive depression, personal factors and environmental conditions almost always work together. Frequently, conflicts with another person or persons are involved. The danger is particularly pronounced in patients characterized by feelings of insecurity, tendency to self-observation, difficulty in establishing personal relationships, or lack of willpower, or whenever the conflict becomes so embedded in the patient that essential mainstays are on the verge of collapsing. This may be the case for instance when the patient feels unable to prevent the breakdown of his marriage, if an intimate romance is broken off by his partner, or if his social esteem or security is jeopardized. The same applies for addicts, especially alcoholics, a group with an extremely high suicide rate. These patients also tend to implement their suicidal intents once breaks become apparent in their social environment — usually as a result of their worsening addiction — or when this environment completely breaks asunder (8, 13).

The older the potential suicide victim is, the sooner he will successfully
commit suicide, particularly since he will be more thorough in carrying out the act. The danger is especially high in elderly people, particularly if they are lonely, if they have had a violent quarrel with their children, or if social problems arise. Acute illness can lead to panicky reactions and chronic disease can eventually intensify beyond the tolerance level. However, these factors alone are usually not sufficient reason to cause the elderly person to commit suicide. Many patients do not decompensate until the ‘transitional syndrome’ caused by cerebral circulatory disturbances considerably reduces their emotional reaction and resistance. These organically based psychological disturbances are only a slightly visible aspect of the overall state, but have a decisive effect. It is therefore imperative that the underlying disease be taken into consideration in the therapy plan.

Other potential suicide cases are patients suffering from severe hereditary or acquired defective states or chronic progressive diseases such as cancer, degenerative neural disease, etc. A higher risk is found in all marginal social groups, for instance convicts, divorced people, immigrant workers, and increasingly in the unemployed. These very general guidelines are of course not an adequate basis for the doctor to recognize suicide potential in individuals. Not every elderly patient who goes to the doctor with cardiac insufficiency or any other disease has suicidal intentions at the time. In order to recognize those who are endangered, a potential suicidal nature must be considered for every patient belonging to a high-risk group, and his situation must be clearly assessed. As a part of this assessment, the doctor must be informed of the social situation of the patient, he should not fail to notice significant conflicts, and should be able to judge whether the individual is capable of handling the situation he is confronted with. If, in the course of this examination, signs of problems are uncovered, the possibility of suicide must be considered until it can be completely dispelled. This also applies to cases in which suicidal tendencies are expressed openly. The saying ‘He who speaks of suicide will not commit it’ is simply untrue. The majority of those endangered announce their intentions either openly or indirectly before making the attempt.

As a rule, the subject of suicidal intentions must be discussed with patients suspected of wanting to commit suicide. This must be done, however, in a caring and understanding way. The appropriate therapeutic measures must of course follow. If the doctor proceeds in this manner, there is no danger of the patient first getting the idea of suicide after being asked about the subject. On the contrary, it has been our experience that most patients are quite thankful and relieved when they have the chance to talk about thoughts that are frightening to them. Another highly endangered group of patients must be mentioned: those who have already survived one suicide attempt. At least 20% of these repeat the attempt after a period of weeks or years (3). Both the acute treatment and longterm
therapy of these patients are still very poorly organized today.

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Summary

In the Federal Republic of Germany, it is necessary to justify the assertion that suicide prophylaxis is an important part of humane medical treatment and a humane society. Nearly all diseases and disturbances having psychological bearing are associated with suicide. The general practitioner, in particular, is in a position to recognize and treat these conditions at an early stage.

References

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