Review Article

Suicide Prevention: A Resource for the Family

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The family can play an important role in the prevention of suicide if it is capable of aiding the mental health care services in the early detection and management of family members at risk. In order to attain that goal the whole family should be qualified and rid of some myths associated with suicidal behavior. Some scientific criteria which should be taken into consideration by the family in order to prevent suicide among its members will be explained.

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Suicide ranks as the eighth to 12th leading cause of death for all ages combined in most countries for which information is available throughout the world (1-5). The family can play an important role in its prevention since it is an avoidable cause of death (4-7). In order to be able to prevent suicide among its members, the family should rid of some myths associated with suicidal behavior.

Myths can be defined as culturally accepted criteria which are rooted in the minds of the people and do not reflect any scientific truthfulness because they are wrong judgments concerning suicide and the suicides. Such myths ought to be removed if people at risk, are to be helped.

Myths tend to justify their advocates' attitudes and become a hindrance in the prevention of suicide. There are many myths in relation to suicide. Let us look into some of them, not all, of course. We will also explain some scientific criteria which should be taken into consideration from now on by the family in order to prevent suicide among its members.

1. Myth: He who wants to do away with his life will not say so.

The wrong criterion leads to not paying attention to people who express their suicide ideas or threaten with committing suicide.

Scientific criterion: Nine out of ten people, who committed suicide, had expressed their purposes clearly and the tenth person hinted his /her intentions to put an end to his/her live.

2. Myth: He, who says he will do it, will not.

Wrong criterion: suicide threats are not taken seriously because they are taken as blackmail, manipulation, bluff, etc.

Scientific criterion: Every person who commits suicide announces with words, threats, gestures or changes of behavior what is about to happen.

3. Myth: A person who will commit suicide does not give any hints about what he/she is up to.

Wrong criterion tries to ignore the prodromic manifestations of suicide.

Scientific criterion: Every person who commits suicide announces with words, threats, gestures or changes of behavior what is about to happen.

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4. Myth: He who attempts suicide is a coward.

Wrong criterion tries to avoid suicide by attributing this kind of behavior to a negative personality trait.

Scientific criterion: Those who commit suicide are not cowards but people who suffer.

5. Myth: He who attempts suicide is a courageous person.

Wrong criterion tries to attribute the suicide behavior to a positive personality trait. This criterion hinders suicide prevention because this kind of behavior is justified since it is considered synonymous to bravery, an asset that everybody would like to possess.

Scientific criterion: Those who attempt to commit suicide are neither brave people nor cowards; since bravery and cowardice are personality traits which can not be quantified or measured by the number of times you kill yourself or decide to give yourself another opportunity.

6. Myth: Asking a person at risk if he/she has thought to commit suicide may stimulate him/her to do it.

Wrong criterion instills fear to speak about the topic of suicide with people who are at risk of committing it.

Scientific criterion: It has been proven that talking about suicide with a person at risk does not stimulate the idea but instead contributes to reduce the likelihood of the act and it may be the only possibility offered by the subject for analysis of his/her self-destructive purposes (8,9).

In addition to these myths about suicide, the family should also learn about suicide risk groups.

Suicide risk groups are groups of people who according to their particular characteristics may be at greater risk of committing suicide than those who are not included in such groups. Major suicide risk groups are:

a. the depressed
b. subjects who have had previous suicide attempts
c. subjects who have had suicide ideas or have threaten to commit suicide
d. survivors
e. vulnerable subjects facing a crisis (1)

Let us describe each group briefly.

a) The depressed- Depression is a common disease related to people's moods. The most common symptoms are sadness, lack of motivation to do things, lack of will, desire to die, multiple somatic complaints, suicidal ideation, suicidal acts, sleep and appetite disorders, and carelessness about personal hygiene.

Some characteristics of adolescents' depressive pictures:

1. they tend to be more irritable than to be sad
2. fluctuations of their affective behavior is more frequent, in comparison with adults whose moods tend to be more stable
3. hypersomnia is more frequent than insomnia
4. they are more likely to complain of physical symptoms when they feel depressed
5. they are more prone to exhibit episodes of violence and antisocial behavior as a manifestation of mood disorders, in comparison with adults
6. they may show risky behaviors such as alcohol or drug abuse, driving motor vehicles at high speeds sober or drunk
7. the likelihood of committing suicide is higher in adolescents than in adults in similar situations

In the elderly depression can appear disguised as:

I. Depression as normal aging.

In this case, the old person loses interest in the things he/ she used to like most, lacks vitality and willpower, tends to revive the past,loses weight,suffers from sleep disorders, complains about memory impairment, and has a tendency to live isolated so he/she spends most of the time in his/her bedroom. (for many people this picture is a normal behavior of old people and not a tractable depression).

II. Depression as abnormal aging.

In the elderly, different degrees of disorientation to time, place and person may be present, they confuse people they know, they are not able to recognize places; there is deterioration of their abilities and habits, sphincter relaxation appears, i.e., the old person urinates and/ or defecates uncontrollably; they may present gait impairments that resemble cerebrovascular disease; they suffer from behavior disorders, for instance, they refuse to be fed, etc. (for many people this picture is consistent with irreversible dementia and not a tractable depression).

III. Depression as physical, somatic or organic disease.

Old people complain of multiple physical symptoms such as headache, backache, chest pain or pain in the legs. They may also complain of digestive disturbances such as slow digestion, heartburn, or abdominal bloating even without having eaten anything. They take laxatives, antacids and other medications to get relief for their gastrointestinal disturbances, they complain of losing their taste sensation, they lack appetite, they lose weight, they have cardiovascular problems such as palpitations, oppression, breathlessness, and etc. (for many people this picture is consistent with a somatic disease and not a tractable depression).

IV. Depression as a non-depressive mental disease.

Old people often have the feeling that someone is watching or following them, that someone wants to kill them or that everybody is talking about them. When they are asked, why they think so; they answer that they deserve it because “they are the worst human beings on earth”, “the greatest of all sinners”, and similar expressions that show depression.

V. Depression as a depressive mental disease.

It is characterized by:

- a depressive state of mind most of the day or everyday
- marked reduction of pleasure or interest for all or most of their daily activities
- loss of weight without going on a diet or weight gain of about 5%
- daily insomnia or hypersomnia
- psychomotor agitation or retardation
- daily fatigue or lack of energy
- inappropriate feelings of guilt which may lead to guilt delusion
- decreased capacity to think or to concentrate and hesitancy during most of the day
- recurrent thoughts of death or suicide(10)

As we can see, it is not wise to infer that any symptom presented by old people is due to their oldness and the ailments that characterize that period of life to dementia or to a physical illness. Those can be manifestations of a tractable depression and, consequently, vitality and the remaining compromised functions can be recovered. If depression is not properly diagnosed, it can become chronic and it may lead to suicide (11-13).

b) Subjects who have had previous suicide attempts.

According to some studies, 1 to 2% of those who had had a suicide attempt committed suicide during the first year that followed the attempt and 10 to 20% of them did it during the rest of their lives.

c) Subjects who have had suicide ideas or have threatened to commit suicide.

Having suicide ideas does not necessarily lead to committing suicide. Several studies have reported individuals who had had suicide ideas during their lives and never experienced a self-aggression. However, when suicide ideas appear as a symptom of mental disorder and they are accompanied by a high suicidal tendency, an increasing frequency, and a detailed planning in circumstances that favor the act, the risk of suicide is very high.

d) Survivors.

Survivors are those people who have very close affective links with a person who dies as a result of suicide. Among the survivors are relatives, friends, mates, and even the

doctor, psychiatrist, or any other therapist who attended to the deceased.

e) Vulnerable subjects facing a crisis.

This group includes mainly non-depressed mental patients such as schizophrenic and/or alcoholic patients, drug addicts, anxious people, people with personality disorders, and those with impulse control disorders. This group also includes individuals who suffer from a terminal, malignant, painful or disabling physical illness which jeopardizes their quality of life.

This group also includes certain groups of individuals such as ethnic minorities and immigrants who are not able to adapt themselves to the receiving country, the relegated ones, those who have been tortured or have been victims of violence in any of its manifestations(14,15).

When those individuals face a conflict or a significant event beyond their capacity to solve problems, they tend to resort to suicide. When subjects from any risk group are in crisis, they may communicate their suicide intentions in different ways. For instance, the subject may threaten to commit suicide or say that:

- he/she wishes to kill himself/herself
- he/she wants to die
- other people would feel better if he/she did not exist
- it is preferable to be dead than alive
- he/she has had bad ideas
- the rest of the people will not have to stand him/her any longer
- he/she does not want to live
- it is preferable to be dead than to live his/her life
- he/she has thought to put an end to his/her life
- his/her life should not be lived
- he/she does not want to be a burden for other people
- his/her life is not worth being lived
- he/she would like to fall sleep and not to wake up ever more
- he/she is tired of living (16,17)

When the family becomes aware of the many different forms of suicide communication, they should learn to identify the situations that can lead to suicide risk in order to increase family support. Among these situations are the following:

I. In childhood:

- watching painful events(domestic violence)
- familial rupture
- the death of a beloved person who provided emotional support
- living with a mentally- ill person as the only next of kin
- having been scolded in a humiliating way

II. In adolescence:

- facing a troubled love relationship
- having a faulty relationship with significant figures (father, mother, or teacher)
- parents' expectations and demands beyond the reach of adolescents' capacities
- unwanted pregnancies
- concealed pregnancies
- examination periods
- having friends who exhibit a suicidal behavior or consider suicide as a way to solve problems
- love disappointments
- the hustle and bustle phenomenon
- having been scolded in a humiliating way
- sexual abuse or harassment perpetrated by significant figures
- loss of significant figures as a result of marriage breakage, death or abandonment
- examination periods
- periods of adaptation to military regimens or boarding school systems
- awareness of serious mental disease

III. In adulthood:

- unemployment (during the first year)
- having a competitive wife in some machista cultures
- public personalities involved in sexual scandals (politicians, religious people, etc.)
- bankruptcy
- recent psychiatrist hospitalization
- hospital discharge with a serious mental disease

IV. In old age:

- initial period of institutionalization

- first year of widowhood in men and second year in women
- physical and psychological abuse
- physical illnesses that affect sleeping (chronic insomnia)
- loss of mental capacity (18-20)

In the presence of a subject belonging in one of the risk groups mentioned before facing any of the situations described it is mandatory to carry out a thorough exploration for suicide ideation. The following are variants to approach this topic:

First variant:

You can ask the family member at risk: "Obviously you are not feeling well. I have noticed that and I would like to know how you think to solve the problem."

In this variant an open question can be asked to give the subject the opportunity to express his/ her thoughts so that his/ her suicidal purposes can be found out.

Second variant:

Questions can be asked based on the symptom or symptoms that most annoy the subject to find out any suicide ideas. For instance, "You say you have difficulty to sleep and I know that when it happens sometimes queer ideas strike our minds. Would you like to talk about it? What do you think of when you cannot sleep?"

Third variant:

The subject can also be approached in this way: "I know you have not been feeling well lately. Have you had any bad thoughts?"

In this case *bad thoughts* is synonymous to *suicide ideas*. It is also possible to use expressions like *unpleasant ideas*, *recurrent* or *queer thoughts*, etc. If the subject answers affirmatively, the questioner should try to find out what those bad thoughts are since they may be associated with unjustified fears such as fear of becoming diseased or receiving a bad news, which are not necessarily suicide ideas.

Fourth variant:

The subject can be asked directly whether he has had suicide ideas, like this: "Have you considered killing yourself as a solution to all your problems?", "Have you thought to commit suicide?", "Has the idea of ending your life ever struck your mind?"

Fifth variant:

It is necessary that both the subject at risk and the questioner know a previous case of suicide committed by a family member, a friend or neighbor. The question should be asked in this way: "Are you thinking of solving your problem by ending your life as so-and-so did?"

If the answer to this question suggests that the subject has a suicide idea, it is advisable to continue asking the following sequence of questions:

- QUESTION: How do you plan to do it?

This question is intended to find out the suicide method. Any method can be lethal. Suicide risk is greater if there are previous cases of suicide committed by other family members using that method. The risk is even greater in the case of repeaters in search of more lethal suicide methods. In the prevention of suicide it is vital to avoid the availability of or access to methods that may inflict harm to the subject.

- QUESTION:When do you plan to do it?

This question does not aim to get an exact date to commit suicide, but to find out if the subject is making arrangements as for instance to bequeath or whether he/she has written farewell notes, if he/she is giving away valuable items, if the person expects a significant event to take place such as the breakage of an important relationship, the death of a beloved person, etc.

Subjects at risk of committing suicide should always be in the company of someone else, since being alone increases the likelihood for the act to be accomplished.

- QUESTION:Where do you plan to do it?

This question may lead to find out where the subject has thought to commit suicide.

This act usually takes place in spots visited by the suicide on regular bases, mainly his home, his school, or family members' or friends' homes. Other high risk places are distant places, places hard to find or places that have been used before by other suicides.

- QUESTION: Why do you want to do it?

This question tries to find out the motive or reason why the subject wants to commit suicide. Among the most common motives are the presences of troubled relationships, academic problems, having been scolded in a humiliating way, etc. Motives should always be considered significant for the subject at risk and they should never be appraised from the point of view of other family members.

- QUESTION: What do you want to do it for?

The aim of this question is to find out the meaning of the suicidal act. Wishing to die is the most dangerous motive but not the only one. There may be other meanings involved such as calling other people's attention, to show the magnitude of their problems, to express rage or frustration, to ask for help, to attack others, and the like. (9,11)

The more questions the subject can answer the better shaped his suicidal plan is. It means that the risk is very high. Then the following question is raised: What should the family do when one of its members has suicide ideas?

I suggest four main measures:

1. Never leave him/her alone.
2. Avoid that the method chosen by the subject can be used.
3. Make all family members aware of the subject's suicide crisis so that they can help to keep an eye on the subject and to provide emotional support.
4. Contact a mental health institution so that the subject can receive specialized professional care.

Remember:

A suicide crisis lasts hours, days, rarely weeks, so the main goal is to keep the subject alive until he/she can receive specialized care.

Never forget:

Suicide is a death that can be avoided.

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