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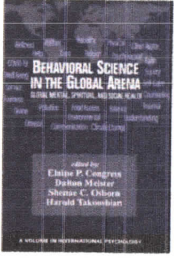

Behavioral Science in the Global Arena: Global Mental, Spiritual, and Social Health

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CHAPTER 3

SUICIDE PREVENTION

Global Trends

Ani Kalayjian and Amna Khan

Even before Covid-19 in 2020, why has suicide increased into a global crisis, and what can be done to reduce this? This chapter offers a panoramic overview of suicide: global trends, a focus on four diverse regions (Armenia, Haiti, Palestine, Nigeria), one case study, and methods of effective suicide intervention and prevention.

INTRODUCTION

Suicide has been a topic of much recent conversation, primarily due to two high-profile deaths in early June 2018. Kate Spade, a prominent fashion designer, died by apparent suicide at the age of 55, found by her housekeeper on June 5th. Later that week, it was reported that Anthony Bourdain, a celebrity chef, writer, and host of two popular television series about food and cooking throughout the world had also passed away at the age of 61, a death attributed to suicide (Tanner, 2018).

Kate Spade joined a list of other high-profile and influential fashion designers to die by suicide in recent years (Ahmed, 2018). In 2014, L'Wren Scott, a former model and designer, died in a similar manner to Spade at the age of 49. Four years earlier, British fashion mogul Alexander McQueen died just nine days after his

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mother, leading many to speculate that grief may have had a great impact on his mental health. Both Spade and Bourdain, like other high-profile celebrities who died by suicide before them, had profound impacts on their respective fields and on overall society. The question that tends to accompany suicidal deaths is why? With cases like Spade and Bourdain's, this question becomes even more urgent for fans (Key, 2018).

For many, success can symbolize happiness and can serve as a strong motivation to continue with life. Celebrity deaths such as these can damage this ideology and bring into question the attainability of happiness. According to the Center for Disease Control and Prevention (CDC, n.d.-a), suicide is the third leading cause of death among 15- to 24-year-olds and the second leading cause of death among 25- to 34-year-olds. In addition, one in seven high school students, grades 9–12, considered suicide in 2009 (CDC, n.d.-a). According to the United Nations (UN) health agency's first global report on suicide prevention (UN News, 2014), over 800,000 people commit suicide every year. That is approximately one person every 40 seconds.

SUICIDE TRENDS AND STATISTICS

With many celebrity suicidal deaths, there is the threat of suicide contagion that may increase rates of depression and anxiety diagnoses, as well as heighten aggression. After Robin Williams' suicidal death in 2014, for instance, national suicidal rates spiked around 10% (DuCharme, 2018). Even outside of the issue of contagion, suicidal deaths have been on the rise in the United States (US). Between 1999 and 2016, suicide rates jumped 28%, with 45,000 Americans dying by suicide in 2016 alone (Center for Disease Control, n.d.-b). The most affected demographic is middle-aged and older adults, as 45- to 64-year-olds have seen the largest increase in suicide rates between 1999 and 2016 (Connor et al., 2018).

Adolescents and young adults, too, have seen high rates of suicidal ideation and attempts leading to hospitalization, with these hospitalizations nearly doubling between 2007 and 2014 (CDC, 2016). The rates of suicide among 10- to 19-year-olds increased 56% from 2007 to 2016, with the rates of suicides among 10- to 14-year-old girls nearly tripling (Spiller et al., 2019). Even those who devote their professional lives to providing care to those with mental health issues are not immune to the societal problem of suicidal thoughts. Psychological practitioners have been found to have an elevated risk for suicidality, as well as professional functional impairment because of anxiety and depression (Kleespies et al., 2011). This sort of psychological distress can have negative effects on the quality of care that these professionals provide for their clients.

Physicians have also been shown to be at an increased risk of suicidal ideation. The rate of suicide has been found to be greater in male and female physicians than the general population (Schernhammer & Colditz, 2004). This is of particular concern as physicians can more easily access medication and have the medical knowledge to use it in suicide attempts. The issue of care providers' increased risk of suicidality brings to light many questions of the underlying predictors of suicidal thoughts. Stress of the occupations, difficulties of vicarious trauma through treatment of patients with mental illness, social isolation, and possible stigma against seeking of treatment may be illustrative of the issues these professionals face.

SUICIDE STATISTICS INTERNATIONALLY

Suicide continues to be one of the leading causes of mortality worldwide (McLoughlin et al., 2015). It has become a major public health concern for adolescents, being the second leading cause of mortality in the US for teenagers between 15 and 19 years of age (Ahmed et al., 2017). Across New Zealand, Australia, and Canada, a similar pattern of high suicidality among indigenous youth is evident among teenage populations (McLoughlin et al., 2015).

Female teenagers have been found to be more likely than their male counterparts to experience suicidal ideation and attempts, yet boys' complete suicide more frequently than girls (McLoughlin et al., 2015). Globally, over twice as many boys between 15- and 19-years-old completed suicide, with a rate of 10.5 per 100,000 persons (McLoughlin et al., 2015). The greater frequency of completed suicides among boys has been attributed to greater risk-taking behaviors (McLoughlin et al., 2015). However, in countries such as China and India, there are higher rates of suicide among teenaged girls (McLoughlin et al., 2015). These rates may be due to existing gender conflicts that are more pronounced in traditional agricultural societies (McLoughlin et al., 2015).

The lack of data on suicide rates in developing countries, along with the inconsistencies in completed suicide reporting worldwide, creates gaps in the knowledge concerning the true extent of suicide mortality in those countries. Many studies on suicidal ideation and attempts derive their data from the World Health Organization (WHO) regions, yet the WHO has almost no data from certain African regions, as well as several Southeast Asian, Mediterranean, and Latin American countries and regions (Bertolote & Fleischmann, 2002). As such, the data derived from the WHO may differ from real figures of suicide.

In Armenia, the rate of suicide per 100,000 people as reported as 5.7 in 2016, with the rate found to be increasingly high in men (GHO, 2018). The rate of suicide attempts in adolescents is particularly concerning, with 15- to 16-year-old students indicating a lifetime rate of 4.1% in a study where the median lifetime rate was 10.5% (Kokkevi et al., 2012). Armenian students also ranked high when reporting self-harm thoughts in addition to having attempted suicide (Kokkevi et al., 2012). The need for suicide prevention and intervention becomes even greater when looking at gender differences in suicide attempts. There is an increased risk for suicide attempts among female adolescents compared to males in several countries; however, this risk is particularly high in Armenia (Kokkevi et al., 2012).

In Haiti, little is currently known regarding the prevalence or risk factors associated with depression and suicide, with unmet mental health needs becoming a chronic issue (Wagenaar et al., 2012). Most published studies of depression in Haiti reflect pre-2010 earthquake levels, yet the WHO predicted that mental health disorders would become a pressing matter following a natural disaster such as the earthquake in 2010 (Wagenaar et al., 2012). A study looking at a rural population of adults in Haiti following the earthquake found over 6% of the participants engaging in suicidal ideation, which was most strongly associated with alcohol use (Wagenaar et al., 2012). This is supported by the WHO's finding of suicide rates in Haiti per 100,000 population to be 12.2 in 2016 (GHO, 2018).

Although the suicide mortality rate in the Eastern Mediterranean region was estimated to be lower than the global average, it is suspected to be under-reported (Itani et al., 2017). In the occupied territory of Palestine, the population has experienced constant threats to its mental well-being, with the situation deteriorating further in 2015 (Manenti et al., 2016). The WHO estimates that 20% of the population of Gaza suffers from mental health problems, with the prevalence of PTSD among children to be particularly high (Manenti et al., 2016). A study conducted with 14,303 Palestinian middle school students indicates a prevalence of 23.7% in suicidal ideation, with suicidal planning found to be 18.5% (Itani et al., 2017). Results indicate that the rate of suicidal thinking in Palestinian students is higher than in other studies of adolescents from around the world and higher than any other country in the Middle East that completed that same survey (Itani et al., 2017).

In Nigeria, according to 2018 World health Organization reports, there were 17.3 suicides per 100,000 people (GHO, 2018). Depending on levels of reporting, Nigeria had the 15th highest suicide rate in the world (7th in Africa), and the rates of suicide are similar between genders (African Argument, 2018). Suicidality has been reported to be common in persons living with HIV/AIDS, and approximately 4 million Nigerians are infected with HIV (Chikezie et al., 2012). A study found that 34.7% of participants living with HIV/AIDS had suicidal ideations, compared to 4.7% of participants without HIV/AIDS (Chikezie et al., 2012). Additionally, 9.3% of participants living with HIV/AIDs who participated in the study had attempted suicide in the past six months (Chikezie et al., 2012).

REASONS FOR INCREASED SUICIDE RATES

It is unclear why such a significant increase in suicide rates continues to be seen across the globe, but the following speculations have been proposed. For one, economic instability has been cited in recent years, with the stock market crash of 2008 as a contributing factor (Chang et al., 2013). The current opioid crisis, too, has been discussed as possibly contributing to this crisis (Fornili, 2018). Indeed, Anthony Bourdain had discussed in detail his addiction to drugs, though more recent conversations had found him stable in this area (Bourdain et al., 2018).

Because of the multifaceted nature of the issue, speculation is all that can truly be discussed when it comes to causes of suicide rates.

As suicide rates increase, however, celebrity deaths by suicide can bring a heightened awareness to the issue of depression and suicidal ideation. With social media posts on the recent deaths, many have included phone numbers to crisis hotlines around the country, leading to an increase of between 25% and 30% in call volume to these lines, whose counselors are trained in deescalating crises. Many people are also sharing information throughout their circles and via social media, helping others learn what signs to notice and how to talk to a loved one about possible suicidal thoughts. For many people, mental health treatment can be discussed, but social connectedness may be most important in preventing more suicidal deaths. Though these high-profile deaths by suicide are tragic and saddening, people are taking the opportunity to help those closest to them in preventing additional suicides.

PUBLIC HEALTH, EDUCATION, AND INCREASING AWARENESS

Exploration of further interventions may be beneficial in facilitating our understanding and prevention of the increase in suicide rates. When dealing with the thoughts of suicide, an essential tool used for intervention is the 7-step Integrative Healing Model (Kalayjian, 2002, see also Kalayjian & Paloutzian, 2010), adapted for all age groups. This is a biopsychosocial and eco-spiritual model that utilizes seven steps in which various aspects of feelings are assessed, identified, explored, processed, and finally re-integrated. It is an integrative tool, as it incorporates multifarious proven psychological modalities from psychodynamic, interpersonal, existential, humanistic, learning-theory, energy theory, electromagnetic field balancing, and mind-body-eco-spirit practises. The success of this model is its focus on emotional management, and it nurtures emotional intelligence. Another strength is its focus on meaning-making, mindfulness, forgiveness, and lessons learned. Intervention follows the following steps:

1. Assessment of an individual's stress levels through valid and reliable psychological assessment methods measuring the severity of the emotions;
2. The individual is encouraged to identify and express their feelings with a user-friendly "Emotional Management" handout;
3. The individual should receive empathy and validation for the feelings expressed feelings. This helps one feel acknowledged, understood, heard, and supported, and greatly alleviates one's levels of anxiety and distress;
4. Encouraging the discovery of meaning in the expressed experience or situation. For example, one is asked to think about the lessons that can be learned from the situation/experience. This in turn helps one find value and meaning in the experience, giving the individual the strength to move forward as a victor and transform victimhood;

5. Sharing helpful and didactic information such as practical tools and resources, which are shared to help now and in the future;
6. Encouraging the connection with the Mother Earth, helping understand the value of one's environment towards self-healing;
7. Holistically based breathing and yoga-based exercises, known as "Soul-Surfing," aids the individual's connection with their mind and body, as well as with feeling more grounded and centered.

In summary, all seven steps work together to provide the individual with support and tools to manage their emotions in a way that helps reduce levels of suicidal thoughts. This is primarily achieved by empowering the person to reframe the calamity and distress as a steppingstone. Alternatively, when one contemplates suicide, an immediate goal could be to distract oneself from that self-destructive inner voice using the following four simple-but-effective steps (NIMH, 2018). In step 1 of the process, one should seek support from family and friends or use the suicide hotline. One should feel open to being vulnerable with the people around them to share anxieties and pain with the people one feels supported by. It is okay to show and express vulnerability. Family and friends can be an unbelievable rock during the darkest times. If not a family or friend, then just a stranger who is willing to listen can help one feel better like professionals at the suicide hotline. There is no stigma behind seeking therapy. It is for all.

The indulgence of seeking healthy endeavours can be very healing. Getting outside of the home and seeking new opportunities is helpful. Finding solace in nature and animals, waking up and embracing the sunrise or volunteering at an animal shelter are other important ways to create new, exciting opportunities. Playing sports or watching favourite, funny movies is yet other ways to find happiness. One should also remember to count their blessings. No matter how dark a situation may be, one will never run out of things that are good in life. Gratitude can be a source of great inner strength and will help overcome the negative inner voice. If nothing else counts, appreciating the fact that a breath can be taken is essential.

In addition to intervention techniques, such as the 7-step integrative healing model (Kalayjian, 2018), humanitarian teams have worked in Armenia to launch a suicide prevention lifeline. This larger project's mission is to create a public service that offers those in need of psychological guidance a direct, toll-free telephone lifeline in coordination with local law enforcement and mental health providers. The lifeline would aid in preventing loss of life and instill hope by teaching emotional management and increasing the availability of Armenia's psychological health care.

As discussed, since 2003, suicide rates in Armenia have increased by more than 100%, and there has been a significant increase in teenage and young adult suicide. Armenia has the third highest rate of suicide in countries that were part of the previous Soviet Republic. The Kievyan Bridge in Yerevan, Armenia's capitol, is now called "Suicide Bridge" due to how often people jump off, taking their own lives. In May of 2102, the Meaningful World team attempted to launch a toll-free lifeline to provide free and anonymous support so that 24-hour service for crisis management and suicide prevention was available. This project was created to aid in increasing the availability of psychological health care for Armenians, as well as providing follow-up mental health and psychological care, crisis management, and long-term care if needed. The following objectives of the project were identified:

- Reduce the risk of suicidal behavior and prevent loss of life among young and older age groups in Armenia;
- Provide a 24/7 service of staff trained by local and international psychologists that are skilled in crisis management and suicide prevention;
- Provide intensive training to volunteers who will service the lifeline;
- Work in collaboration with law enforcement officials and local psychological health centers if immediate intervention or additional care is warranted.
- Provide crisis management and follow-up mental health and psychological care.

UNITED NATIONS EFFORTS

The United Nations calls on national governments to establish and implement a plan of action on suicide prevention. Unfortunately, only 28 countries out of 200 are currently known to have a national suicide prevention strategy (UN News, 2014). This plan of action brings together 10 years of research from around the world, reinforcing that suicide can take place anywhere at any age. Suicide is the second leading cause of death for those between the ages of 15 and 29 years of age and the rates of suicide are highest in people over the age of 70.

Approximately 70% of suicides occur in people with low socioeconomic status and in richer countries three times as many men die by suicide than women. The WHO recommends the following:

1. Early identification and management of mental and substance use disorders;
2. Focus on health workers in particular;
3. Community support;
4. Follow-up care for those who have attempted suicide in the past;
5. World Suicide Prevention Day celebrated annually on 10 September (WHO, 2014).

CASE PRESENTATION

A 50-year-old white female presented to private practice reporting severe depression, high anxiety, suicidal ideation, and a history of suicide attempts. She is compliant with treatment, but she still reports an escalation in her symptoms to the point of being fearful of another suicide attempt. This patient has a history of

treatment-resistant major depressive disorder, social anxiety, generalized anxiety disorder, and borderline personality disorder with three failed suicide attempts. Client indicated that she has had problems with chronic depression since childhood. Client dated the onset of her depression at age 7, which could correlate with an alcoholic father, depressed mother, sexual abuse, and with moving to a new town and a new school. The client has been treated since the age of 19 with multiple medications and treatments, such as SSRIs, mood stabilizers, and narcotics, as well as holistic treatments of vitamins, supplements, homeopathy, and flower essences. This patient has been treated with various therapeutic techniques, including three complete series of electroconvulsive therapy, eye movement desensitization and reprocessing, cognitive behavioral therapy, dialectical behavior therapy, and logotherapy. She has been hospitalized 15–20 times, ranging from 7–30 days per episode. This patient has also participated in several day programs in dialectical behavioral therapy.

During childhood, the patient reported being shy with peers and adults and reported being thought to be "gifted" in school. Regardless of shyness, the patient presented as somewhat confident with herself until a change of school at age 7, at which point she became fearful of other students and punitive teachers. She then fell behind in classes in this new school, leading to feelings of diminished self-esteem and reported that self-punitive thoughts became unrelenting. At the onset of puberty, the patient reported becoming extremely moody, angry, and impulsive, exhibiting passive-aggressive behavior with peers and adults. She reported being angry often and "pushing away" adults whom she wanted to care for or liked. The patient completed her university education with a BA in Education and BFA in Fine Arts.

As for the patient's family history, she reported undiagnosed depression in multiple family members, including her mother, father, some grandparents, brother, and other family members on both sides. Her father, paternal and maternal grandparents, and brother displayed alcohol abuse. The patient reported undiagnosed ADHD in her brother. The patient's parents are deceased. Her relationship with her only brother is nonexistent. The patient has no history of substance abuse herself.

The patient reported long-lasting friendships with childhood friends, yet no interest in intimate relationships, and maintained a distance from friends when feeling too close. At age 23, the patient had her first intimate relationship, which resulted in marriage and three children. After her children were born, the patient reported having lost interest in intimacy and stopped engaging in a sexual relationship with her partner. She is currently still living with her three children and husband, although divorced. She reported having difficulty trusting people and noted feeling like she is in "fake relationships." The patient is currently on disability due to her diagnosis of major depressive disorder, and her inability to keep a full-time job.

This patient has been taught how to manage her emotions with the following tools and coping mechanisms: 7-step integrative healing model, dialectical behavioral therapy, mindfulness, meditation, exercise through walking and soul-surfing, expression of emotions with more socially appropriate means, becoming more adept in seeking out friends, and therapists who are able to provide empathy and emotional connection. The 7-step model has provided healing for the patient as she is able to utilize the guidelines for emotional management and feels more grounded and connected with her surrounding environment through the various soul-surfing movements she practices. She finds meaning in her life and discovers and engages in activities which mean a great deal to her.

Discussion

As discussed, the burden of suicide mortality is a public health crisis that is evident not only in the United States, but also globally. While suicide rates in the United States may be sparked through high-profile cases of celebrity suicides, the worldwide rates of suicide indicate that individuals of all ages and backgrounds can be affected. Suicide is a growing concern in adolescents and older individuals. Political turmoil, economic instability, tribal and religious conflicts, and natural disasters are some of the causes that may contribute to growing rates of suicide globally. In Palestine, the ongoing political turmoil has been implicated in the prevalence of mental health conditions in children who have presented with PTSD. Physical barriers, such as walls and checkpoints in Palestine, for example, increase frustrations and makes the option of seeking mental health facilities impossible. In Nigeria, the relationship between suicide attempts in individuals living with HIV/AIDS makes suicide an increasingly prevalent health concern. In Armenia, the ongoing conflict with Azerbaijan, and Azeri and Turkish aggression has caused many lives through suicide. In Haiti, the economic depression, the political instability, and poverty has caused many suicides.

With increasing rates of suicide globally, prevention and intervention efforts need to be just as widespread and effective to be applied cross-culturally. The 7-step integrative healing model is one such intervention effort as it has been adapted for all age groups. Its utilization of interpersonal, humanistic, psychodynamic, energetic, electromagnetic, and learning theory makes it so that it can be applicable across populations. The model begins by assessing the psychological health of the individual before moving on to discover meaning in one's situations, providing tools for catharsis, discharge, healing, and recovery, as well as facilitating connection with one's surroundings and their social network, to aid healing. As described in the case presentation, the 7-step model can serve as a tool for coping and provide individuals with techniques to find meaning in their lives even in the direst situations. This model benefits individuals, groups, and communities.

However, several barriers exist that impact the adoption of prevention and intervention efforts. The WHO provides statistics on rates of suicide from around the world. However, the WHO is only able to retrieve data from countries and

regions that are a part of the WHO, meaning several countries or regions that are not part of the organization do not contribute to the data. This poses the problem of the data being incomplete and unreliable. In addition, the information that the WHO receives from participating countries and regions may be inconsistent based on cultures and customs, leading to underreporting. Due to shame, 'honor,' and other cultural and religious restrictions, according to our research, suicide is always underreported.

CONCLUSION

With suicide becoming a public health crisis globally, intervention efforts must be widespread and accessible. The 7-step integrative healing model has been adapted to be used across age groups, cultures, and religions, as suicide mortality is a growing concern in adolescents as well as middle-aged and older individuals. For the prevention and intervention effort to be useful and effective, researchers must focus their work on countries and regions that have not been included in past studies in order to present a complete and a more comprehensive picture of the ongoing suicide crisis globally. It is also recommended to gather up-to-date information, as most of the United Nations' reports on this topic are over a decade old.

GLOSSARY

Contagion. The communication of disease from one person to another by close contact.

Functional Impairment. Limitations of carrying out certain functions in daily life due to illness.

Integrative. Serving or intending to unify or separate things

Suicidal ideation. Thinking about, considering, or planning suicide.

Suicide. Death caused by injuring oneself with the intent to die.

Vicarious trauma. Emotional residue of exposure that practitioners have from working with people as they are hearing their trauma stories and become witness to the pain, fear, and terror that trauma survivors have endured.

STUDY QUESTIONS

1. With prevention efforts such as the 7-step integrative healing method and a suicide lifeline, how can they be adapted to be more culturally sensitive for use in different countries?
2. If suicide is prevalent across socioeconomic levels, how can intervention and prevention efforts be applied widely?
3. In addition to resources and lifelines that are especially necessary in cases of celebrity suicide, what are some other steps that can be taken to address the issue of suicide contagion?

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CHAPTER 4

MENTAL HEALTH IN THE WORKPLACE

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With the incidence of mental health issues on the rise, how can companies step up to address these issues to maintain profitability and improve the work conditions in times of crisis? This chapter aims to answer this question based on the integration of organizational and workplace psychology with mental health as it relates to the implementation of the United Nations Sustainable Development Goals (SDGs) 3 and 8. The chapter also provides recommendations on how to implement mental health programs in organizations effectively.

PSYCHOLOGY APPLIED TO ORGANIZATIONS AND THE WORKPLACE

One of the primary goals of a business is profit maximization through sales and purchase of its products or services. Although it looks like a simple formula, the profitability depends on numerous factors such as organizational structure; the management style of its leaders; the culture of the organization; and the attitudes, goals, and motivation of its employees (American Psychological Association, 2013). Workplace and organizational psychology focus on these factors to assess

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