Chapter – 1

Entry into the Subject

1.1 Introduction

Most of us cannot help but wonder how our personality works, how our personality came to be and what it might mean for our future. We also wonder about the personalities of others how they are the same or different from us. Personality psychology concerns what our personalities are, how they work, and what they can mean to our own and others' futures. The discipline of personality psychology helps answer some of these questions. If such questions interest you, you may want to learn more.

In a phrase, personality is not just who we are, Gordon Allport (1937) described two major ways to study personality: the homothetic and the idiographic. Homothetic psychology seeks general laws that can apply to many different people, such as the principle of self-actualization, or the trait of extraversion. Idiographic psychology is an attempt to understand the unique aspects of particular individual. Personality psychologists are interested in the unique characteristics of individuals, as well as similarities among groups of people.

In quality of life research, one often distinguishes between the subjective and objective quality of life. Subjective quality of life is about feeling good and being satisfied with things in general. Objective quality of life is about fulfilling the societal and cultural demands for material wealth, social status and physical well-being.

The approach to the measurement of the quality of life derives from the position that there are a number of domains of living. Each
domain contributes to one's overall assessment of the quality of life. The domains include family and friends, work, neighborhood (shelter), community, health, education, and spiritual.

These problems had acknowledged in a workshop on Suicidal Behaviors in Adolescents and Young. Because of this concern about the state his colleagues was commissioned critically review the literature on the assessment of suicidal behaviors among adolescents. Based on their review, several conclusions regarding the assessment of juvenile suicidal behavior were offer, including the following. First, clear and operational definitions of the suicidal behaviors assessed with various instruments were need. Second, more attention needed to be paid to the validity of instruments, particularly discriminative and predictive validity, and the validity of claims that instruments can identify a group of “high-risk” youths. Third, for case-finding instruments, greater concern regarding the sensitivity and specificity of the instruments was warrant. Fourth, many of the assessment instruments focused on suicidal ideation despite the fact that the relationship between suicidal ideation and other suicidal behaviors was far from clear. Fifth, the intended purposes of many of the instruments were unclear. Sixth, normative data were need for many of the instruments, as well as data pertaining to gender and ethnic differences.

1.2 Personality

Different answers are possible to the question "Why Study Personality?" Here is one answer that can help you understand something of what personality and its study is about. Each of us, as human beings, influences much that is within us and around us. Each of us has many
psychological attributes feelings, thoughts, motivations, and the like. Our personality orchestrates our psychological qualities. Our feelings strong or slight determine some of how we act and react. Our thoughts guide us and influence others, who may entertain by our wit or attracted to our wisdom. Our sense of self helps inform us of how to make choices among alternatives choices that may help us grow, or, that may harm us. The personality of ours slowly and persistently influences how we feel, what we do, who we are, and how we influence the world around us.

1.2.1 What is Personality?

**Personality psychology** is a branch of psychology that studies personality and individual differences. Its areas of focus include:

- Constructing a coherent picture of the individual and his or her major psychological processes.
- Investigating individual differences—how people are unique.
- Investigating human nature—how people are alike.

"Personality" can defined as a dynamic and organized set of characteristics possessed by a person that uniquely influences his or her cognitions, emotions, motivations, and behaviors in various situations. The word "personality" originates from the Latin **persona**, which means mask. Rather was a convention employ to represent or typify that character? Personality may also refer to the patterns of thoughts, feelings and behaviors consistently exhibited by an individual over time that strongly influence our expectations, self-perceptions, values and attitudes, and predicts our reactions to people, problems and stress.
1.2.2 Defining Personality

“Personality is made up the characteristic patterns of thoughts, feelings and behaviors that make a person unique. Personality arises from within the individual and remains fairly consistent throughout life.”

Allport argues that the psychology of personality can make these contributions (Allport, 1937, pp. 550-566), which I have summarized as follows:

- Develop general laws as to how an individual's uniqueness comes about.
- Predict a person's behavior on the basis of his/her individual characteristics.
- Discover the individual person's own point of view of who she or he is.
- Discover the parts of personality.
- Discover the structure that holds those parts together.
- Give preference to certain concepts e.g., ego-system, trait, life-history that recognize a person's individuality.
- Discover common traits.
- Codify knowledge as to the nature of human nature.
- Turn interpersonal impressions into more reliable knowledge.
- Adequately represent the individual in science, and provide that individual with respect.
Henry Murray and the Harvard Guidance Clinic (Murray, 1938) had this to say:

Man is to-day's great problem. What can we know about him and how can it said in words that have clear meaning? The point of view adopted in this book is that personalities constitute the subject matter of psychology, the life history of a single man being the unit with which this discipline has to deal. (Murray, 1938, p. 3)

1.2.3 Theories of Personality

The study of personality is base on the essential insight that all people are similar in some ways, yet different in others. For example, all people learn, yet people learn different things, in different ways, and to different extents. There have been many different definitions of personality proposed. Most contemporary psychologists though would agree on the following definition:

“Personality is that pattern of characteristic thoughts, feelings, and behaviors that distinguishes one person from another and that persists over time and situations.”

1.2.3.1 Trait theories

According to the Diagnostic and Statistical Manual of the American Psychiatric Association, personality traits are "enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts."
Theorists generally assume (a) traits are relatively stable over time, (b) traits differ among individuals (for instance, some people are outgoing while others are reserved), and (c) traits influence behavior. When people are describing a person, they constantly talk about traits to help define the person as a whole. Traits are relatively constant; they do not usually change. Traits are also bipolar; they vary along a continuum between one extreme and the other (e.g. friendly vs. unfriendly).

The most common models of traits incorporate three to five broad dimensions or factors. All trait theories incorporate at least two dimensions, extraversion and neuroticism, which historically featured in Hippocrates' humeral theory.

- **Allport** delineated different kinds of traits, which he also called dispositions. Central traits are basic to an individual's personality, while secondary traits are more peripheral. Common traits are those recognized within a culture and thus may vary from culture to culture. Cardinal traits are those by which an individual may strongly recognized. In his book, Personality: a Psychological Interpretation, Allport (1937) both established personality psychology as a legitimate intellectual discipline and introduced the first of the modern trait theories.

- **Raymond Cattell's** research propagated a two-tiered personality structure with sixteen "primary factors" (16 Personality Factors) and five "secondary factors." In Cattell's lengthy career, he had written 50 books, 500 journals, and 30 different types of standardized tests.
For Cattell, personality itself was defined in terms of behavioral prediction. He defined personality as “that which permits a prediction of what a person will do in a given situation.”

- **Hans Eysenck** believed just three traits - extraversion, neuroticism and psychotics - were sufficient to describe human personality. Differences between Cattell and Eysenck emerged due to preferences for different forms of factor analysis, with Cattell using oblique, Eysenck orthogonal rotation to analyze the factors that emerged when personality questionnaires were subject to statistical analysis. Today, the Big Five factors have the weight of a considerable amount of empirical research behind them, building on the work of Cattell and others. Eysenck, along with another contemporary in trait psychology named **J. P. Guilford** (1959), believed that the resultant trait factors obtained from factor analysis should be statistically independent of one another - that is, the factors should be arranged (rotated) so that they are uncorrelated or orthogonal (at right angles) to one another.

- **Lewis Goldberg** proposed a five-dimension personality model, nicknamed the "Big Five":
  
  1. **Openness to Experience**: the tendency to be imaginative, independent, and interested in variety vs. practical, conforming, and interested in routine.
  2. **Conscientiousness**: the tendency to be organized, careful, and disciplined vs. disorganized, careless, and impulsive.
3. **Extraversion**: the tendency to be sociable, fun loving, and affectionate vs. retiring, somber, and reserved.

4. **Agreeableness**: the tendency to be softhearted, trusting, and helpful vs. ruthless, suspicious, and uncooperative.

5. **Neuroticism**: the tendency to be calm, secure, and self-satisfied vs. anxious, insecure, and self-pitying.

**1.2.3.2 Type theories**

Personality type refers to the psychological classification of different types of people. A personality type is distinguished from personality traits, which come in different levels or degrees. For example, according to type theories, there are two types of people, introverts and extroverts. According to trait theories, introversion and extroversion are part of a continuous dimension, with many people in the middle. The idea of psychological types originated in the theoretical work of Carl Jung and William Marston, whose work is reviewed in Dr. Travis Bradberry's Self-Awareness. Jung's seminal 1921 book on the subject is available in English as Psychological Types.

The model is an older and more theoretical approach to personality, accepting extroversion and introversion as basic psychological orientations in connection with two pairs of psychological functions:

- **Perceiving functions**: sensing and intuition (trust in concrete, sensory-oriented facts vs. trust in abstract concepts and imagined possibilities)
• **Judging functions:** thinking and feeling (basing decisions primarily on logic vs. considering the effect on people).

**Type A and Type B personality theory**

During the 1950s, Meyer Friedman and his co-workers defined what they called Type A and Type B behavior patterns. They theorized that intense, hard-driving Type A personalities had a higher risk of coronary disease because they are "stress junkies." Type B people, on the other hand, tended to be relaxed, less competitive, and lower in risk. There was also a Type AB mixed profile.

**1.2.3.3 Psychoanalytic theories**

Psychoanalytic theories explain human behavior in terms of the interaction of various components of personality. Sigmund Freud was the founder of this school. Freud drew on the physics of his day (thermodynamics) to coin the term psycho-dynamics. Based on the idea of converting heat into mechanical energy, he proposed psychic energy could be converted into behavior. Freud's theory places central importance on dynamic, unconscious psychological conflicts.

Freud divides human personality into three significant components: the id, ego, and super-ego. The id acts according to the pleasure principle, demanding immediate gratification of its needs regardless of external environment; the ego then must emerge in order to realistically meet the wishes and demands of the id in accordance with the outside world, adhering to the reality principle. Finally, the superego
(conscience) inculcates moral judgment and societal rules upon the ego, thus forcing the demands of the id to be met not only realistically but morally. The superego is the last function of the personality to develop, and is the embodiment of parental/social ideals established during childhood. According to Freud, personality is based on the dynamic interactions of these three components.

The channeling and release of sexual (libido) and aggressive energies, which ensues from the "Eros" (sex; instinctual self-preservation) and "Thanatos" (death; instinctual self-annihilation) drives respectively, are major components of his theory. It is important to note that Freud's broad understanding of sexuality included all kinds of pleasurable feelings experienced by the human body.

Freud proposed five psychosexual stages of personality development. He believed adult personality is dependent upon early childhood experiences and largely determined by age five. Fixations that develop during the infantile stage contribute to adult personality and behavior.

1.2.3.4 Behaviorist theories

Behaviorists explain personality in terms of the effects external stimuli have on behavior. It was a radical shift away from Freudian philosophy. This school of thought was developed by B. F. Skinner who put forth a model which emphasized the mutual interaction of the person or "the organism" with its environment. Skinner believed children do bad things because the behavior obtains attention that serves as a reinforce. For
example: a child cries because the child's crying in the past has led to attention. These are the response, and consequences. The response is the child crying, and the attention that child gets is the reinforcing consequence. According to this theory, people's behavior is formed by processes such as operant conditioning. Skinner put forward a "three term contingency model" which helped promote analysis of behavior based on the "Stimulus - Response - Consequence Model" in which the critical question is: "Under which circumstances or antecedent 'stimuli' does the organism engage in a particular behavior or 'response', which in turn produces a particular 'consequence'."

Richard Herrnstein extended this theory by accounting for attitudes and traits. An attitude develops as the response strength (the tendency to respond) in the presences of a group of stimuli become stable. Rather than describing conditional traits in non-behavioral language, response strength in a given situation accounts for the environmental portion. Herrstein also saw traits as having a large genetic or biological component as do most modern behaviorists.

Ivan Pavlov is another notable influence. He is well known for his classical conditioning experiments involving dogs. These physiological studies led him to discover the foundation of behaviorism as well as classical conditioning.

1.2.3.5 Social cognitive theories

In cognitive theory, behavior is explained as guided by cognitions (e.g. expectations) about the world, especially those about other
people. Cognitive theories are theories of personality that emphasize cognitive processes such as thinking and judging.

**Albert Bandura**, a social learning theorist suggested the forces of memory and emotions worked in conjunction with environmental influences. Bandura was known mostly for his "Bobo Doll experiment". During these experiments, Bandura videotaped a college student kicking and verbally abusing a bobo doll. He then showed this video to a class of kindergarten children who were getting ready to go out to play. When they entered the play room, they saw bobo dolls, and some hammers. The people observing these children at play saw a group of children beating the doll. He called this study and his findings observational learning, or modeling.

Baron relates early development of cognitive approaches of personality to ego psychology. More central to this field have been:

- Attribution style theory dealing with different ways in which people explain events in their lives. This approach builds upon locus of control, but extends it by stating we also need to consider whether people attribute to stable causes or variable causes, and to global causes or specific causes.

- Achievement style theory focuses upon identification of an individual's Locus of Control tendency, such as by Rotter's evaluations, and was found by Cassandra Bolyard Whyte to provide valuable information for improving academic performance of students. Individuals with internal control tendencies are likely to
persist to better academic performance levels, presenting an achievement personality, according to Cassandra B. Whyte.

Walter Mischel (1999) has also defended a cognitive approach to personality. His work refers to "Cognitive Affective Units", and considers factors such as encoding of stimuli, affect, goal-setting, and self-regulatory beliefs. The term "Cognitive Affective Units" shows how his approach considers affect as well as cognition.

Cognitive-Experiential Self-Theory (CEST) is another cognitive personality theory. Developed by Seymour Epstein, CEST argues that humans operate by way of two independent information processing systems: experiential system and rational system. The experiential system is fast and emotion-driven. The rational system is slow and logic-driven. These two systems interact to determine our goals, thoughts, and behavior.

1.2.3.6 Humanistic theories

In humanistic psychology it is emphasized people have free will and they play an active role in determining how they behave. Accordingly, humanistic psychology focuses on subjective experiences of persons as opposed to forced, definitive factors that determine behavior. Abraham Maslow and Carl Rogers were proponents of this view, which is based on the "phenomenal field" theory of Combs and Snygg (1949).

Maslow spent much of his time studying what he called "self-actualizing persons", those who are "fulfilling themselves and doing the best they are capable of doing". Maslow believes all who are interested in
growth move towards self-actualizing (growth, happiness, satisfaction) views. Many of these people demonstrate a trend in dimensions of their personalities. Characteristics of self-actualizers according to Maslow include the four key dimensions:

1. **Awareness** - maintaining constant enjoyment and awe of life. These individuals often experienced a "peak experience". He defined a peak experience as an "intensification of any experience to the degree there is a loss or transcendence of self". A peak experience is one in which an individual perceives an expansion of his or herself, and detects a unity and meaningfulness in life. Intense concentration on an activity one is involved in, such as running a marathon, may invoke a peak experience.

2. **Reality and problem centered** - they have a tendency to be concerned with "problems" in their surroundings.

3. **Acceptance/Spontaneity** - they accept their surroundings and what cannot be changed.

4. **Unhostile sense of humor/democratic** - they do not like joking about others, which can be viewed as offensive. They have friends of all backgrounds and religions and hold very close friendships.

### 1.2.3.7 Biopsychological theories

Some of the earliest thinking about possible biological bases of personality grew out of the case of **Phonies Gage**. In an 1848 accident, a large iron rod was driven through Gage's head, and his personality...
apparently changed as a result, although descriptions of these psychological changes are usually exaggerated.

Cattell and Eysnck have proposed that genetics have a strong influence on personality. Twin studies show that there are correlations between twins and the five factor personality model: neuroticism, extroversion openness, agreeableness and conscientiousness. Identical twins however, have higher correlations in personality traits than fraternal twins. It is suggested that heredity and environment interact to determine one's personality.

1.2.4 Gender differences

Research has consistently found that on average, women score moderately higher than men on neuroticism. A study examining gender differences in big five personality traits in 55 nations found that across nations the most pronounced gender difference in personality was in neuroticism. In 49 of the 55 nations studied, women scored significantly higher in neuroticism than men. In no country did men report significantly higher neuroticism than women. Gender differences in neuroticism within...
nations ranged from very small to quite large. Women, on the other hand tended not to differ in neuroticism across regions. Gender differences were also positively associated with measures of Human Development that is long and healthy life, access to knowledge and education, and decent standards of living. That is, sex differences became more pronounced in countries with higher levels of human development.

1.2.5 Neuroticism

Neuroticism is a fundamental personality trait in the study of psychology. It is an enduring tendency to experience negative emotional states. Individuals who score high on neuroticism are more likely than the average to experience such feelings as anxiety, anger, envy, guilt, and depressed mood. They respond more poorly to environmental stress, and are more likely to interpret ordinary situations as threatening, and minor frustrations as hopelessly difficult. They are often self-conscious and shy, and they may have trouble controlling urges and delaying gratification. Neuroticism is a risk factor for the "internalizing" mental disorders such as phobia, depression, panic disorder, and other anxiety disorders (traditionally called neuroses).

1.2.6 Personality Disorders:

An estimated 10 to 15% of adults in the United States experience symptoms of at least one personality disorder. What are personality disorders? A personality disorder is a chronic and pervasive
mental disorder that affects thoughts, behaviors, and interpersonal functioning. The DSM-IV currently lists 10 different personality disorders.

1.2.7 Personality Tests:

You can find a number of personality tests here on the About Psychology site. These tests and quizzes are designed to give readers an idea of how formal assessments are used. However, these personality tests are not intended for use in assessment or diagnosis.

1.2.8 Characteristics of Personality

- Personality is organized and consistent.
- Personality is psychological, but is influenced by biological needs and processes.
- Personality causes behaviors to happen.
- Personality is displayed through thoughts, feelings, behaviors and many other ways.

1.2.9 The Study of Personality

There are a number of different techniques that are used in the study of personality. Each technique has its own strengths and weaknesses.

- **Experimental methods** are those in which the researcher controls and manipulates the variables of interests and takes measures of the results. This is the most scientific form of research, but experimental research can be difficult when studying aspects of personality such as
motivations, emotions, and drives. These ideas are internal, abstract, and extremely difficult to measure.

- **Case studies and self-report methods** rely on in-depth analysis of an individual as well as information provided by the individual. Case studies rely heavily on the interpretation of the observer, while self-report methods depend upon the memory of the individual of interest. Because of this, these methods tend to be highly subjective and it is difficult to generalize the findings to a larger population.

- **Clinical research** relies upon information gathered from clinical patients over the course of treatment. Many personality theories are based upon this type of research, but because the research subjects are unique and exhibit abnormal behavior, this research tends to be highly subjective and difficult to generalize.

In any case, people fluctuate in their behavior all the time, and even extreme introverts and extraverts do not always act according to their type.

The trait of **extraversion - introversion** is a central dimension of human personality theories.

**1.2.10 Extraversion**

Extraversion is "the act, state, or habit of being predominantly concerned with and obtaining gratification from what is outside the self". Extraverts tend to enjoy human interactions and to be enthusiastic, talkative, assertive, and gregarious. They take pleasure in activities that involve large social gatherings, such as parties, community activities,
public demonstrations, and business or political groups. Politics, teaching, sales, managing and brokering are fields that favor extraversion. An extroverted person is likely to enjoy time spent with people and find less reward in time spent alone. They tend to be energized when around other people, and they are more prone to boredom when they are by themselves.

### 1.2.11 Introversion

Introversion is "the state of or tendency toward being wholly or predominantly concerned with and interested in one's own mental life". Some popular writers have characterized introverts as people whose energy tends to expand through reflection and dwindle during interaction. This is similar to Jung's view, although he focused on psychic energy rather than physical energy. Few modern conceptions make this distinction.

### 1.2.12 Eysenck's theory

**Hans Eysenck** described extraversion-introversion as the degree to which a person is outgoing and interactive with other people. These behavioral differences are presumed to be the result of underlying differences in brain physiology. Extroverts seek excitement and social activity in an effort to heighten their arousal level, whereas introverts tend to avoid social situations in an effort to keep such arousal to a minimum. Eysenck designated extraversion as one of three major traits in his P-E-N model of personality, which also includes psychotics and neuroticism.

Eysenck originally suggested that extraversion was a combination of two major tendencies, impulsiveness and sociability. He
later added several other more specific traits, namely liveliness, activity level, and excitability. These traits are further link in his personality hierarchy to even more specific habitual responses, such as partying on the weekend.

Eysenck compared this trait to the four temperaments of ancient medicine, with choleric and sanguine temperaments equating to extraversion, and melancholic and phlegmatic temperaments equating to introversion.

Twin studies find that extraversion/introversion has a genetic component.

1.2.13 Biological factors

The relative importance of nature versus environment in determining the level of extraversion is controversial and the focus of many studies. Twin studies find a genetic component of 39% to 58%. In terms of the environmental component, the shared family environment appears to be far less important than individual environmental factors that are not share between siblings.
Extraversion has been linked to higher sensitivity of the mesolimbic dopamine system to potentially rewarding stimuli. This in part explains the high levels of positive affect found in extroverts, since they will more intensely feel the excitement of a potential reward. One consequence of this is that extroverts can more easily learn the contingencies for positive reinforcement, since the reward itself is experienced as greater.

One study found that introverts have more blood flow in the frontal lobes of their brain and the anterior or frontal thalamus, which areas are dealing with internal processing, such as planning and problem solving. Extroverts have more blood flow in the anterior cingulated gyros, temporal lobes, and posterior thalamus, which are involved in sensory and emotional experience. This study and other research indicate that introversion-extraversion is related to individual differences in brain function.

Extraversion has also been linked to physiological factors such as respiration, through its association with assurgency.

1.2.14 Behavior

Extraverts and introverts have a variety of behavioral differences. According to one study, extraverts tend to wear decorative clothing, whereas introverts prefer practical, comfortable clothes. Extraverts are likely to prefer more upbeat, conventional, and energetic music than introverts are. Personality also influences how people arrange their work areas. In general, extraverts decorate their offices more, keep their doors open, keep extra chairs nearby, and are more likely to put
dishes of candy on their desks. These are attempts to invite co-workers and encourage interaction. Introverts, in contrast, decorate less and tend to arrange their workspace to discourage social interaction.

1.2.15 Extraversion, introversion, and happiness

Extraverts found to have higher levels of happiness and positive affect than introverts do. Personality, specifically extraversion and emotional stability, was the best predictor of subjective well-being. As examples, Argyle and Lu (1990) found that the trait of extraversion, as measured by Extraversion Scale of the Eysenck Personality Questionnaire (EPQ), positively and significantly correlated with happiness, as measured by the Oxford Happiness Inventory. Using the same happiness and extraversion scales, Hills and Argyle (2001) found that happiness was again significantly correlated with extraversion. Similar result was found in a large longitudinal study by Diener, Sandvik, Pavot, and Fujita (1992), which assessed 14,407 participants from 100 areas of continental United States. Using the abbreviated General Well-Being Schedule, this tapped positive and negative effects. Larsen and Ketelaar (1991) showed that extraverts respond more to positive affect than to negative effect, since they exhibit more positive-affect reactivity to the positive-affect induction, yet they do not react more negatively to the negative-affect induction.

1.2.16 Components of Personality

While there are many different theories of personality, the first step is to understand exactly what meant by the term personality. A brief definition would be that personality made up of the characteristic patterns...22...
of thoughts, feelings and behaviors that make a person unique. In addition to this, personality arises from within the individual and remains consistent throughout life.

1.2.17 Some of the fundamental characteristics of personality:

- **Consistency** - There is generally a recognizable order and regularity to behaviors. Essentially, people act in the same ways or similar ways in a variety of situations.

- **Psychological and physiological** - Personality is a psychological construct, but research suggests that biological processes and needs also influence it.

- **Impact behaviors and actions** - Personality does not just influence how we move and respond in our environment; it also causes us to act in certain ways.

- **Multiple expressions** - Personality is display in more than just behavior. It can also see in our thoughts, feelings, close relationships and other social interactions.

1.3 Quality of Life

The best way of approaching quality of life measurement is to measure the extent to which people's 'happiness requirements' are met - i.e. those requirements which are a necessary (although not sufficient) condition of anyone's happiness - those 'without which no member of the human race can be happy.' QOL may be defining as subjective well-being. Recognizing the subjectivity of QOL is a key to understanding this construct. QOL reflects the difference, the gap, between the hopes and
expectations of a person and their present experience. Human adaptation is such that life expectations are usually adjust to life within the realm of what the individual perceives to be possible. This enables people who have difficult life circumstances to maintain a reasonable QOL.

1.3.1 What is Quality of Life?

"Quality of Life is tied to perception of 'meaning'. The quest for meaning is central to the human condition, and we are brought in touch with a sense of meaning when we reflect on that which we have created, loved, believed in or left as a legacy."


Our definition of quality of life is “The degree to which a person enjoys the important possibilities of his/her life. Possibilities result from the opportunities and limitations each person has in his/her life and reflect the interaction of personal and environmental factors. Enjoyment has two components: the experience of satisfaction and the possession or achievement of some characteristic, as illustrated by the expression: "She enjoys good health." Three major life domains are identifying Being, Belonging, and Becoming. The conceptualization of Being, Belonging, and becoming the domains of quality of life were developed from the insights of various writers."

“Quality of Life is the product of the interplay among social, health, economic and environmental conditions which affect human and social development.”

- Ontario Social Development Council, 1997
“Quality of Life is the product of the interplay among social, health, economic and environmental conditions which affect human and social development.”

1.3.2 Quality of Life: A Systems Model

UNDP has been publishing the annual Human Development Index (HDI) for countries around the worlds. It examines the health, education and wealth of each nation's citizens by measuring:

- life expectancy
- educational achievement -- adult literacy plus combined primary, secondary and tertiary enrolment; and
- Standard of living -- real GDP per capita based on PPP exchange rates.


...25...
The purpose of the Quality of Life (QOL) is to provide a tool for community development, which can be us to monitor key indicators that encompass the social, health, environmental and economic dimensions of the quality of life in the community. The QOL can be us to comment frequently on key issues that affect people and contribute to the public debate about how to improve the quality of life in the community. It is intend to monitor conditions that affect the living and working conditions of people and focus community action on ways to improve health. Indicators for the QOL include:

- **SOCIAL**: Children in care of Children’s Aid Societies; social assistance beneficiaries; public housing waiting lists etc.
- **HEALTH**: Low birth weight babies; elderly waiting for placement in long-term care facilities; suicide rates etc.
- **ECONOMIC**: Number of people unemployed; number of people working; bankruptcies etc.
- **ENVIRONMENTAL**: Hours of moderate/poor air quality; environmental spills; tones diverted from landfill to blue boxes etc.

### 1.3.3 Dynamic Fitness

Quality of Life is often define in a very negative way, simply as the absence of health threatening hazards from the environment or as the absence of disease or medical problems. Even if we take a more positive approach and consider the advantages the environment offers (e.g. in arts, schools, natural beauty, access and so on), this is again a static viewpoint and assumes that a body that is functioning at its optimum in an optimum
environment is somehow also optimize. Nothing could be further from the truth; a vegetable could perhaps say that - but not a human.

1.3.4 Optimizing Needs

We saw earlier that our human needs group into many areas, but initially we will take for granted the measurable external Primal (survival) and Social (environmental) needs and concentrate on those higher psychological needs that actually comprise our humanity and what they can contribute to our 'Quality of Life' (QOL). We saw that these needs are implementing at an abstract level, they do not relate to the physical world, thus our evaluation of them (in ourselves or in others) is problematical - we cannot measure beauty, or love or understanding using any instrument.

1.3.5 Attitudes to Life

In many respects, life is what we make it. It is our personal psychological attitude that defines our abstract level satisfaction or otherwise with our lives. Thus if we are an optimist we will see the good aspects of our environment, whilst a pessimist will only see the bad - thus the same environment is perceived differently. This means that environmental or material change is a poor method of optimization; it is crude global changes that can make life seen worst for some - even if most like the change. Thus our concentration here on the psychological aspects of fitness should prove beneficial, in the fulfillment of those personal goals that lies behind most definitions of Quality of Life.
1.3.6 Meta needs

Even our media and educational systems are locked into this narrow repetitive world - the full diversity and beauty of knowledge and of our world is hidden by a fear of being different, of going beyond the lowest common denominator.

The move towards multiple TV channels, towards online information, towards virtual reality breaks down the stranglehold over information that has steered (and manipulated) our societies over the centuries. New information is itself fitness enhancing, since it provides choice, new options in state space. It also allows us to counter misinformation, to challenge the views that we have had imposed upon us by those holding power (by whatever means). This freedom is itself a major component of Quality of Life.

1.3.7 Social Needs

This level of needs relates strongly to the structure of our society, to the cultural norms that we invent to simplify our interactions. Moreover, make no mistake, we do invent these ideas, the values we put on things, on position, on fame or money are arbitrary. Many alternative value systems are possible and many of these will give a better quality of life. We need carefully re-evaluate all these social attitudes and behaviours to specify just what benefit or fitness they provide, and to be prepared to discard those that have no benefit. We should augment or add alternatives that are more appropriate to a modern interdisciplinary and multidimensional view of quality.
1.3.8 Primary Needs

Control of nature was one of the early ideas behind science. Despite a rather human centered domination ideology, we now have the ability seriously raise the quality of life for millions, perhaps billions of the inhabitants of this planet. Given that we are connected nowadays more than ever before, this would considerably increase the fitness of the complex system of which we are a part. Like most aspects of fitness maximization. It is a problem of attitude and needs to address initially from the abstract level. Quality of Life essentially is again all in the mind.

We are all connected parts of one global ecosystem, interdependent and interrelated. What we do affects other people, it affects their Quality of Life - their fitness and they in turn (in co evolutionary fashion) affect ours. Considering these interactions is the key to maximizing fitness both as individuals and as a species. This is a multidimensional task, there are many values, at many need levels and many social groupings. This web of diversity comprises our Quality of Life.

1.3.9 Quality of life (healthcare)

The Economist Intelligence Unit’s quality-of-life, 2005
### Quality of Life (QOL)

Quality of Life (QOL) is a phrase used to refer to an individual’s total wellbeing. This includes all emotional, social, and physical aspects of the individual’s life. However, when the phrase is used in reference to medicine and healthcare as Health Related Quality of Life, it refers to how the individual’s wellbeing may be impacted over time by a disease, a disability, or a disorder.

#### 1.3.10 Why is it important?

There is a growing field of research concerned with developing, evaluating, and applying quality of life measures within health related research (e.g. within randomized controlled studies, especially in relation to Health Services Research. Well-executed QOL research informs those tasked with health rationing or anyone involved in the decision-making process of agencies such as the Food and Drug Administration.

The understanding of Quality of Life is recognizing as an increasingly important healthcare topic because the relationship between cost and value raises complex problems, often with high emotional attachment because of the potential impact on human life. For instance,
healthcare providers must refer to cost-benefit analysis to make economic decisions about access to expensive that may prolong life by short amount of time and/or provide a minimum increase to quality of life. An emphasis is place on improving QOL through interventions such as symptom management, adaptive technology, and palliative care.

1.3.11 Future Implications of QOL

The Center for Disease Control and Prevention (CDC) is using their QOL survey, Healthy Day Measures, as part of research to identify health disparities, track population trends, and build broad coalitions around a measure of population health. This information can then be used by multiple levels of government or other officials to "increase quality and years of life" and to "eliminate health disparities" for equal opportunity.

1.3.12 Research Pertaining to QOL

Research revolving around Quality of Life is extremely important because of the implications that it can have on current and future treatments and health protocols. Thereby, validated QOL questionnaires can become an integral part of clinical trials in determining the trial value in a cost-benefit analysis.

...31...
The Remarkable 0.5 of Standard Deviation

In a study by Norman et al. about QOL surveys, it found that most survey results were within a half standard deviation. Norman et al. theorized that this is due to the limited human discrimination ability as identified by George A. Miller in 1956. Utilizing the Magic Number of 7 ± 2, Miller theorized that when the scale on a survey extends beyond 7 ± 2, humans fail to be consistent and lose ability to differentiate individual steps on the scale because of channel capacity.

1.4 Suicide Tendency

As indicated by the decision to include suicide as one of the leading indicators of health status in Healthy People 2010, (“Public Health Response to Youth Suicide and Violence Act of 1999”), Senate Resolution (“Recognizing Suicide as a National Problem and Declaring Suicide Prevention to be a National Priority”), and the Public Health Service Revised Program Announcement for Studies of Suicide and Suicidal Behavior, research related to the understanding, prevention, and treatment of suicidal behaviors is a high priority. Because of increased awareness of suicidal as a problem, and because completed suicide is the third leading cause of death among young people, efforts to identify youths who have

...32...
engaged in suicidal behaviors or are at “high risk” for engaging in suicidal behavior have increased markedly over the last years.

As a case in point, In November 1998, “Suicidal in Youth: Developing the Knowledge Base for Youth at Risk,” which brought together researchers in juvenile suicidal behavior, as well as researchers in other areas including developmental epidemiology, child psychiatry, and human development. Several areas of need were identified – the continuing need for consistently used operational definitions of suicidal behaviors, the need for some consensus on important constructs regarding the study of suicidal behavior, the need to examine suicidal behaviors in the context of high-risk behaviors, and the need for some consensus as to the most useful ways of assessing suicidal. It was suggested that it would be useful for researchers to have an updated critical review of the instruments that have been used to assess suicidal behaviors among children and adolescents. Problems inherent in designing treatment studies for suicidal individuals discussed in this study, and a particular need identified for knowledge regarding which measures of suicidal should be of most utility in treatment studies. This commissioned review of instruments used to assess suicidal behaviors and risk among youths.

1.4.1 What is Suicide?

“Work with a warning against notions vulgates, together with an insistence that our first task must be to determine the order of facts to be studied under the name of suicide.”

- Durkheim, 1997
“Such foreknowledge is a matter of degree, varying considerably from one person or situation to another. At what point, for example, does the death of a professional dare-devil or that of a man neglectful of his health cease to be an "accident" and start to become suicide."

“Situational crime prevention assumes that crime can be prevented, at least to some extent, by reducing opportunities for crime.”

- Clarke, 1992

In 1621, Robert Burton writes: “Melancholy seldom has a fatal outcome, except in those cases and that is namely the greatest and most painful tragedy, this exterior misfortune, in which the affected commit suicide”.

The suicidal tendencies of depressive-melancholic cases are best analyzed using a developmental model incorporating psychophysical triggers, both acquired and constitutional aspects of personality including physical illness, as well as factors originating in the socio-cultural environment. This permits the integration of psychodynamic, inside psychological, psychiatric-biological and social points of view. Current psychobiological models regard a defective central impulse control as the cause for suicidal behaviour, which is accompany by serotonin metabolism dysfunction in the central nervous system. Psychiatric and psycho-pathological approaches describe the status of despair and cognitive perception disorders in depression or schizophrenia, but also in crisis-related psychic limitations. Sociological approaches refer to the importance
of the aspects of anomie in society and the difficulties of social integration of the affected groups (for an overview sees Maris, 1986; Blumenthal & Kupfer, 1990; Wedler et al., 1992).

In the light of aetiopathogenetic and developmental points of view, the following aspects are of importance in the current discussion concerning suicidal tendencies:

1. **Suicidal ideas**: May appear just as well in healthy people, however, acquire a pathological status when they occur in the context of illness, e.g., depression or physical illness.

2. **Biological readiness to act (impulsivity)**: This refers to a neurobiochemical and genetic disorder involving impulsiveness and behaviour control, which manifests itself on the neurobiochemical level mainly in a central serotonin disturbance (Praag, van., 1986). In certain circumstances, this biological readiness to act can also be activating by psychosocial or psychodynamic means, however also by biological, i.e., medicament us means. As an example, see the discussion on "suicide promotion" caused by anti-depressants.

3. **Current psycho reactive triggering factors**: In this point, particular importance is attributing to the psychoanalytic and inside-psychological concept of suicidal tendency as the manifestation of a narcissistic crisis (Reimer, 1986) of a significant role model. Loss, insult, existential inevitability all plays an important role in this experience.
4. **Despair, helplessness, hopelessness**: Convictions of lacking prospects for the future and the impossibility of changing this outlook are central psychopathological phenomena that form the threshold between suicidal ideas and suicidal action (Beck, 1990).

5. **Loss of or loss of effectiveness of protective factors**: "bonds", social control of aggression (societal norms on aggression control), religious, spiritual or family bonds, group cohesion, etc.

### 1.4.2 Overdoses and Suicide

Lester (1989) found that, for the states of the U.S., accidental death rates from poisoning by solids/liquids and by gases was positively associated with the suicide rates using these two methods. Lester and Agarwal (1989) found a similar association for poisoning in general over the regions of India. Neither of these studies examined the possible occurrence of displacement to other methods for suicide.

In the case of suicide, these social currents are express as suicide rates, rates that differ among societies, and among different groups in society. These rates show regularities over time, with changes in the rates often occurring at similar times in different societies. Thus, these rates can said to be social facts (or at least the statistical representation of social facts) in the sense that they are not just personal, but are societal characteristics.

### 1.4.3 Suicide Rates as Social Facts

At each moment of its history, therefore, each society has a definite aptitude for suicide. The relative intensity of this aptitude is
measure by taking the proportion between the total number of voluntary deaths and the population of every age and sex. We will call this numerical datum the rate of mortality through suicide, characteristic of the society under consideration. The suicide-rate is therefore a factual order, unified and definite, as is shown by both its permanence and its variability. For this permanence would be inexplicable if it were not the result of a group of distinct characteristics, solitary with one another, and simultaneously effective in spite of different attendant circumstances; and this variability proves the concrete and individual quality of these same characteristics, since they vary with the individual character of society itself. In short, these statistical data express the suicidal tendency with which each society is collectively afflicted. Each society is predisposed to contribute a definite of voluntary deaths. (Suicide, pp. 48, 51).

1.4.4 Social Explanation

It is not because heat disturbs the organism, but because social life is more intense. To be sure, this greater intensity derives from the greater ease of development of social life in the summer than in the winter, owing to the sun's position, the state of the atmosphere. Nevertheless, the physical environment does not stimulate it directly; above all, it has no effect on the progression of suicide. (Suicide, pp. 121-122).

1.4.5 Four Types of Suicide

The manner which social integration and regulation work can be seen by examining the four-fold classification of suicides that Durkheim developed. Durkheim ends his discussion of the organic-psychic and physical environmental factors by concluding that they cannot explain
"each social group specific tendency to suicide". By eliminating other explanations, Durkheim claims that these tendencies must depend on social causes and must be collective phenomena. The key to each type is a social factor, with the degrees of integration and regulation into society being either too high or too low.

1. Egoistic Suicide.

This is the type of suicide that occurs where the degree of social integration is low, and there is a sense of meaningless among individuals. In traditional societies, with mechanical solidarity, this is not likely to be the cause of suicide. There the strong collective consciousness gives people a broad sense of meaning to their lives. Within modern society, the weaker collective consciousness means that people may not see the same meaning in their lives, and unrestrained pursuit of individual interests may lead to strong dissatisfaction. One of the results of this can be suicide. Individuals who are strongly integrate into a family structure, a religious group, or some other type of integrative group is less likely to encounter these problems, and that explains the lower suicide rates among them.

The factors leading to egoistic suicide can be social currents such as depression and disillusionment. For Durkheim, these are social forces or social facts, even though it is the depressed or melancholy individual who takes his or her life voluntarily. "Actors are never free of the force of the collectivity: 'However individualized a man may be, there is always something collective remaining – the very depression and
melancholy resulting from this same exaggerated individualism." In addition, Durkheim says, "Thence are formed currents of depression and disillusionment emanating from no particular individual but expressing society's state of disillusionment." Durkheim notes, "The bond attaching man to life relaxes because that attaching him to society is itself slack. The individual yields to the slightest shock of circumstance because the state of society has made him a ready prey to suicide." (Suicide, pp. 214-215).

2. Altruistic Suicide.

This is the type of suicide that occurs when integration is too great, the collective consciousness too strong, and the "individual is forced into committing suicide." Integration may not be the direct cause of suicide here, but the social currents that go along with this very high degree of integration can lead to this. The followers of Jim Jones of the People’s Temple or the members of the Solar Temple are an example of this, as are ritual suicides. Ritzer notes that some may "feel it is their duty" to commit suicide. Examples in primitive society cited by Durkheim are suicides of those who are old and sick, suicides of women following the death of their husband, and suicides of followers after the death of a chief. According to Durkheim this type of suicide may actually "springs from hope, for it depends on the belief in beautiful perspectives beyond this life."

3. Anomic Suicide.

Anomie or anomy comes from the Greek meaning lawlessness. Nomo’s means usage, custom, or law and nemesis means to
distribute. Anomy thus is social instability resulting from breakdown of standards and values. (Webster's Dictionary).

This is a type of suicide related to too low a degree of regulation, or external constraint on people. As with the anomic division of labour, this can occur when the normal form of the division of labour is disrupt, and "the collectivity is temporarily incapable of exercising its authority over individuals." This can occur either during periods associated with economic depression or over-rapid economic expansion. A new situation with few norms, the regulative effect of structures is weakening, and the individual may feel rootless. In this situation, an individual may be subject to anomic social currents. People that are free from constraints become "slaves to their passions, and as a result, according to Durkheim's view, commit a wide range of destructive acts, including killing themselves in greater numbers than they ordinarily would." In addition to economic anomie, Durkheim also spends time examining domestic anomie. For example, suicides of family members may occur after the death of a husband or wife.

4. Fatalistic Suicide.

When regulation is too strong, Durkheim considers the possibility that "persons with futures pitilessly blocked and passions violently choked by oppressive discipline" may see no way out. The individual sees no possible manner in which their lives can be improve, and when in a state of melancholy, may be subject to social currents of fatalistic suicide.
1.4.6 Overview of Suicide

Suicide ranks as the tenth leading cause of death in the United States. Globally, an estimated 700,000 people take their own lives annually. In certain populations, such as adolescents and young, suicide constitutes 1 of the top 3 causes of death.

An alarming increase in suicides has reported in the last decade. Rockett, all have reported that over the past decade, mortality rates for suicide, poisoning, and falls have substantially increased. Because of traffic safety measures, suicide has surpassed motor vehicle crashes as the leading cause of injury mortality. This phenomenon is even more compelling because, in many instances, suicides can prevent. Therefore, clinicians must recognize the risk factors for suicide as a way of intervening in a self-destructive event and cycle. See the image below.

This article discusses the following:

- Basic terminology applied to self-destructive activities and events.
- Risk factors that can alert the clinician to early warning signs of suicide.
- Interventions if a person's attempt at suicide is imminent.
- The diagnosis and treatment of the underlying mental disorder causing the self-destructive behaviour.
- Appropriate actions for a clinician if a person being treated does commit suicide.
1.4.7 Diagnostic and treatment considerations

Once it has been assured that the patient is safe, the reasons for the individual’s self-destructive behavior must be found. The diagnosis requires a complete psychiatric history and mental status examination.

1.4.8 Terminology of Suicide

Suicide means killing oneself. The act constitutes a person willingly, perhaps ambivalently, taking his or her own life. Several forms of suicidal behavior fall within the self-destructive spectrum.

A completed suicide means the person has died. It is important not to use the term successful suicide; the goal is to prevent suicide and provide treatment.

A suicide attempt involves a serious act, such as taking a fatal amount of medication and someone intervening accidentally. Without the accidental discovery, the individual would be dead.

A suicide gesture denotes a person undertaking an unusual, but not fatal, behavior as a cry for help to get attention.

A suicide gamble is one in which patients gamble their lives that they will be found in time and that the discoverer will save them. For example, an individual ingests a fatal amount of drugs with the belief that family members will be home before death occurs.

A suicide equivalent involves a situation in which the person does not attempt suicide. Instead, he or she uses behavior to get some of...
the reactions that suicide would have caused. For example, an adolescent boy runs away from home, wanting to see how his parents respond. (Do they care? Are they sorry for the way that they have been treating him?) The action can see as an indirect cry for help.

1.4.9 Etiology of Suicide

A number of factors correlate with serious suicide attempts and completed suicides, including, but not limited to, the following:

- Medications
- Mental illness
- Sex
- Genetics
- Availability of firearms
- Life experiences
- Physical illness
- Economic instability and status
- Media and the Internet
- Psychodynamic formulation

1.4.9.1 Medications

A number of medications have been linked to suicidal behaviour, which has prompted the Food and Drug Administration (FDA) to require a warning on certain prescription drugs, including antidepressants, anticonvulsants, and analgesics.
1.4.9.1.1 Anticonvulsants

In 2008, the FDA required a suicidal behaviour warning be placed on anticonvulsants. In a 2010 exploratory analysis, colleagues suggested that the use of gabapentin, lamotrigine, oxcarbazepine, and tiagabine, compared with the use of topiramate, might be associated with an increased risk of suicidal acts or violent deaths.

1.4.9.1.2 Pain medication

Tramadol is a narcotic like pain reliever that, on May 26, 2010, received an FDA addition of a suicide risk warning. The FDA noted linkage between tramadol prescriptions and patients with emotional instability and suicidal ideation and increased self-destructive behavior.

1.4.9.1.3 Smoking cessation medications

Moore et al determined that the risk of depression and suicidal or self-injurious behaviors is substantially increased and statistically significant with the use of varenicline. Risk was also present, but smaller, with bupropion, and was even smaller with nicotine replacement. The investigators suggested that varenicline is unsuitable as a first-line agent to aid in smoking cessation.

1.4.9.2 Mental illness

Although mental illness is generally linked to premature deaths, certain mental illnesses carry with them remarkably high lifetime instances of suicide. In fact, 95% of people who commit suicide have a
mental illness. In a general sense, mental illness all too often is an isolating experience, with such isolation correlating with suicide.

### 1.4.9.2.1 Depression

Because depression involves a preoccupation with death, the twin killers of hopelessness and helplessness, and withdrawal, it is a major contributor to suicide. A dangerous time in depression occurs when a patient is coming out of the deepest part of the experience. At that point, the individual may mobilize his or her newly acquired energy to commit suicide.

The protracted and profound emotional roller coaster of manic-depressive illness puts a patient at risk both during the depressive phase and in the psychosis of mania. Suicide is a particular risk when executive functions and judgment have been compromise by bipolar disorder. In particular, men with bipolar disorder have an increased risk for suicide.

### 1.4.9.2.2 Schizophrenia

Schizophrenic patients are at a significantly high risk for suicide. They may experience hallucinations, often auditory, such as voices commanding them to kill themselves (command hallucinations). In addition, these individuals may, in the context and because of their illness, become depressed; they realize that they are different from others.
1.4.9.2.3 Anxiety disorders

Obsessive-compulsive disorder (OCD) and phobic disorders have symptoms that make suicide a possibility. Persons struggling with these symptoms feel frightened, terrorized, isolated, and physically paralyzed by feelings of anxiety, panic, and dread that often seem inexplicable. In many instances, people feel that the symptoms are growing, expanding, and becoming incapacitating.

A study by Katz et al showed that panic attacks and panic symptoms in individuals with a major mood disorder meeting criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), may carry an increased risk of suicidal ideation. This ideation may progress to suicide attempts, especially in individuals with prominent catastrophic cognitions. An example would be a woman with agoraphobia who becomes progressively more isolated and depressed by her inability to leave her home.

1.4.9.2.4 Substance abuse

Substances can contribute to self-destructive behaviors in all 3 phases of their use-intoxication, withdrawal, and chronic usage. A depressed person commonly becomes acutely suicidal after a few drinks. Similarly, some people can become suicidal after ingesting lysergic acid diethylamide (LSD). Still others encounter depression during substance withdrawal and respond by killing themselves. (See the graph below.)
A person who engages in chronic alcohol and drug use often experiences a number of major losses, including of his or her job, spouse, and family, and these, in turn, contribute to the individual becoming suicidal.

The physical and mental health effects associated with methamphetamine (MA) use have been documented; however, little known about the effects of injection MA and suicidal behavior.

The Vancouver Injection Drug Users Study (VIDUS) found that MA injection was associated with an 80% increase in the risk of attempted suicide, suggesting that individuals who inject MA should be monitor for suicidal behavior. The study elicited information regarding socio demographics, drug use patterns, and mental health problems, including suicidal behavior.

1.4.9.2.5 Delirium and dementia

Delirium and dementia involve the loss of memory, disorientation, hallucinations, delusions, and poor judgment. These conditions often lead to self-destructive behavior. An example might be an
accountant who slowly starts to have difficulty remembering numbers and solving addition problems. Although others might view these problems as minimal, he may feel that he is losing his mind and career, leading him to take his own life.

1.4.9.2.6 Bulimia

Bulimia has accompanied by suicidal activity. Predisposing factors include feelings of loneliness, stimulant use, and family history of psychiatric disorders, childhood abuse, and difficulty dealing with the public.

1.4.9.3 Sex

There is a distinct difference in suicide rates by sex. Men have a significantly higher rate of completed suicides than do women. There is nearly 4 times the number of completed suicides among men than among women. However, women have a much higher rate of suicide attempts. Often, women select methods, such as an overdose of medication, that allow more time for intervention. Men frequently use methods such as firearms, which are much more lethal.

Females more often use poison when attempting suicide. A study by Hoon et al investigated the risk factors associated with the repetition of deliberate self-poisoning. The associated factors for repeat suicide attempt were sex (female), living without a family, using antidepressants, and a history of psychiatric treatment. Early psychological
intervention and close observation is required for patients meeting these criteria. (See the chart below.)

Attempted suicide rates in males and females in a midsized to large municipality in, 1984-2006.

1.4.9.4 Genetics

Some authorities believe that genetic factors alone may be involved in suicide, that suicide runs in families, and that having a relative who commits suicide is indeed a risk factor. Therefore, a family history of suicide is very significant. Careful assessments of family history of mental illness and suicide should be a routine aspect of patient evaluation.

1.4.9.5 Family history

A family history of suicidal behavior represents a significant risk factor for the same behavior in offspring. In some families, suicide constitutes a dynamic to deal with crises. Geulayov et al reviewed the literature on these associations and found such a relationship. They also determined that the association is stronger with maternal suicidal behavior versus paternal suicidal behavior and that the risk is increase more in children than in adolescents or adults.
1.4.9.6 Availability of firearms

The leading method of suicide remains firearms (see the chart below). When a person with a depressed mood consumes alcohol and has a handgun available, the situation can easily turn lethal.

Of 34,598 completed suicides, 17,352 used guns. Therefore, a psychiatrist must inquire not only into the patient's suicidal ideation and plans but also into the presence of firearms. Clinicians also must know their state statutes concerning persons with mental illness possessing firearms. Of interest, the limiting of the purchasing of firearms by local and state background checks has decreased the rate of suicide by guns.

Data from the National Institute of Mental Health on the differences between men and women and the method of suicide are as follows:

- Suicide by firearms - Males (56%), females (30%)
- Suicide by suffocation - Males (24%), females (21%)
- Suicide by poisoning - Males (13%), females (40%)
1.4.9.7 Physical illness

Suicide encountered in patients who have a severe medical problem. The risk for suicide increases in the face of a protracted, painful, progressively debilitating disease.

1.4.9.8 Life experiences

Certain recent life events can precipitate suicidal behavior. These include romance-related losses, such as the termination of a love relationship or a divorce; a job termination, or the loss of a pet. The acute loss can be devastating.

A number of past life events are also linked to suicide. The most important is suicide by a family member or a friend. Not infrequently, history of a father, mother, or sibling committing suicide correlates with suicide by another member of that family.

Suicide by a friend may provoke others to duplicate the event; indeed, suicide has a contagious aspect, especially among adolescents. One suicide in a high school is followed by other suicides or attempts.

One study found that sexual violence and having witnessed violence were significant predictors of lifetime suicide attempts. The study, which examined the possible link between trauma exposure and suicidal behavior, was conducted with 4351 adult South Africans from 2002-2004 as part of the World Health Organization (WHO) World Mental Health Surveys. Future research needed better understand how and why these experiences in particular increase the risk of suicidal outcomes.
1.4.9.9 Economic instability and status

Times of economic change, especially economic depressions, have also been associated with suicides. Emile Durkheim noted that in times of major societal alternations, when the rules are in flux and people do not know what expected of them, the self-destructive rate increases. He termed this period of cultural changes anomie.

1.4.9.10 Media and the Internet

Media can be a suicidal factor in negative and positive ways. The Internet, and other media, can provide information concerning "how-to" methods. A 2008 study found many Websites providing specific techniques on suicide. That same study also found many any suicide sites and a surprising number of pro suicide sites.

However, a number of Web sites do provide encouragement for treatments, accounts of successful interventions, and key resources. In addition, individuals have used the Internet to take online questionnaires that can indicate depression and suicide potential; some college students found to have sought treatment because of taking these surveys.

1.4.9.11 Psychodynamic formulation

Several individual psychodynamic ways of viewing suicide exist. In one situation, patients deflect anger inward to hurt themselves when they want to strike out at others. An example would be a young person taking a drug overdose to punish his or her parents after grounded for misbehavior.
Alternately, the psychoanalytic notion exists of incorporation and killing the interject. In this situation, patients have unconsciously incorporated an ambivalently held object (e.g., a family member). For example, a man incorporates his father. He then attacks the interject (father) by killing himself.

1.4.10 Impulsivity of Suicide

In many cases, suicidal behavior results from a person acting impulsively. Colleagues showed that a lack of executive functioning in the form of poor impulse control inhibition represents a suicide risk. Impulsivity can often separate people who just have suicidal ideation from those who actually attempt suicide.

1.4.11 other risk factors

A number of other factors linked to suicide, including marital status, perceived/actual incarceration, lack of exposure to daylight, and even geographic altitude.

1.4.11.1 Marital status

People who married are less suicidal than are those who are single, divorced, or widowed. Isolated individuals are at greater risk for suicide than are those involved with others and their community.

1.4.11.2 Geographic altitude

A study by Kim et al described altitude as a risk factor for suicide. Their study concluded that when gun ownership, altitude, and
population density considered as predictor variables for suicide rates on a state-by-state basis, altitude is a significant independent risk factor. Thus, the higher the altitude, the higher the risk of suicide. This association may relate to metabolic stress associated with mild hypoxia in individuals with mood disorders.

1.4.11.3 Incarceration and hospitalization

If an individual feels or is indeed trapped, especially those who are incarcerated, they are at suicide risk. Prisoners have a high rate of suicide; this is common during the first hours to first week of placed in confinement. In contrast, during the first week after a patient's discharge from a psychiatric hospital or unit, the risk of suicide is particularly high. For many, the transition is difficult, challenging, and anxiety provoking.

The risk of suicide should extend to all persons involved with the criminal justice system. Webb et al determined that major health and social problems frequently coexist in this population, including offending, psychopathology, and suicidal behavior. Further prevention strategies needed for this group, including improved mental health service provision for all people in the criminal justice system, even those found not guilty and those not given custodial services. Better coordination needed in public services to tackle coexisting health and social problems.

1.4.11.4 Lack of daylight

Lack daylight correlates with depression and suicide. Regions with long, dark winters, such as Scandinavia and parts of Alaska (eg,
Nome), have high suicide rates. Indeed, persons with seasonal affective disorder (SAD) who live in these regions experience depression in the absence of sunlight and, hence, have a higher susceptibility to depression, which may lead to suicide.

### 1.4.11.5 Serum cholesterol

A correlation has long noted between low levels of total serum cholesterol and suicidal activity. Ollie and associates found lower cholesterol levels in persons who attempted suicide, suggesting serum cholesterol levels could possibly used as a biologic marker for potential suicide risk.

### 1.4.11.6 Sleep problems

Sleep difficulty remains an indicator for not only depression and anxiety disorders but also a risk factor for suicide. Colleagues studied sleeping problems and suicide in 75,000 Norwegian adults for 20 years. They concluded that problems with sleeping, perhaps in combination with or because of anxiety and depression, should consider a marker of suicide risk.

In the United States, certain states have higher suicide rates than others, as illustrated by the map below. The Western states have the highest suicide rates, with the exception of Vermont. In addition, living in rural areas carries a higher risk of suicide than living in urban areas.

The top 15 causes of death (in persons aged 1-85+ y) in the United States in 2007, according to the National Institute of Mental Health, are as follows:

- Heart disease - 615,616
- Malignant neoplasm - 562,795
- Cerebrovascular - 135,814
- Chronic lower respiratory disease - 127,875
- Unintentional injury - 122,387
- Alzheimer disease - 74,629
- Diabetes mellitus - 71,373
- Influenza and pneumonia - 52,492
- Nephritis - 46,304
- **Suicide - 34,592**
- Septicemia - 34,543
Liver disease - 29,185
Hypertension - 23,963
Parkinson disease - 20,056
Homicide - 17,984

1.4.12 Religion-related demographics

Religion may also play a role in suicide. Protestants have had a higher rate of suicide than either Catholics or Jews. Some religions may encourage suicide in situations of disgrace or for patriotic reasons.

1.4.13 Race-related demographics

In the United States, most suicides occur within the white population. The rate for white men in 2007 was 13.5 cases per 100,000 populations; for black men, 5.1 cases per 100,000 populations; and for Hispanic men, 6.0 cases per 100,000 populations. However, the rate for Native American and Alaska Native men was 14.3 cases per 100,000 populations.

Voracek et al found that regardless of sex or age, people with a lighter skin color have a higher rate of suicide than do those with darker skin color.

1.4.14 Sex-related demographics

The relationship between sex and suicide represents one of the most salient and enduring features in suicide-related statistics. Men commit suicide far more frequently than women do. The difference is quite
striking. Suicide was the $7^{th}$ leading cause of death for males and the $15^{th}$ leading cause of death for females, in 2007.

However, women make 2-3 times more suicide attempts than men do. Furthermore, the sex differential continues in those who are suicidal who seek help; females are much more prone to go for medical and psychiatric aid than men are.

Although the facts can be interpreted in many ways, including as they relate to method (men use firearms, and women use poison) and the ability to handle feelings, the fact remains that difference in frequency related to sex is a powerful and relatively consistent finding across a wide range of other demographic categories, such as age, socioeconomic factors, and region.

1.4.15 Age-related demographics

In general, the suicide rate increases with age, with a major spike in adolescents and young adults. In recent decades, the number of adolescent suicides has increased dramatically. The 2007 Youth Risk Behavior Surveillance showed that 6.9% of high school students had attempted suicide in the year before the survey.
Rate of suicides, sex, race and age.

1.4.16 Occupation-related demographics

Police and public safety officers are at increased risk for suicide. The long hours of work, the scenes they witness daily, the availability of guns, and the silence encouraged by the profession (keeping within the "wall-of-blue"), as well as alcohol usage and divorce, contribute to this risk.

Physicians, especially those who deal with progressively terminally ill patients, as well as dentists, also have a high rate of suicide. The medical field loses the equivalent of a medical school class each year by suicide. Perhaps, elements of obsessive and perfectionist tendencies combined with personal feelings of isolation may contribute to this high number of self-induced deaths.

Suicide risk in military personnel has been increasing, as demonstrated in the chart below.

1.4.17 Seasonal variances in suicide

Most suicides occur in the spring; the month of May particularly has noted for its high rate of suicide. The speculation is that during the winter and early spring, persons who are feeling downhearted because of the weather often surround people with depression. However, with the arrival of the spring season and the month of May, people who are depressed because of the weather cheered and people who are depressed for other reasons remain depressed. As others cheer up, those who remain miserable must confront their own unhappiness.

1.4.18 Suicidal ideation

Determine whether the person has any thoughts of hurting him or herself. Suicidal ideation is highly linked to completed suicide. Some inexperienced clinicians have difficulty asking this question. They fear the inquiry may be too intrusive or that they may provide the person with an idea of suicide. In reality, patients appreciate the question as evidence of the clinician’s concern. A positive response requires further inquiry.
1.4.19 Suicide plans

If suicidal ideation is present, the next question must be about any plans for suicidal acts. The general formula is that more plans that are specific indicate greater danger. Although vague threats, such as a threat to commit suicide sometime in the future, are reason for concern, responses indicating that the person has purchased a gun, has ammunition, has made out a will, and plans to use the gun are more dangerous. If the person envisions a gun-related death, determine whether he or she has the weapon or access to it.

1.4.20 Purpose of suicide

Determine what the patient believes his or her suicide would achieve. This suggests how seriously the person has been considering suicide and the reason for death. For example, some believe that their suicide would provide a way for family or friends to realize their emotional distress. Others see their death as relief from their own psychic pain. Still others believe that their death would provide a heavenly reunion with a departed loved one. In any scenario, the clinician has another gauge of the seriousness of the planning.

1.4.21 Things and risk factors

The following is a list of 12 things that should alert a clinician to a real suicide potential:
• Patients with definite plans to kill themselves - People who think or talk about suicide are at risk; however, a patient who has a plan has made a clear statement regarding risk of suicide.

• Patients who have pursued a systematic pattern of behavior in which they engage in activities that indicate they are leaving life - this includes saying goodbye to friends, making a will, writing a suicide note, and developing a funeral plan.

• Patients with a strong family history of suicide, family history of suicide is especially indicative of suicide risk if the patient is approaching the anniversary of such a death or the age at which a relative committed suicide.

• The presence of a gun, especially a handgun.

• Being under the influence of alcohol or other mind-altering drugs - drug abuse is especially significant if the drugs are depressants.

• If the patient encounters a severe, immediate, unexpected loss - Ego, when a person is fired suddenly or left by a spouse.

• If the patient is isolated and alone.

• If the person has a depression of any type.

• If the patient experiences command hallucination - A command hallucination ordering suicide can be a powerful message of action leading to death.

• Discharge from psychiatric hospitals - Patients are at suicide risk upon discharge from a psychiatric hospital, which is a very difficult time of transition and stress; the structure, support, and safety of the institution are no longer available to the patient; the patient feels
apprehension and is confronted with the reality of change, which translates into fright and vulnerability.

- Anxiety - Anxiety in all of its forms leads to a risk for suicide; the constant sense of dread and tension proves unbearable for some.
- Clinician's feelings - As mentioned earlier, regardless of what the patient says or does, it matters if the clinician has a feeling that patient is going to commit suicide; such perceptions are part of clinical judgment and are an important part of the suicide assessment and intervention.

1.4.22 Suicide-related characteristics

Individuals who suicidal have a number of characteristics, including the following:

- A preoccupation with death.
- A sense of isolation and withdrawal.
- Few friends or family members.
- An emotional distance from others.
- Distraction and lack of humor - they often seem to be "in their own world" and lack a sense of humor.
- Focus on the past - they dwell in past losses and defeats and anticipate no future; they voice the notion that others and the world would be better off without them.
- Haunted and dominated by hopelessness and helplessness - they are without hope and therefore cannot foresee things ever improving; they also view themselves as helpless in 2 ways: (1) they cannot help
themselves, and all their efforts to liberate themselves from the sea of
depression in which they are drowning are to no avail; and (2) no one
else can help them.

1.4.23 Affect of Suicide

Depression and anxiety commonly seen in people are suicidal.
One specific emotion of concern is the patient exhibiting a flat affect when
describing his or her thoughts and plans of suicide and self-destructive
behavior.

1.4.24 Thoughts of Suicide

Three types of thought changes represent areas for major focus
and concern.

The first consists of command hallucinations telling the patient
to kill him or herself. These are usually auditory in nature and often take
the form of the deity's voice ("I hear God commanding me to kill myself,
because I am bad").

The second type consists of delusions. These include, "The
world and my family would be better off with me dead" or "If I take my
life, I will be reunited in heaven with my mother."

The third type of thought involves the obsession of a patient
wanting to take his or her own life. Some patients focus their lives on their
suicide. (See the chart below.)
1.4.25 Suicide and homicide

Inquiring into suicide potential is an absolute requirement. The more specific the ideas and plans for suicide, the greater the possibility of suicide. Those with plans to purchase a gun exhibit a clear danger.

In addition to suicide inquiry, the clinician must ask about homicidal potential. Aggression turned inward is suicide; aggression turned outward is homicide. Homicide needs to be inquiring about for the following reasons:

- It is part of a complete mental status examination.
- There is linkage between the homicide and suicide - for example, in adolescents, 2 of the 4 leading causes of violent death are homicide and suicide.

1.5 Outline of Chapter

Chapter-1 : Introduction
  - Personality
    - Meaning of Personality
Chapter – 1

Entry into the Subject

- Definition of Personality
- Theory of Personality
- Caricaturist of Personality

- Quality of Life
  - Meaning of Quality of Life
  - Definition of Quality of Life
  - Types of Quality of Life
  - Caricaturist of Quality of Life

- Suicide Tendency
  - Meaning of Suicide Tendency
  - Definition of Suicide Tendency
  - Types of Suicide Tendency
  - Caricaturist of Suicide Tendency

**Chapter-2 :** Review of Literature

- Review of Personality
- Review of Quality of Life
- Review of Suicide Tendency

**Chapter-3 :** Method and Process

- Objective
- Hypothesis
- Sample
- Design
- Tools
- Statistical Technique

**Chapter-4 :** Analysis and Result Discussion

**Chapter-5 :** Conclusion

- Reference
- Biography

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