CHAPTER I
INTRODUCTION
Shneidman (1998) writes: Suicide is never born out of exaltation or joy. I have heard the expression "I'm so happy I could die," but I have never heard the statement that "I'm so happy I could kill myself."

Understanding suicidal behavior owes much to the work of Erwin Stengel (1964) "Attempted Suicide". Stengel (1964) found that the suicide process though directed towards dying, was also in most cases directed towards life. He therefore referred to the suicidal act as being Janus-faced (Janus a god with two faces pointing in opposite directions). Suicide (from Latin sui caedere, to kill oneself) is the act of willfully ending one's own life. The common sense typology of suicide is as follows:

1. Suicide: individual intends to die and does die.
2. Attempted suicide: individual intends to die, but fails.
3. Suicidal gesture: individual does not want to die and does not
4. Accident: individual does not intend to die, but does.

The simplest form of suicide is the act of refusing the adventures and challenges that offer themselves to us every day. Yet, "Life is impoverished; it loses interest, when the highest stake in the game of living, life itself, may not be risked. It becomes shallow and empty"- Sigmund Freud (1957). It may be nothing more than the steadfast commitment to sameness.

People who commit suicide are not necessarily 'sick' or 'sinners', but simply our sisters and brothers, resigned housewives, the compulsive playboys, the despairing priests, the addicted teenagers, the reckless drivers, the bored bureaucrats, the lonely salesmen, the smiling stewardesses, the restless drifters etc.

We might lack the nerve to commit the final act, and we might not recognize our 'sinful' tendencies for what they are, but day in and day out we confront the problem of our innate attraction to self-destruction. We live in a world that encourages the small daily acts of negation that prepare us for the great one. There are meanings of suicide that neither the courts nor the dictionaries admit, but that make it impossible for us to regard those thousand
people a day who do themselves in as very different from us. Thousands of books have tried to answer the question of why people kill themselves. To summarize them in three words: to stop pain. As Shneidman (1998) had put it "The author of suicide is pain". Sometimes this pain is physical, as in chronic or terminal illness; more often it is emotional, caused by a myriad of problems. In any case, suicide is not a random or senseless act, but an effective, if extreme, solution. Suicide is a permanent solution to a temporary problem.

PREVALENCE OF SUICIDE

Suicide is the third leading cause of death in young people aged 15-24 years and the 8th leading cause of death among the general population in the United States (National Center of Health Statistics, 1999). In 1998, the World Health Organization ranked suicide as the twelfth leading cause of death worldwide and eighth for the United States (Staff, 2006). It is estimated that global annual suicide fatalities could rise to 1.5 million by 2020. Worldwide, suicide ranks among the three leading causes of death among those aged 15-44 years. Suicide attempts are up to 20 times more frequent than completed suicides (Staff, 2006). A recent report by the WHO stated that nearly a million people took their own lives every year, more than those murdered or killed in war (Suicide prevention, 2006). WHO figures show that a suicide takes place somewhere in the world every 40 seconds.

But this is only the tip of the iceberg. Rosenberg et al. (1987) reported that at least ten times this number each year engaged in suicidal behavior which comes to the attention of health professionals; and, on the basis of community surveys, it was probable that a similar number also risked their lives in some way, but did not seek attention and were thus not treated at all. In addition to this obvious mortality and morbidity, it has also been estimated that for every person who suicides, at least six people are directly affected.

By race, in the United States, non-Hispanic whites are nearly 2.5 times more likely to kill themselves than are blacks or Hispanics. Suicide rates for younger blacks and whites are approximately equal, but older whites, elderly white men especially, commit suicide far more often than older blacks. Among Native Americans, the pattern of suicide resembles that of Black Americans:
males peak in early twenties, and decreasing thereafter. This pattern differs from that of White Americans, where elderly White males have the highest rates.

Compared to those of older people, adolescents' suicide-attempt statistics show two significant differences. First the fatality rate for boys is hundred times that of girls, a much greater gender difference than with any other age group. The immediate reason is clear enough: most teenage girls use relatively low-lethality methods like drugs and wrist cuts, while a substantial number of boys use guns and hanging. The reasons behind these choices are not known. Second, the fatality rate among adolescents, less than 2%, is much lower than that among the elderly, variously reported to be between 25% and 50%. This may be because the young, however miserable, usually have more reason for optimism about the future than do the old, who are too often without friends, family, job, and health.

Suicide attempts are relatively common during adolescence, although the rate of completed suicide is lower than in older age groups. Thus, in Western countries, the ratio of suicide attempts to completed suicide was higher among adolescents than in any other age group (King, 1997). This may imply that the threshold for nonfatal suicidal behavior is low during adolescence and that suicide attempts have a less serious outcome in this young age group. But does a suicide attempt during adolescence represent a lower risk for new suicidal acts than in older age groups?

Suicide was the leading cause of injury death for teenagers in the United States and other places (Holinger, Offer, Barter, & Bell, 1994). In some countries, including the United States, suicide by children and teenagers had been rising in number and rate over the last generation (Center for Disease Control and Prevention, 1995). Similar to the National College for Health risk behavior survey conducted by the Center for Disease Control and Prevention (1995); Kisch, Leino, & Silverman (2005) found that 9.5 % of students reported that they had seriously considered attempting suicide and 1.5 % of students reported that they had attempted suicide within the last school year.

Teenagers attempt suicide roughly 10 times more frequently than adults, although their fatality rate of 11.1 per 100,000 people is about the same as adults'. This is the third leading cause of death among 15-19 year-olds. This corresponds to about 2000 suicides among 15-19 year-olds per year. While it's
true that the suicide rate is substantially higher among old people, suicide is a relatively more frequent cause of death in the young, who have few deaths from other illness. That's why it's the third leading cause of death among 15-24 year-olds, but ranks ninth or tenth for 55-74 year old. Suicide rates have been essentially unchanged between 1980-1994, while 15-19 year-old rates have risen significantly and elderly rates held steady. Among children between the ages of 10 and 14, the suicide rate increased 110 percent (from 0.8 per 100,000 to 1.7 per 100,000) between 1980 and 1994.

About four times more girls than boys make suicide attempts, but boys are much more likely to die: about 11% of (reported) males' attempts were fatal, compared to 0.1% of females', a ratio of more than 100:1. This also gives a ballpark average of about 50 attempts for every fatality in this age group.

**SUICIDE IDEATION**

O'Carroll et al. (1996) defined suicide ideation as any self-reported thoughts of engaging in suicide related behavior. Suicide ideation may result from the experience of emotional pain outweighing the individual's coping strategies and resources for dealing with that pain or from an individual's unwillingness to impose self-discipline and care about others more than him or herself. Acts of suicide are necessarily committed only by human beings. No other known healthy organism possesses both the will and the capability to intentionally terminate its own life for the sole sake of death. Among adults, those aged 18-24 had the highest incidence of reported suicide ideation (Crosby, Cheltenham, & Sacks, 1999). The three leading causes of death for adolescents and young adults aged 15-24 years-unintentional injury, homicide, and suicide—are all injury related. Increased risk for all three of these causes of death might be related to suicide ideation (Barrios, Everett, Simon, & Brener, 2000).

Crosby, Cheltenham and Sacks (1999) used a random-digit-dialed telephone survey to estimate the 12-month incidence of suicide ideation, planning, and attempts among U.S. adults. Of 5,238 respondents, 5.6% (representing about 10.5 million persons) reported suicide ideation, 2.7% (about 2.7 million) made a specific suicide plan, and 0.7% (about 700,000) made a suicide attempt (estimate 1.1 million attempts). Hence, suicidal behaviors are not uncommon and occur along a continuum ranging from ideation to completed
suicides. Most suicide ideation and behavior occurs on a continuum of severity that ranges from events that were less severe and more prevalent (e.g., thinking about suicide) through events that were increasingly severe and less prevalent (e.g., completed suicide) (Garland & Zigler, 1993).

Suicide ideation in the 12 months preceding the survey was reported by 310 adults. The weighted total estimate of persons having suicide ideation was 10,549,336, or 5.6% (95% CI = 4.8-6.3) of the U.S. population. The following variables demonstrated statistically significant differences concerning thoughts of suicide: age, marital status, employment status, poverty level, and income (p < 0.05). In addition, there was a significant linear trend with age; reported suicide ideation decreased with increasing age. There was no significant difference in suicide ideation by sex, educational attainment, Latino origin, region of the United States, or whether the person lived in one of the 21 largest U.S. metropolitan statistical areas. Acts of suicide are necessarily committed only by human beings. No other known healthy organism possesses both the will and the capability to intentionally terminate its own life for the sole sake of death.

In 1971, a committee on nomenclature of an National Institute of Mental Health (NIMH) task force on research in suicide (Beck et al., 1973) proposed a tripartite classification of suicidal individuals into those who were currently thinking about suicide (ideators), those who had made a nonfatal suicidal attempt (attempters) and those who had made a fatal suicide attempt (completers).

Suicide ideation may result from the experience of emotional pain outweighing the individual's coping strategies and resources for dealing with that pain or from an individual's unwillingness to impose self-discipline and care about others more than him or herself.

**HISTORY**

Suicide has been present since recorded history. There had been no period of history without records of suicide and no societies where suicide does not occur. Scientific research and theory of a sociologic, psychologic and statistical nature began in the literature towards the end of the nineteenth century. It is only in the last more 100 years that intensive studies from a number of different perspectives have evolved. These have followed from the 1897 work, "Le Suicide" of Emile Durkheim, a French...
sociologist. At times such sociological theories have predominated; at other times theological; psycho-analytical; educational; behavioral; and more recently biological perspectives have been in the forefront. But before these names came to be associated with suicide literature, certain ancient philosophical views already existed.

Ancient and Classical Views of Suicide

Philosophical discourse about suicide stretches back at least to the time of Plato. He explicitly discussed suicide in two works. First, in Phaedo, that suicide is always wrong because it represented releasing ourselves (i.e., our souls) from a "guard-post" (i.e., our bodies) (Phaedo 61b-62c.) Later, in the Laws, Plato claimed that suicide is disgraceful and its perpetrators should be buried in unmarked graves.

Aristotle's only discussion of suicide (Nicomachean Ethics 1138) attempts to explain how suicide can be unjust and deserving of punishment if the individual who could be treated unjustly is the suicidal individual herself. But, the Stoics largely believed that the moral permissibility of suicide did not hinge on the moral character of the individual pondering it. The Roman Stoic Seneca, who was himself compelled to commit suicide, was even bolder, claiming that since "mere living is not a good, but living well", a wise person "lives as long as he ought, not as long as he can." For Seneca, it was the quality, not the quantity, of one's life that mattered.

David Hume opined that suicide was an affront to God. He argued that it was no more a rebellion against God than to save the life of someone who would otherwise die or to change anything else in the environment's position. By this time many religious views had also started gaining popularity.

The Christian Prohibition

The advent of institutional Christianity was perhaps the most important event in the philosophical history of suicide, for Christian doctrine has by and large held that suicide is morally wrong. St. Augustine is generally credited with offering the first thoroughgoing justification of the Christian prohibition on suicide (Amundsen, 1989) He saw the prohibition as a natural extension of the fifth commandment. Law and popular practice in the Middle Ages sanctioned the desecration of the suicidal corpse, along with confiscation of property and denial of Christian burial. Renaissance intellectuals
Religious views on suicide

For Buddhists, since the first precept is to refrain from the destruction of life, including oneself, suicide is clearly considered a negative form of action. Despite this view, an ancient Asian ideology similar to seppuku (hara-kiri) continues to influence oppressed Buddhists to choose the act of “honorable” suicide.

In Hinduism, murdering one’s own body is considered equally sinful as murdering another. Scriptures generally state that to die by suicide (and any type of violent death) results in becoming a ghost and is sinful and illegal.

Islam views suicide as sinful and highly detrimental to one’s spiritual journey. However, human beings are said to be liable to making mistakes, thus, Allah, can forgive the sins. Despite this, nevertheless, many claim Islam does permit the use of suicide - though only against the unjust and oppressors- if one feels there is absolutely no other option available and life otherwise would end in death.

Judaism has traditionally, in light of its great emphasis on the sanctity of life, viewed suicide as one of the most serious of sins. Life in the physical world presents a person’s soul a unique opportunity, and to consciously and willfully break away from this opportunity is regarded as a gravest sin.

Suicide in Indian history

Indian culture has historically taken an ambivalent view on suicide. It has been commonly mentioned throughout Indian history and frequently tolerated. Thakur (1963) provided a complete and detailed history of suicide in India. According to his review of the religious texts of the Vedas, the Upanishads, and the Dharmasastras, many characters of high and low origin killed themselves either for religious purposes or other motives. However, during the period of the Dharmasastras, suicide was viewed as a great sin and punished by the prohibition of death ceremonies. There were exceptions when self-sacrifice was performed for very specific religious rites, as in the case of sati, the death of a widow voluntarily burning herself at the cremation ceremony of her husband.

Thakur (1963) also reported a type of male suicide among the higher castes, similar to the Japanese seppuku. During ancient and medieval times, men sometimes killed themselves in front of the house of an enemy in order for their ghost to harass the offender forever. More recently, after Pakistan was
partitioned from India in 1947, communal strife led to the rape of a significant number of young girls subsequently this led to suicide by the girls and their families.

Suicide was at one time permitted to put an end to an incurable disease, to atone for the killing of a Brahman, or because one was too old to fulfill his religious duties (Balodhi, 1992). In other words, death was permissible if everything had been achieved or nothing more could be done on earth to perfect one's soul.

In an extensive article, Andriolo (1993) explained how the Hindu society came to regard a category of voluntary self-inflicted death not so much as suicide but as a welcome departure from earthly life when the goal of one's life had been completed. These deaths such as sati, Jauhar, self-immolation, starvation, juggernaut etc. should preferably be classified in the category of sacrifice rather than suicide. Andriolo (1993) pointed out that these sacrificial deaths conform to a cultural script, the planning of which contrasts with the impulsivity of immoral suicides.

THEORIES

Many theories have been developed to explain the causes of suicide. Physiological theories (Bunney & Fawcett, 1965) gave importance to genetic and biochemical imbalances, psychodynamic (Freud, 1917/1957,) and psychological theories (Shneidman, 1985) emphasized personality and poor coping skills, while sociological theories (Hendin, 1964; Durkheim, 1897; Durkheim, 1951), stressed the influence of social and environmental pressures. Epidemiological approaches (Dublin, 1963) had focused on demographic characteristics. Philosophical theorists (Battin, 1982) had attempted to answer difficult questions about the nature and purpose of life. Naturally, each approach had emphasized a distinctive feature, aspect, or characteristic of suicide and suicidal behavior, frequently at the purposeful exclusion of others.

Sociological Theories

I) Integration Theories:-

(a) Durkheim (1897): "The number of suicides is a direct mathematical measure of the real mood of society", wrote Durkheim (1897) in his classic study Le suicide. He suggested that although suicide seemed the most personal act a
human being can do, it was exclusively determined by social factors (Durkheim, 1897; 1993). He claimed that greater social integration translated to fewer suicides. This model tended to equate social change with the breakdown of social control resulting in more suicides.

b) **In Status Integration theory**, Gibbs and Martin (1964) emphasized that as more and more persons come to share characteristics, integration among this 'status group' would increase and suicide rates would be low. They argued that status integration theory would predict that as African Americans have entered the middle and upper-classes, difficulty becoming truly accepted in mainstream American culture could result in "A corroding sense of internal alienation (which) ultimately may result in self-destruction"

c) **Thoits Identity theory (1995)** examined how suicide represents a social-psychological response to frustration and depression that people experience in highly salient areas of their lives. For example, work-related stressors will negatively impact males more than females (in general), while problems in primary relationships (e.g., spouse, friend, etc.) will be more problematic for females. "In other words, identity-relevant experiences may be more powerful predictors of psychological distress (and well-being) than identity-irrelevant experiences . . ." (p. 106) and thus suicide. Thoits' work on identity theory was central to the social study of suicide since individuals do vary to the extent that they value some areas of life over others.

Based on above theories it can be emphasized that "equilibrium" is important in controlling suicidal behavior. It is an appropriate degree of integration (commitment to norms, values and beliefs) and regulation (group control), any imbalance increases suicide social.

II) Interactionistic Approach:-

a) **Sacks (1967)**: The Search for Help: No One to Turn to:-Sacks was interested in the process whereby the potential suicide came to the conclusion that they had 'no one to turn to'. Sacks (1967) suggested that the search for help is a course of action routinely pursued by the suicidal. No one to turn to, does not mean just physical absence. This gives rise to the important point that suicide is interactional-it depends on others reaction to a potential suicide.

b) **Stephens (1985)** echoed Sacks' point that suicidal acts have to be understood as interactional, the product of a relationship(s) rather than the
product of individual traits which led to suicidal behavior. He felt that all the women, as a result of their relationships had low self-esteem, felt powerlessness and worthlessness. She found four recurring themes: Over-dependence on the male partner, infidelity, brutality and violence, denial of affection.

III) Subjective Approach:-

a) Taylor's Structural theory (1982) suggested that suicide was the consequence of an imbalance between two factors in individuals' lives; certainty and uncertainty; and detachment and attachment to others.

It led to the development of a structural theory which distinguishes between four basic meanings, caused by a combination of certainty/uncertainty, and attachment/detachment,

- **Thanatation-uncertainty and detachment.** An individual feels their existence is problematic to themselves and others cannot tell the individual what they want to know.
- **Submission-certainty and detachment.** An individual feels their existence is over and others cannot persuade them from what they know.
- **Appeal-uncertainty and attachment.** An individual feels they know nothing worth knowing and others lack of concern makes existence problematic.
- **Sacrifice-certainty and attachment.** An individual feels they know everything worth knowing and others have made it impossible to go on living.

IV) Models Emphasizing both Individual And Social Factors

(a) Henri and Short (1954)-: The classic theory elaborated by Henri and Short (1954) provided a nice example. Its basic psychological assumptions are simple: frustration is positively related to aggression and people attribute the responsibility for their frustration externally or internally, external attributions determining aggressive acts oriented toward others (homicide) and internal attributions determining self aggressive acts (suicide). They also suggested that, as economic quality-of-life improves, homicide should decrease and suicide increase.

(b) Coherence Optimization model of suicide: This model dealt with the automatic components of suicidal thoughts as suicidal thoughts have a central
role in the suicidal process (Truant, O'Reilly, & Donaldson, 1991). Individuals have a base of interrelated cognitive units of integrated cognitive units that represent the starting point from which they integrate new pieces of information. This base being relatively stable (Mischel & Shoda, 1995), it is likely that at different moments the same individual will do the integration of new information in the same direction. To put it differently, if a person has suicidal thoughts today, it is likely that he or she has the same thoughts tomorrow. Some persons will succeed to cope with their situation and avoid suicide, while other persons will not.

In the coherence model of suicide, the basic elements are the cognitive unit sets (CUS). It is a collection of integrated constructs, evaluations, beliefs, affects or other cognitive units that focus on the same external or internal object or situational domain that can affect suicide and can usefully be regarded as a whole. The nine CUS considered essential in the development of suicidal thoughts closely follow this categorization: Economic, Relational, Professional, Health, Ego, Suicidal thought, Life, Death and Suicide CUS.

In the coherence model, the most plausible solution is to assume that there are several central attitudes that affect suicidal thoughts, in this case the way people think and feel about life (life CUS), death (death CUS), and suicide (suicide CUS), and that religion affects them and the relations between them.

Suicidal rates are supposed to be smaller because not all the people who have suicidal thoughts actually commit suicide: there are also suicidal attempts, microsuicidal behavior etc. however, the group of suicidal persons comes from the group of suicidal thought persons.

(c) Baumeister model (1990):- Baumeister (1990) incorporating over 200 empirical studies on suicide attempts, had developed a plausible conceptual model of how personality and social psychological variables combine to increase the chances that a person will make an attempt on his/her life. He pointed out that suicide attempts are attempts to escape from the affective, motivational, and cognitive consequences of unacceptable experiences. He posited four stage theory:

Stage 1: falling short of standards. When some people experience a problem or have an experience that is below their standards, they make an attribution to their self for this negative experience.
Stage 2: attributing failure to the self.

Stage 3: a state of "cognitive deconstruction," characterized by shortness of time perspective, loss of concreteness in thinking, loss of focus on distal goals, and loss of emotional tone.

Stage 4: irrationality and disinhibition. Irrational thought patterns render the person vulnerable to suicidal thoughts and put him/her at risk for actual suicide attempts.

(d) The approval of suicide: A social-psychological model by Robert Agnew (1998): The model drew on the three leading theories of crime/deviance: strain, social learning, and social control theories. It was predicted that individuals will be most approving of suicide when (1) they have had major life problems that could not be solved through conventional channels and are low in coping ability and social support (2) they were taught or exposed to beliefs that favored or were conducive to suicide, and (3) they are not strongly attached or committed to conventional individuals and groups i.e. they are low on social control.

Individuals who approve of suicide may be more likely to think about committing suicide, threaten to commit suicide, and attempt suicide (de Wilde, Kienhorst, Diekstra, & Wolters, 1993). Individuals are more likely to take their own lives if they are surrounded by others who approve of suicide. Hence, examining factors that influence the approval of suicide may prove useful in preventing suicide.

Suicide attempts and completions occur when several factors converge, including the inability to effectively cope with problems (i.e., strain), weak ties to others (i.e., low social control), and suicide approval.

(e) Strain/Stress and the Ability to Cope (Cohen, 1955):- According to Cohen (1955), individuals experiencing strain seek for a solution to their problems. Legitimate solutions are most desirable, since they do not carry the high costs often associated with deviance. Many individuals, however, are unable to find legitimate solutions to their problems. This is partly a function of the severity of their problems, low coping resources, coping skills, and social support. Such individuals, who were unable to solve their problems through legal channels, seek for deviant solutions, with suicide being one possible solution.
V) Biological Theories

(a) Serotonin Levels: Particularly promising are the significant advances being made in scientific understanding of the neurological basis of suicidal behavior (Mann & Stoff, 1997) and the mental conditions associated with it. There is a lot of evidence that a relationship between low serotonin levels (5-HT) and suicide exist. It is as much as ten times more likely to be low in victims (Molcho, Stanley & Stanley, 1991; Asberg, Thoren, Trasman, Bertilsson & Ringberger, 1976). This line of reasoning identify proclivity to suicide as a unique biological syndrome independent of the other correlates of low serotonin, such as depression and aggression.

(b) Genetic: Suicidal behavior runs in families. A notable example is the suicides of the Hemingway family in which five members committed suicide. In 1985, the American Journal of Medical Genetics studied an Amish community in Pennsylvania. The studies revealed that four families, representing only 16 percent of the total Amish population, accounted for 73 percent of all Amish suicides. Some scientists claim 10 to 15 genes account for triggering suicide attempts.

VI) Psychological Theories

(a) Sigmund Freud (1953/1965): Freud (1953/1965) developed some of the first psychological theories of suicide. In his opinion suicide is essentially a basic concept of the human mind and everyone is in some measure vulnerable to suicide. He considered suicide an intrapsychic phenomenon originating primarily within the unconscious. The pressure impelling a person towards death

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\begin{align*}
\text{OH} & \quad \text{CH}_2 \\
\text{NH}_2 & \quad \text{CH}_2^\prime \\
\text{Serotonin} & \quad (5\text{-hydroxytryptamine})
\end{align*}
\]
could increase, depending on life events, and under conditions of enormous stress, a person could be expected to regress to more primitive ego states. Freud felt that life and death forces remain in constant conflict within the individual. He conceptualized that persons’ identity ambivalently with their own internalized love objects. When a person is frustrated, the aggressive side of his or her conflicting emotions becomes inner directed, resulting in suicide.

(b) Karl Menninger (1938):- He described suicide as the winning of the death instinct over the life instinct under conditions of stress and conflict. He perceives that all suicides have three interrelated emotions: revenge, depression, and guilt.

(c) Edwin Shneidman (1993):- He argued victims of suicide show a sense of unbearable psychological pain, a sense of isolation, and the perception that death is the only solution to their problems. Shneidman (1993) had distilled existing theory and research down to one simple and definitive statement: "suicide is caused by psychache". Psychache is defined as "psychological pain in the psyche, the mind". In accordance with this approach, suicide and suicidal behavior are viewed as intrinsically psychological phenomena, a function of individual pain and tolerance, both of which are determined, influenced, and modified by a multitude of factors (e.g., epidemiological, philosophical, sociological, socio-cultural, familial, psychiatric, and biological). Psychache is the result of frustrated psychological needs and, in recognition of the multidimensional nature of suicidal behavior itself, there are innumerable potential causes for the blocked need(s).

Shneidman (1993) distinguished between modal, or day-to-day, needs and vital those that when frustrated produce intolerable psychological pain and, if unchecked and under the right circumstances, can lead to suicidal behavior or suicide. He also emphasized the variable nature of vital needs from individual to individual, but nonetheless, the consistent fact is that we all have psychological/emotional needs that are more important and meaningful than others, and when frustrated or blocked, result in more intense psychological/emotional pain.

Shneidman (1993) invented the word suicidology and many of its key concepts, including "psychache," "subintentioned death," and "psychological autopsy."
VII) Motivational Theory

It is accepted that those who have ended their lives throughout history have done so for a variety of reasons, both conscious and unconscious. Suicide is often seen as a means to end suffering, pain, or shame. On an individual level, the driving forces behind suicide vary across a range of themes such as romance, heroism, persecution, religion, altruism, martyrdom etc. Common intentions behind suicidal actions include those of guilt, remorse, escapism and the provoking of guilt in those left behind.

VIII) Cognitive Theories

Cognitive theories of suicide ideation and behavior had emphasized the critical importance of enduring cognitive patterns or styles (Sheehy & O'Connor, 2002; Dieserud, Roysamb, Ekeberg, & Kraft, 2001). Most of this research had focused on cognitive styles that may promote hopelessness (O'Connor, Sheehy, & O'Connor, 2000) or depression (Mazure & Maciejewski, 2003).

TYPES OF SUICIDE

The categories of suicide are arbitrary and overlap to some degree. Durkheim's Le Suicide, published in 1897 and translated into English in 1952, is considered to be a landmark in scientific enquiry into suicidal behavior. Durkheim (1897) distinguished between psychopathic states and normal psychological states. Within the psychopathic state, he identified four types of suicide:

1. Maniacal suicide is most common among those suffering from hallucinations, usually schizophrenia.
2. Melancholy suicide is characterized by extreme depression, created or imaginary, and often unrelated to a person's circumstances.
3. Obsessive suicide usually lacks authentic motive and committing suicide becomes an instinctive drive.
4. Impulsive or automatic suicide also frequently lacks motive, and is characterized by an irresistible impulse to commit suicide.

Indeed, his typology of egoistic, altruistic, and anomic suicides, as well as the less frequently recognized fatalistic suicide which he referred to in a footnote, has entered everyday language. Durkheim (1897) classified suicide (psychological states) into three types:
1. Egoistic suicide - Egoism is commonly defined as self-centeredness, thus people in this state are concerned with themselves over anything else such as religion, family, education, beliefs, and politics. It occurs when an individual's ties to society and morality are too lax. This kind of suicide occurs when a person indulges in extreme individualism due to self-centeredness. This individualism leads to a desire to learn due to which common beliefs and traditions of a given society are called into question and the individual is left to make sense of the world on his or her own.

2. Altruistic suicide is often seen as the opposite of egoistic suicide. An individual who commits altruistic suicide does so because his or her ties to society, or a particular group in society, are too strong. In this case, the individual is placing the group's agenda above his or her own. In suicide, Durkheim (1897) identified three types of altruistic suicide: obligatory, optional, and acute.
   
a) Obligatory altruistic suicide occurs in cults and primitive religion when common beliefs in a society require individuals to kill themselves as a part of punishment or religious duty.
   
b) Optional altruistic suicide occurs when the society or group does not force the idea of suicide. They merely recommend it to the society or group in question and suicide is seen as honorable.

   c) Acute altruistic suicide occurs when one is motivated by beliefs of what he or she will gain after death. Suicide bombers are an example of this in that they believe, through their religion; they will be rewarded in the after-life.

3. Anomic Suicide: Anomie is a term used by Durkheim (1897) to refer to a state of normlessness or conflicting norms. With anomic suicide, it is an individual's interaction with society that is the cause. But in modern society individuals set unattainable goals and produce for themselves a constant state of discontent and possibly even depression.

   In *Man Against Himself*, Karl Menninger (1938) divided suicidal behavior into three groups:
   
   1. "chronic" suicide includes alcoholism, martyrdom, psychiatric illness, and antisocial actions.
   
   2. "focal" suicide targets specific parts of the body, as in self-mutilation.
   
   3. "accidents"; and "organic" suicide, where people supposedly lose their will to live and die of illness and disease that they would otherwise overcome.
4. Others are called “slow suicide” or “suicide on the installment plan”.

Douglas (1967) argued that suicidal analysis should focus on meaning rather than social structure. He suggested a number of typical meanings of suicide:

1. Suicide as reunion in the context of release from cares/pressures.
2. Suicide as atonement in the context of transforming oneself for others.
3. Suicide as revenge occurring in the most increased form in 20th century.

Baechler (1975) identified four main types:

1. Escape: from intolerable situations such as grief or punishment.
2. Aggressive: an attempt to harm others.
3. Oblative: as sacrifice, or to attain a desired state in others opinion.
4. Ludic: a test to prove oneself.

Generally suicide can be of various types;

I. Altruistic/Heroic suicide:
   This is where someone (more-or-less) voluntarily dies for the good of the group, such as the Buddhist monks and others who, starting in 1963, burned themselves to death trying to stop the Vietnam war; elderly Inuit (Eskimos) killing themselves to leave more food for their families.

II. Philosophical suicide:
   Various philosophical schools, such as stoics and existentialists, have advocated suicide under some circumstances.

III. Religious suicide:
   There is a long history of religious suicide, usually in the form of martyrdom such as the San Diego Hale-Boppers in March, 1997, the Branch Davidians in Waco, Texas, and some of the people at Jonestown, Guyana.

IV. Honor suicide:
   In ancient times, suicide sometimes followed defeat in battle, to avoid capture and possible subsequent torture, mutilation, or enslavement by the enemy. During World War II, Japanese units would often fight to the last man rather than surrender such as Japanese seppuku.

V. Romantic suicide:
   “My life is not worth living without him”. This is most celebrated among the young, as in Romeo & Juliet, but is probably most frequent among people who have lived together for many years, when one of them dies.
VI. Anniversary suicide:

"Anniversary" suicide is characterized by use of the same method or date as a dead loved one, usually a family member. "Imitative" suicide is similar to anniversary suicide in its focus on the dead, but uses a different date and method.

VII. Contagion suicide:

"Contagion" suicide- This is where one suicide seems to be the trigger for others, and includes "cluster" and "copycat" suicides, most often among adolescents.

VIII. Manipulative suicide:

Suicide in which there is an attempt to manipulate others. "If you don't do what I want, I'll kill myself," is the basic theme here. The intention in this case is to generate guilt in the other person and the person is serious in his decision.

IX. Seek help or send a distress signal:

This form of suicide is the expression of too much pain and misery. This may occur at any age, but it is more frequent in the young.

X. "Magical thinking" and punishment:

This is associated with a feeling of power and complete control when if you can't win you can at least get in the last word by killing yourself. An illustration is the old Japanese custom of killing oneself on the doorstep of someone who has caused insult or humiliation. This is similar to "manipulative suicide", but a fatal result is intended. It's sometimes called "aggressive suicide."

XI. Cultural approval:

Japanese (like Roman) society has traditionally accepted or encouraged suicide where matters of honor were concerned. Thus, the president of a Japanese company whose food product had accidentally poisoned some people killed himself as an acknowledgment of responsibility for his company's mistake.

XII. Ritual suicide:

Ritual suicide is the act of suicide motivated by a religious, spiritual, or traditional ritual such as practice of Sati.
XIII. Martyrdom Suicide:
In modern times Spies have carried suicide pills or pins to use when captured, partly to avoid the misery of captivity, but also to avoid being forced to disclose secrets. For the latter reason, spies may even have orders to kill themselves if captured.

XIV. Social Protest:
This kind of suicide involves committing self destructive acts as a protest. The Kaiowas tribe in the South American rainforest committed a mass suicide in protest of a government that was taking away their land and beliefs.

CAUSES
The risk factors for suicidal behavior are manifold (Gould, Greenberg, Velting, & Shaffer, 2003). Among personal characteristics, psychopathology and a previous suicide attempt are the strongest risk factors. Other personal characteristics are aggressive-impulsive behavior (Apter, Plutchik, & van Praag, 1993), somatic illness, low self-esteem, and hopelessness (Groholt, Ekeberg, Wichstrom, & Haldorsen, 2000). However, the last three factors may be closely related to depression (Gould et al., 2003). Family characteristics include divorce, which may be reduced once other psychosocial factors, such as parent discord, are taken into account. Poor parenting as indicated by childhood physical or sexual abuse also increases the risk for suicidal behavior (Groholt et al., 2000). On the other hand, mutual positive involvement in the family may have a protective function (Johnson et al., 2002). It is doubtful that low socioeconomic status has an independent contribution, while school problems or being a school drop-out seem to increase the risk (Gould et al., 2003).

Cross-sectional studies comparing first and second attempts among adolescents have identified the same risk factors (Goldston et al., 2001; Kotila, & Lönnqvist, 1987). High intent predicted suicide among adolescents (Kotila, 1989). Three studies included adolescents admitted to medical wards after a suicide attempt, with a follow-up after 3 to 12 months (Spirito, Valeri, Boergers, & Donaldson, 2003; Hawton, Kingsbury, Steinhardt, James, & Fagg, 1999; Spirito, Lewander, Levy, Kurkjian, & Fritz, 1994). Depression, hostility, hopelessness, and low self-esteem were found to increase the risk for repetition. Another study of 15- to 24-year-olds with a follow-up period of 5 years found the same risk
factors (Beautrais, 2004). Beautrais (2004) found that childhood separation and sexual abuse also represented risk factors for repeated suicidal attempts.

Eskin (1996) described past suicide attempts being one of the most consistent predictors of current suicide ideation in Swedish and Turkish males and females. Similar results were reported by Vega, Gil, Zimmerman and Warheit (1993) who showed that, among those who reported ideation, 36.8% of Nicaraguans, 32.2% of African Americans, 30.5% of Cuban Americans, 31.7% of other Hispanics, and 20.3% of non-Hispanic Whites reported prior suicide attempts. Overall, the consensus is strong that, in the majority of cultures studied, previous suicidal behavior predicts future suicidal behavior.

Ethnicity and suicidal behavior- Some studies have found ethnicity as not predictive or related to suicide risk (Greening & Stoppelbein, 2002; Warheit, Zimmerman, Khoury, Vega, & Gil, 1996; Garrison, Jackson, Addy, McKeown, & Waller, 1991), others have found it to be relatively important (Blum et al., 2000; Yuen, Nahulu, Hishinuma, & Miyamoto, 2000). Roberts and Chen (1995) found ethnicity as being significantly related to the risk of suicide ideation, even after controlling for a number of possibly confounding factors. Tortolero and Roberts (2001) found that the higher suicide ideation risk for Mexican Americans compared to European Americans remained almost unchanged after adjusting for many variables such as gender, age, family structure, depression, low social support, and self-esteem. Ethnicity had a main affect also on South African suicide rates, as reported by Flisher and Parry (1994).

Hence, as argued by Krai (1998): "Today we have lists of risk factors that characterize those in the West who have killed themselves. These risk factors do not directly address the subjective experience and idea of suicide and its relationship to the self."

Culture and suicidal behavior: It is the need of the hour to go back to culture, race, and ethnicity their complexity and importance they have in our inner lives. It is essential to return to beliefs, mental constructions, views, attitudes, mental processes and representations, values, motives, reasons, and meanings importance they have in the life of a suicidal person.

Two studies have compared Indian students with European students, using the Suicide Attitude Questionnaire, where subjects were asked to answer
several questions posed in relation to themselves, people in general, and the closest person. Kerkhof and Nathawat (1989) compared students in Jaipur and Leiden. Indian students were more condemnatory or more restrictive than Dutch students for many questions, including: "Are you of the opinion that you must be mentally disturbed to commit suicide?" and "Do you think you have the right to commit suicide?" For "Under what circumstances would you commit suicide?" Dutch students overall scored higher and the three main reasons were: terrible pain, incurable illness, and becoming an invalid. Indians also endorsed incurable disease, followed by becoming an invalid, and having someone's death on your conscience. The same more restrictive view was evidenced in the Etzersdorfer, Vijayakumar, Schoeny, Grausgruber and Sonneck study (1998), with students from Madras rejecting the right to commit suicide, whereas in Vienna the majority accepted it. More students in Madras viewed mental illness as an important factor of one's own suicide, but disagreed with assisted suicide. Viennese students did not see suicide as cowardly, a significant proportion seeing suicide as brave, and more as a deliberate act.

In the studies reviewed, young Americans showed more positive attitudes toward suicide than Ghanian, New Zealander, Nigerian, and Mexican American youth but Canadians and Japanese were more accepting of suicide than Americans. Indian students manifested more negative attitudes toward suicide than both Dutch and Austrian students, and Singaporeans more than Australians. Other groups that have been compared on this aspect are Zambia (Groholt et al., 2000), Swedish, Chinese, and Turkish. More positive attitudes seem to be correlated with suicide ideation (Eshun, 2003; Domino, Su, & Lee Johnson, 2001/02; Zhang & Jin, 1996).

Suicide is a highly complex phenomenon that involves the interactions between genetic, biochemical, psychological, societal, and cultural factors. Suicide is an enigmatic and disconcerting phenomenon. Because of others' inability to directly occupy the mental world of the suicidal, suicide appears to elude easy explanation. This inexplicability is stunningly captured by Jeffrey Eugenides (1993) in his novel The Virgin Suicides. In the novel, the narrator describes the reactions of several teenage boys to the suicides of five sisters. The boys keep a collection of
the dead girls' belongings, repeatedly sifting through them in a vain attempt to understand their deaths.

Keeping in view, what has been said in the preceding paragraphs, it is imperative to examine suicide ideation and its relevant correlates in a proper perspective among adolescents. There is need for conducting research on suicide ideation among adolescents as already been emphasized. Needless to say, that suicide ideation is the first step on the continuum ranging from suicide ideation to completion of suicide.