ORIGINAL ARTICLE UDC: 616.89-008.441.44:159.9.072.7

Psychological assessment of persons following suicide attempt by self-poisoning

Psihološka procena osoba posle pokušaja samoubistva trovanjem

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Abstract

Background/Aim. Urgent psychiatric help and effective psychotherapeutic treatments are required soon after revival of a person after suicide attempt by self-poisoning. The aim of this article was to define an assessment of actual psychological characteristics of a person after suicide attempt by self-poisoning in order to apply psychotherapeutic crisis intervention after suicide attempt, as well as to show an approach to the treatment guided by the assessment that uses a psychodynamic model of suicidal crisis intervention based on our clinical experience. **Methods.** Hamilton Depression Rating Scale (HAMD), Center for Epidemiological Studies-Depression Scale (CES-D), Defensive Questionnaire Scale (DSQ-40), Scaling of Life Events (Paykel), and Pierce Suicide Intent Scale (SIS) were applied in 30 hospitalized persons following suicide attempt by self-poisoning and in 30 patients who had asked for psychiatric examination at the outpatient clinic due to various life crises not resulting in suicide attempt. The examinees of both groups were matched by sex, age, and education, professional and marital status. Comparison of the patient groups was done by the t-test. Logistic regression analysis was used for suicidal risk assessment. **Results.** The suicide attempters were depressed (HAMD = 22.60 ± 5.93, CES-D = 29.67 ± 7.99), with medium suicide risk factor (SIS = 4.5 ± 4.17), using immature (projection, dissociation, devaluation, acting-out) and neurotic (altruism) defense mechanisms. The most important motives for suicide attempt were separation problems, problems with parents and a problem of loneliness. The commonest feelings and thoughts of a subject preceding suicide attempt were a wish to escape an unbearable situation, loss of control, desire to show love for a partner and wish to be helped. After a suicide attempt, 90% of the persons felt relief because the attempt failed, although almost half of them intend to repeat it. The risk of repeated suicide attempt was 1.8 (90% CI = 0.09–37.70, $p < 0.001$) times higher if values on the SIS Total Score were increased and 1.62 (90% CI = 0.03–81.39, $p < 0.001$) times higher if values on the SIS 1 (Circumstances Score) subscale were increased, too. **Conclusion.** Before starting with psychotherapy for persons after suicide attempt by self-poisoning it is very important to define psychological assessment of a person, choose the treatment (out-patient clinic or inpatient/hospital), assess indications for pharmacotherapy and psychotherapy that also must include a selection of patients for application of this therapeutic method. Assessment of conscientious and unconscientious conflicts leading to a suicide attempt represents initial basis for a therapist's work with a patient after suicide attempt and for application of psychotherapeutic crisis intervention.

Key words:
suicid, attempted; pharmaceutical preparations; poisoning; psychological tests; psychotherapy.

Apstrakt

Uvod/Cilj. Nakon povratka u život, osobi koja je pokušala samoubistvo trovanjem neophodno je pružiti neodložnu psihijatrijsku pomoć i efikasan psihoterapijski tretman. Cilj ovog rada bio je da se procene stvarne psihološke karakteristike osobe posle pokušaja samoubistva trovanjem u cilju primene odgovarajuće intervencije u psihičkoj krizi posle pokušaja samoubistva, kao i da se pokaže pristup lečenju primenom procene za koju se koristi psihodinamički model intervenisanja u krizi samoubistva na osnovu kliničkog iskustva. **Metode.** *Hamilton Depression Rating Scale* (HAMD), *Center for Epidemiological Studies-Depression Scale* (CES-D), *Defensive Questionnaire Scale* (DSQ-40), *Scaling of Life Events* (Paykel), i *Pierce Suicide Intent Scale* (SIS) primenjeni su kod 30 bolnički lečenih osoba i 30 osoba koje su zatražile psihijatrijsku pomoć ambulantno zbog različitih životnih kriza koje nisu dovele do pokušaja samoubistva. Grupe su bile upoređivane pomoću *t*-testa. Logistička regresiona analiza korišćena je za procenu suicidnog rizika. **Rezultati.** Osobe koje su pokušale samoubistvo ispoljavale su depresiju (HAMD

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= 22,60 ± 5,93, CES-D = 29,67 ± 7,99) sa suicidnim rizikom srednjeg stepena (SIS = 4,5 ± 4,17) i koristile su nezrele (projekcija, disocijacija, devalvacija i *acting-out*) i neurotske (altruizam) mehanizme odbrane. Najznačajni motivi pokušaja samoubistva bili su separacioni problemi, problemi sa partnerom i problem usamljenosti. Najčešća osećanja i misli koji su prethodili pokušaju samoubistva bili su želja da pobegnu iz nepodnošljive situacije, gubitak kontrole ili želja da pokažu partneru da ga vole ili potreba da dobiju pomoć od voljene osobe. Nakon pokušaja samoubistva, 90% osoba osećale su olakšanje što im pokušaj samoubistva nije uspeo, mada je skoro polovina nameravala da ga ponovi. Povišene vrednosti SIS (ukupni skor) povećavale su rizik od recidiva pokušaja samoubistva 1,8 puta (90% CI = 0,09–37,70, $p < 0,001$), a supskale SIS 1 (okolnosti za izvršenje suicida) 1,62 puta (90% CI= 0,03–81,39, $p < 0,001$). **Zaključak.** Pre početka psihoterapije osobe nakon pokušaja samoubistva veoma je važno izvršiti psihološku procenu, izbor lečenja (ambulantno, bolničko), proceniti indikacije za farmakoterapiju i psihoterapiju koja uključuje i procenu podobnosti bolesnika za primenu psihoterapijske intervencije u krizi sa psihodinamičkim pristupom. Procena svesnih i nesvesnih konflikata koji dovode do pokušaja samoubistva, kao i procena psiholoških karakteristika osobe nakon pokušaja samoubistva trovanjem predstavljaju početnu osnovu za psihoterapijski rad sa bolesnikom koji je pokušao samoubistvo i za primenu psihoterapijske intervencije u krizi nakon pokušaja samoubistva.

Ključne reči:
samoubistvo, pokušaj, lekovi; trovanje; psihološki testovi; psihoterapija.

Introduction

Although there are possible ways of identification of people in need of psychotherapeutic intervention following suicide attempt, it is necessary to define a psychological assessment of suicide attempters in order to determine an immediate disposition, intensity of treatment and the level of care to target areas of vulnerability and thereby help the individuals to reduce the risk of repeated suicidal behavior [1–4]. An urgent psychiatric help and effective psychotherapeutic treatment soon after revival of a person after suicide attempt are required [5, 6].

The fear of stigmatization is associated with rendering psychiatric help to persons after suicide attempt; it can be seen that psychotherapeutic crisis intervention applied in patients after suicide attempt during their hospitalization is their only contact with a psychiatrist [7]. It suggests, unfortunately, that rendering psychiatric help during their hospitalization is, in fact, of greatest importance.

Before starting with psychotherapy for persons after suicide attempt it is very important to define the psychological assessment of a person, choose a treatment (outpatient clinic or inpatient/hospital), assess indications for pharmacotherapy and psychotherapy that also include selection of patients for application of this therapeutic method [8–10].

The aim of this article was to define an assessment of actual psychological characteristics of a person after suicide attempt by self-poisoning in order to apply psychotherapeutic crisis intervention after suicide attempt, as well as to show an approach to the treatment guided by the assessment that uses a psychodynamic model of suicidal crisis intervention based on our clinical experience.

Methods

The study was carried out on the group of 30 subjects (24 females and 6 males) who were, after suicide attempt (93.3% of them with tablets, 6.7% with corrosive agents) hospitalized in the National Poison Control Center, Clinic of Emergency and Clinical Toxicology of the Military Medical Academy (MMA) in Belgrade. The study included only the patients who had met the patients' selection criteria for application of the psychotherapeutic crisis intervention. So, the study excluded patients with diagnosis from F 00 to F 09, F 10 to F 19 (except F1x.0), F 20 to F 29 and F 30 to F 31 and F 32.3 satisfying ICD 10 (World Health Organization criteria) [11].

The control group consisted of 30 patients (24 females and 6 males) who asked for psychiatric examination at the outpatient clinic due to various life crises not resulting in suicide attempt.

The examinees of both groups were matched by sex, age, education, professional and marital status.

In analysing quantitative characteristics of suicide attempt the following methods were used for both groups of examinees: the Sociodemographic Questionnaire and Psychological Tests – HAMD (Hamilton Depression Rating Scale), CES-D (Center for Epidemiological Studies-Depression Scale), DSQ-40 (Defensive Style Questionnaire) and the Scaling of Life Events (Paykel), but for the persons who attempted suicide Pierce Suicide Intent Scale (SIS) was used, as well.

The Sociodemographic Questionnaire included basic data on the patients of both groups: age, years of schooling, marital and professional status. For the patients who had attempted suicide the obtained data included the way of the suicide attempt, characteristics of its plan and then the psychiatrist gave a recommendation for further treatment. The patients encircled all motives of their suicide attempt, feelings and thoughts preceding suicide attempt and after the suicide attempt on the basis of the offered answers most often obtained from interviews with the patients after suicide attempt.

The Hamilton Depression Rating Scale (HAMD) is used for quantification of a symptom intensity in patients with diagnosed depression after clinical and pharmacologic examinations, as well as during routine practice. The basic characteristics of the scale are that it is not too long, it covers the most important symptoms for assessment of depression, it is reliable when used by two examiners and there is a high

correlation with other common scales for assessment of depressiveness. The original version with 21 items was used in our study [12].

The Center for Epidemiological Studies-Depression Scale (CES-D) is a brief questionnaire that assesses frequency and duration of symptoms associated with depression. It should not be viewed as a diagnostic tool, but rather as screening tests to identify individuals or groups at risk for depression. The S scale consists of 20 items by which the incidence and duration of depressive symptoms in the course of the preceding week are assessed. It is a self-rating scale including all principal components of depression having, therefore, identification of depression as its goal. This scale is used for general adolescent and adult population both at outpatient clinics and clinics. It has 4 degrees (0-rarely or never, up to 4-mostly or all the time). A total score is 0 to 60, but items 4, 8, 12 and 16 are not to be added. A score up to 16 points out a milder degree of depression, from l7 to 22 moderate degree and over 22 serious degree of depression [13].

The Defensive Style Questionnaire (DSQ-40) consists of 40 statements about personal attitudes. It is a self-rating scale including 20 defensive mechanisms, two questions for each. There are 8 questions for mature and neurotic defensive mechanisms and 24 questions for immature ones. By using a 9-number scale each examinee is requested to sign whether he/she agrees or not with the presented statements. A defensive mechanism represents a score of a total of all items of the same set, that is, a score of each defensive mechanism is counted as an average of the item answers which makes that defensive mechanism [14].

The Scaling of Life Events (Paykel) consists of 61 items and stressfulness of each event is evaluated from 0 to 20. Events are ranged so that catastrophic and upsetting ones are on the top of the scale (death of a child), while favorable and trivial (child's marriage agreed by parents) are on the bottom. They are also ranged on the basis of mean score values of some events covering the entire scale. The scale is sensitive and therefore reliable in the follow-up of individual differences and among some psychopathologic groups. It is filled in by ticking the most important event happened in relation with the suicide attempt [15].

The Pierce Suicide Intent Scale (SIS) is a scale for assessment of a suicidal risk and seriousness of a patient's intention to die. It is important for diagnosis and prevention of the risk and it is a useful method, but not a replacement for clinical assessment. The scale consists of 12 items divided into three segments: SIS 1 (Circumstances Score), SIS 2 (Self-Report Score) and SIS 3 (Medical Risk Score). A total score is a sum of all three subscales, (a total score 0–3 = Low Intent; 4–10 = Medium Intent; more than 10 = High Intent) [16].

Analysis of qualitative characteristics of the suicide attempters by self-poisoning was presented by vignettes in which we showed feelings that subjects had been flooded with, both before and after the suicide attempt.

The statistical data processing was carried out by SPSS (Statistical Package for the Social Science version 10 for age Windows (SPSS Inc. 2000).

Frequency (f), mean value ($\bar{x}$) and standard deviation (SD) were calculated for each variable. Comparison of the patient groups was done by the t-test. Logistic regression analysis was used for suicidal risk assessment.

Results

The patients after suicide attempt treated at the Clinic of Emergency and Clinical Toxicology of the MMA (aged 15–57 years, 28.20 ± 12.46, on average) had 10.60 ± 3.06 years of schooling, on average, while the examinees from the control group (aged 15–55 years, 30.03 + 12.78, on average) had 12.33 ± 2.31 years of schooling, on average. Between these two groups of examinees there were no statistically significant differences either in their age ($p > 0.l$), or in years of schooling ($p > 0.l$). Most of the subjects who attempted suicides were permanently employed some of them only temporarily, some were students or secondary school pupils and there were no retired persons in the groups. With regard to marital status, most of the examinees in both groups were single, while the number of divorced ones was identical. Also, there were no statistically significant differences with regard to employment ($p > 0.5$) and marital status ($p > 0.5$).

Table 1 shows motives for suicide attempt, commonest feelings and thoughts of a subject preceding the suicide attempt and after it.

A half of the subjects attempted suicide because of problems with a partner and subsequent problems of loneliness. Problems with parents or due to being left by a partner were present in about one quarter of the subjects, problems with establishment of interpersonal relations in less than one fifth, and those related with losing a job in less than 10% of the subjects.

Commonest feelings and thoughts of a subject preceding suicide attempt were in more than 3/4 of them a wish to escape from an unbearable situation, in 1/2 of them a loss of self-control and in 1/3 a wish to show the partner how much they loved him/her or need to be helped by someone. More than one quarter of the examinees cited the presence of "unbearable" thoughts or wish to show someone else their despair or wish to die. Less than one quarter had a desire to alleviate problems of other people or they had taken tablets wanting to sleep. One fifth of them cited a wish to see who really cared of them, and less than one fifth a wish to convince someone to change opinion about them. The least frequently cited was a wish to make close environment feel guilty or to punish it for what it had done to the attempter.

After suicide attempt, 90% of the persons felt a relief because it had failed, while almost half of them intend to repeat it.

In Table 2 the Scaling of Life Events is presented. The subjects who had attempted suicide most frequently cited quarrels with their parents and similarly frequent were marital quarrels and emotional break off. The control group examinees firstly cited more frequent quarrels with a fiancé (boyfriend), change of school and, finally, financial problems. Between these two groups of examinees there was not a statistically significant difference ($p > 0.1$).

Table 1

Distribution of suicide attempters regarding commonest motives, feelings and thoughts preceding and after suicide attempt

Motives and feelings of suicide attempters	% of suicide attempters
Motives of suicide attempt	
problems with a partner	50
problems of loneliness	40
problems with parents	26.7
left by the partner	23.3
problems with interpersonal relationship establishment	16.7
unemployment or lost job	6.7
Feelings and thoughts preceding suicide attempt	
wish to escape from the unbearable situation	76.7
loss of self-control	50
desire to show love for partner	30
wish to be helped	30
presence of unbearable thoughts	26.7
desire to show despair	26.7
wish to die	26.7
wish just to sleep a little	23.3
wish to make things easier for other people	23.3
wish to see who really cares for him/her	20
wish to convince environment to change opinion about him/her	16.7
wish to make other people feel guilty	10
wish to punish other people for what they have done to him/her	6.7
Feelings after suicide attempt	
relief because of the failed suicide attempt	90
belief that a suicide attempt will influence upon other behavioral changes	10
intention to repeat suicide attempt	46.7

Table 2

Scaling of Life Events in suicide attempters

Rank	Life Events	Suicide attempters	Controls
7	Unsuccessful business	3.3	
9	Spontaneous abortion	3.3	
11	Separation of spouses because of quarrels	3.3	6.7
14	Hospitalization of a family member	3.3	6.7
22	Failed education	3.3	3.3
24	Broken engagement	3.3	
25	Rather frequent quarrels with the spouse	13.3	6.7
26	Rather frequent quarrels with parents	30	
27	Rather frequent quarrels with fiancé (boyfriend)	6.7	26.7
34	Not very serious financial problem	3.3	13.3
38	Change of working hours		3.3
42	Change of job		6.7
43	Interrupted going out on dates with a boyfriend	10	
44	Movement to another town	3.3	
45	Interrupted regular schooling		26.7
46	The child left home	3.3	
47	The child left school	3.3	
51	Pregnancy	3.3	
58	Child's engagement	3.3	

In Table 3 psychological assessment of depression, defensive mechanisms and assessment of the suicidal risk in the persons after suicide attempt are shown.

A total HAMD score showed moderately serious depression in the subjects after suicide attempt and a mild form in the control group of examinees. In comparison with the latter group, the persons who attempted suicide showed higher values in the total score on the HAMD scale and in all other subscales except in the scale of retardation. Between these two groups of examinees there was a high statistically significant difference in the total score and loss of weight ($p < 0.005$), anxiety and insomnia ($p < 0.05$) and cognition factor ($p < 0.01$). A statistical significance for retardation and diurnal variations was lower ($p < 0.1$).

A total CES-D score suggested serious depression in both groups of examinees. Unlike a previous scale, CES-D scale did not show statistically significant differences between the examinees of both groups.

Table 3

Depression, defensive mechanisms, suicidal risk in the persons after suicide attempt

Sociodemographic Questionnaire and Psychological Tests	Suicide attempters		Controls		*p*
	x̄	SD	x̄	SD	
HAMD					
Anxiety	6.40	1.97	3.13	1.41	< 0.05
Loss of weight	1.40	1.00	0.70	0.65	< 0.005
Diurnal variations	1.53	0.62	0.37	0.49	< 0.1
Cognitive disorder	5.23	2.22	2.80	1.24	< 0.01
Retardation	5.27	3.06	5.63	2.12	< 0.1
Insomnia	2.80	1.88	1.30	1.12	< 0.05
Total score	22.60	5.93	10.23	2.66	< 0.005
CES-D	29.67	7.99	28.83	9.04	
Mature defenses					
Humor	6.68	1.78	6.31	2.05	
Anticipation	5.38	2.19	6.10	2.26	
Suppression	5.78	2.31	6.51	2.10	
Sublimation	6.65	3.23	6.03	2.14	
Neurotic defenses					
Altruism	6.58	2.38	6.26	1.65	< 0.05
Reaction formation	5.93	2.03	4.13	1.87	
Undoing	4.81	2.71	4.18	2.14	
Idealization	5.46	2.55	4.85	2.41	
Immature defenses					
Fantasy	5.75	2.86	4.03	2.32	
Projection	4.75	2.36	2.93	1.70	< 0.01
Dissociation	5.11	2.58	4.50	1.99	< 0.05
Somatisation	5.56	2.74	4.83	2.24	
Rationalization	6.38	2.23	5.76	2.13	
Replacement	2.91	1.97	3.40	1.85	
Withdrawal	5.41	2.83	5.23	2.45	
Acting-out	6.15	2.51	5.76	2.02	< 0.1
Devaluation	5.93	2.27	5.31	1.80	< 0.1
Denial	5.60	2.14	4.40	2.18	
Passive-aggression	5.35	2.14	4.51	2.02	
Splitting	6.31	1.89	5.18	1.86	
Suicidal risk					
SIS1	2.50	2.63			
SIS2	2.00	2.19			
SIS3	0.00	0.00			
SIS	4.50	4.16			

HAMD (Hamilton Depression Rating Scale); CES-D (Center for Epidemiological Studies-Depression Scale); SIS (Total Score); SIS1 (Circumstances Score); SIS2 (Self-Report Score); SIS3 (Medical Risk Score)

In comparison with the control group suicide attempters had higher values for defensive mechanisms, except for anticipation, suppression and replacement. Between the group of attempters and the control group examinees there was a highly statistically significant difference for projection ($p < 0.01$), dissociation and altruism ($p < 0.05$), devaluation and acting-out ($p < 0.l$). At the same time there were no statistically significant differences for the groups of mature, immature and neurotic defensive mechanisms between both groups of the examinees.

A total score on the SIS scale was of moderate degree (4.5 ± 4.16).

Table 4 presents assessment of the risk factor of the repeated suicide attempt. The risk of the repeated suicide attempt was 1.8 (90% CI = 0.09–37.70; $p < 0.001$) times higher if values in the SIS Total Score were increased and 1.62 (90% CI = 0.03 – 81.39; $p < 0.001$) times higher if values on the SIS 1 (Circumstances Score) subscale were increased, too.

Table 4

Assessment of risk factors of the repeated suicide attempt

Variable	OR	CI 95%	*p*
Mature defenses	0.84	0.19–3.74	0.001
Immature defenses	0.78	0.45–1.39	0.001
Neurotic defenses	1.64	0.39–6.82	0.001
The Scaling Of Life Events	0.90	0.59–1.37	0.001
HAMD Total score	0.22	0.01–9.48	0.001
CES-D	1.22	0.78–1.89	0.001
SIS Total Score	1.79	0.09–37.70	0.001
Circumstances Score (SIS 1)	1.62	0.03–81.39	0.001

HAMD (Hamilton Depression Rating Scale); CES-D (Center for Epidemiological Studies-Depression Scale); SIS (Pierce Suicide Intent Scale) OR – Odds ratio; CI – Confindence Interval

Discussion

In this study we presented psychological assessment of the persons after suicide attempt mostly by drugs and by corrosive agents. A battery of chosen instruments was used in order to compare the group of persons who attempted suicide with the control group of patients who came to outpatient clinic for psychiatric consultation because of various forms of life crisis not resulting in the suicide attempt. The examinees of both groups were matched by sex, age, and education, professional and marital status.

The most important motives for suicide attempt are separation problems, problems with parents and problem of loneliness. A suicidal person needs a relationship with an object out of himself/herself; an essential link that enables and protects such relationship is a feeling of love. Between he/she as a subject and an object of love, always and unavoidably there are two components: separation and fusion. Although separation is often greater and more important, love is an essential bond by which a suicidal person establishes and maintains a relationship between himself/herself as a subject and an object important for her/him. In narcissistic dimension, love is a relationship with a person similar to himself/herself, which is important for cohesion and integration of self and for self-preservation representing, in this way, a condition for normal life. However, if this does not exist, a subject becomes "single" in emotional relationship [17].

Development of self-destruction could be an expression of a developmental conflict emerged at the surface and associated with a latent chronic pathologic dynamics in the family system. It could also be an expression of a characteristic of a person who grew up in his/her early developmental period within a dysfunctional family in which the process of adaptation during his/her developmental period could not be established for a long time. In young people, development of destruction is always interpreted in the background of specific developmental phases during puberty and adolescence [18]. Suicidal risk assessment is related to the conflict level, structural development and relations within the family. On the cognitive level, the quality of relations with parents, a person in crisis assesses as bad ones; parents consider them problematic because they cannot control his/her behavior [19]. The roots of this crisis lie deeply in quality attachment during the oral phase of development characterized by ambivalent relationship with important figures, primarily the mother and are important in development of depression in later life [20].

Suicide is a result of a long reflection and a sudden decision. Persons in crisis bear tension with difficulty and at one moment, which they describe as a "hot head", "wish for a change because they are fed up with everything" they feel that they have to get rid of tension because they cannot bear it. This is a reason of their taking tablets for sedation. They take sedatives one by one convinced that they can "control" taking, and then, at one moment, they stop counting. Persons who attempted suicide by self-poisoning most often say that they did it because of unbearable feelings and thoughts they wanted to escape from, unbearable situation at that very moment or that they had lost self-control. When inundating fears are present, feeling of an internal restrain is broken and can result in some sort of action including suicide. In acting-out it seems as if emotions do not "work" together with thinking. Or only emotions are present and persons in crisis react impulsively, without thinking. Or when thinking it seems that "acts" are not followed by emotions. Suicide can also be a "way" of "communication" with environment (partner, parents) hoping that they will help in overcoming the crisis or "may" show them his/her love and despair. It has been written about mother's reverie function and containment as ways for detoxication of the baby's primitive experience [21]. When this is missing either because mother is unavailable or the baby is not capable to benefit from mother's capability, then, instead of development of internal safety feeling, the baby retains fundamental anxiety and inclination to strongly react when unsafe. As if transformation of these fantasies into action results in the feeling of releasing Self from the dangerous world. It is better outside than inside and unbearable situation threatening Self is then out of it and safe.

Wanting to make a "break" in their life, suicide attempt may be a result of wish "not to be here" because for persons in crisis the offered reality is unacceptable and death is considered as a temporary pleasant status which, at least, for a while, releases accumulated tensions. A problem in cognitive segment of thinking is solved by the need to stop everything in only one moment in which they "only want to fall asleep", "to be calm just till tomorrow", or to find in themselves "additional preserved strength, to relax, have a rest" believing that after awakening it will be as it was "before". However, a need for change may also appear as a wish to disappear forever.

In favor of the mentioned also speaks the presence of defensive mechanisms: projection, dissociation, devaluation and acting-out of all those from the group of immature defensive mechanisms. Orienting heteroaggression through projection to the "culprit" of the suicide attempt, feeling worthless, these persons solve the conflict through acting-out in a dissociative condition when he/she separates feelings from conscientious segment of personality and easily transfer one to the other state of consciousness [8]. Yet, the presence of altruism shows that they cherish hope in good intentions of other people who will help them to overcome actual crisis [21]. Actual traumatization blocks person's capability to experience feelings and intensive anxiety end helplessness inhibit mental activities. Denial is an omnipotent annulment of reality in which a person does not have a contact with actual reality. External reality exists, but an attempter denies it. Denial and regression belong to the group of immature defensive mechanisms and they refer to primitive defensive activity of Ego, which competes with reality causing anxiety. The ego is protected by denial against thoughts the person cannot cope with. While, on one hand, it protects a person against anxiety and pain, on the other hand it requires additional energy investment. Therefore, other defensive mechanisms are used with the aim to protect a person against inaccessible feelings that can endanger him/her if they get through from

unconsciousness to consciousness. Denial is aimed at avoiding refacing with painful affects.

Some persons after suicide attempt were accommodated to intensive care rooms at the Clinic of Emergency and Clinical Toxicology where they were intubated and put on respirator. When they were later removed to "common" patient rooms among other patients, they seemed as if not considered as patients, particularly the serious ones, but the ones with least endangered life since, in fact, some of them were healthy a day or two ago as it was about some other persons.

The greatest number of persons attempted suicide because of separation and interpersonal problems with the parents or partners, problems that on the Scaling of Life Events are not objectively highly ranged (about 30) but they subjectively cause depressive feeling shown with increased CES-D scale values. Patients after suicide attempt express a serious degree depression diagnosed by the self-assessment test (CES-D), but according to objective examiner's assessment (HAMD) it is a moderate degree depression (total score from l7 to 24, determines moderate depression, and these patients are treated in out-patient clinics). This difference between objective psychiatrist's and subjective examinee's evaluation of both groups can be explained by a difference in subjective experience of depression which is for both groups of examinees a new and unpleasant life experience being *per se*, very intensive. On the other hand, an experienced psychiatrist evaluates such feelings of his patient objectively, graduating them with lower degrees [23]. So, it is very important to combine pharmacotherapy and psychotherapy in patients after they attempted suicide.

Suicidal risk in patients after suicide attempt is of moderate degree. There is a difference in assessment whether somebody has taken several sedatives from a bottle knowing that spouse/mother will come home soon, or has poured in the hand all drugs found at home; whether tablets have been taken in an isolated place where they could hardly or even impossibly be found, or in the presence of all people, or in the neighboring room with the door left ajar.

Even though motives of a suicide attempt are related to the feeling of inability to bear unbearable situation, loss of self-control or need to be helped by a person they are in emotional relationship, 90% of patients feel relieved because of the failed suicide, as if their unbearable feelings preceding suicide attempt were wiped out. One patient poetically said: "When I woke up I saw the light. I was happy. God help me! So let the light be, and new life, new life with old people". In most of them there was the presence of a feeling of guilt associated with the feeling of helplessness. A female patient said: "If I was asked, I would never do it again. I have never taken even a tablet for a headache. I have never taken drugs before". Another patient said: "Now, I have made a fool of myself. I have done it now and never again". Feeling of shame due to what was done is also present together with the need to conceal the truth from close persons: "I have never intended to kill myself before. I will hide from everybody I have done this. I will tell everybody that I was in a hospital for the problems with the heart. I do not want to discover that I have done such stupidity. Now, everybody will tell me they are disappointed in me". Some attempters believe that their behavior and act of suicide attempt hurt those who loved them. "I am sorry, I should not have done it because of him". Yet, almost one half of attempters stated intention to repeat suicide. "Even today I stick to my decision to kill myself. When I woke up I wanted to scream, howl because I did not manage to kill myself" [24].

Conclusion

Suicide attempters are depressed with medium suicide risk factor, use immature (projection, dissociation, devaluation, acting-out) and neurotic (altruism) defense mechanisms. Most important motives for suicide attempt are separation problems, problems with parents and a problem of loneliness. Commonest feelings and thoughts of a subject preceding suicide attempt are a wish to escape from unbearable situation, loss of control, desire to show love for a partner and wish to be helped. After a suicide attempt, 90% of persons feel relief because the attempt failed, while almost half of them intend to repeat it. Risk of the repeated suicide attempt is higher if values in the SIS Total Score are increased and if values in the SIS 1 subscale are increased, too.

Before starting with psychotherapy for persons after a suicide attempt by self-poisoning it is very important to define a choice of the treatment (outpatient clinic or inpatient/hospital), assess indications for pharmacotherapy and psychotherapy, as well as to select patients for application of this therapeutic method. Psychological assessment of a person and assessment of conscientious and unconscientious conflicts leading to a suicide attempt represent an initial basis for the therapist's work with a patient after a suicide attempt and for application of psychotherapeutic crisis intervention.

Urgent psychiatric help soon after revival of a person after a suicide attempt helps individuals to reduce the risk of repeated suicidal behavior. If crisis remains unrecognized, it can be a risk factor of repeated suicide attempt. So, we must pay a special attention to persons after a suicide attempt when the values in the SIS and SIS1 subscale are increased.

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The paper received on February 17, 2009.
Accepted on June 11, 2009.