

Suicide Prevention

The Manual for Primary Health Care Personnel

Dr. Lakshmi Vijayakumar MBBBS DPM PhD *

Topics

- Suicide - The Size of the problem**
- Why focus on Primary Health Care personnel?**
- Suicide and Mental Disorders**
- Physical Illness and Suicide**
- The state of mind of suicidal persons**
- The state of mind of suicidal persons**
- How to reach out to the Suicidal person?**
- Suicide - Fiction and Fact**
- How to identify a suicidal person?**
- How to assess the risk of suicide?**
- What, How and when to ask the suicide question?**
- How to manage a suicidal person?**
- Referral**
- Do's and Don'ts**

Suicide - The Size of the problem

- One million people are likely to commit suicide in the year 2000.
- Every 40 seconds a person commits suicide in the world.
- Every 3 seconds a person attempts to die.
- Suicide is one of the top three causes of death among the young in the age group of 15 – 35 years.
- Each suicide has a serious impact on at least 6 other people.
- The psychological, social and financial impact of suicide on the family and the society is immeasurable.¹

Suicide is a complex problem for which there is no one explanation. There is no single reason why a person commits suicide. Suicide results due to a complex interaction of biological, genetic, psychological, social, cultural and environmental factors.

It is also difficult to explain why certain people take this decision while others in a similar, or even worse situation do not. However, most suicides can be prevented.

Suicide is now a major public health issue in all countries. Empowering primary health care personnel in identifying, assessing, managing, and referring the suicidal persons in the community is a very important step in Suicide Prevention.

Why focus on Primary Health Care personnel?

1. Primary health care personnel have long and intimate contact with the community and are well accepted.
2. They provide the vital link between the community and the health care system.
3. In many developing countries where mental health services are not well developed, they are often the primary source of mental health care.
4. Their knowledge of the community enables them to gather support from family, friends, non-governmental organizations etc.
5. They are in a position to offer continuity of care.
6. They are often the entry point for those in distress. In short, they are available, accessible, knowledgeable, and they care.

Suicide and Mental Disorders

Studies from both developing and developed countries reveal two factors :

1. A majority (80 – 100%) of suicides have a diagnosable mental disorder.
2. Suicide and suicidal behaviour are more frequent in psychiatric patients.

The various diagnostic groups in decreasing order of risk are :

1. Depression (all forms)
2. Alcoholism (Substance abuse in adolescents)
3. Schizophrenia
4. Personality disorder (antisocial and border line personality with traits of impulsivity aggression and frequent mood changes)
5. Organic Mental Disorder and
6. Other psychiatric disorders

Though most of those who commit suicide have mental disorders, a majority of them do not see a mental health professional even in developed countries. Hence the role of the primary health care personnel becomes vital.

Mood Disorder

Depression is the most common diagnosis in completed suicide. Everyone feels depressed, sad, lonely and unstable from time to time, but usually those feelings pass over. However when the feelings are persistent and disrupt a person's usual normal life, they cease to be depressive feelings and the condition becomes a Depressive Disorder.

Some of the common symptoms of depression are :

1. Feeling sad or anxious most of the time everyday.
2. Losing interest in activities.
3. Losing weight (when not dieting) or gaining weight.
4. Sleeping too much or too little or waking too early.
5. Feeling tired and weak all the time.
6. Feeling worthless, guilty or hopeless.
7. Feeling irritable and restless all the time.
8. Having difficulty in concentrating, making decisions or remembering things.
9. Having repeated thoughts of death and *suicide*

Why Depression is Missed?

1. People are often embarrassed to admit that they are depressed, as they see the symptoms as a "sign of weakness".
2. People are familiar with the feelings associated with depression and so are not able to recognize it as a disease.
3. Depression is more difficult to diagnose when the person has another physical illness. Depression may present with a wide variety of vague aches and pains.
Depression is Treatable. Suicide is Preventable.

Alcoholism

- One third of suicides were found to be dependant on alcohol.
- 10 – 15% of alcoholics end their life by suicide.
- At the time of the suicidal act many were found to be under the influence of alcohol.

Alcoholics who commit suicide are likely to have the following characteristics:

- Start drinking at a very young age.
- Consume alcohol for a long time
- Drink heavily
- Have poor physical health
- Feel depressed

- Have disturbed and chaotic personal lives
- Suffer a recent major interpersonal loss like separation from spouse or/and family, divorce, bereavement
- Have poor work performance.
- Substance Abuse has been increasingly found in adolescents who engage in suicidal behaviour.

Presence of alcoholism and depression in an individual increases the suicide risk enormously.

Schizophrenia

Approximately 10% of schizophrenics ultimately commit suicide.

Schizophrenia is characterized by disturbances in 1) speech 2) thought 3) hearing or seeing 4) personal hygiene and 5) social behaviour; or by strange ideas. in short by a drastic change in behaviour and feelings

Schizophrenics with an increased risk of suicide are :

1. Young, unemployed male
2. Early stage of illness
3. Depressed mood
4. Frequent relapses
5. High level of education
6. Paranoid (suspiciousness)

Schizophrenics are more likely to commit suicide at the following times :

1. Early stage of illness - when they are confused or / and perplexed
2. Early recovery - when outwardly they are better but internally vulnerable,
3. Early relapse - when they feel to be better, but symptoms recur,
4. Soon after discharge from the hospital.

Physical Illness and Suicide

Physical illness is associated with an increased suicide rate.

Neurological Disorders

1. Early dementia - Suicide rate is high at the time of diagnosis when the patient becomes aware of the diagnosis and prognosis.
2. Huntington's Chorea.
3. Epilepsy - The increased impulsivity, aggression and chronic disability are the likely reasons for increased suicidal behaviour.
4. Spine & head injuries - The more serious the injuries the more the risk of suicide.

Cancer

Terminal illness is associated with increased suicide rate. The risk of suicide is more among Men, particularly soon after diagnosis and while undergoing chemotherapy.

HIV / AIDS

The stigma, the poor prognosis and the nature of the illness increases the suicide risk of HIV infected people. At the time of diagnosis when the person has not had proper counselling the suicide risk is high.

Chronic Medical Conditions

1. Diabetes
2. Multiple Sclerosis
3. Chronic Renal, Liver and Gastro-intestinal conditions
4. Bone and Joint Disorder
5. Hypertension
6. Sexual Disorders

Environmental Factors Influencing Suicides

- I. Life Stressors : Majority of those who committed suicide have had a number of difficult life stressors in the three months prior to suicide like :
 - a. Interpersonal problems - eg. Quarrels with spouses, family, friends, lovers
 - b. Loss Events - financial loss, bereavement etc.
 - c. Work & financial problems - eg. Job loss, retirement, financial difficulties.
 - d. Rejection - eg. Separation from family and friends and
 - e. Others which include a variety of stressors like shame and threat of being found guilty.
- II. Easy Availability : The immediate availability of a method to commit suicide is an important factor in determining whether or not an individual will commit suicide. Reducing the access to the means to commit suicide is an effective suicide prevention strategy.
- III. Exposure to suicide: A small portion of suicides consists of vulnerable adolescents who are exposed to suicide in real life or through media and are more likely to engage in suicidal behaviour.

The state of mind of suicidal persons

1. Ambivalence : Most people have mixed feelings about committing suicide. The wish to live and the wish to die wage a sea-saw battle in the suicidal individual. There is an urge to get away from the pain of living and an undercurrent of the desire to live. Many suicidal persons do not really want to die - it is just that they are unhappy with life. If support is given and the wish to live is increased, suicidal risk is decreased.
2. Impulsivity: Suicide is also an impulsive act. Like any other impulse, it is transient and lasts for a few minutes or hours. It is usually triggered by negative day to day events. By defusing such crises and by playing for time, the suicide wish can be reduced.

3. Rigidity: When a person is suicidal, his or her thinking, feelings and actions are constricted. They constantly think about suicide and are unable to perceive other ways out of the problem. They think drastically.

A majority of suicidal people communicate their suicidal thoughts and intentions. They often send out signals and make statements about “wanting to die”, “feeling useless” etc. Ignoring all those pleas for help would indeed be a tragedy.

How to reach out to the Suicidal person?

Very often when someone says “I am tired of life”, “There is no point in living” etc., he is usually brushed off, or is given examples of persons who have had more difficulties. Neither of these helps the suicidal person. The initial contact with the suicidal person is very important. Often the contact occurs in a busy clinic, home or public place where it may be difficult to have a private conversation.

1. The first step is to find a suitable place where a quiet conversation can be had with some privacy.
2. The next step is allocating the time. Suicidal persons usually need more time to unburden themselves and one must be mentally prepared to give them time.
3. The most important task is to listen to them effectively. “To reach out and listen is itself the first major step in reducing the level of suicidal despair”.²
4. The aim is to bridge the gap created by mistrust, despair and loss of hope and give them the hope that things could change for the better.

How to communicate?

1. Listen attentively, be calm
2. Understand their feelings (empathise)
3. Give non-verbal messages of acceptance and respect
4. Express respect for their opinions and values
5. Talk honestly with genuineness
6. Show your concern, care and warmth
7. Focus on their feelings



How not to communicate

1. Interrupting too often
2. Becoming shocked, emotional
3. Conveying that you are busy
4. Being patronizing
5. Intrusive and unclear communication
6. Asking loaded questions

A calm, open, caring, accepting and non-judgmental approach is required to facilitate communication.

Listen with Warmth
 Treat with Respect
 Empathise with emotions
 Care with Confidence

Suicide - Fiction and Fact

FICTION	FACT
1 People who talk about suicide do not commit suicide	1 Most people who kill themselves have given definite warnings of their intentions
2 Suicidal people are absolutely intent on dying	2 A majority are ambivalent
3 Suicide happens without warning	3 Suicidal people often give enough indication
4 After a crisis, improvement means that the suicide risk is over	4 Many suicides occur in a period of improvement when the person has the energy and the will to turn despairing thoughts into destructive action
5 Not all suicides can be prevented	5 True. But a majority are preventable. Suicidal thoughts may return but
6 Once a person is suicidal he/she is always suicidal	6 they are not permanent and in some, it may never return

How to identify a suicidal person?

Signals to look for:

1. Withdrawn behaviour. Inability to relate to family and friends.
2. Psychiatric illness
3. Alcoholism
4. Anxiety or panic
5. Change in personality – irritability, pessimism, depression, apathy
6. Change in eating habits / sleeping habits
7. Earlier suicide attempt
8. Hating oneself, feeling guilty, worthless or ashamed
9. A recent major loss – death, divorce, separation etc
10. Family history of suicide
11. Sudden desire to tidy up one's affairs – writing a will etc.
12. Feeling of loneliness, helplessness, hopelessness
13. Suicide notes
14. Physical ill health
15. Repeated mention of death/ suicide

How to assess the risk of suicide?

When the primary health care worker suspects that suicidal behaviour is a possibility, then there is a need to assess the following factors :

1. Current mental state and thoughts about death and suicide
2. Current suicidal plan, how prepared, how soon
3. The support system the person has (family, friend etc)

The best way to find whether a person has suicidal thoughts is to ask them. Contrary to popular thinking talking about suicide does not plant the ideas in the person's head. Actually they are very grateful and relieved that they are able to talk openly about the issues and questions they are struggling with.

What, How and when to ask the suicide question?

It is not easy to ask a person about their suicidal ideas. It is useful to lead into the topic gradually.

Some useful questions are :

1. Do you feel sad?
2. Do you feel no one cares about you?
3. Do you feel that life is not worth living?
4. Do you feel like committing suicide?

When to ask?

1. When the person has a feeling of being understood
2. When the person is comfortable talking about his/her feelings
3. When the person is talking about negative feelings of loneliness, helplessness etc.

What to ask?

1. Whether the person has a definite plan to commit suicide.

- Questions :
1. Have you made any plans?
 2. Do you have an idea about how you are going to end your life?

2. Whether the person has the means (method)?

- Questions :
1. Do you have pills, gun, insecticides etc.?
 2. Is it readily available for you?

3. Whether the person has fixed a time frame?

- Questions :
1. Have you decided when you plan to end your life?
 2. When are you planning to do it?

All these questions must be asked with care, concern and compassion

How to manage a suicidal person?

Low risk

1. The person has had some suicidal thoughts but has not made any plans. Has thoughts like “I can’t go on”, “I wish I were dead”.

Action

1. Offer emotional support.
2. Work through the suicidal feelings. The more openly a person talks of loss, isolation and worthlessness the less becomes his or her emotional turmoil. When the emotional turmoil becomes less, the person is likely to be reflective. This process of reflection is crucial as nobody except that individual can revoke the decision to die and make a decision to live.
3. Focus on the positive strengths the person has by making the person talk of how he/she has resolved problems earlier without resorting to suicide.
4. Refer to a mental health professional or a doctor.
5. Meet at regular intervals and maintain on going contact

Medium Risk

The person has suicidal thoughts and plans but there are no plans to commit suicide immediately.

Action

Offer emotional support, work through the suicidal feelings and focus on positive strengths, and in addition :

1. *Use the ambivalence* The primary health care worker should focus on the ambivalence felt by the suicidal person, so that gradually the wish to live is strengthened.
2. *Exploring alternatives to suicide:* The health care worker should try to explore the various alternatives to suicide with the hope that the person considers at least one of them.
3. *Contracting:* Extract a promise from the suicidal person that he / she will not commit suicide without contacting the health worker for a specific period. *The suicidal persons usually keep their promises.*
4. Refer to psychiatrist, counsellor, doctor and make an appointment as soon as possible.
5. Contact the family, friends, colleagues etc. and get their support.

High Risk

When the person has a definite plan, has the means to do it, and plans to do it immediately.

Action

1. Stay with the person. Never leave the person alone.
2. Gently talk to the person and remove the pills, knife, gun, insecticide etc. (Distance the means of suicide)
3. Make a contract.
4. Contact a mental health expert or doctor immediately and arrange for ambulance and hospitalization.
5. Inform the family and get their support.

Referral

When to refer?

When the person has :

1. psychiatric illness.
2. History of previous suicide attempt.
3. Family history of suicide, alcoholism or mental illness.
4. Physical ill health.
5. No social support.

How to refer

1. The primary health care worker must take the time to explain to the person the reason for the referral.
2. Arrange for the appointment.
3. Convey that referral does not mean that he/she is washing his/her hands off.
4. See the person after the consultation.
5. Maintain periodic contact.

Resources:

The usual support systems available are :

1. Family
2. Friends
3. Colleagues
4. Clergy
5. Crisis Centres
6. Health Care professionals

How to approach the resources?

1. Try to get the permission from the suicidal person to enlist the support of the resources and then contact them.
2. Even if permission is not given, try to locate a person who would be most sympathetic to the suicidal person.
3. Talk to the person before hand and explain to him/her that it is sometimes easier to talk to a stranger than a loved one, so that he/she does not feel neglected or hurt.
4. Talk to them without accusing them or making them feel guilty.
5. Enlist their support in the actions to be taken.
6. Be aware of their needs also.

Do's and Don'ts

Do's

- Listen. Show empathy, and be calm.
- Be supportive and caring
- Take the situation seriously and assess the degree of risk
- Ask about previous attempts
- Explore possibilities other than suicide
- Ask about suicide plan
- Buy time – make a contract
- Identify other supports
- Remove the means, if possible
- Take action, tell others, get help
- If the risk is high, stay with the person

Don'ts

- Ignore the situation
- Be shocked or embarrassed and panic
- Say that everything will be all right
- Challenge the person to go ahead
- Give advice
- Make the problem appear trivial
- Give false assurances
- Swear to secrecy
- Leave them alone

Conclusion

Commitment, sensitivity, knowledge and concern for another human being, a faith that life is worth nurturing are the main resources a Primary Health Care worker has, that can help prevent suicide.

References

1. Figures and Facts about Suicide 1999 Dept. of Mental Health. World Health Organisation, Geneva.
2. Morgan G.H. 1994. Suicide Prevention. The challenge confronted: NHS Health Advisory Thematic Review ; p. 17-22.

* Dr. Lakshmi Vijayakumar MBBBS DPM PhD
Consultant Psychiatrist, Voluntary Health Services, Chennai
Founder, SNEHA, Suicide Prevention Centre, Chennai
Vice President and National Representative, International Association for Suicide Prevention
Member, WHO's International Network for Suicide Prevention and Research

Dr. Lakshmi Vijayakumar is a practicing psychiatrist by profession and a suicide prevention volunteer by choice. She is the Founder Trustee of Sneha, Chennai and Head of the Department of Psychiatry in VHS Hospital, Adyar. She took an MBBS from Madras University, a PG Diploma in Psychological Medicine from IMH, Madras and wrote a thesis on "risk factors for suicides in India" for a doctorate. She was the first Asian Vice President of the International Association for Suicide Prevention (IASP). She has published scores of expert papers on the subject. Important gatherings on suicidology around the world carry her name on the invitation. She has conducted counselling workshops in several countries on behalf of Befrienders' International, to which SNEHA is affiliated. Dr. Lakshmi has been a friend, guide and philosopher to Maithri from its very inception.
