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Suicide Factors & Management

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Abstract:
Suicidal behavior is a major public health problem. As it has for decades, suicide remains one of the leading causes of death in the western world. Suicide is among the top three causes of death among youth worldwide. According to the WHO, every year, almost one million people die from suicide and 20 times more people attempt suicide; a global mortality rate of 16 per 100,000, or one death every 40 seconds and one attempt every 3 seconds, on average.
WHO estimates for the year 2020, approximately 1.53 million people will die from suicide; and ten to 20 times more people will attempt suicide worldwide. These estimates represent on average one death every 20 seconds and one attempt every one to two seconds. Although of low predictive value, the presence of psychopathology is probably the single most important predictor of suicide. Accordingly, approximately 90 percent of suicide cases meet criteria for a psychiatric disorder, particularly major depression, substance use disorders, cluster B personality disorders and schizophrenia. Other more transient factors that reflect an imminent risk of suicide crisis and therefore require immediate intervention include unbearable mental pain and related experiences of depression and hopelessness.

Keywords: Aggression, Violence, Suicide and Gender, Impulsivity Mental Pain, Loneliness, Alienation, Communication Difficulties Suicide Risk, Suicidal Measures to prevent Suicide

Introduction:

Suicide is an act of intentional self-harm that ultimately results in death. Although suicide may seem out of place or show no warning signs, people who die by suicide often experience mental health problems or lifelong depression before they die.
Suicide is a big problem in India. More than 100,000 people die by suicide every year in our country. In the last 20 years, suicide has increased from 7.9 to 10.3 per 100,000 people.
The majority (37.8%) of suicides in India are among people under the age of 30. The fact that 71% of suicides in India are under the age of 44 has a tremendous emotional and financial impact on our lives.

Motives for Suicide:

A truism in suicide literature is that “not all persons who commit suicide want to die and not all persons who want to die commit suicide”. In India, the top 10 causes or correlates of suicide in 2009 were family problems (23.7%), illness (21%) [including insanity/mental illness (6.7%)], unemployment (1.9%), love affairs (2.9%), drug abuse/addiction (2.3%), failure in examination (1.6%), bankruptcy or sudden change in economic status (2.5%), poverty (2.3%), and dowry dispute (2.3%).
The high rates of suicide among persons with mental illness and drug abuse/addiction, though not a measure of intent, are of much concern. Many of the remaining causes [namely, suspected/illicit relation, cancellation/non-settlement of marriage, not having children (barrenness/impotency), death of a dear

one, dowry dispute, divorce, ideological causes/hero worship, illegitimate pregnancy, physical abuse (rape, incest, etc.), poverty, professional/career problem] reflect the unique social structure of our society and the social pressures that individuals face.

Risk Factors:

Psychopathology

Most people, including youth, who contemplate, attempt and/or die from suicide suffer from one or more psychopathologies.

Mood disorders are the most common mental disorders reported as associated with suicidal behavior. Several studies found a correlation between suicide attempters suffering from depression and high levels of impulsive and aggressive behaviors.

Others who tend to engage in suicidal behaviors are those suffering from schizophrenia. Methods used in suicide attempts by individuals suffering from schizophrenia are largely non-violent. Suicide attempts in alcoholics are common and have been also linked to behavioral inhibition, impulsivity and aggression with the use of violent methods for the attempts.

TRAITS: AGGRESSION AND IMPULSIVITY

Aggression- Multiple epidemiologic, clinical, retrospective, prospective, and family studies have identified a strong link between aggression and suicide. In a different perspective on the relation between suicide and aggression, several studies focused on choices of methods for the suicide attempt. They found that the use of violent methods of suicide is a behavioral marker of a higher level of lifetime impulsive-aggressive behaviors and is more often used by males than females.

Gender is a factor that is closely related to suicide attempts and to the lethality of the attempt. It has been found across different studies, that actual suicide is more prevalent among men, whereas nonfatal suicidal behaviors are more prevalent among women.

Violence, Suicide and Gender: Among individuals with histories of violence, gender does not appear to protect against suicide risk. Yet, relatively less research has focused on potential gender differences in the relationships between suicidality, violence, and associated variables.

Gender made an independent contribution to the prediction of both suicide risk and violence risk, but in opposite ways, with female gender contributing to the suicide risk and male gender contributing to violence. Similarly, studies on exposure to violence demonstrated gender-specific associations between exposure to violence and suicide risk.

Impulsivity- Impulsivity, a prominent construct in most theories of personality, encompasses a broad range of behaviors that reflect impaired self-regulation, such as poor planning, premature responding before considering consequences, sensation-seeking, risk-taking, an inability to inhibit responses, and preference for immediate over delayed rewards. Suicide attempts are often impulsive and many studies have identified impulsivity as a common correlate and risk factor for suicidal behavior.

INTRAPERSONAL AND INTERPERSONAL FACTORS: -

- **Mental Pain-** Mental pain is an important concept that is studied from different perspectives: theoretically, clinically and empirically. The most extensive contribution to the clarification of the concept has been provided by Shneidman who coined the term 'psychic' (i.e., unbearable mental pain). According to his view psychache is the result of frustrated or thwarted essential needs (e.g., to

love; to have control; to protect one's self-image; to avoid shame, guilt, humiliation; to feel secure) that arouse a mixture of negative emotions like guilt, shame, hopelessness, disgrace, rage and defeat.

- **Loneliness, Alienation, Communication Difficulties-** Several studies have highlighted the significant role of interpersonal risk factors in suicide. People who are able to share t heir difficulties with family, friends or others benefit in various ways. Communication enhances intimate relations and helps to cope with stress and traumatic events.

People who communicate their difficulties to their environment are less likely to kill themselves. On the other hand, when communication fails, the risk for suicide arises. For instance, the association between social isolation and suicidal ideation, attempts, and lethal suicidal behavior was found in various samples varying in age, nationality, and clinical severity.

Estimation of Suicide Risk:

Suicide and suicidal behaviors cause severe personal, social, and economic consequences. Despite the severity of these consequences, suicide and suicidal behaviors are statistically rare, even in populations at risk. For example, although suicidal ideation and attempts are associated with increased suicide risk, most individuals with suicidal thoughts or attempts will never die by suicide. It is estimated that attempts and ideation occur in approximately 0.7% and 5.6% of the general U.S. population per year, respectively. In comparison, in the United States, the annual incidence of suicide in the general population is approximately 10.7 suicides for every 100,000 persons, or 0.0107% of the total population per year. This rarity of suicide, even in groups known to be at higher risk than the general population, contributes to the impossibility of predicting suicide.

Some factors may increase or decrease risk for suicide; others may be more relevant to risk for suicide attempts or other self-injurious behaviors, which are in turn associated with potential morbidity as well as increased suicide risk. It is estimated that attempts and ideation occur in approximately 0.7% and 5.6% of the general U.S. population per year, respectively. In comparison, in the United States, the annual incidence of suicide in the general population is approximately 10.7 suicides for every 100,000 persons, or 0.0107% of the total population per year. This rarity of suicide, even in groups known to be at higher risk than the general population, contributes to the impossibility of predicting suicide.

The statistical rarity of suicide also makes it impossible to predict on the basis of risk factors either alone or in combination. For the psychiatrist, knowing that a particular factor (e.g., major depressive disorder, hopelessness, substance use) increases a patient's relative risk for suicide may affect the treatment plan, including determination of a treatment setting. At the same time, knowledge of risk factors will not permit the psychiatrist to predict when or if a specific patient will die by suicide. This does not mean that the psychiatrist should ignore risk factors or view suicidal patients as untreatable.

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Suicide Victims based on various status:

PROFESSIONAL STATUS- Out of a total of 1,18,979 male suicides, wage earners (37,751) committed suicide the most, followed by self-employed (18,803) and unemployed (4,444 (11.724)). in 2021, a total of 45,026 women and 4,444 suicides occurred in countries. among women, the highest

number of suicides was (23,178) housewives, students (5693), and daily waged (4246), a total of 28 trans committed suicide times.

SOCIAL STATUS- Social status of Victims is classified in seven Categories: Namely, "Un-married", "Married", "Widowed/Widower", "Divorcee", "Separated", "Others" and "Status not Known".

Signs Someone May Be Suicidal: -

- Excessive Quietness
- Withdrawal from loved Ones
- Avoiding Physical contact or eye contact.
- Fatigue
- Irritability
- Outbursts of Anger
- Strange act that could be a way to practice for Suicide.

Measures to prevent Suicide: -

- **Strengthen economic supports**
  1. Improve household financial security
  2. Stabilize housing
- **Create protective environments**
  1. Reduce access to lethal means among persons at risk of suicide
  2. Create healthy organizational policies and culture
  3. Reduce substance use through community-based policies and practices
- **Improve access and delivery of suicide care**
  1. Cover mental health conditions in health insurance policies
  2. Increase provider availability in underserved areas
  3. Provide rapid and remote access to help
  4. Create safer suicide care through systems change

PSYCHIATRIC MANAGEMENT: -

Psychiatric management consists of a broad array of therapeutic interventions that should be instituted for patients with suicidal thoughts, plans, or behaviors. It includes determining a setting for treatment and supervision, attending to patient safety, and working to establish a cooperative and collaborative physician-patient relationship. For patients in ongoing treatment, psychiatric management also includes establishing and maintaining a therapeutic alliance; coordinating treatment provided by multiple clinicians; monitoring the patient's progress and response to the treatment plan; and conducting ongoing assessments of the patient's safety, psychiatric status, and level of functioning. Additionally, psychiatric management may include encouraging treatment adherence and providing education to the patient and, when indicated, family members and significant others.

Patients with suicidal thoughts, plans, or behaviors should generally be treated in the setting that is least restrictive yet most likely to be safe and effective. Treatment settings and conditions include a continuum of possible levels of care, from involuntary inpatient hospitalization through partial hospital and intensive outpatient programs to occasional ambulatory visits. In treating suicidal patients,

particularly those with severe or recurring suicidality or self-injurious behavior, the psychiatrist should be aware of his or her own emotions and reactions that may interfere with the patient's care.
For difficult-to-treat patients, consultation or supervision from a colleague may help in affirming the appropriateness of the treatment plan, suggesting alternative therapeutic approaches, or monitoring and dealing with counter transference issues. The suicide prevention contract, or "no-harm contract," is commonly used in clinical practice but should not be considered as a substitute for a careful clinical assessment.

Specific Treatment Modalities:
In developing a plan of treatment that addresses suicidal thoughts or behaviors, the psychiatrist should consider the potential benefits of somatic therapies as well as the potential benefits of psychosocial interventions, including the psychotherapies. Clinical experience indicates that many patients with suicidal thoughts, plans, or behaviors will benefit most from a combination of these treatments. The psychiatrist should address the modifiable risk factors identified in the initial psychiatric evaluation and make ongoing assessments during the course of treatment.

Somatic interventions:
Evidence for a lowering of suicide rates with antidepressant treatment is inconclusive. However, the documented efficacy of antidepressants in treating acute depressive episodes and their long-term benefit in patients with recurrent forms of severe anxiety or depressive disorders support their use in individuals with these disorders who are experiencing suicidal thoughts or behaviors. It is advisable to select an antidepressant with a low risk of lethality on acute overdose, such as a selective serotonin reuptake inhibitor (SSRI) or other newer antidepressant, and to prescribe conservative quantities, especially for patients who are not well-known.
Since antidepressant effects may not be observed for days to weeks after treatment has started, patients should be monitored closely early in treatment and educated about this probable delay in symptom relief. To treat symptoms such as severe insomnia, agitation, panic attacks, or psychic anxiety, benzodiazepines may be indicated on a short-term basis with long-acting agents often being preferred over short-acting agents.
There is strong evidence that long-term maintenance treatment with lithium salts is associated with major reductions in the risk of both suicide and suicide attempts in patients with bipolar disorder, and there is moderate evidence for similar risk reductions in patients with recurrent major depressive disorder.

Psychosocial interventions:
Psychotherapies and other psychosocial interventions play an important role in the treatment of individuals with suicidal thoughts and behaviors. A substantial body of evidence supports the efficacy of psychotherapy in the treatment of specific disorders, such as non-psychotic major depressive disorder and borderline personality disorder, which are associated with increased suicide risk. For example, interpersonal psychotherapy and cognitive behavior therapy have been found to be effective in clinical trials for the treatment of depression. In addition, cognitive behavior therapy may be used to decrease two important risk factors for suicide: hopelessness and suicide attempts in depressed outpatients. For patients with a diagnosis of borderline personality disorder, psychodynamic therapy and dialectical

behavior therapy may be appropriate treatments for suicidal behaviors, because modest evidence has shown these therapies to be associated with decreased self-injurious behaviors, including suicide attempts.

SUMMARY: -

Suicide is a complex and multidimensional phenomenon stemming from the interaction of several factors. Suicide remains an important and major cause of death in various populations' samples varying in age, nationality, and clinical severity. It cuts through nosological boundaries and across psychiatric diagnoses; it also characterizes non-psychiatric populations. Non fatal suicidal behavior is also associated with a great deal of suffering and risk. Although suicidal behavior has been extensively studied, major problems still remain to be solved. Among them are those of definition of different subtypes and phenotypes of suicidal behaviors, and associated factors (such as aggression, impulsivity, suicide intent)

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