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A SURVEY ON SUICIDE AND RELIGIOUS MYTH

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Abstract

Few studies have investigated the association between religion and suicide either in terms of Durkheim's social integration hypothesis or the hypothesis of the regulative benefits of religion. The relationship between religion and suicide attempts has received even less attention. Religiously unaffiliated subjects had significantly more lifetime suicide attempts and more first-degree relatives who committed suicide than subjects who endorsed a religious affiliation. Unaffiliated subjects were younger, less often married, less often had children, and had less contact with family members. Furthermore, subjects with no religious affiliation perceived fewer reasons for living, particularly fewer moral objections to suicide. In terms of clinical characteristics, religiously unaffiliated subjects had more lifetime impulsivity, aggression, and past substance use disorder. No differences in the level of subjective and objective depression, hopelessness, or stressful life events were found.

Keywords: *Associated, Investigated, Myth, Religious, Suicide, Spirits, After life, Beliefs.*

I. INTRODUCTION

Suicide rate lower in religious countries than in secular ones. Some of this distinction can be due to underreporting in spiritual nations due to issues over stigma. but, some of the difference may be actual, although it isn't always acknowledged whether or not the negative affiliation among religion and suicide is due to its integrative benefits (consisting of social cohesion, as proposed with the aid of Durkheim in 1951 or to the ethical imperatives of non-secular perception, given its prohibitions towards suicidal conduct [1]. Maximum preceding studies had been epidemiologic and feature investigated the association between finished suicide and religion. An inverse dating between non secular dedication and suicidal ideation. But, reports regarding spiritual affiliation and suicide strive are sparse. In comparison 50 suicide attempters hospitalized after self-poisoning with appreciate their non-secular beliefs and practices. He observed no massive differences in phrases of Catholic versus Protestant

affiliation. in addition, pronounced that religious persuasion, defined as Catholic and non-Catholic, did no longer fluctuate between suicide attempters and no attempters [2].

As compared suicide strive rates in Chinese language, Malay, and Indian ladies in Singapore and concluded that the relatively low rate of tried suicide in Malay girls became because of their faith, given that Islam strictly forbids suicide. Studies of non-secular dedication in fashion advocate a defensive impact as properly [3]. In a pattern of institutionalized chronically sick aged, showed that intensity of non-secular commitment turned into negatively associated with suicide gestures. In a move-countrywide examine of 25 countries, concluded that protective effects were not because of any precise non secular denomination according to see but as a substitute to a robust non secular commitment to fundamental existence-keeping values, ideals, and practices that reduce rates of suicide [4].

Consequently, we examined elements related to religious association and no affiliation in depressed inpatients, generally considered to be at highest hazard for a suicide attempt. We hypothesized that the spiritual topics would record extra ethical objections to suicide as measured with the motives for dwelling stock. This device includes questions that reflect traditional non secular ideals [5]: "I believe the handiest God has the right to stop a existence," "My spiritual ideals forbid it," "I am afraid of going to Hell," and "I recollect it morally wrong." We examined the courting between non secular affiliation and social cohesion via inspecting the amount of time spent with family in religiously affiliated versus unaffiliated sufferers. To our expertise, that is the first observe investigating the relation-ship among religious affiliation popularity and suicide attempts in a clinical sample.

II. THE MYTHS & FACTS OF YOUTH SUICIDE

Myth: Talking about suicide or asking someone if they feel suicidal will encourage suicide attempts.

Fact: Talking about suicide provides the opportunity for communication. Fears shared are more likely to diminish. The first step in encouraging a person with thoughts of suicide to live comes from talking about those feelings. A simple inquiry about whether or not the person is intending to end their life can start the conversation. However, talking about suicide should be carefully managed [6].

Myth: Young people who talk about suicide never attempt or die by suicide.

Fact: Talking about suicide can be a plea for help and it can be a late sign in the progression towards a suicide attempt. Those who are most at risk will show other signs apart from talking about suicide. If you have concerns about a young person who talks about suicide:

- Encourage him/her to talk further and help them to find appropriate counseling assistance.
- Ask if the person is thinking about making a suicide attempt.
- Ask if the person has a plan.
- Think about the completeness of the plan and how dangerous it is. Do not trivialize plans that seem less complete or less dangerous. All suicidal intentions are serious and must be acknowledged as such.
- Encourage the young person to develop a personal safety plan. This can include time spent with others, check-in points with significant adults/ plans for the future [7].

Myth: A promise to keep a note unopened and unread should always be kept.
Fact: Where the potential for harm, or actual harm, is disclosed then confidentiality cannot be maintained. A sealed note with the request for the note not to be opened is a very strong indicator that something is seriously amiss. A sealed note is a late sign in the progression towards suicide [8].
Myth: Suicide attempts or deaths happen without warning.
Fact: The survivors of a suicide often say that the intention was hidden from them. It is more likely that the intention was just not recognized. These warning signs include:

- The recent suicide, or death by other means, of a friend or relative.
- Previous suicide attempts.
- Preoccupation with themes of death or expressing suicidal thoughts.
- Depression, conduct disorder and problems with adjustment such as substance abuse, particularly when two or more of these are present.
- Giving away prized possessions/ making a will or other final arrangements.
- Major changes in sleep patterns - too much or too little.
- Sudden and extreme changes in eating habits/ losing or gaining weight.
- Withdrawal from friends/ family or other major behavioral changes.
- Dropping out of group activities.
- Personality changes such as nervousness, outbursts of anger, impulsive or reckless behavior, or apathy about appearance or health.
- Frequent irritability or unexplained crying.
- Lingering expressions of unworthiness or failure.
- Lack of interest in the future.
- A sudden lifting of spirits, when there have been other indicators, may point to a decision to end the pain of life through suicide [9].

Myth: If a person attempts suicide and survives, they will never make a further attempt.
Fact: A suicide attempt is regarded as an indicator of further attempts. It is likely that the level of danger will increase with each further suicide attempt.
Myth: Once a person is intent on suicide, there is no way of stopping them.
Fact: Suicides can be prevented. People can be helped. Suicidal crises can be relatively short-lived. Immediate practical help such as staying with the person, encouraging them to talk and helping them build plans for the future, can avert the intention to attempt or die by suicide. Such immediate help is valuable at a time of crisis, but appropriate counseling will then be required.
Myth: People who threaten suicide are just seeking attention [10].
Fact: All suicide attempts must be treated as though the person has the intent to die. Do not dismiss a suicide attempt as simply being an attention-gaining device. It is likely the young person has tried to gain attention and, therefore, this attention is needed. The attention they get may well save their lives.
Myth: Suicide is hereditary.

Fact: Although suicide can be over-represented in families, attempts are not genetically inherited. Members of families share the same emotional environment, and the death by suicide of one family member may well raise the awareness of suicide as an option for other family members.

Myth: Only certain types of people become suicidal.

Fact: Everyone has the potential for suicide. The evidence shows disposing conditions may lead to either suicide attempts or deaths. It is unlikely those who do not have the predisposing conditions (for example, depression, conduct disorder, substance abuse, feeling of rejection, rage, emotional pain and anger) will die by suicide.

Myth: Suicide is painless.

Fact: Many suicide methods are very painful. Fictional portrayals of suicide do not usually include the reality of the pain.

Myth: Depression and self-destructive behavior are rare in young people.

Fact: Both forms of behavior are common in adolescents. Depression may manifest itself in ways which are different from its manifestation in adults but it is prevalent in children and adolescents. Self-destructive behavior is most likely to be shown for the first time in adolescence and its incidence is on the rise.

Myth: All young people with thoughts of suicide are depressed.

Fact: While depression is a contributory factor in most suicides, it need not be present for a person to attempt or die by suicide.

Myth: Marked and sudden improvement in the mental state of an attempted following a suicidal crisis or depressive period signifies the suicide risk is over.

Fact: The opposite may be true. In the three months following an attempt, a young person is at most risk of dying by suicide. The apparent lifting of the problems could mean the person has made a firm decision to die by suicide and feels better because of this decision.

Myth: Once a young person thinks about suicide, they will forever think about suicide.

Fact: Most young people who are considering suicide will only be that way for a limited period of their lives. Given proper assistance and support, they will probably recover and continue to lead meaningful and happy lives unhindered by suicidal concerns.

Myth: Young person’s thinking about suicide cannot help themselves.

Fact: While contemplating suicide, young people may have a distorted perception of their actual life situation and what solutions are appropriate for them to take. However, with support and constructive assistance from caring and informed people around them, young people can gain full self-direction and self-management in their lives.

Myth: The only effective intervention for suicide comes from professional psychotherapists with extensive experience in the area.

Fact: All people who interact with adolescents in crisis can help them by way of emotional support and encouragement. Psychotherapeutic interventions also rely heavily on family, and friends providing a network of support.

Myth: Most young people thinking about suicide never seek or ask for help with their problems.

Fact: Evidence shows that they often tell their school peers of their thoughts and plans. Most adults with thoughts of suicide visit a medical doctor during the three months prior to killing themselves. Adolescents are more likely to 'ask' for help through non-verbal gestures than to express their situation verbally to others.
Myth: Young people thinking about suicide are always angry when someone intervenes and they will resent that person afterwards.
Fact: While it is common for young people to be defensive and resist help at first, these behaviors are often barriers imposed to test how much people care and are prepared to help. For most adolescents considering suicide, it is a relief to have someone genuinely care about them and to be able to share the emotional burden of their plight with another person. When questioned some time later, the vast majority express gratitude for the intervention.
Myth: Break-ups in relationships happen so frequently, they do not cause suicide.
Fact: Suicide can be precipitated by the loss of a relationship.
Myth: Young people thinking about suicide are insane or mentally ill.
Fact: Although adolescents thinking about suicide are likely to be extremely unhappy and may be classified as having a mood disorder, such as depression, most are not legally insane. However, there are small numbers of individuals whose mental state meets psychiatric criteria for mental illness and who need psychiatric help.
Myth: Most suicides occur in winter months when the weather is poor.
Fact: Seasonal variation data are essentially based on adult suicides, with limited adolescent data available. However, it seems adolescent suicidal behavior is most common during the spring and early summer months.
Myth: Suicide is much more common in young people from higher (or lower) socioeconomic status (SES) areas.
Fact: The causes of suicidal behavior cut across SES boundaries. While the literature in the area is incomplete, there is no definitive link between SES and suicide. This does not preclude localized tendencies nor trends in a population during a certain period of time.
Myth: Some people are always suicidal.
Fact: Nobody is suicidal at all times. The risk of suicide for any individual varies across time, as circumstances change. This is why it is important for regular assessments of the level of risk in individuals who are 'at risk'.
Myth: Every death is preventable.
Fact: No matter how well intentioned, alert and diligent people's efforts may be, there is no way of preventing all suicides from occurring.
Myth: The main problem with preventive efforts is trying to implement strategies in an extremely grey area.
Fact: The problem is that we lack a complete understanding of youth suicide and know more about what is not known than what is fact.

III. CONCLUSION

Religious affiliation is associated with less suicidal behavior in depressed inpatients. After other factors were controlled, it was found that greater moral objections to suicide and lower

aggression level in religiously affiliated subjects may function as protective factors against suicide attempts. Further study about the influence of religious affiliation on aggressive behavior and how moral objections can reduce the probability of acting on suicidal thoughts may offer new therapeutic strategies in suicide prevention.

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