



SUICIDE ATTEMPT

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SUMMARY OF ARTICLE

This article describes "suicide attempt", sign and symptoms, investigations, complications, etiology, general informations, Also, processing in the researching materials to find different way of treatments above suicide attempt disorder persons and give prognosis.

KEYWORDS- *Suicide attempt, self-destructive, disorder, self-induced, therapeutic, secularization, religious affiliation, cognitive-behavioral, aggressiveness, Psychopathology, Suicidal ideation, adolescent age, antidepressants.*

INTRODUCTION

Suicide attempt can be defined as a voluntary act intended to end the life of the actor. Although not a mental disorder itself, suicide attempt can be a fatal complication of mental disorder and can result from the self-destructive impulses that accompany mood, substance use, thought, or personality disorder[1].

Common means of attempted suicide include intentional overdoses, jumping from a height, self-induced gunshot or knife wounds, self-induced lacerations, hanging, and self-immolation.

Patients who have attempted suicide usually present for treatment of the physical consequences of the attempt (eg, traumatic injuries, toxic overdoses, burns) or the psychologic source of despair that leads to the attempt (eg, depression, substance intoxication). Physical signs and symptoms depend on the selected mode of attempted suicide. Similarly, psychologic symptoms largely depended on the underlying psychiatric disorder.

-The best and most effective investigation is a careful and empathic patient interview.

-No reliable screening instruments or tests for suicide risk are available.

-After careful examination for injury sustained in the attempt and therapeutic attention to such injuries as indicated, all survivors of a suicide attempt should be examined to screen for the presence of mental disorder and to estimate the risk of a recurrent suicide attempt.

-All attempts at suicide should be taken seriously and evaluated. Evaluation should include history from the patient and collateral sources, a full

mental status examination, elaboration of the details of the attempt and any persistent suicidal ideation, and assessment of any risk factors for repeated suicide attempts.

Suicide and suicide attempt are a behavior confined to human beings. They are rooted fundamentally in the human existence and have as a prerequisite self-reflecting properties of the individual, i.e., conscious acting with the consequence or the attempt to extinguish the own existence.

The attempts to describe suicide and suicide attempt based on a single cause in only one dimension has been tried by Esquirol (1838) in biology, Durkheim (1897) in sociology, or Freud (1917) in psychology and seems to be inappropriate. Suicide and suicide attempt are multidetermined acts (Roy 2000). However, the weighting of different aspects of suicide and suicide attempt seems to be rather difficult to explain, so that in the following, only a synopsis of the empirical findings will be given.

Suicide is lacking in animals and even in nonhuman primates. However, it has already been found in Neolithic societies as well as later on in the old Greek and Latin societies. Precise empirical data about suicide in different countries and cultures has been lacking up to the nineteenth century so that a description of the development of suicide from the antiquity via the medieval to modern times is impossible. However, there is a considerable increase of suicides in societies with a high degree of secularization, industrialization, and individualization starting in the middle of the



nineteenth century. For individual countries, there is often a stability of suicide rates on a high or low level depending at least in Europe on the degree of industrialization, religious affiliation and climate: northern countries with a high degree of industrialization, Protestant religious affiliation and rather few sunny days have considerably higher suicide rates than southern countries with a low degree of industrialization, Catholic religious affiliation, and many sunny days have lower suicide rates. The differences could best be explained by human bonding as a protective factor, whereas climate could influence biological rhythms, hence, triggering suicidal behavior.

The most important motive for suicidal behavior is certainly the impending loss of a human relationship, even if the wish to die outweighs the wish to survive in the suicidal act, i.e., in the seriousness of the suicide attempt. Besides that, the turning of aggressive tendencies towards the own character and narcissistic vulnerability are personality traits predisposing to suicidal behavior. From the cognitive-behavioral point of view, classical conditioning, operant conditioning, and model learning are basic learning principles, which also can be transferred to behaviors such as suicide and suicide attempt. This way, model learning is not only important for perpetuating suicidal behavior in families and peer groups but also in societies with traditional high (Hungary) suicide rates (so called imitation hypothesis).

In certain families, a genetic burden of suicidal behavior could be confirmed by twin and adoption studies. This genetic burden is often connected to psychiatric illnesses such as depressive disorder, addiction, anxiety disorder, schizophrenia, and personality disorder. Biological studies (postmortem brain and peripheral biochemical studies) could demonstrate a dysfunction of the serotonergic system in suicide victims and suicide attempters, which in psychopathological terms is correlated to a loss of impulse control, aggressiveness, affective instability, and violent suicide attempt.

As empirical studies could confirm, suicidal behavior is not a 'normal' behavior, but is rooted in psychological and biological abnormalities of the respondent with the corollary of prevention and therapy. However, empirical data about successful prevention of suicidal behavior is still lacking and successful therapeutic interventions only exist for subgroups of suicide attempters such as depressives with a successful treatment with lithium and serotonin reuptake inhibitors as well as cognitive-behavioral therapy for patients with a borderline personality disorder. Life as a precious good, desperation, and suffering of the respondents as well as suffering of the relatives should bring the focus on

suicide more into the scientific scope of view as other life threatening illnesses already have been for a long time [2].

Object of research. Risk Factors for Suicide in Adolescents.

Prior suicide attempts are the biggest risk factor for a subsequent suicide attempt or completed suicide. Psychopathology is a risk factor for suicide attempts. Approximately 90% of suicide victims have a psychiatric illness at the time of their death. Significant increases in the risk of suicidal behavior are associated not only with depression but also with psychosis, substance abuse, disorders that involve impaired impulse control, and a variety of other psychiatric disorders.

Epidemiological studies of adolescent suicide have demonstrated an increased risk of suicidal behavior with age and significant gender effects that depend entirely on the distinction between completed suicide and suicide attempts. Suicide is relatively uncommon before age 12, and incidence rates rise in the late teens and early twenties. Suicidal ideation and suicide attempts are more common among females than males. In contrast, completed suicide is three to five times more common among males than females. The higher rate of completed suicide in males has been attributed to a variety of factors, including the use of more lethal methods (such as firearms) and higher rates of aggression and substance abuse. The most common way that females attempt suicide is to overdose. In some countries where more lethal drugs are accessible or where emergency medical care is less effective, the rate of completed suicide in females exceeds that of males. Race has been demonstrated as a risk factor for completed suicide. Completed suicide is more common in Whites than African Americans in the United States. The highest rates are among Native Americans and the lowest are among Asian/Pacific Islanders. Similar rates have been described for suicide attempts and recent data suggest that some groups, such as Hispanic females, may be exhibiting more frequent suicide attempts over recent years.

When evaluating an adolescent's risk for suicide, late adolescent age, male gender, and Native American race suggest a higher risk. The presence of significant psychiatric illness, substance abuse/intoxication, and particularly past suicide attempts also increase an individual's risk. In addition, the presence of significant family conflict, dysfunction with peers, or hopelessness increases the risk of suicide [3].

Suicidal ideation and suicide attempts are much more common among adolescents than deaths by suicide. The Youth Risk Behavior Surveillance Survey (YRBSS) is a national anonymous survey administered to high school students across the



United States that often is used to estimate rates of suicide ideation and attempts. According to the results from the 2007 YRBSS administration, 14.5% of high school students seriously considered attempting suicide within the prior year, 11.3% developed a suicide plan, 6.9% of adolescents made one or more suicide attempts, and 2.0% of adolescents made a suicide attempt that required medical attention [4].

Approximately 95% of patients who complete suicide suffer from a mental disorder.

Completed suicide is associated with depression in 50% of cases, with substance abuse or intoxication in -25% of cases, with psychotic illness in -10% of cases, and with character disorder in -5% of cases.

Depressive disorder carry the highest sustained risk of suicide (15%-25% lifetime risk).

Alcohol and other substance use disorders also markedly increase the risk of suicide attempts; 21% of those who commit suicide are intoxicated at the time.

Other factors that elevate the risk for suicide include male gender; past history of suicide attempts, family history of mental disorder or suicide, chronic illness, being single, unemployed, and socially isolated.

Unsuccessful suicide attempts are more likely to be impulsive acts performed by a person who is ambivalent about a desire to die and who chooses a relatively low-risk method of suicide (eg, witnessed over dose). Such attempts are more common in females and younger persons, in the setting of acute life stresses, and in patients who are intoxicated or who suffer from personality disorders.

The first and most important aspect of treating those who have survived a suicide attempt is the maintenance of patient safety. Most suicidal ideation will resolve; proper treatment will hasten this process. Those who make decisions about management and disposition (eg, whether to use restraints or one-to-one supervision, whether to transfer the patient for inpatient psychiatric care) of suicide attempt survivors should err on the side of patient safety. For a patient experiencing a depth of despair sufficient to trigger a suicide attempt, contact with a concerned and emphatic clinician can be lifesaving.

Pharmacologic treatment should be directed to the underlying cause of the suicide attempt (eg, antidepressants for depression, antipsychotic for psychosis, etc.).

CONCLUSION

If the acute precipitant of an unsuccessful suicide attempt is detected and treated, the majority of those who attempt suicide recover and do well; however, 6%-8% of those who survive a suicide

attempt will die by suicide within 5 y. Patients with a history of repeated suicide attempts are at high risk of more attempts in the future.

The low base rate of suicide combined with the relatively low rate of recurrent suicide attempt makes accurate prediction of future suicide risk very difficult. Attempts to refine prognostic accuracy in suicide-risk prediction have not been successful [5]

Suicide risk evaluation is best viewed as a short-term assessment of suicide risk, valid for a period of -24-48 hours.

REFERENCE AND E-RESOURCE

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