Suicide Prevention Measures are Necessary Ingredients of Public Health. Are we Failing in this Regard?

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***"For if society lacks the unity that derives from the fact that the relationships between its parts are exactly regulated, that unity resulting from the harmonious articulation of its various functions assured by effective discipline and if, in addition, society lacks the unity based upon the commitment of men's wills to a common objective, then it is no more than a pile of sand that the least jolt or the slightest puff will suffice to scatter."* – Émile Durkheim**

Another young Bollywood actor has ended up taking his life. Outwardly, he had appeared stoic and wore a cheerful disposition and none of his kin were able to appreciate the inner turmoil he must have been going through for some time which finally convinced him that he would be unlikely to emerge from the throes of hopelessness that had engulfed him. I am reliably advised that he was a very popular actor with a massive fan following, and had through sheer hard work ensured himself a very salubrious lifestyle in one of the posh localities in Bombay.

I was reminded of a very big movie icon from Hollywood viz. Marilyn Monroe who had seemingly everything going for her when she committed suicide in 1962. I recall the whole world was in a state of shock. Two years later, perhaps the most promising film-maker in India who had also built up a reputation as an excellent actor fatally overdosed himself. Tragic though it was, in his case it was not considered unexpected as he was known to have had repeated bouts of melancholia which had resulted in at least two previous suicide attempts. The year was 1964 and mental health was perhaps right at the bottom of national priorities. I do not remember any discussion at the time as to why no preventive measures were taken by the kin when it was established that he was a high risk patient.

Decades later, when I was in the United States, I read reports about a 19 year old very promising Bollywood starlet who committed suicide by jumping from a building. There probably had been other instances in the intervening period but immediately on my relocation back to India after more than three decades, I witnessed a news item on the television about another Bollywood starlet who had committed suicide.

It is certainly nobody's case that the entertainment industry is alone in being at a very high risk. Other professions like journalism also have a very high risk of mental health problems. The medical profession, in particular the psychiatrists, have a very high incidence of suicide which has raised a lot of concern worldwide.

What has become very obvious is that we have not given mental health issues the priority they deserve. And that is a matter of serious concern for all of us. While this apathy is global, it is much more pronounced in India. And if this unfortunate young boy's death triggers a national debate, at least some positivity would have emerged from this tragedy.

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Figures in India are hard to come my but I shall reproduce the information from the Centre for Disease Control in the United States:

- Every day, approximately 105 Americans die due to suicide
- Overall suicide rates increased 28% from 2000 to 2015
- One person dies by suicide every 12.3 minutes in the United States
- There is one completed suicide for every 25 attempted suicide attempts
- In the elderly, there is one suicide for every 4 attempted suicide attempts
- Suicide is the 10th leading cause of death in the United States across all ages

I refuse to believe that the situation is any better in India - rather it would not come as a surprise if it is much worse. I have been in the profession for almost 45 years and have spent two years researching on suicide in the early stages of my career. I can therefore state with a degree of confidence that the incidence of suicides can be substantially reduced if some very elementary precautions are exercised.

We need to bear in mind that more than three-fourths of those who have completed suicide have been known to give out signals to their kin. The trouble though is that in almost all cases, these signals are cryptic and not generally deciphered by those who receive them as a serious cry for help. It is at this stage we need to indulge in massive public education programme. Simultaneously we need to have voluntary services like the Samaritans in the West readily accessible. I know there are helplines which can be approached but they have not be publicized and most of my patients in my mofussil town remain unaware of them. A few of them do provide competent counseling but they are certainly not as widespread and accessible as they ought to be.

Mental disorders play an overwhelming role in the increased risk of suicide—with estimates suggesting up to 90% of individuals who take their own life suffer from some type of psychiatric disorder. Risk of suicide for individuals suffering from mental disorders drastically decreases once admitted to treatment. The mental disorders with the greatest prevalence of suicide risk associated with them include major depressive disorder, bipolar disorder, schizophrenia, personality disorders, post-traumatic stress disorder, and eating disorders. Individuals suffering from major depressive disorder and bipolar disorder are at the highest risk of suicide—with risk of suicide increasing 20-fold. Behind major depressive disorder and bipolar disorder, substance abuse ranks as the second-highest risk factor for suicide. Statistics indicate that alcoholism is present at the time of death in up to 61% of completed suicide cases. Heroin and cocaine use is also a common risk factor for suicide, with heroin users having a 14-fold greater risk of suicide and cocaine users having a higher risk of suicide during withdrawal drug use. Cannabis use has not been found to increase suicide risk among users. Genetics is thought to play a role in risk of suicide—such that a family history of suicide tends to indicate an increased risk of suicide among other family members—accounting for up to 55% of suicidal behaviors. Family history of mental disorders and substance abuse is also a risk factor for suicide.

But to make a real difference, we have to understand that attempted and completed suicides do not form a homogeneous group. It is this very crucial point that rarely comes up in contemporary debates although it has been thoroughly researched for nearly 125 years. The French sociologist Emile Durkhiem provided us guidelines which are still very useful in understanding suicides. He broadly identifies four types of suicides:

- Egoistic suicide corresponds to a low level of social integration. When one is not well integrated into a social group it can lead to a feeling that they have not made a difference in anyone's lives.
- Altruistic suicide corresponds to too much social integration. This occurs when a group dominates the life of an individual to a degree where they feel meaningless to society.
- Anomic suicide occurs when one has an insufficient amount of social regulation. This stems from the sociological term anomie, meaning a sense of aimlessness or despair that arises from the inability to reasonably expect life to be predictable.
- Fatalistic suicide results from too much social regulation. An example of this would be when one follows the same routine day after day. This leads to a belief that there is nothing good to look forward to. Durkheim suggested this was the most popular form of suicide for prisoners.

It is abundantly clear that different types of suicides would require different measures and this rarely comes across in any of the discussions I notice in the print media or the television. Those with identifiable mental illnesses would require treatment for those conditions after crisis intervention. And it is the crisis

intervention services that are in short supply in India. They could make a very meaningful difference and open the doors for further management after diffusion of the crisis.

Childhood and adolescent suicides are a very real problem in India and we need to equip the mental health professionals with special skills.

Cognitive Behavioural Therapy and Dialectical Behaviour Therapy have been found to be very helpful in a crisis of this nature. The sad part is that they are almost completely lacking in India. The very cognitive therapists we have are all located in the major metropolitan cities, and almost all of them are in private practices and never a part of the public hospital setup. While there has been a commendable effort to increase the number of psychiatrists, there has been no commensurate effort to increase the number of clinical psychologists who generally train as cognitive therapists so essential in a mental health setup. And I am yet to come across a dialectical behavior therapist in any center outside Bangalore and Delhi.

These are matters of serious debate. And given the magnitude of the problem and its potential consequences, the sooner we attend to it the better. We are in no position to afford such a colossal waste of human life and talent.

— *This is a guest editorial. Views expressed are of the author's own.*

Bibliography:

- Judith S. Beck. "Questions and Answers about Cognitive Therapy". About Cognitive Therapy. *Beck Institute for Cognitive Therapy and Research*. Retrieved 2008-11-21.
- Dohrenwend, Bruce P. (1959). "Egoism, Altruism, Anomie, and Fatalism: A Conceptual Analysis of Durkheim's Types". *American Sociological Review*. 24 (4): 473.
- Durkheim, Emile (1897) [1951]. Suicide : a study in sociology. *The Free Press*. ISBN 0-684-83632-7.
- Pearce, F. (1987). A reworking of Durkheim's suicide. *Economy and Society*, 16, 526-567.
- Peck, D. L. (1981). Towards a theory of suicide: The case for modern fatalism. *Omega*, 11(1), 1-14.
- Perfetti, A. R. (2018). Fate and the clinic: A multidisciplinary consideration of fatalism in health behaviour. *Medical Humanities*, 44(1), 59.
- Preventing suicide factsheet : *Center for Disease Control* (Link: https://www.cdc.gov/violenceprevention/pdf/Suicide-factsheet_508.pdf)
- Zalewski, Maureen; Lewis, Jennifer K; Martin, Christina Gamache (June 2018). "Identifying novel applications of dialectical behavior therapy: considering emotion regulation and parenting". *Current Opinion in Psychology*. 21: 122–126.

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