CASE REPORT

Oman Medical Journal [2016], Vol. 31, No. 5: 378-380

Surviving a Suicide Attempt

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ARTICLE INFO

Article history:
Received: 1 July 2015
Accepted: 28 January 2016

Online:
DOI 10.5001/omj.2016.74

Keywords:
Suicide; Mental Illness; Depression; Oman.

ABSTRACT

Suicide is a global phenomenon in all regions of the world affecting people of all age groups. It has detrimental consequences on patients, their families, and the community as a whole. There have been numerous risk factors described for suicide including mental illness, stressful life situations, loss of social support, and general despair. The association of suicide with Islam has not been extensively studied. The common impression from clinical practice is that being a practicing Muslim reduces the risk of suicide. Another factor associated with suicide is starting a patient on antidepressants. However, this has been questioned recently. This report describes a middle-aged man with depression and multiple social stressors who survived a serious suicide attempt. The discussion will focus on the factors that lead him to want to end his life and the impact of the assumed protective factors such as religious belief and family support on this act of self-harm. Such patients can be on the edge when there is an imbalance between risk factors (such as depression, insomnia, and psychosocial stressors) and protective factors (like religious affiliation and family support). All physicians are advised to assess the suicide risk thoroughly in patients with depression regardless of any presumed protective factor.

Suicide and deliberate self-harm are considered major concerns for health professionals, particularly for psychiatrists. Despite efforts to predict the risk of self-harm, the rate of suicide is increasing worldwide.[1] Various risk factors have been hypothesized to alert psychiatrists to the seriousness of suicidal ideation or plans including previous attempts, hopelessness, and insomnia.[2,3] On the other hand, religious affiliation and social support are considered protective factors.[4,5]

Suicide is under-reported in Arab and Islamic countries. One of the main contributing factors is that it is culturally unacceptable, and the families of the deceased do not report it to avoid shame and stigma.[6] Moreover, the legal system in these countries depends on written suicidal notes, and this is not commonly done. These countries are also less likely to report the identified cases to the World Health Organization (WHO).[7] Research about suicide is scarce in the Arab and Islamic world,[8] and this limits our understanding of the possible predisposing and precipitating factors.

Many rating scales are available for clinicians to assess the risk of suicide. However, these scales cannot predict suicide accurately, but they can provide an estimate of suicidal risk, which may help in patient management.[9]

Clinically, the threshold for intervention in patients presenting with thoughts or acts of self-harm should be low, and treatment of any underlying mental or medical illness needs to be vigorous.

CASE REPORT

A 52-year-old, retired man presented to the Accident and Emergency Department of his local hospital after wounding his neck with a knife with an intention to end his life. He was diagnosed with major depressive disorder three years before the attempt after he presented with depressed mood, insomnia, and multiple somatic complaints. His depressive episode was precipitated and maintained by financial problems and the stress of caring for his elderly father who was diagnosed with dementia. He responded well to treatment with mirtazapine 45 mg and was followed-up regularly for three years. He stopped attending the clinic and discontinued his medication two months before the attempt. He presented to the psychiatry clinic one month before the attempt complaining of a depressed mood, insomnia, helplessness, and coping difficulties. At that time, he denied any suicidal ideation or plan. He was restarted on mirtazapine and asked to attend an appointment two weeks later; however, he did not attend his appointment and discontinued his

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medication. During this period, his family observed that he was socially withdrawn and had insomnia.

One morning, he came back from dawn prayer and found his family sleeping. He drove to his farm located in a remote area. He used a knife to cut his throat and bled profusely. His wife found him in a critical condition. She took him to a local hospital where he underwent an emergency surgery, which included a tracheostomy. After recovering from surgery, he was reviewed at the psychiatry clinic and expressed that he was happy to survive the incident, but that he felt ashamed others knew about his suicide attempt and that he breached the religious beliefs on self-harming behavior.

DISCUSSION

In this case, the presence of insomnia, social stressors, and depression culminated in a serious suicide attempt. Despite the presence of several protective factors, like strong family support and living in a community where self-harm behavior is prohibited, these factors failed to prevent the suicide attempt in this patient. The psychosocial stressors most likely imposed an overwhelming effect and rendered the patient helpless.

Suicide has been poorly studied in Islamic countries, and there are religious sanctions against suicide in Islam. Suicide is illegal in several Islamic countries.[2] The stigma of suicide together with related cultural and religious factors lead to under-reporting of cases. Patients who commit suicide are often reported as accidental deaths.[10]

Suicide is referred to in the Quran (4:29) as *qatl-al-nafs* (self-murder) and *intihār* (cutting of the throat). The Quran is free of explicit thematic reference to suicide; however, it does contain verses where the term *qatl-nafs* appears. The Prophetic teachings forbid suicide and condemn the perpetrator to eternal retribution in the form of never-ending repetitions of the act and the anguish of the mode of suicide. Additionally, the Prophetic traditions not only prohibit suicide but also explicitly deter from wishing for death.[2] Abiding to these regulations plays an important role in reducing the suicidality among Muslims. Gal and his colleagues compared the suicide rate among Muslims and Jews.[10] He found the rate to be much lower in Muslims (3 in 100 000 compared to 8 in 100 000 in Jews). Nevertheless, suicidal ideation and plans may be translated into a serious suicidal attempt even with these prescriptions.

This case illustrates the interplay between risk and protective factors of suicidality. The patient was well for two years, and his depression was adequately treated. After stopping the treatment, his depression recurred. The gloomy ideation associated with depression and the preoccupation with hopelessness are known to trigger suicidal ideation and attempt.[4]

The classical teaching in psychiatry suggests increasing risk of suicide following treatment with an antidepressant. The accepted hypothesis for this assumption is the motivation and energy prompted by antidepressant treatment. However, there is no evidence to support this hypothesis and recent studies found no association between initiation of antidepressant treatment and suicidal ideation or act.[10–12]

CONCLUSION

This case illustrates that, despite having a strong religious affiliation, patients with mental illness can become helpless and hopeless and try to end their lives. Depressive illness, insomnia, and social stressors can trigger a person to attempt suicide despite knowing the consequences of their actions from a religious point of view. Mental health professionals should perform detailed risk assessment in patients with depression regardless of their religious beliefs.

Disclosure
The authors reported no conflicts of interest.

Acknowledgements
We thank the patient and his family for giving their consent to publish this report.

REFERENCES

1. Khan MM. Suicide on the Indian subcontinent. Crisis 2002;23(3):104-107.
2. Shah A, Chandia M. The relationship between suicide and Islam: a cross-national study. J Inj Violence Res 2010 Jun;2(2):93-97.
3. (US) O of the SG. (US) NAA for SP. National Strategy for Suicide Prevention Goals and Objectives for Action Summary List. [cited 2016 June 1]. Available from: http://www.ncbi.nlm.nih.gov/books/NBK109910/.
4. Wetzel RD. Hopelessness, depression, and suicide intent. Arch Gen Psychiatry 1976 Sep;33(9):1069-1073.
5. Li SX, Lam SP, Yu MW, Zhang J, Wing YK. Nocturnal sleep disturbances as a predictor of suicide attempts among psychiatric outpatients: a clinical, epidemiologic, prospective study. J Clin Psychiatry 2010 Nov;71(11):1440-1446.
6. Pritchard C, Amanullah S. An analysis of suicide and undetermined deaths in 17 predominantly Islamic countries

contrasted with the UK. Psychol Med 2007 Mar;37(3):421-430.

7. Khan MM. Suicide and attempted suicide in Pakistan. Crisis 1998;19(4):172-176.
8. Morad M, Merrick E, Schwarz A, Merrick J. A review of suicide behavior among Arab adolescents. ScientificWorldJournal 2005 Aug;5:674-679.
9. Cochrane-Brink KA, Lofchy JS, Sakinofsky I. Clinical rating scales in suicide risk assessment. Gen Hosp Psychiatry 2000 Nov-Dec;22(6):445-451.
10. Gal G, Goldberger N, Kabaha A, Haklai Z, Geraisy N, Gross R, et al. Suicidal behavior among Muslim Arabs in Israel. Soc Psychiatry Psychiatr Epidemiol 2012 Jan;47(1):11-17.
11. Simon GE, Savarino J, Operskalski B, Wang PS. Suicide risk during antidepressant treatment. Am J Psychiatry 2006 Jan;163(1):41-47.
12. Olfson M, Marcus SC, Shaffer D. Antidepressant drug therapy and suicide in severely depressed children and adults: A case-control study. Arch Gen Psychiatry 2006 Aug;63(8):865-872.