CHAPTER-1
INTRODUCTION

For some tragic reason, this has been a year of suicides among young, successful, urban women. On December 10 when the 2002 Gladrags Megamodel winner Rakhee Choudhari was found dead in her Mumbai apartment, she added yet another number to a growing list of depressed young women who had everything to live for and yet chose death. Barely two months ago, 18-year-old Delhi-based singer Saumya Sharma had jumped to death from the 22nd floor of a building. Earlier this year, Delhi socialite Natasha Singh, her sister-in-law, model Ritu Singh, former Lok Sabha Speaker Shivraj Patil’s daughter Sapna Patil and 21-year-old Tamil actress Monal all committed suicide within a span of two months. The common elements in these cases are too obvious to ignore. All were young, affluent and had a lot going for them in life. Yet, all suffered from bouts of depression, eventually leading to their premature deaths. Depression is the biggest underlying cause behind the extreme step of suicide; according to mental health professionals, there are five depressed women for every one such man in affluent sections of the society (Cf. Vasudev, 2002).

Self murder cases or instances where the death instinct triumphs over the life instinct, like the ones enumerated above, are on an alarming upswing in Chandigarh. Suicides, unfortunately, are fast becoming a natural concomitant of the
fast-paced lives we live in. Scientists, however, are yet to unravel this mystery while lives continue to be lost. Our knowledge of what happens in the core of one's mind that drives a person to commit suicide is, unfortunately poor, say scientists.

The health of the young is of great importance for the future of societies. In this context, the suicide rate is a sensitive measure of psychological and social state. As a consequence, suicide has always been a topic of considerable interest in different geographical areas of the world because an examination of the suicide rate, worldwide, of young adults may reveal something of their well-being. Suicide remains such an anigma that the reasons for so many adolescents and young adults choosing to take their own life are unclear.

The first act of suicide probably occurred before the beginning of written records. In order to explore the history of suicide with any understanding, one must have some conception of the prevailing taboos and attitudes toward this behavioural phenomenon. Historically, society's attitudes toward suicide and the suicidal act reveal a wide range between a rational one of acceptance, an irrational one of superstition and a hostile one of punishment.

David Hume (1711-1776), English Philosopher-essayist of the Enlightenment Period, noted in his essay on suicide that the Bible does not prohibit suicide. He interpreted the commandment

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* The first known document dealing with suicide is an Egyptian record known by several titles—"The Dispute of a Man with His Soul", "The Dialogue of a Misanthrope with His Soul" or "The Suicide". This document has been dated by historians as having been inscribed before the Eleventh Egyptian Dynasty, or some time between 2000 and 1900 years B.C. (Williams, 1962).
Thou Shalt Not Kill to forbid only the killing of others. Hume felt that man has a right to dispose of his own life, although he viewed suicidal people as somewhat deranged mentally, otherwise they would not violate the instinct for self-preservation.

Immanuel Kant (1724-1804), German philosopher, denied the right to suicide. In his Metaphysics of Ethics he regards the taking of one's own life as an offense against the universal law of nature. Kant had a lasting regard for religion and found also that suicide was inconsistent with reason.

Other great philosophers explored the meaning of suicide: Arthur Schopenhauer (1788-1860), German Philosopher, although agreeing with the penalties visited on suicide, wrote that suicide was a futile and foolish act. Friedrich Wilhelm Nietzsche (1844-1900), German poet, musician, essayist, classical philologist and philosopher, supported the case for suicide. In The Twilight of the Idols, he affirmed that “one should die proudly when it is no longer possible to live proudly”.

Some current religious views are still reflective of early thinking. For example, in 1966 suicide became a criminal offense in Israel. When suicide is verified, the Orthodox Jew is refused religious burial rites. Islamic law also forbids suicide. The act is viewed by Islam as a form of murder, and since murder is most evil, it is “logical” that suicide too must be forbidden. The performer of this criminal act is not free from the curse of God. Obviously the crime cannot be punished on earth, but paradise will be denied the malefactor. Catholic opposition to suicide remains an unbroken tradition, based on the principal that “life belongs to God and only God may terminate it”. However, when a catholic does commit
suicide, funeral rites are often conducted on the assumption that the victim was not in possession of his or her faculties at the time, hence not responsible for the act.

Going back in time, in the early nineteenth century, attitudes toward suicide were revealing a less moral or theologic bias and by the middle of the nineteenth century opinions with noticeable social and medical overtones were being heard. Medical writers began to have an influence on public opinion about suicide, giving rise to the popular feeling that no decent or respectable person ever takes his life. Medical workers were at that time seeking the psychologic causes of suicide and they came to the conclusion that the person who seek his life was insane. This viewpoint intensified existing prejudice against suicide by casting aspersions on the sanity of the entire family. Thus, suicide stigmatized an entire family and its descendants. These prevailing attitudes caused families to avoid any talk of suicide in order to protect the family reputation. Suicide had over the years changed status from a sin to a disgrace and as a topic of discussion, a taboo—an attitude still quite prevalent today.

Thus, in the historical perspective it can be seen that probably there has been no human society or period in recorded history in which the phenomenon of 'suicidal behaviour' was non-existent (Latha, Bhat, & D’Souza, 1996, p. 26). Much has been written on this subject. Suicides are numerous in Shakespeare’s plays and in the entire romantic theater. Suicide has a place in ethics, history, literature and art. Physicians, jurists and theologians are concerned about it. It continues to provoke curiosity, to awaken sentiments of pity and terror and to offer rich, paradoxical material for discussion. Many facets exist which
arouse deeper human interest and which the sciences of man have more reasons to examine. Though suicide is ancient, undoubtedly as ancient as humanity, its study did not advance much before the middle of the nineteenth century, when the psychopathology of the individual became an active field of research. Research on suicide attempts in the recent past has revealed that the phenomenon has now assumed the proportions of a major health problem. The burden on the medical services of caring for suicide attempters is of growing concern to medical and mental health professionals. There is substantial evidence of the disturbing nature and extent of suicidal behaviour as an epidemiological problem.

Realizing the gravity of the phenomenon of suicidal behaviours, the World Health Organisation (WHO) has identified suicide as an increasingly important area of public health, and has issued guidelines to member state in order to develop and implement co-ordinated, comprehensive, national and international strategies intended to halt this trend by the year 2000 (WHO, 1990). The number of suicides per 100,000 people was about 10.7 in 1998, according to the world Health Organisation.

It is important to note that much of the data on suicidal behaviour is based on information obtained from developed western countries. All such data need to be evaluated within their specific cultural context as well as cross-culturally, because the number of suicide attempts in third world countries (Sadanandan, Unni, & Mani, 1996) is also increasing at an alarming rate. As a consequence this study is in the direction of examining suicide ideation, an important component of suicide behaviour. Research
has previously confirmed that the intensity of suicide ideation is an important predictor of suicide attempts and eventual suicide (e.g., Beck, Brown, & Steer, 1989).

**Correlates of Suicide Behaviour**

By the turn of the nineteenth century, the approach to an understanding of suicide had changed from a religious, moral, and philosophical approach to psychological, sociological and statistical approach. The research and scientific interpretation of suicidal phenomenon, however, made their greatest advance in the twentieth century.

The sociological study of suicide, of course, started with Durkheim [(1897) 1951] and has continued to the present day, primarily by the following sociologists: Henry & Short (1954); Gibbs & Martin (1964); Gibbs (1988); Douglas (1967); Maris (1969; 1981); Phillips (1974; 1991); Stack (1982); Wasserman (1989); and Pescosolido & Georgianna (1989).

Durkheim claimed that the suicide rate varied inversely with social integration and that suicide types were primarily ego-anomic. However, Durkheim did not operationally define “social integration.” Gibbs & Martin (1964) created the concept of “status integration” to correct this deficiency in Durkheim. They hypothesized that the less frequently occupied status sets would lead to lower status integration and higher suicide rates. Putting it differently, they expected status integration and suicide rates to be negatively associated. In a large series of tests from 1964 to 1988 Gibbs found his primary hypothesis to be confirmed only for occupational statuses (which Durkheim also had said were of central importance).
Henry & Short (1954) expanded Durkheim’s concept of external and constraining social factors to include interaction with social-psychological factors of “internal constraint” (such as strict superego restraint) and frustration-aggression theory. Henry and Short reasoned that suicide rates would be highest when external restraint was low and internal restraint was high (and that homicide rates would be high when internal restraint was low and external restraint was high).

A vastly different sociological perspective on suicide originated with the work of ethnomethodologist Jack Douglas (in the tradition of Max Weber’s subjective meanings) argued that Durkheim’s reliance and official statistics (like death certificates) as the data base for studying suicide was fundamentally mistaken (Douglas, 1967). What Douglas said we need to do is to observe the accounts or situated meanings of actual individuals who are known to be suicidal, not some third-party official like a coroner or medical examiner who is not a suicide and who may use ad hoc criteria to classify a death as a suicide. There are probably just about as many official statistics as there are officials.

Maris (1981) extended Durkheim’s empirical survey of suicidal behaviour, but not just by measuring macrosocial and demographic or structural variables. Instead Maris focused on actual interviews (“psychological autopsies”) of the intimate survivors of suicides (usually their spouses) and compared these cases with control or comparison groups of natural deaths and nonfatal suicide attempters. Maris claimed that individuals who committed suicide had long “suicidal careers” involving complex mixes of biological, social and psychological factors.
In contrast, Sigmund Freud (1917) was responsible for detailing the psychological theory of self destruction. In his opinion suicide is essentially a basic concept of the human mind and everyone is in some measure vulnerable to suicide. Freud considered suicide an intrapsychic phenomenon originating primarily within the unconscious. The pressures impelling a person toward death could increase, depending on life events, and under conditions of enormous stress, a person could be expected to regress to more primitive ego states. Freud felt that life and death forces are in constant conflict within the individual. He conceptualized that persons identify ambivalently with their own internalized love objects. When a person is frustrated the aggressive side of his or her conflicting emotions becomes innerdirected. Suicide in this context may be viewed as a form of murder with the suicide victim unconsciously wanting the other entity of a dyad dead. Litman (1968) traced Freud’s writings on suicide from 1881 to 1939 and described Freud’s explanations of suicide not only as theoretical and philosophical in essence but also based on psychanalytic experiences.

Among various factors associated with suicide or deliberate self harm, researches in the recent past have shown that there is a crucial relationship of suicidal behaviour with psychiatric illness and/or personality disorder (Crammer, 1984). Suicide is the most important consequence of psychiatric disorder and most major psychiatric disorders carry a high suicide risk. According to some investigators (Roy, 1989) psychiatric patients risk of suicide is three to twelve times greater than that of the general population. Robins (1986) and Barraclough et al. (1974), analysed several
hundred cases of suicide and concluded that more than 90% of them had been suffering from mental illness at the time they killed themselves. Based upon Western International research, there is general agreement that the most important factor associated with suicide is mental illness (Isometsa, Henriksson, & Aro, 1994; King, 1994), followed by substance abuse and personality disorder (Marttunen, Aro, & Henriksson, 1994), with the dominant affect being depression and hopelessness (Beck, Steer, & Newman, 1993; MacClod, Williams, & Linehan, 1992). Thus various psychiatric disorders have been associated with attempted and completed suicide; depression and alcoholism are both associated with excess of suicide mortality.

When the incidence of suicide is examined, patients with depressive disorders are found to be at higher risk than patients in all other psychiatric diagnostic categories combined. The annual suicide rate for the depressive disorders has been estimated to be 3.5-4.5 times higher than that for all other psychiatric groups and 22-36 times higher than that for the general population (Kraft & Berbigian, 1976; Pokorny, 1964; Temoche, Pugh, & McMohan, 1964). In fact, 'warns the World Health Organisation (WHO), depression will become the biggest killer disease of women in the coming decade. For every suicide, there are 20 others who attempt it and 40 more who contemplate it. A World Mental Health report published last year found that unipolar depressive disorder (consistent, long-term sadness) was the largest malady afflicting women between 15 and 44, disabling 18.6 percent globally. The toll is higher than that for heart disease and of breast / cervical cancers.
Although not all studies carefully distinguished between primary depression (depressive disorder uncomplicated by any other psychiatric or major medical illness) and secondary depression at the time of assessment, those studies that reported data for primary depression confirmed the strong relationship between this disorder and suicide. For instance, in extrapolating from 17 such studies, Guze & Robins (1970) estimated that the life time risk of suicide for primary depression is about 15%, whereas the life time risk for the general population is 1%. More recently, Cheng’s (1995) study of mental illness and suicide in East Taiwan revealed that the risk of completed suicide is reportedly highest among subjects with both major depression and substance use disorders. The most common comorbid pattern in completed suicides has been found to be depression with substance use disorders. However, it is unclear what accounts for the increased risk of suicide in primary depression, but a number of contributing variables have been suggested in the literature. These variables include demographic characteristics and environmental factors, such as the impact of events or the availability of social support, personality differences, treatment availability or effectiveness and biological factors affecting symptomatology or course of the illness, (Crook, Raskin, & Davis, 1975; Rorsman, 1973; Lester, 1972; Murphy, 1972; Paykel & Dienelt, 1971; Rosen, 1970; Flood & Seager, 1968; Sainsbury, 1968).

Over the last 15 years research has also suggested that hopelessness is the key mediating variable between suicidal ideation and depression (Cole, 1988; Wetzel, Margulies, Davis, & Karam, 1980; Beck, Kovacs, & Weissman, 1975), but not all
findings are consistent with this interpretation (Strosahl, Chiles & Linehan, 1992). Beck, Steer, Kovacs, & Garrison (1985) reported that a Beck Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974) cut off score of 9 or above was successful in predicting 90.9% of the eventual suicide (suiciders) in a sample of 165 hospitalized suicide ideators, who were followed from 5 to 10 years. Beck (1986) also described a preliminary study with 1969 out patients evaluated between 1978 and 1984 in which a hopelessness score of 9 or above on Beck Hopelessness Scale identified 15 (93.8%) of the 16 suiciders. The author concluded that hopelessness is predictive of actual suicide both in psychiatric outpatients and in hospitalized suicidal ideators.

Mendonca & Holden (1996), however, found that unusual and irrational thinking and not hopelessness was the strongest predictor of serious suicidal intent. The regression results in fact suggested that hopelessness and even past history of suicide behaviour do not contribute as significant predictors after unusual and irrational thinking has been taken into account. Ideation items describing the frequency, duration and acceptance of a wish to die were significantly correlated with feelings of hopelessness. However, items reflecting preoccupation with a method of self-harm showed only a weak correlation with hopelessness, although the relationship varied according to diagnosis. Thus, the role of depression and hopelessness in suicide fluctuates in different studies.

The diagnostic inference which attributes suicidal behaviours to underlying depression and hopelessness may be misleading because it might stem from uncontrollable rage, frustration,
distortion in perception, loss of contact with reality and the like. Young, Fogg, Schefiner, & Fawcett (1994) found that in patients with affective disorders, the degree of hopelessness appeared to be an important factor predicting eventual suicide, although its significance may depend on the history of drug and alcohol abuse. Thus the role of hopelessness may vary between mental disorders. However, no previous study has investigated the role of hopelessness in relation to psychoticism, the most important element militating against the individual's survival. The combination of depression, hopelessness and psychoticism seems to play an important role in suicidal behaviour.

Moreover treating suicidal behaviour as depression for example, with psychotherapy and antidepressant medication might prove hazardous if treatment does not deal with the psychotic aspect of such behaviour, the most significant element militating against the individual's survival. Thus any investigation of suicidal ideation cannot afford to neglect the psychotic aspect of behaviour.

Overview

1. The number of suicide attempts in third world countries has been increasing, but such attempts go unreported for various reasons. In India, a suicide attempt was until recently a publishable legal offence, hence, it is either 'covered up' or labeled as 'accidental' in order to avoid social stigma and legal consequences. However, an increasing number of suicide attempts are being treated as emergencies in hospitals and the data are obtained from individual reports rather than from official records.
2. Research on suicide attempts has revealed that the phenomenon has now assumed the proportions of a major health problem. The burden on the medical services of caring for suicide attempters is of growing concern to medical and mental health professionals. There is a need for information about the various aspects of suicide attempters, so that further strategies can be planned to aid this particular group.

The number of suicide attempts in developing countries has been increasing progressively, as in the west. It is important to note that much of the data on suicidal behaviour is based on information obtained from developed western societies. All such data need to be evaluated within their specific culture as well as cross-culturally.

3. Despite the associations of depression and hopelessness with suicidal behaviour, it seems, likely that maladaptiveness in the context of psychoticism is more greater and more life-threatening than even the most debilitating depression and hopelessness. Indeed the extent of maladaptiveness suggests that suicidal behaviours may involve comorbidity of depression with psychoticism in which a circumscribed transient thought disorder suspends the individuals' capacity to comprehend the consequences of their action. After all many suicidal individuals are not fully cognizant of the potentially irreversible impact-both on themselves and others of their actions at the time of suicidal episode. The apparent suspension of rational decision making at the time of the suicidal attempt appears somewhat comparable to the
diminished capacity often observed in homicidal behaviour; this parallel is presumably led Menninger (1938) to refer to suicide as “murder of the self”, because the self becomes the target of lethal aggression. The literature suffers from an important omission in the sense that the role of depression and hopelessness in suicide ideation has been examined without bringing ‘psychoticism’ into the purview of the study. The role of psychoticism cannot be ignored in any study of suicide ideation.

4. The heterogeneous nature of suicidal intent is an important but insufficiently explored issue. Studies investigating suicidal ideation have often used the global score on the Beck Scale for Suicidal Ideation (SSI) to assess suicide ideation. Some studies have used single global rating scales scores. Both overall ratings of ideation and a single global score on the Scale for Suicide Ideation treat ideation as a homogeneous construct and neither of them distinguished between types of ideation, e.g. between ‘general inclination’ and ‘focused inclination’ involving plans for self harm. In this context Mendonca & Holden (1996) isolated two dimensions, ‘suicidal desire’ and ‘suicide preparation’. Because these two dimensions of suicidal ideation represent two different levels of seriousness of suicidal ideation, the use of global measure of suicide ideation seems to be an important methodological flaw. It would be important to clarify their relationships to relevant risk factors.

Keeping in view the above mentioned conclusions the aim of the present study is to examine the relation of different types of
suicide ideation with depression, hopelessness and psychoticism. The three key variables were included in the current study because previous research on predisposing symptoms of suicide intent has largely investigated the independent variation of individual key symptoms with suicide risk. In real life, however, a clinician has to deal with the concurrent effect of more than one acute symptom in a suicidal person’s presenting state.