Suicide and Suicide Prevention: A Historical Preview

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Abstract: Suicide is a public health crisis, particularly for low and middle class countries like India. India is among the top seeded country in case of suicide in the world. If we have to do something for the prevention of suicide, we will have to know the origination of suicide. Different theories of suicide provide a possible benchmark for suicide prevention. Looking at a phenomenon form different point of view gives a clear idea about the understanding of that phenomenon. In the same fashion, looking suicide from different perspective will provide a base for understanding of this subject. 

The present paper is in the light of suicide, its history, different theories and preventive measures so far taken for suicide.

Keywords: suicide, theories of suicide, suicide prevention.

Introduction:
Suicide has been part of history for as long as there have been written records and is probably as ancient as mankind. In every age of the world, and in the history of almost every country, there are a lot of instances more or less numerous of men and women who, preferring the dim uncertainty of the future to the painful realities of the present, have sought relief from all their troubles by suddenly terminating their own existence (Westcott, 1925). The first known document about suicide is an Egyptian record, written on papyrus, that historians believe was written between 2000 and 1900 B.C. (Williams, cited in Allen, 1977). From that time to the present, suicide has been a topic of considerable interest to many authors from a variety of disciplines. In the present time, suicide is the leading cause of death all around the world (Brown, 2011). Specifically, suicide is the third leading cause of death among young adults 15 to 24 years old in the United States (Anderson & Smith, 2005) and the second leading cause of death among college students (Dogra, Basu, & Das, 2008). According to the Center for Disease Control in America (2009), there are approximately 100-200 suicide attempts for every completed suicide among young adults age 15 to 24 years, and suicide accounts for 12% of all deaths annually for the same age group. Westefeld et al. (2005) have found that 24% of sample of 1,865 college students have thought about attempting suicide. Globally 1 out of every 10 students suffers significant distress leading to suicide. Suicide is considered as a public health crisis. World health organization estimates that in India, every year approximately one and half million people end their life and close to eight million worldwide choose to commit suicide (WHO). It is a global phenomenon which affects all the countries and especially low and middle income countries are mostly affected by it. There is an estimation that 78% of suicides occurred in low- and middle-income countries in 2015 (WHO, 2017). In the top seeded country regarding suicidal rate, India is one among them. Where the reported rate of suicide is 10.7 per 100,000 populations worldwide, the crude suicidal rate of India is 17.9 per 100, 000 population (WHO, 2017). Thus, suicide being a major public and mental health problem demands urgent action. There is not a single cause which leads a person to commit suicide, rather it is the result of a complex combination of personal, social, and health factors, and therefore suicide prevention is a challenge, requiring a systems approach incorporating public health strategies, screening at-risk individuals, targeted interventions, and follow-up for suicide survivors and those bereaved by suicide. A nationwide suicide prevention strategy is the first in the steps needed to reduce the number of suicides. Ironically, we do not have a system who can watch over suicide or suicidal attempt. While there are at least 50 suicide crisis help lines in India that are working tirelessly to handle callers who are suicidal, there are other proven ways to prevent suicide and suicide battle suicide ideation. India does not have a single organization that is working towards suicide prevention, suicide awareness, engage with
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the media, conduct Gatekeeper training, and promote mental health self care. The WHO states that there are only 28 countries that have a suicide prevention policy in place, and India is not one of them. Although mental health act, 2017 states that any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the section 309 of Indian penal Code. Government shall have a duty to provide care, treatment and rehabilitation to a person, having severe stress and who attempted to commit suicide, to reduce the risk of recurrence of attempt to commit suicide. In addition, Government shall, in particular, plan, design and implement public health programs to reduce suicides and attempted suicides in the country (GOI, 2017), but proper implementation of policy and sound preventive measures are yet to be achieved.

History of Suicide:

A history of suicide is a history of man’s eternal quest for the meaning of life, death and the hereafter. The earliest recorded text dealing with suicide is to be found in an Egyptian papyrus from the middle kingdom (2160-1788 BC) in the Berlin Museum, entitled “The Dispute with his soul of one who is tired of life”. Unfortunately, this papyrus is incomplete because the beginning is missing. Therefore, the identity of the author is not known and it is not certain that the person is talking about suicide. Suicide is seen differently in different cultures. Both Greeks and Romans accepted suicide as an alternative to a life of shame and misery. However, Greeks do not condone it. Plato, in his Laws, states that those who commit suicide “from sloath or want of manliness” shall be buried in unmarked graves (Plato, 1921). Aristotle in his Nicomachean Ethics states that committing suicide is in against of the law of states and should be punished (Aristotle, 1980). The Romans were somewhat indifferent to suicide and attached no stigma to it, but in case of slave and soldiers, roman laws clearly forbid them to commit suicide as these were considered the property of state and they were not independent to take their own decision. Suicide is also taken as seen in bible. Opinion has long been divided on the seriousness of suicide. The excessive martyrdom of early Christians persuaded church leaders to define suicide as a sin; by the 13th century, St. Thomas Aquinas emphasized that it was a mortal sin because it usurped God’s power over humanity’s life and death. It is from these beginnings that the stigma and taboo have taken root in regard to suicide. Stigma is attached with suicide not only in western civilization, but Islam specifically forbids suicide as an act against God. Similar beliefs can be found in other cultures. It is believed that the souls of the suicides are not admitted to the heaven but must hover eternally as a ghost between heaven and earth. The body of the person who committed suicide were not allowed to bury ground but thrown out in the ground to be devoured by wild beasts in Dahomey culture (Westermark, 1906-08). The common thread behind the practices is the belief prevalent in many societies and cultures that the damned soul of the suicide will haunt the living and bring about disasters such as famine, flood and diseases unless some ritual is invoked (Valente, 1977). But the rise of humanism made the person think of himself as an individual. The human body is looked upon as a marvel of creation and not as a temptation and source of sin. At this time, suicide arose as an alternative of life of suffering. In Sir Thomas More’s Utopia, suicide is considered to be a form of euthanasia acceptable to those suffering with incurable disease. Later, Michel de Montaigne in chapter 3 book II of his Essays, in a section entitled “a custom of the Island of Cea” presented the pros and cons of suicide. As noted by Alvarez (1971), the earliest use of the word suicide in English language appeared in Sir Thomas Browne’s Religio Medici, 1642:

Yet herein are they in extreames, they can allow a man to be his own assassin, and so highly extol the end and suicide of Cato, this is indeed not to fear death but yet to bee afraid of life (Browne, 1964).

Before this time other euphemisms were used such as self murder or self destruction. The Latin word qui sibi mortem consciverit (who inflicts death upon himself) was also used. One of the most revealing apologies from suicide in the English language is John Donne’s Biathanatos or self
homicide. Another classic which associate suicide with melancholy (or depression) is Richard Burton's Anatomy of Melancholy of 1621. Here while describing the relationship between melancholia and suicide; he clearly states that individuals who commit suicide do so because of forces beyond their control. Edwin S. Shneidman, the co-founder of the Suicide Prevention and Crisis Intervention Center at San Mateo, and founder of the American Association on Suicidology, traced the theory of suicide, starting with the word's etymology. The word "suicide" was first defined in 1651 by Walter Charleton, according to The Oxford Dictionary, as' vindicate [ing] ones-self from...inevitable Calamity," and it was not considered a crime. The Roman stoic Seneca wrote, "Living is good, but living well. The wise man, therefore, lives as well as he should, not as long as he can." In seventeenth century, the rise of science crept into the human thought that there must be some scientific basis of suicide. Many were of the thought that the most of the problems of the human race are caused by environmental forces. George Cheyne in 1733 published his work The English malady in which he made his observation that the English had more nervous distemper because they ate too many rich food, sat too much, did not exercise and lived in large cities like London with its pollution and this distemper likely produced the want of self murder (Cheyne, 1733). William Battie, contemporary of Cheyne wrote a book entitled A Treatise on Madness in 1758 which is first scientific work on psychiatry in English language. The eighteenth century also called the age of enlightment led to a change in laws that punished those who commit suicide or attempted to do so. During the 18th century, Jean-Jacques Rousseau transferred the locus of power to society, and, in keeping with the ideology of the Enlightenment, discussed suicide in the absence of sin. Montesquieu was one of the supporters of suicide. In his words, When I am overwhelmed by pain, poverty and scorn why does one want to prevent me from putting an end to my troubles, and to deprive me cruelly of a remedy which is in my hands? ..... Life has been given to me as a gift. I can therefore return it when it is no longer (Montesquieu, 1961).

In the beginning of nineteenth century industrial revolution was on full swing and brought many sociological and environmental changes with it. The use of statistics was introduced to support or refute any theory and along with this, accuracy of data was also questioned. In 1822, Falret published first statistical table of suicide in De L'Hypochondrie et du Suicide. Esquirol (1838) in his book Des maladies Mentales discussed the contributing factors of suicide and possible treatment. In 1856, Briere de Boismont published a fundamental study on suicide Du Suicide et de la folie suicide. He collected secondary data of 4595 individuals who either committed suicide or attempted to do so. Many of his findings are still valid as relationship between suicide and alcoholism.

Theoretical and research advances over the last 100 years have added to these sociological and psychological theories, sometimes modifying them drastically. Psychological theories assume that suicide attempts suffer from mental aberrations, while sociological theories make no such assumption, instead offering a group-oriented explanation. Modern suicidology began with the extensive work of Emile Durkheim named Le Suicide (1897). By the 20th century, Emile Durkheim, in Le Suicide, expostulated on society's impact upon the individual, furthering the sociological view of suicide. His view was that suicide resulted from society's strength or weakness of control over the individual. Three types of suicide were thus defined: altruistic (self-sacrifice), egoistic (absence of ties to the community), and anomie (severe breakdown of the relationship between the individual and society, creating alienation and confusion). He characterized the role of social regulation and social integration on suicide. He emphasized on the role of society on an individual's life and thus he was of an opinion that society as a whole should be studied in reference of suicide.

The sociological view of suicide is bolstered by research demonstrating that it is impossible to link suicide unequivocally to mental illness. According to this view, suicide is best explained by institutional and sociological variables, and is rooted less in the individual than in the character of social institutions, patterns and networks. Such factors as urbanization, poverty, racism, sexism,
corporate exploitation of individuals, and other environmental stressors are encompassed by this model. Television has even been indicated as a factor in suicide: Phillips (1982) revealed that in 1977, suicides, motor vehicle deaths and non-fatal accidents rose immediately following soap opera stories. Gil (1977), in a paper presented to the American Association on Suicidology, described life as an autonomous process of the unfolding of genetically determined potential. This life process relies on needs-satisfying exchanges between individuals and their physical/social environment. Social orders of human beings can obstruct or facilitate these exchanges. The obstruction of exchange, and thus of satisfaction of develop-mental needs, can be defined as violence; when socially constructed institutions are the block, "structural violence" is the result. Gil postulates that suicidal urges, thoughts, desires and acts seem to be one response of individuals who feel trapped by conditions which violate the unfolding of their life process and the development of their innate potential. His theory is similar to Viktor Frankl's view in that both acknowledge the need for meaning in our lives. Gil locates the cause of lack of meaning in hierarchical organizations which treat people as means to an end, rather than as ends in themselves. To foster a healthier society, Gil advocates replacing the dominant cultural values of competition, domination, exploitation, inequality, selfishness and other-negating individualism with cooperation, liberty, self-direction, equality, and genuine individuality.

The advent of Freud and psychoanalysis brought an entire opposite outlook of suicide. Now it was the individual who needed to be studied not the society. Freud was of the view that suicidal person has an aggressive drive that is not overtly expressed but is instead expressed against the person himself. In his own words, 

*Probably no one finds the mental energy required to kill himself unless, in the first place, in doing so he is at the same time killing an object with whom he has identified himself and, in the second place, is turning against himself a death wish which had been directed against someone else* (Freud, 1955).

Sigmund Freud advanced the psychological view of suicide, theorizing that such self-destructive behavior derived from unconscious hostility toward an ambivalently-viewed love object turned inward against the self. One kills oneself in order to murder the image of the loved-hated father or mother. Freud recognized that suicide was an emotional powerhouse encompassing guilt, anxiety, dependency, helplessness and hopelessness as well as rage. From Freud's theories comes the traditional view of suicide as the manifestation of the desire to kill someone else. This theory explains what happens but cannot go to the root of why. Moreover, there are other factors like hate, shame, loss of autonomy, love, fear, hopelessness, helplessness, despair etc. which can contribute in suicide. Psychological theories, starting with Freud's psychoanalytic approach, expanded to include the behaviorist view, which identifies the cause of suicidal ideation as inadequate reinforcement. In the first case, the attempter is treed through psychotherapy, tricyclic antidepressants, and/or electroconvulsive shock therapy. In the second, treatment entails positive rewards and reinforcement.

A third psychological approach is the humanist-existential view, fostered by Viktor Frankl, which locates the cause of suicide in the loss of meaning and purpose in life. Treatment according to this view involves logo therapy, a future-oriented form of psychotherapy in which the therapist tries to help the client detect unconscious values that could give meaning to life. Meaning can be realized through creative endeavors, experiences and contact with the Good, the True, and the Beautiful (such as loving someone), and through one's attitude toward suffering. Frankl believed that an honorable kind of suffering may be the highest human achievement (Missinne & Wilcox, 1981).

A more recently developed theory of suicide is the medical view, in which emotional and psychological imbalances are thought to be chemically induced. Treatment then consists of hospitalization and chemical therapy. Other theorists explain suicidal behavior as a logical, if not necessarily rational, way to solve in surmountable dilemmas in one's life. The counselor's responsibility in such a situation, as well as the legal ramifications of what has been referred to as the "right to die," are currently the subject of intense private and public controversy.
From Durkheim’s sociological to Freud psychoanalytical point of view to modern biochemical approach, we have gone a far way in understanding of suicide. We have also decriminalized it and established humanistic approach towards understanding of suicide. But despite all these understanding, the stigma attached with suicide is not yet been resolved. We as a society will have to join hand to remove this.

**History of Suicide Prevention**

Choron (1963, 1968) points out that probably the first recorded instance of suicide prevention program was recorded by Plutarch (46-119 AD), who notes an ordinance of magistrates of Miletus, which was intended to put an end on sudden increasing incidences of suicide among young women of that Greek city.

The shift from the view of suicide as an ugly, tabooed secret to a respectable subject of research began in 1950s (Allen, 1977). In modern suicidology, the first suicide prevention centre was established in United State of America in 1905. The significant events in suicide prevention program worldwide are listed below in chronological order.

**Table 1: Milestone in Suicide Prevention: A Chronology**

<table>
<thead>
<tr>
<th>Year</th>
<th>Facility</th>
<th>Founder</th>
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<tr>
<td>1906</td>
<td>The London Anti-Suicide Department, London, U.K.</td>
<td>The Salvation Army</td>
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<tr>
<td>1933</td>
<td>The Suicide Flotilla (a squadron of suicide prevention boats that patrolled the Danube river to rescue potential suicides), Budapest, Hungary.</td>
<td>No known Founder</td>
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<tr>
<td>1947</td>
<td>The Society for the Care of People Tired of Life, Vienna, Austria</td>
<td>Dr. Erwin Ringel</td>
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<tr>
<td>1958</td>
<td>The Los Angeles Suicide prevention Centre, Los Angeles, California</td>
<td>Dr. E.S. Shneidman &amp; Dr. N.L. Farberow</td>
</tr>
<tr>
<td>1961</td>
<td>The International Association for Suicide Prevention (Headquarter in Vienna, Austria)</td>
<td>Dr. Erwin Ringel</td>
</tr>
<tr>
<td>1966</td>
<td>Centre for the Study of Suicide Prevention of the national Institute of Mental Health</td>
<td>NIMH, US Department of Health Education and Welfare</td>
</tr>
<tr>
<td>1968</td>
<td>The American Association of Suicidology</td>
<td>Dr. E.S. Shneidman</td>
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Source: Allen (1977)

In Indian setting, nothing much is done in prevention of suicide. Although, there are more than 50 hotlines all over the country which are tirelessly working for the suicidal crisis and helping people over the phone, there is not a single organization, which work for suicide prevention, conduct awareness program, organizes seminars in this direction. Some of the help lines which tirelessly work for suicidal people or people in crisis work with online mode or telephonic conversation are Aasra (Mumbai), Sneha (Chennai), Roshni (Hyderabad), Saath (Ahmedabad), Maitreyi (Pondicherry), Sumaitri (New Delhi), Lifeline Foundation (Kolkata). These all run by NGOs. It is an irony of our nation that in spite of rising trend of suicide in country, not a single government organization works in that field.

It is the need of our society that government as well as society should come forward as a whole to remediate this evil of society.

**References:**

The prevention of suicide is equally complex and, while feasible, is no easy task: it involves a whole series of activities, ranging from the environmental control of risk factors and means, through the early identification and effective treatment of people with mental and substance use disorders, to the responsible reporting of suicide in the media. A physician could then be called in to examine the body and take a history from the closest available person. A suspected suicide might then be examined by a medical examiner or a forensic pathologist, but the examination would be waived if the family could prove the deceased had been in psychiatric treatment.