Dissociative phenomena in attempted suicide
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Introduction
Suicide is not actively encouraged by any group or belief system, whether highly religious or not. Even in nonreligious nations where suicide is considered as a moral and viable option, it is perceived as an abnormality (Dervic et al., 2004). Until recently, suicide attempts were punishable by both religious and criminal law in Western and Islamic countries. Criminal penalties for attempting suicide were eliminated across Europe, but still many governments prohibit anyone from assisting a person to put an end to their lives (Khan and Prince, 2003).

United Arab Emirates (UAE) has low rates of suicide as one of the Islamic countries (Bertolote and Fleischmann, 2002). The UAE law deals with suicide and suicide attempts as prohibited acts, and this may play a role in controlling the phenomena within the community. Individuals who try to put an end to their lives are treated as suspects. A person who attempts to commit suicide but fails to do so for any reason will be prosecuted for murder trial. Under Article 335 of the UAE Federal Penal Law, a suspect who attempted suicide faces a punishment of 6 months in prison and/or a fine. Expatriates will be sent back home with permanent job loss in UAE. Hence, most of the individuals involved in attempted suicide cases are admitted to the hospitals under direct police supervision with restricted mobility. Throughout the time, these patients are under medical care and their cases are simultaneously under psychiatric consultation.

Background
Dissociation may play a role in forgetting the events during self-inflicted behaviors and suicidal trials.

Objective
A trial was conducted to investigate the presence of dissociative phenomena among people attempting suicide.

Participants and methods
A convenient sample of 77 suicide attempters who joined the study (Group 1) was admitted to ‘Sharjah Kuwaiti Hospital’ in 2007 under police supervision. These patients reported forgetting the details of the suicidal trial, and hence they were referred for psychiatric consultation. Only fully conscious patients with clear sensorium who gave consent were included. Clinical assessment of Group 1 included SCID to diagnose patients according to Diagnostic and Statistical Manual of Mental Disorders. 4th ed (DSM-IV). Psychometric assessment for patients was performed using the Questionnaire of Experience of Dissociation (QED) and the Dissociative Experience Scale (DES) for dissociative phenomena, the analysis of their response to a direct question about suicidal ideation in item 9 of the Beck Depression Inventory as the suicidal index and the assessment of the degree of hopelessness using the Hopelessness Scale (HS). A matching control group of 50 volunteers with ‘no psychiatric disorder’ from the general population (Group 2) was included in the study for comparison.

Results
Although 29 (37.66%) of the suicidal attempters in Group 1 had no psychiatric diagnosis, 48 (62.34%) had psychiatric diagnosis and three of them had both Axis I and Axis II DSM-IV diagnoses. MDD was the most prevalent diagnosis among these diagnoses [22 (59.46%)]. Results showed significantly high scores ($P = 0.0001$) of QED, DES, and HS in the study group (Group 1) compared with the control group (Group 2). A highly significant difference was found in the mean score of dissociative scales, QED ($P = 0.0040$) and DES ($P < 0.0001$), between attempters with and without psychiatric diagnosis, but not in the mean scores of HS ($P = 0.7640$). A statistically significant difference was found between the method used in the suicidal attempt and the mean scores of HS ($P = 0.0060$) and DES ($P = 0.0001$), but not QED ($P = 0.4755$).

Conclusion
Suicidal attempters have a high prevalence of dissociative phenomena. The presence of psychiatric diagnosis and not the method used in suicide may play a role in increasing the suicidal intent.

Keywords:
dissociation, hopelessness, suicidal attempt, suicidal ideation

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investigation by police officers. Liaison psychiatric consultation is part of the medical assessment of these cases, especially when persons have problems in remembering the detailed events of the suicidal trial. Along the years, interviewing these patients revealed that most of them do not give enough information either about the events preceding the act or about the steps of the procedure, and mention that they simply ‘do not remember’. These answers are received by police officers as malingering, in a trial to escape responsibility of the act and hence its legal consequences. However, as mentioned in the psychiatric literature, dissociation may play a role in forgetting the events during self-inflicted behaviors (Sadock et al., 2009).

As a continuation to the previous retrospective study of suicidal phenomena in Northern emirates in UAE (Roshdi and Fakhry, 2004), the work in this prospective case control study is a trial to investigate the prevalence of dissociative phenomena among suicidal attempters who forget details of their attempt and to find the relation between suicidal ideation (SI) or hopelessness and the presence of dissociation.

Participants and methods

Study design

This prospective case control study was performed in the outpatient clinics of the only ‘Psychiatric Department’ in government general hospitals in ‘Sharjah Medical District’ in UAE, located in ‘Sharjah Kuwaiti Hospital’. For comparison, a group of 50 healthy volunteers above 18 years of age from both sexes were included in the study as the control group (Group 2). These control cases were selected from employees in the Kuwaiti Hospital and relatives or friends of nonpsychiatric patients attending in the hospital waiting area with no psychiatric illness (on the basis of the Present Mental State examination) and a negative history of psychiatric illness or treatment and suicidal attempts and no family history of a first-degree relative with psychiatric illness, suicide, or suicidal attempt; all participants were included after obtaining their consent for participating in the study.

Ethical consideration

Ethical approval for the study was granted by the Ethics Research Committee of the Sharjah Kuwaiti Hospital, where patients were selected. An informed consent was obtained from all patients, after being informed in detail about the study and about what they were asked to do. Patients were assured about the confidentiality of information and that participation in the study was completely voluntary and they had the freedom to withdraw from the assessment at any time. Patients joining the study who were diagnosed as having major psychiatric disorder (according to DSM-IV) continued psychiatric treatment and follow-up in the psychiatric clinic even after the research ended (for ethical reasons).

Procedures

Participants’ assessment included the following:

(1) A Clinical Psychiatric Interview was carried out by a consultant psychiatrist to all participants using SCID to diagnose patients in Group 1 according to DSM-IV criteria (American Psychiatric Association, 1994) and to include only members with ‘no psychiatric disorder’ in Group 2.

(2) Psychometric assessment of cases in both groups (Groups 1 and 2) was carried out using the following tools:

(a) For the prevalence of dissociative phenomena, the Dissociative Experience Scale (DES)

Participants and methods

All patients referred to the Psychiatric clinic in ‘Sharjah Kuwaiti Hospital’ in the year 2007 for ‘Psychiatric Consultation’ after a suicidal attempt, who reported forgetting detailed events, and who fulfilled the inclusion and exclusion criteria were registered to be recruited in the study as a convenient sample (Group 1), when they were fully conscious and with clear sensorium as denoted by the treating team of Medical and Neurology Consultants. Inclusion of delirious patients was postponed till they regained their full clear consciousness to be able to give consent and cooperate in the psychometric assessment. Patients above 18 years of age were included after obtaining their consent, irrespective to their sex, nationality, or the method they used in their suicidal attempt.

In the year 2007, 94 patients who had attempted suicide and were unable to recollect details of the procedure and its sequelae were referred to the Psychiatric Department in Sharjah Kuwaiti Hospital for psychiatric consultation. Seventeen of them were excluded from the study because 15 of them did not give consent and two Asians had language barrier interfering with their psychometric assessment. Among the 15 who refused to give consent 3 fell from height (1 UAE woman, 1 Syrian woman, and 1 Asian man) and the other 12 attempters used drug overdose (2 men (from UAE) and 10 women (six UAE, one Palestinian, one Iraqi, one Egyptian, and one Asian). Those with language barrier included one man who cut his wrist and one woman fell from a height. Finally, Group 1 included only 77 patients.
(Bernstein and Putnam, 1986) and the Questionnaire of Experience of Dissociation (QED) (Riley, 1988) were applied. The two instruments are used to assess dissociative tendencies.

The DES was developed by Bernstein and Putnam in the mid-1980s. It consists of a 28-item self-reporting questionnaire probing amnesias, identity alteration, depersonalization/derealization, and absorption. The total score ranges from 0 to 100. Individuals are asked to make slashes on 100-mm lines to indicate where they fall on a continuum for each question. The DES is not a diagnostic instrument. It is rather a screening test for major dissociative psychopathology. Scores of 25–30 are usually considered as suggestive of the presence of dissociation. The higher the score, the more it is indicative of pathological dissociation.

The QED was developed by Riley (1988) as another self-administered questionnaire intended for screening purposes and psychometric studies. The scale is formed of 26 true/false items. The questionnaire demonstrated good reliability and validity in studying dissociative phenomena. Similar to DES, QED is not a diagnostic instrument, but is rather a screening tool for the presence of dissociation. High scores are indicative of pathological dissociation.

(b) SI measurement was performed using the analysis of their response to direct questions about SI in item 9 of the Beck Depression Inventory covering the previous 2 weeks (Beck et al., 1961). The first response (SI-1 scoring 0) demonstrated nonideators, whereas other responses denoted ideators with the severity graded as mild (SI-2 scoring 1), moderate (SI-3 scoring 2), and severe or serious ideation (SI-4 scoring 3) (Casey et al., 2006).

(c) Assessment of the degree of hopelessness using the Hopelessness Scale (HS), which is considered as a powerful predictor of eventual suicide helping the measurement of three major aspects of hopelessness: feelings about the future, loss of motivation, and expectations. It consists of 20 true or false items, wherein patients can either endorse a pessimistic statement or deny an optimistic statement. Scores are considered normal (0–5), mild (6–10), moderate (11–15), and severe (16–20) (Beck et al., 1974).

Translated and back-translated forms of all questionnaires (DES, QED, SI, and HS) were used to allow easy administration to the Arabic-speaking patients studied.

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### Statistical analysis

Data collected were reviewed, coded, and analyzed using statistical package for social science version 11 (SPSS Inc., Chicago, Illinois, USA). Numerical data were presented as mean and SD values. Categorical data were presented as frequencies and percentages. Comparison between groups was performed using the $\chi^2$-test with correction for the eventual small numbers. The $P$ value was presented and the threshold of significance was fixed at the 5% level. The Kruskal–Wallis test was used to compare different categories of SI regarding age, HS, DES, and QED.

### Results

Comparison the mean age in Group 1 (30.455 ± 9.702) with the mean age in Group 2 (32.500 ± 10.632) revealed a statistically nonsignificant difference ($P = 0.266$). Other demographic characteristics of the study sample are summarized in Table 1, denoting statistically nonsignificant differences. More than half the sample (43; 55.84%) attempted suicide by drug overdose, and the highest frequency for suicidal attempts was equally distributed as 11 (14.28%) in April and May (Table 2). However, 29 (37.66%) patients in Group 1 had No DSM-IV Psychiatric Diagnosis, 48 (62.34%) had DSM-IV Diagnosis, 34 patients had only Axis I diagnosis, 11 patients had only Axis II Diagnosis, and three patients had both Axis I and Axis II diagnoses together. The distribution of Axis I and Axis II diagnoses is shown in Figs 1 and 2 consecutively. Study results in Table 3 showed statistically significant high scores ($P < 0.0001$) of QED, DES, and HS in Group 1 compared with the control group Group 2. In Table 4, results showed a statistically significant difference in the severity of both HS and SI ($P = 0.0001$) between Group 1 and Group 2. Suicidal attempters who reported SIs

<table>
<thead>
<tr>
<th>Table 1 Demographic data of Groups 1 and 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparing item</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Sex</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Nationality</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Religion</td>
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</tbody>
</table>
were significantly more among those with psychiatric diagnoses \((P = 0.0037)\) with no significant association with the method used in the suicidal attempt \((P = 0.3439)\) (Table 5). A significant age difference was found between specific categories of SI \((P = 0.019)\), with an increasing severity of ideation among the elder group of patients, but neither significant sex difference between them \((P = 0.130)\) nor significant difference regarding dissociation scores \((\text{DES} \ P = 0.560, \text{QED} \ P = 0.677)\) or hopelessness \((\text{HS} \ P = 0.978)\) was found. Regarding mean scores of DES, QED, and HS, there was neither a significant correlation with age \((P = 0.582, 0.293, \text{and } 0.160, \text{respectively})\) nor significant sex differences \((P = 0.5192, 0.7245, 0.0970, \text{respectively})\) in Group 1 of suicidal attempters.

A positive correlation was found between the two dissociative scales DES and QED \((P = 0.026)\). However, no significant correlation was found between hopelessness as measured by HS and each of the dissociative scales DES \((P = 0.259)\) and QED \((P = 0.233)\).

In Table 6, a significantly higher difference in DES and QED was found in suicidal attempters with psychiatric diagnosis \((P < 0.0001 \text{ and } P = 0.0040, \text{respectively})\), and a significantly higher DES and HS was found in those using methods other than drug overdose in their suicidal attempts \((P < 0.0001 \text{ and } P = 0.0060, \text{respectively})\).
Discussion
The WHO has official data on completed suicide, but not on attempted suicide worldwide. It seems that no country in the world report official statistics on attempted suicide to WHO and probably, most countries do not collect such data. This makes it impossible to relate national trends of suicide to national trends of attempted suicide, even in the presence of data on completed suicide. However, when national data are absent, local studies would be the only reliable source in spite of the considerable variability in their operational definition of attempted suicide (Bertolote and Fleischmann, 2002).

This study sample was from a population in UAE, which like other Islamic countries has very low suicidal rate reports (Bertolote and Fleischmann, 2002; Goueli et al., 2003). In general, as in other religious communities, the very low suicide rates reported in Islamic countries — including UAE — might be related to under-reporting concerning stigma (Stack and Lester, 1991) or even as a response to the legal criminalization of the act. There are few reports on suicide from the Gulf region (Dervic et al., 2012). The annual rate of suicide in Dubai — UAE between 1992 and 2000 was 6.2/100 000 (Koronfel, 2002), whereas the rate in Northern Emirates (Sharjah, Ajman, Um Al Quaiin, Al Fujairah, Ras Al Khaima) was found to be 3/100 1000 in 2001, 3.7/100 000 in 2002, and 2.3/100 000 in 2003 (Roshdi and Fakhry, 2004). From 2003 to 2009, the suicide rate among expatriates (6.3/100 000) was seven times higher than the rate among the nationals (0.9/100 000) (Dervic et al., 2012). Although the number of individuals who committed suicide differs from the number of attempters, these numbers are overlapping; as attempt carries the risk of 1% commitment (Hjelmeland, 1996).

The impact of dissociative phenomena in clinical practice has been described in the last century as early as 1907 by Janet, and then by Freud in 1936, with more emphasis of its role in everyday life by Miller in 2000 (Azab et al., 2005). Misdiagnosis — with the consequent delay in treatment — is a major problem in dissociative disorders (Steinberg et al., 1991), but dangers of making such diagnoses without evidence are also emphasized (Moene et al., 2000). Hence, in spite of the fact that patients in this study sample reported amnesia to a major individual event in the form of detailed information about their suicidal attempt, the researcher did not jump to the diagnosis of ‘dissociative amnesia’, because the malingering effect suspected by police officers and mentioned in the psychiatric literature (Simeon and Loewenstein, 2009) in cases expecting punishment for criminal

Table 4 Comparison between the severity of hopelessness scale and the suicidal index among the two groups

<table>
<thead>
<tr>
<th>Test</th>
<th>Group 1 [n (%)]</th>
<th>Group 2 [n (%)]</th>
<th>χ²</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>HS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>11 (14.29)</td>
<td>23 (46)</td>
<td>32.657</td>
<td>0.0001**</td>
</tr>
<tr>
<td>Mild</td>
<td>28 (36.36)</td>
<td>25 (50)</td>
<td>9.302</td>
<td>0.0026**</td>
</tr>
<tr>
<td>Moderate</td>
<td>29 (37.66)</td>
<td>2 (4)</td>
<td>12.308</td>
<td>0.0004**</td>
</tr>
<tr>
<td>Severe</td>
<td>9 (11.69)</td>
<td>0 (0)</td>
<td>19.306</td>
<td>0.0001**</td>
</tr>
<tr>
<td>Total</td>
<td>77 (100)</td>
<td>50 (100)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No ideation</td>
<td>35 (45.45)</td>
<td>41 (82)</td>
<td>21.506</td>
<td>0.0001**</td>
</tr>
<tr>
<td>Mild</td>
<td>21 (27.27)</td>
<td>9 (18)</td>
<td>5.206</td>
<td>0.0222</td>
</tr>
<tr>
<td>Moderate</td>
<td>14 (18.18)</td>
<td>0 (0)</td>
<td>3.327</td>
<td>0.0680</td>
</tr>
<tr>
<td>Severe/serious</td>
<td>7 (9.1)</td>
<td>0 (0)</td>
<td>4.475</td>
<td>&lt;0.0001**</td>
</tr>
<tr>
<td>Total</td>
<td>77 (100)</td>
<td>50 (100)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HS, Hopelessness scale; SI, suicidal index; **P is extremely significant.

Table 5 Comparison between group 1 suicidal index responses on the basis of the psychiatric diagnosis and the method used in the suicidal attempt

<table>
<thead>
<tr>
<th>SI</th>
<th>Psychiatric diagnosis [n (%)]</th>
<th>χ²</th>
<th>P</th>
<th>Method used [n (%)]</th>
<th>χ²</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes [48 (100%)]</td>
<td>No [29 (100%)]</td>
<td></td>
<td>Overdose</td>
<td>Yes [48 (100%)]</td>
<td>No [29 (100%)]</td>
</tr>
<tr>
<td>No ideation</td>
<td>17 (35.42)</td>
<td>18 (62.07)</td>
<td>13.495</td>
<td>0.0037**</td>
<td>20 (46.51)</td>
<td>15 (44.12)</td>
</tr>
<tr>
<td>Mild</td>
<td>11 (22.9)</td>
<td>10 (34.48)</td>
<td>4.475</td>
<td>&lt;0.0001**</td>
<td>14 (32.56)</td>
<td>7 (20.59)</td>
</tr>
<tr>
<td>Moderate</td>
<td>13 (27.08)</td>
<td>1 (3.45)</td>
<td>5.102</td>
<td>0.0243**</td>
<td>5 (11.63)</td>
<td>9 (26.47)</td>
</tr>
<tr>
<td>Severe/serious</td>
<td>7 (14.6)</td>
<td>0 (0)</td>
<td>4.475</td>
<td>&lt;0.0001**</td>
<td>4 (9.30)</td>
<td>3 (8.82)</td>
</tr>
<tr>
<td>Total</td>
<td>48 (100)</td>
<td>29 (100)</td>
<td>13.495</td>
<td>0.000002</td>
<td>43 (100)</td>
<td>34 (100)</td>
</tr>
</tbody>
</table>

SI, suicidal index; **P is highly significant.

Table 6 Comparison between mean scores of dissociative experience scale, questionnaire of experience of dissociation, and hopelessness scale on the basis of the psychiatric diagnosis and the method used in the suicidal attempt in group 1

<table>
<thead>
<tr>
<th>Psychometric tool</th>
<th>Psychiatric diagnosis (mean ± SD)</th>
<th>t</th>
<th>P</th>
<th>Method used in suicidal attempt (mean ± SD)</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes [48 (100%)]</td>
<td>No [29 (100%)]</td>
<td></td>
<td>Overdose [48 (100%)]</td>
<td>Other methods [34 (100%)]</td>
<td></td>
</tr>
<tr>
<td>DES</td>
<td>54.253 ± 21.197</td>
<td>31.812 ± 21.530</td>
<td>4.475 &lt;0.0001**</td>
<td>35.858 ± 23.314</td>
<td>58.376 ± 18.044</td>
<td>4.638 &lt;0.0001**</td>
</tr>
<tr>
<td>OED</td>
<td>12.708 ± 4.881</td>
<td>9.483 ± 4.154</td>
<td>2.966  0.0040**</td>
<td>11.140 ± 4.533</td>
<td>11.941 ± 5.268</td>
<td>0.7172 0.4755</td>
</tr>
<tr>
<td>HS</td>
<td>10.708 ± 4.881</td>
<td>10.414 ± 3.978</td>
<td>0.3014 0.7640</td>
<td>9.465 ± 3.912</td>
<td>12.029 ± 4.004</td>
<td>2.827 0.0060**</td>
</tr>
</tbody>
</table>
activity — such as patients in this study — could not be excluded easily. However, dissociative phenomena in the form of amnesia as a symptom — and not as a diagnosis — could occur in these patients as evidenced by the high scores of Group 1 on dissociative scales DES (P < 0.0001) and QES (P < 0.0001) compared with the control group (Group 2). During the clinical interview, on active inquiry by the interviewer to uncover amnesia, suicidal attempters in Group 1 described their experiences of disturbed memories as losing time, black-out spells, or major gaps in recall for important personal information. These experiences were further documented by examples such as regaining awareness only in the ambulance or even in the hospital in a similar waking–up experience with remarkable evidence of being indulged into self-harm behavior. Such experiences are highly suggestive of dissociative disturbances as described by Simeon and Loewenstein (2009), who added that dissociative “time loss” bouts typically have a sharp onset and offset that cannot be explained by normal forgetting and are not happening under the effect of intoxication or substance abuse, although a high prevalence of drug and alcohol abuse in dissociative patients may complicate the picture (Simeon and Loewenstein, 2009). Suicidal attempters engaged in self-harm have a high risk of further trials; with a higher probability—than the general population—to die from successful suicide (Hawton and Fagg, 1988; Sakinofsky, 2000; Owens et al., 2002). Considering the high level of dissociation in such individuals, the retraiment could be explained by the fact that developing dissociative amnesia disrupts the understanding of cause-and-effect sequences, so that negative or risky behaviors may not appear to be connected to their subsequent consequences, with considerable difficulty in learning from experience, predisposing an individual to revictimization, carrying the risk of retraiment. Furthermore, dissociation may have a negative impact on the metacognitive function of self-control secondary to disruption of integrating the experiences within certain contexts, ending in increasing a lack of self-control and impulsivity (Simeon and Loewenstein, 2009).

In the current study, the total number of suicidal attempters coming to the emergency room in 2007 was 94, which is nearly similar to those found in the retrospective study of suicidal phenomena in the same region in UAE (85 in 2001, 91 in 2002, and 89 in 2003) (Roshdi and Fakhry, 2004). However, only 77 individuals who gave consent and fulfilled the inclusion and exclusion criteria were included in the current study (Group 1). Comparing the mean age (P = 0.266) and other demographic data of both groups (Table 1) revealed statistically nonsignificant differences denoting a well-matched control group. The mean age of the suicidal attempters in the current study (30.455 ± 9.702) was slightly higher, but within the same range of suicidal attempters in the Roshdi and Fakhry study (2004). Mean age in their findings was (25.21 ± 5.52 years for men and 22.2 ± 6.09 years for women) in 2001, (25.53 ± 8.34 years for men and 22.51 ± 5.53 years for women) in 2002, and (25.92 ± 6.9 years for men and 21.95 ± 5.6 years for women) in 2003. However, together with the slight increase in the total number of attempters, this could be explained by the coincident stressful time of economic recession in 2007 creating severe financial troubles to much of the adults in the society.

Suicidal attempts were more common among women [51 (66.23%)], at almost twice the number of men [26 (33.77%)], which is in agreement with the findings of Roshdi and Fakhry (2004), who reported that more women attempted suicide compared with men [women 56 (65.9%) vs. men 29 (34.1%) in 2001; women 59 (64.9%) vs. men 32 (35.1%) in 2002; and women 65 (73.9%) vs. men 24 (27.1%) in 2003]. This is matching with most of the literature denoting that female attempters are three times the number of male attempters (Sudak, 2009) and even they may account for 60% of the parasuicide cases (Hawley et al., 2010). This was mentioned to be unclearly understood; however, it was explained by the greater tendency among women to choose methods that have lower lethality, cause less disfigurement, and are less painful (such as pills), with a subsequent greater margin of safety after the attempt among women compared with men who usually choose methods of higher lethality with lower incidence of failed suicide. However, this again raises the question of “why do they choose such methods?” and whether this is related to their tendency to be more impulsive when feeling suicidal and thus rushing to whatever is available (such as pills) regardless of how lethal it is, or whether they feel lesser compulsion for dying compared with men with less intention for actual suicide (Sudak, 2009).

Assessment of SI as an index for the intent in this study revealed a significant age difference between specific categories of SI (P = 0.019). SIs were found to be more severe with increasing age among attempters, and this was also confirmed in many previous studies (Dyer and Kreitman, 1984; Nimeus et al., 2002; Harriss et al., 2005).

Meanwhile, the relation with sex difference was debatable. Findings in this study showed no significant sex difference in SIs (P = 0.130), replicating the results of Dyer and Kreitman (1984) and Nimeus et al. (2002), but were contradictory to the findings of Harriss et al. (2005), who reported a higher intent in male patients than in female patients among attempters, and followed up the cases — or their records — supporting...
their findings by the fact that suicidal intent scores of both sexes were higher among those who later died by suicide, with a greater difference among female patients.

The highest frequency of suicidal attempts was equally distributed as 11 (14.28%) in April and May (Table 2). This finding is similar to the results of Rosdi and Fakhry (2004), who related the increase in suicidal attempts in these months of the year to the coincident stressful time for most families during that time of final exams at most of the schools and universities in UAE. The motive of influencing other people, for example relatives and family members, to make them feel guilty for having failed them or the motive of seeking unconsciousness as a temporary escape of feeling nothing as they cut or burn themselves. This could be related to the state of detachment from their surroundings with little experience of self-injurious behavior frequently seen in these patients (Simeon and Loewenstein, 2009; Cowen et al., 2012). They usually report a state of detachment from their surroundings with little or no pain during the inflicted self-injurious behavior. Dissociation was higher in patients using methods other than overdose, with more lethality (Table 6), and this was mentioned in previous studies denoting that suicidal intent scores were related to the potential lethality of the method used to induce self-harm (Hamdi et al., 1991; Haw et al., 2003). However, the trial to compare SI responses with the method used in the suicidal trial (Table 5) revealed nonsignificant differences ($P = 0.3439$).

Psychiatric diagnosis was estimated to be 30–70% in suicidal attempters by Hawley et al. (2010), reaching up to 90% by Cowen et al., (2012) among those who deliberately harm themselves, with a similar percentage in those who kill themselves as mentioned by Sudak (2009). In the current study, 48 (62.3%) of the suicidal attempters in Group 1 had psychiatric diagnosis. MDD was the most prevalent diagnosis among Axis I diagnoses in 22 (59.46%) patients (Fig. 1). This finding is in agreement with most of the literature (Sudak, 2009; Hawley et al., 2010; Cowen et al., 2012). Attempters with depressive disorders represent typical completers in future (Simeon and Loewenstein, 2009). Comorbidity among suicidal attempters is frequent, especially between psychiatric disorders and personality disorders (Cowen et al., 2012). Borderline PD was the most prevalent diagnosis among Axis II diagnoses in 10 (71.43%) patients (Fig. 2), which is in agreement with the findings of Haw et al. (2001), denoting the presence of 46% personality disorders among parasuicide cases and 33% with accentuated personality traits. Impulsivity (Sudak, 2009; Cowen et al., 2012) and poor skills in solving interpersonal problems (Cowen et al., 2012) are the common denominators relating suicidal tendencies to Axis II disorders. Borderline PD has suicidal behavior as one of its diagnostic criteria in DSM-IV (American Psychiatric Association, 1994), and thus, is the most closely Axis II diagnosis associated with suicide. The self-injurious behavior frequently seen in these patients reflects a wish to relieve anxiety rather than a wish to die. However, they can kill themselves and so they warrant careful monitoring (Sudak, 2009). They usually report a state of detachment from their surroundings with little or no pain during the inflicted self-injurious behavior (Simeon and Loewenstein, 2009; Cowen et al., 2012).

A significantly higher difference in DES and QED in suicidal attempters was found with psychiatric diagnosis ($P < 0.0001$ and $P = 0.0040$, respectively). This finding confirms that dissociation can occur as a phenomenon in a wide spectrum of psychiatric disorders (Fakhry, 1992).

Hopelessness as measured by HS in the current study revealed significantly higher scores among the patients compared with the control group ($P < 0.0001$) in Table 3. This result warrants the seriousness of the attempts as HS is the most commonly used test to ensure suicide prediction (Sudak, 2009). HS is mentioned to be an indicator of suicidal probability, but no significant correlation was found with dissociative scales (DES and HS $P = 0.259$ and QED and HS $P = 0.233$), meaning that dissociation does not need higher levels of hopelessness to occur. The method used in suicide as an indicator for fatality was confirmed with higher HS scores in individuals using methods other than overdose, with more lethality (Table 6), and this was mentioned in previous studies denoting that suicidal intent scores were related to the potential lethality of the method used to induce self-harm (Hamdi et al., 1991; Haw et al., 2003). However, the psychiatrist’s inability to compare SI responses with the method used in the suicidal trial (Table 5) revealed nonsignificant differences ($P = 0.3439$).

Dissociation was higher in patients using methods other than overdose as indicated by DES ($P < 0.0001$). This could be related to the state of detachment from their surroundings with little experience of pain described by patients causing deliberate self-harm (Cowen et al., 2012). Dissociative patients also describe self-inflicting pain in attempts to break through depersonalization feelings, and they report feeling nothing as they cut or burn themselves. This alienation from the self is mentioned to play a role in the high rate of suicide attempts in dissociative phenomena.
patients (Simeon and Loewenstein, 2009) However, QED scores failed to show a significant difference in the QED ($P = 0.0040$). Despite the positive correlation found between the 2 dissociative scales ($P = 0.026$), DES may be more reliable, being a visual analogue scale.

Even with the lowest suicidal rates as in UAE, suicide remains a major — but possibly preventable — public health problem. Suicide prevention programs need multisystem cooperation with a major role of psychiatrists to share effectively as the only predictive risk factor for a completed suicide is a psychiatric diagnosis. (Bertolote and Fleischmann, 2002) Further studies in different circumstances, as in other areas of the world lacking the illegal aspect of the act, may help to elaborate this correlation more clearly.

Conclusion

(1) Suicidal attempters have a high prevalence of dissociative phenomena and may or may not have psychiatric diagnoses.
(2) The presence of a psychiatric diagnosis and not the nature of the method used in the suicide may be associated with a higher suicidal intent.
(3) The degree of hopelessness may play a role in choosing the method to be used in the suicidal act.
(4) The role of dissociation in the choice of the method used in the suicidal trial is debatable.

Clinical implications

(1) Attempted suicide is often a cry for help, carrying the risk of reattempt and the probability of success in following trials. Psychiatric intervention by health professionals can save lives.
(2) Cooperation with the legal system is highly recommended to help patients with dissociative amnesia receive adequate care, rather than merely punishment and malingering label.
(3) Persons with mental health problems need well-qualified psychiatric treatment. The healthier the individuals, the more reliable they will be to control attempted suicide urges.

Limitations

(1) The selected patients recruited in this study were criminalized by Law in UAE, and so the malingering effect to escape punishment and sequels could not be eliminated.
(2) The sample in this study was convenient, and so a larger sample size may be needed before generalization of the results.

Recommendation

The author recommends encouragement of research in this area to determine the extent of the presence of dissociation in suicidal trials, especially in other areas of the world where criminalization of the act is eliminated, to exclude the impact of legal responsibility on malingering effect.

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Conflicts of interest

None declared.

References


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