

Do Patients Volunteer Their Life Weariness and Suicidal Ideations? A Sri Lankan Study

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Summary: *Objectives:* Sri Lanka has a high suicide rate. The importance of suicidal ideations and their relationship to the Common Mental Disorders (CMD) have not been adequately explored. This study examined whether patients harboring suicidal thoughts or life weariness would volunteer them. It also examined the relationship between life weariness, suicidal ideations, and the probability of underlying CMD.

Method: A case control study was nested within a cross-sectional survey of attendees to the outpatients department in a General Hospital. The index group consisted of patients presenting with multiple complaints and repeated visits, the control group was 100 patients randomly selected from a total of 5,767 between 16 and 65 years of age, not fulfilling criteria for the index group. Presence of underlying CMD was assessed by the General Health Questionnaire 30 (GHQ-30). The two groups were compared for symptoms volunteered, response to questions from GHQ-30 on suicidal ideations, and hopelessness.

Results: Somatic symptoms were the most common in both groups. Eighty-one patients (81%) in the index group and 34 patients (34%) in the control group had probable CMD. No patient in either group volunteered suicidal ideation as a symptom. However, 59% of index patients and 26% of controls admitted life weariness, and 51/59 index patients and 15/26 controls who had life weariness also had underlying CMD as defined by GHQ scores.

Conclusion: Patients who have suicidal thoughts do not volunteer them unless directly asked. There is a strong relationship between suicidal ideation and the probability of underlying CMD.

Keywords: Suicidal ideations, common mental disorders, life weariness, GHQ-30.

Introduction

Since the 1970s there has been a dramatic upward trend in suicide rates in Sri Lanka. In 1970, the suicide rate was 19.2 per 100,000 population but by 1995 it had increased to 46.6 per 100,000 population, and was one of the highest rates in the world (Dissanayake & De Silva, 1974; Eddleston et al., 1998). Among the completed suicides, the availability of lethal methods is considered an important etiological factor. (Eddleston et al., 1998). In Sri Lanka during the year of 1997, the most common method used by those who completed suicide was ingestion of agrochemicals (40.3%) followed by hanging (12.4%). The World Health Organization has identified targeting high-risk groups as one of the main components in strategies for prevention of suicide (WHO, 1993).

This study examined whether patients harboring suicidal thoughts and life weariness would volunteer them as

symptoms, either by acknowledging them in a symptom questionnaire or when asked directly. It also examined the relationship between life weariness, suicidal ideation, and the probability of underlying Common Mental Disorder (CMD).

This paper examines the data in a case control design involving [ok?]suicidal ideation and volunteering these thoughts, and the relationship between suicidal ideations and the probability of underlying CMD.

Method

Study Design

A case control design was nested within a cross-sectional survey of attendees to the outpatients department of a General Hospital in a suburb of Colombo.

Participants

A group of patients ($n = 100$) with medically unexplained multiple symptoms and frequent consultations was compared to a random control group from other outpatients. The index group was comprised of patients with multiple complaints, and/or repeated visits during the preceding 6 months. Multiple complaints were defined as more than five complaints and repeated visits were defined as more than five visits. Definitions of the other parameters were described in an earlier publication (Sumathipala et al., 2000). The 100 control patients were randomly selected from a total of 5767 outpatients between the ages of 16 and 65 years who did not fulfill criteria for the index group.

Assessment Instruments

Semistructured Interview

As patients do not necessarily present with all the symptoms they perceive, to standardize the way the symptoms were elicited and counted only the following two open-ended questions were administered.

- What are your symptoms/problems?
- Are there any other symptoms or problems?

Direct Questions on Symptoms

In addition, four close-ended structured questions on the presence or absence of sleep changes, appetite changes, health worries, and life weariness (feeling sick of life) were asked.

General Health Questionnaire-30 (GHQ-30)

The GHQ-30 (Goldberg & Blackwell, 1970) is widely used to assess the probability of the presence of CMD (Odell et al., 1997). The GHQ, in short (GHQ 12, 28, 30) and long (GHQ-60) forms, has been widely used in different cultures and health care settings (Goldberg & Huxley, 1980; Ustun & Sartorius, 1995). A Sri Lankan version, in the Sinhala language, of the GHQ-30 has been validated and used in Sri Lanka (De Silva & Samarasingha, 1990; De Silva, 1990, Sumathipala et al., 2000). The probability of underlying CMD was assessed by using this version of the GHQ-30. Those who score 7 or more will be considered a “probable case” of psychiatric morbidity, presence of CMD, somatization including medically unexplained symptoms, and other so-called “minor psychiatric illness” and adjustment disorders.

Outcome Measures

1. Suicidal ideation as a symptom volunteered by the patients (presenting complaint),

2. Responses to GHQ Question 25 for hopelessness: Feeling that life is entirely hopeless,
3. Responses to GHQ Question 29 for suicidal ideations: Feeling that life isn't worth living (Goldney et al., 1998),
4. Response to direct question on life weariness,
5. Probability of underlying CMD as estimated by the total GHQ scores.

Results

Symptoms Volunteered by the Patients (Presenting Complaints)

Somatic symptoms were the most common in both groups and were similar in nature, although the index patients were a selective group with medically unexplained symptoms and the control group was a random sample of other attendees. The most common symptom was chest pain, including in the back of the chest; 42% in the index group and 17% in the controls. Similarly, abdominal pain, including abdominal cramp, was 37% and 19%, pain in the limbs 38% and 14%, pain in the joints 25% and 10%, numbness over various parts of the body 27% and 8%, lifelessness 16% and 13%, and shortness of breath 17% and 6% in the index and control groups, respectively. Pain along the spine, lower backache, feeling of faintness, loss of appetite, sleep disturbance, and burning sensations were common in index but not in control patients.

However, 81 (81%) in the index group and 34 (34%) in the control group had high GHQ scores qualifying them to be within the GHQ definition of caseness. Mean GHQ scores for index and control groups were 14 (95% CI 12.4–15.5) and 6.1 (95% CI 4.9–7.3), respectively.

No patient in either group volunteered suicidal ideation or life weariness as a symptom.

Responses to GHQ Questions (25 and 29) on Hopelessness and Suicidal Ideations

When the GHQ-30 was given, a total of 32 in both groups gave positive responses to Question 25, and of those, 24 (75%) were in the index group. Similarly, a total of 31 from both groups gave positive responses to Question 29, and of these, 23 (75%) were from the index group (see Table 1).

Response to Direct Question on Life Weariness

When directly questioned, “Do you feel sick of every thing,” 59% in the index group and 26% in the controls admitted experiencing life weariness. The difference be-

Table 1. Difference in response rates in volunteering and eliciting ideas of life weariness.

	Multiple complaints (N = 100)*	Control group (N = 100)*
Volunteered as a symptom	0	0
Affirmative response to "Felt that life is entirely hopeless" (Question 25 of GHQ)	24	8
Affirmative response to "Felt that the life isn't worth living" (Question 29 of GHQ)	23	8
Affirmative response to "Do you feel sick of every thing?"	59	26

*Four in the control group and three in the study group did not answer Question 25 of the GHQ, and two in the control group and three in the study group did not answer Question 29 of the GHQ.

Table 2. Association between affirmative response to GHQ-30 Question 25 and 29, and mean score of GHQ-30.

	GHQ-30 Question 25 "Felt that life is entirely hopeless"				GHQ-30 Question 29 "Felt that life isn't worth living"			
	Multiple complaints (N = 92)**		Control group (N = 92)**		Multiple complaints (N = 93)**		Control group (N = 94)**	
	Yes	No	Yes	No	Yes	No	Yes	No
Number	24	68	08	84	23	70	08	86
Mean GHQ Score (95% CI)	23.4 (21–26)	10.8 (9–12)	19.9 (15–24)	4.9 (4–6)	21.4 (18–24)	11.7 (10–13)	15.9 (8–24)	5.2 (4–6)
ANOVA (Residual SD)	F = 84.43 Sig. 0.00 (5.79)		F = 62.13 Sig. 0.00 (5.13)		F = 34.43 Sig. 0.00 (6.84)		F = 23.8 Sig. 0.00 (5.89)	

**The total numbers are less than the numbers in Table 1 because some did not answer the GHQ at all and some who answered did not complete either Question 25 or 29 or both.

Table 3. Relationships between the mean GHQ scores and admitting to "life weariness" ("Do you feel sick of every thing?").

"Do you feel sick of every thing?"	Mean GHQ scores in the Index group (95% CI)	Mean GHQ scores in the Control group (95% CI)
YES	16.92 (14.7–19.0)	10.31(7.2–13.4)
NO	10.02 (8.3–11.8)	4.68 (3.5–5.9)

tween these two groups is 33% (95% CI 21.67–44.33). This was a statistically significant difference ($p < .05$)

Detailed comparison of the volunteered symptoms, GHQ responses, and direct questioning on life weariness are given in Table 1.

Probability of Underlying CMD as Estimated by the Total GHQ Scores

When the mean GHQ scores were analyzed for the differences between the patients who had a positive and a negative response to Questions 25 and 29, (whether in the control or study group) strong association between the total GHQ score and positive responses to these two questions was seen. Detailed analysis of these associations is given in Table 2.

From participants who admitted life weariness on direct questioning, 51/59 in the index group and 15/26 in the control group were GHQ cases (GHQ > 7). The relationship

between the mean GHQ scores and life weariness is given in Table 3.

Discussion

Patients with medically unexplained multiple complaints revealed a higher probability of underlying CMD in terms of the GHQ definition of caseness as compared to the control group. However, the people who had medically unexplained multiple symptoms with associated ideas of life weariness, hopelessness, and suicidal ideations had the highest GHQ mean score. Even in the patients without multiple complaints (control group), patients with ideas of life weariness, hopelessness, and suicidal ideations had higher GHQ means compared to those without such ideas.

A strong association between positive responses to hopelessness (Question 25), suicidal ideation (Question 29), and total GHQ scores was observed. In other words, patients with hopelessness or suicidal ideations indicated a higher probability of underlying CMD.

A higher number of patients (59%) gave affirmative responses to “Do you feel sick of every thing” in comparison to the GHQ Questions 25 and 29. Those patients who gave affirmative responses had high mean GHQ scores whether they were in the control or the study group. Therefore, an affirmative response to the above question predicts a higher probability of underlying CMD.

Use of GHQ-30 for Eliciting Suicidal Ideation

A four-item suicidal ideation subscale of the GHQ-28 has been validated in comparison to a well-established suicidal intent scale (Watson et al., 2001). GHQ-12 has also been used to assess the relationship between psychological distress and suicidal ideation (Gili-Planas et al., 2001). Neither of these has been validated in Sri Lanka. However, GHQ-30, which has only one item for suicidal ideation, has not been validated for measurement of suicidal ideation. As our finding has shown a strong association between life weariness, hopelessness, and suicidal ideation, further validation of GHQ-30 to measure these items is justified.

“Etic-Emic” Paradigm

Cross-cultural studies can be approached from two different perspectives, which, together, have been called the “etic-emic” paradigm. (Brislin et al., 1973) The “emic” perspective involves the evaluation of the studied phenomenon from within the culture and context, aiming to understand its significance and relationship with other intracultural elements. While a thorough understanding of concepts relevant to one culture is obtained using this approach, these concepts are not necessarily comparable to those of other cultures. The “etic” perspective, on the other hand, involves the evaluation of a phenomenon from outside the culture, aiming to identify and compare similar phenomena across different cultural contexts. (Bravo et al., 1993). Therefore, the use of standardized instruments, structured interviews, or a questionnaire, developed outside a particular culture, is essential to compare and understand phenomena across linguistically and culturally different populations.

Weaknesses of This Study

The “etic” criteria, detection of hopelessness and suicidal ideation, was done by the GHQ-30, which was translated from English to Sinhala. The “emic” criterion, idea of life weariness, was elicited by a question in Sinhala. The meanings of these three words in Sinhala have similarities and differences with some overlap. For example, hopelessness and life weariness have similar connotations in the Sinhala language. Hopelessness is the best predictor of suicidal be-

havior (Beck, 2001). Therefore, we can hypothesize that life weariness also will be associated with suicidal ideation. However, as these words may have different connotations, the meanings of these words need to be further clarified in qualitative studies to clarify whether life weariness and hopelessness are the same or different in their relationship to suicidal ideations.

Current systems of classifications such as ICD or DSM remain unsatisfactory for those patients with medically unexplained symptoms (Escobar et al., 1998). Only half of these patients meet criteria for mood and anxiety diagnosis (Kroenke et al., 1994). Some patients with somatic complaints have neither physical nor severe mental illness (Wesley, 1996). However, even if the results of a structured psychiatric interview could have an academic value, a validated diagnostic instrument was not available in Sri Lanka. In the absence of structured interviews, an instrument such as the GHQ offers the best alternative to measure psychiatric outcome (Odell et al., 1997). Although the GHQ-28 would have been best, a validated version of the GHQ-28 for Sri Lanka was not available. Validation of one was not feasible with the limited resources available for this study and the time constraints. For this reason, this research in a developing country had to be pragmatic and the authors had to settle on the best alternative option.

The Relationship Between the Perception of a Symptom, Volunteering it and Acknowledging its Presence

After evaluating their bodily perceptions, patients either act or do not act on them. Even if they decide to seek medical help, they may volunteer only some of the symptoms. On the other hand, in clinical practice the number of complaints elicited will depend on how actively the physician probes. If left without assertive follow up, the patient may only mention those symptoms that they believe important. Our findings confirm this illness behavior. Patients who had suicidal thoughts did not volunteer them as a symptom unless they were directly asked. Our study provides evidence on this relationship.

Implications

It is evident that one single direct question on life weariness can detect patients who have hopelessness or suicidal ideation, or CMD as detected by the GHQ-30. This fact can be used in a busy clinical setting in Sri Lanka for Sinhala-speaking people. Validation of this approach for patients in other developing countries may be useful and, therefore, worth evaluating in future studies.

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Athula Sumathipala MBBS, MD, MRCPsych, CCST, a Sri Lankan who originally graduated and trained in Sri Lanka, obtained an MBBS Diploma in Family Medicine and an MD (by research), then re-qualified in the UK, underwent postgraduate training in Psychiatry (MRCPsych) and also obtained a Certificate of Completion of Specialist Training (CCST) in the UK (EU) and just completed a PHD. Although attached to the Institute of Psychiatry, Kings College, University of London (Section of Epidemiology), he has been based in Sri Lanka for the last 7 years conducting research. He has extensive experience in crosscultural research and has established a reputation in Cognitive Behavioral Therapy for medically unexplained symptoms, twin research, and bioethics. He has carried out two controlled clinical trials using CBT, and cofounded the Sri Lankan Twin Registry, the first of this kind in the developing world (<http://info.lanka.com/org/twin-registry/>). He also cofounded the Forum for Research and Development, which is dedicated to building up capacities and establishing an ethical research culture in Sri Lanka. He has strong links with both the developed and developing countries and is involved in many academic activities and programs. His skills in leadership and management of multidisciplinary teams qualify him especially well for the task in this project.

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