Chapter One

INTRODUCTION

ATTRIBUTIONAL ANALYSIS OF SUICIDE

The major objective of the Present investigation is to focus at the attributional analysis of suicide. The hidden Grief of suicide was reported by youths and adults. Suicide is the chronic case which occurs in day today life. It is regional, National and International Problem. Suicide is unwanted, undesirable and unexpected event which takes place due to multifactor. Suicide is the process of purposely ending one's own life. The way societies view suicide varies widely according to culture and religion. For example, many Western cultures, as well as mainstream Judaism, Islam, and Christianity tend to view killing oneself as quite negative. One myth about suicide that may be the result of this view is considering suicide to always be the result of a mental illness. Some societies also treat a suicide attempt as if it were a crime. However, suicides are sometimes seen as understandable or even honorable in certain circumstances, such as in protest to persecution (for example, hunger strike), as part of battle or resistance (for example, suicide pilots of World War II; suicide bombers) or as a way of preserving the honor of a dishonored person (for example, killing oneself to preserve the honor or safety of family members).
Nearly one million people worldwide commit suicide each year, with anywhere from 10 million to 20 million suicide attempts annually. About 30,000 people reportedly kill themselves each year in the United States. The true number of suicides is likely higher because some deaths that were thought to be an accident, like a single-car accident, overdose, or shooting, are not recognized as being a suicide. Suicide is the eighth leading cause of death in males and the 16th leading cause of death in females. The higher frequency of completed suicides in males versus females is consistent across the life span. In the United States, boys 10-14 years of age commit suicide twice as often as their female peers. Teenage boys 15-19 years of age complete suicide five times as often as girls their age, and men 20-24 years of age commit suicide 10 times as often as women their age. Gay, lesbian, and other sexual minority youth are more at risk for thinking about and attempting suicide than heterosexual teens.

Suicide is the third leading cause of death for people 10-24 years of age. Teen suicide statistics for youths 15-19 years of age indicate that from 1950-1990, the frequency of suicides increased by 300% and from 1990-2003, that rate decreased by 35%. However, from 2000-2006, the rate of suicide has gradually increased, both in the 10-24 years and the 25-64 years old age groups. While the rate of murder-suicide remains low at 0.0001%, the devastation it creates makes it a concerning public-health issue.
The rate of suicide can vary with the time of year, as well as with the time of day. For example, the number of suicides by train tends to peak soon after sunset and about 10 hours earlier each day. Although professionals like police officers and dentists are thought to be more vulnerable to suicide than others, important flaws have been found in the research upon which those claims are based.

As opposed to suicidal behavior, self-mutilation is defined as deliberately hurting oneself without meaning to cause one's own death. Examples of self-mutilating behaviors include cutting any part of the body, usually of the wrists. Self-tattooing is also considered self-mutilation. Other self-injurious behaviors include self-burning, head banging, pinching, and scratching.

Physician-assisted suicide is defined as ending the life of a person who is terminally ill in a way that is either painless or minimally painful for the purpose of ending suffering of the individual. It is also called euthanasia and mercy killing. In 1997, the United States Supreme Court ruled against endorsing physician-assisted suicide as a constitutional right but allowed for individual states to enact laws that permit it to be done. As of 2009, Oregon and Washington were the only states with laws in effect that authorized physician-assisted suicide. Physician-assisted suicide seems to be less
offensive to people compared to assisted suicide that is done by a non-physician, although the acceptability of both means to end life tends to increase as people age and with the number of times the person who desires their own death repeatedly asks for such assistance.

**Common Methods of Suicide**

The unfortunate and depressing issue of suicide has become a staggering piece of harsh reality in today's world. In the US, ranking 46th in the world of rates per capita, we experience 11,000 self-inflicted deaths per year, and the UK: 7,000. This has become a serious issue for many countries whether the factors be family issues, health issues, money problems, or relationship failures. The ways in which people decide to shuffle this mortal coil are numerous and varying. Ten of the most often seen are as follows.

1. **Drowning**

*How it's Done:* Maybe a relationship tremor has caused you to rethink your life here on the planet, and the weight of it all has made you decide to drown yourself. Sometimes, driving or even convincing yourself to walk into a large body or water will do it, otherwise many perish in as little water as a slightly-filled bathtub.
2. Electric Shock

*How it's Done:* Sometimes the thought of continuing to live in a world inundated with problems and insurmountable issues results on one wanting to die by electric shock. Something as simple as jamming a utensil in a wall outlet, to the more notable dunking an appliance in an occupied bathtub, can result in death by electric shock.

3. Exsanguination

*How it's Done:* Frequently the most obvious way to rapidly harm one's self yet pass on relatively slowly, is to slit the wrists or the carotid, radial, ulnar, or femoral artery. Using a sharp implement is the easiest way to go. Razors or knives are popular. Contrary to popular belief, the effective method for this is not to cross the wrist, but to draw the blade up the forearm (as is evident in the photograph above). This is the same way Japanese perform Jigai (women) and Seppuku (men), although their's is often for more spiritual purposes.

4. Jumping

*How it's Done:* Pondering the emptiness in one's life can be a painful experience. Yet, when it all seems so overwhelming, you might decide to
plummet from a significant height to your own death. Leaping from a building to the pavement below is quite lethal, and popular. However, romantics may choose to use a cliff over jagged rocks. Or bridges.

5. Suffocation

*How it's Done:* You've decided that your life is in disarray and you can no longer stand the pressure. One way to end it all is to encase your head in a plastic bag and asphyxiate yourself. Or, if you're really ready to go, nitrogen or helium directly inhaled is useful.

6. Carbon Monoxide Inhalation

*How it's Done:* It's all so difficult and the full weight of the world is seemingly square upon your shoulders. You've decided to go to the great beyond and you are going to lock yourself in a car, in a closed garage with the engine running and go to sleep. Or, if you have any appliance that puts of CO, that'll do.

7. Poisoning

*How it's Done:* Romeo and Juliet had it down when, once seeing the other presumably dead, the other fatally poisons himself. Taking a substance
internally not meant to be done so can be considered poisoning: cleaners, industrial fluids, diazepam, cyanide, and the like.

8. Hanging

_How it's Done:_ It's all over. Nothing in life seems to make it worth living any more. You can acquire a length of rope and construct yourself a noose, which is, by the way, considered a deadly weapon if tied correctly. Once built, wrap one end securely around something high: a rafter or a ceiling fan, and leap, head fastened within the loop, from a chair. Or, if you're short of rope, anything strong enough to support your weight from your neck can be employed.

9. Drug / Alcohol Overdose

_How it's Done:_ The pressure and stress of daily routines has beaten you down for the final time. Within your medicine cabinet lies the answer to your extermination: prescription and over-the-counter meds. A huge mouthful can do you right in. Or, to speed along the process, couple your target pills with a few swigs of alcohol. Many of our favorite musicians have chosen this route. Even alcohol alone, in extreme excess can kill you.
10. Gun Shot

*How it's Done:* One of the most often achieved forms of suicide is by gun shot. Generally a head shot is desired since its results are 99 percent effective, however a chest shot can be equally as devastating.

**Support**

Suicide is never a solution. There is no problem so great that it can not be resolved with time and care. This list is meant not as an instruction guide, but a description of the most common forms of suicide. The following is a list of sites you can visit to get help if you are feeling beyond help. Please remember, no matter how bad things get, someone, somewhere is able to listen to you and help you through.

**Effects of Suicide:**

The effects of suicidal behavior or completed suicide on friends and family members are often devastating. Individuals who lose a loved one to suicide (suicide survivors) are more at risk for becoming preoccupied with the reason for the suicide while wanting to deny or hide the cause of death, wondering if they could have prevented it, feeling blamed for the problems that preceded the suicide, feeling rejected by their loved one, and
stigmatized by others. Survivors may experience a great range of conflicting emotions about the deceased, feeling everything from intense emotional pain and sadness about the loss, helpless to prevent it, longing for the person they lost, and anger at the deceased for taking their own life to relief if the suicide took place after years of physical or mental illness in their loved one. This is quite understandable given that the person they are grieving is at the same time the victim and the perpetrator of the fatal act.

Individuals left behind by the suicide of a loved one tend to experience complicated grief in reaction to that loss. Symptoms of grief that may be experienced by suicide survivors include intense emotion and longings for the deceased, severely intrusive thoughts about the lost loved one, extreme feelings of isolation and emptiness, avoiding doing things that bring back memories of the departed, new or worsened sleeping problems, and having no interest in activities that the sufferer used to enjoy.

**Some Possible Causes of Suicide:**

There is little hard evidence to explain why some people commit suicide while other people in similar circumstances do not. However, some important factors that makes suicide more likely have been identified. These are explained below.
Vulnerability to suicide

Many experts believe that several factors determine how vulnerable a person is to suicidal thinking and behaviour.

Factors that make someone more vulnerable include:

- genetics and family history - see below
- life history - for example having a traumatic experience during childhood, such as a bereavement
- mental health - for example developing a serious mental health condition, such as schizophrenia
- lifestyle - people who misuse alcohol and drugs are at increased risk of suicidal thoughts
- job - poor job security, low levels of job satisfaction or not having a job can increase a person’s risk of dying by suicide
- relationships - people who are socially isolated and have few close relationships with others have a higher risk of dying by suicide

As well as these factors, one or more stressful events may push a person "over the edge" and lead to suicidal thinking and behaviour. The amount of stress it takes to do this will depend on the person’s level of vulnerability.
In some cases, it may only take a minor event, such as having an argument with a partner. In other cases, it may take one or more very stressful or upsetting events before a person feels suicidal, such as a partner dying or being diagnosed with a terminal illness. In many cases, it may take a combination of different factors to increase a person's risk of suicidal thoughts.

**Other risk factors for suicide**

Other factors that can increase the risk of suicide include:

- having a history of sexual or physical abuse
- having a history of parental neglect, either emotional or physical neglect or both
- having a parent with a serious mental health condition, such as severe depression or schizophrenia
- having a parent who died by suicide
- having previously attempted suicide
- being socially isolated, such as living alone or having few close friends or family members
- being gay, arising from the prejudice that gay people often face
• being unemployed, having poor job security or working in an unskilled occupation
• being in debt
• being homeless
• being recently released from prison
• having recently experienced a traumatic event, such as the end of a relationship or the death of a loved one
• misusing drugs or misusing alcohol
• working in an occupation that provides access to potential ways of dying by suicide, such as working as a doctor, nurse, pharmacist, farmer or as member of the armed services

Antidepressants and suicide risk

Research has found that young people under 25 years of age have a small increased risk of suicide or having suicidal thoughts when taking antidepressants, usually when they first begin treatment.

Contact your GP immediately or go to your local hospital if you have thoughts of killing or harming yourself at any time while taking antidepressants.
It may be useful to tell a relative or close friend that you have started taking antidepressants and to ask them to read the leaflet that comes with your medication. Ask them to tell you if they think your symptoms are getting worse or if they are worried about changes in your behaviour.

**Genetics and suicide**

It has been known for some time that suicide can run in families. This has led to speculation that certain genes may be associated with suicide.

Recent research has identified several genetic mutations that may disrupt the chemical make-up of the brain, making a person more vulnerable to suicidal thinking and behaviour.

A mutation is where the normal genetic instructions inside the cells become scrambled so that some cells do not work in the way that they should. However, it would be too simple to claim that there is a "suicide gene" and that whoever had a copy of that gene would attempt suicide.

Suicide is not just a matter of biology. It is a complex phenomenon and a wide range of factors is involved. However, a better understanding of the genetics associated with suicide may eventually make it possible to
screen people who are at risk and to provide them with treatment and support.

Classic Psychological Theories of Suicide

Emile Durkhem Theory

Durkheim performed a classic study of suicide and published his conclusions in 1897 on the following reasons of the suicide:

1. Egoistic-Not enough Integration. Due to a looser social network or belief system. For example Protestants are more likely to commit suicide than Catholics because the belief system is not as tight.

2. Anomic-Not enough regulation. Society doesn’t have enough control over individuals. Often in periods of economic depression does this occur. Because of such change people find it very hard to adapt.

3. Altruistic-Too much integration. The person sacrifices their life for the benefit of others. For example suicide bombers or a recent case in the UK was that a family was set to be deported due to immigration however if the mother was a widow then they could stay so the father killed himself for the family’s benefit.
4. Fatalistic-Too much regulation. The individual has little freedom as a result of the control of society. For example slaves.

**Thomas Masaryk Theory**

Masaryk considered that the main basis of morality in society is religion. An increase in irreligiosity deregulates the social organism, makes people feel unhappy and increases social disorganization. Suicide, as well as mental illnesses, can be seen as a measure of societal disturbances: the suicide rates increase observed during the 19th century, for example, is interpreted by Masaryk as a result of increasing irreligiosity. Religion, he says, is a system that makes psychological life coherent because it offers a structured way of thinking.

Modern education destroys religious perspective without offering anything similar, because science does not include an ethical component. Without a structured and satisfactory perspective on life, people are more likely to take their lives and are higher exposed to mental sicknesses.

**Sigmund Freud Theory**

Freud classified suicide as form of built up aggression or tension that causes inward animosity. Or, in other words, it represents a psychological
conflict, which cannot be worked out due to the great force of melancholy and depression.

**Benjamin Wolman Theory**

Benjamin Wolman, a sociologist who theorized on the “anti-culture” of suicide, blamed estrangement and contemporary societal mechanization and alienation for growing suicide rates. Wolman sums up the sociological standpoint in his statement for the main reasons why so many people now tend to hurt one another and to hurt themselves:

1. The estrangement inherent in our way of life;
2. The decline of family ties;
3. The depersonalization in human relations;
4. The loss of the individual in a mass society.

The ability of people to internalize such aggression and turn it into self-criticism and self-hate is one of the most prominent ties between sociology and psychology. While most psychologists do not hold that society is so exceedingly influential in human development and personal motives, the connection is obviously there.
David Malan Theory

David Malan, a psychologist, suggests that suicide is the cause of accumulated trauma. Though it sounds extremely simplistic, most psychologists, to a certain degree, concur with this theory. Many psychiatrists feel suicide is a result of mental and emotional disturbances that are already present and which external circumstances worsen. Rather than outside forces, personality, character, temperament (which is often thought to be inherited, and thus biochemical), and emotional stability are all psychological factors. This shows suicide as being a personal reaction, with external forces merely contributing to the final outcome. Some views stress personality far more than others, however, and the psychological school that seems to have developed the dominant position on suicide is the psychodynamic approach.

Edwin Shneidman Theory

Edwin Shneidman, in an essay evaluating the psychodynamic view, explains most suicides are marked by ambivalence toward life and death, as well as feelings of hopelessness and helplessness. He explains a type of suicide, termed “egotic suicide,” results from a conflict of internal aspects of
self to which the only response is the ending of the personality. Such internal aspects are not always as solitarily self-related as egotic conflict, however.

**Krauss Theory**

Krauss, in a discussion on psychosocial causes of suicide, explained Freud’s view that suicide is often the result of an unachieved goal or dysfunctional relationship, which is similar to the sociological standpoint. Krauss explains, however, in killing oneself one is really killing the internal representation of the unattainable object. The primary dispute between sociology and psychology, then, is whether the external or the internal has more power. Considering the superego is supposedly the internalization of external morals and parental values, all is relative. Internal and external factors are all relevant and the subjectivity is based, again, in terms of “reality”.

**Eric Ericson Theory**

There is a developmental theory from Erik Erikson in which life occurs in stages and when people perceive to be unsuccessful, the overwhelming feeling of guilt exceeds the ability to cope effectively. The hopelessness theory is probably one of the more accepted psychological
theories. Hopelessness refers to Aaron Beck’s cognitive triad which states an individual has a negative outlook on themselves, the future, and the world in general.

**Joiner Theory**

Joiner has proposed a theory of why people suicide which he believes is more accurate than previous formulations offered by writers like Edwin Schneidman, Ph.D. and Aaron Beck, MD. According to Schneidman’s model, the key motivator which drives people to suicide is psychological pain. In Beck’s understanding, the key motivator is the development of a pervasive sense of hopelessness. Dr. Joiner suggests that these are correct understandings but are also too vague to be useful for predictive purposes and not capable of offering a complete motivational picture.

Joiner proposes that there are three key motivational aspects which contribute to suicide. These are:

1) a sense of being a burden to others,

2) a profound sense of loneliness, alienation and isolation, and

3) a sense of fearlessness.
All three of these motivations or preconditions must be in place before someone will attempt suicide. Psychological pain and a sense of hopelessness correspond roughly to Joiner’s concepts of burdensomeness and alienation, and contribute to the content of much suicidal ideation. These are necessary but not sufficient preconditions for a suicide act, however. So long as a person remains fearful of death and the actions and consequences of the activities that will create death, the actual act of suicide is unlikely.

**Mental health conditions**

Having a mental health condition is the most significant risk factor for suicide. It is estimated that 90% of people who attempt or die by suicide have one or more mental health conditions. The mental health conditions that lead to the biggest risk of suicide are described below.

**Severe depression**

Severe depression is where a person has severe symptoms of despair and hopelessness that interfere with their life. People with severe depression are 20 times more likely to attempt suicide than the general population.

**Bipolar disorder**

Bipolar disorder is where a person swings from feeling very high and happy to feeling very low and depressed. About 1 in 3 people with bipolar
disorder will attempt suicide at least once, and 1 in 10 people with the condition will take their own life.

Schizophrenia

Schizophrenia is a long-term mental health condition that causes hallucinations (seeing or hearing things that are not real), delusions (believing in things that are not true) and changes in behaviour. It is estimated that 1 in 20 people with schizophrenia will take their own life. People with schizophrenia are most at risk of suicide when their symptoms first begin. The risk reduces as they learn to cope with their condition.

Borderline personality disorder

Borderline personality disorder is characterized by unstable emotions, disturbed thinking patterns, impulsive behaviour and intense but unstable relationships with other people. It is estimated that just over half of people with borderline personality disorder will make at least one suicide attempt. People with a borderline personality disorder who have a history of childhood sexual abuse have a particularly high risk of suicide.

Anorexia nervosa

Anorexia nervosa is where a person is very anxious about their weight and keeps it as low as possible by strictly controlling and limiting what they
eat. It is estimated that around 1 in 5 people with anorexia will make at least one suicide attempt.

**Generalised anxiety disorder**

Generalised anxiety disorder is where a person has persistent, recurring feelings of stress and anxiety.

**The Risk Factors and Protective Factors for Suicide:**

Ethnically, the highest suicide rates in the United States occur in non-Hispanic whites and in Native Americans. The lowest rates are in non-Hispanic blacks, Asians, Pacific Islanders, and Hispanics. Former Eastern Bloc countries currently have the highest suicide rates worldwide, while South America has the lowest. Geographical patterns of suicides are such that individuals who live in a rural area versus urban area and the western United States versus the eastern United States are at higher risk for killing themselves. The majority of suicide completions take place during the spring.

In most countries, women continue to attempt suicide more often, but men tend to complete suicide more often. Although the frequency of suicides for young adults has been increasing in recent years, elderly Caucasian males continue to have the highest suicide rate. Other risk factors
for taking one's life include single marital status, unemployment, low income, mental illness, a history of being physically or sexually abused, a personal history of suicidal thoughts, threats or behaviors, or a family history of attempting suicide.

Data regarding mental illnesses as risk factors indicate that depression, manic depression, schizophrenia, substance abuse, eating disorders, and severe anxiety increase the probability of suicide attempts and completions. Nine out of 10 people who commit suicide have a diagnosable mental-health problem and up to three out of four individuals who take their own life had a physical illness when they committed suicide. Behaviors that tend to be linked with suicide attempts and completions include violence against others and self-mutilation, like slitting one's wrists or other body parts, or burning oneself.

Risk factors for adults who commit murder-suicide include male gender, older caregiver, access to firearms, separation or divorce, depression, and substance abuse. In children and adolescents, bullying and being bullied seem to be associated with an increased risk of suicidal behaviors. Specifically regarding male teens who ultimately commit murder-suicide by school shootings, being bullied may play a significant role in putting them at risk for this outcome. Another risk factor which renders
children and teens more at risk for suicide compared to adults is that of having someone they know commit suicide, which is called contagion or cluster formation.

Generally, the absence of mental illness and substance abuse, as well as the presence of a strong social support system, decrease the likelihood that a person will kill him- or herself. Having children who are younger than 18 years of age also tends to be a protective factor against mothers committing suicide.

**The Signs and Symptoms for Suicide:**

Warning signs that an individual is imminently planning to kill themselves may include the person making a will, getting his or her affairs in order, suddenly visiting friends or family members (one last time), buying instruments of suicide like a gun, hose, rope, pills or other forms of medications, a sudden and significant decline or improvement in mood, or writing a suicide note. Contrary to popular belief, many people who complete suicide do not tell their therapist or any other mental-health professional they plan to kill themselves in the months before they do so. If they communicate their plan to anyone, it is more likely to be someone with whom they are personally close, like a friend or family member.
Individuals who take their lives tend to suffer from severe anxiety or depression, symptoms of which may include moderate alcohol abuse, insomnia, severe agitation, loss of interest in activities they used to enjoy (anhedonia), hopelessness, and persistent thoughts about the possibility of something bad happening. Since suicidal behaviors are often quite impulsive, removing guns, medications, knives, and other instruments people often use to kill themselves from the immediate environment can allow the individual time to think more clearly and perhaps choose a more rational way of coping with their pain.

**How are Suicidal thoughts and Behaviors Assessed:**

The risk assessment for suicidal thoughts and behaviors performed by mental-health professionals often involves an evaluation of the presence, severity, and duration of suicidal feelings in the individuals they treat as part of a comprehensive evaluation of the person's mental health. Therefore, in addition to asking questions about family mental-health history and about the symptoms of a variety of emotional problems (for example, anxiety, depression, mood swings, bizarre thoughts, substance abuse, eating disorders, and any history of being traumatized), practitioners frequently ask the people they evaluate about any past or present suicidal thoughts, dreams, intent, and plans. If the individual has ever attempted suicide, information
about the circumstances surrounding the attempt, as well as the level of
dangerousness of the method and the outcome of the attempt, may be
explored. Any other history of violent behavior might be evaluated. The
person's current circumstances, like recent stressors (for example, end of a
relationship, family problems), sources of support, and accessibility of
weapons are often probed. What treatment the person may be receiving and
how he or she has responded to treatment recently and in the past, are other
issues mental-health professionals tend to explore during an evaluation.

Sometimes professionals assess suicide risk by using an assessment
scale. One such scale is called the SAD PERSONS Scale, which identifies
risk factors for suicide as follows:

- **Sex** (male)
- **Age** younger than 19 or older than 45 years of age
- **Depression** (severe enough to be considered clinically significant)
- **Previous suicide attempt** or received mental-health services of any
  kind
- **Excessive alcohol or other** drug use
- **Rational thinking lost**
- Separated, divorced, or widowed (or other ending of significant relationship)
- Organized suicide plan or serious attempt
- No or little social support
- Sickness or chronic medical illness

**Treatment for Suicidal thoughts and Behaviors:**

Those who treat people who attempt suicide tend to adapt immediate treatment to the person's individual needs. Those who have a responsive and intact family, good friendships, generally good social supports, and who have a history of being hopeful and have a desire to resolve conflicts may need only a brief crisis-oriented intervention. However, those who have made previous suicide attempts, have shown a high degree of intent to kill themselves, seem to be suffering from either severe depression or other mental illness, are abusing alcohol or other drugs, have trouble controlling their impulses, or have families who are unwilling to commit to counseling are at higher risk and may need psychiatric hospitalization and long-term outpatient mental-health services.

Suicide-prevention measures that are put in place following a psychiatric hospitalization usually involve mental-health professionals trying
to implement a comprehensive outpatient treatment plan prior to the individual being discharged. This is all the more important since many people fail to comply with outpatient therapy after leaving the hospital. It is often recommended that all firearms and other weapons be removed from the home, because the individual may still find access to guns and other dangerous objects stored in their home, even if locked. It is further often recommended that sharp objects and potentially lethal medications be locked up as a result of the attempt.

Vigorous treatment of the underlying psychiatric disorder is important in decreasing short-term and long-term risk. Contracting with the person against suicide has not been shown to be especially effective in preventing suicidal behavior, but the technique may still be helpful in assessing risk, since refusal to agree to refrain from harming oneself or to fail to agree to tell a specified person may indicate intent to harm oneself. Contracting might also help the individual identify sources of support he or she can call upon in the event that suicidal thoughts recur.

Talk therapy that focuses on helping the person understand how their thoughts and behaviors affect each other (cognitive behavioral therapy) has been found to be an effective treatment for many people who struggle with thoughts of harming themselves. School intervention programs in
which teens are given support and educated about the risk factors, symptoms, and ways to manage suicidal thoughts in themselves and how to engage adults when they or a peer expresses suicidal thinking have been found to decrease the number of times adolescents report attempting suicide.

Although concerns have been raised about the possibility that antidepressant medications increase the frequency of suicide attempts, mental-health professionals try to put those concerns in the context of the need to treat the severe emotional problems that are usually associated with attempting suicide and the fact that the number of suicides that are completed by mentally ill individuals seems to decrease with treatment. The effectiveness of medication treatment for depression in teens is supported by the research, particularly when medication is combined with psychotherapy. In fact, concern has been expressed that the reduction of antidepressant prescribing since the Food and Drug Administration required that warning labels be placed on these medications may be related to the 18.2% increase in U.S. youth suicides from 2003-2004 after a decade of steady decrease. Also, the use of specific antidepressants has been associated with lower suicide rates in adolescents. Mood-stabilizing medications like lithium (Lithobid) -- as well as medications that address bizarre thinking and/or severe anxiety, like clozapine (Clozaril),
risperidone (Risperdal), and aripiprazole (Abilify) -- have also been found to decrease the likelihood of individuals killing themselves.

How can People Cope with Suicidal Thoughts:

In the effort to cope with suicidal thoughts, silence is the enemy. Suggestions for helping people survive suicidal thinking include engaging the help of a doctor or other health professional, a spiritual advisor, or by immediately calling a suicide hotline or going to the closest emergency room or mental-health crisis center. In order to prevent acting on thoughts of suicide, it is often suggested that individuals who have experienced suicidal thinking keep a written or mental list of people to call in the event that suicidal thoughts come back. Other strategies include having someone hold all medications to prevent overdose, removing knives, guns, and other weapons from the home, scheduling stress-relieving activities every day, getting together with others to prevent isolation, writing down feelings, including positive ones, and avoiding the use of alcohol or other drugs.

How can People Cope with the Suicide of a Loved One:

Grief that is associated with the death of a loved one from suicide presents intense and unique challenges. In addition to the already significant pain endured by anyone who loses a loved one, suicide survivors may feel
guilty about having not been able to prevent their loved one from killing themselves and the myriad conflicting emotions already discussed. Friends and family may be more likely to experience regret about whatever conflicts or other problems they had in their relationship with the deceased, and they may even feel guilty about living while their loved one is not. Therefore, individuals who lose a loved one from suicide are more at risk for becoming preoccupied with the reason for the suicide while perhaps wanting to deny or hide the cause of death, wondering if they could have prevented it, feeling blamed for the problems that preceded the suicide, feeling rejected by their loved one and stigmatized by others.

Some self-help techniques for coping with the suicide of a loved one include avoiding isolation by staying involved with others, sharing the experience by joining a support group or keeping a journal, thinking of ways to handle it when other life experiences trigger painful memories about the loss, understanding that getting better involves feeling better some days and worse on other days, resisting pressure to get over the loss, and the suicide survivor's doing what is right for them in their efforts to recover. Many people, particularly parents of children who commit suicide, take some comfort in being able to use this terrible experience as a way to establish a memorial to their loved one. That can take the form of everything from
planning a tree or painting a mural in honor of the departed to establishing a scholarship fund in their loved one's name to teaching others about surviving child suicide. Generally, coping tips for grieving a death through suicide are nearly as different and numerous as there are bereaved individuals. The bereaved person's caring for him- or herself through continuing nutritious and regular eating habits and getting extra, although not excessive, rest can help strengthen their ability to endure this very difficult event.

Quite valuable tips for journaling as an effective way of managing bereavement rather than just stirring up painful feelings are provided by the Center for Journal Therapy. While encouraging those who choose to write a journal to apply no strict rules to the process as part of suicide recovery, some of the ideas encouraged include limiting the time journaling to 15 minutes per day or less to decrease the likelihood of worsening grief, writing how one imagines his or her life will be a year from the date of the suicide, and clearly identifying feelings to allow for easier tracking of the individual's grief process.

To help children and adolescents cope emotionally with the suicide of a friend or family member; it is important to ensure they receive consistent caretaking and frequent interaction with supportive adults. All children and teens can benefit from being reassured they did not cause their loved one to
kill themselves, going a long way toward lessening the developmentally appropriate tendency children and adolescents have for blaming themselves and any angry feelings they may have harbored against their lost loved one for the suicide. For school-aged and older children, appropriate participation in school, social, and extracurricular activities is necessary to a successful resolution of grief. For adolescents, maintaining positive relationships with peers becomes important in helping teens figure out how to deal with a loved one's suicide. Depending on the adolescent, they even may find interactions with peers and family more helpful than formal sources of support like their school counselor.
In the present research intends to analyze participants perception of suicidal events and their coping strategies for dealing with suicidal events in order to fill a gap in the existing literature on response to suicidal events. Answering questions related to suicidal events will be a basis for professionals to develop intervention programs for youths and adults.

Objectives:

The present study is undertaken with a view to study the following objective and the major objective of the present investigation is to find out psychological determinants of suicide.

Hypotheses:

On the basis of above objectives, following hypotheses were formulated. It was hypothesized that:

1. The level of deprivation (Weaker & Stronger) would show differences on the measure of attributional suicidal scale and story telling of suicide
2. Gender (Male & Female) would show differences on the measure of attributional suicidal scale and various stories
3. Age groups (Youth & Adult) would show differences on the measure of attributional suicidal scale and various stories of suicide