Suicidal Thoughts and Behaviour: Assessment and Treatment

Pratima Sharma Mehandru

ABSTRACT

This paper aimed to explore, how societies view suicide, varies by culture, religion, ethnic norms, and the circumstances under which it occurs. Treatment of suicidal thinking or attempt involves adapting immediate treatment to the sufferer’s individual needs. The purpose of this paper is: how are suicidal thoughts and behaviour assessed and what is the treatment for suicidal thoughts and behaviours and how can people cope with suicidal thoughts.

INTRODUCTION

Suicide is the act of a human being intentionally causing his or her own death. Suicide is often committed out of despair, or attributed to some underlying mental disorders which include depression, bipolar disorders, schizophrenia, alcoholism, and drug abuse (Hawton and Hearinger, 2009). Financial difficulties, troubles with interpersonal relationships and other undesirable situations play a significant role.

Over one million people die by suicide every year. The World Health Organization estimates that it is the thirteenth leading cause of death worldwide (Gross, 2006) and the National Safety Council rates it sixth in the United States. It is leading cause of death among teenagers and adults under 35 (Rory and Sheehy, 2000: 33-37). The rate of suicide is higher in men than in women (Gelder et. al., 2005: 169). There are estimated 10 to 20 million non-fatal attempted suicides every year worldwide (Bertolote, and Fleischmann, 2002: 181-185).

Views on suicide have been influenced by broader cultural view on existential themes such as religion, honour, and the meaning of life. The Abramic religion consider suicide an offense towards God due to religious belief in the sanctity of life. In the West it was often regarded as a serious crime. Conversely, during the samurai era in Japan, seppuku was respected as a means of atonement for failure or as a form of protest. In the 20th century, suicide in the form of self-immolation has been used as a form of protest, and in the form of Kamikaze and suicide bombing as a military or
terrorist tactic. *Sati* is the Hindu funeral practice in which the widow would immolate herself on her husband’s funeral pyre, either willingly or under the pressure of family and society.

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 oneself but to save another, however, Emile Durkheim’s theory termed such acts “altrustic suicide” (Blake, 1978: 46-59).

**INDIA: SUICIDE CAPITAL OF THE WORLD**

India is the suicide capital of the world. According to medical proof, suicidal tendencies have been present in the 1/3 of people with mild cases of depression and in nearly three quarters of people who are severely depressed. No age, group or social professional class is exempt from suicide, think of the famous people who have killed themselves like Boudicca, Brutus, Mark Antony, Cleopatra VII, Judas Iscariot, Hannibal, Virginia Woolf, Sigmund Freud, Adolf Hitler, Eva Braun, and so many others.
India has the highest number of suicide cases in the world. More than 100,000 people in India die by suicide each year. Here are some more suicide statistics in India:

1. The highest number of suicides and attempted suicides happen in Mumbai and parts of Maharashtra.

2. South India also known as World’s suicide capital. In the Union Territory of Pondicheery, every month at least 15 youths between the ages of 15 and 25 commit suicide.

3. In 2002, there were 10,982 suicides in Tamil Naidu, 11,300 in Kerala, 10,934 in Karnataka, and 9,433 in Andhra Pradesh.

4. Kerala, the country’s first fully literate state, has the highest number of suicides. Some 32 people commit suicide in Kerala every day.

Three major reasons for suicide is academic disappointments, relationship failures and financial downfalls and the “high risk group” for suicide are those who have severe depression, past history of suicide attempts and if there are no deterrents to hold back (family, friends or religious beliefs).
Rate of Suicides in States / UTs during 2006

State/UT wise Percentage Variation in Suicides
During 2006 over 2005
Particularly shocking and by no means rare, is the suicide among young. Out of every three cases of suicide reported every 15 minutes in India, one is committed by a youth in the age group of 15-29. On average, adolescents aged 15-19 years have an annual suicide rate of about 1 in 10,000 people. Among youths 12 to 16 years of age, up to 10% of boys and 20% of girls have considered suicide.

**Major Causes of Suicide in Teens & Youngsters**

*Parental Pressure major cause of child suicides*

Sab but true… parents are responsible for giving children lives and in some odd ways, even taking their lives. No parents want to kill her kids, but they do so by setting unrealistic goals in front of them. Every parents wants her children to be the best and the brightest; they are not necessarily in the areas that their parents set their eyes upon. Parents believe that they are thinking good for their children, but they are actually thinking good ‘according to their perception’. Parents are not always right. What they think is right, may not be right for their children.

*Flawed Education System*

Flawed education system is one of the major reasons for child and teen suicide. The system of rating, testing and marks need to be scraped. Don’t need competition at the cost of losing lives. How many 90+ percentage have actually done great jobs in their lives. We see their happy smiling faces on the newspaper headlines, when the results out. But no one knows what happened to them later. Extreme is happened currently when one of the renowned university of India declared his cut off list 100%, without analysing what may be the consequences. Rating and grades no means, a measure of intelligence. It may be retention, but definitely not knowledge.

Most of the colleges in India have namesake counseling centres which are locked most of the times. Why does our education system look down upon a child who is caught coping and treat her like an out-caste? Imagine the shock the child goes through, the embarrassment of being torn apart by her parents, by her teachers and by everyone they knows? The child will try to seek an end to the misery.
Troubling & difficult situations

Many troubling and difficult situations can make a teen consider suicide. The same emotional states that make adults vulnerable to considering suicide also apply to adolescents. Those with good support networks in family and society are likely to have an outlet to help them deal with their feelings. Others without such networks are more susceptible during their emotional changes, and may feel alone in times of trouble.

Specific Circumstances

Some specific circumstances can contribute to an adolescent’s consideration of suicide. It’s especially difficult when adolescents are confronted with problems that are out of their control such as: divorce, physical or sexual abuse, emotional neglect, exposure to domestic violence, alcoholism in the home, substance abuse, etc.

Table-1: Major risk factors for suicide (Allen: 75-113)

<table>
<thead>
<tr>
<th>“Fixed” factors</th>
<th>Potentially modifiable factors</th>
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<tbody>
<tr>
<td>Gender</td>
<td>Access to means</td>
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<tr>
<td>Age</td>
<td>Mental disorders</td>
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<tr>
<td>Ethnicity</td>
<td>Medical illnesses</td>
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<td>Sexual orientation</td>
<td>Social isolation</td>
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<td>Previous attempts</td>
<td>Marital status</td>
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<td></td>
<td>Employment status</td>
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<td></td>
<td>Anxiety</td>
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<td></td>
<td>Hopelessness</td>
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<td></td>
<td>Life satisfaction</td>
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Observe these changes in children who are suicide prone

- total withdrawal and non interaction with people.
- changes in day-to-day activity pattern.
- continuous claims of having an urge to end one’s life.
- if a person runs to an isolated place to cry often or looks continually lost or depressed, there is a feeling that something wrong.
- violent or rebellious behaviour.
- persistent boredom, difficulty concentrating, or a decline in the quality of work.
- frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches fatigue, etc.
- not tolerating praise or rewards.
- complain of being a bad person or rotten inside.
- give verbal hints with statements such as: I won’t be a problem for you much longer, Nothing matters, It’s no use and I won’t see you again.
• become suddenly cheerful after a period of depression.
• Have signs of psychosis (hallucinations or bizarre thoughts).

In 2007, suicide was the third leading cause of death for young people in each age group, the following number died by suicide:
• Children ages 10 to 14 - 0.9 per 100,000
• Adolescents ages 15 to 19 - 6.9 per 100,000
• Young adults ages 20 to 24 - 12.7 per 100,000

There were also gender differences in suicide among young people as follows:
• Nearly five times as many as females ages 15 to 19 died by suicide
• Just under six times as many males as females ages 20 to 24 died by suicide

**ASSESSMENT OF SUICIDAL THOUGHTS AND BEHAVIOUR**

The risk assessment for suicidal thoughts and behaviours 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 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 (e.g., Anxiety, depression, mood swings, bizarre thoughts, substance abuse, eating disorders and any history of being traumatized), practitioners frequently ask 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 behaviour might be evaluated. The person’s current circumstances, like recent stressors (for example, end of a relationship, family problems, etc.) sources of support, and accessibility of weapons are often probed. What treatment and how he or she has responded to treatment recently 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 PERSON Scale, which identifies risk factors for suicide as follows:
• Sex (male/ female)
• Age younger than 19 or older than 45 years of age
• Depression (severe enough to be considered clinically significant)
• Previous suicide attempts 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 plans or serious attempt
• No or little social support
• Sickness or chronic medical illness.
TREATMENT AND PREVENTION

Suicide prevention is an umbrella term for the collective efforts of local citizen organisation, mental health practitioners and related professionals to reduce the incidence of suicide. It may not be possible to eliminate entirely the risk of suicide but it is possible to reduce this risk. Suicide should not be viewed solely as a medical or mental health problem, since protective factors such as social support and connectedness appear to play significant roles in the prevention of suicide.

Mental Health Treatment

Treatment, often including medication, counselling, and psychotherapy, is directed at the underlying causes of suicidal thinking. According to a 2005 randomized controlled trial by Gregory Brown, Aaron Beck and others, Cognitive therapy can reduce repeat suicide attempts by 50% (Brown, Have, Henriques, Xie, Hollander, and Beck, 2005). A thorough discussion of the comparative effectiveness of types of intervention is beyond the scope of this paper. Broadly speaking, major interventions for the prevention of suicide can be grouped under the following headings:

- **Reduction of access to methods and means of suicide** — An overview of the evidence indicates that reduction of access to methods (e.g., Medication, pesticides, car exhausts, firearms) is perhaps the intervention with strongest impact at the population level (Lester, 1997: 304-310).

- **Treatment of people with mental disorders** — It is remarkable that the introduction, by the middle of the 20th century, of effective medication for the control of major mental disorders associated with suicide (e.g., depression and schizophrenia) has brought no significant reduction in national suicide rates in those countries where the medication was widely used. The recent introduction of new antidepressant medication has led to controversial evidence concerning its impact on suicide rates (World Health Organization). However, the evidence is far better when examined for specific diseases, e.g., major depression (Angst, Angst and Stassen, 1999: 57-62), and schizophrenia (Meltzer, 2001: 44-58) or treatment approaches (e.g., the use of lithium in mood disorders) (Coppen, 2000: 52-56). Probably a close follow-up of people who previously have attempted suicide would also fall under this heading (Retterstol, and Mehlun, 2001: 125-131).

- **Improvement of media portrayal of suicide** — Although there is a consistent evidence about the improvement of media portrayal of suicide (Schmidtke and Schaller, 2003: 675-697), the impact of this intervention at the national level remains to be convincingly demonstrated.

- **Training of primary health care personnel** — The evidence of the efficacy of training primary health care personnel as an approach to suicide prevention, although much touted, remains based on a single remarkable but limited—both geographically and in terms of gender differences. Larger ongoing studies (e.g., in Hungry and UK (Thompson, Kinmoth, Stevens, et al., 2000: 185-191)) should shed additional light on this issue.

- **School-based Programmes** — The same applies to school-based programmes. The ever-quoted example of Dade County (Zenere and Lazarus, 2002: 387-402), (nevertheless more related to suicide attempts than to completed suicides) stands unfortunately in isolation. Environmental and epidemiological specificities of school populations should be carefully considered in programmes with them (Silverman, Meyer and Sloane, F., et al. 1997: 285 303).
Availability of hot lines and crises centres — In spite of their popularity and attractiveness, so far there is no conclusive evidence on the effectiveness of suicide prevention hotlines and crises centres (Diekstra, and Kerkhof, 1994: 145-165 and Lester, 2001: 7-24). Admittedly, it seems that their efficacy to help people in crises (not necessarily suicidal) is far greater than their impact on suicide rates.

Other than these some specific strategies have also been used in suicide prevention:

- Selection and training of volunteer citizen groups offering confidential referral services.
- Promoting mental resilience through optimism and connectedness.
- Education about suicide, including risk factors, warning signs and the availability of help.
- Increasing the proficiency of health and welfare services at responding to people in need. This includes better training for health professionals and employing crises counseling organization.
- Reducing domestic violence and substance abuse are long term strategies to reduce many mental health problems.
- Reducing access to convenient means of suicide (e.g., toxic substances, handguns).
- Reducing the quantity of dosages supplied in packages of non-prescription medicines e.g. aspirin.
- Interventions targeted at high risk groups.

Table-2: Examples of effective preventive interventions for suicidal behaviours (Forster, and Wu, 2002: 75-113)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Prevention of mental disorders</th>
<th>Prevention of suicide</th>
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<tbody>
<tr>
<td>Universal</td>
<td>Adequate pre-natal care</td>
<td>Limitation of access to toxic substances.</td>
</tr>
<tr>
<td>Selective</td>
<td>Psychological support to people in crises situation or with physical diseases</td>
<td>Treatment of people with mental disorders (including substance use disorders).</td>
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<tr>
<td>Indicated</td>
<td>Programmes for parents of pre-school children with marked aggression and rebelliousness.</td>
<td>Close therapeutic follow-up of people with bipolar disorders or with recurrent psychotic episodes. Close (psychosocial) follow-up of previous attempters.</td>
</tr>
</tbody>
</table>

COPE 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 professionals, a spiritual adviser, or by immediately calling a suicide hotline or going to the closest emergency room or mental health crises centre. 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.
FOOTNOTES
1 Seppuka-seppuka was used voluntarily by samurai to die with honour rather fall into the hands of their enemies. The ceremonial disembowelment, consists of plunging a short blade, traditionally a tanto, into the abdomen and moving the blade from left to right in a slicing motion.
2 Kamikaze- the kamikaze were suicide attacks by military aviators. Kamikaze pilots would to crash their aircrafts into enemy ships- planes.

REFERENCES


