International Journal of Medical and Health Research
ISSN: 2454-9142
www.medicalsjournals.com
Volume 1; Issue 4; November 2015; Page No. 119-121

Don't commit suicide- A suggestion by attempters after a suicide attempt

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Abstract
Aims: The decision to commit suicide could be the result of faulty decision arising out of emotional dysregulation or cognitive distortion that is often experienced before an attempt. Following an attempt they often review the appropriateness of their decision and action, based on direct experience. This study was conducted to examine the views of attempters about others suicide attempt.
Subjects and Methods: This was a cross sectional hospital based study.one hundred and nine consecutive patients admitted for a suicide attempt were recruited after recovery with treatment, before they were discharged and assessed with Socio-demographic and clinical proforma designed for this study and Pierce suicide intent scale (PSIS) and a questionnaire for their views about others suicide.
Results: Contrary to their act, ninety eight percent of patients opined against committing a suicide attempt and Hindu religion status statistically significantly predicted this response.
Conclusions: It may concluded that contrary to their act, suicide attempter feels that others should not commit a suicide attempt

Keywords: Suicide attempt, suicide attitude.

1. Introduction

According to Shneidman, a person decides to commit suicide in order to get rid of psychological pain [1]. Such decision is often mediated by underlying cognitive distortion and emotional deregulation [2], [3]. Commonly reported cognitive distortion are distorted contents (e.g. faulty beliefs and schemas), modes of thinking (e.g., negativity, rigidity, irrationality), emotional tone of cognitions (pessimism, threats, catastrophization), and thought processes (e.g., negative attributions, faulty generalizations, illogical conclusions, faulty reasoning, memory distortions and selectivity, and difficulties in producing alternatives [4]. These cognitive distortions develop due to adverse social life event, psychiatric illness and physical illness and may change after an attempt [5]. People often review the appropriateness of their decision and action after direct experience (suicide attempt) [6]. There is indirect evidence to suggest that cognitive distortion may improve after a suicide attempt. Following an attempt they often feel guilty and realize that their suicide attempt could have prevented [5], [7]. Studies on such attitudes toward suicide are of great interest to researchers worldwide. However, research have focused more on the general population and remained unexplored among attempters. Understanding the status of attitude towards a suicide attempt after an attempt may have therapeutic and preventive implication. This exploratory study was undertaken to examine the views of attempters about others suicide attempt with a hypothesis that their view will be against a suicide attempt.

2. Materials and Methods

This cross-sectional, hospital-based study was done at a tertiary care centre in south India after the approval of the Institutional Ethical Committee. One hundred and nine consecutive patients admitted for a suicide attempt between September 2009 till June 2010 in the Intensive Care Unit were recruited after recovery with treatment, before they were discharged. Both male and female, who were aged between 16 -70, with a severe suicide attempt (Suicidal attempt requiring significant medical treatment or likely to cause severe injury /death or associated with permanent medical sequelae) ≤ 15 days of assessment (for better recall accuracy) were included. Due to the reliability issue subjects with an ICD 10 diagnosis of dementia or mental retardation, presence of any psychotic symptoms or any condition associated with the significant impaired cognitive function during the attempt or unable to provide reliable information about their suicidal behaviour were excluded from this study. Subjects were also excluded if they were suffering from treatment resistant psychiatric disorder, severe physical illness, or terminal physical illness.

The study did not interfere with the ongoing treatment by the physician, and all participants were received psychological intervention as per hospital protocol for suicide prevention. Out of one hundred sixty eight patients, one hundred nine met the selection criteria, and included in this study after obtaining informed consent. All included patients were assessed with Socio-demographic and clinical proforma designed for this study. Severity of the intent of the last suicide attempt was assessed with Pierce suicide intent scale (PSIS) [8] and their views about others suicide is assessed with a questionnaire that state that "what is your suggestion for those contemplating a suicide attempt- 1) Don't commit suicide, 2) Agree with them". Statistical analysis was done using SPSS vs. 16.1. Descriptive data were expressed with frequency, percentages, mean and standard deviation. Kruskal-Wallis Test was carried out to find out the group difference of demographic variables on the score of (for or against) others suicide. Dummy variable Hindu and non-Hindu was created and linear regression analysis was done to know if they predict the subject response about others

suicide attempt. Statistical significance was denoted with p values. (That was fixed to 0.05 and 0.01 levels).

3. Results

The study sample has a mean score of 23.26 (SD±3.93) on PSIS. Those who suggested that others should not commit suicide were comprised of 98% of the sample and had a mean score of 23.30 (SD±3.96) on PSIS. They were more likely to be below 39 years of age, self-employed/employed, educated, Hindu, used poison for their suicide attempt and did not have any concurrent medical diagnosis or family history of suicide (Table 1).

Table 1: Suggestion about others suicide

Patient suggestion for other suicide	n	%
Should not commit suicide	107	98.2
Should commit suicide	2	1.8

On Kruskal-Wallis Test subject with different religion had a different opinion about others suicide attempt that reached a statistically significant level (p=.002) (Table 2).

Table 2: Sociodemogrphic and clinical relationship of Subjects suggession about other suicide

Variables		n	Mean rank	χ^2	df	Asymp. Sig.
Age	Early adult <39	96	55.43	3.555	2	.169
	Middle adult 40-59	11	51.05			
	Late adult > 60	2	56.00			
Gender	Male	54	56.00	1.982	1	.195
	Female	55	54.02			
Marital status	Unmarried	54	54.99	.000	1	.990
	Married	55	55.01			
Occupation	Self-employed/employed	61	54.21	1.588	1	.208
	Unemployed	48	56.00			
Socioeconomic status	Lower socioeconomic status	43	54.70	.349	2	.840
	Middle socioeconomic status	53	54.95			
	Upper socioeconomic status	15	56.00			
Residence	Rural	53	54.97	.002	1	.969
	Urban	56	55.02			
Education	Illiterate	20	56.00	.454	1	.501
	Educated	89	54.78			
Religion	Hindu	104	55.48	9.512	1	.002
	Muslim	5	45.10			
Method	Poisoning	103	54.94	.118	2	.943
	Hanging	4	56.00			
	Wrist Cutting	2	56.00			
Psychiatric diagnosis	No diagnosis	58	55.06	.008	1	.927
	Currently mental illness present	51	54.93			
Medical diagnosis	No diagnosis	104	54.95	.097	1	.755
	Medical illness present	5	56.00			
Family history of suicide	No family history of suicide	99	54.90	.204	1	.652
	Family history of suicide present	10	56.00			

On further analysis (linear regression analysis). A Hindu religion status significantly positively predicted an opinion of "don't commit suicide" while non-Hindu status negatively predicted the same opinion (Table 3).

Table 3: Relationship of religion on the score of don't commit suicide

	Model Variables		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
			B	Std. Error	Beta		
1	1	(Constant)	.800	.058		13.829	.000
		Hindu	.190	.059	.297	3.215	.002
2	1	(Constant)	.990	.013		78.080	.000
		Non-hindu	-.190	.059	-.297	-3.215	.002

Dependent Variable: don't comit suicide
R^2=.088, F=10.334, p=.002.

4. Discussion

Contrary to their act, ninety eight percent of the participants opined that others should not commit suicide. Such observation may be due to difference in mental state during and after a suicide attempt, when they probably evaluated the appropriateness of the act based on direct experience or improvement in cognitive distortion leading to changes their view [5], [6]. An impulsive attempt is common among educated Indian adult, as they are more vulnerable to pressure of achievement/ carrier or interpersonal issues [9]. Emotional exacerbation / dysregulation are common before an attempt, which can interfere with rational and advantageous decision making, and increases the focus on the immediate interest [3]. Socio-cultural protective factors such as social connectedness and social support, intact family or married and having children may also have influenced the perception after an attempt [10].

Indian culture considers it inappropriate / wrong to take a life (self or others) that might also mediate the view change when they found it in conflict with their culture [11]. Due to ease of availability administration and accessibility, the poison is commonly used for suicide attempt [12]. We could not find any group difference between those suggested for or against committing suicide. The main reason appears to be less number of participants (2 vs. 107) who opined for a suicide attempt that might have resulted in such statistical finding. Relationship of religion and perception about others suicide in this study does not appear to be straight forward as numbers of non-Hindus were small. Most religion's emphasis that only God should have the right to dictate the end of life of a person and suicide attempt is considered as a sinful act and condemned. Hindus have a socialization practice that promotes pro-social behaviour and their scripture emphasis that death by suicide does not lead to achievement of salvation (Moksha) [13]. It also brings dishonour to the entire lineage, social stigma and other consequences [14].

With this study finding it can be concluded that, contrary to their act, suicide attempter feels that others should not commit a suicide attempt. The limitations of this study were the small sample, less number of non-Hindu participants and data collected at a tertiary centre.

5. References

1. Shneidman ES. Suicide as psychache. J Nerv Ment Dis. 1993; 181:145-147.
2. Chesley K, Loring-Mcnulty NE. Process of Suicide: Perspective of the Suicide Attempter. J Am Psy Nurses Asso. 2003; 9(2):41-45.
3. Chapman AL, Dixon-Gordon KL. Emotional antecedents and consequences of deliberate self-harm and suicide attempts. Suicide Life Threat Behav 2007; 37(5):543-52.
4. Orbach I. Self-Destructive Processes and Suicide. Isr J Psychiatry Relat Sci. 2007; 44(4):266-279.
5. Ram D, Darshan MS, Rao T, Honagodu AR. Suicide prevention is possible: A perception after suicide attempt. Indian J Psychiatry. 2012; 54:172-6.
6. Gąsiorowski J, Rudowicz E. Expectations, experiences, and attitude change during medical school: through the eyes of Polish medical students. Teach Learn Med. 2014; 26(3):217-24.
7. Scocco P, Corinto B, Pavan L. The aftermath of a suicide attempt: the emotional Impact on patient and psychiatrist. A pilot study. Clinical Neuropsychiatry 2008; 5(5):240-244.
8. Pierce DW. Suicidal intent in self-injury. Br J Psychiatry. 1977; 130:377-85.
9. Singh P, Solanki RK, Bhatnagar PS. BIS-11A -Hindi version: A preliminary study of impulsivity in rural and urban Indian adolescents. Indian J Psychiatry. 2008; 50:96-9.
10. Maris R. Suicide. The Lancet 2002: 360:319-326.
11. Nebhinani N, Mamta, Gaikwad AD, Tamphasana L. Nursing students' attitude toward suicide prevention. Ind Psychiatry J. 2013; 22(2):114-7.
12. Logaraj M, Felix JW, Vedapriya DR. Attempted suicide in adolescents reported at a medical college hospital in Tamilnadu-some observations. Indian J Prev Soc Med. 2005; 36:68-72.
13. Miller JG, Bersoff DM, Harwood RL. Perceptions of social responsibilities in India and in the United States: Moral imperatives or personal decisions? J Pers Soc Psychol, 1990.
14. Yadwad BS, Gouda HS. Is attempted suicide and offence? J Indian Acad Forens Med. 2005; 27:108-11.