

Half a Century of Suicide Studies - a Plea for New Directions in Research and Prevention

(Kajian Bunuh Diri Selama Separuh Abad - Seruan ke Arah Halatuju Baru dalam Penyelidikan dan Pencegahan)

T. MANIAM* & L. F. CHAN

ABSTRACT

Suicide studies in Malaysia tend to be repetitive. Data from hospital studies, small scale community surveys and national epidemiological studies over nearly 50 years have consistently shown that there are real ethnic differences in terms of suicides and attempted suicides in this country, though some of these differences appear to be narrowing somewhat. Malays have shown significantly lower rates of suicidal ideas, attempts and completed suicides. Indians, on the other hand, figure prominently at the other end with high rates in all the above parameters. The reasons for these are also necessarily complex. Experience elsewhere from studies of the Indian diaspora have elucidated a number of explanations, which include the effects of poverty, acculturation, alcoholism, the lack of a strong religious protective factor as well as increased rates of mental ill-health. Efforts to contain this public health problem have been somewhat patchy. This has largely depended on efforts by non-government organizations such as the Befrienders whereas the public response lags behind in providing the financial and other resources necessary for a comprehensive national program. This paper reviews the relevant literature and suggest new areas for research as well as steps to provide a fresh impetus to suicide prevention in Malaysia.

Keywords: Ethnicity; Malaysia; risk factors; suicide; suicide prevention

ABSTRAK

Kajian mengenai masalah bunuh diri di Malaysia sering mengulangi topik yang sama. Data daripada kajian hospital, kaji selidik komuniti skala kecil dan kebangsaan, kajian epidemiologi selama hampir 50 tahun di Malaysia telah secara tekal menunjukkan bahawa terdapat perbezaan etnik yang nyata daripada segi kejadian bunuh diri dan cubaan bunuh diri di negara ini, walaupun jurang perbezaan ini adalah agak rapat sekarang. Kaum Melayu telah menunjukkan kadar yang jauh lebih rendah daripada segi pemikiran untuk bunuh diri, cuba membunuh diri dan bunuh diri. Kaum India pula menunjukkan kadar yang tinggi dalam semua parameter di atas. Sebab-sebab untuk penemuan ini adalah kompleks. Pengalaman di tempat lain daripada kajian diaspora India telah memberi beberapa penjelasan, termasuk, kesan kemiskinan, pembudayaan, alkoholisme, kekurangan faktor pelindung agama yang kukuh serta peningkatan kadar masalah kesihatan mental dan sebagainya. Usaha untuk membendung masalah kesihatan awam ini agak kurang dengan sebahagian besarnya bergantung kepada usaha oleh badan bukan kerajaan (NGO) seperti Befrienders manakala sambutan rasmi seolah-olah kekurangan daya untuk menyediakan sumber kewangan dan lain-lain yang perlu bagi program kebangsaan. Kertas ini menyelidik kajian yang berkaitan dan mencadangkan topik yang perlu dikaji dan juga langkah-langkah untuk memberi dorongan baru kepada pencegahan bunuh diri di Malaysia.

Kata kunci: Bunuh diri; faktor risiko; keturunan; Malaysia; pencegahan bunuh diri

INTRODUCTION

Suicide and attempted suicide are serious, yet largely preventable public health problems. They are costly not only in tangible economic terms but also in equally important intangible ways. Families pay heavy emotional costs and the rate of suicide in survivors is higher than in the general population. The causes of suicidal behaviour, be it ideation, plans, attempts or completed suicide, are multifaceted. Multiple factors interact in complex ways resulting in suicidal behaviour.

Studies on suicidal behaviour in Malaysia have been repetitive usually reporting on the socio demographic profiles, precipitating factors and methods. After half a

century of studies on suicidal behaviour in Malaysia, there is as yet no up-and-running focussed and formal public sector preventive effort, though some progress appears to have been made in recent months. It goes without saying that any efforts at prevention of a health problem must be evidence-based. A number of questions must be answered if the limited resources of a developing country are to be effectively used in prevention. How serious is the problem of suicide and which segments of the population are at increased risk? What are the most popular methods used in committing suicide? Which of these factors are modifiable? It is time to move on to more in-depth areas of research on suicidal behaviour.

The aim of this paper was to glean answers to these questions from the relevant literature with particular emphasis on ethnicity as it has a bearing on preventive efforts.

WHAT IS THE MAGNITUDE OF THE PROBLEM?

This is a thorny question. It must be said at the outset that there are no reliable data on the magnitude of the suicide problem in Malaysia. The national suicide registry Malaysia (NSRM), (Ministry of Health Malaysia 2009) was an attempt to address this deficiency by systematically collecting data at forensic pathology departments (Hayati et al. 2008) An earlier in-depth study of Malaysian vital statistics concluded that there is a systematic misclassification of suicide data and consequently the national suicide rate is a gross underestimate (Maniam 1995). Large number of suicides were being misclassified as undetermined deaths. It is to be noted that this occurs even in countries where suicide data is more efficiently captured.

Despite these efforts we are nowhere near to obtaining reliable and realistic figures. The NSR in 2008 reported a rate of 1.3 per 100000 (Hayati et al. 2008) (Figure 1). The contributors to the NSR themselves recognised the limitations of this figure. A major problem with the NSR is missing data. In the NSR, data collection depended on already overworked, relatively junior staff in the forensic pathology departments to interview relatives to determine whether the cause of death was due to suicide. Interviewing grieving relatives is an emotionally arduous task not to mention the additional paperwork. One can foresee leakage of data. At times a whole state did not report a single suicide in a particular year. Nevertheless the NSR data was very useful as it provided enormous amounts of information on

methods and reasons for suicide. It was improving year to year, until it lost its funding and had to wind down. Greater urgency on the part of the authorities concerned is needed to redress this since accurate data are fundamental to any preventive programme.

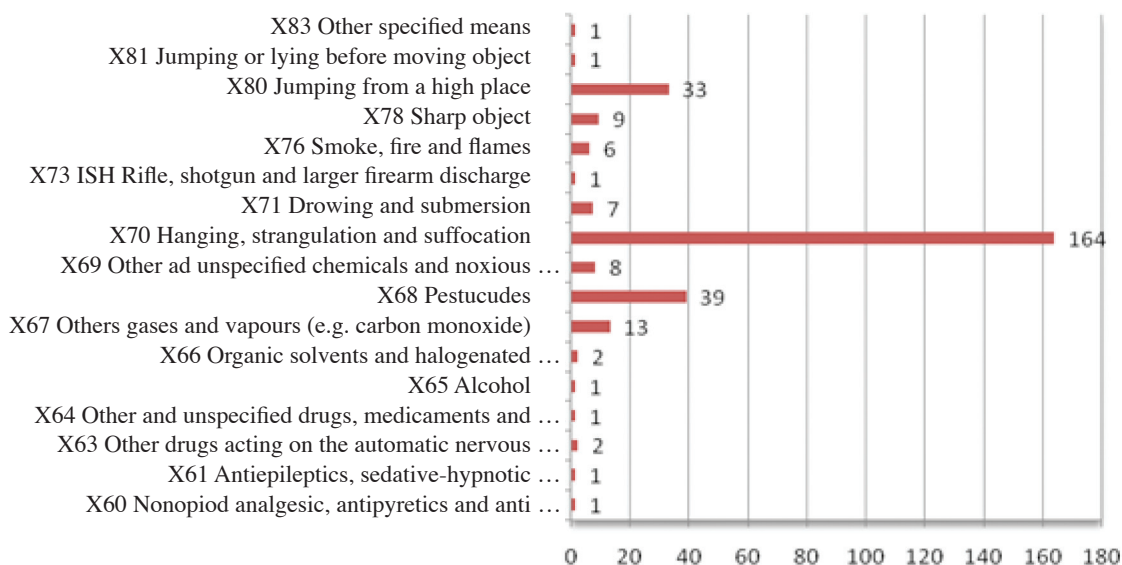
It is hoped that policy makers, who at one time accepted the higher estimates of suicide rates in Malaysia (Ministry of Health Malaysia 2005), would not backtrack and adopt the view that the true suicide rate is reflected by the lower NSRM data. This is so that the problem of suicide prevention would receive the necessary attention it deserves.

Although we are not able to answer this question, but indications are the rate of suicide in Malaysia is a cause for concern.

WHO ARE PARTICULARLY AT HIGH RISK?

This is an important question because where particularly vulnerable people are identified, preventive efforts may be more economically planned to address the issue. The answers to some of these questions are already available, while others await further enquiry.

Numerous studies in this country from the 1960s onwards have consistently shown that some sections of the community appear to be at particularly high risk. From the earliest studies of poisoning data by Amarasingam & Lee (1969), hospital-based data on attempted suicides (Orr & Tin 1985; Yeoh 1981) and small community studies (Maniam 1988, 1994) all have shown similar results. Reviews of the literature, by Morris and Maniam (2001) and more recently by Aishvarya et al. (2013), point to the almost invariable finding that Indians in this country show disproportionately high rates of suicide and



(Source: Ministry of Health Malaysia 2009)

FIGURE 1. Methods of suicide (in absolute numbers)

attempted suicides, followed closely by the Chinese. Two studies covering a 20-year period in the relatively isolated community of Cameron Highlands revealed alarmingly high rates of suicides among the Indian population (Maniam 1988, 1994). In the first of these studies it was found that Indians had much higher suicide rates than are usually reported anywhere in the world. Others have demonstrated the same, though less dramatically (Hayati et al. 2004). Suicide ideation also appears to be higher among the Indians (Maniam et al. 2011). A more recent, albeit small, study among depressed inpatients found that the Chinese seemed to have the highest risk of attempted suicide (Chan et al. 2011). This is an unexpected finding as it differs from older studies which seemed to consistently show that Indians had the highest risk of suicidal behaviour. It is unclear whether this finding is an artefact of differential admission rates in that particular inpatient clinical population studied or whether there has been a recent shift in socio economic or cultural stressors that may put certain other ethnic groups at a higher risk of suicidal behaviour? Less is known about the suicide rates of the indigenous peoples of Sabah and Sarawak, which we have reason to suspect, may not be low.

An in-depth analysis of the reasons why Indians have such high rates is beyond the scope of this paper. Suffice it to say that there is evidence from the literature that Indians appear to suffer from higher rates of psychiatric morbidity, besides being relatively less protected by cultural and religious prohibitions against suicidal behaviour; these factors have been discussed elsewhere (Maniam 2003; Maniam et al. 2011).

One of the best ways of preventing suicide is restricting access to the methods of suicide. The preferred method is often determined by its availability (Azhar 1991) and sometimes by sensational media reporting (Bollen & Phillips 1982). The most popular methods in Malaysia are hanging, poisoning (especially pesticides), jumping from tall buildings and car exhaust gas (Figure 1). Hayati et al. in 2004 showed that in Kuala Lumpur the method of suicide had undergone an interesting change. In one decade suicide by jumping had doubled in popularity, no doubt reflecting the ease of availability of this method with increasing number of people living in high-rise buildings.

Reducing suicides due to pesticides is achievable. Secure access to dangerous substances by people who are distressed is a promising strategy. Car exhaust gas can be detoxified by using catalytic converters. Fixing metal grills on windows of high rise buildings may not always be feasible or desirable, but families with depressed members may consider this step.

A sizeable minority of suicide decedents communicate their wish to die prior to their death (Ministry of Health Malaysia 2009). It is therefore useful to think about educating gatekeepers such as primary health care personnel, general practitioners and teachers, to detect suicidality early and refer. GPs need to be trained to recognize and treat depression early and effectively and refer to psychiatrists where necessary.

ROLE OF EMERGENT MEDIA

It has been suggested that about 10% of people are influenced by social media in their decisions about suicide. New media such as Tweeter, Facebook, Lowyat forum and other chat rooms accessible over the internet sometimes help suicidal people find the assistance they need, but others promote suicide or provide wrong information about suicide that turns people away from seeking help. It may become necessary not only for governments to ban sites that actively and maliciously promote suicide, but also for IT savvy professionals to get on the internet and counter these sites.

CONCLUSION

The socio demographic profile of ideators, attempters and completed suicides, has pretty much been clearly elucidated. What is lacking is in-depth studies on the problem of suicidal behaviour in Malaysia. Questions like 'who commits suicide? what are the associated factors? and what are the most commonly used methods?' have been answered again and again; there is therefore no need to repeat these studies. They merely provide boring and repetitive data, as the results obtained will be broadly similar. New areas should be studied. To the best of the authors' knowledge studies on the neurobiology of suicide have not been carried out. How do these interact with sociocultural factors? Why do Indian Muslims have higher rates than Malay Muslims? Is this due to genetic vulnerability? Or is this due to cultural influences since Indian Muslims often practice many non-religious aspects of Indian culture, speak Indian languages and watch Indian movies? How do reasons for living differ among the different ethnic groups in Malaysia? As the Malay community becomes more urbanized and live in nuclear families, will their suicide rates increase? What psychotherapeutic methods might prevent a person who has attempted suicide from going on to commit suicide? What role do the emergent social media play in promoting or decreasing suicidal behaviour, especially in the young? Do they affect the ethnic groups differently? More comprehensive studies among diverse ethnic groups are needed to further delineate the relationship between ethnicity and suicidal behaviour. What preventive strategies would be most effective in the Malaysian context? These await further investigations. But one doesn't have to wait for all the answers to be in, before some preventive steps are taken.

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Department of Psychiatry
 Faculty of Medicine
 Universiti Kebangsaan Malaysia
 Jalan Yaakob Latif, Bandar Tun Razak, Cheras
 56000 Kuala Lumpur
 Malaysia

*Corresponding author; email: tmaniam@yahoo.com

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