Suicide Prevention: Emerging from Darkness

Celebrate Life
Suicide Prevention: Emerging from darkness

Contents

Introduction 6
Historical background 7
Myths and misconceptions about suicide 10
Some facts and figures 12
Why does it happen? 26
Impact of suicide 30
Neglect of suicide 37
Persons at risk 38
What can be done? 42

Individuals... Savelives
Families... Besupportive
Communities... Widernetwork
High-risk places... Keepawatch
Health sectors... Emergingtasks
Health professionals... Beyondmedicines
Media... Shapethesociety
Teachers... Help thechildren
Legaleform... Lawsandimpact
Spiritual leaders and faith healers... Wisdomtoaction
NGOs... Pillarsofstrength
Nationalgovernments... Timetoact
Research... Towardsunderstanding

Epilogue 70

©World Health Organization 2001

This document is not a formal publication of the World Health Organization (WHO), and all rights are reserved by the Organization. The document may, however, be freely reviewed, abstracted, reproduced or translated in part or in whole, but not for sale or for use in conjunction with commercial purposes.

The views expressed in documents by named authors are solely the responsibility of those authors.

- Paintings on pages 6, 13, 30, 47, 59, 65, and 70 are contributed to WHO complimentary by Yogeeta, an eminent artist.
- Paintings on pages 9, 23, 27, 33, 41, 63, and 69 are part of a WHO-sponsored globalschoolcontestonmentalhealthforchildrenaged6-9years.
- Computer graphics on pages 10, 15, 29, 35, 39, 44, 54, and 61 were created at ExposureMultiples.
Suicide Prevention: Emerging from Darkness

Authors

Coordinating Author:
Dr. G. Gururaj
Additional Professor and Head
Department of Epidemiology
National Institute of Mental Health and Neurosciences
Bangalore, India

Dr. Mohan K. Isaac
Professor
Department of Psychiatry
National Institute of Mental Health and Neurosciences
Bangalore, India

Dr. Mintarish A. Latief
National Narcotics Co-ordinating Board
Jakarta, Indonesia

Dr. Ranil Abeyasinghe
Department of Psychiatry
Faculty of Medicine
Peradeniya, Sri Lanka

Dr. Prawate Tantipwatanaskul
Child Mental Health Centre
Rachathiw
Bangkok, Thailand

© World Health Organization 2001

This document is not a formal publication of the World Health Organization (WHO), and all rights are reserved by the Organization. The document may, however, be freely reviewed, abstracted, reproduced or translated in part or in whole, but not for sale or for use in conjunction with commercial purposes.

The views expressed in documents by named authors are solely the responsibility of those authors.

- Paintings on pages 6, 13, 30, 47, 59, 65, and 70 are contributed to WHO complimentary by Yogeeta, an eminent artist.
- Paintings on pages 9, 23, 27, 33, 41, 63, and 69 are part of a WHO-sponsored global school contest on mental health for children aged 6-9 years.
- Computer graphics on pages 10, 15, 29, 35, 39, 44, 54 and 61 were created at Exposure Multiples.

Contents

Introduction 6
Historical background 7
Myths and misconceptions about suicide 10
Some facts and figures 12
Why does it happen? 26
Impact of suicide 36
Neglect of suicide 37
Persons at risk 38
What can be done? 42

- Individuals... Savelives
- Families... Besupportive
- Communities... Widensupport
- High-risk places... Keepawatch
- Health sector... Emergingtasks
- Health professionals... Beyond medicines
- Media... Shapethesociety
- Teachers... Help the children
- Legal reforms... Lawsandimpact
- Spiritual leaders and faith healers... Wisdomtoaction
- NGOs... Pillarsofstrength
- National governments... Timetoact
- Research... Towardstounderstanding

Epilogue 70
Preface

Suicide, as an issue, has attracted the attention of society since time immemorial. The writer, Paul-Louis Landsberg (1901-1943) wrote, “Suicide is something on its own. It seems to be a flight by which man hopes to recover Paradise Lost instead of trying to deserve Heaven.” It has been condemned by some religions and communities, glorified in some situations or treated as a personal matter affecting an individual and, at most, his immediate family. Regardless of how it is viewed, it attracts the attention of the community and evokes mixed reactions. Recently, the thinking on suicide has changed. It is now recognized as a major public health problem to be addressed scientifically like any other medical condition.

Countries of the South-East Asia Region have a rich and robust culture which incorporates strong family bonds, widespread community support and faith in religious teachings. Although some of these values may be eroding, they continue to provide substantial moral support to individuals in times of physical and mental adversity. Therefore, it is particularly distressing to note that suicide rates in some Member Countries are unacceptably high. Another issue of concern is that the risk factors for suicide identified in western studies (such as substance abuse, broken families, death of a spouse) do not seem to explain a vast majority of suicides in the Region. All these factors call for a major effort by countries of the Region to launch an intensive effort to prevent suicide.

The WHO Regional Office for South-East Asia is committed to supporting Member Countries in project and programmes related to reduction in deaths due to suicide by providing support in research for the identification of unique risk factors, development of study methodology, establishing and strengthening surveillance activity and control programmes; establishing regional networks to disseminate information; advocacy with governments and the community to launch appropriate control programmes; developing manpower, including counsellors and therapists when needed, and promotion of ongoing social and developmental reforms.

There is an urgent need for all Member Countries to recognize the impact of suicide on the family and the community and to develop culturally appropriate programmes to contain it. As James Garfield (1831-1881) the famous US statesman wrote, "Suicide is not a remedy." Also, we need to "celebrate life," not end it. These messages must reach the community.

Dr Vijay Chandra
Regional Adviser, Health and Behaviour
World Health Organization
Regional Office for South-East Asia
Preface

Suicide, as an issue, has attracted the attention of society since time immemorial. The writer, Paul-Louis Landsberg (1901-1943) wrote, “Suicide is something on its own. It seems to be a flight by which man hopes to recover Paradise Lost instead of trying to deserve Heaven.” It has been condemned by some religions and communities, glorified in some situations or treated as a personal matter affecting an individual and, at most, his immediate family. Regardless of how it is viewed, it attracts the attention of the community and evokes mixed reactions.

Recently, the thinking on suicide has changed. It is now recognized as a major public health problem to be addressed scientifically like any other medical condition.

Countries of the South-East Asia Region have a rich and robust culture which incorporates strong family bonds, widespread community support and faith in religious teachings. Although some of these values may be eroding, they continue to provide strong moral support to individuals in times of physical and mental adversity. Therefore, it is particularly distressing to note that suicide rates in some Member Countries are unacceptably high. Another issue of concern is the risk factors for suicide identified in western studies (such as substance abuse, broken families, death of a spouse) do not seem to explain the vast majority of suicides in the Region. All these factors call for a major effort by countries of the Region to launch an intensive effort to prevent suicide.

The WHO Regional Office for South-East Asia is committed to supporting Member Countries in projects and programmes related to reducing deaths due to suicide by providing support in search for the identification of unique risk factors, development of study methodology, establishing and strengthening surveillance activity and control programmes; establishing regional networks to disseminate information; and advocating with governments and the community to launch appropriate control programmes; developing manpower, including counsellors and therapists where needed, and promoting ongoing social and developmental reforms.

There is an urgent need for all Member Countries to recognize the impact of suicide on the family and the community and to develop culturally appropriate programmes to contain it. As James Garfield (1831-1881) the famous US statesman wrote, “Suicide is not a remedy.” Also, we need to “celebrate life,” not end it. These messages must reach out to the community.

Dr. Vijay Chandra
Regional Adviser, Health and Behaviour
World Health Organization
Regional Office for South-East Asia
Suicide finds mention in the ancient treatises of all cultures. As early as the sixteenth century, the Christian church declared suicide an unacceptable act and a form of murder, and concluded that it was immoral and could never be justified. Suicide victims were even refused burial in the early part of the thirteenth century. In the New Testament, there is only one case of direct suicide, that of Judas Iscariot who betrayed Jesus Christ. Filled with remorse, he hanged himself. Islam views suicides as sin: as by deliberately killing oneself, the individual not only destroys his skills and qualities, but also deprives his family and society. Zoroastrian philosophers consider taking one’s own life a grievous crime. The early Greeks considered suicide an appropriate solution to certain stress situations such as terminal illness, love or disappointment. However, the Romans were against suicide, in the sense that committing suicide was a sin, whereby the person deprived the State of his moral duties. Judaism also considers suicide to be a sin. In the New Testament, according to the French philosopher Albert Camus (Myth of Sisyphus), "suicide is the only philosophical problem in the world." He emphasized that "an act of suicide is prepared within the silence of the heart, as is a great work of art." In certain situations and wars, suicide was considered a moral and heroic act (e.g. hari-kiri by Japanese Samurai).

However, this understanding has not been effectively translated into practice, thus leading to continued loss of lives.

Today, it is possible to predict and prevent suicide.
Countries of the South-East Asia Region (SEAR) are witnessing rapid changes in population growth, socioeconomic development and health profiles. Suicide is now being recognized as a major public health problem in the complex scenario of development and lifestyle changes. In the socio-culturally diverse communities of this Region, suicide is a very important issue cutting across diverse disciplines and sectors such as health, religion, spirituality, law and welfare.

Suicide evokes mixed reactions: varying from anger, distress, ridicule, anxiety, tension, fear and sadness. Often, one wonders: “Why did it happen?” “Could this have been prevented?” “Can young lives be saved?” “Was there an alternative solution to the problem?” Though suicides and para-suicides have been attempted since the beginning of mankind, each change has been observed recently in our understanding of the problem. Cumulative research, media reports and anecdotal evidence over the past three decades reveal that suicides are an emerging epidemic the world over. Research in different regions of the world has focused on understanding the problem in its various dimensions.

Today, it is possible to predict and prevent suicide.

However, this understanding has not been effectively translated into practice, thus leading to continued loss of lives.

Suicide finds mention in the ancient treatises of all cultures. As early as the sixteenth century, the Christian church declared suicide an unacceptable act and a form of murder, and concluded that it was immoral and could never be justified. Suicide victims were even refused burial in the early part of the thirteenth century. In the New Testament, there is only one case of direct suicide, that of Judas Iscariot who betrayed Jesus Christ. Filled with remorse, he hanged himself. Islam views suicide as an asbydeliberately killing oneself, the individual not only destroys his skills and qualities, but also deprives his family and society. Zoroastrian philosophers consider taking one’s own life a grievous crime. The early Greeks considered suicide an appropriate solution to certain stressful situations such as terminal illness, love or disappointment. However, the Romans were against suicide, in the sense that committing suicide was an act, whereby the person deprived the state of his moral duties. Judaism also considers suicide to be an insult. According to the French philosopher Albert Camus (Myth of Sisyphus), “suicide is the only philosophical problem in the world.” He emphasized that “an act of suicide is prepared within the silence of the heart, as is a great work of art.” In certain situations and wars, suicide was considered a moral and heroic act (e.g., hara-kiri by Japanese Samurai).

The word “suicide” was first used by Sir Thomas Browne in 1642 in his Religio Medicinae. The word originated from SUI (of one self) and CAEDES (murder). Since then, the word has evoked constant and continuous debate and has been defined in various ways: medical, social, psychological, administrative, legal, spiritual and religious purposes.
Suicide is commonly referred to as Atmahya in (Hindi, India), KhutaTa in (Thai, Thailand), BunuhDiri in (Bahasa, Indonesia), Itahathyain (Bangla, Bangladesh), SiyaDivina in (Sinhalese, Sri Lanka) and by other local terms in different countries. Even within the same country, people use different terms in their language, culture and communication. The practice of singing Maromi is prevalent in South-West Bangladesh, where suicide rates are high. Information from Sri Lanka, which has a predominantly Buddhist population, reveals that a large number of suicides are among Buddhists, even though their religion does not favour suicide. The belief in rebirth and the lack of definite statements on suicide by Buddhism, suicide is much less ‘sinful’ than killing another person. However, in Thailand, where a large majority of the population is Buddhist, suicide is considered as sin. The same is true within the Islamic and Christian communities of Indonesia.

Suicide has been glorified or condemned through the ages and the debate continues today. With the thinking on understanding of suicide changing, it is now regarded more as a tragedy than a ritual. The first scientific attempt to understand the rationale behind suicide was made in 1763 with the work of Merian, who emphasized that suicide was neither a sin nor a crime, but a disease. The first in-depth examination by Farlet in 1822 of suicide by an accused against himself showed that the writer graphically and sequentially described the circumstances leading to his own death, thus enabling a broader understanding of suicide. In 1905, a famous psychiatrist, Dr. R. Gaupp, indicated that the first step in therapy was to recognize the peculiar and unique personality traits among people committing suicide. Over the last 50 years, researchers have advanced this idea further to conclude that it is the state of mind, along with all external influences, which result in suicide.

### Commonly Used Terms...

- **Suicide**: Act of killing oneself intentionally, performed by the person with the full knowledge or expectation of the fatal outcome.
- **Suicidal attempt**: An act of self-harm or threat to oneself with the intent to end one’s life, requiring medical intervention after the act.
- **Suicidal gesture**: An act on display of self-threatening behaviour which may be injurious or non-injurious.
- **Suicidal idea**: A wish or thought, often setting up the process leading to the ending of one’s own life.
- **Suicidal risk**: A characteristic, the presence of which leads to an increase or decrease of the tendency to commit suicide.
- **Suicidal pact**: An agreement between two or more people to die simultaneously by committing suicide.
- **Suicidal cluster**: Groups of people committing suicide usually for a common cause.
- **Suicidal counters**: Set of factors operating within the individual, family or society, likely to prevent suicide.

Suicide means an intentional or voluntary determination to end one’s life.
- Insuicide, the willingness to die originates within the person.
- The presence of a known or hidden reason causes one to end one’s life.
- Suicide is a state in which choices or options are never considered before the act.
Suicide is commonly referred to as Atmahatya in (Hindi, India), Khautai in (Thai, Thailand), BunuhDiri in (Bahasa, Indonesia), Itahathyain (Bangla, Bangladesh), SiyaDinasa Ganima in (Sinhalese, Sri Lanka) and by other local terms in different countries. Even within the same country, people use different terms in their language, culture and communication. The practice of singing Maromi is prevalent in south-west Bangladesh, where suicide rates are high. Information from Sri Lanka, which has a predominantly Buddhist population, reveals that a large number of suicides are among Buddhists, even though their religion does not favour suicide. The belief in rebirth and the lack of definitive statements on suicide by Buddhists makes suicide much less ‘sinful’ than killing another person. However, in Thailand, where a large majority of the population is Buddhist, suicide is considered as sin. The same is true with the Islamic and Christian communities of Indonesia.

Suicide has been glorified or condemned through the ages and the debate continues to this day. With the thinking on and understanding of suicide changing, it is now regarded more as a tragedy than a ritual. The first scientific attempt to understand the rationale behind suicide was in 1763 with the work of Emmanuel Phrater who emphasized that suicide was neither a sin nor a crime, but a disease. The first in-depth examination by Farlet in 1822 of suicide by Jean Jacques Rousseau concludes that the great writer had graphically and sequentially described the circumstances leading to his own death, thus enabling a broader understanding of suicide. In 1905, a famous psychiatrist, Dr. R. Gaupe, indicated for the first time that there were some peculiar and unique personality traits among people committing suicide. Over the last 50 years, researchers have advanced this idea further to conclude that it is the state of mind, along with all external influences, which results in suicide.

- Suicide means an intentional or voluntary determination to end one's life.
- Insuicide, the willingness to die originates within the person.
- The presence of a known or hidden reason causes one to end one's life.
- Suicide is a state in which choices or options are never considered beforehand.

**Commonly Used Terms...**

- **Suicide**: Act of killing oneself intentionally, performed by the person with the full knowledge and expectation of the fatal outcome.
- **Suicidal attempt**: A life-threatening act with a conscious intent to end one's life, requiring medical intervention afterwards.
- **Suicidal gesture**: An act of display of self-threatening behaviour which may be injurious or non-injurious.
- **Suicidal idea**: A wish or thought, often setting up the process leading to the ending of one's own life.
- **Suicidal risk**: A characteristic, the presence or absence of which leads to increase or decrease of the tendency to commit suicide.
- **Suicidal pact**: An agreement between two or more people to die simultaneously by committing suicide.
- **Suicidal cluster**: Groups of people committing suicide usually for a common cause.
- **Suicidal counters**: Set of factors operating within the individual, family or society, likely to prevent suicide.
There are many myths and misconceptions about suicide.

**Myth:** A person attempting suicide says, “God beckons me.”

**Fact:** This goes with some religious beliefs and is a debatable issue. It is likely that the person is experiencing hallucinations in which he/she is hearing voices or seeing images. Many categories of mentally ill persons have this symptom, and timely medical help can save them.

**Myth:** When even some religious treatments have advocated suicide, how can it be prevented?

**Fact:** This is a controversial area varying from religion to religion. Most religions in the world considers suicide as a sin, since God’s gift of life should not be cut short in a tragic way without completing the allotted span.

**Myth:** Only others commits suicide. It will not happen to me.

**Fact:** Everyone has a fleeting thought of ending his/her life in a crisis situation, but not everyone pursues the thought. When these thoughts and wishes become repetitive, progressive, cumulative and interfere with one’s activities, suicide is likely.

**Myth:** People who talk about suicide do not commit it, but only threaten to do so.

**Fact:** While a few use the technique of minor degrees of self-injury to draw the attention of people around them, many give early clues at some point. After such clues, some progress to complete the attempt. In Indonesia, nearly two-thirds of patients had seen their doctors on month before killing themselves and one-third of these had expressed suicidal intentions before carrying it out. In India, nearly 10-20% of suicidal victims had seen a physician a few days prior to the act.

**Myth:** A person attempting suicide never reveals his/her intention to anyone.

**Fact:** This is not always true. The majority of people give a clear warning signal, sign or act which should be taken seriously, as a cry for help. According to a recent study from Bangalore, about one-third of those committing suicide had verbally communicated or told someone or indicated their suicidal ideation indirectly a few days earlier. In Thailand, half of those committing the act gave clear warning signs.

**Myth:** A person who attempts suicide will definitely complete it sometime.

**Fact:** Not everybody who attempts suicide is likely to repeat it. Timely help, support and buffering mechanisms can prevent the death wish. Studies show that the risk of completing suicide among those who attempt varies between 1 and 10%.

**Myth:** If a person is saved once, there is no need to bother about him later.

**Fact:** A large number of those who attempt suicide need to be watched carefully for a period of time. There is evidence to show that 1-10% of such people repeat the act. After a brief period of recovery, if the person goes back to contemplating death, he needs to be observed, supported and cared for.

**Myth:** Only poor people commits suicide.

**Fact:** Suiciderunsin families, so nothing can be done.

**Fact:** Even though suicide has a biological basis, evidence of a hereditary basis is scientifically lacking. There is a possibility that some psychiatric conditions which predispose to suicide can occur in families.

**Myth:** Suicidal persons are always mentally ill.

**Fact:** This again is not entirely true. However, a large number of people attempting suicide are depressed, unhappy, sad or violent before the act. Further, mentally ill persons carry higher risk of suicide due to the disease process and consequent difficulties in reasoning, judgment and actions. But many physically and mentally healthy people also commit suicide.

**Myth:** Asking about suicidal thoughts may precipitate it.

**Fact:** Asking about suicidal ideas does NOT precipitate it. In fact, not asking about suicidal ideation may prevent identification of persons at risk for suicide. Frequently, doctors will directly ask patients about their suicidal ideation if they feel they are at risk.

As one family member pointed out...

“How can this person be expected to be happy after going through a horrible life with poverty, with no money for clothing, shelter or food, and an unemployed and drunken husband indulging in illicit affairs?”
There are many myths and misconceptions about suicide.

**Myth:** A person attempting suicide says, "God beckons me."
**Fact:** This goes with some religious beliefs and is a debatable issue. It is likely that the person is experiencing hallucinations in which he/she "hearing voices or seeing images." Many categories of mentally ill persons have this symptom, and timely medical help can save them.

**Myth:** When even some religious treatises have advocated suicide, how can it be prevented?
**Fact:** This is a controversial area varying from religion to religion. Most religions in the world consider suicide as a sinful act, since God's gift of life should not be cut short in a tragic way without completing the allotted span.

**Myth:** Only others commits suicide. It will not happen to me.
**Fact:** Everyone has a fleeting thought of ending his/her life in a crisis situation, but not everyone pursues the thought. When these thoughts and wishes become repetitive, progressive, cumulative and interfere with daily activities, suicide is likely.

**Myth:** People who talk about suicide do not commit it, but only threaten to do so.
**Fact:** While a few use threats or minor degrees of self-injury to draw the attention of people around them, many give early clues at some point. After such clues, some progress to complete the act. In Indonesia, nearly two-thirds of patients had seen their doctors on the month before killing themselves and one-third of these had expressed suicidal intentions before carrying it out. In India, nearly 10-20% of suicidal victims had seen a physician a few days prior to the act.

**Myth:** A person committing suicide never reveals his/her intention to anyone.
**Fact:** This is not always true. The majority of people give a clue or warning feeling, sign or act which should be taken seriously, as a cry for help. According to a recent study from Bangalore, about one-third of those committing suicide had verbally communicated or told someone or indicated their suicidal ideation indirectly a few days earlier. In Thailand, half of those committing the act gave clear warning signs.

**Myth:** A person who attempts suicide will definitely complete it sometime.
**Fact:** Not every body who attempts suicide is likely to repeat it. Timely help, support and buffer mechanisms can prevent the death wish. Studies show that the risk of completing suicide among those who attempt it varies between 1 and 10%.

**Myth:** If a person is saved once, there is no need to bother about him later.
**Fact:** A large number of those who attempt suicide need to be watched carefully over a period of time. There is evidence to show that 1-10% of such people repeat the act. After a brief period of recovery, if the person goes back to contemplating death, he needs to be observed, supported, and cared for.

**Myth:** Only poor people commits suicide.
**Fact:** Not true. Suicide is not a problem related to class, age or gender. Depending on the social, environmental, economic or mental health status, anybody can commit suicide. Because of social deprivation among the poor, the frequency of suicide among them is comparatively higher.

**Myth:** Suiciderunsinfamilies, so nothing can be done.
**Fact:** Even though suicide has a biological basis, evidence of a hereditary basis is scientifically lacking. There is a possibility that some psychiatric conditions which predispose to suicide can occur in families.

**Myth:** Suicidal persons are always mentally ill.
**Fact:** This is again not entirely true. However, a large number of people attempting suicide are depressed, unhappy, sad or violent before the act. Further, mentally ill persons carry a higher risk of suicide due to the disease process and consequent difficulties in reasoning, judgement and actions. But many physically and mentally healthy people also commit suicide.

**Myth:** Asking about suicidal thoughts may precipitate it.
**Fact:** Asking about suicidal thoughts does not precipitate it. In fact, not asking about suicidal thoughts may prevent identification of persons at risk for suicide. Frequently, doctors will directly ask patients about their suicidal ideation if they feel they are at risk.

As one family member pointed out...

"How can this person be expected to be happy after going through a horrible life with poverty, with no money for clothing, shelter, food, and ununemployed and drunken husband indulging in illicit affairs?"
Some Facts and Figures

Global Situation

Worldwide, the exact number of people ending, attempting or thinking of ending their lives is not known. Suicide is one of the leading causes of death across the world, especially in the 15-35 year age group. As per WHO estimates, nearly one million people will commit suicide during the first year of this millennium. This amounts to an average of one death every 40 seconds and an attempt every three seconds. Deaths recorded due to suicide across the world indicate only the tip of the iceberg.

The global rate of occurrence (new deaths per year) of suicide rose from 10 per 100,000 population in the 1950s to 18 per 100,000 during 1995 (Figure 1). While it has declined in some countries, there has been a significant increase in some developing countries, with plateauing in others. Collectively, an upward trend is noticeable across the world, which is a matter of concern.

It is also known that more men complete suicide as compared with women, though this might vary across countries (from equal to high rates). Globally, nearly 60% of these deaths are among young adults in their productive years of life. This is a distinct change, as earlier, more suicides were recorded among the elderly.

The various factors contributing to suicide in a country are determined by the size of the population, age and sex distribution, sociocultural ethos, extent of sociotechnological development, availability of methods for suicide, and intervention efforts.

Suiciderates in SEAR Member Countries

Among the SEAR Member Countries, suicide rates vary from 8 to 50 per 100,000 population. Some countries, such as India, Indonesia, Sri Lanka, and Thailand, include suicides in their health information systems, while others do not. In Bangladesh, suicide is included in the category of accidents. India and Sri Lanka record the highest number of suicide rates (11 and 37 per 100,000 population respectively) and occupy the 45th and seventh positions globally. Nearly 10,400 persons in India, 1,060 in Sri Lanka, 5,095 in Thailand, and 2,548 in Bangladesh committed suicide (1997-1998) as per official reports. Precise information from other countries of the Region are not available for recent years.

In every country, suicide is reported to the police, whereas the health sector conducts forensic examination for completed suicides and provides care for the attempted ones. Deaths due to suicide are underreported to avoid sociocultural stigma, escape police enquiries and legal harassment, and benefit from the insurance sector. They are also misclassified as accidents. Hence, these official numbers are gross underestimates. Further, the information related to attempted suicide is not compiled by any single agency.

Changing Trends in Suicides in SEAR

Bangladesh

From an average of 600 suicides per month during 1972-1988, the number of suicides increased to 984 per month during 1992-1993. The overall national rate is estimated to be 8 per 100,000 for the period 1972-1988 and 10 per 100,000 during 1992-1993, based on secondary sources. The total number of suicides reported to the Forensic Medicine Department of Dhaka Medical College indicates that suicides have increased from 12 per month in 1989 to 18 per month in 1998.

On an average, 15% of the total number of autopsies have been associated with suicides. Within Bangladesh, focused studies from Jhenaighat and Jessore districts indicate an increasing trend of suicides from 29 per 100,000 in 1973 to 33 per 100,000 in 1985.

From Indonesia...

Ms D, 20 years of age, was admitted to a private mental hospital in February 2000, for a suicide attempt by injection of a poison. This was her fourth such attempt in the last four years. Her mother had died when she was 10 years old, and after that she had refused to go to school and used to be alone most of the time. Since July 2000, she had received treatment, including psychiatric consultation and counselling for her drug abuse problem. She is now more stable, cooperative, willing to work and has made friends. She is confident, sure of herself and does not feel lonely or have any thought of ending her life.

Figure 1

Global Suicide Rates (per 100,000 Population) 1950-1995

Yogeeta
SOME FACTS AND FIGURES

Global Situation
Worldwide, the exact number of people ending, attempting or thinking of ending their lives is not known. Suicide is one of the leading causes of death across the world, especially in the 15-35 year age group. As per WHO estimates, nearly one million people will commit suicide during the first year of this millennium. This amounts to an average of one death every 40 seconds and an attempt every three seconds. Deaths recorded due to suicide across the world indicate only the tip of the iceberg.

The global rate of occurrence (new deaths per year) of suicide rose from 10 per 100,000 population in the 1950s to 18 per 100,000 during 1995 (Figure 1). While it has declined in some countries, there has been a significant increase in some developing countries, with a plateauing off in other countries. Collectively, an upward trend is noticeable across the world, which is a matter of concern.

It is also known that more men complete suicide as compared with women, though this might vary across countries (from equal to high rates). Globally, nearly 60% of these deaths are among young adults in their productive years of life. This is a distinct change, as earlier, more suicides were recorded among the elderly.

The various factors contributing to suicide in a country are determined by the size of the population, age, sex distribution, sociocultural ethos, extent of sociotechnological development, availability of methods for suicide and intervention efforts.

Suiciderates in SEAR Member Countries
Among the SEAR Member Countries, the suicide rates vary from 8 to 50 per 100,000 population. Some countries, such as India, Indonesia, Sri Lanka, and Thailand, include suicides in their health information systems, whereas others do not. In Indonesia, suicides are included in the category of accidents. India and Sri Lanka record the highest number of suicide rates (11 and 37 per 100,000 population respectively) and occupy the 49th and 7th positions globally. Nearly 10,000 persons in India, 10,600 in Sri Lanka, 5,095 in Thailand and 2,548 persons in Bangladesh committed suicide (1997-1998) as per official reports. Precise information from other countries of the Region are not available for recent years.

In every country, suicide is reported to the police, whereas the health sector conducts forensic examination for completed suicides and provides care for the attempted ones. Deaths due to suicide are underreported to avoid sociocultural stigma, escape police enquiries and legal harassment, and benefit from the insurance sector. They are also misclassified as accidents. Hence these official numbers are gross underestimates. Further, the information related to attempted suicides is not compiled by any singency.

Changing trends in suicides in SEAR
Bangladesh
From an average of 600 suicides per month during 1972-1988, the number of suicides increased to 984 per month during 1992-1993. The overall national rate is estimated to be 8 per 100,000 for the period 1972-1988 and 10 per 100,000 during 1992-1993 based on secondary sources. The total number of suicides reported to the Forensic Medicine Department of Dhaka Medical College indicates that suicides have increased from 12 per month in 1989 to 18 per month in 1998. On an average, 15% of the total number of autopsies have been associated with suicides. Within Bangladesh, focused studies from Jhenaidah and Jessore districts indicate an increasing trend of suicides from 29 per 100,000 in 1973 to 33 per 100,000 in 1985.

From Indonesia...
Ms D, 20 years of age, was admitted to a private mental hospital in February 2000, for a suicide attempt by injection of a poison. This was her fourth such attempt in the last four years. Her mother haddied when she was 10 years old, and after that, she had refused to go to school and used to be alone most of the time. Since July 2000, she had received treatment, including psychiatric consultation and counseling for her depression problem. She is now more stable, cooperative, willing to work and has made friends. She is confident, sure of herself and does not feel lonely or have any thoughts of ending her life.

Figure 1
Global Suicide Rates (per 100,000 population) 1950-1995
With a rate of 11 per 100,000 suicides per year, an increase from 6 per 100,000 (Figure 2) during the 1980s, India occupies the second highest rate of suicides in the Region. When corrected for underreporting, these rates are likely to be much higher. While 89,000 persons committed suicide in 1995, the number increased to 96,000 in 1997 and to 104,000 in 1998, an increase of 25% compared to the previous year. During 1988-1998, suicides increased by a staggering 33.7%. Major variations are noticed across the country, probably related to reporting practices (Figures 3 and 4). Kerala (29 per 100,000), Karnataka (21 per 100,000) and Tripura as well as West Bengal (19 per 100,000) had the highest rates of suicide. Among the cities, Bangalore (17%), Mumbai (14%), Chennai (11%) and Delhi (7.5%) accounted for nearly 50% of the total suicides in the country.

Eventhough nationwidedata are not available, information indicates that suicide is on the increase. Data from metropolitan Jakarta indicate that in just one city alone, the number of suicides increased from 112 in 1996 to 146 in 1998 (Indonesia underwent a severe economic crisis during 1997-1998), with corresponding rates of 1.6 and 1.8 per 100,000, respectively. Interestingly, Jakarta, which was registering a decline till 1996, showed a sudden increase during 1997-1998. There are substantial geographical variations within Indonesia, e.g., suicide rate in Gunung Kidul is 9 per 100,000, compared with 1 per 100,000 in metropolitan Jakarta.

While the exact incidence of suicide is not clearly known, death due to self-poisoning was found to be the third leading cause of death during 1998 and 1999.
With a rate of 11 per 100,000 suicides per year, an increase from 6 per 100,000 (Figure 2) during the 1980s, India occupies the second highest rate of suicides in the Region. When corrected for underreporting, these rates are likely to be much higher. While 89,000 persons committed suicide in 1995, the number increased to 96,000 in 1997 and to 104,000 in 1998, an increase of 25% compared to the previous year. During 1988-1998, suicides increased by a staggering 33.7%. Major variations are noticed across the country, probably related to reporting practices (Figures 3 and 4). Kerala (29 per 100,000), Karnataka (21 per 100,000) and Tripura as well as West Bengal (19 per 100,000) had the highest rates of suicide. Among the cities, Bangalore (17%), Mumbai (14%), Chennai (11%) and Delhi (7.5%) accounted for nearly 50% of the total suicides in the country.

Eventhough nationwidedata arenot available, information indicates that suicide is on the increase. Data from metropolitan Jakarta indicate that in just one city alone, the number of suicides increased from 112 in 1996 to 146 in 1998 (Indonesia underwent a severe economic crisis during 1997-1998), with corresponding rates of 1.6 and 1.8 per 100,000, respectively. Interestingly, Jakarta, which was registering a decline till 1996, showed a sudden increase during 1997-1998. There are substantial geographical variations within Indonesia, e.g., suicide in Gunung Kidul is 9 per 100,000, compared with 1 per 100,000 in metropolitan Jakarta.

While the exact incidence of suicide is not clearly known, death due to self-poisoning was found to be the third leading cause of death during 1998 and 1999.
Sri Lanka

During the past 15 years in war-torn Sri Lanka, it is estimated that nearly 50,000 persons have been killed. Deaths due to suicide, in the same period, are estimated to be 106,000—twice the number due to war. As late as the 1950s, Sri Lanka had a low suicide rate of 6 per 100,000. This rate doubled to 12 per 100,000 by 1964 and increased to 19 per 100,000 by 1969. This was followed by a sharp increase. The official estimates for 1996 are 37 per 100,000, making Sri Lanka one of the countries with the highest number of suicides per unit of population (Figure 2). A study revealed substantial underreporting and there was an extent of the problem and current rates are estimated to be 44-50 per 100,000. Significantly, the proportion of youths committing suicide increased from 33% in 1960 to 44% in 1980. Regional variations as in other countries are reported from Sri Lanka also (Figure 2). Suicides are the fourth most frequent cause of death in hospitals in Sri Lanka.

Thailand

The country recorded increasing rates from 1970 (4 per 100,000) to 1980 (8 per 100,000) with a gradual decline thereafter. The rates again increased to 6.7 in 1990, 7.6 in 1996, 7.0 in 1997, 8.3 in 1998 to 8.6 in 1999 (Figure 2). This signifies that the declining trend noticed earlier has reversed, with an upward surge from the 1990s.

It is likely that the rates of suicide reported in all the SEAR countries are underestimated as some deaths are never reported or are misclassified. In Sri Lanka, the extent of underreporting was to the extent of 40%. Apart from national rates, it is important to examine the problem at both regional and local levels. As some places within each country are likely to have rates much higher than the national rates (e.g., while the national rate was 7.1 per 100,000 in India, one of the Indian cities had a rate of 22-33 per 100,000 during the 10-year period) (Figure 3). This suggests the need for immediate national and local preventive measures in the Member Countries of the Region.
Sri Lanka

During the past 15 years in war-torn Sri Lanka, it is estimated that nearly 50,000 persons have been killed. Deaths due to suicide, in the same period, are estimated to be 106,000—twice the number of war casualties. As late as the 1950s, Sri Lanka had a lower suicide rate of 6 per 100,000. This rate doubled to 12 per 100,000 by 1974 and increased to 19 per 100,000 by 1969. This was followed by a sharp increase. The official estimates for 1996 are 37 per 100,000, making Sri Lanka one of the countries with the highest number of suicides per unit of population (Figure 2). A study revealed substantial underreporting and the real extent of the problem and current rates are estimated to be 44-50 per 100,000. Significantly, the proportion of youth committing suicide increased from 33% in 1960 to 44% in 1980. Regional variations as in other countries are reported from Sri Lanka also (Figure 2). Suicides are the fourth most frequent cause of death in hospitals in Sri Lanka.

Thailand

The country recorded increasing rates from 1970 (4 per 100,000) to 1980 (8 per 100,000) with a gradual decline thereafter. The rates again increased to 6.7 in 1990, 7.6 in 1996, 7.0 in 1997, 8.3 in 1998 to 8.6 in 1999 (Figure 2). This signifies that the declining trend noticed earlier has reversed, with an upwards surge from the 1990s.

It is likely that the rates of suicide reported in all the SEAR countries are underestimated as some deaths are never reported or are misclassified. In Sri Lanka, the extent of underreporting was as high as 40%. Apart from overall national rates, it is important to examine the problem at both regional and local levels, as some places with high country rates are likely to have rates much higher than the national rates (e.g., while the national rate was 7.1 per 100,000 in India, one of the Indian cities had a rate of 22-33 per 100,000 during the 10-year period) (Figure 3). This suggests the need for immediate national and local preventive measures in the Member Countries of the Region.
Age variations

There is also a distinct difference in the occurrence of suicides among various age groups. Nearly 25-60% of suicides in SEAR Member Countries occur in the age group of 15-29 years. Recently, more than 60% of suicides have occurred in the 15-44 year age group. Figure 4 shows that in India, Indonesia, Sri Lanka, and Thailand, the highest rates of suicide (30-60%) are seen between 15-29 years, followed by 30-44 years. In most countries, suicide is on the increase among the youth, leading to loss of lives in the most productive years.

Gender differences

In all the countries except Bangladesh, a greater number of men committed suicide compared to women, as shown in Figure 5. This varied from an almost equal ratio of 1:1 in India, to 2:1 in Indonesia, and 3:1 in Sri Lanka and Thailand for men and women, respectively. The pattern was reversed in Bangladesh with 58% of women committing suicides compared with 42% of men.

Figure 4
Agedistribution of suicides in selected countries of SEAR (%)

Figure 5
Gender differentials in suicide rates (%)
Age Variations

There is also a distinct difference in the occurrence of suicides among various age groups. Nearly 25-60% of suicides in SEAR Member Countries occur in the age groups of 15-29 years. Recently, more than 60% of suicides have occurred in the 15-44 year age group. Figure 4 shows that in India, Indonesia, Sri Lanka, and Thailand, the highest rates of suicide (30-60%) are seen between 15-29 years, followed by 30-44 years. In a majority of the countries, suicide is on the increase among the youth, leading to loss of lives in the most productive years.

Gender Differences

In all the countries except Bangladesh, a greater number of men committed suicide compared to women, as shown in Figure 5. This varied from an almost equal ratio of 1.2:1 in India, to 2:1 in Indonesia, and 3:1 in Sri Lanka and Thailand for men and women, respectively. The pattern was reversed in Bangladesh with 58% of women committing suicides compared with 42% of men.
Urban/rural differences

In all SEAR Member Countries, an increase in the number of suicides has been noticed in urban areas, suggesting that it may be linked to urbanization, industrialization, migration and changing socioeconomic patterns. Though detailed urban/rural comparisons are not available in India, nearly 50-60% of suicides still occur in rural areas. This variation may not reflect the exact picture of urban/rural differences due to differential reporting in rural vs urban areas. Many factors, such as societal and family pressures, limited access to healthcare, and education and employment determinants, may play a role in these variations.

Methods

A study of the methods of suicide reveals that individuals choose from a variety of facts to end their lives. The choice of a method for suicide or attempted suicide is related to the person's culture and tradition, and depends upon the intent, seriousness, situation (time and presence of family members), motive and availability of means. A distinct difference is noticed across SEAR Member Countries (Figure 6). Self-poisoning with a variety of substances ranging from pesticides to common available household products is the commonest method, ranging from 70% in Sri Lanka to 23% in Thailand. Indonesia (47%) and India (37%) also show high incidence of self-poisoning. Hanging is the other frequently adopted method with 26% in India, 59% in Thailand, 46% in Indonesia, and 45% in Bangladesh adopting this method. Self-burning (immolation) is a method commonly adopted in India (11%). A comparison with the West indicates that gunshot injuries are not common in SEAR, except in a small minority of cases in Thailand (5%). This pattern in the methods of committing suicide is also likely to change over a period of time depending on the availability of methods to people, indicating the need for constant surveillance in all SEAR Member Countries.

![Figure 6: Suicide methods in SEAR countries](image)
Urban/rural differences

In all SEAR Member Countries, an increase in the number of suicides has been noticed in urban areas, suggesting that it may be linked to urbanization, industrialization, migration, and changing socioeconomic patterns. Though detailed urban/rural comparisons are not available in India, nearly 50-60% of suicides still occur in rural areas. This variation may not reflect the exact picture of urban/rural differences due to differential reporting in rural vs. urban areas. Many factors, such as societal and family pressures, limited access to healthcare, and education and employment determinants, may play a role in these variations.

Methods

A study of the methods of suicide reveals that individuals choose from a variety of actions to end their lives. The choice of a method for suicide or attempted suicide is related to the person's culture and tradition, and depends on the intent, seriousness, situation (time and presence of family members), motive, and availability of means. A distinct difference is noticed across SEAR Member Countries (Figure 6). Self-poisoning with a variety of substances ranging from pesticides to commonly available household products is the commonest method, ranging from 70% in Sri Lanka to 23% in Thailand. Indonesia (47%) and India (37%) also show high incidence of self-poisoning. Hanging is the other frequently adopted method with 26% in India, 23% in Thailand, 46% in Indonesia, and 45% in Bangladesh adopting this method. Self-burning (immolation) is a method commonly adopted in India (11%). A comparison with the West indicates that gunshot injuries are not common in SEAR, except in a small minority of cases in Thailand (5%).

Figure 6
SuicidemethodsinSEARcountries

This pattern in the methods of committing suicide is also likely to change over a period of time depending on the availability of methods to people, indicating the need for constant surveillance in all SEAR Member Countries.
Attempted suicides

Attempted suicides are on the increase in every SEAR Member Country. The magnitude of attempted suicides (parasuicides) is not clearly known for each individual country as no reporting agency compiles this type of data. However, it is acknowledged that for every completed suicide, nearly 10-20 persons attempt suicide. This ratio varies across countries, being as low as 1:5 to as high as 1:70, varying with age group, gender and place of occurrence. Nearly 30% of registrations in hospital emergency departments are due to attempted suicides. In every country, patients who attempt suicide are provided care in government or private health care institutions. Data on attempted suicide may be underreported because attempting suicide is a crime in many countries, and this information may be suppressed by families or healthcare providers at the request of the person's family.

- **Bangladesh**: Bangladesh has seen an unprecedented increase in attempted suicides. Anecdotal evidence and media reports indicate that the majority of people who attempt suicide are young, illiterate and urban residents. Nearly 15% of hospital admissions were due to self-poisoning.

- **India**: A recent study conducted in Bangalore, India, estimated that there were 19000 reported attempted suicides in one year in the city alone (population 5.8 million). A majority of the attempted suicides were among the young (20-24 year age group), more among males (53%) than females (47%), and from poor middle class, nuclear families. Self-inflicted burns as the method of attempted suicides is common among women, as was self-poisoning with organophosphorus compounds and drugs among men.

- **Indonesia**: A study revealed that young people in the age group of 15-30 years and elderly females are at greater risk of attempted suicide.

- **Sri Lanka**: The country has been recording the highest rates of attempted suicide among youth, especially females, since 1990.

- **Thailand**: During 1998, 6253 attempted suicides were reported from public hospitals. The problem has increased from 2 per 100000 to 8 per 100000, a fourfold increase during the past 10 years. The majority of the attempts were made by women.

Suicidal thoughts

While completed and attempted suicides are clearly discernible events, there is a large number of persons in the community who harbour suicidal thoughts, wishes or ideas. While the extent of this problem is not clearly known, estimates vary from 5% to 25% of the population. Some focused hospital-based or population-based surveys estimate that 1 in 10 to 1 in 100 attempt an act, an attempt and a thought to be in the range of 1:10,000 to 1:10,000, respectively. Though such fleeting thoughts pass through an individual’s mind once in a while, it is essential to consider the seriousness, repetitiveness and interference with the individual’s present mental health status of the person on the future course of action. The extent of suicidal thoughts can also increase with stress occurring at individual, familial and societal levels. An important aspect of this phenomenon is that not all of these individuals consider the problem serious and will not seek any professional help. The presence of such persistent thoughts only pushes the individual to the next step of attempting or committing suicide.

Some studies report the presence of suicidal thoughts among 5-10% of the population in India. Suicidal thoughts are higher among women in the reproductive age group, according to a recent study in Bangalore. Such thoughts are related to age, gender, situation and ongoing crises in different walks of life. Those living in socially underprivileged environments and suffering from mental health problems, such as depression and alcohol use, are more prone to such thoughts.

![During the economic crisis in Thailand, telephonicsurveys, conducted twice a year by the Department of Mental Health, Ministry of Public Health, revealed that 58% of respondents reported suicidal thoughts.](image-url)

Tanya Sen
Attemptedsuicides

AttemptedsuicidesareontheincreaseineverySEARMemberCountry.Themagnitudeofattemptedsuicides(parasuicides)isnotclearlyknownforeachindividualcountry,assin singlesourceforthistypeofdata.However,itisacknowledgedthatfor every completed suicide, nearly 10-20 persons attempt suicide. This ratio variesacrosscountries,beingaslowas1:5toashighas1:70, varying withagegroup,genderandplaceofoccurrence. Nearly 10-30% of registrations in hospital emergency departments are due to attemptedsuicides. In every country, patients who attempt suicide are provided care in government or private health care institutions. Data on attempted suicide may be underreported because attempting suicide is a crime in many countries, and this information may be suppressed by families or health care providers at the request of the person's family.

- **Bangladesh**: Bangladesh has seen an unprecedented increase in attemptedsuicides. Anecdotalevidenceand media reportsindicate that the majority of the people who attempt suicide are young, illiterate and urban residents. Nearly 15% of hospital admissions were due to self-poisoning.
- **India**: A recent study conducted in Bangalore, India, estimated that there were 19000 registered attemptedsuicides in one year in the cityalone (population 5.8 million). A majority of these attemptedsuicides were among the young(20-24yearagegroup),more among males(53%)thanfemales(47%),andfrompoormiddleclass,nuclearfamilies.Self-inflictedburnsasasthemethodof attemptedsuicidewasonlycommonamongwomen,aswas self-poisoning with organophosphorus compounds and drugs among men.
- **Indonesia**: A study revealed that young peoplein the age group of 15-30 years and elderly females are at greater risk of attemptedsuicide.
- **Sri Lanka**: The country has been recording the highest rates of attempted suicide among youth, especially females, since 1990.
- **Thailand**: During 1998, 6253 attemptedsuicides were reported from public hospitals. The problem has increased from 2 per 100000 to 8 per 100000, a fourfold increase during the past 10 years. The majority of the attemptswere made by women.

Suicidalthoughts

While completed and attempted suicides are clearly discernible events, there are a large number of persons in the community who harbour a suicidal thought, wish or idea. While the extent of this problem is not clearly known, estimates vary from 5% to 25% of the population. Some focused hospital-based or population-based surveys estimate that there is an event between an act, an attempt and a thought to be in the range of 1:10:100, respectively. Though such fleeting thoughts pass through an individual's mind once in awhile, its essential to consider the seriousness, repetitiveness and interference with the life and present mental health status of the person on the future course of action. The extent of suicidalthoughts can also increase with stress occurring at individual, familial and societal levels. An important aspect of this phenomenon is that none of these individuals consider the problem serious and will not seek any professional help. The presence of such persistent thoughts only pushes the individual to the next step of attempting or committing suicide.

Some studies report the presence of suicidalthoughts among 5-10% of the population in India. Suicidalthoughts are higher among women in the reproductive agegroup, according to a recent study in Bangalore. Such thoughts are related to age, gender, situation, and ongoing crises in different walks of life. Those living in socially underprivileged environments and suffering from mental health problems, such as depression and alcohol abuse, are more prone to such thoughts.
Suicides: Extent of the Problem

Figure 7 shows that as one looks deeper into the problem of reporting of suicides and suicidal attempts, the expanding circles become clear. For example, in the city of Bangalore, the media reported only 210 deaths in one year. The official reports indicated that 1900 deaths were due to suicide. An estimate of attempted suicides from healthcare institutions indicated that over a period of one year, nearly 19,200 persons were likely to have been registered (estimates based on under-reporting and an epidemiological study from selected hospitals). The number of persons with a repetitive, progressive suicidal idea or wish is not clearly known and could only be a "guessimate", indicating the severity of the problem. Thus, the ratio of media reported: officially reported: hospital reported suicides is in the range of 1:9:90. This situation might be similar across all Member Countries of the Region.

Differences between attempted and completed suicides

Clear differences exist in the nature, pattern, and intent of attempted suicides and completed suicides, though they are events or steps of the same process. Understanding these differences can significantly help in devising intervention strategies.

<table>
<thead>
<tr>
<th>Attempted suicides</th>
<th>Completed suicides</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predominantly younger age group</td>
<td>Adults and the elderly</td>
</tr>
<tr>
<td>More common in young unmarried females</td>
<td>More common in unmarried and married males [high among single, divorced and widowed]</td>
</tr>
<tr>
<td>Ambivalent in nature</td>
<td>Definitive in nature</td>
</tr>
<tr>
<td>Less lethal methods used</td>
<td>More lethal methods used</td>
</tr>
<tr>
<td>Some related to attention-seeking behaviour</td>
<td>Related to strong death wishes</td>
</tr>
<tr>
<td>Poisoning is the commonest method</td>
<td>Hanging, severe types of poisoning and burns are common</td>
</tr>
<tr>
<td>Stressors are frequently immediate family and interpersonal conflicts</td>
<td>Stressors are generally varied and include terminal illness and socioeconomic factors.</td>
</tr>
</tbody>
</table>
Suicides: Extent of the Problem

Figure 7 shows that as one looks deeper into the problem of reporting of suicides and suicidal attempts, the expanding circles become clear. For example, in the city of Bangalore, the media reported only 210 deaths in one year. The official reports indicated that 1900 deaths were due to suicide. An estimate of attempted suicides from healthcare institutions indicated that over a period of one year, nearly 19,200 persons were likely to have been registered (estimates based on underreporting and an epidemiological study from selected hospitals). The number of persons with a repetitive, progressive suicidal idea or wish is not clearly known and could only be a "guess estimate", indicating the severity of the problem. Thus, the ratio of media reported: officially reported: hospital reported suicides is in the range of 1:9:90. This situation might be similar across all Member Countries of the Region.

Differences between attempted and completed suicides

Clear differences exist in the nature, pattern and intent of attempted suicides and completed suicides, though they are events or steps of the same process. Understanding these differences can significantly help in devising intervention strategies.

<table>
<thead>
<tr>
<th>Attempted suicides</th>
<th>Completed suicides</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predominantly younger age group</td>
<td>Adults and the elderly</td>
</tr>
<tr>
<td>More common in young unmarried females</td>
<td>More common in unmarried and married males [high among single, divorced and widowed]</td>
</tr>
<tr>
<td>Ambivalent in nature</td>
<td>Definitive in nature</td>
</tr>
<tr>
<td>Less lethal methods used</td>
<td>More lethal methods used</td>
</tr>
<tr>
<td>Some related to attention-seeking behaviour</td>
<td>Related to strong death wishes</td>
</tr>
<tr>
<td>Poisoning is the commonest method</td>
<td>Hanging, severe types of poisoning and burns are common</td>
</tr>
<tr>
<td>Stressors are frequently immediate family and interpersonal conflicts</td>
<td>Stressors are generally varied and include terminal illness and socioeconomic factors.</td>
</tr>
</tbody>
</table>
WHY DOES IT HAPPEN?

The cause of suicide, i.e., precisely why people end their lives, has been an enigma since time immemorial and remains a topic of controversy and debate. Anything and everything happening under the "sun and moon", including the "sun and moon" have been incriminated in the causation of suicides (acts, attempts, and behaviour). Towards the end of the last century, many suicides were believed to be due to heroic acts, romantic sentiments, or hero worship. In the twentieth century, suicide was attributed to disintegrating social systems. In the USA, where suicide is condemned, the number is relatively low, whereas in Japan, where suicide is praised, it is higher. What is established as the cause is dependent on the person involved, the prevailing circumstances, and the person examining the issue. It is difficult to establish the intent, motive or reasons as there are difficulties in investigating, collecting, documenting, analysing, and establishing causes, partly due to inadequate nature and skills of investigating agencies and reporting mechanisms.

Knowing what is happening to us, what we are going through and how to come out goes a long way to get better control over our lives, emotions and actions.

As a suicide survivor

Pathways...

Human beings are unique, as are their reasons for suicide. An occasional fleeting thought passes through the minds of people at one time or the other, depending on individual strengths, weaknesses and life situations. Some factors known to influence suicide are low frustration tolerance, severe hostility, life expectations and failures, interpersonal conflicts between family members and peers, mental health problems, behavioural problems of alcohol and drug abuse, suffering from diseases such as HIV/AIDS, and other environmental factors. "To live" or "not to live", are the questions constantly plaguing the mind of a potential suicide attempter, and understanding this depends on what is/was the problem in the present/past. However, not everyone will commit or complete the act as they are reminded by themselves or others about their role-family responsibilities, the care, love, affection and comfort that they can give and receive. Nevertheless, some people act impulsively, few plan definitively, and others pass through a gradual process, with suicidal ideas and wishes becoming stronger over a period of time. These and the person from the stage of hopelessness-helplessness to a harmful state of self-destructive behaviour. This process takes a person into states of self-despair, depression, isolation, and in the end, the act. It is important to identify and address the issues to promote a healthy individual, family and society. Being aware of the steps shown in Figure 8 will help people to break this chain by intervening at the right time.

Figure 8

Pathways to suicide

1. Stray ideas/passing thoughts
2. Repetitive thoughts (happens frequently)
3. Difficulty in overcoming these thoughts (tries, but unable to gain control)
4. Start affecting daily activities
5. Wishes become stronger (repeats to him/herself "Why should I live?")
6. Thinks of ending life prematurely (it is time)

Selects a plan

Attemps

Completes
Knowing what is happening to us, what we are going through and how to come out goes along way to get better control over our lives, emotions and actions.

As a suicide survivor, I think the cause of suicide, i.e., precisely why people end their lives, has been an enigma since time immemorial and remains a topic of controversy and debate. Anything and everything happening under the 'sun and moon', including the 'sun and moon' have been incriminated in the causation of suicides (acts, attempts and behaviour). Towards the end of the last century, many suicides were believed to be due to heroic acts, romantic sentiments or hero worship. In the 20th century, suicide was attributed to disintegrating social systems. In the USA, where suicide is condemned, the number is relatively low, whereas, in Japan, where suicide is praised, it is higher. What is established as the cause depends on the person involved, the prevailing circumstances and the person examining the issue. It is difficult to establish the intent, motive or reasons as there are difficulties in investigating, collecting, documenting, analysing and establishing causes, partly due to the inadequacy of nature and skills of investigating agencies and reporting mechanisms.

Pathways...

Human beings are unique, as are the reasons for suicide. An occasional fleeting thought passes through the mind of people at one time or the other, depending on individual strengths, weaknesses and life situations. Some factors known to influence suicide are low frustration tolerance, severe hostility, life expectations and failures, interpersonal conflicts between family members and peers, mental health problems, behavioural problems of alcohol and drug abuse, suffering from diseases such as HIV/AIDS, and other environmental factors. To live or 'not to live', are the questions constantly plaguing the mind of an attempted suicide attempter, and understanding this is dependent on what is/was the problem in the present/past. However, not everyone will commit or complete the act as they are reminded by themselves or others about their role-family responsibilities, ortho care, love, affection and comfort that they can give and receive. Nevertheless, some people act impulsively, few plan deliberately and others pass through a gradual process, with suicidal ideas and wishes becoming stronger over a period of time. These and a person from a state of hopelessness, helplessness to a harmful state of self-destructive behaviour. This process takes a person into states of self-despair, dejection, isolation, depression and finally, to the act. It is important to identify and address the issues to promote a healthy individual, family and society. Being aware of the steps shown in Figure 8 will help people to break this chain by intervening at the right time.

**Figure 8: Pathways to suicide**

- Stray ideas/passing thoughts
- Repetitive thoughts (happens frequently)
- Difficulty in overcoming these thoughts (tries, but unable to gain control)
- Starts affecting daily activities
- Wishes become stronger (repeats to himself/“Why should I live?”)
- Thinks of ending life prematurely (it is time)

**Shabeba Ahmed**

- Attempts
- Selects a plan
- Completes
Causes...

Beginning with the work of Emile Durkheim published in 1897, and the Freudian school of thought, there are four broad categories of people who commit suicide. These are: egoistic (lack of social integration), altruistic (excessive integration), anomie (without regulation and norms of living in society), and fatalistic (excessive regulation) attitudes of individuals. The individual is viewed as a part of society in terms of integration or disintegration and this forms the basis along with forces, values, beliefs and moral systems of that culture. Another French sociologist, Baecher, categorized suicides as escapist, aggressive, obliative and lucid, depending on the motive of the heart. Recent developments in suicidology have provided insights into the psychological, biochemical and biological basis for suicides with changes in the neuroendocrine systems as the imminent cause of the act. The biochemical and neuroendocrine systems are interrelated with the emotional life and feelings of a person. It is acknowledged that both social and biological factors operate in isolation or in isolation, leading to suicide. Over a period of time, these developments have led to a better understanding of the suicidal phenomenon and in planning some intervention mechanisms.

There are three separate patterns observed in suicides. The first category is the class of impulsive suicides, spurred by one or more sudden emerging factors, often resulting in hospitalization and/or death. The second category is a group of suicides “likely or unlikely to be definitive”, especially among high-risk individuals and groups or communities. The third category is “decisive and planned” and includes those passing through the suicidal process at the end of a torturous and struggle-filled journey of life.

From Bangladesh...

A 20-year-old young girl living in a joint family was not happy with her marriage. Her husband (college lecturer) used to pressurize her to get a motorcycle as dowry from her parents. Since her parents were poor, they could not satisfy the demand of her husband. As a result, she had strained relations with her husband and was often rebuked for not bringing the motorcycle. One day the young housewife committed suicide by consuming poison.

“Whataelsecouldhave doneat this stage of my life when I did not have any choice?”

Suicidesurvivor

Socioeconomic factors...

Suicide is due to a complex interaction of social, environmental, biological and cultural factors operating in an individual’s life. Cultural beliefs, social standards, gender bias, educational problems, income levels, living status, growing aspirations, pressures of modern life, the need to excel and compete in the modern world, employment issues, marriage-related factors, interpersonal conflict due to disturbed family relations, breakdown of family values and systems, terminal or serious illness, social isolation and death of a loved one, are all capable of initiating suicidal thoughts. These factors could be as varied as gender discrimination at the birth of a girl child in India, to the problem of being affected with HIV/AIDS in Thailand, economic upheavals in Indonesia, and poverty in Bangladesh. Certain suicidal deaths related to dowry issues or inability to accept decreased academic performance or failures among students. The “emphynest syndrome” of the elderly are also major concerns in the Region. The various factors, whether initiating, motivating, triggering or precipitating in nature, operate in combination with one another in driving a person to a stage of suicide or parasuicide. Frequently, these factors (e.g., financial losses, family conflicts, and failures in life) are cumulative, repetitive, progressive and may act as building blocks in a continuum of the process.

From Thailand...

Mr K, aged 35 years, was married with one child. His wife was detected to be HIV-positive. One month before her death, he spoke less than usual, ate less, showed no interest, could not concentrate, looked sad and anxious. After his wife’s death, K left a note and hanged himself. “I miss you so much. I do not want to live in this world anymore. Sister, please take care of my child.”
Causes...

Beginning with the work of Emile Durkheim published in 1897, and the Freudian school of thought, there are four broad categories of people who commit suicide. These are: egoistic (lack of social integration), altruistic (excessive integration), anomic (without regulation and norms of living in society), and fatalistic (excessive regulation) attitudes of individuals. The individual is viewed as a part of society in terms of integration or disintegration and this forms the basis on which forces, values, beliefs, and moral systems of that culture. Another French sociologist, Baecher, categorized suicides as escapist, aggressive, oblate, and lucid, depending on the motive of the heart. Recent developments in suicidology have provided insights into the psychological, biochemical, and biological basis for suicides, with changes in the neuroendocrine systems as the imminent cause of the act. The biochemical and neuroendocrine systems are interrelated with the emotional and mental state of a person. It is acknowledged that both social and biological factors operate in isolation or in conjunction, leading to suicide. Over a period of time, these developments have helped in a better understanding of the suicide phenomenon and in planning some intervention mechanisms.

There are three separate patterns observed in suicides. The first category is the class of “impulsive suicides,” spurred by an unexpected or sudden emerging factor, often resulting in hospitalization and/or death. The second category is a group of suicides “likely or unlikely to be definitive,” especially among high-risk individuals, groups, or communities. The third category is “decisive or planned” and includes those passing through the suicidal process at the end of a torturous and struggle-filled journey of life.

Socioeconomic factors...

Suicide is due to a complex interaction of social, environmental, biological, and cultural factors operating in an individual’s life. Cultural beliefs, social standards, gender bias, educational problems, income levels, living status, growing aspirations, pressures of modern life, the need to excel and compete in the modern world, employment issues, marriage-related factors, interpersonal conflict due to disturbed family relations, breakdown of family values and systems, terminal or serious illness, social isolation, and death of a loved one, are all capable of initiating suicidal thoughts. These factors could be as varied as gender discrimination at the birth of a girl child in India, to the problem of being inflicted with HIV/AIDS in Thailand, economic upheavals in Indonesia, and poverty in Bangladesh. Certain suicidal deaths are due to dowry issues or inability to accept new family situation in India. The various factors, whether initiating, motivating, triggering, precipitating in nature, operate in combination with one another in driving a person to a stage of suicide or parasuicide. Frequently, these factors (e.g., financial losses, family conflicts, and failures in life) accumulate, repetitive, progressive, and may act as building blocks in a continuum of the process.

From Bangladesh...

A 20-year-old young girl living in a joint family was not happy with her marriage. Her husband (a college lecturer) used to pressurize her to get a motorcycle as dowry from her parents. Since her parents were poor, they could not satisfy the demand of the son-in-law. As a result, she had strained relations with her husband and was often rebuked for not bringing the motorcycle. One day, the young housewife committed suicide by consuming poison.

"What else could I have done at this stage of my life, when I did not have any choice?"

Suicides survivor

From Thailand...

Mr. K, aged 35 years, was married with one child. His wife was detected to be HIV-positive. One month before his death, he spoke less than usual, ate less, showed no interest, could not concentrate, looked sad and anxious. After his wife’s death, he left a note and hanged himself. “I miss you so much, I don’t want to live in this world anymore. Sister, please take care of my child.”

Digital Creativity
Failingsystems...
The increasing economic turmoil, political unrest, social upheaval, communal disharmony and widening gap between the haves and have nots have added another dimension to the problem of suicides. In these situations, serious losses or threats of loss of property, loved ones, job, pride, honour, status, independence and support systems operate in a major way. Loss of property, loss of loved ones, failure, shame and feelings of despair and dejection. These tenets question the fundamental survival of human beings in their respective societies based on existence, ideologies and strategies. The recent crop failures in India, the civil war in Sri Lanka, economic turmoil in Thailand and economic and political upheaval in Indonesia are some indicators of sociopolitical instability in SEAR Member Countries. Solutions to these problems need to focus on equitable distribution of resources and socioeconomic reforms.

Didyouknow...

In Sri Lanka, 90% of suicides are committed by Buddhists, who form 70% of the population. Belief in reincarnation, a better life in the next birth, and the belief that life is full of suffering and nothing including life is permanent, need clarification. When one believes that all that there is to life is merely suffering, and that when one dies there is no other birth, suicide cannot be far away.

From India...

Professor M, aged 68 years and Ms V, aged 60 years, committed suicide by consuming barbiturates. They had two children, settled abroad. Professor M lost his right leg in a road accident four years back and was diagnosed with hypertension and also had joint pains in both legs. Since the last two years, both had extreme difficulty in managing their lives without any support. They left notes for their children wishing them success and happiness.

Religion and culture...

Another dimension to this process are the religious and cultural aspects of suicide emanating from strongly held beliefs and value systems. This association in some individuals is propelled more by tolerance, acceptance and respect. The notion that a person has reached his heavenly abode, is close to God, has complied with the wishes of elders, joined the family in heaven, taken the destined way of leaving earth, followed a self-created path of life can only be explained by religious, spiritual and earthly modes of causality. The increasing realization that “precious, valuable, human lives should not be lost as emphasized in religious texts” should form the focus for future preventive measures.

Didyouknow...

The village of Gunung Kidul in Indonesia has a very high suicide rate. The spiritual leaders in the area predict the arrival of a fireball, pulung, which can only be seen by them. The occurrence of suicide after this is considered to be a call from a supernatural power. In reality, the increased rate of suicide in this village is mostly related to the presence of severe illness among the elderly.

Yogeeta

In Sri Lanka, 90% of suicides are committed by Buddhists, who form 70% of the population. Belief in reincarnation, a better life in the next birth, and the belief that life is full of suffering and nothing including life is permanent, need clarification. When one believes that all that there is to life is merely suffering, and that when one dies there is no other birth, suicide cannot be far away.

From India...

Professor M, aged 68 years and Ms V, aged 60 years, committed suicide by consuming barbiturates. They had two children, settled abroad. Professor M lost his right leg in a road accident four years back and was diagnosed with hypertension and also had joint pains in both legs. Since the last two years, both had extreme difficulty in managing their lives without any support. They left notes for their children wishing them success and happiness.

Religion and culture...

Another dimension to this process are the religious and cultural aspects of suicide emanating from strongly held beliefs and value systems. This association in some individuals is propelled more by tolerance, acceptance and respect. The notion that a person has reached his heavenly abode, is close to God, has complied with the wishes of elders, joined the family in heaven, taken the destined way of leaving earth, followed a self-created path of life can only be explained by religious, spiritual and earthly modes of causality. The increasing realization that “precious, valuable, human lives should not be lost as emphasized in religious texts” should form the focus for future preventive measures.

Didyouknow...

The village of Gunung Kidul in Indonesia has a very high suicide rate. The spiritual leaders in the area predict the arrival of a fireball, pulung, which can only be seen by them. The occurrence of suicide after this is considered to be a call from a supernatural power. In reality, the increased rate of suicide in this village is mostly related to the presence of severe illness among the elderly.

Yogeeta
Failingsystems...

The increasing economic turmoil, political unrest, social upheaval, communal disharmony and widening gap between the haves and have-nots have added another dimension to the problem of suicide. In these situations, serious losses or threat of loss of property, loved ones, job, pride, honour, status, independence and support systems operate in a major way to push an individual to states of despair and depression. These tenets question the fundamental survival of human beings in their respective societies based on existence, ideologies and strategies. The recent crop failures in India, the civil war in Sri Lanka, economic turmoil in Thailand, economic and political upheaval in Indonesia are some indicators of sociopolitical instability in SEAR Member Countries. Solutions to these problems need to focus on equitable distribution of resources and socioeconomic reforms.

- Nearly 1000 farmers from the three southern states of India, Karnataka, Andhra Pradesh, and Maharashtra have committed suicide in the last three years.
- The economic and political unrest in Indonesia in 1997 and 1998 left many without jobs and income. Failure to rehabilitate people in such situations by the concerned authorities may have led to many acts of suicide.
- The changing social situation in SEAR has thrown new problems and challenges. The emerging "empty nest syndrome" in all countries (children moving away from parents), "latch-key children syndrome" (parents leaving children alone due to their working status) has also been identified as a major factor for suicide. With the aged, terminally ill, or isolated individuals having no one to take care of them and no resources, the situation has become more difficult. At the extreme, the economic need for both parents to work coupled with educational pressures has contributed to the increasing social and health problems among children and adolescents.

An added problem in SEAR Member Countries is the easy availability of poisonous substances such as organophosphorus compounds. Various pesticides, herbicides, rodenticides and similar poisonous drugs are manufactured in large quantities, advertised extensively and are available freely. A total ban on these products is impossible, as agriculture is the major occupation in these countries. Unregulated distribution and sales have been major factors for suicide in SEAR Member Countries.

Didyouknow...

The village of Gunung Kidul in Indonesia has a very high suicide rate. The spiritual leaders in the area predict the arrival of a "fireball," which can only be seen by them. The occurrence of suicide after this is considered to be a call from a supernatural power. In reality, the increased rate of suicide in this village is mostly related to the presence of severe illness amongst the elderly.

Religionandculture...

Another dimension to this process are the religious and cultural aspects of suicide emanating from strongly held beliefs and value systems. This association in some individuals is propelled more by tolerance, acceptance and respect. The notion that a person has reached his/her abode, is close to God, has complied with the wishes of elders, joined the family in heaven, taken the destined way of leaving earth, followed a self-created path of life can only be explained by religious, spiritual and earthly modes of causality. The increasing realization that "precious, valuable, human lives should not be lost" or emphasized in religious texts should form the focus for future preventive measures.

Didyouknow...

In Sri Lanka, 90% of suicides are committed by Buddhists, who form 70% of the population. Beliefs in reincarnation, a better life in the next birth, and the belief that "life is full of suffering and nothing including life, is permanent," need clarification. When one believes that all that there is to life is merely suffering, and that when one dies there is another birth, suicide cannot be far away.

From India...

Professor M, aged 68 years and Ms V, aged 60 years, committed suicide by consuming barbiturates. They had two children, settled abroad. Professor M lost his right leg in an accident four years back and was known as a diabetic on regular treatment. Ms V was diagnosed to have hypertension and ALSO had joint pains in both legs. Since the last two years, both had extreme difficulty in managing their lives without any support. They left notes for their children wishing them success and happiness.

Yogeeta
From India...

Ms R came from a poor family and was married to a casual labourer. Her husband, a chronic alcoholic, spent all his money on his drinking habit. He used to physically abuse his wife whenever she asked him to take care of the family. She had to borrow money regularly from relatives and friends. Two years after marriage, she gave birth to a female child. Things became difficult as her husband wanted a baby boy. His irresponsible behaviour made her life miserable. One day she left the child in an orphanage (giving a false reason) and committed suicide by burning herself.

**Bangladesh**

A recent study in Jhenidah revealed that torture by family members, quarrels with relatives, extreme poverty and a lack of food, loss of agricultural land, suffering from an incurable disease and lack of money for health care were the major causes for suicide.

**Indonesia**

A recent study revealed that the majority of suicides were related to mental health problems, disruption within the family, alcohol and drug abuse in the lower socioeconomic groups, disrespectful attitude towards religion and poor social integration.

**Sri Lanka**

The steep increase in suicides in Sri Lanka during the last two decades is closely related to the agricultural revolution and sociopolitical turmoil. The easy availability of pesticides and herbicides has been a major contributing factor; these were used in nearly 70% of suicides. Suicide rates have been reduced in certain villages by regulating the sale of pesticides.
From India...

Ms R came from a poor family and was married to a casual labourer. Her husband, a chronic alcoholic, spent all his money on his drinking habit. He used to physically abuse his wife whenever she asked him to take care of the family. She had to borrow money regularly from relatives and friends. Two years after marriage, she gave birth to a female child. Things became difficult after her husband wanted a baby boy. His irresponsible behaviour made her life miserable. One day she left the child in an orphanage (giving a false reason) and committed suicide by burning herself.

Bangladesh

A recent study in Jhenidah revealed that torture by family members, quarrels with relatives, extreme poverty and a scarcity of food, loss of agricultural land, suffering from incurable diseases and lack of money for healthcare were the major causes for suicide.

Indonesia

A recent study revealed that the majority of suicides were related to mental health problems, disruption within the family, alcohol and drug abuse in the lower socioeconomic groups, disrespectful attitude towards religion and poor social integration.

Sri Lanka

The steep increase in suicides in Sri Lanka during the last two decades is closely related to the agricultural revolution and sociopolitical turmoil. The easy availability of pesticides and herbicides has been a major contributing factor; these were used in nearly 70% of suicides. Suicide rates have been reduced in certain villages by regulating the sale of pesticides.
Biochemical imbalance...

Though much attention is focused on the cultural, social and economic aspects of suicides, changes in the brain also contribute in several ways. Adverse socioeconomic conditions create biochemical imbalances by themselves or some psychiatric conditions in turn produce these imbalances, thereby precipitating suicidal behaviour. Some of the known mental health problems such as depression, alcoholism and other substance abuse problems, schizophrenia, and affective disorders, cause biochemical imbalances by themselves. It is believed by some that suicidal behaviour runs as a distinct feature and requires triggering by disorders or adverse psychosocial factors. The biochemical basis of suicide endorses the fact that the decline of certain neurotransmitters in the brain is a major reason. Ongoing research worldwide is likely to throw more light on the understanding of suicides.

Some mental health problems carry a higher risk of suicide during the course of the illness. Biochemical imbalances in the brain of such individuals alter their rational thinking and judgment, contributing significantly to the occurrence of suicide. Depression is one of the commonest conditions leading to suicide. The risk of suicide among persons who are depressed varies from 40-60% across countries in the Region. Depression occurring alone or in combination with other illnesses or interacting in an insidiously difficult situation is known to contribute to suicide. Alcoholism is known to be a distinct risk associated with suicides, especially when drinking starts at an early age. Alcoholism, depression and suicide are known to be interrelated in a vicious circle. Abuse of alcohol among men is often linked to suicide among spouses. The lifetime risk of suicidewhether or not with disorders such as alcoholism, schizophrenia and personality disorders is estimated to be 6.15%, 7.15% and 20-30%, respectively. Drug abuse is also more prone to suicide. About 20-30% of reported suicides among drug abusers occur following a period of rehabilitation. The risk increases further when persons with these disorders are untreated or inappropriately managed, having an long history of illness and multiple relapses. The course of these illnesses also leads to significant socioeconomic problems. A past history of attempts or family history of suicide is known to carry an additional risk of 5-10%.

Did you know...

- Depression, alcohol dependence and stress prevailing within families are the leading causes of suicide in Sri Lanka. Immediate abuse and stress arising within the family, low economic status, gender bias, and chronic physical illness emerged as other major factors. For various reasons, the suicide culture among youth has been gaining momentum from the early 1990s. The "suicidesquads" of Sri Lanka are a recognized political and social entity.

- Family conflict, chronic illness, financial debt and marital disharmony were the major causes for suicide in India according to a recent study from Bangalore. Further, nearly 27% of men were alcohol dependent and 84% of the used alcohol in combination with other substances. 10% of individuals were found to be suffering from a mental disorder prior to the act of suicide, with only 10% of them being under treatment (90% of them were undetected). Nearly one-third had given clues about their impending act.

- The emergence of the HIV/AIDS epidemic in Thailand has led to many suicidal thoughts and action. Suicide risks are especially high in those who have learned they have AIDS, or as physical health deteriorates and medical treatments remain out of reach. The situation is likely to worsen in the Region due to this uncontrolled epidemic.

- Pressures of examination and high expectations from parents lead to some students taking the extreme path of suicide amongst adolescents.

- Economic adversity, both at high levels such as business failures, and at low levels such as asc described in the text, are preventable.

Thus, suicide is influenced by ecological and environmental characteristics, the social fabric, individual predispositions and current circumstances. The causes for suicide are multifactorial, interlinked, cumulative, often repetitive and progressively over a period of time (acute and chronic), pushing an individual through stages of helplessness, hopelessness and worthlessness. The impact of these factors often stands on the pedestal of values, traditions and support systems for the individual.
Biochemical imbalance…

Though much attention is focused on the cultural, social and economic aspects of suicides, changes in the brain also contribute in several ways. Adverse socioeconomic conditions create biochemical imbalances by themselves or some psychiatric conditions in turn produce these imbalances, thereby precipitating suicidal behaviour. Some of the known mental health problems such as depression, alcoholism and other substance abuse problems, schizophrenia, and affective disorders, cause biochemical imbalances by themselves. It is believed by some that suicidal behaviour runs as a distinct feature and requires triggering by disorders or averse psychological factors. The biochemical basis of suicide endorses the fact that the decline of certain neurotransmitters in the brain is a major reason. Ongoing research worldwide in this direction is likely to throw more light on the understanding of suicides.

Some mental health problems carry a high risk of suicide during the course of illness. Biochemical imbalances in the brain of suicidal individuals alter their rational thinking and judgment, contributing significantly to the occurrence of suicide. Depression is one of the commonest conditions leading to suicide. The risk of suicide among persons who are depressed varies from 40-60% across countries in the region. Depression occurring alone or in combination with other illness is a significant risk factor for suicide. Alcoholism is known to be distinctly associated with suicide, especially among drinking starts at an early age. Alcoholism, depression and suicide are known to occur simultaneously. Abstinence from alcohol, efforts to stop drinking and other treatments are helpful in reducing the risk of suicide. The lifetime risk of suicidal with disorders such as alcoholism, schizophrenia and personality disorders is estimated to be 6.15%, 7.15% and 20-30%, respectively.Drug users are also more prone to suicide. About 20-30% of reported suicides among drug users occur following abstention from drugs and during rehabilitation. Their skin increases further when persons with these disorders are untreated or inappropriately managed, having a long history of illness and recurrent relapses. The course of these illnesses also leads to significant socioeconomic problems. A past history of suicidal attempts or family history of suicide is known to carry an additional risk of 5-10%.

Did you know…

- Depression, alcohol dependence and stress prevailing within families are the leading causes of suicide in Sri Lanka. Immediate abuse and stress arising within the family, low economic status, gender bias, and chronic physical illness emerged as other major factors. For various reasons, the suicidal culture among youth has been gaining momentum from year to year. The “suicides squad” of Sri Lanka are known political and social entity.
- Family conflict, chronic illness, financial debts and marital disharmony were the major causes for suicide in India according to a recent study from Bangalore. Further, nearly 27% of men were alcohol dependent and 84% of the used alcohol and other substances; 10% of individuals were found to be suffering from mental illness disorder prior to the act of suicide, with only 10% of the mental disorders being treated. Nearly 70% of the mental disorders were not detected. Nearly one-third the victims concerned about their impending act.
- The emergence of the HIV/AIDS epidemic in Thailand has led to many suicidal thoughts and action. Suicides are especially high in the heterosexual person living with HIV/AIDS, as physical health deteriorates and medical treatments remain out of reach. The situation is likely to worsen in the region due to the uncontrolled epidemic.
- Pressures of examination and high expectations from parents of their children to excel in studies, is in some cases taking the extreme path of suicide among adolescents.
- Economic adversity, both at high levels such as business failures, and at low levels such as a decrease in income, can lead to suicide.

Thus, suicide is influenced by ecological and environmental characteristics, the social fabric, individual predispositions and current circumstances. The causes for suicide are multifactorial, interlinked, cumulative, often repetitive and progressive. A period of time (acute or chronic), pushing an individual through stages of hopelessness, hopelessness and worthlessness. The impact of these factors often stands the pedestal of values, traditions and support systems for the individual.
The sudden, unexpected (sometimes expected) death of a person has profound and lasting effects on all spheres of life for the individual, family, and society. There have been several instances of immediate family members committing or attempting suicide after witnessing a suicide within the family. Such a situation, keeping in mind the considerable stigma associated with suicide, may affect the healthy growth of a child, a marriage, employment opportunities, and social interactions within the family. For a person who has attempted suicide, the problem is not only immediate recovery but giving reasons and explanation to those around him. The risk of such persons repeating or completing the act in their lifetime varies between 1 and 10%. To avoid social trauma, many people change houses and even educational institutions and jobs. These events psychological trauma after an act leaves the person confused and with the question “what next?”

...see, she left me. But now how do I take care of my children, family, and elderly parents? If only she had told me...

A husband

The sudden loss of a precious life has different meanings for people in terms of social, psychological, economic, and caring roles of the person. It is said that “suicide is the skeleton left by the deceased in the survivors’ closet”. To witness a death can be traumatic, confusing, dangerous, and frightening for a young child. Adolescents, newly-married and elderly individuals feel the loss, particularly, because death takes away the pillar of their family. In our traditional societies, members of the family, the mourning period is filled with guilt, shame, and stigma. Legal and investigative procedures, which result in unanswerable questions, add insult to injury.

Suicide by a person affects friends, acquaintances, employers, loved ones, and the society differently. Some families and friends keep the suicide notes or letters for the rest of their lives, feeling close to the person they loved and cared for. While the socioeconomic loss (life cannot be measured in monetary terms alone) is not known clearly for any country, it is estimated that about 2.5% of the total economic burden due to diseases is contributed by suicides.
THE SUDDEN, UNEXPECTED (SOMETIMES EXPECTED) DEATH OF A PERSON HAS PROFOUND AND LASTING EFFECTS ON ALL SPHERES OF LIFE FOR THE INDIVIDUAL, FAMILY AND SOCIETY. THERE HAVE BEEN SEVERAL INSTANCES OF IMMEDIATE FAMILY MEMBERS COMMITTING OR ATTEMPTING SUICIDE AFTER WITNESSING A SUICIDE WITHIN THE FAMILY. FOR A PERSON WHO HAS ATTEMPTED SUICIDE, THE PROBLEM IS NOT ONLY IMMEDIATE RECOVERY BUT GIVING REASONS AND EXPLANATIONS TO THOSE AROUND HIM. THE RISK OF SUCH PERSONS REPEATING OR COMPLETING THE ACT IN THEIR LIFETIME VARIES BETWEEN 1 AND 10%. TO AVOID SOCIAL TRAUMA, MANY PEOPLE CHANGE HOUSES AND EVEN EDUCATIONAL INSTITUTIONS AND JOBS. THESE SEVERE PSYCHOLOGICAL TRAUMAS AFTER AN ACT LEAVE THE PERSON CONFUSED AND WITH THE QUESTION "WHAT NEXT?"

"...see, she left me. But now how do I take care of my children, family and elderly parents? If only she had told me..."

A husband

The sudden loss of a precious life has different meanings for people in terms of social, psychological, economic, and caring roles of the person. It is said that 'suicide is the skeleton left by the deceased in the survivors' closet'. To witnesses, death can be traumatic, confusing, dangerous and frightening for a young child. Adolescents, newly married, and elderly individuals feel the loss, particularly, because death takes away the pillar of their family. In our traditional societies, members of the family, the mourning period is filled with guilt, shame, anxiety, and stigma. Legal and investigative procedures, which result in unanswerable questions, add insult to injury.

Suicide by a person affects friends, acquaintances, employers, loved ones, and the society differently. Some families and friends keep the suicide notes or letters for the rest of their lives, feeling close to the person they loved and cared for. While the socioeconomic loss (life cannot be measured in monetary terms alone) is not known clearly for any country, it is estimated that about 2.5% of the total economic burden due to diseases is contributed by suicides.

THOUGH EVERY YEAR MANY LIVES ARE LOST, MANY PEOPLE ARE HOSPITALIZED AND THE IMPACTS SIGNIFICANT, THERE HAS BEEN LITTLE PROGRESS IN PREVENTING SUICIDE. THERE IS INSUFFICIENT REALIZATION ABOUT THE HUMAN AND SOCIETAL IMPACT OF THIS PROBLEM, AND SYSTEMATIC AND COORDINATED EFFORTS ARE LACKING. SOME IMPORTANT REASONS FOR THIS SITUATION ARE:

- People consider suicide as karma, apathetic, and the "act of God". Fatalistic attitudes have been a major cause for poor health in general and particularly for suicide. Many families believe that losing a loved one is a sign of "God's will".
- Witnessing, listening, or reading about suicide is common, leading to a sense of futility. Mixed reactions are evoked only when a known person dies or is hospitalized.
- The idea of "self-blame" or "victim blame" has been a known factor without realizing that social, biological, and environmental factors play a major role in the act of suicide.
- Even in societies witnessing high rates of suicide, it is not regarded as a public health problem but an individual issue. The media gives widespread publicity to suicides, but public debate never seems to take place or to find solutions to the problem.
- With many misconceptions and myths surrounding suicide, families completely conceal and act. False information and declarations are given for official purposes with real issues never surfacing.
- Legal complications and police investigation make families completely conceal the act. False information and declarations are given for official purposes with real issues never surfacing.
- Lack of reliable information at the local/regional/national level significantly undermines the problem. In the case of suicide, considerable underreporting and misclassification occurs in data gathering. Hospital information systems do not include suicides and these are often listed under "injuries and accident" or "suicide and self-injury".
- The lack of healthcare and emergency care in developing SEAR countries is a major contributing factor. This is particularly important for people with depression, alcohol abuse, schizophrenia, and acute or chronic terminal disorders such as AIDS and cancer.
- Compartmentalization of sectors without interdisciplinary participation and coordination affects the efforts at suicide prevention. The absence of integrated prevention activities is a major factor for non-recognition of suicides as a public health problem.
"How does one know who will commit/attempt or is possibly thinking about suicide?" is the commonest question and a first step towards understanding the problem and providing care. Research has demonstrated that it is possible to identify such individuals if one is sensitive and open to words, actions, and signals. Some "high-risk individuals" live in uncertain situations and are more prone to suicides. These are persons:

- losing their status, jobs, and income;
- facing sudden economic loss due to migration, crop failure, economic upheaval, loss of day-to-day livelihood, natural disasters;
- expressing their loss of confidence, self-esteem, and faith;
- feeling guilt, shame, hatred, worthlessness, hopelessness, and helplessness;
- repeating that "destiny is calling them", "hearing words from God", or "joining a known person in heaven";
- participating in excessive religious activities, significantly more than previously observed;
- showing decreasing interest in hobbies, sex, and other activities which they enjoyed earlier;
- with history of previous suicidal attempt(s);
- complaining of "persistent boredom", inertia, lethargy, and "don't know what to do";
- experiencing recent loss of a person due to death, violence, separation, or broken relationship;
- who are unemployed and unable to find employment, especially youth;
- who are victims of domestic or other forms of violence, especially women;
- having conflicts within themselves or with other members of the family on a continual basis;
- recently discharged from hospitals, especially those with mental disorders or other terminal illnesses (such as cancer, HIV/AIDS, tuberculosis, and congenital health problems);
- staying at home and suffering from terminal illness without family and economic support, and
- pressurized by family for economic gains (such as dowry, or high achievement in academics).

While these persons are more susceptible to suicide, they also generally exhibit certain behavior. These are symptomatic of their low interest in life and typical of their passing through the ambivalent stage of "tolive or not to live".

A large number of individuals with mental illness, such as depression, schizophrenia, affective disorders, alcohol and other substance abuse, manifest various identifiable symptoms specific to their illness. However, there are some common symptoms noticed among suicide-prone individuals such as:

- sadness;
- weeping spells;
- anxiety and restlessness;
- mood swings (extreme happiness to sadness);
- excessive smoking and drinking;
- repetitive, continuous sleep disturbances;
- confusion and irritability;
- decreased interest in daily activities (hygiene, appearance, eating, sleeping);
- hinting at suicide (e.g., "This is the last time we meet," "I will put an end to all this suffering," "There is no point going on");
- difficulty in decision-making;
- self-injurious behavior (starving, injuring self);
- having strained and difficult relations with spouse or other family members;
- becoming highly religious or atheist, and
- exercising special care in distributing money or property.

If you know an individual with these symptoms - reach out and help. Your intervention can save a life or prevent a suicidal act.

#youknowanindividualwiththesesymptoms-reachoutandhelp.Yourinterventioncansavealifeorpreventasuicidalact.
“How does one know who will commit/attempt or is possibly thinking about suicide?” is the commonest question and a first step towards understanding the problem and providing care. Research has demonstrated that it is possible to identify such individuals if one is sensitive and open to words, actions, and signals. Some “high-risk individuals” live in uncertain situations and are more prone to suicides. These are persons

- losing their status, jobs, and income;
- facing sudden economic loss due to migration, crop failure, economic upheaval, loss of day-to-day livelihood, natural disasters;
- expressing their loss of confidence, self-esteem, and faith;
- feeling guilt, shame, hatred, worthlessness, hopelessness and helplessness;
- repeating that “destiny is calling them,” “hearing words from God,” or “joining a known person in heaven”;
- participating in excessive religious activities significantly more than previously observed;
- showing decreasing interest in hobbies, sex, and other activities which they enjoyed earlier;
- with history of previous suicidal attempt(s);
- complaining of “persistent boredom,” inertia, lethargy and “don’t know what to do”;
- experiencing recent loss of a person due to death, violence, separation, or broken relationship;
- who are unemployed and unable to find employment, specially youth;
- who are victims of domestic or other forms of violence, specially women;
- having conflicts within themselves or with other members of the family on a continual basis;
- recently discharged from hospitals, especially those with mental disorders or other terminal illnesses (such as cancer, HIV/AIDS, tuberculosis, and congenital health problems);
- staying at home and suffering from terminal illness without familial and economic support, and
- pressurized by family members or economic gains (such as dowry, high achievement in academics).

While these persons are more susceptible to suicide, they also generally exhibit certain behavior. These are symptomatic of their low interest in life and typical of their passing through the ambivalent stage of “toliveornottolive”.

A large number of individuals with mental illness, such as depression, schizophrenia, affective disorders, alcohol and other substance abuse, manifest various identifiable symptoms specific to their illness. However, there are some common symptoms noticed among suicide-prone individuals such as:

- sadness;
- weepingspells;
- anxiety and restlessness;
- moodswings (extreme happiness to sadness);
- excessivesmokingand/or drinking;
- repetitive, continuous sleep disturbances;
- confusion and irritability;
- decreased interest in daily activities (hygiene, appearance, eating, sleeping);
- hinting at suicide (e.g., “This is the last time we meet,” “I will put an end to all this suffering,” “There is no point going on”);
- difficulty in decision-making;
- self-injurious behavior (starving, injuring self);
- having strained and difficult relations with spouse or other family members;
- becoming highly religious/atheist, and
- exercising special care in distributing money or property.

If you know an individual with these symptoms, reach out and help. Your intervention can save a life or prevent a suicidal act.
From India...

Thirty-two persons (24 men and 8 women) committed suicide in a village with a population of 2000 over a period of six months. Many more tried and failed. There were several more on the brink of attempting it. The investigation by local school teachers revealed that 60% of the suicides were debt-related, 25% alcohol-related, 10% associated with severe mental health problems and 5% for unknown reasons. Following the suicides, the local parish started regular suicide prevention classes for the people.

These families:
- going through recent bereavement;
- having a mentally ill or terminally ill patient, or handicapped child at home;
- living with a person whose alcohol-dependent or drug addict;
- with a person who has attempted or completed suicide in the past;
- showing strong likelihood of a break-up in relations, disturbed emotional state;
- with interpersonal conflicts (regular, continuous, never-ending) between family members and others;
- subsisting on poor incomes, unemployment (sudden loss of job);
- living in dangerous (crime-ridden), underprivileged environments, and
- with recent migration to urban areas and living in situations without social support systems.

While individuals and families are more prone to suicide as mentioned above, it is also possible to identify communities or localities or specified places within defined geographical areas with high suicide rates. These are:
- certain pockets in geographical areas with high rates of suicide;
- economically impoverished communities (slums, migrant population);
- communities facing frequent natural disasters (floods, cyclones, droughts);
- agricultural communities with recurrent crop failures;
- regions with political and communal violence where hero worship is in vogue;
- societies with high rates of alcohol use, drug abuse, violence and prostitution, and
- certain high-risk places such as prisons, police stations, isolated places, hotels/lodges and even hospitals.
From India...

Thirty-two persons (24 men and 8 women) committed suicide in a village with a population of 2000 over a period of six months. Many more tried and failed. There were several more on the brink of attempting it. The investigation by local school teachers revealed that 60% of the suicides were debt-related, 25% alcohol-related, 10% associated with severe mental health problems, and 5% for unknown reasons. Following the suicides, the local parish started regular suicide prevention classes for the people.

There could be a number of families having persons with the above-mentioned characteristics requiring focused identification and help-seeking strategies. It is also known that a significant number of families are at a greater risk for suicide. As the entire family goes through a crisis together, symptoms in one person may not be noticed by other members.

These are families:
- going through recent bereavement;
- having a mentally ill or terminally ill patient, or handicapped child at home;
- living with a person who is alcohol-dependent or a drug addict;
- with a person who has attempted or completed suicide in the past;
- showing strong likelihood of a break-up in relations, disturbed emotional state;
- with interpersonal conflicts (regular, continuous, never-ending) between family members and others;
- subsisting on poor incomes, unemployment (sudden loss of job);
- living in dangerous (crime-ridden), underprivileged environments, and
- with recent migration to urban areas and living in situations without social support systems.

While individuals and families are more prone to suicides mentioned above, it is also possible to identify communities or localities or specified places within defined geographical areas with high suicide rates. These are:
- certain pockets in geographical areas with higher rates of suicide;
- economically impoverished communities (slums, migrant population);
- communities facing frequent natural disasters (floods, cyclones, droughts);
- agricultural communities with recent crop failures;
- regions with political and communal violence where hero worship is in vogue;
- societies with high rates of alcohol use, drug abuse, violence and prostitution, and
- certain high-risk places such as prisons, police stations, isolated places, hotels/lodges and even hospitals.

Prizewinning painting by Dhruv Suri
While the problem is enormous and the loss to the society phenomenal, the obvious questions drawing the attention of the public, professionals and societies are: “Can suicides be prevented?”, “Can lives be saved?” “Are there effective approaches?” The answer is definite ‘Yes’. Each and every member of society can take effective action, which would lead to saving a life, preventing an actor breaking the suicidal process.

**WHAT CAN BE DONE?**

Remember...

Suicide is not a solution to any problem. Many persons consider suicide as an option. The word “option” by definition indicates that there are choices. If one considers suicide as a choice, it takes away the options and life even before a solution can be found and put in practice. With death, the problem, the pain, the suffering, the trauma is merely transferred to those who survive. Therefore, consider other choices.

While the problem is enormous and the loss to the society phenomenal, the obvious questions drawing the attention of the public, professionals and societies are: “Can suicides be prevented?”, “Can lives be saved?” “Are there effective approaches?” The answer is definite ‘Yes’. Each and every member of society can take effective action, which would lead to saving a life, preventing an actor breaking the suicidal process.

**PREVENTIONS**

Preventing suicide includes...
- identifying the problem in its various dimensions;
- understanding risk factors;
- developing interventions, and
- establishing what works or doesn’t work in individuals or societies.

Often what works in one situation may not work in another as it is determined by people, choice of method and strategies. Certainly, the lessons learnt or approaches developed (Figure 9) can be shared and translated across countries and communities, keeping the sociocultural values and belief systems in mind. Only the combined efforts of individuals, families, communities, professionals and governments can help in mitigating the problem.

**Figure 9**

Approaches to prevention of suicides

- Identifying the problem in its various dimensions.
- Understanding risk factors.
- Developing interventions.
- Establishing what works or doesn’t work in individuals or societies.

**STRATEGIES**

- What can be done?
- Implementation of interventions
- Has it worked effectively?

**INFORMATION**

- What is the problem and pattern?

**RISK FACTORS**

- What are the causes and factors associated with the problem?

**PREVENTIVE STEPS**

- What can be done at individual, family, and societal levels?

**EVALUATION**

- How can these be implemented?
- What can be done?
- Has it worked effectively?
While the problem is enormous and the loss to the society phenomenal, the obvious questions drawing the attention of the public, professionals and societies are: “Can suicides be prevented?”, “Can lives be saved?”, “Are there effective approaches?”. The answer is a definite ‘Yes’.

Each and every member of society can take effective action, which would lead to saving a life, preventing an actor or breaking the suicidal process.

Preventing suicide includes...
- identifying the problem in its various dimensions;
- understanding risk factors;
- developing interventions, and
- establishing what works or does not work in individual societies.

Remember...

Suicide is not a solution to any problem. Many persons consider suicide as an option. The word option by definition indicates that there are choices. If one considers suicide as a choice, it takes away the options and life even before a solution can be found and put in practice. With death, the problem, the pain, the suffering, the trauma is merely transferred to those who survive. Therefore, consider other choices.

Often, what works in one situation may not work in others as it is determined by people, choice of method and strategies. Certainly, the lessons learnt or approaches developed (Figure 9) can be shared and translated across countries and communities, keeping the sociocultural values and belief systems in mind. Only the combined effort of individuals, families, communities, professionals and governments can help in mitigating the problem.
Prevention of suicide is a challenge to society. With multiple approaches and meaningful interventions, many lives can be saved. It is crucial to identify the person at risk, analyze their thoughts and circumstances and act immediately and appropriately. Most persons pass through different stages of ambivalence and undetermined responses of “willing to live and willing to die” before attempting suicide. The majority of these people are extremely unhappy with life, feel that the doors are closed and choices are nil. For some, suicide is an impulsive phenomenon, the impulse lasting for only a short time. If the ongoing crisis can be defused, they can be pulled out of such situations. Some others are rigid in their thoughts and behaviour. Such people require long-term persuasion to change their behaviour. Preventing suicide requires interventions at individual, family and societal levels.

Individuals... can save lives
Its important to realize that reaching out and establishing contact with a person on the verge of suicide is the first step. This is taken by observing people, by listening to people or by hearing about people. It is also possible to observe suicidal behaviour among people around you by watching their actions, reactions and feelings. Such people can help themselves, and can be helped by others in a planned manner. Whenever people say “I wish to die,” “I am sick and tired of life,” “I should not live anymore,” “I must leave this world,” it should be taken seriously, as it is a cry for help. One should not hesitate to bring up the subject, especially if the person is depressed and socially unstable. Many studies have shown that talking about suicide has never harmed anyone or precipitated suicide, instead, it has helped many and saved their lives. Individuals should step in bravely, offering a helping hand. Whenever such people are encountered, one should:
- try to establish contact and find out who they are;
- listen carefully and allow them to talk about themselves and their feelings;
- try to recognize the problem and understand their feelings;
- respect their thoughts and not say, “You are wrong;” “You made a mistake;” “Why did you do this?”;
- know the present situation, as well as past experiences and beliefs;
- explore the possible, positive, alternative options;
- identify the best possible way of helping them in the crisis;
- givethemhopeandoptimism;
- releasethemfrom theircircleofthoughts;
- engage them in social and recreational activities such as meeting people, listening to friends, watching television (not films or serials showing suicides), attending social functions like marriages, etc.;
- refer them to a counselor or a mental health professional (psychiatrist, psychologist, social worker);
- follow the advice of the doctor or counselor strictly, especially with regards to compliance with treatment;
- be with them and help them in every possible way and continue to interact, listen and offer support.

Once the crisis situation has passed, it is essential to offer continued support to enable them to overcome challenges in a positive way. If previous thoughts continue to persist, support through counselors and other professionals is required, they must be referred to the appropriate agency. Undoubtedly, all members of the society can act as counsellors in their limited way to communicate, empathize, support and show positive directions.

Families... be supportive
The family is the nucleus of all activities in an individual’s life. Interpersonal conflicts, disturbed relations and non-harmous living are the principal triggers precipitating factors for suicide, apart from specific family-related factors of status, recognition and struggles. Apart from identifying those in the family with suicidal feelings, thoughts and behaviour, the family must be supportive and driving force for preventing suicide. Family members can effectively intervene in a number of ways by:
- identifying warning signals of stress and suicidal tendencies. Since these expressions are signs of a serious condition, families should know such tendencies;

In a study in Chiang Mai, Thailand, half of those committing suicide had given some warning signs. Relatives did not consider them serious enough to intervene.

Each person contemplating suicide needs someone to support, a comforting shoulder and apatient hearing.
Prevention of suicide is a challenge to society. With multiple approaches and meaningful interventions, many lives can be saved. It is crucial to identify the person at risk, analyze their thoughts and circumstances and act immediately and appropriately. Most persons pass through different stages of ambivalence and uncertainty of willingness to live and wish to die before attempting suicide. The majority of these people are extremely unhappy with life, feel the doors are closed and choices are nil. For some, suicide is an impulsive phenomenon, the impulse lasting for only a short time. If the ongoing crisis is bedeviled, they can be pulled out of such situations. Some of them are rigid in their thoughts and behavior. Such people require long-term persuasion to change their behavior. Preventing suicide requires interventions at individual, family, and societal levels.

**Individuals... Can save lives**

It is important to realize that reaching out and establishing contact with a person on the verge of suicide is the first step. This is taken by observing people, by listening to people or by hearing about people. It is also possible to observe suicidal behavior among people around you by watching their actions, reactions, and feelings. Such people can help themselves, and can be helped by others in a planned manner. Whenever people say “I wish to die,” “I am sick and tired of life,” “I should not live anymore,” “I must leave this world,” it should be taken seriously, as it is a cry for help. One should not hesitate to bring up the subject, especially if the person is depressed and socially unstable. Many studies have shown that talking about suicide has never harmed anyone or precipitated suicide, instead, it has helped many and saved their lives. Individuals should step in bravely, offering a helping hand. Whenever such people are encountered, one should:

- **try to establish contact and find out who they are;**
- **listen carefully and allow them to talk about themselves and their feelings;**
- **try to recognize the problem and understand their feelings;**
- **respect their thoughts and not say, “You are wrong;” “You made a mistake;” “Why did you do this?”;**
- **know the present situation, as well as past experiences and beliefs;**

- **explore the possible, positive, alternative options;**
- **identify the best possible way of helping them in the crisis;**
- **give them hope and optimism;**
- **release them from their circle of thoughts;**
- **engage in social and recreational activities such as meeting people, talking to friends, listening to radio, watching television (not films or serials showing suicides), attending social functions like weddings, etc.;**
- **refer them to a counselor or a mental health professional (psychiatrist, psychologist, social worker);**
- **follow the advice of the doctor or counselor strictly, especially with regard to compliance with treatment;**
- **be with them and help them in every possible way, and continue to interact, listen, and offer support.**

Once a crisis situation has passed, it is essential to offer continued support to enable them to overcome challenges in a positive way. If previous thoughts continue to persist, support from counsellors and other professionals is required, they must be referred to the appropriate agency. Undoubtedly, all members of the society can act as counsellors in their limited way to communicate, empathize, support, and show positive directions.

**Families... Be supportive**

The family is the nucleus of all activities in an individual’s life. Interpersonal conflicts, disturbed relations, and non-harmonious living are the principal trigger in precipitating factors for suicide, apart from specific family-related factors of status, recognition, and struggles. Apart from identifying those in the family with suicidal feelings, thoughts, and behavior, the family has to be supportive and driving force for preventing suicide. Family members can effectively intervene in a number of ways by:

- **identifying warning signals of stress and suicidal tendencies. Since these expressions are unique to each culture (some are general), families have to know such tendencies;**

In a study in Chiang Mai, Thailand, half of those committing suicide had given some warning signs. Relatives did not consider them serious enough to intervene.
establishing close relations with the person by caring, listening, respecting feelings and understanding emotions;

building on the potential strengths of the person rather than weaknesses;

not leaving alone a person harbouring suicidal wishes;

working gradually (rapidly in some situations) to promote the "wish to live";

teaching and practising problem-solving methods with the affected person and inculcating a sense of optimism;

trying to minimize conflicts at home and developing problem-solving exercises jointly with other family members;

encouraging the person to seek timely help from a professional, suitable agency or hospital. Those with underlying mental health problems do not want to be labelled as mentally ill. Hence, persuasion is a key factor in actually taking the person to a doctor. Further, a one-time visit is not likely to result in significant change. Regular interaction with the doctor and following the advice given are crucial elements for success;

helping the affected person to overcome the crisis with alternative, feasible, realistic and sustainable options;

continuing to observe the reactions and behaviour of the person and acting fast even at the slightest suspicion or doubt;

keeping a specific watch on those who are elderly, terminally ill, mentally ill (depressed, alcoholic, violent and others) and disabled;

identifying agencies in the community for assistance with regard to specific causes (schools, employment agencies, social welfare agencies, healthcare institutions, spiritual leaders and elders in the neighbourhood), and

by giving love, understanding and support, besides prescribed medicines, following a suicidal attempt.

Communities...widernetwork

To a great extent, the responsibility for preventing suicides in society rests with the community. Societies should establish behavioural norms to help people grow in a healthy and positive way. Thus, positive influences in a society can influence an individual being taught from harmful behaviour. A major problem in transitional societies is the slow breakdown of values systems, rapid reforms and accompanying conflict generated by new opportunities, and frustrations arising due to societal changes. Thus each social institution and individuals within them can play a vital role in preventing suicide. Every society needs to build social defence mechanisms, covering preventive, therapeutic and after-care services to reduce suicides.

Individual communities, organizations and agencies have an extremely important role in developing preventive services, emergency services, after-care service and preventive programmes. Thus, enlisting the support of local groups is a vital step for organizing programmes and identifying resources. Local communities can help in suicide prevention programmes by taking up local issues, problems and causes with the local authorities (e.g. improving the quality of life among low-income communities, reducing violence and crime rates, removing stigma, eliminating discriminatory attitudes, influencing the local press and improving information databases on suicides). Apart from this, a number of activities can be taken up, e.g.:

- Area-based helplines can be established, if not already in existence. With information and communication technology slowly expanding in the SEA Region, establishing 24-hour emergency direct telephone lines can be of great help (for example, telephone numbers 1091 and 1098 have been set up for women and children, respectively, in Bangalore, India by the City Police Department).

- Greater publicity and awareness about these helplines can be generated by encouraging people to access these services and by having personnel on 24-hour duty to listen to and answer calls.

- Local voluntary youth services can be developed to act as emergency help personnel for the distressed and needy in crisis situations.

- Local people from various agencies can be brought together to develop an intersectoral support system based on local problems and available resources.
establishing close relations with the person by caring, listening, respecting feelings and understanding emotions;

building on the potential strengths of the person rather than weaknesses;

not leaving a person harboursing suicidal wishes;

working gradually (rapidly in some situations) to promote the “wish to live”;

teaching and practising problem-solving methods with the affected person and inculcating a sense of optimism;

trying to minimize conflicts at home and developing problem-solving exercises jointly with other family members;

encouraging the person to seek timely help from a professional, suitable agency or hospital. Those with underlying mental health problems do not want to be labelled as mentally ill. Hence, persuasion is a key factor in actually taking the person to a doctor. Further, one-time visits are not likely to result in any significant change. Regular interaction with the doctor and following the advice given are crucial elements for success;

helping the affected person to overcome the crisis with alternative, feasible, realistic and sustainable options;

continuing to observe the reactions and behaviour of the person and acting (fast) even at the slightest symptoms of danger;

keeping a specific watch on those who are elderly, terminally ill, mentally ill (depressed, alcoholic, violent and others) and disabled;

identifying agencies in the community for assistance with regard to specific causes (schools, employment agencies, social welfare agencies, healthcare institutions, spiritual leaders, and elders in the neighbourhood), and

by giving love, understanding and support, besides prescribed medicines, following a suicidal attempt.

Communities... widemesh network

To a great extent, the responsibility for preventing suicides in society rests with the community. Society should establish behavioural norms to help people grow in a healthy and positive way. Thus, positive influences in a society can influence people being born to refrain from harmful behaviour. A major problem in transitional societies is the breakdown of traditional systems, rapid reforms and accompanying conflict generated by new opportunities, and frustrations arising due to societal changes. Thus each social institution and individuals within them can play a vital role in preventing suicide. Every society needs to build social defence mechanisms, covering preventive, therapeutic and after-care services to reduce suicides.

Individual communities, organizations and agencies have an extremely important role in developing preventive services, emergency services, after-care service and preventive programmes. Thus, enlisting the support of local groups is a vital step for organizing programmes and identifying resources. Local communities can help in suicide prevention programmes by taking up local issues, problems and causes with the local authorities (e.g., improving the quality of life among low-income communities, reducing violence and crime rates, removing stigma, eliminating discriminatory attitudes, influencing the local press, and improving information databases on suicides). Apart from this, a number of activities can be taken up, e.g:

- Area-based helplines can be established if not already in existence. With information and communication technology slowly expanding in the SEA region, establishing 24-hour emergency direct telephone lines can be of great help (for example, telephone numbers 1091 and 1098 have been set up for women and children, respectively, in Bangalore, India by the City Police department).
- Greater publicity and awareness about these helplines can be generated by encouraging people to access these services and by having personnel on 24-hour duty to listen to and answer calls.
- Local volunteer youth services can be developed to act as emergency help personnel for the distressed and needy in crisis situations.
- Local people from various agencies can be brought together to develop an intersectoral support system based on local problems and available resources.
Mental and social health promotional activities in schools and colleges, industries, hospitals and high-risk communities can be organized through local programmes, with the involvement of families and individuals.

Meaningful information can be given to the local media on actual causes, situations and circumstances of suicides. High-risk places, popular with those contemplating suicide, can be made safer through increased security measures.

Educational programmes in local languages by using local dialects and communication strategies can be facilitated for proper sociocultural applications.

Suicides have also been attempted in several places like hospitals, jails and lodging establishments and hence these can be "high-risk" places. It is important to develop mechanisms for preventing suicides in these places by special efforts.

- Individuals who are at a "high-risk" of suicides in each of these places should be identified and focused, targeted, prioritized intervention programmes developed.
- The staff in these places must be trained to identify people and keep a watch on them. Periodic on-the-job training is essential to reinforce the problem and methods of prevention.
- A screening programme should be developed at the time of registration by evaluating the personalities of inmates.
- Local health personnel, legal officers, police personnel, social workers and counselors should be involved to offer corrective help on a regular basis.
- Joint intervention should be developed with family and close friends, local spiritual leaders, rehabilitation staff and professional counsellors.
- A stock of emergency first-aid material should be kept to intervene in sudden and unexpected suicidal attempts.
- Special caution must be taken in placing a high-risk personal along with others. This should only be done if there are no threats to others.

Suicide prevention must focus on the four pillars of improving physical, social and mental health; early detection; appropriate management, and specific rehabilitation.

**High-risk places... keep a watch**

Suicides have also been attempted in several places like hospitals, jails and lodging establishments and hence these can be "high-risk" places. It is important to develop mechanisms for preventing suicides in these places by special efforts.

- Individuals who are at a "high-risk" of suicides in each of these places should be identified and focused, targeted, prioritized intervention programmes developed.
- The staff in these places must be trained to identify people and keep a watch on them. Periodic on-the-job training is essential to reinforce the problem and methods of prevention.
- A screening programme should be developed at the time of registration by evaluating the personalities of inmates.
- Local health personnel, legal officers, police personnel, social workers and counselors should be involved to offer corrective help on a regular basis.
- Joint intervention should be developed with family and close friends, local spiritual leaders, rehabilitation staff and professional counsellors.
- A stock of emergency first-aid material should be kept to intervene in sudden and unexpected suicidal attempts.
- Special caution must be taken in placing a high-risk personal along with others. This should only be done if there are no threats to others.

Suicide prevention must focus on the four pillars of improving physical, social and mental health; early detection; appropriate management, and specific rehabilitation.

**Health sector... emerging tasks**

Presently, there are no focused, specific, targeted programmes for suicide prevention in the Region. While no single intervention can yield 100% results, integrated programmes are likely to yield moderate results. There has been progress in the last few decades in the global understanding of the causes of suicides. This understanding has to be utilized to develop prevention programmes in the Region.

Suicide is not merely a social, cultural or religious phenomenon. In order to become an active partner in preventing suicides, the health sector needs to expand its role and responsibilities. The health sector should take the lead in promoting and undertaking multisectoral research, as understanding the problem, risk factors, and methods are the key issues for effective interventions and prevention.

In order to effectively address the situation, the health sector should, among other things:

- Start manpower development programmes in suicidology by equipping health functionaries with better knowledge, skills, techniques and strategies to deliver care;
- Improve emergency facilities and services for immediate care of attempted suicides, combined with referral and after-care services;
- Employ, promote and integrate mental health components into primary health care systems, since identification, management and referral of individuals, especially those with depression and alcohol abuse (and other mental health problems), along with promoting positive attitudes at community levels, will definitely help in reducing suicides;
Mental and social health promotional activities in schools and colleges, industries, hospitals and high-risk communities can be organized through local programmes, with the involvement of families and individuals.

Meaningful information can be given to the local media on actual causes, situations and circumstances of suicides. High-risk places, popular with those contemplating suicide, can be made safer through increased security measures.

Educational programmes in local languages by using local dialects and communication strategies can be facilitated for proper sociocultural applications.

Suicides have also been attempted in several places like hospitals, jails and lodging establishments; and hence these can be "high-risk" places. It is important to develop mechanisms for preventing suicides in these places by special efforts.

Individuals who are at a "high-risk" of suicides in each of these places should be identified and focused, targeted, prioritized intervention programmes developed.

The staff in these places must be trained to identify people and keep a watch on them. Periodic on-the-job training is essential to reinforce the problem and methods of prevention.

A screening programme should be developed at the time of registration by evaluating the personalities of inmates.

Local health personnel, legal officers, police personnel, social workers and counsellors should be involved to offer correct help/panoregular basis.

Joint interventions should be developed with family and close friends, local spiritual leaders, rehabilitation staff and professional counsellors.

A stock of emergency first-aid material should be kept to intervene in sudden and unexpected suicidal attempts.

Special caution must be taken in placing a high-risk personal along with others. This should only be done if there are no threats to others.

Suicide prevention must focus on the four pillars of improving physical, social and mental health; early detection; appropriate management, and specific rehabilitation.

High-risk places... keep a watch

Suicides have also been attempted in several places like hospitals, jails and lodging establishments, and hence these can be "high-risk" places. It is important to develop mechanisms for preventing suicides in these places by special efforts.

Potentialy injurious objects (any object which people can use to hang or poison themselves) should be removed and safety features increased.

Security checks in the environment (especially hotels and lodges) should be increased, and

Healthy and valuable social interactions should be promoted and people involved in recreational activities such as songs, prayers, meditation, physical exercise, good hobbies, reading, listening to radio and watching television, top promote positive social and mental health among inmates.

Health sector... emerging tasks

Presently, there are no focused, specific, targeted programmes for suicide prevention in the Region. While no single intervention can yield 100% results, integrated programmes are likely to yield moderate results. There has been progress in the last few decades in the global understanding of the causes of suicides. This understanding has to be utilized to develop prevention programmes in the Region.

Suicide is not merely a social, cultural or religious phenomenon. In order to become an active partner in preventing suicides, the health sector needs to expand its role and responsibilities. The health sector should take the lead in promoting and undertaking multisectoral research, as understanding the problem, risk factors, and methods are the key issues for effective interventions and prevention.

In order to effectively address the situation, the health sector should, among other things:

- Start manpower development programmes in suicidology by equipping health functionaries with better knowledge, skills, techniques and strategies to deliver care;
- Improve emergency facilities and services for immediate care of attempted suicides, combined with referral and after-care services;
- Employ, promote and integrate mental health components into primary health care systems, since identification, management and referral of individuals, especially those with depression and alcohol abuse (and other mental health problems), along with promoting positive attitudes at community levels will definitely help in reducing suicides;
provide guidance to local media personnel and other sector to develop a realistic information dissemination policy to shape positive attitudes in the community;

develop an intersectoral, integrated, coordinated approach for suicide prevention programme;

develop a poison centre which can give information and advice on management of poisoning, and

develop and implement a demonstration project in all SEAR Member Countries. The lessons learnt from international or local experiences should be implemented with local culture-specific interventions.

An act of suicide is often reported/witnessed by some near family member, neighbour, relative or friend. The immediate reaction is to call for medical help at the site or shift the patient to an emergency health centre. In many cities, a 24-hour hotline emergency telephone service is available. The immediate management depends on the age, gender, physiological status, method of suicide, type and amount of poisonous substance consumed or extent of burns or management of other methods of attempted suicide. What is essential is a prompt response.

Immediate acceptance of the patient and treatment should be the first duty of hospitals. Some hospitals in some countries do not accept patients with suicide attempts. A non-accepting attitude of the hospital staff, considering suicide emergencies as increasing their workload, thinking that patients are just seeking attention, and medical and legal fears are some of the common reasons for refusing registration and admission. The unsympathetic attitude of some hospital staff might discourage people from seeking help.

Wide publicity should begin about minimal and safe first-aid measures and emergency help centres, especially for those with drug and alcohol dependence. Many common household first-aid practices can, in fact, be dangerous. However, there should be a delay in taking the affected person to a hospital;

minimum facilities to handle emergencies must be available at the community level in each country. Considerable time is spent in transporting patients from rural to urban areas;

doctors and nurses should be provided training in the management of patients who have attempted suicide, especially in rural areas, at referral hospitals, and the services/programmes can be strengthened by improving emergency care services;

along with immediate management, medical personnel should be trained in initiating after-care services. At the time of discharge, the health status of the person should be reviewed. Future health services, including follow-up, should be strongly recommended to family members, and

referral to local mental health professionals such as psychiatrists, psychologists, and social workers should form an integral part of after-care to ensure that suicide attempts are not repeated.

Health professionals beyond medicines

In every country, health professionals at secondary or tertiary levels can play an essential role in preventing, managing or rehabilitating persons with suicide tendencies, those who have committed suicide, and families of such persons. Usually, after a family member, it is the health sector that first comes in contact with the person, who has attempted suicide. On the other hand, due to stigmatizing attitudes of several societies, health professionals may also be the last persons to come in contact with possible attempters, after every possible option has been tried. Unfortunately, in a majority of countries, attempting suicide is not considered a serious health problem, and some health workers believe that suicide is more of a social/religious/cultural problem. Thus, the health professionals need to reorient their thinking to effectively meet this challenge.

Health professionals should be in close touch with the community and nontargeted people and, to be able to intervene in a variety of action-oriented programmes. Due to their involvement in health matters, they are unique and respected. Thus, health professionals can offer a wide range of services to people with suicidal thoughts and behaviour, and to those families with a history of suicide among its members.

Need for partnerships...

The health sector is a partner in socioeconomic development and health promotion. For suicide prevention to be a reality, an intersectoral approach is key. Sensitization of teachers, doctors, lawyers, and other product manufacturers can be effectively undertaken by the health sector. Coordination between health-related sectors is essential for achieving success.
provide guidance to local media personnel and other sectoral development realistic information dissemination policy to shape positive attitudes in the community;  
- develop an intersectoral, integrated, coordinated approach for suicide prevention programme;  
- develop a poison centre which can give information and advice on management of poisoning, and develop and implement pilot demonstration projects in all SEAR Member Countries. The lessons learnt from international or local experience should be implemented with local culture-specific interventions.

An act of suicide is often reported/witnessed by a near family member, neighbour, relative or friend. The immediate reaction is to call for medical help at the site or shift the patient to an nearby health centre. In many cities, a 24-hour hotline emergency telephone service is available. The immediate management depends on the age, gender, physiological status, method of suicide, type and amount of poisonous substance consumed or extent of burns or management of other methods of attempted suicide. What is essential is a prompt response.

Immediate acceptance of the patient and treatment should be the first duty of hospitals. A few hospitals in some countries do not accept patients with a suicide attempt. A non-accepting attitude of the hospital staff, considering suicide emergencies as increasing their workload, thinking that patients are just seeking attention, and medical/legal fears of some of the common reasons for refusing registration and admission. The unsympathetic attitude of the hospital staff might discourage people from seeking help.

Wide publicity should begin about minimal and safe first-aid measures and emergency help centres, especially for burns, poisoning and burns injuries. Many common household first-aid practices can, in fact, be dangerous. However, there should be delay in taking the affected person to a hospital;

Minimum facilities to handle emergencies must be available at the community level in each country. Considerable time is spent in transporting patients from rural to urban areas;

Doctors and nurses should be provided training in the management of patients who have attempted suicide, especially in rural areas, as transfers to urban hospitals can delay treatment. Apart from providing skills, facilities and resources for treatment, such medical centres should be strengthened by improving emergency care services;

Along with immediate management, medical personnel should be trained to initiate after-care services. At the time of discharge, the health status of the person should be reviewed. Future help of referrers and counsellors and other interventions should be strongly recommended to family members, and

Referral to local mental health professionals such as psychiatrists, psychologists and social workers should form integral part of after-care to ensure that suicide attempts are not repeated.

In every country, health professionals at primary, secondary or tertiary levels can play an effective role in preventing, managing or rehabilitating persons with suicidal tendencies, those who have committed suicide or families of such persons. Usually (after a family member), it is the health sector that first comes in contact with the person, who has attempted suicide. On the other hand, due to the stigmatizing attitudes of several societies, health professionals may also be reluctant to come in contact with possible attempters, after every possible option has been tried. Unfortunately, in a majority of countries, attempting suicide is not considered a serious health problem and some health workers believe that suicide is more of a social/religious/cultural problem. Thus, the health professionals need to reorient their thinking to effectively meet this challenge.

Health professionals should be in close touch with the community in order to know the people better, and to be able to intervene in a variety of action-oriented programmes. Due to their involvement in health matters and their unique and respected status, health professionals can offer and deliver a wider range of services to people with suicidal thoughts and behaviour, and to those families with a history of suicide among its members.

Health professionals beyond medicines

It was observed in Sri Lanka that 36% of suicidal deaths occurred at places far away from hospitals (Kekirawa), while those living closer to hospitals (Peradeniya and Kandy regions) had a death rate of only 20%.

Health professionals partner in socio-economic development and health promotion. For suicide prevention to be reality, an intersectoral approach is needed. Sensitization of teachers, doctors, medics and product manufacturers can be effectively undertaken by the health sector, as it has access to first-hand information. Coordination between health and related sectors is an essential element for achieving success.

Need for partnerships...
Health professionals should

- equip themselves with knowledge and skills about managing and preventing suicides along with counselling techniques. They should identify the resources required and attempt to obtain them from local or national agencies;
- learn and adopt simple mental health assessment methods in their practice to identify persons with potential social and psychiatric problems;
- promote mental health in their area and within their institution. The assessment procedures and treatment plans for these at-risk individuals need to take into account the frequent presence of co-morbidity conditions;
- pay special attention and care to individuals or families with a member suffering from depression, alcoholism, schizophrenia, personality problems (mood disorders and behaviour disorders). Since these are high-risk people, they should be observed, monitored, and provided care. Other individuals, such as those with a history of HIV/AIDS, paralysis, epilepsy, chronic terminal illness and disability, need counselling, diagnostic services, and continuous support;
- not make an abrupt discontinuation, change or alteration in medications without reason;
- as a first step, establish contact with the affected person, listen carefully, and not pass judgment after the first sentence. The patient should be offered non-judgmental hearing and allowed to talk. Exploring the situation and understanding his/her feelings, will provide confidence, hope and direction for the person and the family. The family and friends must be involved;
- depending on the individual patient and his state, prescribe simple medication along with counselling. The patient must be observed over a period of time to see his/her response;
- establish a referral and after-care programme with the nearest social and mental health agency in the area. If necessary, high-risk geographical area, this is important, as the majority of those who cannot be managed at the local level need help at the tertiary level. Many patients might refuse referral and there is a need to persuade them to contact the tertiary-level hospitals;

- bring together people with suicidal actions in the area or in the institution and develop a self-help or survivors group. This approach favours an environment for sharing feelings, thoughts, and experiences among people. These groups help in developing positive, empathetic, sharing attitudes. Such interactions can change the feelings of many. More importantly, such opportunities allow individual storememoﬆigma and shame and loneliness to be shared and learned from each other. A small, initial success can have a snowballing effect and become a movement;
- encourage health workers to be in regular touch with individuals and families. Apart from health worker visits, follow-up visits at frequent intervals should be organised;
- be on the lookout for potential acts of suicide in the area or going through natural disasters, crop failure, or religious turmoil. While basic necessities such as food, clothing and shelter are vital, community awareness and resource mobilisation programmes should also be developed, and
- recognize, listen and identify the problems of suicides in its various dimensions in the respective communities. Key informants such as local leaders, traditional healers, temple priests/mosque imams/church priests should be contacted to get a clearer picture. Small and simple research projects in the area could be undertaken to understand "what is causing suicides" among people. Without getting into the complexities of research and by just using the "eyes and ears open" approach, the problem could be identified.

Dear Doctor:

This note is to express my deep sense of gratitude to you and your colleagues for your kind words and help. In the last six months, I have met you anxiety, tension and with death wishes. I could not tell you my problems initially because of fear. But you listened to all my problems over a period of time and always said, "Meet me, call me or write to me anytime you have a problem." These words have given me faith, confidence and I know I can contact you any time. I know I can fall back on you for support and guidance. Thank you very much.

Yours sincerely,
Suicidesurvivor

A training programme for general practitioners on the identification of depression and suicide prevention in the Dutch island of Gotland in Sweden resulted in a decline in suicide rates. Many studies have shown a decline in the number of suicides among depressed persons after proper management.

Dear Doctor:

This note is to express my deep sense of gratitude to you and your colleagues for your kind words and help. In the last six months, I have met you anxiety, tension and with death wishes. I could not tell you my problems initially because of fear. But you listened to all my problems over a period of time and always said, "Meet me, call me or write to me anytime you have a problem." These words have given me faith, confidence and I know I can contact you any time. I know I can fall back on you for support and guidance. Thank you very much.

Yours sincerely,
Suicidesurvivor

A doctor is more than a healer...

The role of a doctor or health worker does not end with listening to symptoms, observing body signs, prescribing drugs or giving injections. Exploring the hidden problems, identifying support mechanisms and providing follow-up services begins at this time. The objectives should be to improve the quality of life of the person and ensure better physical, social and mental health in the community.
Health professionals should

- equip themselves with knowledge and skills about managing and preventing suicides along with counselling techniques. They should identify the resources required and attempt to obtain them from local or national agencies;
- learn and adopt simple mental health assessment methods in their practice to identify persons with potential social and psychiatric problems;
- promote mental health in their area and within their institution. The assessment procedures and treatment plans for those at risk of suicide need to take into account the frequent presence of co-morbid conditions;
- pay special attention and care to individuals or families with members suffering from depression, alcoholism, schizophrenia, personality problems (mood disorders and behaviour disorders). Since these are high-risk people, they should be observed, monitored and provided care. Other individuals, such as those with a history of HIV/AIDS, paralysed, epilepsy, chronic terminal illness and disability, need counselling, diagnostic services and continued support;
- not make an abrupt discontinuation, change or reallocation of medication without reason;
- as a first step, establish contact with the affected person, listen carefully, and not pass judgment after the first sentence. The patient should be offered non-judgemental hearing and allowed to talk. Exploring the situation and understanding his/her feelings will provide confidence, hope and direction for the person and family. The family and friends must be involved;
- depending on the individual patient and his state, prescriptions include medication along with counselling. The patient must be observed over a period of time to see his/her response;
- establish a referral and after-care programme with the nearest social and mental health agency in that area. If it is a high-risk geographical area, this is important, as the majority of those who cannot be managed at the local level need help at the tertiary level. Many patients might refuse referral and there is an need to persuade them to contact tertiary-level hospitals;

- bring together people with suicidal actions in the area or in the institution and develop a self-help or survivors group. This approach favours an environment for sharing feelings, thoughts, and experiences among people. These groups help in developing positive, empathetic, sharing attitudes. Such interactions can change the feelings of many. More importantly, such opportunities allow individual store important information by sharing and learning from each other. A small, initial success can have a snowballing effect and become a movement;
- encourage health workers to be in regular touch with individuals and families. Apart from health workers’ visits, follow-ups at frequent intervals should be arranged;
- be on the lookout for potential acts of suicide in the area, going through natural disasters, crop failure or religious turmoil. While basic necessities such as food, clothing and shelter are vital, community awareness and resource mobilization programmes should also be developed, and
- recognize, listen and identify the problems of suicide in its various dimensions in the respective communities. Key informants such as local leaders, traditional healers, temple priests and church priests should be contacted to get a clearer picture. Small and simple research projects in the area could be undertaken to understand “what is causing suicides” among people. Without getting into the complexities of research and by justising the “eyes and ears open” approach, the problem could be identified.

Dear Doctor: 

This note is to express my deep sense of gratitude to you and your colleagues for your kind words and help. In the last six months, I have met you many times, but I couldn’t tell you all my problems. Initially, I was afraid. But you listened to all my problems over a period of time and always said, “Meet me, call me or write to me anytime you have a problem.” These words have given me faith, confidence, and I know I can contact you any time. I know I can fall back on you for support and guidance. Thank you very much.

Yours sincerely,

As a suicide survivor

A training programme for general practitioners on the identification of depression and suicide prevention in the Dutch island of Gotland in Sweden resulted in a decline in suicide rates. Many studies have shown a decline in the number of suicides among depressed persons after proper management.
Media... shape the society

The media (visual and print) has a profound impact on the lives of people. A responsible way of presenting the problem of suicide would be in describing what led to the act and the consequences of such an action. While the media has the freedom to report, mediapersonnel need to be aware of the consequences of such reporting.

Across the world, a number of novels, television shows, films, soap operas, serials, magazines and newspapers have reported suicide as a heroic act, resulting in “copycat suicides.” Research has clearly demonstrated that reporting of self-inflicted or intentional (suicide and homicide) injuries, especially celebrity acts, definitely results in an increase in suicides over a period of time.

Reporting and publicity about suicides is often determined by who commits the act, place of committing the act, motive and lethality of the act, method employed and whether it was justified. This leaves a lasting image on the person viewing, reading or listening to the event and also to his/her state of vulnerability. The media can play a positive role in shaping people’s thoughts and can show the direction, avenue or option to a distressed person.

Asearlyas1774,Goethe’snovel,DieLeidendesJungenWerther(The Sorrows of Young Werther) projected a young hero shooting himself after an ill-fated love affair. Following this, many a young man used this method to commit suicide. Even though the book was banned in some places, within a few days, it had set a trend for many youngsters.

FromSrilanka...

The heroine in a Tamil film committed suicide by eating oleander seeds, as her boyfriend jilted her. The film was shown in the eastern district, which has a significant Tamil population. Soon, there was an epidemic of oleander-seed-related suicides in that province. This spread to the neighbouring northern central province, with a sizeable Tamil population. Now, the problem has become a national one. This reflects the power of the media to influence suicide.

The following suggestions, if implemented by the media, could help significantly in increasing appropriate awareness among people on the problem of suicide:

- Suicide statistics should be reported to stress the fact that every suicide is a loss to the society.
- Celebrity suicides should not be given undue emphasis or shown as heroic acts. Special caution should be exercised reporting such incidents with minimum publicity to such acts.
- Detailed descriptions of the place and method of suicide should be avoided as people might come to know about such places and might plan a journey with a similar motive. If there is a known high-risk place, the media should highlight how it could be made safe.
- No suicide occurs due to a single cause. The entire blame should not be put on the victim, as the act could be due to a combination of causes. Hence, highlighting what failed love affair, poor marks in examination or failure to go abroad, are the only causes which lead to suicide is improper reporting. The public should be informed about how this act or attempt could have been avoided.
- The warning signs of social adversities, economic problems and mental illness (especially depression) should be conveyed to the society. Possible remedial measures in these situations should be suggested by working closely with health professionals.
- A realistic description of the impact of suicides on survivors, employers and families should be provided and its short-term and long-term consequences on individuals.
- The misconceptions, culture, beliefs and myths about suicide should be explained. Raising awareness and changing people’s beliefs is one of the major responsibilities of the media.
- The local press can give views on public responsibility, crisis prevention centres, poison treatment centres and agencies, providing help to individuals and families.
- Simple choice of phrases such as “completed suicide” instead of “successful suicide” can change people’s perceptions. Hence, the right words and language should be used. The media should not report these phrases in sensationalizing the act.
- The media should work closely with local health personnel in ascertaining facts before reporting them.

A greater responsibility of the media as a gift to society is to prepare and inform people that suicide can be prevented.

InThailand, the Ministry of Public Health organized a seminar with media editors to address appropriate ways of presenting views on suicide. This was found to be a very positive effect.
Media... shapethesociety

Themedia (visual and print) has a profound impact on the lives of people. A responsible way of presenting the problem of suicide would be in describing what led to the act and the consequences of such an action. While the media has the freedom to report, media personnel need to be aware of the consequences of such reporting.

Across the world, a number of novels, television shows, films, soap operas, serials, magazines and newspapers have reported suicide as a heroic act, resulting in "copycat" suicides. Research has clearly demonstrated that reporting of self-inflicted or intentional (suicide and homicide) injuries, especially celebrity acts, definitely results in an increase in suicides over a period of time.

Reporting and publicity about suicides is often determined by who commits the act, where the act is committed, motive and lethality of the act, method employed and whether it was justified. This leaves a lasting image on the person viewing, reading or listening to the event and also to his/her state of vulnerability. The media can play a positive role in shaping people's thoughts and can show the direction, avenue or options to a distressed person.

A seminar by the Ministry of Public Health organized a seminar with media editors to address appropriate ways of presenting views on suicide. This was found to have a positive effect.

Whatthemediacando...

The following suggestions, if implemented by the media, could help significantly in creating appropriate awareness among the people on the problem of suicide:

- Suicide statistics should be reported to stress the fact that every suicide is a loss to the society.
- Celebrity suicides should not be given undue emphasis or shown as heroic acts. Special cautions should be exercised in reporting such incidents with minimum publicity to such acts.
- Detailed descriptions of the place and method of suicide should be avoided as people will come to know about such places and might plan a journey with a similar motive. If there is a known high-risk place, the media should highlight it could be made safer.
- No suicide occurs due to a single cause. The entire blame should not be put on the victim, as the act could be due to a combination of causes. Hence, highlighting that a failed love affair, poor marks in examinations, or failure to go abroad, are the only causes which lead to suicide is improper reporting. The public should be informed about how the act or attempt could have been avoided.
- The warning signs of social adversities, economic problems and mental illness (especially depression) should be conveyed to the society. Possible remedial measures in these situations should be suggested by working closely with health professionals.
- A realistic description of the impact on survivors, employers and families should be provided and its short-term and long-term consequences on individuals.
- The misconceptions, culture, beliefs and myths about suicide should be explained. Raising awareness and changing people's beliefs is one of the major responsibilities of the media.
- The local press is a view to public visibility but helplines, crisis prevention centres, or poison treatment centres, agencies providing help to individuals and families.
- Simple choice of phrases such as "completed suicide" instead of "successful suicide" can change people's perceptions. Hence, the right words and language should be used. The media should not report sensationalizing the act.
- The media should work closely with local health personnel to ascertain facts before reporting them.

A greater responsibility of the media is to help society. It should prepare and inform people that suicide can be prevented.

Headlinenewsfromthethemedia, in Sri Lanka and India:

20 October 2000

Threadless "suicide bomber" strikes near Chandrika Kumaratunga's residence in Sri Lanka

23 September 2000

Scolded, two school girls hanged themselves

14 September 2000

Software engineer commits suicide

16 September 2000

Failure in examination leads youth to suicide

28 June 2000

Stage artist performs his last rites after wife's death

12 March 2000

Woman ends life after boyfriend's evasive answer

In Thailand, the Ministry of Public Health organized a seminar with media editors to address appropriate ways of presenting views on suicide. This was found to have a positive effect.
Recent trend in suicides has been its high occurrence among children and adolescents. Nearly 22% of the suicides in India have been among students caused by non-attainment of expectations. Among the SEAR Member Countries, Sri Lanka has one of the highest rates of youth suicides. The proportion of suicides among youth increased from 33% in 1960 to 44% in 1980. In Thailand, the rate of suicide among youth and adolescents is also high. Among the major causes are examination failures, parental pressures, high expectations of schools and colleges, disappointment in love and conflicts. The term became popular that entered the youth sub-culture so popular that it entered the media and widely publicized the event. This started an epidemic of Polydol drinking by youths. The term became so popular that it entered the youth sub-culture as a measure of one's love. It became common for mento write to their girlfriends that they would drink Polydol if they lost their loved ones.

**What teachers can do...**

- South-East Asian countries strongly adopt follow traditional wisdom and solutions. Life-skills education combined with problem-solving approach can equip young people to cope with and handle the problems of life in an optimistic and realistic manner.

- The period of transition from childhood to adolescence is always a turbulent phase. A number of behavioural problems are frequently noticed at this stage (mood swings, impulsiveness, difficulty incoping, building self-identity, fantasies, violent, angry behaviour, anxiety states, complex feelings about self and others and attraction to the opposite sex). Proposupportive and adequate buffer mechanisms need to be built into the child's life to handle this transformation crisis effectively.

- Child abuse is an emerging problem in SEAR societies due to problems at home or in the environment. This problem exists in all countries across all sections of society. Such children are often traumatized, victimized and afraid of sharing their problem with others due to family and cultural reasons. They require support and help in overcoming their mental stress and learning coping mechanisms.

- Certain adolescents require special attention in schools and colleges due to their high-risk susceptibility to suicide. Some traits of such children are lack of interest in school and study, decline in academic performance, school absence, indulging in violent behaviour, excessive tobacco, alcohol or drug abuse, low self-esteem, poor self-image, eating and sleeping disturbances and increased anxiety levels.

- Children, especially those coming from disturbed family environments, such as those with broken homes, asingle parent, divorced parents, marital conflicts, unemployed parents and low-income large families, are at an elevated risk for suicide. Special attention is needed for promoting positive mental health in such children.

- Development of school-based counselling services would be a positive direction. In countries where teachers are held in highest esteem, they can help in building better role models. However, this would call for equipping teachers with adequate knowledge and skills, changing their attitudes and imparting better quality training to enable them to act as agents of change.

- Teachers in SEAR need to become more socially and psychologically adaptive to the changing realities. Teachers should identify 'crisis children' at an early stage and refer/offer counselling and referral services. A recent survey in Sri Lanka showed that only 20% of teachers were adequately equipped in this direction. There is considered it important to focus on this labi, rather than relating to students as individuals.

- Children should be equipped with good social skills, confidence-building measures, sharing crisis situations with others, seeking advice while making choices, and being open to new knowledge. Fostering a healthy environment for productive interaction among students and teachers through school integration would be very helpful. Schools and colleges should take a lead role in building counter-measures for suicide prevention programmes.

- Promoting self-esteem among children and helping them to cope with stressful situations by sharing positive life experiences, exerting less school pressures and by communicating in a positive way with children will definitely be beneficial.

**From Sri Lanka...**

Somewhere in the country, a youth used a popular pesticide named Polydol to commit suicide following a fight with his girlfriend. The print media picked this up and widely publicized the event. This started an epidemic of Polydol drinking by youths. The term became so popular that it entered the youth sub-culture as a measure of one's love. It became common for mento write to their girlfriends that they would drink Polydol if they lost their loved ones.

**Several initiatives are currently in India aimed at developing school-based mental health programmes, training of teachers, school counsellors and special educators. Specific strategies are also being used to reduce suicide pressures. Special emergency hotlines have been established in major cities during examination time to help distressed children.**

Bangladesh is planning an initiative to impart training to school teachers on mental health, with emphasis on suicides.
**Teachers... help the children**

A recent trend in suicides has been its high occurrence among children and adolescents. Nearly 22% of the suicides in India have been among students caused by non-attainment of expectations. Among the SEAR Member Countries, Sri Lanka has one of the highest rates of youth suicides. The proportion of suicides among youth increased from 33% in 1960 to 44% in 1980. In Thailand, the rate of suicide among youth and adolescents is also high. Among them, major causes are examination failures, parental pressures, high expectations of schools and colleges, disappointment in love and conflicts.

Destructive youth behaviours such as smoking, drinking and unprotected sexual activities are on the increase. Schools and colleges serve as the building blocks of an individual's life and can play a vital role in preventing such activities. Building value systems, setting acceptable individual aspirations and inculcating appropriate goal-setting mechanisms are of prime importance for preventing suicides in the younger age groups.

**What teachers can do...**

- South-East Asian countries strongly adopt follow traditional wisdom and solutions. Life-skills education combined with problem-solving approaches can equip young people to cope with and handle the problems of life in an optimistic and realistic manner.

- The period of transition from childhood to adolescence is always a turbulent phase. A number of behavioural problems are frequently noticed at this stage (mood swings, impulsiveness, difficulty in coping, building self-identity, fantasies, violent, angry behaviour, anxiety states, complex feelings about self and others and attraction to the opposite sex). Proper supportive help and adequate buffer mechanisms need to be built into child's life to handle this transformation crisis effectively.

- Child abuse is an emerging problem in SEAR societies due to problems at home in the environment. This problem exists in all countries across all sections of society. Such children are often traumatized, victimized and afraid to share their problem with others due to family and cultural reasons. They require support and help in overcoming their mental stress and learning coping mechanisms.

- Certain adolescents require special attention in schools and colleges due to their high-risk susceptibility to suicide. Some traits of such children are lack of interest in school and studies, decline in academic performance, school absenteeism, indulging in violent behaviour, excessive smoking, alcohol or drug abuse, low self-esteem, poor self-image, eating and sleeping disturbances and increased anxiety levels.

- Children, especially those coming from disturbed family environments, such as those with broken homes, single or divorced parents, marital conflicts, unemployed parents and lower-income families, are at an elevated risk for suicide. Special attention is needed for promoting positive mental health in such children.

- Development of school-based counselling services would be an important step in direction. In countries where teachers are held in high esteem, they can help in building better role models. However, this would call for equipping teachers with adequate knowledge and skills, changing their attitudes and imparting better quality training to enable them to act as agents of change.

- Teachers in SEAR need to become more socially and psychologically adaptive to the changing realities. Teachers should identify “crisis children” at an early stage and refer them to other professionals. A recent survey in Sri Lanka showed that only 20% of teachers were adequately equipped in this direction. Therefore, it is important to train the teachers in this area, rather than relating to students as individuals.

- Children should be equipped with good social skills, confidence-building measures, sharing crisis situations with others, seeking advice, while making choices, and being open to new knowledge. Fostering a healthy environment for productive interaction among students and teachers through school integration would be very helpful. Schools and colleges should take a lead role in building counter-measures for suicide prevention programmes.

- Promoting self-esteem among children and helping them cope with stressful situations by sharing positive life experiences, exerting less school pressures and by communicating in a positive way with children will definitely be beneficial.
Making the school a healthy place through better development of school activities for greater interpersonal relationships and preventing harmful behaviour would promote better interaction among students and teachers.

Setting up crisis intervention programmes to resolve interpersonal conflicts, helping children with disorders of substance abuse and promoting trustful communication strategies are vital interventions required in the educational institutions of SEAR Member Countries.

Developing a regular counselling and referral service in schools is a crucial step in providing timely help for many children when teachers alone are unable to handle the problem.

Having regular parent-teacher interactions to discuss the development of a child’s personality in totality and not just the academic improvements or failures is essential in schools and colleges.

Identifying high-risk children and involving parents and friends in various measures over a period of time will reduce the risk of suicides among such children.

In a survey in Sri Lanka, it was found that teachers could not recognize learning disabilities or childhood depression. Despite many obstacles, imparting essential life education skills has been introduced in the education sector in Sri Lanka. A problem-solving approach to handle life situations positively is a step in the right direction.

Thailand has developed a programme of “school counsellors” in public schools. The programme is likely to be strengthened in the coming years. A school-based general mental health programme is also in progress.
Making the school a healthy place through better development of school activities for greater interpersonal relationships and preventing harmful behaviour would promote better interaction amongst students and teachers.

Setting up crisis intervention programmes to resolve interpersonal conflicts, helping children with disorders of substance abuse and promoting trustful communication strategies are vital interventions required in the educational institutions of SEAR Member Countries.

Developing a regular counselling and referral service in schools is a crucial step in providing timely help for many children when teachers alone are unable to handle the problem.

Having regular parent-teacher interactions to discuss the development of a child's personality in totality and not just the academic improvements or failures in schools and colleges.

Identifying high-risk children and involving parents and friends in various measures over a period of time will reduce the risk of suicides among such children.

In a survey in Sri Lanka, it was found that teachers could not recognize learning disabilities or childhood depression. Despite many obstacles, imparting essential life education skills has been introduced in the education sector in Sri Lanka. A program of "school counsellors" in public schools has been developed. The programme is likely to be strengthened in the coming years. School-based general mental health programmes are also in progress.

Thailand has developed a programme of "school counsellors" in public schools. The programme is likely to be strengthened in the coming years. A school-based general mental health programme is also in progress.
Legalreforms...Lawsandimpact

AllSEARMemberCountrieshavetheirownlegalsystems
andprocedureswithregardtosuicides.Manycountrieshave
adiscriminatoryattitudeandsuicidesareconsideredan
offence.AspereSection174oftheIndianCodeofCriminal
Procedures,everyintentionaldeathhastobeinvestigated
unlessotherwise-directed.Sections305,306and309ofthe
IndianPenalCodeconsider"abetmentofsuicideofachild"
and"attempttosuicide"asanoffencepunishableunderthe
code.Thepunishmentsundersuchactsvaryfrommonetoto10
yearsimprisonmentandheavyfines.During1994,thiswas
declaredasunconstitutional,onlytoberevertedtothe
originaltwoyearslater.Rigorouspunishmentsforsuicide
existedinSriLankauntil1998,afterwhichitisnolonger
consideredacrime.Significantprogresshasbeenmade
recentlybymodifyingthelawwherebysurvivorsosuicide
attemptsnorelongerprosecuted.Thailanddoesnothave
anylawbutisstrengtheningmentalhealththrough
parliamentaryprocedures.TheBangladeshPenalCode
specifiesthatcompletedorattemptedsuicidesispunishable
act,whileIndonesiadoesnотavosuchlaw.Theremaybe
afewcountriesstillpractisinglawswhichimposesevere
punishment.

Whilethelegalstatuswithregardtosuicideinneverycountry
isdebatedextensivelyitismeritsanddemerits,thelaw
makesitmandatoryforsuicidetobeinvestigatedbypolice
authoritiesandforjudgementtobedeliveredbycourts.This
leadstoasituationwherehospitalsofferadvicebutpatients
whohaveattemptedsuicideandevenifthespatientsare
admitted,itisforunrelatedreasons.Thisleadstogrowth
underreportingservicestohelptheaffectedperson,increased
stigmatizationoftheiractions,andconcealmentofthefacts,all
ofwhichresultintheaffectedpersonnotreceivingproper
medicalpsychiatrichelp.

EverySEARMemberCountryneedstore-examinesuchlaws.
Attemptsshouldbeemadeofremovestigma,removoffences
andpunishmentsandmakeitpeoplefriendly.Legal
authoritiesneedtobemadeawareoftheconsequences
ofsuchlawsandtheirroleinmakingitservicesavailable,decreasingharassmentandtheburdenonindividuals,and
eliminatingstigma.Agreaterinteractionbetweenlaw-
makers, enforcing agencies and health professionals
isrequiredforsmoothtransitiontowardsanewphase.

Spiritualleadersandfaithhealers...wisdomtoaction

Spiritualleadersandfaithhealersoccupyauuniqueposition
inSouth-EastAsiansocietiesowingtotheirstature,position,
wisdomandtheirabilitytoinfluencepeople'sbeliefsand
values. While the spiritual and religious dimensions of
suicidesaredebateable,itisessentialtorealizethat"human
lifeisprecious".Sincethepeoplehaveenormousfaith,respect
andconfidenceinspiritualleaders,theyshouldemphasize
theactthatsuicideissuicidepreventableandindividualscanbe
helpedbycounselling,medicationandsupportiveservices.
Spiritualleaderscanemphasizetheimportanceoflifeandits
meaningbypromotingpositivebeliefsandvalues.

Faithhealersshouldbeinvolvedinsuicideprevention
activitiesatthecommunitylevelastheyarethefirstlevelof
contactformanyhealthproblems.Iftheycanplayapositive
roleinidentifyingsuicidalthoughts,behaviour,depressive
statesandofferemotionalupporttopeople,itiswilla
stepinttherightdirection.Severalnon-pharmacologicalmethods
ofmanagementaregainingpopularityinSEARMember
Countries. Someoftheseareyoga,meditation,acupuncture
andreiki.Whilenon-establishedrandomizedcontrolledtrials
areavailabletoproveefficacyandeffectivenessinthe
managementofcertainpsychologicalproblems,their
acceptanceinthecommunityhasbeenincreasing.Itisvitalto
developabetterunderstandingabouttheroleofthese
systemsto incorporatepositive, harmless and culturally-
acceptedmethods. The involvement of spiritual leaders
(imamsinBangladesh,monksinSriLankaandThailand,
religiousleadersinIndia)incommunitydecision-making
activitieswillbeofhelpinpromotingsolidarityinthe
community.
Legal reforms...laws and impact

All SEAR Member Countries have their own legal systems and procedures with regard to suicides. Many countries have a discriminatory attitude and suicidal acts are considered an offence. As per Section 174 of the Indian Code of Criminal Procedure, every intentional death has to be investigated unless otherwise directed. Sections 305, 306 and 309 of the Indian Penal Code consider “abettment of suicide of a child” and “attempt to suicide” as an offence punishable under the code. The punishments under such acts vary from 10 years of imprisonment and heavy fines. During 1994, this was declared as unconstitutional, only to be reverted to the original two years later. Rigorous punishments for suicide existed in Sri Lanka until 1998, after which it is no longer considered a crime. Significant progress has been made recently by modifying the law whereby survivors of suicide attempts are no longer prosecuted.

While the legal status with regard to suicide in every country is debated extensively for its merits and demerits, the law makes it mandatory for suicide deaths to be investigated by police authorities and for judgement to be delivered by courts. This leads to situations where hospitals refuse to admit persons who have attempted suicide and even if such patients are admitted, it is for unrelated reasons. This leads to gross underreporting, refusal, and helplessness in affected persons, increased stigma,得不到policevisits, and concealment of the facts, all of which result in the affected person not receiving proper medical or psychosocial help.

Spiritual leaders and faith healers... wisdom to action

Spiritual leaders and faith healers occupy a unique position in South-East Asian societies. Owing to their stature, position, wisdom and their capability to influence people’s beliefs and values. While the spiritual and religious dimensions of suicides are debatable, it is essential to realize that “human life is precious”. Since people have enormous faith, respect and confidence in spiritual leaders, they should emphasize the fact that suicide is preventable and individuals can be helped by counseling, medication and supportive services.

Faith healers should be involved in suicide prevention activities at the community level as they are the first level of contact for many health problems. If they can play a positive role in identifying suicidal thoughts, behavior, depressive states and offer emotional support to people, it will be a step in the right direction. Several non-pharmacological methods of management are gaining popularity in SEAR Member Countries. Some of these are yoga, meditation, acupuncture and reiki. While not established randomized controlled trials are available to prove the efficacy and effectiveness in the management of certain psychological problems, their acceptance in the community has been growing. It is vital to develop a better understanding about their role in these systems to incorporate positive, harmless and culturally-accepted methods. The involvement of spiritual leaders (imams in Bangladesh, monks in Sri Lanka and Thailand, religious leaders in India) in community decision-making activities will be of help in promoting solidarity in the community.
Nongovernmental organizations (NGOs)...pillars of strength

NGOs in every country are involved in a number of health and development programmes. Their knowledge of the community, family and individual is vast due to their close rapport with the people. Many NGOs in developmental and mental healthcare have suicide prevention as a major agenda (directly or indirectly). Such NGOs initiatives should be expanded in terms of their geographical coverage and the range of services. Governments and communities should encourage and support their activities, especially those related to welfare activities of children and women.

What NGOs can do...

NGOs can offer direct intervention efforts and related supportive services. The Samaritan's Movement has branches in Hyderabad and Chennai in India and has become an international movement with over 1000 centres in several countries. Sneha in Chennai, India, has a wide range of activities by committed volunteers, available and accepted by society. Vimochana in Bangalore, India, offers supportive services to women and has taken up the issues of investigation, legal matters, recording and reporting people's rights, and helping families to cope with suicide or attempted suicide. Sanjivini in New Delhi, India, has teams of committed volunteersto provide timely help. Sumithrayo in Sri Lanka, with 11 branches across the country, has "untrained volunteers" capable of providing sympathetic care to distressed people. Slavs in another NGO in Sri Lanka, has initiated peer counselling services for youth by training them in basic counselling techniques. Befrienders (Samaritans) in Thailand has established hotline services in Bangkok and Chiang Mai with partial funding from the government. The Bersama, hotline service in Indonesia, offers timely assistance. Individual, family and group therapies are offered by a number of hospitals and NGOs in their day-to-day practice. Several NGOs have also taken up a greater role with regard to laws, stigma removal, rehabilitation of people attempting suicides, counselling for children, supportive services for women, public awareness programmes among the public and doctors, improving the life of the elderly, and basic social and welfare reforms. There is an need to expand these movements in countries to increase the availability and accessibility of such services and to share the successes and failures.
Nongovernmental organizations (NGOs)...pillars of strength

NGOs in every country are involved in a number of health and developmental programs. Their knowledge of the community, family, and individual is vast due to their close rapport with the people. Many NGOs in developmental and mental health care have suicide prevention as a major agenda (directly or indirectly). Such NGO initiatives should be expanded in terms of their geographical coverage and the range of services. Governments and communities should encourage and support their activities, especially those related to welfare activities of children and women.

What NGOs can do...

NGOs can offer direct intervention efforts and related supportive services. The Samaritan’s Movement has branches in Hyderabad and Chennai in India and has become an international movement with over 1000 centres in several countries. Sneha in Chennai, India, has a wide range of activities by committed volunteers, available and acceptable by society. Vimochana in Bangalore, India, offers supportive services to women and has taken up the issues of investigation, legal matters, recording, and reporting people’s rights, and helping families to cope with suicide or attempted suicide. Sanjivini in New Delhi, India, has teams of committed volunteers to provide timely help. Sumithrayo in Sri Lanka, with 11 branches across the country, has “untrained volunteers capable of providing sympathetic care to distressed people. Slavs, another NGO in Sri Lanka, has initiated peer-counselling services for youth by training them in basic counselling techniques. Befrienders (Samaritans) in Thailand has established hotline services in Bangkok and Chiang Mai with partial funding from the government. The Bersama, hotline service in Indonesia, offers timely assistance. Individual, family, and group therapies are offered by a number of hospitals and NGOs in their day-to-day practice. Several NGOs have also taken up a greater role with regard to laws, stigma removal, rehabilitation of people attempting suicides, counselling for children, supportive services for women, public awareness programs among the public and doctors, improving the life of the elderly, and basic social and welfare reforms. There is a need to expand these movements in countries to increase the availability and accessibility of such services and to share the successes and failures.

Due to the vision and mission of Reverend Chad Varah, a small movement began in the early 1980s in the south-western part of London. It was basically a telephone befriending service for suicidal people. Following the death of a young man due to loneliness in a crisis situation, the priest realized there had been no one to lend sympathetic ear to this man. Subsequently, he displayed small notes saying that anybody who wanted to talk about his problems could contact him. Innumerable calls followed from people from all walks of life. Since he was alone and unable to handle the large volume of calls, he invited a group of like-minded, friendly people to join him. This voluntary service by non-professional volunteers has developed into a 24-hour telephone service. It encourages people to visit the centre and even end patches of fings squads. Confidentiality, immediate service, referral network, non-judgmental approach, and public awareness building are the hallmarks of this movement. The staff provide voluntary, sympathetic, and listening human to people in distress. The guiding principles of work are “no advice”, “no patronage”, “nomoney”, and “donothangupupon the caller.” In totality, the services are available, acceptable and affordable.

This small movement, begun 20 years ago, has nearly 1000 centres across countries. The Indian movement, started in 1992, already has 10 branches in major cities. Branches in South-East Asian countries, such as Sri Lanka, Thailand, and Indonesia are accepted for their human services.
National governments... time to act

With limited information on the problem and limited preventive programmes in SEAR, suicides are unrecognized, silent and hidden epidemic. With nearly 200,000 officially reported deaths, 20,000,000 attempted suicides and millions with suicidal thoughts, the problem has not received due attention from national governments. While the debate continues on causes and issues among professionals and the public, there is an urgent need to prevent suicides. Countries of the Region have to assume greater responsibility for reducing the problem through coordinated and integrated approaches. No country in the Region has a focused "suicide prevention policy" except Sri Lanka. Even in Sri Lanka, strategies have been made but not implemented.

In Sri Lanka...

A presidential committee examined the problem of suicides in 1998 and suggested:
- reducing easy access to pesticides;
- introducing measures to reduce lethality by presenting dilute formulations and promoting non-lethal forms of pesticides and poisons;
- formulating strategies to improve medical management by improving facilities in district hospitals and setting up poison treatment centres;
- ensuring appropriate treatment of depressed and alcoholic people;
- changing the present law to decriminalize suicide (implemented by an Act of Parliament since May 1998), and
- developing media policies on the reporting of suicides.

Every SEAR Member Country must develop a National Suicide Prevention Policy. Implementation should be through an intersectoral approach with participation and inputs from all sectors. Only when there is a policy can there be a programme and resources for implementation (Figure 10).

Figure 10
An intersectoral approach

<table>
<thead>
<tr>
<th>Health</th>
<th>Education</th>
<th>Social/Welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>Industry</td>
<td>Drug industries</td>
</tr>
<tr>
<td>Economics and finance</td>
<td>Traditional systems of medicine</td>
<td></td>
</tr>
<tr>
<td>Prevent suicide</td>
<td>Improvermental and social health of people</td>
<td></td>
</tr>
<tr>
<td>Reduce suicidal behaviour in communities</td>
<td>Identify and provide care for attempted suicides</td>
<td></td>
</tr>
<tr>
<td>Information</td>
<td>Media</td>
<td>Local governments</td>
</tr>
<tr>
<td>NGOs</td>
<td>Police</td>
<td></td>
</tr>
</tbody>
</table>
National governments... time to act

With limited information on the problem and limited preventive programmes in SEAR, suicide is an unrecognized, silent and hidden epidemic. With nearly 200,000 officially reported deaths, 200,000 attempted suicides and millions with suicidal thoughts, the problem has not received due attention from national governments. While the debate continues on causes and issues among professionals and the public, there is an urgent need to prevent suicides. Countries of the Region have to assume greater responsibility for reducing the problem through coordinated and integrated approaches. No country in the Region has a focused "suicide prevention policy" except Sri Lanka. Even in Sri Lanka, strategies have been made but not implemented.

In Sri Lanka...

A presidential committee examined the problem of suicides in 1998 and suggested:
- reducing easy access to pesticides;
- introducing measures to reduce lethality by presenting dilute formulations and promoting non-lethal forms of pesticides and poisons;
- formulating strategies to improve medical management by improving facilities in district hospitals and setting up poison treatment centres;
- ensuring appropriate treatment of depressed and alcoholic people;
- changing the present law to decriminalize suicide (implemented by an Act of Parliament since May 1998), and
- developing media policies on the reporting of suicides.

Every SEAR Member Country must develop a National Suicide Prevention Policy. Implementation should be through an intersectoral approach with participation and inputs from all sectors. Only when there is a policy can there be a programme and resources for implementation (Figure 10).
Examples from the West

- Thereduction in the availability of toxic products is one of the best means of reducing suicide. In Samoa, suicid rates were around 5 per 100000 in 1974. "Paraquat", a pesticide, was introduced around 1975 in the country. Suicide rates continued to rise, reaching a peak around the 1980s. Atrendovera periodof timeshould be used todetermine the impact of interventions. Health departments must be encouraged to report both completed and attempted suicides on a regular basis. Simultaneously, police personnel must be sensitized to the importance of accurate reporting to initiate preventive measures.

- National centres should be identified in all countries to undertake research, policy support, programme development and evaluation. It is obvious that the lack of research on the contributing factors for the lack of suitable programmes. Funding should be available to examine specific research issues, implement interventions and evaluate programmes.

- Every country must identify cities and towns with high suicide rates. They must consider interventions on a country-specific and cost-effective basis.

- Components of mental health care must be strengthened to identify at-risk subjects. Mental health must be integrated into primary healthcare under the respective national mental health programmes. There is an urgent need to focus on small-scale training programmes at all levels to identify and manage depression and alcohol dependence along with mental health problems.

- Removal of stigma should receive the highest priority. As long as it remains, suicide will be a hidden and undisclosed phenomenon. Public awareness programmes, elimination of punishable laws, friendly attitudes of health-care workers and expenditures with community leaders are essential prerequisites in this direction.

- Immediate measures should be taken to restrict public access to pesticides and other organophosphorus compounds. As agriculture is the predominant occupation in this region, a total ban on such products may not be possible. However, control of supply and distribution of pesticides may save many lives.

- Advertising in the media provides information about the contents and the poisonous effects of pesticides. This information may suggest means of preventing suicide among vulnerable people. Realizing the implications, pesticides manufacturers should resort to responsible advertising.

- Similarly, drugs such as sedatives, hypnotics and anxiolytics should not be sold over the counter. Better coordination among the Ministries of agriculture, industry, health, economics and laws is required in this direction.

- Though many interventions are beginning to be considered useful, their universal applicability remains doubtful. Therefore, culture-specific, cost-effective and sustainable strategies must be developed with people's involvement. This process must have targeted interventions for youth, adults and women.

- Supportive mechanisms for care for the elderly, HIV/AIDS prevention, cancer prevention and rehabilitation components must be strengthened. It is felt that with the entry of the private sector, the cost of healthcare will be beyond the reach of the ordinary man. Unless specific efforts are made by governments and local agencies, unaffordable healthcare might result in increased suicide rates.

- Majorsociocultural reforms are required in many areas. Poverty alleviation, removing gender discrimination and bias, encouraging the role of women in employment and decision-making, alcohol prevention programmes, reforms in the education sector, and an emphasis on skills and values, promoting lifelong education and better employment opportunities for youth should be implemented. It is doubted whether there is a state of despair. Large-scale public awareness programmes are required; each country should move their respective populations from a state of despair to a state of hope and optimism. An investment in these areas will improve the life and social status of the marginalized and underprivileged sections of society.

- What Member Countries can do...

- Most Member Countries have begun implementing country-specific mental health programmes. The various components must be strengthened. The inclusion of suicide prevention as a thrust area is required. Related components of detection and management of mental health problems must be given adequate emphasis to prevent suicides.
Examples from the West

Member Countries should also consider the following steps to strengthen suicide prevention mechanisms:

- Countries must establish and strengthen ‘suicide surveillance at local and national levels’ to understand the problem and identify risk groups as well as the causes and prevention methods. Attention to periodical measures should be used to monitor the impact of interventions. Health departments must be encouraged to report both completed and attempted suicides on a regular basis. Simultaneously, police personnel must be sensitized to the importance of accurate reporting to initiate preventive measures.

- National centres should be identified in all countries to undertake research, policy support, programme development and evaluation. It is obvious that the lack of research is one of the contributing factors for the lack of suitable programmes. Funding should be available to examine specific research issues, implement interventions and evaluate programmes.

- Every country must identify its towns and high suicide rates within their countries for priority interventions on a culture-specific and cost-effective basis.

- Components of mental health care must be strengthened to identify at-risk subjects. Mental health must be integrated into primary healthcare under the respective national mental health programmes. There is an urgent need to focus on small-scale training programmes at all levels to identify and manage depression and alcohol dependence along with other mental health problems.

- Removal of stigma should receive the highest priority. As long as it remains, suicide will be a hidden and undisclosed phenomenon. Public awareness programmes, elimination of punishable laws, friendly attitudes of enforcing agencies and open discussions with community leaders are essential prerequisites in this direction.

- Immediate measures should be taken to restrict public access to pesticides and other organophosphorus compounds. As agriculture is the predominant occupation in this region, a total ban on such products may not be possible. However, control of supply and distribution of pesticides may save many lives.

- Advertising in the media provides information about the contents and the poisonous effects of pesticides on weeds and pests infesting crops. This information may suggest means of committing suicide to vulnerable people. Realizing the implications, pesticides manufacturers should report responsibly advertising.

- Similarly, drugs such as sedatives, hypnotics and anxiolytics should not be sold over the counter. Better coordination among the ministries of agriculture, industries, health, economics and laws is required in this direction.

- Though many interventions are beginning to be considered useful, their universal applicability remains doubtful. Therefore, culture-specific, cost-effective and sustainable strategies must be developed with the people’s involvement. This process must have targeted interventions for the youth, adults and women.

- Supportive mechanisms for care of the elderly, HIV/AIDS prevention, cancer prevention and rehabilitation programmes must be strengthened. It is felt that the entry of the private sector, the cost of healthcare will be beyond the reach of the ordinary man. Unless specific efforts are made by governments and local agencies, unaffordable healthcare means higher suicide rates.

- Major sociocultural reforms are required in numerous areas. Poverty alleviation, removing gender discrimination and violence, encouraging a greater role for women in employment and decision-making, alcohol prevention programmes, reforms in the education sector with an emphasis on skills and values, promoting life-skills education, and better employment opportunities for youth should be implemented urgently to prevent this avoidable, man-made tragedy. Large-scale public awareness programmes are required in each country to move the respective populations from a state of despair to one of hope and optimism. An investment in these areas will improve the life and social status of the marginalized and underprivileged sections of the society.

Most SEAR Member Countries have begun implementing country-specific mental health programmes. The various components must be strengthened with the inclusion of suicide prevention as a thrust area of action. Related components of detection and management of mental health problems must be given adequate emphasis to prevent suicides.
Research... towards understanding

Developing and implementing suicide prevention programmes requires a basic understanding of the problem, risk groups, patterns, methods, and causes at the national and local levels. However, research in this area has been very limited. As SEAR countries are in different stages of transition, methods and causes as delineated in the West may not be applicable. A general review of available literature from SEAR Member Countries reveals distinct differences in age and gender ratio, methods and specific causes leading to suicide.

There is an urgent need to develop suicide surveillance programmes in SEAR countries. The specific questions to be addressed are:

- How big is the problem in its various sociodemographic dimensions?
- What are the causes of suicides in general, and specifically among adults and the middle-aged groups?
- What is the role of social, economic, family, and health problems in the context of suicide?
- What specific interventions are likely to yield results?
- What is the impact of rapid societal changes on suicides?
- What are the specific issues related to suicide among women from a sociocultural point of view?
- What will be the socioeconomic impact on survivors, families, and society at large?
- What is the burden of suicides on SEAR Member Countries and facilities to be augmented for prevention and management?
- How can after-care services for a large number of survivors be developed, and
- What societal and governmental reforms are required in this direction?

In order to specifically address these questions, there is a need for four supportive mechanisms. Firstly, centres of excellence (healthcare institutions) capable of coordinating with national and local agencies having adequate infrastructural facilities should be designated in all SEAR Member Countries. Secondly, manpower within and outside these institutions (through short-term programmes) should be developed within countries. Thirdly, the most important aspect is related to the development of culture-specific, acceptable and standardized tools and methodologies for suicide surveillance with optional variables depending on unique local situations. Fourthly, required funding should be made available from national and international agencies for undertaking and evaluating research.

The type of research required to be undertaken deserves special mention. Epidemiological research (descriptive, analytical, case control designs, interventional research) is required to understand who, what, when, where, and why of the suicide phenomenon in the Region. Also, there is an immediate need for social and behavioural research to understand people's perceptions for identifying specific areas for interventions. Clinical research to support causation and management are crucial to save lives. Research into legal issues also requires to identify the merits and demerits of existing laws, for future strengthening. The need for evaluatory research to learn "What works?" and "What does not work?" is crucial for learning from experiences. More importantly, policy-oriented research to initiate, strengthen and establish culture-specific programmes is vital.
In order to specifically address these questions, there is a need for four supportive mechanisms. Firstly, centres of excellence (healthcare institutions) capable of coordinating with national and local agencies having adequate infrastructural facilities should be designated in all SEAR Member Countries. Secondly, manpower within and outside these institutions (through short-term programmes) should be developed within countries. Thirdly, the most important aspect is related to the development of culture-specific, acceptable and standardized tools and methodologies for suicide surveillance with optional variables depending on unique local situations. Fourthly, the required funding should be made available from national and international agencies for undertaking and evaluating research.

The type of research required to be undertaken deserves special mention. Epidemiological research (descriptive, analytical, case control designs, interventional research) is required to understand the who? what? when? where? and why? of the suicide phenomenon in the Region. Also, there is an immediate need for social and behavioural research to understand people’s perceptions for identifying specific areas for interventions. Clinical research to support causation and management are crucial to save lives. Research into legal issues also requires to identify the merits and demerits of existing laws for future strengthening. The need for evaluatory research to learn “What works?” and “What does not work?” is crucial for learning from experiences. More importantly, policy-oriented research to initiate, strengthen and establish culture-specific programmes is vital.
EPILOGUE

SURE Member Countries are passing through a major revolution in the social, economic, health, demographic, information and technological spheres. In their quest for modernization, traditional value systems are being replaced by a modern paradigm of liberalization. While the problem of suicide has grown significantly, countries are yet to realize its impact. The problem needs to be understood in its totality. Resources have to be shared and generated, and interventions prioritized. Even at the global level, successful programmes are very few and cannot be replicated as such in developing countries, as the situation, problem, pattern and methods are very different. Further, while developing interventions, the social, economic, political and cultural factors need to be considered. Some of the major strategies likely to yield significant and positive results are: reducing access to organophosphorus compounds and drugs; training of primary health care physicians (early recognition and treatment of depression); developing social support networks, specially for those at risk; establishing crisis intervention centres; changing public attitudes about suicide; and augmenting social reforms across societies. The need of the hour is to develop national suicide prevention strategies along with early implementation and evaluation. Successes and failures have to be shared across and within countries. The word ‘success’ does not have a meaning without the letter ‘U’. Similarly, success is not possible without ‘YOU’. The time to act and save precious human resources in the Region is NOW.
Member Countries are passing through a major revolution in the social, economic, health, demographic, information and technological spheres. In their quest for modernization, traditional value systems are being replaced by modern paradigms of liberalization. While the problem of suicide has grown significantly, countries are yet to realize its impact. The problem needs to be understood in its totality, resources have to be shared and generated, and interventions prioritized. Even at the global level, successful programmes are very few and cannot be replicated as such in developing countries, as the situation, problem, pattern and methods are very different. Further, while developing interventions, the social, economic, political and cultural factors need to be considered. Some of the major strategies likely to yield significant and positive results are: reducing access to organophosphorus compounds and drugs; training of primary health care physicians (early recognition and treatment of depression); developing social support networks, especially for those at risk; establishing crisis intervention centres; changing public attitudes about suicide; and augmenting social reforms across societies. The need of the hour is to develop national suicide prevention strategies along with early implementation and evaluation. Successes and failures have to be shared across and within countries. The word 'success' does not have a meaning without the letter 'U'. Similarly, success is not possible without 'YOU'. The time to act and save precious human resources in the Region is NOW.