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RISK FACTORS OF SUICIDAL PHENOMENON: PREVENTION AND INTERVENTION

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ABSTRACT

Around the world suicide has caused more deaths per year than homicide or war (World Health Organization, 2002). Suicidal attempts (the person survives) and suicidal ideation (thinking seriously about suicide) are others dimensions of the suicide phenomenon.

A number of risk factors have been considered as factors contributing to the increased likelihood of suicidal ideation, attempts, and completions. Sociological (external) factors and psychological (internal) factors have been considered in increasing suicidal risk.

Beyond the individual factors research has also explained the family, social, and community aspects of the suicidal phenomenon. Helping professionals planning suicide intervention and prevention strategies need to be aware of both the myths and misperceptions of the suicide phenomenon, as well as research based risk factors.

Suicide is the "conscious, deliberate attempt to take one's life quickly." Suicidal attempts (the person survives) and suicidal ideation (thinking seriously about suicide) are others dimensions of the suicide phenomenon.

Suicide represents a major national public health problem with about 30,000 deaths in the United States each and every year. The estimated cost to the nation in lost income alone is 11.8 billion dollars per year. Suicide is the eleventh leading cause of death for all ages in the United States, and the third leading cause of death among adolescents. During the period of the Vietnam War, four times the number of Americans died by suicide than died in combat. Two hundred thousand more people died of suicide than died of AIDS in the past 20 years (Institute of Medicine,2001).

Because suicide has been considered such a "taboo" subject to think or to talk about, there are a lot of misconceptions about which individuals may be at risk, about when, how and why people might consider killing themselves, and about how best to help yourself or someone else who is contemplating suicide. Four common myths are:

Myth: "People who die from suicide don't warn others."

***Fact**: Out of 10 people who kill themselves, eight have given definite clues to their intentions. They leave numerous clues and warnings to others, although some of their clues may be nonverbal or difficult to detect.*

Myth: "People who talk about suicide are only trying to get attention. They won't really do it."

***Fact**: WRONG! Few people commit suicide without first letting someone else know how they feel. Those who are considering suicide give clues and warnings as a cry for help. In fact, most seek out someone to rescue them. Over 70% who do threaten to carry out a suicide either make an attempt or complete the act.*

Myth: "Discussing suicide may cause someone to consider it or make things worse.

***Fact**: Asking someone if they're suicidal will never give them an idea that they haven't thought about already. Most suicidal people are truthful and relieved when questioned about their feelings and intentions. Doing so can be the first step in helping them to choose to live.*

Myth: "It's best to keep someone's suicidal feelings a secret."

***Fact**: Never, ever keep your or someone else's suicidal thoughts and feelings a secret – even if you're asked to do so. Friends never keep deadly secrets!*

Psychological Factors that should be considered are:

1. Cognitive Distortions;
2. Hopelessness;
3. Self-Efficacy; and
4. Coping Style and Affect Regulation.

Individuals with mental disorders, especially those with depression, often display cognitive distortions such as rigid or dichotomous thinking, overgeneralization, exaggeration or minimization of events, drawing conclusions based on insufficient/contradictory evidence or selectively attending to relevant information, and falsely attributing causality to themselves. Studies have found greater cognitive distortions, in particular, cognitive rigidity (dichotomous thinking), among suicidal youths and adults than among non-suicidal mentally ill or healthy controls (Weishaar and

Beck, 1990). Such rigid thinking appears related to the interpersonal and general problem-solving deficits commonly seen in suicidal individuals. Cognitive behavioral and problem solving therapy specifically target such variables and appear effective in reducing suicidality.

The relationship between hopelessness and suicidality has been the subject of studies for over 25 years. Hopelessness appears to arise from multiple sources, including low self-esteem combined with interpersonal losses and lack of confidence in one's ability to regulate mood or solve personal problems (Catanzaro, 2000).

Cognitive behavioral therapy is designed to reduce clinical symptoms by changing thoughts and behaviors. Numerous studies show cognitive behavioral therapy is effective in reducing depression and hopelessness in various populations including adolescents (Brent et al., 1999).

Self-efficacy beliefs, the assessment of one's ability to manage or control external and internal threats, exert a primary influence on human emotion, cognition and behavior. Positive self-efficacy beliefs represent the opposite of hopelessness and appear to protect individuals from suicidality. Coping self-efficacy beliefs affect physiological stress responses involving the catecholamines, opiods, and the hypothalamic-pituitary adrenal axis, and directly contribute to emotional arousal, psychological distress and well-being, and anxiety (Cantanzaro and Mearns, 1999).

Emerging research on school-based suicide prevention programs for at-risk youth demonstrates increased self-efficacy and decreased suicidality in program participants. Coping and emotion regulation styles refer to how individuals manage stressful conditions or events (actively or passively) and how they regulate their own emotional, physiological, behavioral, and cognitive reactions to stress. Coping styles contribute to physical and mental health following stressors or trauma. Active coping styles such as planning, engaging problems, and seeking social support, and cognitive reinterpretation coping (finding meaning and benefit from adverse events) appear to decrease symptoms of psychological disorder.

Maladaptive coping styles generally correlate with negative outcomes. Suicidologists consistently find ineffective coping styles for mood and impulse regulation and interpersonal problem-solving among suicidal individuals. Suicidal individuals use fewer active coping strategies and more avoidant (passive) coping styles such as suppression and blame. Impulsive problem-solving style and difficulty regulating mood are related to increased rates of suicide attempts (Catanzaro, 2000).

Sociological Factors that should be considered are:

1. Marital Status and Parenthood;
2. Social Support;
3. Religion/Spirituality; and
4. Economic/Socioeconomic Status.

The social and cultural factors correlated with suicide have been considered at different levels. The level I write about is the individual focus on the influence of specific events in someone's life and their affiliation with and participation in social groups. An approach at this level assumes that critical life events or circumstances are responsible for suicides.

Across societies, family attachments influence suicide probability. In general, across many cultures, being in a marriage is associated with lower overall suicide rates,

while divorce and marital separation are associated with increased suicide risk. Widowed persons are also more likely to complete suicide. Being single also influences the likelihood of committing suicide. Being a parent, particularly for mothers, appears to decrease the risk of suicide. Pregnant women have a lower risk of suicide than women of childbearing age who are not pregnant. Having a young child appears to be a significant protective factor for women (Qin et al., 2000).

Those who enjoy close relationships with others cope better with various stresses, including bereavement, rape, job loss, and physical illness and enjoy better psychological and physical health (Institute of Medicine, 2001). Research has demonstrated that social support moderates suicidal ideation and risk of suicide attempts among various racial/ethnic groups, abused youths and adults, those with psychiatric diagnoses, and those facing acculturation stresses. Men and women may differ in use of types of social support (Mazza and Reynolds, 1998).

In general, participation in religious activities is a protective factor for suicide. In the United States, areas with higher percentages of individuals without religious affiliation report correspondingly higher suicide rates. The protection afforded by religion may have several components. Involvement with religion may provide a social support system through active social networks. Suicide may be reduced with religious affiliation because of the proscription against the act. Belief structures and spirituality may also be protective at an individual level as a coping resource and via creating a sense of purpose and hope (Werner, 1996).

Epidemiological analyses reveal that occupation, employment status, and socioeconomic status affect the risk of suicide (Institute of Medicine, 2001). Police officers, manual laborers, physicians and dentists have elevated suicide rates. While some find that blue-collar workers are more likely to complete suicide, others find high suicide among professional classes, confirming earlier theories suggesting that the risk of suicide is elevated at both ends of the occupational prestige spectrum.

Unemployment is clearly associated with increased rates of suicide. A recent study in the United States based on National Longitudinal Mortality Study (Kposowa, 2001), revealed a two-fold increase in risk of suicide among the unemployed. The analysis also suggested that while the relationship is stronger in men within the short term, when followed for 9 years, unemployed women were actually more vulnerable to suicide than unemployed men.

A strong predictor of suicide is socioeconomic disadvantage. Overall suicide rates appear to be associated with indicators of economic distress. Suicide rates are highest in low-income areas and the greater changes in economic cycle have been associated with greater increase in the suicide rate. Economic conditions can affect suicide in other ways as well. Alcohol consumption and marital discord can increase with financial difficulties, which can increase risk of suicide. Relocation of individuals or families can result as a consequence of unemployment or financial strain. The increased stress of breaking social bonds increase suicide risk (Stack, 2000).

Although suicide rates of most age groups have remained fairly constant, females attempt suicide more often than males but are less successful at completion of the attempt. Males use more violent methods to commit suicide. Of concern should be the fact that the means by which females attempt to end their lives has changed with a nearly 10% increase in the use of firearms (U.S. Bureau of Census, 1996).

In the United States, Native Americans are 2.5 times more likely than Blacks to commit suicide. With a suicide rate half as high as that for Whites, some American Indian tribes have the highest suicide rate of all racial groups. Although general suicide rates among American Indian adolescents appear to be the highest, it is important to note that this is not the case for all American Indian tribes (LaFromboise & Bigfoot, 1988). Native Americans have the highest suicide rates of any ethnic group in the United States, although there are large differences across tribes, with the Navajos having rates close to the national average (12 per 100,000) and some Apache groups having rates as high as 43 per 100,000 (Garland & Zigler, 1993).

There are a number of risk factors which must be considered by helping professionals, I hope you will now be more aware of suicide factors and be able to recognize those at risk.

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Author's Biography

Lisa M. Meyer is currently pursuing a master's degree in School Counseling and is Rule 25 certified by the State of Minnesota to perform Chemical Dependency Assessments. Earlier experience has included writing a proposal which was funded in the amount of $12,432 for the Undergraduate Research Conference at Minnesota State University, Mankato, serving on a grant writing team that was funded in the amount of $1,100,000 for a McNair Scholars Program at Minnesota State University, Mankato, providing assistance with Early Childhood Special Education, providing care to children in a home day care, and served as Vice President on the Lake Crystal Wellcome Memorial Athletic Boosters and as a member of the Dakota County Child Abuse Prevention Board.

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Dr. John W. Seymour has taught in the Counseling and Student Personnel Department since 2001, where he teaches courses in counseling, including family therapy, play therapy, child and adolescent counseling. His major research interests are in play therapy, professional/ethical issues, and family health issues. Earlier professional experience has included providing family and play therapy clinical services in private practice, agency, and treatment center settings, as well as treatment program management and development.