# SUICIDE: CAUSES, PREVENTION AND INTERVENTION STRATEGIES

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## ABSTRACT

Suicide is a major cause of death in the present world. It remains a significant social and public health problem. In this paper, causes of suicide are identified as mental illness, traumatic experience, bullying, personality disorders, drug addiction/substance abuse, eating disorders, unemployment, social isolation/loneliness, relationship problems, genetics/family history, philosophical desire/existential crisis, terminal illness, chronic pain, financial problems and prescription drugs. In preventing suicide, a combination of evidence-based interventions-universal, selective and indicated should be employed. The general population is targeted by universal interventions (e.g. restricting access to means of suicide), selective interventions focus on high-risk subgroups (e.g. people with mental disorders), whereas those who have attempted suicide are considered high-risk individuals and are therefore addressed with indicated interventions, which include a range of behavioural therapies and approaches such as cognitive therapy. A brief intervention and contact approach had been demonstrated to be effective in reducing suicide mortality among suicide attempters.

## INTRODUCTION

Suicide is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities nationwide. It places a heavy burden on the nation in terms of the emotional suffering that families and communities experience as well as the economic costs associated with medical care and lost productivity (National Strategy for Suicide Prevention, 2012).

Every year, almost one million people die by suicide around the world. Suicide remains a significant social and public health problem. In 1998, suicide constituted 1.8% of the total disease burden; this is estimated to rise to 2.4% by 2020. Young people are increasingly vulnerable to suicide behaviours. Worldwide, suicide is one of the three leading causes of death among those in the economically productive age group (15 – 44 years), and the second leading cause of death in the 15 – 19 years age group. At the other end of the age spectrum, the elderly are also at high risk in many countries (Public Health Action for the Prevention of Suicide, 2012).

According to Behera, Balabantray and Nayak (2005), suicide is a major cause of death in the present world. In every country, the rate for a particular figure of population is increasing day by day. Suicide is death resulting directly or indirectly from a positive or negative act of the victim himself which he knows will produce this result. Suicide from a existential point of view reflects a behaviour that seeks and finds the solution to an existential problem by making an attempt on life of the subject. It is applicable to all acts terminating totally.

Based on the report of 2012 National Strategy for Suicide Prevention in the United States, suicide is the 10th leading cause of death, claiming more than twice as many lives each year as does homicide. On average, between 2001 and 2009, more than 33,000 Americans died each year as a result of suicide, which is more than 1 person every 15 minutes. More than 8 million adults report having serious thoughts of suicide in the past year, 2.5 million reports making a suicide plan in the past year and 1.1 million report a suicide attempt in the past year. Almost 16 percent of students in grades 9 to 12 report having seriously considered suicide and 7.8 percent report having attempted suicide one or more times in the past 12 months.

In the same vein, World Health Organization estimated that 877,000 deaths were due to suicide in the year 2002, the majority of which (87%) occurred in low and middle income countries (WHO, 2003; Krug, Dahlberg, Mercy, Zwi & Lozaho, 2002).
Causes of Suicide

Suicidal behaviours can be conceptualized as a complex process that can range from suicidal ideation, which can be communicated through verbal or non-verbal means, to planning of suicide, attempting suicide, and in the worst case, suicide. Suicidal behaviours are influenced by interacting biological, genetic, psychological, social environmental and situational factors (Wassermann, 2001).

Risk factors for suicide include mental and physical illness, alcohol or drug abuse, chronic illness, acute emotional distress, violence, a sudden and major change in an individual's life, such as loss of employment, separation from a partner, or other adverse events, or, in many cases, a combination of these factors. While mental health problems play a role which varies across different contexts, other factors, such as culture and socio-economic status, are also particularly influential (Public Health Action for the Prevention of Suicide, 2012).

Although suicide continues to remain a serious problem in high income countries, it is the low and middle income countries that bear the larger part of the global suicide burden. It is also these countries that are relatively less equipped to prevent suicide. Unable to keep pace with the rising demand for mental health care, they are especially hindered by inadequate infrastructure and scarce economic and human resources. These countries have also lower budgetary allocations for health in general and for mental health in particular. As a result, there are few sustained efforts and activities that focus on suicide prevention on a scale necessary to reduce the number of lives lost to suicide (Uijayakomer,

2005). Beyond financial realities, for all countries political will is an essential ingredient to bring about change at the policy and programme level. Suicide behaviour is considered a criminal offence in some countries, which poses additional challenges for suicide prevention activities.

**Common causes of suicide that could be considered include the following:**

• **Mental Illness:** Among the most common causes of suicide is that of mental illness. Most people end up trying a variety of psychiatric drugs and/or talk therapies. After years of trying various medications, going through medication withdrawals, and experimenting with therapies, some people are stuck in a constant state of mental pain and despair. Mental illness may be in form of:

• **Anxiety:** Having generalized anxiety, social phobia, panic attacks, or obsessive compulsive disorder (OCD) can drive a person crazy. Some forms of anxiety make it extremely difficult to maintain friendships, finish school, or hold down a steady job. The combination of loneliness and fear can lead a person to contemplate suicide.

• **Bipolar Disorder:** It involves fluctuation in mood from states of severe depression to elevations in mood such as mania and hypomania. These mood fluctuations can make it difficult for people with this disorder to maintain relationships and a balanced life. Additionally, the depression can lead a person to feel suicidal.

• **Depression:** Major depression is a leading cause of suicide throughout the world. People that do not treat their depression symptoms have a greater risk to following through with suicide.

• **Schizophrenia:** This is a highly severe mental illness with an array of symptoms including severe depression, hallucinations and cognitive impairment. Having this illness makes it difficult to function in life and can serve as a major challenge due to the fact that most medications to treat this illness carry severe side effects. Anywhere from 20% to 40% of people with this illness attempt suicide.

• **Traumatic Experience:** Any type of traumatic experience can lead a person to feeling helpless, guilty and/or ashamed. Victims of physical abuse, sexual abuse or war are more likely to end up with Post-Traumatic Stress Disorder (PTSD). This disorder and the feelings associated with traumatic experiences can lead a person to become suicidal.

• **Bullying:** Most people experience bullying to some degree while growing up and going through school. Bullying can have a profound effect on the way people think and how they feel. Most people that are bullied end up feeling extremely depressed, worthless and hopeless to change their situation. Additionally, now there is a phenomenon called "cyber bullying" in which people fall victim to being bullied online. This happens on social media sites, comments sections of websites, and various blogs that aim to ruin people's reputation and make them feel ashamed. When a person is bullied online

and/or has privacy exposed online, he/she may view a ruined reputation as the end of the world and feel helpless to change his/her situation which could lead to suicide.

• **Personality Disorders:** Personality disorders can be closely related to mental illness, but are considered a set of traits that make it difficult to function within society. People with a personality disorder may have trouble maintaining relationships, holding down a steady job, and/or coping with life. The bottom-line is that a person with personality disorder is at increased risk of suicide. The personality disorder that is most associated with increased suicide risk is that of Borderline Personality Disorder (BPD). This disorder is characterized by impulsive behaviour, difficulty regulating emotions, and instability in relationships.

• **Drug Addiction/Substance Abuse:** People that are addicted to drugs and/or abuse drugs or alcohol on a consistent basis are more likely to become depressed. Many people use drugs to escape painful feelings of depression and hopelessness of their current life situation. Being addicted to drugs or alcohol may provide some short-term relief from the pain that they feel, but over the long term, drug use tends to alter brain functioning and neurotransmitters. An addiction could escalate to feelings of deep depression. Inability to overcome addiction may result to people seeing suicide as the only way out of the addiction trap.

• **Eating Disorders:** Eating disorders are a series of dysfunctional eating patterns that satisfy the person in ways other than nutrition. Many eating disorders are thought to be caused by body image problems, low self esteem, and other mental health issues. They are a way a person attempts to cope with unrelated issues such as abuse, troublesome emotions, communication problems, or an identity crisis. Anorexia, bulimia, compulsive overeating and purging disorder tend to affect both physical and mental health negatively. A person dealing with an eating disorder may constantly feel suicidal as a result of a nutrient-deficient diet. poor diets can lead a person to feel depression and constant negative emotions.

• **Unemployment:** Being unemployed can lead to feelings of isolation and make life feel as if it is void of purpose. Being unable to earn money and provide for oneself and/or family can result in significant depression and anxiety. In addition to unemployment, hating ones current job can lead to suicidal thoughts and possibly actions if one feels as if there is no alternative option.

• Social Isolation/Loneliness: Being socially isolated from society can take a toll on mental health and lead a person to become depressed and consider suicide. Socializing and interacting with other people is a basic human need. If social needs are not met, a person can start to feel lonely which leads to depression and possibly suicidal thoughts. Loneliness is defined as a general feeling of sadness as a result of being alone or feeling disconnected from others. Various reasons that a person could feel lonely or isolated include living alone, death of a close friend or family member, poor physical health, mental illness, being introverted, fear of rejection and/or retirement. If the loneliness and/or social isolation is not addressed, it may lead someone to consider suicide as an escape from their situation.

• **Relationship Problems:** Many people struggle with relationships including being in abusive relationships, not feeling appreciated, and/or going through break-ups. Some people may have difficulties making friends and maintaining a close group for socialization. Others may struggle with staying in abusive relationships so that they can avoid feeling isolated and lonely. The need for human belonging is so strong that some people are willing to join gangs and/or humiliate themselves just to be in a relationship with another person. The act of a break-up can trigger intense feelings of depression, anxiety, guilt and panic, leading a person to deal with a lot of emotional pain. There are cases of people committing suicide as a result of a break-up with a significant other.

• **Genetics/Family History**: A lot of suicide risk has to do with genetics and family history. Those who are from a family in which suicide is common are more likely to commit suicide themselves. Additionally, if a mental illness is inherited such as major depression, this can further increase risk of suicide. Also, epigenetic or the activation or deactivation of genes based on environmental factors is thought to play a role. In other words, a person's circumstances, the people a person hangs out with, where a person lives etc. could influence genetic expression and thus be partially influential in determining whether a person becomes suicidal.

• **Philosophical Desire/Existential Crisis:** When life seems void of meaning, people tend to question why they are even living and/or the entire purpose of their existence. This is often referred to as an "existential crisis" and can be difficult to overcome because people dealing with this issue often think themselves in circles of logic as to why there is no point to life. In many cases, people facing an existential crisis consider suicide because they feel as if their entire existence is void of purpose.

• **Terminal Illness:** Many people with terminal illnesses that have no hope of improving their situation based on current science and medicine may become depressed. This depression is usually a result of feeling powerless to one's situation. Terminal illness such as various types of cancer usually leaves a person frustrated, shocked and feeling hopeless. Many elderly individuals who are terminally ill have thought for euthanasia rights and/or travelled to other countries where it has been legalized.

• **Chronic Pain:** This is daily pain that has persisted far between three and six months. This pain often impairs a person's ability to function throughout the day and can affect mobility, the ability to perform certain tasks, and even a person's mental health. Dealing with pain on a daily basis can drive some people into depression, and in some cases, suicide.

• **Financial Problems:** People who are struggling financially sometimes see no end in sight to their debt and bills. The financial stress can take a major toll on a person's mental health. Although, some people in financial troubles eventually end up working their way out of debt, some people are afraid to deal with this situation. In the event that a person becomes embarrassed about his finances and feels depressed about his debt, he may consider suicide as a way to escape this situation.

• **Prescription Drug:** The side effects of various prescription drugs such as antidepressants can result in suicidal ideation. In other words, these drugs affect levels of neurotransmitter that can sometimes put a person at increased risk for suicide. Some antidepressants actually end up making people significantly more depressed because they are targeting neurotransmitter levels, when the original cause of depression was not a result of chemical imbalance.

## Prevention of Suicide

Suicide prevention is an umbrella term for the collective efforts of local citizen organizations, mental health practitioners and related professionals to reduce the incidence of suicide. Beyond just direct interventions to stop an impending suicide, methods also involve;

a. Treating the psychological and psycho physiological symptoms of depression,
b. Improving the coping strategies of persons who would otherwise seriously consider suicide,
c. Reducing the prevalence of conditions believed to constitute risk factors for suicide, and
d. Giving people hope for a better life after current problems are resolved.

General efforts have included preventive and proactive measures within the realms of medicine and mental health, as well as public health and other fields. Because protective factors such as social support and connectedness, as well as environmental risk factors such as access to lethal means, appear to play significant roles in the prevention of suicide, suicide should not be viewed solely as a medical or mental health issue.

In the U.S., suicide prevention efforts are guided by the U.S. National Strategy for Suicide Prevention, published by the Department of Health and Human Services in 2001. Suicide prevention interventions fall into two broad categories: prevention targeted at the level of the individual and prevention targeted at the level of the population.

## Strategies

In recognition of the need for comprehensive approaches to suicide prevention, various strategies have been put forth in the last decade. In 2001, the U.S. Department of Health and Human Services, under the direction of the Surgeon General, published the National Strategy for Suicide Prevention, establishing a framework for suicide prevention in the US. The document calls for a public health approach to suicide prevention, focusing on identifying patterns of suicide and suicidal behaviour throughout a group or population (as opposed to exploring the history and health conditions that could lead to suicide in a single individuals). The document also outlines 11 specific objectives, listed below:

- Promote awareness that suicide is a public health problem that is preventable
- Develop broad-based support for suicide prevention

- Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services
- Develop and implement community-based suicide prevention programs
- Promote efforts to reduce access to lethal means and methods of self-harm
- Implement training for recognition of at-risk behaviour and delivery of effective treatment
- Develop and promote effective clinical and professional practices
- Increase access to and community linkages with mental health and substance abuse services
- Improve reporting and portrayals of suicidal behaviour, mental illness and substance abuse in the entertainment and news media
- Promote and support research on suicide and suicide prevention
- Improve and expand surveillance systems

**Specific Strategies**

Various specific suicide prevention strategies have been used:

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

It has also been suggested that news media can help prevent suicide by linking suicide with negative outcomes such as pain for the suicide and his survivors, conveying that the majority of people choose something other than suicide in order to solve their problems, avoiding mentioning suicide epidemics, and avoiding presenting authorities or sympathetic, ordinary people as spokesperson for the reasonableness of suicide.

According to National Strategy for Suicide Prevention (2012), everyone has a role in preventing suicides. The goals and objectives in the National Strategy work together to promote wellness, increase protection, reduce risk, and promote effective treatment and recovery.

From encouraging dialogue about suicidal behaviour to promoting policies that support suicide prevention, the National Strategy states that suicide prevention efforts should;

- Foster positive public dialogue, counter shame, prejudice, and silence; and build public support for suicide prevention.
- Address the needs of vulnerable groups, be tailored to the cultural and situational contexts in which they are offered, and seek to eliminate disparities
- Be coordinated and integrated with existing efforts addressing health and behavioural health and ensure continuity of care.
- Promote changes in systems, policies, and environments that will support and facilitate the prevention of suicide and related problems.
- Bring together public health and behavioural health
- Promote efforts to reduce access to lethal means among individuals with identified suicide risks; and

## Apply the most up-to-date knowledge for suicide prevention

Based on relevant risk and protective factors, a National Strategy can propose the most suitable type and combination of evidence-based interventions-universal, selective and indicated. Universal intervention targets the general population with coverage of the population as a whole, irrespective of the degree of risk, selective intervention focuses on sub-populations that are known to have an elevated risk and can be employed on the basis of socio-demographic characteristics, geographical distribution or prevalence of mental and substance use disorders, depending on the contribution of these various factors to the overall burden of suicide. Indicated intervention is aimed at those who are already known to be vulnerable to suicide or who have attempted suicide. A comprehensive suicide prevention programme typically employed combination of these three strategies.

## Intervention Strategies

There have been several reviews of interventions that may be considered effective in reducing suicide (Beautrais, 2005; Bertolote, 2004; Mann, Apter, Bertolote, Beautrais, Currier & Haas, 2005). Under the framework of universal, selective, and indicated interventions, the general population is targeted by universal interventions (e.g. restricting access to means of suicide) and selective interventions focus on high-risk subgroups (e.g. people with mental disorders), whereas those who have attempted suicide are considered high-risk individuals and are therefore addressed with indicated interventions, which include a range of behavioural therapies and approaches such as cognitive therapy (Brown, Ten Have, Henriques, Xie, Hollander & Beck, 2005).

Among indicated interventions, various approaches have been tested to prevent subsequent suicidal behaviour by suicide attempters; extensive review articles are available (Hawton, Arensman, Townsend, Bremner, Feldman & Goldney, 1998; Hepp, Wittmann,, Schnyder & Michel, 2004). Usually, the primary outcome measure used for these interventions was repeated suicide attempts. It is suggested that extrapolation from attempted to completed suicide is valid. As completed suicide is a rate outcome in statistical terms, large numbers of suicide attempters would be needed to demonstrate

the effectiveness of an intervention in terms of a reduction of completed suicides. The multi site study presented here tried to tackle this challenge by combining data from different sites that had applied the same research protocol.

Previously, completed suicides were used as an outcome measure in a study that investigated the maintenance of long-term contact (i.e. a total of 5 years and 24 contacts) with high suicide risk psychiatric patients refusing further treatment (Motto, 1976; Motto, Heilbron, Juster & Bostrom, 1981; Motto & Bostrom, 2001). The contact comprised regular short letters expressing concerns for the person's well-being and inviting them to respond. This was associated with a significant reduction in suicide rates for at least 2 years after discharge from the in-patient setting.

In addition, a "tele-help/tele-check" service (i.e. an alarm system that can be activated to call for help and a service that contacts a person twice a week for assessment of their needs and to provide emotional support) could significantly reduce the number of suicide deaths in the elderly, who typically have an elevated risk of suicide compared with an age-adjusted number for the general population (De Leo, Carollo, Dello Buono & Lower, 1995; De Leo, Dello Buono & Dywer, 2002).

These two examples demonstrate that it is possible to reduce the suicide rate in populations at risk by keeping in regular contact with patients. Brief interventions for alcohol problems are another promising type of intervention that has not been previously applied to suicidal behaviours (Babor & Higgins-Biddle, 2000; Babor & Higgins-Biddle, 2001; Bien, Miller & Tonigan, 1993). These are designed to address the specific behaviour of drinking with information feedback, health education and practical advice and focus in order to raise awareness of the problem and advise change. They were found to be effective in reducing alcohol-related problems, to be more effective than no counselling, often as effective as more extensive treatment, and feasible within relatively brief contacts. Repeated follow-up visits were recognized as a factor favouring behaviour change and maintenance.

The multisite intervention study on suicidal behaviours (SUPRE-MISS) launched by WHO in 2000, evaluated an innovative intervention in a large randomized controlled trial, that brought together the elements of information, education, and practical advice from brief interventions with the maintenance of long-term follow-up contact on a regular basis. It used completed suicides as the primary outcome measure because the reduction in mortality is the most convincing evidence for the effectiveness of suicide prevention (Moller, 1989). The multisite randomized controlled trial of different treatment strategies for suicide attempters represented one component of SUPRE-MISS, which, overall, aimed at increasing knowledge about suicidal behaviours and effective interventions for suicide attempters (Bertolote, Fleischmann, De Leo, Bolhari, Botega & De Silva, 2005; Fleischmann, Bertolote, De Leo, Botega, Philips & Sisask, 2005).

World Health Organization has developed and tested at multiple sites a brief intervention and contact approach that have demonstrated its effectiveness for reducing suicide mortality among suicide attempters. This approach is uncomplicated, affordable and particularly appropriate for low-resources settings (Fleischmann, Bertolote, Wasserman, De Leo, Bolhari, Botega, De Silva, 2008).

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**CONCLUSION**

Suicide has being identified as a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families and communities nationwide. It is a priority condition globally and has been identified as such by the WHO. As suicide is largely preventable, it is imperative

that governments-through their health, social and other relevant sectors-invest human and financial resources in suicide prevention.

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