Suicide prevention strategies in Sri Lanka: the role of socio-cultural factors and health services

Suicide prevention is a national priority. The medical profession ought to lead the way in demanding improvements in the availability and quality of mental health services.

Sri Lanka has lost more lives as a result of suicides than due to the ethnic conflict during the past two decades. There is considerable human suffering and economic and social costs from suicides, and preventing suicides is a national priority. Recent data suggest the existence of a pathway of suicidal ideas and suicidal acts culminating in certain instances with fatality (1), and its recognition gives us wider opportunities for interventions. First, I shall briefly describe the nature and extent of the problem of suicidal behaviour in Sri Lanka and how the country has responded to the problem. The latter section proposes initiatives based on recent research findings regarding suicidal behaviour resulting from psychiatric disorders and other life stresses. Politically motivated suicides have not been considered.

The annual suicide rate increased from 6.9 per 100,000 in 1950, to 47 by 1991, the highest in the world. The rates have begun to decline from 1995 (2). The national rates in a given year show two peaks, the first is of youth suicides and the second in those above 65 years. High death rates from suicidal attempts are to a great extent the result of high case fatality rates (3).

Suicide prevention strategies in Sri Lanka can be categorised as population based (eg. measures to reduce availability of pesticides), and those aimed at high-risk groups (eg. detection and treatment of depression).

Population based interventions include the following: a Presidential Task Force was established in 1997, which has released a policy document on suicide prevention; the act of suicide was de-criminalised, and this law was implemented in 1998; the Department of Education has introduced a life-skills program in 1998 which is being implemented in schools providing secondary education; the pesticide registrar has taken steps to limit the use of extremely toxic pesticides. This runs parallel to the programs by the Department of Agriculture, which has attempted to phase out very toxic agro-chemicals and encourage the use of integrated pest management. A minimum pesticide list has also been proposed for developing countries (4).

Examples of interventions that target high-risk groups include: a number of non-governmental organisations, especially “Sumithrayo”, that work with those distressed and who have suicidal ideas; and mental health services that provide care for patients with significant psychiatric disorders in clinics and hospitals.

However, recent research suggests that two specific areas need further attention: socio-cultural determinants of suicidal behaviour and improving mental health services in the country. A recently concluded ethnographic exploration, for example, has thrown more light on the relationships between socio-cultural norms and suicidal behaviour (5). It describes ideas, feelings, motives and communication patterns of people who harmed themselves or others. A significant finding was that the relatives and friends of those who were studied in depth, and community members who participated in focus groups, shared some of the values and beliefs that the participants or the index cases held in relation to suicidal and violent behaviour. They endorsed suicide as a way of problem solving and empathised with those who attempted suicide. The study found that factors such as frequent abuse and aggression led some people to become distressed, and subsequently drove them to suicidal behaviour as a cry for help or as a mark of protest. The communities studied accepted factors such as physical and verbal abuse as appropriate methods of conflict resolution.

Biyawewela too has described the existence of a dominant ideology that sanctions self-destruction as a legitimate form of resistance or escape (6). And Boltz describes a “conflict culture” among Sri Lankans, which contributes to the high suicide rate (7). Abeyesinghe has noted parental abuse of adolescents as accounting for 48.5% of suicides in this group (8).

The culture of suicide and violence (eg. acceptance of suicide as a way of problem solving, aggression as a means of conflict resolution) needs to be countered in an effective and planned way. Interventions could focus on developing programs to challenge and modify such social and cultural beliefs. To do this we need to begin at different levels of society, and intensive public education programmes. These may be considered under two main areas: school based programmes and the role of media.

We need to improve the quality of “life skills” programs introduced in schools by extending them to all schools, tertiary care institutions and non-formal sectors with a high proportion of youth. They should aim to improve self-esteem, problem solving skills, conflict resolution and methods to cope with life events. And the current evidence indicates that media are not responsive to their responsibilities when reporting suicidal behaviour (9). Guidelines issued by the WHO and other organisations are rarely followed. Media can perform a pivotal role to de-normalise suicide and violence, and to educate on alternative methods of problem solving, conflict resolution, and coping with stress and life events. It would also help to strengthen the life skills program in schools.

Recent studies have also re-emphasised the role of three factors associated with suicidal behaviour: depression, alcohol and previous attempts at suicide.

Depression is linked to suicidal behaviour in a number of ways. Firstly, depressive illness may have a causative role in determining such behaviours. Secondly, detection
of depression may be influenced by the explanatory models used by communities as its symptoms. The relationships between depressive disorders and suicidal behaviour is well established. A recent community survey (8) reports that psychological autopsies detected depression as the primary cause in 46.2% of completed suicides. Hospital-based studies of attempted suicide describe 27% to 49% of participants who attempted suicide were suffering from clinical depression (10,11,12). The ethnographic studies include narratives indicative of depressive disorders. Often the community used social explanations to explain these behaviours (5).

Our studies show that alcohol is a factor for suicidal behaviour in men as well as in women who are subject to harassment by men who abuse alcohol (5). Psychological autopsies have revealed alcoholism as the primary cause of death in 60.8% of male suicides (8). Studies in Kurunegala, Udawalawe and the Mahaweli zones confirm the high proportions of men who have abused alcohol around the time of attempted self-harm (11,13,14). A case control study has also identified alcohol abuse and (depressive illness) as two important risk factors for suicide attempts (12).

Studies in other countries have shown that previous deliberate self-harm is one of the strongest risk factors for subsequent suicide even when it had occurred many years ago. A follow up study of 22 years in the UK shows that the increased risk of suicides persists, and that providing a high standard of care to people who deliberately harm themselves could help reduce this rate (15). There is little data about this from Sri Lanka though one study has shown that a high proportion of people attempting self-harm continue to be distressed (5). More evidence is awaited from an ongoing study on suicide prevention (SUPREMISS) conducted by the WHO, which includes Sri Lanka.

The available evidence indicates the need to improve our health services so as to detect and effectively treat unrecognised depressive illness and to care for those who have attempted suicide. The observation that communities give social explanations to depressive symptoms may be one reason why the health services are under-diagnosing these predisposing factors. Regular educational programs for undergraduates and postgraduates, and continuous professional development of medical and allied health care workers on psychiatric disorders (depression in particular) are indicated. Depression must be recognised and treated by all clinicians, because specialised mental health services in the country are sparse (16). The community, particularly those who are depressed and persons close to them, need to be made aware of the symptoms and signs of depression, and the fact that effective treatment is available. Alcohol abuse needs to be addressed at all levels including primary prevention and national policies that affect consumption patterns. Clinical services for alcohol abuse need development.

People who have attempted deliberate self-harm (DSH) are distressed for a long time and include a large proportion of those with depressive illness. Their care would include, developing and implementing guidelines for assessment of DSH by first contact doctors as outlined in the administrative circular of the Ministry of Health, Sri Lanka (17); developing a referral system for people with significant psychiatric disorders to psychiatric services and those in distress due to life events for support and counselling; and developing a monitoring system for assessment and care of those admitted with DSH. This could take the form of a "vertical" health program to reduce morbidity and mortality from suicide, at least in high prevalence areas. The organisational structure would be similar to the existing vertical programs such as the ones for HIV/AIDS or malaria. Another innovative model is the clinic specially for those who have attempted suicide in Kurunegala (11).

Conclusions

Suicide prevention should be a national priority. An integrated approach that combines strategies for high-risk groups and population based strategies would be most effective. Inter-sectoral programs and interventions to identify, and change socio-cultural beliefs that promote suicidal behaviour need to be developed. The medical profession should lead the way in asking for improvements in the quality of mental health services for those with suicidal behaviour.

References

Integrity of scientific research (2)

The most recent high-profile example is the investigation into misconduct by Friedhelm Herrmann and Marion Brach, which was initiated in 1998 by the Deutsche Forschungsgemeinschaft, the main German research funding agency, and completed 2 years ago. It concluded that of 347 examined papers, 85 had either definitely or highly probably been manipulated. The DFG published a list on their website in German only, and they failed to inform the journals concerned. Many of the papers remain in print 2 years later.

Anon. Lancet 2002; 360: 499. (Editorial)