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RESEARCH ARTICLE

SUICIDE PREVENTION IN ARAB WORLD: IS IT ACHEVABLE?

***Raad Saady Madhloom**

Specialist Psychiatrist Mahmodya, Baghdad, Iraq

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ABSTRACT

This Article encourages arab countries to continue the good work where it is already ongoing and to place suicide prevention high on the agenda, regardless of where a country stands currently in terms of suicide rate or suicide prevention activities. Suicide is a serious public health problem; However, suicides are preventable. The Arab completed suicide rates of 1.1 / 100,000 to 6.2 / 100,000, suicide victims were: male gender; the ages 20-40 years old, single, manual workers and unemployed, Female suicide victims were frequently younger than male attempters and were either students or house wives. Depression was the most recorded psychiatric disorder, and family problems were the most recorded precipitating factor. Males being more likely to self - shoot and females to self poison and self immolate.

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INTRODUCTION

Studies that assess suicidality are rare in the Arab world. Given the fact that suicide and attempted suicide are considered disgraceful acts prohibited by religion, condemned by society and hampered by legal consequences, suicidality remains a taboo in this region of the world (Elie, 2008). Every suicide is a tragedy. The impact on families, friends and communities is devastating. Unfortunately, suicide all too often fails to be prioritized as a major public health problem. Despite an increase in research and knowledge about suicide and its prevention, the taboo and stigma surrounding suicide persist and often people do not seek help or are left alone. And if they do seek help, many health systems and services fail to provide timely and effective help. Suicides are preventable, occur in all regions of the world and throughout the lifespan. Suicide impacts on the most vulnerable of the world's populations and is highly prevalent in already marginalized and discriminated groups of society. It is not just a serious public health problem in developed countries; in fact, most suicides occur in low- and middle-income countries where resources and services, if they do exist, are often scarce and limited for early identification, treatment and support of people in need a prior suicide attempt is the single most important risk factor for suicide in the general population (WHO, 2014). Over 80% of people who died by suicide had health care visits in the prior 12 months (Brian, 2014), 45% of people who died by suicide had a primary care visit in the month before death (Patrick, 2014). 19% of people who died by suicide had contact with mental health services in the month before death (Jason, 2002). 10% had an emergency department visit in the 60 days (Runar, 2015). Suicide is a serious public health problem; However, suicides are preventable with timely, evidence - based and often low - cost interventions. For national responses to be effective, a comprehensive multisectoral suicide prevention strategy is needed. Suicide is a complex issue and therefore suicide prevention efforts require coordination and collaboration among multiple sectors of society, including the health sector and other sectors such as education, labor, agriculture, business, justice, law, defense, politics, and the media. These efforts must be comprehensive and integrated as no single approach alone can make an impact on an issue as complex as suicide. . While the link between suicide and mental disorders (in particular, depression and alcohol use disorders) is well established in high - income countries, many suicides happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship break - up or chronic pain and illness. In addition, experiencing conflict, disaster, violence, abuse, or loss and sense of isolation are strongly associated with suicidal behavior.

****Corresponding author:*** Raad Alshammary,
Specialist psychiatrist Mahmodya, Baghdad, Iraq.

Suicide rates are also high amongst vulnerable groups who experience discrimination, such as refugees and migrants; and prisoners. By far the strongest risk factor for suicide is a previous suicide attempt (WHO, 2014). Approximately one third of suicides in schizophrenia and affective disorder occur during admission or the first month after discharge (Elizabeth, 1999).

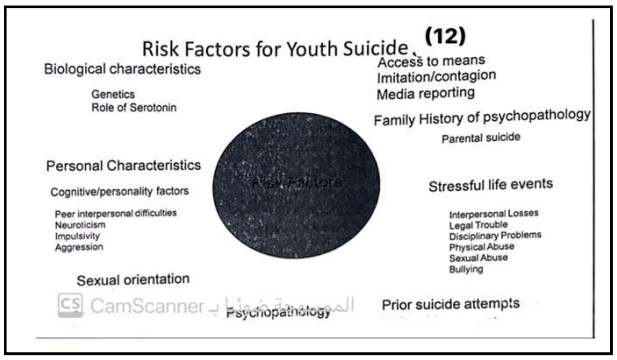
TERMINOLOGY: Suicide describes as a 'multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution (Maris, 1992). And defined as the act deliberately killing oneself. suicide attempt is used to mean any non - fatal suicidal behavior and refers to intentional self - inflicted poisoning, injury or self - harm which may or may not have a fatal intent or outcome (WHO, 2014). Suicidal ideation might be defined as' any self - reported thoughts of engaging in suicidal behavior (O'Carroll, 1996).

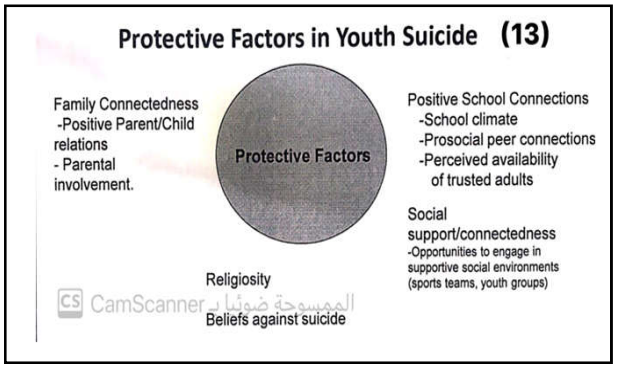
EPEDEMIOLOGY

The lack of national epidemiological studies in the Arab world and the differences in methodologies used, render it difficult to compare results and make generalizations. In addition, properly defined catchment areas for the distribution of health care services are practically non - existent in Arab countries, thus, making it unreliable to make regional estimates of attempted suicide by using hospital based studies. Therefore, results should be interpreted with caution. It has been observed that official records of suicide and attempted suicide are filled with inconsistencies and missing information which create an incomplete picture of suicidal behavior in several Arab countries. The Arab suicide studies that police and government records reported annual completed suicide rates of 1.1 / 100,000 to 6.2 / 100,000, again keeping in mind the caveats of reporting. The most frequently observed characteristics among suicide victims were: male gender; between the ages 20 to 40 years old, single, manual workers and unemployed Female suicide victims were frequently younger than male attempters and were either students or house wives. Information about mental disorders, previous suicide attempts and precipitating factors were typically not recorded on death registrations. With this in mind, depression was the most recorded psychiatric disorder, and family problems were the most recorded precipitating factor. The most commonly used methods to commit suicide, across all Arab suicide studies, were hanging and self poisoning, males being more likely to self - shoot and females to self - poison and self – immolate (Elie, 2008). 79% of global suicides occur in low- and middle-income countries (Riazuddin, 2019). Ingestion of pesticide, hanging and firearms are among the most common methods of suicide globally. Suicide rates are highest among 70+ years old for both men and women in almost all regions of the world (WHO, 2014).

Protective Factors across the lifespan: Skills to think, communicate, solve problems, manage anger and other negative emotions; coping skills. Purpose & value in life; hope for the future, pets, work / life focus, family connections and support; feeling of use in your world. Personal characteristics- health and access to healthcare, positive outlook, healthy lifestyle choices. spirituality or religious belief. Supports- family, friends, mentors, vocational and other caring connected people.

Safe Environment: Restricted access to lethal means. Suicide Risk Factor Suicide does not discriminate. Anyone of any race, gender, age, or socioeconomic status may feel suicidal at any point in their lives. Even someone who seems to be happy or to "have it all" can be vulnerable to suicide. There are certain risk factors to be aware of, though. These are situations, conditions, and other factors that put some people at a greater risk of becoming suicidal:- Having a mental illness, particularly depression, bipolar disorder, anxiety disorder, or conduct disorder and especially an untreated mental illness Having a substance use disorder being ill, living with a chronic or terminal illness, or being in significant, long-term pain. Suffering from a traumatic brain injury . Stressful life situations, especially those that are prolonged, including bullying or relationship problems · Sudden stressful or traumatic situations, like the loss of a loved one. Having experienced childhood trauma and abuse. Having access to lethal means. Being exposed to another person's suicide. Past suicide Attempts . A family history of suicide (Marj, 2016).





Methods of suicide Around 20% of global suicides are due to pesticide self - poisoning, most of which occur in rural agricultural areas in low- and middle income countries. Other common methods of suicide are hanging and firearms. Knowledge of the most commonly used suicide methods is important to devise prevention strategies which have shown to be effective, such as restriction of access to means of suicide (WHO, 2014). Fact missed about suicide The majority of suicides have been preceded by signs of verbal or behavioral warning. Actually, some suicides are committed without previous warning. But it is important to know the warning signs and take them into account. The suicidal behavior indicates a profound unhappiness, but not necessarily a mental disorder. Many people who live with mental disorders are not affected by the suicidal behavior, and not all the people that kill themselves have a mental disorder. Every 40 seconds a person dies by suicide somewhere in the world.

Close to 800 000 people die due to suicide every year. The number of lives lost each year due to suicide exceeds the number of deaths due to homicide and war combined. For every suicide there are many more people who attempt suicide every year. A prior suicide attempt is the single most important risk factor for suicide in the general population. Suicide is the second leading cause of death among 15-29 - year – olds (WHO, 2014).

Challenges and obstacles:

Stigma and taboo Stigma, particularly surrounding mental disorders and suicide, means many people thinking of taking their own life or who have attempted suicide are not seeking help and are therefore not getting the help they need. The prevention of suicide has not been adequately addressed due to a lack of awareness of suicide as a major public health problem and the taboo in many societies to openly discuss it. To date, only a few countries have included suicide prevention among their health priorities and only 38 countries report having a national suicide prevention strategy (WHO, 2014).

Data quality: Globally, the availability and quality of data on suicide and suicide attempts is poor. Only 60 Member States have good - quality vital registration data that can be used directly to estimate suicide rates. This problem of poor - quality mortality data is not unique to suicide, but given the sensitivity of suicide - and the illegality of suicidal behavior in some countries - it is likely that under - reporting and misclassification are greater problems for suicide than for most other causes of death (WHO, 2014)

WHO Response: WHO recognizes suicide as a public health priority. The first WHO World Suicide Report "Preventing suicide: a global imperative", aims to increase the awareness of the public health significance of suicide and suicide attempts and to make suicide prevention a high priority on the global public health agenda. It also aims to encourage and support countries to develop or strengthen comprehensive suicide prevention strategies in a multisectoral public health approach.

Action Programs: Suicide is one of the priority conditions in the WHO Mental Health Gap Action Program (mhGAP) launched in 2008, which provides evidence - based technical guidance to scale up service provision and care in countries for mental, neurological and substance use disorders. In the WHO Mental Health Action Plan 2013- 2020, WHO Member States have committed themselves to working towards the global target of reducing the suicide rate in countries by 10% by 2020 (WHO, 2014). Prevention and control Suicides are preventable, There are a number of measures that can be taken at population, sub population and individual levels to prevent suicide and suicide attempts. Strategies for prevention: Reducing access to the means of suicide (e.g. pesticides, firearms, certain medications); Reporting by media in a responsible way; Providing help lines and online help. Introducing alcohol policies to reduce the harmful use of alcohol. Early identification, treatment and care of people with mental and substance use disorders, chronic pain and acute emotional distress; Training of non specialized health workers in the assessment and management of suicidal behavior Follow up care for people who attempted suicide and provision of community support (WHO, 2014).

Why People Hesitate to Ask for Help Unwilling to admit needing help. Afraid to upset or anger others. Unable describe their feelings or needs. Unsure of available help or resources. Struggling with symptoms of depression. Don't know what to expect. Shame, of stigma May prefer to confide in peers. Why People Hesitate to Help Not sure about how severe the risk is; what if they're wrong? .Worry about doing or saying the "right" thing. Feelings of inadequacy. Afraid to put the idea in someone's head. Feel it's not "their issue. Advice for the communications media what not to do?1- Not publish photographs or notes related to suicide. 2-Not inform specific details about the suicide methods. 3-Not give simplistic reasons. 4 -Not glorify nor sensationalize suicide. 5-Not use religious or cultural stereotypes. 6-Not contribute blames.

Conclusions

Short - term paternalistic interventions with the purpose of assessing a suicidal person for mental illness, treating such illness if it is found, counselling them, providing assistance with any problems they have and giving them time to reflect on their life and suicidal thoughts in a supportive environment is, in our opinion, ethically justifiable. Factors supporting this conclusion include the principle of respect for life, the evidence of mental illness in a significant proportion of suicide victims, the cry for help model, ambivalence in suicidal individuals and the individual's duty to others. Paternalistic intervention with autonomous individuals can also be justified using these factors, in addition to an appeal to preserve the individual's deep autonomy (Chris Kelly, 2011). Occurrence of suicide during treatment or after assessment does not automatcallyn imply negligence or failure:- sadly, some patients will die whatever interventions are offered. Clinicians should change their perceptions of this fact: instead of therapeutic nihilism, they should hope that their interventions will enhance their patient's quality of life and at least postpone a suicide, so protecting that patient's family and friends from the pain of bereavement for that bit longer. In addition to excellent assessment skills, an important aspect of risk management is good medical record - keeping. If documentation is inadequate, a legal case can be devastating for the treating clinician even where there has been no negligence. Notwithstanding the difficulties clinicians face, suicide prevention is successful for many and it remains of paramount importance in saving a significant number of lives (Alys Cole, 2013).

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