

CHAPTER TWO

LITERATURE REVIEW

Introduction

The focal point of this chapter would be a discussion of the various theories on suicide. The theories will be divided into psychoanalytic and non-psychoanalytic theories. In addition this chapter will cover the various studies and researches that were carried out both locally and overseas on the subject of suicide and attempted suicide will be explored.

Theories of Suicide

Psychoanalytic theories

Most psychoanalytic theories has its roots in Freud's theory of depression, with reference to the lost of a loved object, and postulation of the death instinct, "Thanotos", accompanied by "Eros", life instinct. Suicide is seen as a result of a strong aggressive impulse that failed to be expressed outwardly and which as a result is directed inwards. The anger is directed inwards, towards the self. "It is a retroflexed rage; a person kills himself because he originally intended to kill someone else" (Lettieri, 1978, p.18, Freud, 1964; Jackson, 1957).

Karl Menninger further explained Freud's theory by subscribing three elements that motivate a person to suicide – the wish to die, the wish to kill, and the wish to be killed. The wish to die is the basic need to escape from something unpleasant in life, while the wish to kill is an act of revenge, inflicting guilt or suffering on others. The final wish to be killed may be sparked because of a sense of wrongdoing and the need to be punished for it. While all these motives may play a part in every suicide, one may be more preponderant for each person. It is also possible to only have one motive for choosing suicide (Menninger, 1938; Lester & Lester, 1971).

Hendin (1968, 1971, 1991), identified the underlying motives for the wish to die especially among the young are that death is seen as a reunion, as a rebirth, as retaliatory abandonment, as revenge and as self-punishment or atonement. With regard to death as a reunion and rebirth, the person hoped that by dying she/he will be reunited with the dead person, while for the case of a lost love death is seen as a means of being with the person in fantasy. Rebirth reflects the desire to achieve a more ideal self, perhaps a better life by his/her death. As a retaliatory abandonment, Hendin explains that by attempting suicide, the person feels that she/he has gain mastery over the situation through their ability to control their living or dying. With regard to revenge, like Freud he observed that the death wish comprised of self-hatred or anger against the love object turned inwards. While self-punishment or atonement, is a death wish that is inflicted on self as a punishment for ones failure or guilt for what has not being fulfilled or achieved. He further elaborated that having a high and rigid standard of self, the young, feeling self as a failure, falling short of their own needs or parents requirement of academic, vocational and social aspirations may wish

for death. Another category mentioned by Hendin are those who see themselves as already dead, although physically they are still alive. To them suicide would be a release of suffering and pain, and it is merely an act to complete an event or a process that has already happened. Hendin added that feelings of rage, apathy, a sense of hopelessness, worthlessness, despair and guilt are important affective states that a young suicidal person experiences that moved them to commit suicide.

Psychoanalysts advance the theory that early objects of lost love, especially parents, played an important part in the origin of a depressive state, which is responsible for the seed for suicidal tendencies. A history of a broken home due to death or absence of a family member was found to be frequent among those who committed or attempted suicide (Moss & Hamilton, 1957). Palmer, 1941 (in Jackson, 1957), too, stresses the importance of early influences, where an arrest in psychosexual development during the identification stages of growth result in suicidal attempts (Jackson, 1957).

Alfred Adler (1968), further elaborated that suicidal people tend to be those who are considered problem children during childhood. These children characterize a personality that display a tendency to be a spoilt child, very complacent, over sensitive, poor losers, showing extreme hurt feelings or deep grieve over small matters. In addition, they tend to throw tantrums with willful self-injury and expect others to fulfill their every wish. He summaries that those who have a tendency to commit suicide are those who are only capable of thinking of self and too little of others. They basically are incapable to play, function, and live with others.

Thus in the study of suicidal behavior it becomes important that an individual's relationship with his environment, past and present, should be explored.

Non – psychoanalytic theories

As mentioned in the first chapter, suicide is seen as a deviant act by society. Based on Control Theory initiated by Emile Durkheim, a pioneer social scientist, it is found that suicide as a form of deviance was a social phenomena that was related to different degrees of integration and regulation in a society. Durkheim discovered that the incidence of suicide in society was related to the degree of social integration. When people lose their links to one another through attachment, society will suffer an anomie – a state of normlessness, a situation of societal deregulation, where norms are ineffective as sources of social control. His analysis indicated that the suicide rate varies inversely with the degree of a person's social integration and regulation. The more integrated the society, the more it controls the behavior of members, protecting them from suicide, while disintegration results in individualism where individuals have their own beliefs and behaviors, making society less able to protect the individual from the act of suicide. The more integrated the society the lower the suicide rate. Using statistical data from various European countries, Durkheim quoted as an example that the rate of suicide among the Catholic is much lower compared to Protestants, because the Catholic Church provides its members with greater sense of group belonging and participation. In essence, a disintegrated group cannot constrain individual conduct, and thus the more disintegrated a group, the more likely the occurrence of suicide (Durkheim, 1966; Pope, 1976; Frazier, 1976; Clinard, 1963; Clinard & Meier, 1992).

Durkheim (1966), described four types of suicide: I) Egoistic Suicide - When an individual is not wholly integrated into his society i.e. he is not socially

adjusted. He is detached from social life, with few social ties, thus finds no basis of existence in life. Without any attachments or bonding with others, he is left to himself to deviate as he pleases; II) Altruistic Suicide - When an individual is overly integrated with society resulting in self-sacrifice. As his goal and that of society is similar, he is under a strong social restraint to conform to societies needs, example being the act of suttee of the Hindu society; III) Anomic Suicide - When an individual's adjustment to society is disrupted. The individual is faced with a sudden unexpected change in his/her social position, creating a new position that he/she can't cope with, thus making him/her more vulnerable to suicide; IV) Fatalistic suicide – It is suicide derived from excessive regulation which is the opposite of anomic suicide. Durkheim felt that there were few of such suicides in which “individuals found their future was blocked and their passions violently choked by oppressive discipline”.

For Hirschi, 1969, another exponent of Control Theory, attachment, investment, involvement and belief are social bonds that are likely to hold an individual in a society. When these bonds are weakened or broken the individual is then free to deviate (in Stark, 1994).

While the incidence of completed suicide is likely to be higher for those who are not socially integrated and regulated, Lester (1989), hypothesized that attempted suicide would be more prevalent among those who are socially well-regulated and integrated. However, despite having a well-regulated and integrated social environment, their social relationship could be characterized as full of conflict and failing to provide gratification. He made the conclusion on the evidence that the young and females that are more socially regulated face greater external constraints and have the highest occurrence of attempted suicide. To him suicide attempts are not

really an act of killing self, but rather a communication too significant others (Lester, 1989).

A sense of negative self-concept and feelings of self-contempt and worthlessness are also seen as characteristics of a suicidal person, as seen from the seventeen percent of suicide notes, examples being: "*I have always been a failure*" and "*I have always been nobody and unreal*" (Bjerg, 1968, in Diekstra & Hawton, 1987, p.52). Miller, (in Jackson, 1957) when making a comparison on non-suicidal people and those who are suicidal found that those who are suicidal are much more negative about themselves. Beck saw childhood experiences as the cause of the negatives towards self and the world (Diekstra and Hawton, 1987).

Williams, in 1936, (in Jackson 1957), felt that the main reasons for suicide are disappointments and frustration among people who have a rigid personality with strong narcissistic tendencies, which makes them less adaptive. Crichton-Miller (1931), too saw suicide as a failure of adaptation and that it is a final regression from reality. In suicidal acts, he claimed, are signs of social suffering and fears, doubts and dreads and physical pain.

Davidson, in 1934, (in Jackson, 1957), feels that the person at that time of suicidal attempt has actually reached the limit of his resources and has lost his goal. He is overpowered by the situation, losing his ability to think, incapacitating him and consequently not being able to distinguish unhealthy action.

Applebaum, in 1963, (in Lettieri, 1978) commented that suicidal individuals view their suicidal act as a coping mechanism in the face of extreme distress and powerlessness. The individual views his past as what was good, his present a time of hopelessness and his future cannot be improved. Suicide is thus a response to a

feeling of powerlessness, a course of actions in a no-way-out situation other than suicide. Minkoff, Bergman, Beck & Beck (1973), saw hopelessness as a motivating factor for suicidal tendency, and suggested that approaches specifically aimed to alleviate hopelessness could be successful in preventing suicide.

Like Minkoff et al., (1973), Farber (1968), saw hope and a sense of competence as a deterrent to suicide. In a person who saw his/her situation as beyond hope; despair of a solution added to losing a sense of competence will resort to suicide.

Individuals also may commit suicide with the intent of hurting someone who has hurt them. By committing suicide they expect those who have hurt them to feel remorse and suffer great guilt. Sullivan, 1956, expounded this theory (in Lettieri, 1978).

Ten Common Characteristics of Suicide

According to Shneidman (1986), there are 10 common characteristics of suicide

The purpose of suicide is to seek solution

Suicide is done with a reason. It is a way out of the problem or crisis that is creating intense suffering. Suicidal persons see it as an act that provides the best solution in comparison to what life has to offer – *"I am doomed, I must get out, suicide will solve everything, I cannot see any way out"* (p.3).

The goal of suicide is cessation of consciousness

The desire to stop the unbearable situation that one is in. Those who are suicidal do not see death as attractive, but as a way out to the pain and despair that they are experiencing. As such, the cessation of one's consciousness of the unbearable pain becomes the solution of life's painful and pressing problem (p.5).

The trigger in suicide is intolerable psychological pain

No one commits suicide out of joy. According to Shneidman, the emotions (examples are rage, depression, shame or guilt) that a person experiences will only lead to suicide if the person experience unbearable psychological pain from it, which he calls psychache. No psychache, according to him there will be no suicide (p.5).

The stressor in suicide is frustrated psychological needs

Suicide is committed because of thwarted or unfulfilled needs. The mental pain of a suicidal person relates to the frustration of not being able to achieve the need to find a meaning and purpose in life, which is deemed important to a person (p.5 –7).

The emotion in suicide is hopelessness – helplessness

The notion that “there is nothing that I can do (except commit suicide), and there isn't anyone to help me (with the pain that I am suffering) (Shneidman: 1986). Research done with and without using the Hopelessness Scale has showed that there is a relationship between hopelessness and suicide (Beck, Steer, Kovacs and Garrison, 1985; Chinnian, 1989; Morano, 1993).

The internal attitude in suicide is ambivalence

Shneidman expressed that “ most people who commit suicidal acts do not either want to die or to live, but they want to do both at the same time”. While they want to do it, they also yearn to be rescued. This ambivalence to suicide reflects the conflicting feelings of survival and unbearable stress (p.7-8)

The cognitive state in suicide is constriction

With the tunneling of vision, seeing no avenues of escape and not able to see other possible options, suicide is then seen as the only choice. Upendra Thakur (1963, p.17), deemed suicide as “ a reaction to problems that apparently cannot be resolved in any other way: a final response which a human being makes to inner emotional distress” (p.7-8).

The action in suicide is escape

It is common to hear people talking about running away, getting away from it all, escaping from all pressures. The aim being to improve life and it is temporary. However, suicide is actually the ultimate escape as it entails a permanent change (p. 10-11). A research to find out reasons for dying (RFD) and reasons for living (RFL) on 49 suicidal patients resulted in 173 RFL and 145 RFD. Forty two percent of responses of RFD accounted various forms of escape-orientated reasons for dying. (Jobes & Mann, 1999)

The interpersonal act in suicide is communication of intent

According to Shneidman eighty percent of suicides had indirectly communicated their suicidal state. It may not necessarily be a cry for help, but rather an expression of his/her inner state of mind. While they are ambivalent about it, consciously or unconsciously they emit signals of distress either verbally or behaviorally. Examples are putting affairs in order, giving away prized possessions, or saying, "You won't be seeing me anymore; I cannot go on anymore". (Shneidman, 1986, p.11)

The consistency in suicide is with lifelong coping patterns

People are creatures of habit, learning from their experiences, and are generally consistent. According to Frederick & Resnik, 1971, proponent of Behavior theory, suicidal behaviors are "a direct multiplicative function of drive or motivation multiplied by those past learned associations or habits connected with such behavior"(cited in Jeger, 1979, p, 184.). Hence, they would have acquired certain patterns of defenses when coping with stress and crisis, which may reflect their tendency for choosing suicide. It is therefore important that we evoke previous positive patterns of successful coping.

Studies on Suicide

Durkheim's book "Le Suicide" published in 1987, was the first systematic scientific study looking into the understanding of suicide, as well as in defense of suicide, which during the time was seen as a moral resentment and condemned upon

by society. His study thus pioneered the systematic, scientific research on the subject. His book represented a paradigm shift in the study of suicide.

In early 20th Century, attempted suicide was considered as “minor suicide”, there was little work done on it or it was studied along the same lines as suicide, not as a behavior pattern presenting different problems from suicide. However, after 1940's, research groups in United Kingdom, United States and the rest of Europe started studying attempted suicide as a subject requiring attention on its own merit. The method of research done was following up on patients from attempted suicide from a time frame of a couple of years. This actually started a new trend in suicidological research, in contrast to the earlier retrospective approach.

Stengel and Cook (1958) pointed out that the first systematic follow-up of patients who attempted suicide was carried out in Malmo, Sweden. Suicidal acts by men resulted in death is more commonly than those of women, suicide was more frequent in the old than attempted suicide and that there were more divorced persons among attempted suicide than the general population, and men attempting suicide employed more active methods than women.

Stengel and Cook (1958) observed that those who commit suicide and those who attempt are of two different although overlapping populations. So, they did studies to find out the relationship between the two groups; what happened to those who attempted suicide, how many killed themselves later, and who would be moved to do it, how does the attempt affect the person, and had the act in any way changed the person or solved any problems for the person, and what would the effects of the attempt be on the significant others. They found that in most cases the self-injury was an appeal to another human being, whereby the act was made in a situation where

rescue by others is possible or inevitable. There was a tendency to give warning signals of the possible attempt, so that rescue or intervention is probable. The research showed that women were over-represented, the peak age of suicide is from 55-64 years while that of attempted suicide was 24-44 years old and that in only a minority of cases was the intention serious. They concluded that suicidal acts were part of the struggle for adjustment and that suicide attempters and those who died came from two overlapping populations. They also resolved that there's an element of an appeal function present in the act of attempting suicide whereby the appeal is often being answered by changes in behavior towards the attempter by their significant others.

Beck and Lester, (1976) concerned about the degree to which attempted suicide resemble completed suicide, did a study on 235 completed suicides and 246 attempted suicides and found that they differ most in the communication aspects of the suicidal action. While the completed suicide debated between communicating or not to communicate, the attempters decision appears to be when to communicate, that is, before versus after the suicidal action.

Suicide studies in foreign countries

Presently, in Europe concern is shown towards the increasing trend of suicide and attempted suicide amongst its population. A concerted effort to monitor the trends in the epidemiology of suicide attempts are assessed and carried out together. Results of the World Health Organization and Euro Multicenter Study on Parasuicide research, was carried out from 1989-1992 as part of the action to implement WHO program "Health for All by the Year 2000", reflected that out of the 13 European countries participating, the highest female attempters were from Cergy-Pontoise,

France (462/100 000) and the lowest (69/100 000) in Guipuzcoa, Spain. It was also found that attempt rates were higher among women than men and among the younger age group. The methods used were primarily poisoning or cutting. More than 50% of attempters made more than one attempt and nearly 20% of the second attempts were made within a year of the first attempt. In relation to the general population, suicide attempters were found to belong to the social categories associated with social destabilization and poverty (Schmidtke et al., 1996). In an earlier finding by Djekdtra and Gulbinat, 1993, it was found that the incidence of attempted suicide is 10 to 20 times higher than completed suicide; the male to female ratios for suicide and attempted suicide are reciprocal: 3 times more women than men attempted suicide while 3 times more men commit suicide. With regard to adolescence and young adult Suicide ranked among the 5 leading causes of death in many countries. An interesting finding too was the fact that restricting access to the prevailing method of suicide in a country will help decrease suicide rates, while wide publicity about suicidal acts will increase them (Diekdtra and Gulbinat, 1993). In Australia, too, it was shown that the daily average suicide rate increases significantly after the publication and publicity of suicide stories in the media (Riaz Hassan, 1995).

In Edmonton, Canada, a record of 274 cases of attempted suicide reflected a higher rate in the younger age groups, women and unmarried individuals. The most frequent method used was overdose. Forty percent were known to have made a previous attempt (Bland, Newman, Stephen and Dyck, 1994).

Even in Kuala Lumpur, Ong and Yeoh (1992), found that there were more males than females (ratio of 2.5:1) who committed suicide. It was also found that

more females attempted suicide (1:1.12) for the period 1985-1986, which is consistent with those found in studies conducted in other parts of the world (Stengel, 1958; Borus, 1993, Schmidtke et al., 1996). However, in contrast, research to find out the rate and characteristics of suicide attempters among native Hawaiian high school students, carried out in Hawaii (Yuen et al., 1996) showed that younger males are more likely to attempt suicide compared to younger females. The possible reasons given for the difference is the interpretation to the term "tried to commit suicide" and "attempted suicide" among the gender and younger age group.

In France, a study was carried out for all patients who visited the Emergency Psychiatric Services from December 1993 to June 1994, totaling 1073 subjects using the questionnaire. It was found that 52 percent were attempters, younger than the general population, and a high proportion were females, at 61.5 percent. Attempters have a more frequent history of suicide attempts in their family and personal past. Among the suicide attempters, 54% were repeaters. They indicated more depressive disorders and a record of attempted suicide and drug/alcohol abuse in their families (Chastang Rioux, Kovess, Loreau, Bazin, Zarifian, 1996).

Chastang et al. (1998) follow-up research on 369 adolescents and young adults ranging from 15-29 years old admitted to the Emergency Department for psychological problems showed that 60% were suicide attempters. The breakdown being 55% females and 45% males. The unemployment rate was higher among the attempters than the control group. Among female attempters, they were more often unmarried or divorced. In comparison to the control group, separation before the age of 12 years old and perceived depression in the family emerged as the main features distinguishing the attempters' from non-attempters. It was also found that 50% of the

attempters were repeaters. The risk factors for repeated self-attempts were the fact that they were fostered during childhood, perceived depression and suicidal attempts by close relatives.

In the Oceanic region, Beautrais, Joyce and Mulder (1998) in their study of the social and demographic status of youth suicide attempters found, that almost the same number of males (45.7%) and females (54.3%) made medically serious suicide attempts among the 129 patients in the study, which is contrary to most research that show a predominance of female attempters (Stengel, 1958 ; Borus,1993; Kok,1986) . The majority was by overdosing or poisoning, accounting for 78.3 % of suicide attempts. It was also found that 52.7% of females use overdose as a main method of attempt compared to 25.6 % males. The research concluded that those having a background with low education and lower socioeconomic status have an elevated risk of serious suicide attempts.

Recognizing that suicide is one of the leading causes of death among adolescents and young adults worldwide, Kebebe and Ketsela (1993, carried out a survey on a representative sample of high school students from Addis Abeba in Ethiopia, to identify if there were suicide attempters within the group of students. The survey revealed that a substantial proportion of adolescents attempted suicide (14.3%) and that the attempts were strongly and linearly associated with hopelessness, grade and heavy alcohol intake.

In South Africa, Naidoo and Pillay (1993), observed 51 black South Africans (mean age of 23.5 years) referred for a one year period at the general hospital in Durban. The majority was women, attempting suicide for the first time. It was found that the most popular method used was self-poisoning. Moreover, the majority of

attempters were single and lived with their families, while 21 had experienced early parental loss. Factors leading to the attempt were problematic interpersonal relationships with significant others.

With the objective of determining factors associated with completed suicide in young suicide attempters, a case control study on patients who attempted suicide within the ages of 15-24 years old between the year 1968 and 1985 was carried out by Hawton Fagg, Platt, and Hawkins (1993) in Oxford, England. The study, comparing those who died by the end of 1985 due to suicide or possible suicide and those who were still alive in 1985, indicated that the risk of death due to suicide and possible suicide was related to six factors. The factors are social class, unemployment, previous psychiatric treatment, substance misuse, personality disorder and previous suicide attempts.

In a sample study of 50 adolescents aged 13 – 18 admitted for overdose, Hawton, Gady, Osborn and Cole (1982a, 1982b) found that 90% were female. Main reasons for overdoes given by these adolescents were problems with parents, relationship, schoolwork and also due to unemployment. Most of these adolescents expressed that they felt lonely, unwanted or angry with someone and that they took the overdose so as to alleviate or demonstrate their distress. A third of them however, expressed the reason, as they wanted to die. For the majority of cases the problems seemed transient so that one month later, two-thirds of these adolescent had shown considerable improvement. However, fourteen percent were referred to hospital for further suicide attempts in the following year. It was also found that twenty four percent had visited their physician in the previous week while fifty percent visited their doctor one-month prior to the attempt.

In Singapore, a case study carried out by Methra (1976) among 35 Indian women (15- 39 years old) found that family interrelationship problems, (especially with parents and spouse) followed by illness, bereavement and concerned about marriage were factors leading to suicidal behavior. While one third intended to die, two thirds were ambivalent or did not intend to die. The Researcher found that there were three groups of attempters. Serious suicide attempters (12 cases), having the intention to die, pre-meditated their attempts, making sure that chances of rescue were moderate or low. This group consists of a great number of repeaters. Second group; consists of those who were ambivalent about their intention to die. Their attempts were impulsive in nature, with very little planning. Their social constellation indicated that chances of rescue were moderate or high. The characteristic of the third group was that they did not premeditate the attempts and the chances of rescue were moderate or high. With regard to the effect of the suicidal act, two thirds experience positive effect, seeing it as a way to achieve their needs. Thus the act of suicide becomes a possible alternative coping mechanism.

An intensive research of 364 attempted suicides who took an overdose of drugs and poisons was carried out by Kok in 1986 in Singapore (Kok, 1986). The research showed a preponderance of females with a ratio of 2.3:1. In terms of racial distribution, the Indians were overrepresented, and the Malays were underrepresented. The majority of the attempters were in the young age group of 20-29 years old (50.5%). Some of the significant findings that differentiated attempters from the control group include; a higher rate of parental divorce and separation, parental or spousal infidelity, greater parental aggression, a more unhappy childhood, fewer ties with family, and less social support and greater consumption of alcohol. It was also

found that 20% tried to contact someone prior to the attempt, while 9% left a suicide note. With regard to the effect of the suicidal act, half felt that the situation had improved, while 0.3 % thought it had deteriorated.

In Manila, Lourdes and Gensaya (1992), carried out a study of suicide attempters at the government general hospital. Out of the 185 suicide patients, most were first time attempters and the majority is women. Most were single, and they were mostly from the lower income group. The result of the study showed that the affective states of suicidal patients include a sense of sadness, worthlessness and hopelessness. In addition they are also experiencing irritability, social withdrawal and delayed sleep. An interesting finding was that 58.6 percent of the attempts were impulsive in nature but was serious, requiring intensive care. This contradicts the norm whereby the lethality of suicide risk correspondence with the planning and premeditation; that is, the longer the premeditation the greater the suicide risk. The author explained that this could be because of the personality of Filipinos, who are taught that patience is a virtue, thus suppressing their emotions, enduring it, until he/she reaches the maximum threshold, where he/she will snap up, with suicide as a possible choice. The authors also elaborated that the breakdown of the family structure and unity due to social economic and socio-political struggles have created more pressure of adjustment among the women. In the attempt to juggle their role as child-rearing while taking up the new role as leader of a household the women are put under a lot of stress within their family environment which could be one of the reasons for higher proportion of female attempters.

A research carried out by Pillay and Wassenaar (1991) among 40 Indian South Africans (aged 15-20 years old) to find out whether suicide attempters expected to be

rescued following their suicidal gesture, 45 % reported that they expected to be rescued. However, the balance that did not expect to be rescued indicated a higher sense of hopelessness and suicidal intent compared to those who did expect to be rescued.

By using the Suicidal Intent Scale to determine the seriousness of suicide attempts among 62 patients following self-poisoning and self-injury, it was seen that hopelessness and a sense of isolation were significantly more frequent feelings felt by those having high intent. For those with low intent, anger and frustration were the dominant feeling. In addition, most attempters had a low to moderate intention to die. This research was carried out in Dubai, United Arab Emirates (Hamdi, Amin and Mattar, 1991).

In the Soviet Union, by using case histories and personal accounts of 85 suicidal women, Konochuk (1989) brought to light that the common attitudinal features of attempters were wanting relief of affective strain, escape from life problems and a cry for help, reflecting the absence of a true desire to die.

Hall and Platt (1999), study of 100 patients who made suicide attempts found that severe anxiety, depressed mood, recent loss of an interpersonal relationship, abuse of alcohol or illicit substances coupled with feelings of hopelessness, helplessness, worthlessness, insomnia and inability to maintain a job were excellent predictors of suicidal behavior.

Eddins and Jobes (1994), in their investigation in comparing the perceptions of clinicians and attempted suicide patients on the dimensions of suicidality, found that both clinicians and patient independently have similar perceptions based on the dimensions provided except for agitation/emotional upsetness which was underr

by clinicians. As Shneidman (1985) suggested that perturbation (agitation/emotional upsetness) is a lethal force behind suicidal act and that it need to be addressed before the patient can be considered safe from further acts of suicide, it is a course of concerned if clinicians underrated this factor. This is because by underrating it, they may not be able to reduce the agitation and emotional upsetness of the patient, thus being an ineffective care provider. (Eddins and Jobes, 1994). The other three dimensions in the research are psychological pain, external pressure/stressors and self-regard and hopelessness.

Simonds, McMahon and Armstrong (1991), carried out their research in Lubbock, Texas. In their research they compared 15 suicide attempters aged 16-30 with 61 persons in a normal control group. The findings indicated that those who attempted suicide were significantly more hopeless, depressed, and hostile. Furthermore, their suicide attempts suggest a response to stress and a diminished sense of confidence in their ability to improve their life situation. Because of the findings, the authors proposed that intervention should emphasize problem solving skills, with the focus of reducing anger, resolving interpersonal conflict and developing the attempters sense of self-esteem and self-control.

The effectiveness of teaching suicide attempters with problem solving skills was also evident in another study that was carried out by Salkovskis, Atha and Storer (1990) in Oxford, England. In the study of 20 patients who are at high risk of repeated suicide attempts, 12 of them (mean age 26.4 years) were taught cognitive-behavioral problem solving skills, like how to identify problems, generate solutions, and realize goals with an emphasis on flexibility. This group showed improvement on ratings of depression, hopelessness suicidal ideation and target problems at the end of the

treatment and at follow-up at one year in comparison to the balance 8 controls (mean age 28.5 years) who were treated according to the normal control condition.

With reference to abuse and suicidality, there is a direct correlation between suicide and physical abuse. Bryan and Range (1995), study of 182 women showed that when comparing non-abused, physically abused and sexually abused women, those who are sexually abused are at the greatest risk for suicide and those who are physically abused are more so than non-abused. Further, Cohen et al., (1996) found that severely sexually abused adolescents tend to use negative coping strategies more often than those not sexually abused. A research executed in Norway from 1988 to 1993 covering 2068 episodes of attempted suicide involving 1543 persons showed that in comparison to males, young female attempters often reported family problems and more often had been victims of violence and sexual abuse and suicidal behavior among family or friends. In addition young people of both sexes were more often unemployed and abused drugs (Hjelmeland and Bjerke, 1996).

Stiffman (1989) who explored suicidal behavior among 291 adolescents using runaway shelters in St. Louis, found 30 % of the youth reported having attempted suicide. Attempters are seen to have more significant behavioral and mental health problems, and have more family or friends with problems than non-attempters.

Suicide studies in Muslim countries

As regard to suicidal behavior in the Muslim population, a study was carried out by Daradkeh and Al Zayer (1988) in the industrial Eastern Province of Saudi Arabia during 1985 and 1986. The objective was to examine the suicidal behavior among the Muslims, where Islam forbids the act of taking one's life. The research

refuted the hypotheses that suicidal acts are rare among the Muslims. It was discovered that the rate of attempted suicide was found to be at 20.7 per 100 000, substantially lower than the reported rates in the West, although the researchers claimed underreporting and misdiagnosing could have lowered the rate. Similar to findings elsewhere, the study confirms that the act is predominantly female orientated. Faced with interpersonal problems with spouse or parents, leading them to acute stress and depression, these women mostly resorted to self-poisoning.

Medical records of 185 suicide attempters from January 1990 to May 1993 in Turkey by Cosar, Kocal, Arikan and Isik (1997) again showed that single females represented a high proportion of suicide attempters. Drug overdose was the most common method of suicide attempt, while precipitating factors for the act were similar to the above (Daradkeh and Al Zayer, 1988). While 105 subjects (56.7%) attempted suicide for the first time, about 80 subjects (43.3 %) have done it more than once. Moreover, it was found that a family history of suicide was detected in 38.3 % of the subjects (38 females and 33 males) and 19.4 % had a family history of psychiatric disorder.

While it was found that suicidal acts were present in Islamic countries despite it being forbidden by the religion (Cosar et al., 1997; Daradkeh and Al Zayer, 1988), it was discovered that the rate of suicide falls during the month of Ramadhan. Daradkeh's work in Jordan, to find out the impact of suicide during religions events, found that there was a significantly lower rate of attempted suicide reported during Ramadhan than during the month preceding or the month following Ramadhan (Daradkeh, 1992). The author explained that the reason could be attributed to the

strengthening of family bonds and a sense of belonging during Ramadhan, thus diverting the distress from suicide act in solving their problem.

Suicide studies in Malaysia

In the local scene, Deva Dass (1977) in the study of 50 attempted suicide patients at University Hospital, Kuala Lumpur postulated that the psychodynamic motivators involved in suicide attempts were:

1. To inflict emotional pain and to force attention or affection.

For this group there is minimal suicidal intent, and that the objective of the behavior was more of a manipulation of the environment to achieve their end.

2. Loss or threatened loss of loved object

This group has a higher suicidal intent. While they have a high need to establish attachment, they lack the skill, while at the same time faced a difficulty in expressing anger.

3. Guilt – These are predominantly schizophrenics whose psychotic illness has remitted. They are subjected to depression and alienation. The feeling of guilt is a motivating factor especially when they exhibited overt hostility to parental figures and felt rejected in an ambivalent relationship.

Murugesan and Yeoh (1978) studied the demographic and psychotic aspect of 96 cases of suicide attempt in the Klang government hospital. He found that the young individual, female and singles have a higher frequency of suicide. This seems to match with reported studies elsewhere (Stengel, 1958). It also indicated that a much higher rate of attempted suicide occurred in the Indian population involving single Indian females, and that the attempts were due to the objection of parents to

their relationships or conflicts in their roles in the family. These attempted suicides are not seen as a cry for help, but as a scream of anguish and despair against the demands of the family, with the eventual consequence of a change of attitude towards her. This research also determined that 83% of the attempted act were within a domestic surrounding and out of the 75 cases (81%) that were executed from the home, none locked the doors of the room where the attempt was made. This could imply that the intention to be discovered was high.

Chia (1990), in a study of 176 patients who were admitted to the General Hospital in Kuala Lumpur from August 1989 to November 1989 found that the incidence of suicidal act was 0.9 % for the three month period with a sex ratio of 1:2.38 with a female predominance. While 71% were within the 16 - 35 age range, the majority were within (27.3%) the 21-25 years of age. With regard to the type of work, 44.4% were manual workers and 24% unemployed (including housewives). In terms of education, 95% had primary to secondary education, while higher proportion of Indians receive only primary education. The high incidence of manual workers, unemployment and lower education level of attempters could be explained by the fact that this is a government hospital catering for the lower income group. The reasons for the attempt given by the 124 patients that completed the interview were that, 105 admitted the act was for the purpose of self-harm, nine did it with the objective of relieving pain and discomfort while 5 claimed accident. It was interesting to note that a higher proportion of Malays (five) denied suicidal intention, claiming the act as accident. This could be because of the religious taboo on suicide. The balance five patients were psychotic. Ninety percent choose self-poisoning as the method used, with a high proportion used chemicals at 55.4%. There is an increasing trend in the

use of analgesics at 30.8 percent compared to Murugesan's study showing a 0.6 % (1976). Out of the 124 patients, 14.6 % or 18 of the patients had made previous attempt.

Simons and Sarbadhikary (1978) in a demographic and psychosocial study of 94 patients out of the first 504 admissions from University Hospital, Kuala Lumpur, found that suicide attempters were mostly female. Moreover, the research concluded that suicide attempters had been English educated, and a great number had completed some Forms although not Form VI. This could imply that attempters come from a group with higher aspirations than non-suicide attempters, however were ineffectual in achieving it. Another interesting finding was that suicide attempters were readmitted more often than other patients were.

Haq and Bunrich (1980) found that 73% of the young (15-31 years old) were identified as suicide attempters. In the study 70 % of the single females gave being rejected or jilted as the main reason for their act. They also noted a rising incidence of attempted suicide among the Malays.

Yeoh (1981) described the characteristics of patients who attempted suicide in the General Hospital in Penang. Similar to Murugesan and Yeoh (1978), he found the Indian population overly represented while the Malays were underrepresented. The research revealed a high incidence of attempted suicide among Indians, the younger age group, the females and the singles. He noted that conflict with elders were more frequent among females, suggesting that they were faced with a greater degree of role conflict. He also mentioned an association of attempted suicide with urban migration.

The primary reasons for attempting suicide as described by using the 271 parasuicidal patients from General Hospital, Kuala Lumpur, in order of frequency,

Husain Habil, Ganesvaran and Suganthi (1992/1993) research on the psychosocial data of 296 patients found that suicidal behavior is more common among the young and especially among the females. Consistent with previous studies done in Malaysia, the high-risk group seems to be the Indian population, the young and females. It was also found that 71% of attempters come from the lower social class. Comparable to previous studies done locally and foreign, self-poisoning prove to be the commonest method in attempting suicide. (Murugesan and Yeoh, 1978; Yeoh, 1981; Kok, 1986 ; Hussain Habil, 1995; Jae,1992; Fan, Li, Wang and Zhang,1992). Using the Pierce's Scale it was identified that two thirds of the patients had an intention score of less than 10 on the scale. The author elaborated two possible reasons for the low intent scale – one being the nature of acute situational reaction depression experienced by them, which could have been reduced by reassurances received after the attempt. The alternative being that the attempt could actually mean that many of them attempt suicide as an appeal to get help, or in other words as a “cry for help”, hoping to get attention rather than with the intention of killing themselves.

In another research Hussain Habil (1995) found that out of 99 patients who attempted suicide, 67 % of them, with the average mean of once a month, visited a primary healthcare doctor prior to the attempt. Their complaints are mainly of physical symptoms rather than the actual psychosocial conflicts which lead them to suicide. This finding confirms that those who have suicidal intentions make contact with medical doctors prior to their attempt (Isometsa et.al., 1995). This would reflect the need for greater awareness and training among doctors to equip them with the ability to detect and recognize those who are of high risk.

While research on the different demographic, social-cultural and psychosocial factors had been carried out among the suicide attempters, this research will focus on understanding the individual person, her emotions and thoughts at the time of the attempt. An additional focus will be to determine the underlying factors that predispose the person toward suicide, so that remedial actions can be carried out before the actual attempt.