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Research Paper

SUICIDE AND ITS PREVENTION

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Introduction

Suicide is a very democratic phenomenon. It knows no discrimination of race, colour, creed, age, or sex. Nor it is true that a person has to be mentally deranged to commit suicide. It is a highly personal tragedy of purposely ending one's own life, with the loss always leaving hurt, guilt, remorse, bitterness, and other emotional repercussions in its wake. Each suicide represents a unique combination of circumstances. Views on suicide have been influenced by broader cultural views on existential themes such as religion, honor, and the meaning of life. For example, Islam and Christianity tend to view suicide as quite negative due to religious belief in the sanctity of life. Some others treat a suicide attempt as a serious crime. However, suicides are sometimes seen as understandable or even honorable in certain circumstances, such as in protest to persecution (for example, hunger strike), as part of battle or resistance (for example, suicide bombers) or as a way of preserving the honor of a dishonored person (for example, killing oneself to preserve the honor or safety of family members). In the 20th century, suicide in the form of self-immolation has been used as a form of protest and suicide bombing as a military or terrorist tactic. Medically assisted suicide (euthanasia, or the right to die) is currently a controversial ethical issue involving people who are terminally ill, in extreme pain, or have (perceived or construed) minimal quality of life through injury or illness. Self-sacrifice for others is not always considered suicide, as the goal is not to kill one but to save another; however, Émile Durkheim's theory termed such acts "altruistic suicide."

Causes of Suicide

It is estimated that over 100,000 people die by suicide in India every year. Suicide in India is slightly above world rate. Of the half million people reported to die by suicide worldwide every year, 20 per cent are Indians, for 17 per cent of world population. India alone contributes to more than ten per cent of suicides in the world. In the last two decades, the suicide rate has increased from 7.9 to 10.3 per 100,000, with very high rates in some southern regions.

Suicide attempters are ten times than the suicide completers. The majority of suicides in India are by those below the age of 30 years. The fact that 71 per cent of suicides in India are by persons below the age of 44 years imposes a huge social, emotional and economic burden on our society. "It is observed that social and economic causes have led most of the males to commit suicide whereas emotional and personal causes have mainly driven females to end their lives,"

As per the report of the National Crime Record Bureau for 2010, more than 41 percent of suicide victims were self-employed while only 7.5 per were un-employed. More than one lakh persons (1,34,599) in the country lost their lives by committing suicide during the year 2010 and nearly 70.5 per cent of the suicide victims were married males while 67.0 per cent were married females. Thus, suicide is a major public and mental health problem, which demands urgent action.

Kerala, Tamil Nadu, Karnataka Maharashtra and Andhra Pradesh accounted for 65.8 per cent of suicide victims in the age group 60 years and above. Suicides because of 'family problems' (23.7 per cent) and 'illness' (21.0 per cent) combined accounted for 44.7 per cent of total suicides, said the report. The percentage of suicides due to 'property dispute' and 'death of dear person' showed a relatively higher increase of 48.0 per cent and 28.9 per cent respectively. The overall male:female ratio of suicide victims for the year 2009 was 65:35. However, the proportion of boys:girls suicide victims (up to 14 years of age) was 52:48.

Among 25 cities, Jabalpur has reported the highest rate of 41.5 and Kolkata reported the lowest rate at 2.1. The pattern of suicides reported from 35 cities showed that 'hanging' (44.5 per cent), 'poisoning' (20.6 per cent) and 'fire/self-immolation' (12.6 per cent) were the means used the suicide victims in the cities

There is a significant increase in the number of suicides (136.5 per cent) in Patna (from 63 in 2009 to 149 in 2010) while Dhanbad showed a sharp decline of 60.5 per cent (from 152 suicides in 2009 to 60 suicides in 2010). The suicide rate in cities (12.7) was higher as compared to All-India suicide rate (11.4). Tamil Nadu has reported significant increase in suicides (16,561) in 2010 over 2009 (14,424) (an increase of 14.8 per cent) followed by Maharashtra (from 14,300 in 2009 to 15,916 in 2010), the report said.

The highest number of mass/family suicides cases were reported from Bihar (23) followed by Kerala (22) and Madhya Pradesh (21) and Andhra Pradesh (20), out of 109 cases. 33.1 per cent of the suicide victims consumed poison, 31.4 per cent died by hanging, 8.8 per cent by fire/self-immolation and 6.2 per cent by drowning. The trend of suicide by hanging has been mixed during last three years (32.2 per cent in 2008, 31.5 per cent in 2009 and 31.4 per cent in 2010) while suicide by poisoning has shown decreasing trend in 2007 and 2008 (34.8 per cent in 2008, 33.6 per cent in 2009 and 33.1 per cent in 2010). Bengaluru (1,778), Chennai (1,325), Delhi (1,242) and Mumbai (1,192) the four cities together have reported almost 40.5 per cent of the total suicides reported from 35 mega cities. Despite the gravity of the problem, information about the causes and risk factors is insufficient.

The reasons for committing suicide are though multifaceted and complex; life circumstances that may immediately precede someone committing suicide include mental illness, negative life experiences that may cause depression such as divorce, separation, or breakup of a romantic relationship and a serious loss, such as a loss of a

job, house, or money, serious illness and loss of freedom, or loss of other privileges. It is very rare that someone dies by suicide because of one cause. The Indian scenario is not much different from that of the world so far as the reasons of suicide are concerned. Depression is still one of the major causes. However the causes of depression in the people who had committed suicide in India are mainly three: being detected HIV positive, being unable to succeed in the examinations and being unable to return the heavy loans taken to support agricultural pursuits. It's mostly the students and the rural farmers who had committed the maximum number of suicides in India in the recent years.

Signs and Symptoms for Suicide

Making a will, getting his or her affairs in order, suddenly visiting friends or family members (one last time), buying instruments of suicide like a gun, hose, rope, pills or other forms of medications, a sudden and significant decline or improvement in mood, or writing a suicide note are some of the warning signs of an individual's planning to kill imminently themselves. Contrary to popular belief, many people who commit suicide do not tell their therapist or any other mental-health professional they plan to kill themselves in the months before they do so. If they communicate their plan to anyone, it is more likely to be someone with whom they are personally close, like a friend or family member.·

Table – 1: Incidence and Rate of suicidal deaths in India (1989-2006)

Year	Suicide Incidence			Estimated Mid-year Population (in lakhs)	Suicide Rate(per 100,000)
	Male	Female	Total		
1989	40212	28532	68744	8118	8.47
1990	43451	30460	73911	8270	8.94
1991	46324	32126	78450	8496	9.23
1992	47481	32668	80149	8677	9.24
1993	49851	34393	84244	8838	9.53
1994	52752	36443	89195	8999	9.91
1995	52357	36821	89178	9160	9.74
1996	51206	37035	88241	9319	9.47
1997	56281	39548	95829	9552	10.03
1998	61686	43027	104713	9709	10.79
1999	65488	45099	110587	9866	11.21
2000	66032	42561	108593	10021	10.8
2001	66314	42192	108506	10270	10.6
2002	69332	41085	110417	10506	10.5
2003	70221	40630	110851	10682	10.4
2004	72651	41046	113697	10856	10.5
2005	72916	40998	113914	11028	10.3
2006	75702	42410	118112	11198	10.5

Source: www.maithrikochi.org/india_suicide_statistics.htm

Individuals who take their lives tend to suffer from severe anxiety or depression, symptoms of which may include moderate alcohol abuse, insomnia, severe agitation, loss of interest in activities they used to enjoy (anhedonia), hopelessness, and persistent thoughts about the possibility of something bad happening. Since suicidal behaviors are often quite impulsive, removing guns, medications, knives, and other instruments people often use to kill themselves from the immediate environment can allow the individual time to think more clearly and perhaps choose a more rational way of coping with their pain.

Assessing Suicidal Thoughts and Behaviors

The risk assessment for suicidal thoughts and behaviors performed by mental-health professionals often involves an evaluation of the presence, severity, and duration of suicidal feelings in the individuals they treat as part of a comprehensive evaluation of the person's mental health. Therefore, in addition to asking questions about family mental-health history and about the symptoms of a variety of emotional problems (for example, anxiety, depression, mood swings, bizarre thoughts, substance abuse, eating disorders, and any history of being traumatized), practitioners frequently ask the people they evaluate about any past or present suicidal thoughts, dreams, intent, and plans. If the individual has ever attempted suicide, information about the circumstances surrounding the attempt, as well as the level of dangerousness of the method and the outcome of the attempt, may be explored. Any other history of violent behavior might be evaluated. The person's current circumstances, like recent stressors (for example, end of a relationship, family problems), sources of support, and accessibility of weapons are often probed. What treatment the person may be receiving and how he or she has responded to treatment recently and in the past, are other issues mental-health professionals tend to explore during an evaluation.

Sometimes professionals assess suicide risk by using an assessment scale. One such scale is called the SAD PERSONS Scale, which identifies risk factors for suicide as follows:

· Sex (male)
· Age younger than 19 or older than 45 years of age
· Depression (severe enough to be considered clinically significant)
· Previous suicide attempt or received mental-health services of any kind
· Excessive alcohol or other drug use
· Rational thinking lost
· Separated, divorced, or widowed (or other ending of significant relationship)
· Organized suicide plan or serious attempt
· No or little social support
· Sickness or chronic medical illness

The Treatment for Suicidal Thoughts and Behaviors

Those who treat people who attempt suicide tend to adapt immediate treatment to the person's individual needs. Those who have a responsive and intact family, good friendships, generally good social supports, and who have a history of being hopeful and have a desire to resolve conflicts may need only a brief crisis-oriented intervention. However, those who have made previous suicide attempts, have shown a high degree of intent to kill themselves, seem to be suffering from either severe depression or other mental illness, are abusing alcohol or other drugs, have trouble controlling their impulses, or have families who are unwilling to commit to counseling are at higher risk and may need psychiatric hospitalization and long-term outpatient mental-health services.

Suicide-prevention measures that are put in place following a psychiatric hospitalization usually involve mental-health professionals trying to implement a comprehensive outpatient treatment plan prior to the individual being discharged. This is all the more important since many people fail to comply with outpatient therapy after leaving the hospital. It is often recommended that all firearms and other weapons be removed from the home, because the individual may still find access to guns and other dangerous objects stored in their home, even if locked. It is further often recommended that sharp objects and potentially lethal medications be locked up as a result of the attempt.

Vigorous treatment of the underlying psychiatric disorder is important in decreasing short-term and long-term risk. Contracting with the person against suicide has not been shown to be especially effective in preventing suicidal behavior, but the technique may still be helpful in assessing risk, since refusal to agree to refrain from harming oneself or to fail to agree to tell a specified person may indicate intent to harm oneself. Contracting might also help the individual identify sources of support he or she can call upon in the event that suicidal thoughts recur.

Talk therapy that focuses on helping the person

understand how their thoughts and behaviors affect each other (cognitive behavioral therapy) has been found to be an effective treatment for many people who struggle with thoughts of harming themselves. School intervention programs in which teens are given support and educated about the risk factors, symptoms, and ways to manage suicidal thoughts in themselves and how to engage adults when they or a peer expresses suicidal thinking have been found to decrease the number of times adolescents report attempting suicide.

Although concerns have been raised about the possibility that antidepressant medications increase the frequency of suicide attempts, mental-health professionals try to put those concerns in the context of the need to treat the severe emotional problems that are usually associated with attempting suicide and the fact that the number of suicides that are completed by mentally ill individuals seems to decrease with treatment. The effectiveness of medication treatment for depression in teens is supported by the research, particularly when medication is combined with psychotherapy. In fact, concern has been expressed that the reduction of antidepressant prescribing since the Food and Drug Administration required that warning labels be placed on these medications may be related to the 18.2% increase in U.S. youth suicides from 2003-2004 after a decade of steady decrease. Also, the use of specific antidepressants has been associated with lower suicide rates in adolescents. Mood-stabilizing medications like lithium (Lithobid) -- as well as medications that address bizarre thinking and/or severe anxiety, like clozapine (Clozaril), risperidone (Risperdal), and aripiprazole (Abilify) -- have also been found to decrease the likelihood of individuals killing themselves.

Coping With Suicidal Thoughts

In the effort to cope with suicidal thoughts, silence is the enemy. Suggestions for helping people survive suicidal thinking include engaging the help of a doctor or other health professional, a spiritual advisor, or by immediately calling a suicide hotline or going to the closest emergency room or mental-health crisis center. In order to prevent acting on thoughts of suicide, it is often suggested that individuals who have experienced suicidal thinking keep a written or mental list of people to call in the event that suicidal thoughts come back. Other strategies include having someone hold all medications to prevent overdose, removing knives, guns, and other weapons from the home, scheduling stress-relieving activities every day, getting together with others to prevent isolation, writing down feelings, including positive ones, and avoiding the use of alcohol or other drugs.

The Effects of Suicide

The effects of suicidal behavior or completed suicide on friends and family members are often devastating. Individuals who lose a loved one to suicide (suicide survivors) are more at risk for becoming preoccupied with the reason for the suicide while wanting to deny or hide the cause of death, wondering if they could have prevented it, feeling blamed for the problems that preceded the suicide, feeling rejected by their loved one, and stigmatized by others. Survivors may experience a great range of conflicting emotions about the deceased, feeling everything from intense emotional pain and sadness about the loss, helpless to prevent it, longing for the person they lost, and anger at the deceased for taking their own life to relief if the suicide took place after years of physical or mental illness in their loved one. This is quite understandable given that the person they are grieving is at the same time the victim and the perpetrator of the fatal act.

Individuals left behind by the suicide of a loved one tend to experience complicated grief in reaction to that loss. Symptoms of grief that may be experienced by suicide survivors include intense emotion and longings for the deceased, severely intrusive thoughts about the lost loved one, extreme feelings of isolation and emptiness, avoiding doing things that bring back memories of the departed, new or worsened sleeping problems, and having no interest in activities that the sufferer used to enjoy.

Suicide Prevention

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