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Battles Lost - Incidence, Risk factors and Prevention of Suicide

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ABSTRACT

Suicide is the type of Deliberate Self Harm (DSH) and is defined as the human act of self intentional and self inflicted cessation. It is estimated that over 100,000 people die by suicide in India every year. India alone contributes to more than 10% of suicides in the world. The suicide rate in India has been increasing steadily and has reached 11.2 (per 100,000 of population) in 2011 registering 78% increase over the value of 1980 (6.3). Majority of suicides occur among men and in younger age groups. West Bengal, Maharashtra and Tamil Nadu had the highest rates of suicide in India in 2011. Percentage distribution of suicide victims by profession in 2011 showed self-employed as having highest suicide rates. In the present review article indicated psychosocial stress, social isolation and psychiatric morbidity as risk factors for suicide in India. The presence of an Axis I disorder, family history of psychopathology and recent life events were also found to be significant risk factors. These findings suggested that risk factors for completed suicide are universal across countries and cultures. Nearly 80% of persons who commit suicide gave definitive warning and / or clues about their suicidal intention. Though there are a number of help lines and support groups available, many individuals have not been able to access them. More number of Crisis Intervention Programmes, Awareness Programmes and Suicide Prevention Programmes could be answer to the SOS signs of suicide.

Key words: Battle lost, suicide incidence, risk factors, prevention.

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Introduction

Suicide is a model of psychiatric emergencies and is also the commonest cause of death in psychiatric patients. Suicide is the type of deliberate self harm (DSH) and is defined as the human act of self intentional and self inflicted cessation. It ends with a fatal outcome. DSH is an act of intentionally injuring oneself, irrespective of the actual outcome. An attempted suicide is an unsuccessful suicidal act with a non fatal outcome. It is believed that 2-10% of all persons who attempt suicide will eventually complete suicide in the next 10 years. A suicidal gesture, on the other hand, is an attempted suicide where the person performing the action never intends to die by the act. However, some of these persons may accidently die during the act. Attempted suicide is more common in women while completed suicide is 2-4 times commoner in men (Ahuja, 2011). The objective of the present investigation was to review the status of suicide, risk factors in India and prevention of suicide.

Epidemiology

Suicide is among top 10 causes of death in India and most other countries. The official suicide rate in India in

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2008 was 10.8/100000 population/year (9.7 in 1995; 6.3 in 1980). In 2000, the rate in men was 12.2/100000 and in women 9.1/100000) with an overall male female ratio of 64:36 in 2008(NCRB, 2008). However, as there is considerable under-reporting of suicidal behavior, the probable suicide rate per year in India would be around 15/100,000 population (Ahuja, 2011). There are cultural differences in suicide (WHO, 2004). The highest rate of suicide for males is in Lithuania (80/100,000 Population) and the Russian federation, the lowest in the Dominican Republic (0 per 100,000 population). The highest rate of suicide for females is in Sri Lanka (17 per 100,000 population) and China, the lowest (all zero per 100,000 population) in several Caribbean islands, including the Bahamas and Honduras, Egypt and Syrian Arab Republic. The United States rate of suicide is 17 per 100000 populations for males, 4 per 100000 population for females (Santrock, 2007).

Methods used for suicide

Methods Used	Percentage %
Ingestion of poison	34.8
Hanging	32.2
Burning	8.8
Drowning	6.7
Jumping in front of train or another vehicle	3
Alcoholism	1.2

Men often tend to use more violent method for suicide as compared to women (NCRB, 2008).

Clusters of suicide

The media sometimes gives intense publicity to "suicide clusters" - a series of suicides that occur mainly among young people in a small area within a short period of time. These have a contagious effect especially when they have been glamorized, provoking imitation or "copycat suicides". This phenomenon has been observed in India on many occasions, especially after the death of a celebrity, most often a movie star or a politician. The wide exposure given to these suicides by the media has led to suicides in a similar manner. Copying methods shown in movies are also not uncommon. This is a serious problem especially in India where film stars enjoy an iconic status and wield enormous influence especially over the young who often look up to them as role models (Vijaykumar, 2007).

Etiology

Some of the common causes of suicide include:

I Psychiatric Disorders
1. Depression
i. Major Depression
ii. Depression secondary to serious illness
iii. Reactive depression, secondary to life stressors, e.g. Family and/or marital disputes, failure in goal achievement, occupational and financial difficulties, and death of significant others (Ahuja, 2011).

Brian Bird, a psychiatrist, goes to the extent of saying, "for the sake of safety all depressed patients should be assumed to be suicidal" (Prasantham, 2005).

1. Alcoholism and drug dependence
2. Schizophrenia

Genetic factors (a concordance rate of 18% in monozygotic twins) and biochemical factors (low levels of 5-HIAA) are important in some cases of suicide (Ahuja, 2011).

I. Physical Disorders

Patients with incurable or painful physical disorders, such as cancer and AIDS, often commit suicide (21.9% of all suicides in India) (NCRB, 2008).

II. Psychosocial Factors

Psychosocial factors are very important cause of suicide. Some of the examples are failure in examinations, love affairs, dowry difficulties, marital difficulties, illegitimate pregnancy, family problems or family psychopathologies, loss of a loved object by death or otherwise, occupational and financial difficulties and social isolation. In about 16% cases no obvious causes were found (NCRB, 2008).

Risk factors for suicide

The presence of following factors increases the risk of completed suicide:

- Age > 40 years
- Male gender
- Staying single
- Previous suicidal attempt(s)
- Depression (risk about 25 times more than usual)
- Suicidal preoccupation
- Alcohol and drug dependence

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- Severe, disabling, painful or untreatable physical illness
- Recent major loss or major stressful life event
- Social isolation
- Higher degree of impulsivity (Ahuja, 2011).

Warning Signs of Suicide

Most suicidal individuals give warning signs or signals of their intentions. The best way to prevent suicide is to recognize these warning signs and know how to respond if we spot them. If we believe that a friend or family member is suicidal, we can play a role in suicide prevention by pointing out the alternatives, showing that we care, and getting a doctor or psychologist involved. Major warning signs for suicide include talking about killing or harming oneself, talking or writing a lot about death or dying, and seeking out things that could be used in a suicide attempt, such as weapons and drugs. These signals are even more dangerous if the person has a mood disorder such as depression or bipolar disorder, suffers from alcohol dependence, has previously attempted suicide, or has a family history of suicide.

A more subtle but equally dangerous warning sign of suicide is hopelessness. Studies have found that hopelessness is a strong predictor of suicide. People who feel hopeless may talk about "unbearable" feelings, predict a bleak future, and state that they have nothing to look forward to.

Other warning signs that point to a suicidal mind frame include dramatic mood swings or sudden personality changes, such as going from outgoing to withdrawn or well-behaved to rebellious. A suicidal person may also lose interest in day-to-day activities, neglect his or her appearance, and show big changes in eating or sleeping habits (Smith, Segal and Robinson, 2012). If a patient is emotionally disturbed, with vague suicidal thoughts, the opportunity of ventilating thoughts and feelings to a physician who shows concern may be sufficient. Nevertheless, an opportunity for further follow-up should be left open, particularly if the patient has inadequate social support. Whatever the problem, the feelings of the suicidal person are usually a triad of helplessness, hopelessness and despair. The three most common states are:

1. Ambivalence

The majority of suicidal patients are ambivalent till the very end. There is a see-saw battle between the wish to live and the wish to die. If the ambivalence is used by the physician to increase the wish to live, the suicide risk may be reduced.

2. Impulsivity

Suicide is an impulsive phenomenon and impulse by its very nature is transient. If support is provided at the moment of impulse, the crisis may be defused.

3. Rigidity

Suicidal people are constricted in their thinking, mood and action and their reasoning is dichotomized in terms of either/or. By exploring several possible alternatives to death with the suicidal patient, the physician gently makes the patient realize that there are other options, even if they are not ideal (WHO, 2000).

Lethal Risk in Suicidal Ideation

Lethality is a function not only of risk factors, but also of whether protective factors are present (Maris et al., 2000). Below are some general guidelines provided by Schwartz and Rogers (2004) that may be helpful in determining the lethality of a client who acknowledges suicidal ideation:

- Low lethality—suicidal ideation is present but intent is denied, client does not have a concrete plan and has never attempted suicide in the past.
- Moderate lethality—more than one general risk factor for suicide is present; suicidal ideation and intent are present, but a clear plan is denied; and the client is motivated to improve his/her psychological state if possible.
- High lethality—several general risk factors for suicide are present, client has verbalized suicidal ideation and intent, client has a coherent plan to harm himself or herself, and client reports access to resources needed to complete the plan.
- Very high lethality—client verbalizes suicidal ideation and intent, he or she has communicated a well thought out plan with immediate access to resources needed to complete the plan, client demonstrates cognitive rigidity and hopelessness for the future, he or she denies any available social support, and he or she has made previous suicide attempts in the past (Michelle, Robert and Sandy, 2007).

Some common themes in suicide

- A crisis that causes intense suffering with feeling of hopelessness and helplessness
- Conflict between unbearable stress and survival
- Narrowing of the person's perceived options

- Wish to escape (it can often be an escape, rather than going-towards)
- Often wish to punish self and/or punish significant others with guilt (Ahuja, 2011).

Prevention of suicide

The common Misconceptions and Facts about suicide are:

Misconceptions	Facts
People, who talk about suicide, do not commit suicide. Suicide happens without warning	Nearly 80% of persons who commit suicide, give definite warning and / or clues about their suicidal intention.
Suicidal persons are fully intent on dying	Most suicidal persons are undecided about dying or living
Once a person is suicidal he / she is suicidal forever.	Suicidal person is usually suicidal only for a limited period of time
All suicidal persons are mentally ill or psychotic	Although a suicidal person is often extremely unhappy, he / she is not necessarily mentally ill.

(Ahuja, 2011)

The management of suicide lies in preventing the act. This can be done at suicide prevention centers, crisis intervention centers (both of these are not available as yet on a large scale in India), psychiatric emergency services, medical emergency services, social welfare centers (such as Samaritans, Sanjivini, Mytri, Sumaitri, Befrienders International etc.) or even at home of the patient (Ahuja, 2011).

Some important steps for preventing suicide include

1. Take all the suicidal threats, gestures and / or attempts seriously and notify a psychiatrist of a mental health professional.
2. Psychiatrist (or a mental health professional) should quantify the seriousness of the situation (a proper risk assessment) and take remedial precautionary measures.
i. Inspect physical surrounding and remove all meanings of committing suicide, such as sharp objects, ropes, drugs, fire arms etc. Also, search the patient thoroughly.
ii. Surveillance, depending on the severity of the risk.
3. Acute psychiatric emergency interview
4. Counselling and guidance
a. To deal with desire to attempt suicide
b. To deal with ongoing life stressors and teaching coping skills and interpersonal skills.
5. Treatment of the psychiatric disorder(s) with medication, psychotherapy and / or ECT. ECT is the treatment of choice for patients with major depressions with suicidal risk. It should also be used for the treatment of suicidal risk associated with psychotic disorder. Follow up care is very important to prevent future suicidal attempts or suicide (Ahuja, 2011).

Enlisting support

The physician should assess the available support systems, identify a relative, friend, acquaintance or other person who would be supportive to the patient, and solicit that person's help (WHO, 2000).

Contracting

Entering into a "no suicide" contract is a useful technique in suicide prevention. Other people close to the patient can be included in negotiating the contract. The negotiation of the contract can promote discussion of various relevant issues. In the majority of instances patients respect the promises they give to a physician. Contracting is appropriate only when patients have control over their actions (WHO, 2000). In the absence of severe psychiatric disorder or suicidal intent, the physician can initiate and arrange pharmacological treatment, generally with antidepressants, and psychological (cognitive behaviour) therapy. The majority of people benefit from continuing contacts; these should be structured to meet individual needs Except for the treatment of underlying diseases, few persons require support for longer than two or three months and the focus of the support should be providing hope, encouraging independence, and helping the patient to learn different ways of coping with life stressors (WHO, 2000).

It must be noted that there are social and legal obstacles to the preventions and rehabilitation of suicides and persons who attempted suicide. Society must be educated to see that persons who attempt suicide need care and help rather than condemnation. The law a present time considers suicide as an offence which is punishable. This can act as a deterrent to those who attempted suicide from taking help. A viable amendment to the law governing suicide is currently pending before the Indian Parliament. This amendment has been proposed by the Indian Psychiatric Society (Prashantham, 2005).

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Suicidal ideation among adolescents

Suicide is the third leading cause of death among youth between 10 and 19 years of age. However, suicide is preventable. Youth who are contemplating suicide frequently give warning signs of their distress. Parents, teachers, and friends are in a key position to pick up on these signs and get help. Most important is to never take these warning signs lightly or promise to keep them secret. When all adults and students in the school community are committed to making suicide prevention a priority—and are empowered to take the correct actions—we can help youth before they engage in behavior with irreversible consequences (NASP, 2010).

Inability to cope with the medium of instruction and other factors like rural / urban divide, financial standing, and family background lead to low self esteem and sometimes makes them resort to that extreme step of suicide. If a student is able to get himself through in the first six months, he will be able to sail through the rest effortlessly. A good support system is a must. Mentoring should happen in the real sense and not be something that is only on paper (Srinivasan, 2012). Both early and late experiences may be involved in suicide attempts. The adolescents might have a long standing history of family instability and unhappiness. Lack of affection and emotional support, high control and pressure for achievement by parents during childhood are likely to show up as factors in suicide attempts. One recent review of literature found a link that adolescents who had been physically or sexually abused were more likely to have suicidal thoughts than adolescents who had not experienced such abuse (Evans, Hawton and Rodham, 2005). The adolescents might also lack supportive friendships. Recent and current stressful circumstances such as getting poor grades in schools and experiencing the breakup of a romantic relationship may trigger suicide attempts (Antai- Otong and Rudd, 2003).

The Role of the School in Suicide Prevention

Children and adolescents spend a substantial part of their day in school under the supervision of school personnel. Effective suicide and violence prevention is integrated with supportive mental health services, engages the entire school community, and is imbedded in a positive school climate through student behavioral expectations and a trustful student/adult relationship. Therefore, it is crucial for all school staff to be familiar with and watchful for risk factors and warning signs of suicidal behavior. The entire school staff should work to create an environment where students feel safe sharing such information. School psychologists and other crisis team personnel, including the school counselor and school administrator, are trained to intervene when a student is identified at risk for suicide. These individuals conduct suicide risk assessment, warn/inform parents, provide recommendations and referrals to community services, and often provide follow up counseling and support at school (NASP, 2010).

Parental Notification and Participation

Parent notification is a vital part of suicide prevention. Parents need to be informed and actively involved in decisions regarding their child's welfare. Even if a child is judged to be at low risk for suicidal behavior, schools will ask parents to sign a Notification of Emergency Conference form to indicate that relevant information has been provided. These notifications must be documented. Additionally, parents are crucial members of a suicide risk assessment as they often have information critical to making an appropriate assessment of risk, including mental health history, family dynamics, recent traumatic events, and previous suicidal behaviors.

After a school notifies a parent of their child's risk for suicide and provides referral information, the responsibility falls upon the parent to seek mental health assistance for their child. Parents must

- Continue to take threats seriously: Follow through is important even after the child calms down or informs the parent "they didn't mean it." Avoid assuming behavior is attention seeking.
- Access school supports: If parents are uncomfortable with following through on referrals, they can give the school psychologist permission to contact the referral agency, provide referral information, and follow up on the visit. The school can also assist in providing transportation to get the parent and child to the referral agency.
- Maintain communication with the school. After such an intervention, the school will also provide follow-up supports. Your communication will be crucial to ensuring that the school is the safest, most comfortable place for your child (NASP, 2010).

Resiliency Factors

The presence of resiliency factors can lessen the potential of risk factors to lead to suicidal ideation and behaviors. Once a child or adolescent is considered at risk, schools, families, and friends should work to build these factors in and around the youth. These include:

- Family support and cohesion, including good communication.
- Peer support and close social networks.

- School and community connectedness.
- Cultural or religious beliefs that discourage suicide and promote healthy living.
- Adaptive coping and problem-solving skills, including conflict-resolution.
- General life satisfaction, good self-esteem, sense of purpose.
- Easy access to effective medical and mental health resources.(NASP, 2010)

Suicide among Older Adults

Rates of depression are high among the elderly, and suicide rates are considerably higher among younger adults. Old age is inherently a period of high risk, but someone who had studied the elderly (Langer, 1981) report that the risk are especially high in extremely youth- oriented societies, societies that do not so much abuse their elderly as underestimate and overlook them (Morgen, King, Weisz and Schopler, 1993). Older adults are less likely to communicate their suicide intention than are younger adults and adolescents and they make fewer attempts. However, when older adults attempts suicide, they use more lethal methods and more often succeed (McIntosh, 1995). A surviving spouse is especially at risk for depression or suicide (DeLeo, 2002 and Turve et al., 1999).

Conclusion

The study indicated psychosocial stress, social isolation and psychiatric morbidity as risk factors for suicide in India. The presence of an Axis I disorder, family history of psychopathology and recent life events were also found to be significant risk factors. These findings suggested that risk factors for completed suicide are universal across countries and cultures. Nearly 80% of persons who commit suicide gave definitive warning and / or clues about their suicidal intention. Though there are a number of help lines and support groups available, many individuals have not been able to access them. More number of Crisis Intervention Programmes, Awareness Programmes and Suicide Prevention Programmes could be answer to the SOS signs of suicide.

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