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Keva Bethell

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Abstract

The occurrence of suicide and suicidal attempts in the Bahamas should be a major public health concern. In the past decade, there has been a fluctuating trend in the number of suicides. For instance, there were six suicides that occurred in 2011, eleven (11) in 2012 and six in 2013. In regards to suicidal attempts, there were 207 people admitted to the government mental health facilities for attempting suicide in 2010. In 2011, there were 194 persons admitted and in 2012, there were 250 persons admitted for suicidal attempts (Figures 1 and 2). To understand whether this is a developing trend in our country, we need to collect accurate data for the next three years. The occurrence of suicide is not just a concern in the Bahamas. Suicide is now the tenth leading cause of death in the United States (Drexler, 2013). There are now more deaths from suicides than car accidents (Parker-Pope, 2013). In its first report on suicide, the World Health Organization (WHO) advised that one person commits suicide every 40 seconds. In fact, each year, suicides account for 800,000 of the 1.5 million violent deaths. Guyana, North and South Korea have the highest suicide rates (44.2, 38.5 and 28.9, respectively). The UN proposes to cut the national suicide rates by 10

Index terms—

1 Introduction

he occurrence of suicide and suicidal attempts in the Bahamas should be a major public health concern. In the past decade, there has been a fluctuating trend in the number of suicides. For instance, there were six suicides that occurred in 2011, eleven (11) in 2012 and six in 2013. In regards to suicidal attempts, there were 207 people admitted to the government mental health facilities for attempting suicide in 2010. In 2011, there were 194 persons admitted and in 2012, there were 250 persons admitted for suicidal attempts (Figures **??** and 2). To understand whether this is a developing trend in our country, we need to collect accurate data for the next three years. The occurrence of suicide is not just a concern in the Bahamas. Suicide is now the tenth leading cause of death in the United States (Drexler, 2013). There are now more deaths from suicides than car accidents (Parker-Pope, 2013). In its first report on suicide, the World Health Organization (WHO) advised that one person commits suicide every 40 seconds. In fact, each year, suicides account for 800,000 of the 1.5 million violent deaths. Guyana, North and South Korea have the highest suicide rates (44.2, 38.5 and 28.9, respectively). The UN proposes to cut the national suicide rates by 10% by 2020 (Organization, 2014).

The model for the dynamics of suicide used by the Task Force is the Allen Contemplative Discovery Pathway Theory. According to the model the individual at birth has three instinctual needs: (i) Survival/ Security (Safety), (ii) Affection/ Esteem (Connection) and (iii) Power/Control (Empowerment). Life is wounded and sooner or later hurt is experienced in one or all of the three instinctual needs. The hurt experience leads to a deprivation of instinctual needs, producing a deep shame core involving feelings of abandonment, rejection and humiliation. As the hurt becomes impacted the shame core deepens. Shame, Self Hatred Aimed at ME, is a, hidden, deep, pulsating pain, beating at its own frequency in our psyche, and acts against the self. The brain compensates for the painful hurt with the development of the defensive shame false self, involving self absorption, self gratification and control or invincibility. The Shame false self keeps the shame hurt in check. But as the hurt deepens the defensive shame false self is unable to contain the growing hurt and it explodes into a powerful destructive rage. This powerful rage leads a person into the Violent Destructive Tunnel.

In the Violent Destructive Tunnel the person undergoes a powerful physiological arousal with increases in heart rate, pulse and blood pressure. Since the heart is intricately related to the brain through electromagnetic fields, neurological pathways and biochemical influences, the higher centers of the brain are affected, leading to a drop in IQ, increasing the helplessness and vulnerability of the person. When the destructive rage is turned against the self (masochistic) it leads to suicide. When the destructive rage is turned against others (sadistic) it leads to homicide. A most important observation is that in our model, suicide and homicide are part of the same process. Sadly, the Bahamas has experienced, over the past ten years, an exponential increase in homicides. Our challenge is, we must not let this occur in suicides or suicidal attempts. We cannot build a nation if we're killing each other, and killing ourselves.

Mental illness, particularly depression, is one of the leading circumstances surrounding suicides. While depressed people may be more inclined to commit suicide if they don't seek professional help, it has been reported that the most powerful predictor of suicide is a previous attempt (Krug, Dahlberg, Mercy, Zwi, & & Loranzo, 2002). In the Bahamas, there is a stigma attached to mental illness, so people often delay seeking care.

The Bahamian culture is both Christian and community-based. As a result, suicide is a rather taboo topic, so much so that it is almost unheard of. No solutions or preventative efforts can be sought out if the problem (i.e. issue at hand) has not been identified. The only way to identify the problem is to know what to look for. Consequently, the general population needs to be made aware of the various signs and symptoms of suicidal intent.

2 II. M ethods

A team of Bahamian professionals, which include researchers and psychologists, have sought to analyze the incidence of suicides in the country. To do this, we proposed to carry out two studies, one retrospective in scope, and the other prospective. The retrospective study examined the cases of suicides that have already occurred. Data was collected from the Central Detective Unit (CDU), coroner's court, Sandilands, The Rand Memorial Hospital, Department of Statistics, Public Hospital Authority and the Crisis Centre. In the prospective study, a sample of Bahamians was surveyed, in an effort to understand how suicide and mental distress, in the form of depression, are perceived by the Bahamian society. The study's null hypothesis was that in the Bahamas, the rates of suicide among males and females, of all ages, would be the same. The retrospective study was carried out by analyzing suicide case files from the Central Detective Unit (CDU). Cases were analyzed for the years 2000-2013. Case narratives were compiled. The demographics and characteristics of the suicide victims were categorized and trends were documented. The prospective study was carried out by surveying a random sample of Bahamians (n=276). The survey was done to gain some awareness of the public's perception of suicide. The survey consisted of ten (10) questions, and all of the questions were associated with the characteristics of suicide victims, methods of suicide, the season in which most suicides occur, suggestions for the government and the church, accessibility and affordability of mental health care in the Bahamas and the documentation of suicides in the Bahamas. After collecting and analyzing the suicide data, the overall rates of suicide in the Bahamas and the gender-specific rates of suicide, from 2000-2013, were calculated. Ageadjusted rates and risk ratios were also calculated. OpenEpi was used to generate statistics (p-values and confidence intervals).

3 III.

4 Results

The demographics of the Bahamas were described in terms of age and gender. According to the Department of Statistics, an estimated annual population of 331,657 was living in the Bahamas from 2000 until 2013. The populace of the Bahamas was evenly distributed among age groups. However, there were fewer residents living in the Bahamas who were 55 years and older, or between the ages of 0-4 years. This indicates that the majority of Bahamians are either young adults or middle-aged. Males (49%) and females (51%) were also evenly distributed in the Bahamas (Statistics, 2013). According to data provided by the Quality Control Section of the Central Detective Unit (CDU), there were 96 reported suicides in the Bahamas from 2000 to 2013. However, only 61 of these cases were able to be located. Various characteristics of each suicide victim were documented (Table 1). After combining the data for 2000 to 2013, the overall rate of suicide in the Bahamas was 2.1 per 100,000. This rate tells us that two out of every 100,000 Bahamians committed suicide during the study period (2000-2013) (Table 2). The rate of suicide among males (3.7) was more than seven times higher than the rate of suicide among females (0.5) (Table 3). The suicide rates were highest among 35-44 year olds (3.7), and lowest among 5-14 year olds (0.1). The absolute risk of suicides among males in the Bahamas was calculated, and compared to the absolute risk of suicides among females in the Bahamas. A male resident of the Bahamas is 6.7 times more likely to commit suicide than a female resident (RR = 6.7, 95% C.I. = 3.75-12.07, p value = <0.01). On the contrary, the risk of suicide among females living in the Bahamas was 0.15 (RR = 0.15, 95% C.I. = 0.08284-0.2667, p value = <0.01). The p-values of the suicide rates among both males and females living in the Bahamas were less than 0.05, and the actual risk ratios fell between the upper and lower confidence limits.

At Sandilands Rehabilitation Centre, 88% (n=543) of the admissions for attempted suicides (2010-2012) were males, and 12% (n=73) were females (Figure **??**). Comparably, at the Rand Memorial Hospital, 79% (n=131) of the admissions for attempted suicides (2000-2012) were females, and 21% (n=34) were males (Figure **??**).

In terms of the method used to commit suicide, the majority of the victims (55%) hung themselves. Other methods used included gunshot wound (13%), fall (6%), overdose (6%), the use of sharp instruments (6%), drowning (2%), burning (3%) and asphyxiation (1%) (Figure **??**). A study carried out on suicide in the Bahamas found that during the period from 1959 to 1969, there was an overall suicide rate of 2.8 per 100,000. The rate among males at this time was 4.5, and females had a suicide rate of 1.1 (Spencer, 1972). It is interesting to note that the suicide rate in the Bahamas during a 10 year (1959-1969) study period was 2.8, and over four decades later, the rate during a 14 year period (2000-2013) was 2.1. The results of this study were consistent with a Jamaican study carried out in 2010 to investigate suicide among adolescents. The rate of suicide among Jamaican adolescents was 1.1 per 100,000 and more than 75% of the victims were male. Hanging was the most common method used, as 96.2% of the victims hung themselves (Holder-Nevins, et al., 2012).

A random sample of Bahamians (n=276) were surveyed in an effort to document the public's perception of suicide. In response to question 1 "Have you ever wanted to commit suicide?" 28% (n=78) of the people surveyed answered 'yes' and 71% (n=197) answered 'no'. On each island, about 75% of the people surveyed responded 'no' to this question, and 25% responded 'yes'. However, this trend is not true of those surveyed in Mayaguana, Ragged Island, Inagua and New Providence. In Mayaguana and Ragged Island, 100% of the people surveyed answered 'no' to question 1. In Inagua, 52% of people responded 'no', and 48% responded 'yes'. In New Providence, 54% of those surveyed responded 'no', and 46% responded 'yes'. These results could possibly be due to the fact that more people were surveyed in Inagua and New Providence (n=27 and n=50, respectively). Consequently, if the sample size for all the other islands were to be increased, responses to question 1 may follow the same trend as Inagua and New Providence (Figure **??**). In response to question 2 "Do you know anyone who has ever attempted or committed suicide?" 58% (n=159) of those surveyed answered 'yes', while 42% (n=116) answered no (Figure **??**). These responses prove that there is a rather high prevalence of people contemplating, attempting and committing suicide in the Bahamas. *Other methods used included drowning, burning or asphyxiation. *Methods used in seven (7) of the suicides were unknown.

5 Discussion

The occurrence of suicide is steadily increasing in the Caribbean. Guyana, Trinidad and Tobago and Cuba have the highest rates of suicide (22.9, 12.8 and 12.4, respectively) in the region, and Barbados and the Dominican Republic have the lowest rates (0.7 and 1.8, respectively) (Crawford, 2010). Suicide is the 14th leading cause of death, worldwide, accounting for 1.4% of the global burden of disease and 1.5% of all mortality (Holder-Nevins, et al., 2012) (O'Conner & Nock, 2014). It has even been reported that everyday 2,000 people harm themselves via suicide. In other words, every hour, 80 people are attempting to commit suicide. Suicide rates are highest among persons 80 years of age and older. This may be owing to depression associated with institutionalization, fear of dependency or redundant invasive care. Suicide not only affects the victims, but the victims' families as well. A study was carried out by Tazhmoye Crawford, to analyze the impact of selfinflicting violence on the victims' families. Individuals who commit suicide leave their grieving families to experience a cascade of psychological issues, including disappointment, shame, anger and depression. A major public health concern is the challenges to an individual's health caused by self-inflicted injuries. Females who attempt suicide can negatively impact their reproductive system, resulting in sterility, miscarriage or stillbirth. Males who attempt suicide may also be impacted by sterility or impotence. Besides the reproductive system, other systems and organs impacted by an individual's attempt to commit suicide include: the skin, liver, lungs, kidneys, nerves and brain (Crawford, 2010).

The occurrence of suicide should be studied as a process, instead of an event. One of the leading causes of suicide is the feeling of shame. Dr. Allen posits a theory that the shame gap occurs when one struggles with high expectations versus reality. When we come to the realization that we can't live up to certain expectations, and, in actuality, we can't achieve all of our dreams, we experience a sense of shame. Someone contemplating suicide isn't dealing with hurt, they are dealing with shame. Hurt turns into anger, and when this strikes the brain, the shame gap occurs. Shame is impacted hurt (Self Hatred Aimed at ME). We are in a constant battle with ourselves, and we hide the bitterness. Shame can turn into a murderous rage, aimed either at ourselves (suicide) or others (homicide). Suicide is an impulsive act that can occur while one is in the Violence Destructive Tunnel of the shame/love cycle. People who attempt suicide often 'act in a moment of brief but heightened vulnerability'. They are usually facing a cascade of problems, and consider themselves to be in a crisis. Someone experiencing a crisis may be more vulnerable to anxiety, and as a result, may handle the crisis while in an altered state of mind. Crises are usually short-lived, and present an opportunity for either constructive or destructive results (Glick, Berlin, Fishkind, & Zeller, 2008).

Loneliness is a subjective experience of isolation. There is scientific evidence that persistent loneliness can alter our behavior and therefore play a role in mental disorders, such as anxiety and depression. Loneliness is also a known factor in suicide. It is an even more powerful predictor of suicide than hopelessness. If our expectations are unmet, our bodies alert us that something is wrong. Persistent loneliness interferes with our ability to regulate emotions, which can, over time, distort our perception of ourselves in relation to others. The presence of any suicidal ideation is associated with a high risk factor. It is imperative therefore, to ask anyone who expresses hopelessness or depression about the presence of suicidal thoughts, the presence of a plan, as well as about the intent and commitment to follow through with suicidal plans. Suicide is an outcome of the relations between

the ego and a sadistic superego. Suicide acts could also express the fight against an overwhelming melancholia. It can be seen as a way to escape total alienation and choose something else, rather than face the intolerable confusion between the self and the object. No matter the reason, suicide is a cry for help and a cry of pain.

V.

6 Suicide Prevention

Suicide is a major preventable public health problem (Akbarian & Halene, 2013). Mental health is insufficiently addressed within Bahamian society. This is evident by a lack of research, awareness and national discourse surrounding suicide. In order to significantly curtail the occurrence of suicidal attempts and deaths, efficient, empirically supported strategies and services must be made available to Bahamians. We must first examine the issue of stigma as it relates to mental health. Researchers from both the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC), contend that an individual's self worth is cultivated in relation to others; by specifically finding meaning within social contexts (Prevention, 2011) (Europe, 2004). For this reason, it is apathetic to disregard our individual duties to intervene when we are aware of cases where mental health intervention is needed. To reduce mental health bias requires both individual and cultural transformations. It is imperative that Bahamians are provided with pertinent, accurate and accessible information which includes a comprehensible and culturally relative synopsis of suicide.

7 VI.

8 Conclusion

The p values calculated in the results were all statistically significant, which implies that the null hypothesis can be rejected. In the Bahamas, the suicide rates differ among males and females of various ages, in the ratio of 7:1. The survey responses further validated the data. One major limitation of this study was that the case files of all ninety-six (96) suicide victims **??**2000) **??**2001) **??**2002) **??**2003) **??**2004) **??**2005) **??**2006) **??**2007) **??**2008) **??**2009) **??**2010) **??**2011) **??**2012) **??**2013), were unable to be located at the time this report was written. Only sixty-one (61) case files were located and analyzed. Thirty-five (35) case files are still unaccounted for. A second limitation is that the Central Detective Unit (CDU) does not use a standardized questionnaire to interview the victim's loved ones. As a result, the information collected from the witness accounts may cause the statistics to be skewed. A question can't be answered 'yes' or 'no', if it hasn't been asked. Skewed statistics could possibly lead to epidemiological fallacies. What is more, there are still deficits in the information pertaining to risk factors, at risk/vulnerable groups, protective factors and existing health system gaps that may impede persons accessing mental health care. These missing elements are critical to prevention programs. [1]

Figure 1: Figure 1 :Figure 2 :Figure 3 :-

1

Gender	Age	Employed	Relationship Issues	Mental Illness	Medical Illness	Hx. Of Substance Abuse	Method of Suicide	Previous Ideation/ Attempts
Male	58	Yes	Yes	No	Yes	Yes	Hanging	Yes
Male	33	Yes	No	Yes	No	No	GSW	No
Female	35	No	No	Yes	No	No	Hanging	No
Male	56	Yes	Yes	Yes	No	Yes	Hanging	Yes
Male	54	Yes	No	No	Yes	Suspected	Hanging	No

Figure 2: Table 1 :

2

Year	Population	Number of Suicides	Rate of Suicides
2000	303,600	12	4.0
2001	307,800	6	1.9
2002	312,100	3	1.0
2003	316,900	3	1.0
2004	320,800	2	1.0
2005	325,200	5	1.5
2006	329,500	4	1.2
2007	334,000	7	2.1
2008	338,300	11	3.3
2009	342,400	12	3.5
2010	346,900	8	2.3
2011	351,100	6	1.7
2012	355,200	11	3.1
2013	359,400	6	1.7
Total	4,643,200	96	2.1

Data abstracted from cases compiled by the Central Detective Unit (CDU).

Figure 3: Table 2 :

3

Gender	Population	Number of Suicides	Rate of Suicides
Male	2,260,800	83	3.7
Female	2,382,400	13	0.5
Total	4,643,200	96	2.1

[Note: All data presented represents the statistics collected for all 14 years (2000-2013), combined.-Data abstracted from cases compiled by the Central Detective Unit (CDU).]

Figure 4: Table 3 :

[1]Suicide in the Bahamas(2000)(2001)(2002)(2003)(2004)(2005)(2006)(2007)(2008)(2009)(2010)(2011)(2012)(2013)

Suicide is a social scourge. Because of the stigma of suicide in the Bahamas, we do not communicate openly about suicide. This must be changed, because in order to prevent suicides, people need to know that help is available. If people aren't willing to discuss suicide after it happens, how will we ever assess the risks beforehand (Drexler, 2013)? An important public health problem is therefore left shrouded in secrecy, which limits the amount of information available to those working to prevent suicide.

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