

UNIVERSITY OF JAFFNA, SRI LANKA

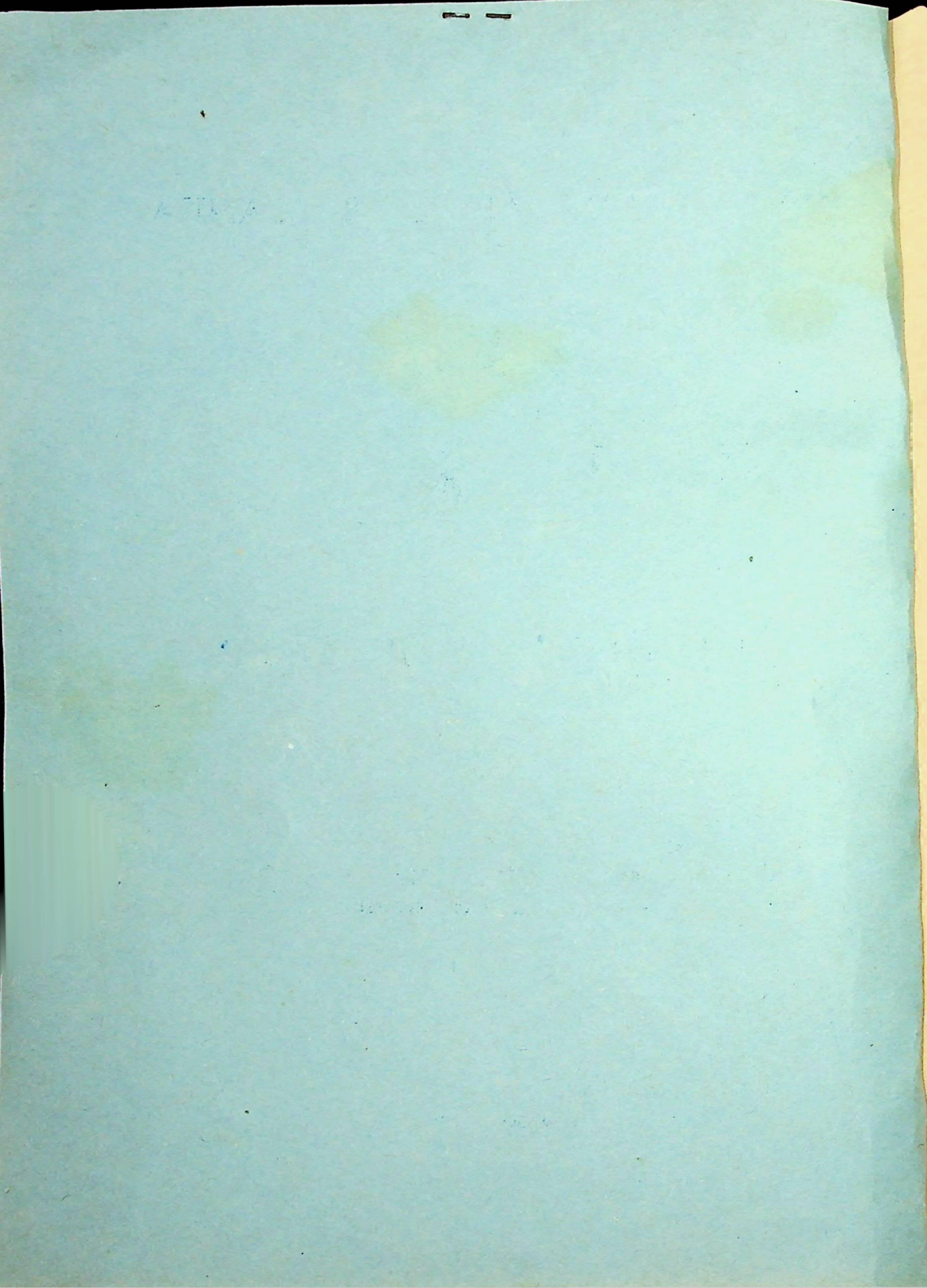


Inaugural Lecture

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Head / Department of Medicine

15 May 1985



Suicide
and
Attempted Suicide

Introduction

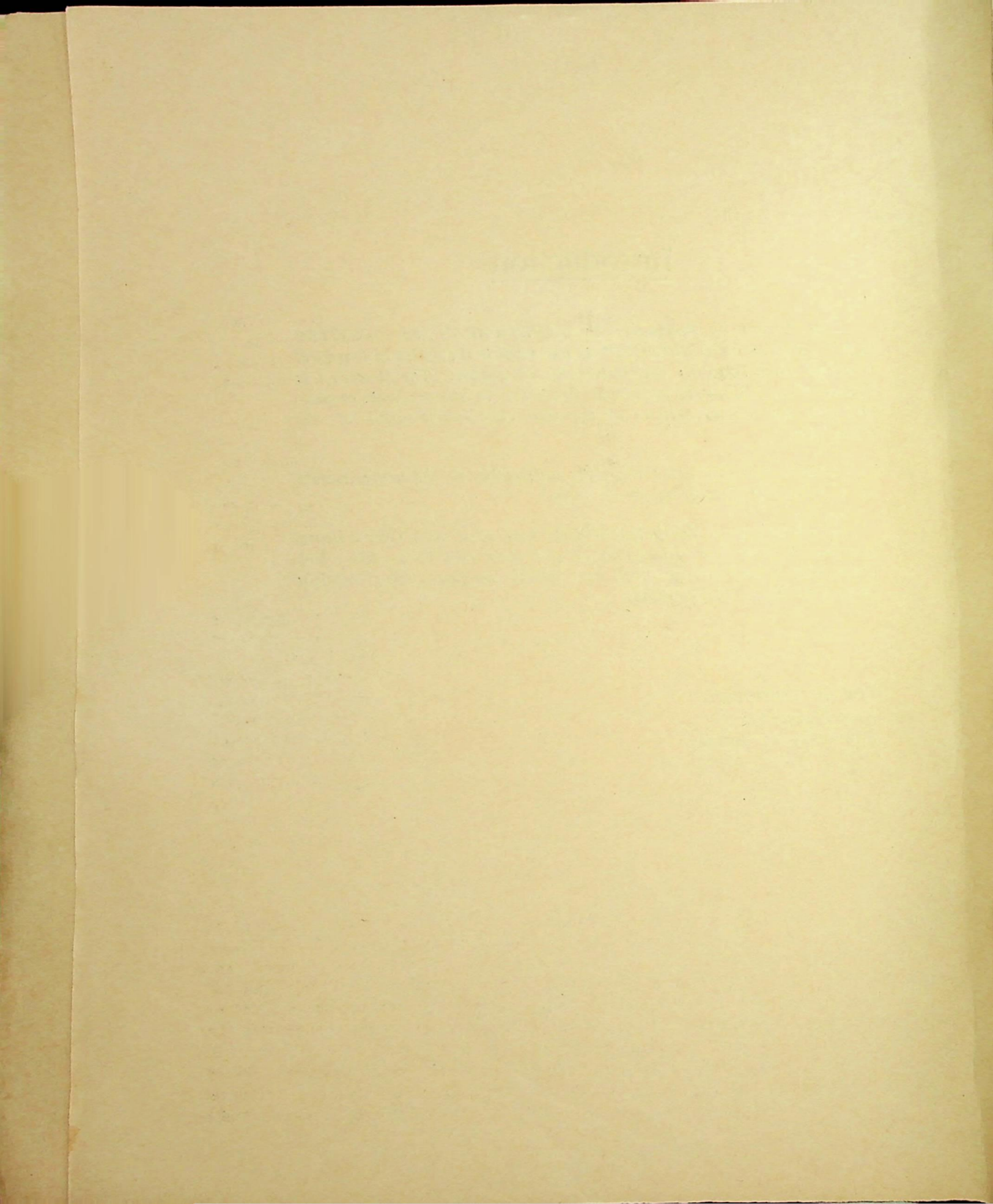
The lecture by Professor T. GANESWARAN on "SUICIDE AND ATTEMPTED SUICIDE" is the sixth in the series of Inaugural Lectures established by the University of Jaffna. The lecture is delivered by the newly appointed Professor to the academic community and the special invitees of the vice-chancellor/Council of the University.

This lecture discusses the many approaches to the understanding of a behaviour that is unique to man.

It considers in depth the subject, how some men show a strong impulse in ending or attempting to end their own lives and how these acts have evoked feelings widely ranging from outright condemnation to glorification.

Prof A. Thurairajah
Vice-Chancellor
University of Jaffna.

22 JUN 1989



Suicide and Attempted Suicide

Vice Chancellor, Dean of the Faculty of Medicine, Colleagues and friends: appointment to the foundation chair in Psychiatry of the University of Jaffna is indeed an honour that demands from its holder the highest traditions of learning in the pursuit of knowledge. I have, sir, accepted this responsibility with humility and devotion.

Scientists with different traditions of learning have attempted to understand a behaviour that is unique to man. In the recorded history of mankind there were instances of men ending their own lives or showing a strong impulse to do so. Such acts have evoked a wide range of feelings ranging from outright condemnation to glorification in prose and verse. The present address is devoted to this intriguing behaviour of suicide and attempted suicide.

The earliest contribution to its understanding was made by Durkheim, a French sociologist in the year 1897. He attempted to see a relationship between social conditions and the rate of suicide for the country. Social situations in which normative values of the community lose their force and whose members therefore have no standards to guide them in times of stress was called anomie. Such situations of social disorder were reflected in criminality, alcoholism, illegitimacy and divorce rates of the country. Suicide under these conditions was called anomic suicide. He also observed a group of members of the society who became separated from their social group and so lost the sense of community involvement ceasing to feel that social norms have any significance for them. The loss of self esteem in such individuals producing suicide was called egoistic suicide. Altruistic suicide was the individual's sacrifice of his life for the greater good of his people. Suicide squads in war or in liberation movements come under this category.

Around the year 1920 Freud was making his own contribution based on the theory of instincts. He first believed that aggression was related to libidinal factors. His source of information came from psychoanalysis of individual patients who showed sadistic and masochistic tendencies. However such relationship was difficult to maintain as the aims of aggression were different from that of sexual instinct. Normal sexual instinct seeks to preserve the object as a source of pleasure with the aim of gratification. Aggression seeks to destroy the object as a source of pain. In aggression the aim was either to inflict pain or to avoid pain. Hence Freud formulated his theory of life and death instinct. This was an attempt to bring the theory of instincts into a biological framework. He postulated that death

instinct (thanatos) was the tendency of all living organisms to return to a state of total quiescence. He felt that the death instinct was the dominant force in biological organisms. In opposition to this force was the life instinct (eros) tendency for organisms to reunite, reorganize and form greater and more complex forms of organization. Freud claimed that repetition or compulsion (a general tendency of human behaviour to repeat painful experiences) and masochism (tendency to accept suffering and pain) are supportive evidences of death instinct. Even these phenomena could be understood on other grounds.

More recently Peter Sainbury, Erwin Stengel and other workers approached the problem by studying the epidemiology of suicide. They studied suicide rates not only of the United Kingdom but also of other countries with reliable vital statistics. Most Western European nations and the USA showed features similar to those of Britain.

Suicide rate of the United Kingdom showed a decrease during the 1st and 2nd world wars and a peak during the economic depression of 1930. World war probably produces greater integration of the society against an external enemy which in terms of Durkheim's theory results in reduction of suicide. The rate has also been shown all over the world to be consistently high in the elderly than in the young and in the males than in the females. There has been a recent trend of an increase of suicide amongst the young all over the world, which I will show later, is assuming serious proportions in Jaffna. The married have the lowest rates; then in increasing order are single, widowed, divorced or separated. The rule is that more socially isolated groups have higher rates. Sainsbury's studies in London showed that suicides have fewer children, more often live alone, lack an occupation, have migrated, live in socially disorganised urban areas and attend church less often than do the general population when age and sex are allowed for. It was also noted that social classes I and II particularly those in the professions have a higher rate but since the war suicides in social class V have been increasing.

Robins et al studying 134 suicides in 1957 at St. Louis noted that majority were mentally ill and most of the suicides suffered from depressive phase of manic depressive psychosis or chronic alcoholism. 91 out of 134 had one or the other of above diagnosis. Thus Stengel observed that male sex, increasing age, widowhood, single and divorced state, childlessness, high density of population and residence in big towns, a higher standard of living, economic crisis, alcohol had addictive drug consumption, broken homes in childhood, mental disorder and physical illness have been shown to be positively correlated with suicide. An inverse relationship has been found with female sex, youth, low density of population (it must not be too low), rural occupation, religious devoutness, married state, large numbers of children, membership of lower socioeconomic classes, and war. These correlations are largely true for most western developed nations and any one factor may assume disproportionate strength in different countries. Based on these findings psycho-social profiles were developed for clinical use in assessing suicidal risk of patients.

Recent trends in Sri Lanka have been studied by Dissanayake and De Silva in 1974 and Ganesvaran and others in 1984. Sri Lanka like most countries of the world has shown an increase in the suicide rate. But the rate itself has more than doubled that of Western developed nations and is probably the highest recorded. The United Kingdom is one of the three countries in the world, that have shown a decrease for the past few decades reaching a figure of about 7.9 per 100,000 general population in 1974, but have shown an upward trend between 1975-1980.

The figures reproduced from Dissanayake and De Silva shows the increasing trend for the nation until 1970 reaching a figure of about 20 per 100,000 general population.

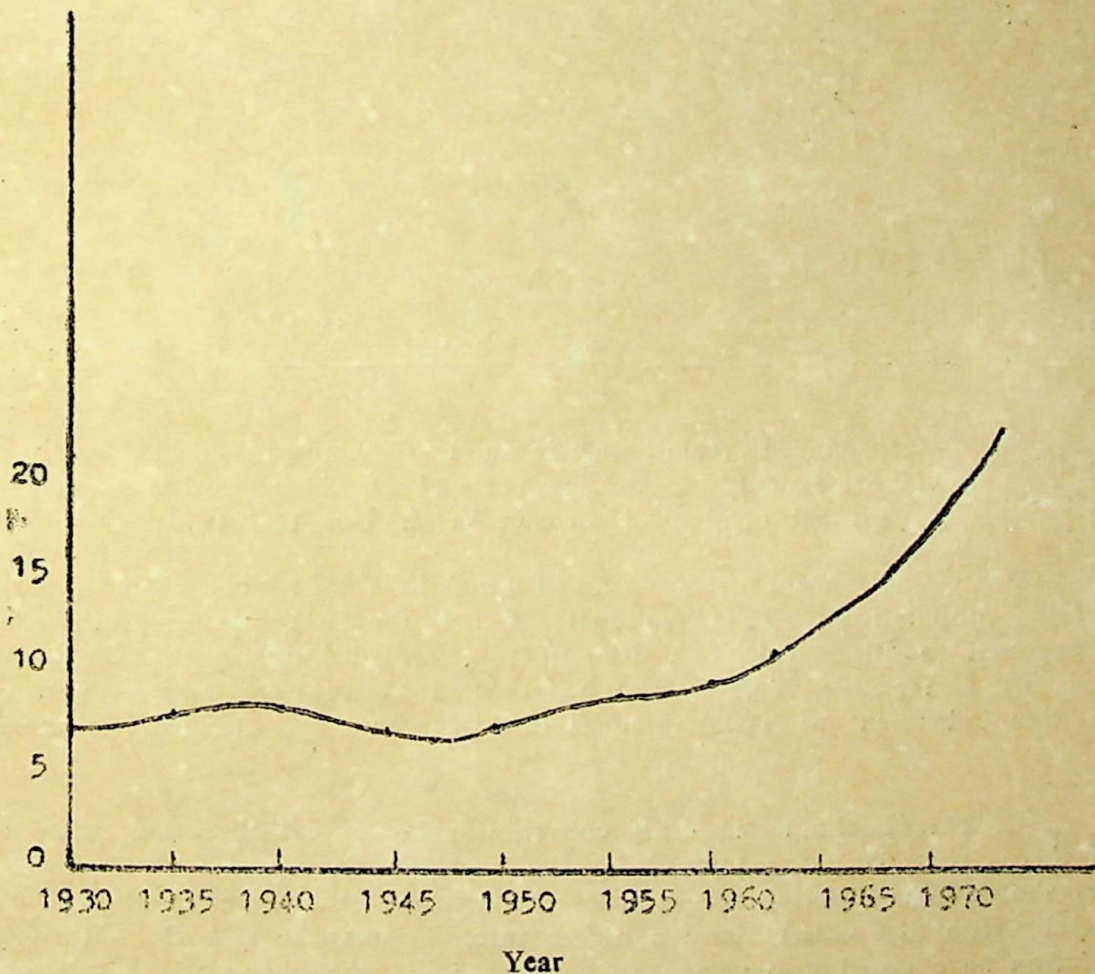


Fig. I Suicide Rates (Sri Lanka) (per 100,000)

(Reproduced from "Suicide and Attempted Suicide in Sri Lanka" by Dissanayayake and De Silva, Ceylon Journal of Medical Science Vol. 23 Nos. 1 & 2, 1974)

Table 1
10 Year Suicide Rates from 1880 1970

Year	Rate per 100,000
1880	2.3
1890	2.9
1900	3.7
1910	5.2
1920	5.6
1930	5.2
1940	6.3
1950	6.9
1960	9.9
1970	19.2

Reproduced from "Suicide and Attempted Suicide in Sri Lanka" by Dissanayake and De Silva, Ceylon Journal of Medical Science Vol. 23 Nos. 1&2, 1974

Our own assessment for Jaffna in 1982 is 53.5 per 100,000 general population. The national figures for 1982 are not available but are not expected to differ widely. A drop of 19% recorded during the 2nd world war is not remarkable. This was to be expected as we were only a subject colony who were indifferent or unwilling allies in a war that was decided elsewhere.

In Sri Lanka as in other countries males have higher rate than females and this is true for all groups. (Fig II Table II) Examination of age specific rates shows some differing trends from the rest of the world. Though it are generally true that elderly have a higher rate, Dissanayake and De Silva and we in Jaffna have noted two peaks one in the 15-34 age group and the other in old age (Fig. III Table III). As shown by Robins and others a large proportion of suicides suffered from disabling mental and physical disorders. This has been found to be true in Jaffna as well. In our retrospective diagnosis after examining the coroners' records and past medical records of the deceased, we found, about 1/3, suffering from depression, grief reactions and chronic alcoholism, another 1/3

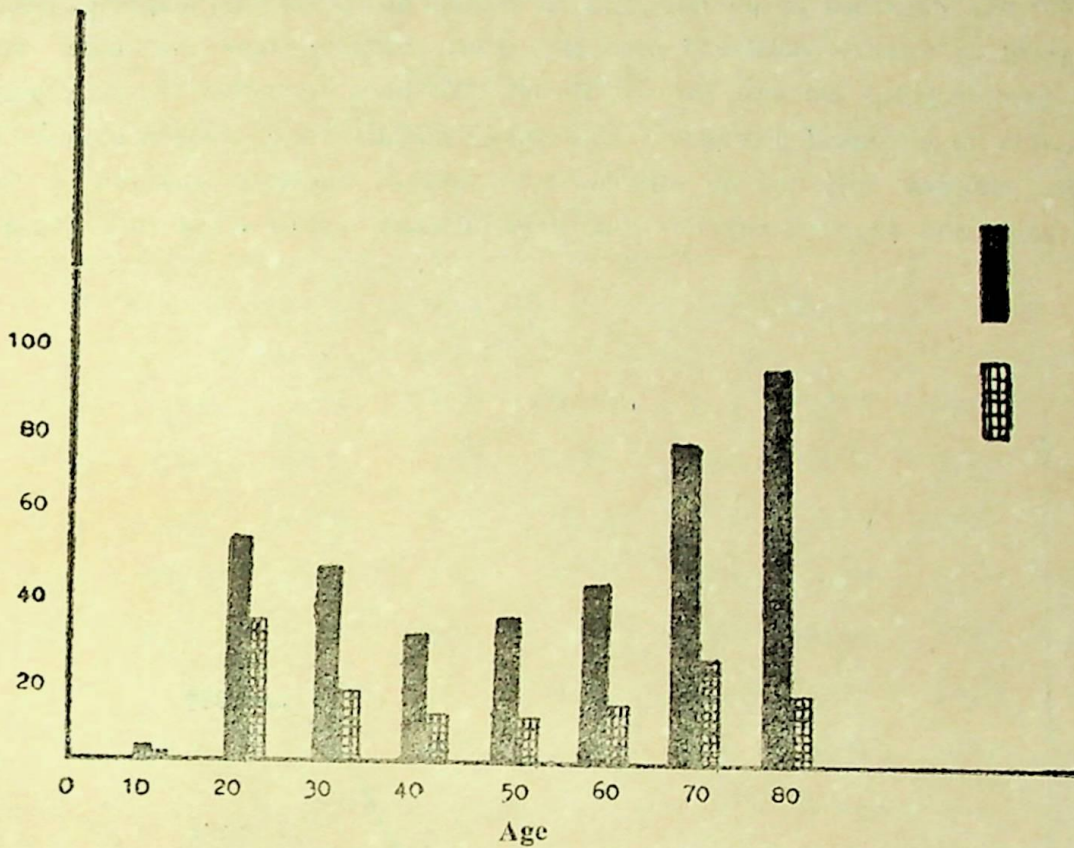


Fig. II Suicide Rates — Age and Sex Specific — 1969 Reproduced from “Suicide and Attempted Suicide in Sri Lanka” by Dissanayake and De Silva, Ceylon Journal of Medical Science Vol. 23 Nos. 1 & 2, 1974

Table II
Suicide Rates by Sex for Age Groups 1969

Age Group	Male	Female	Total
5 - 14	2.8	1.9	2.4
15 - 24	52.2	33.1	42.8
25 - 34	45.4	14.7	29.6
35 - 44	31.0	10.2	21.4
45 - 54	34.0	7.9	22.4
55 - 64	41.0	11.5	28.4
65 - 74	77.0	22.9	53.0
75 & over	96.3	15.7	58.7
Total	25.0	11.4	19.7

Reproduced from “Suicide and Attempted Suicide in Sri Lanka” by Dissanayake and De Silva, Ceylon Journal of Medical Science Vol. 23 Nos. 1&2, 1974.

suffering from other mental disorders and physical illnesses while in another 1/3 the act was described as an impulsive act without any psychiatric diagnosis. The 23% diagnosed as marital social and economic stress reactions may in other studies have been included amongst the depressions. We have restricted the diagnosis of depression to biological depressions with predominantly endogenous or constitutional factors. However 36% had no psychiatric or medical diagnosis and this is indeed remarkable and supports the view that powerful social factors are at work. (Table IV)

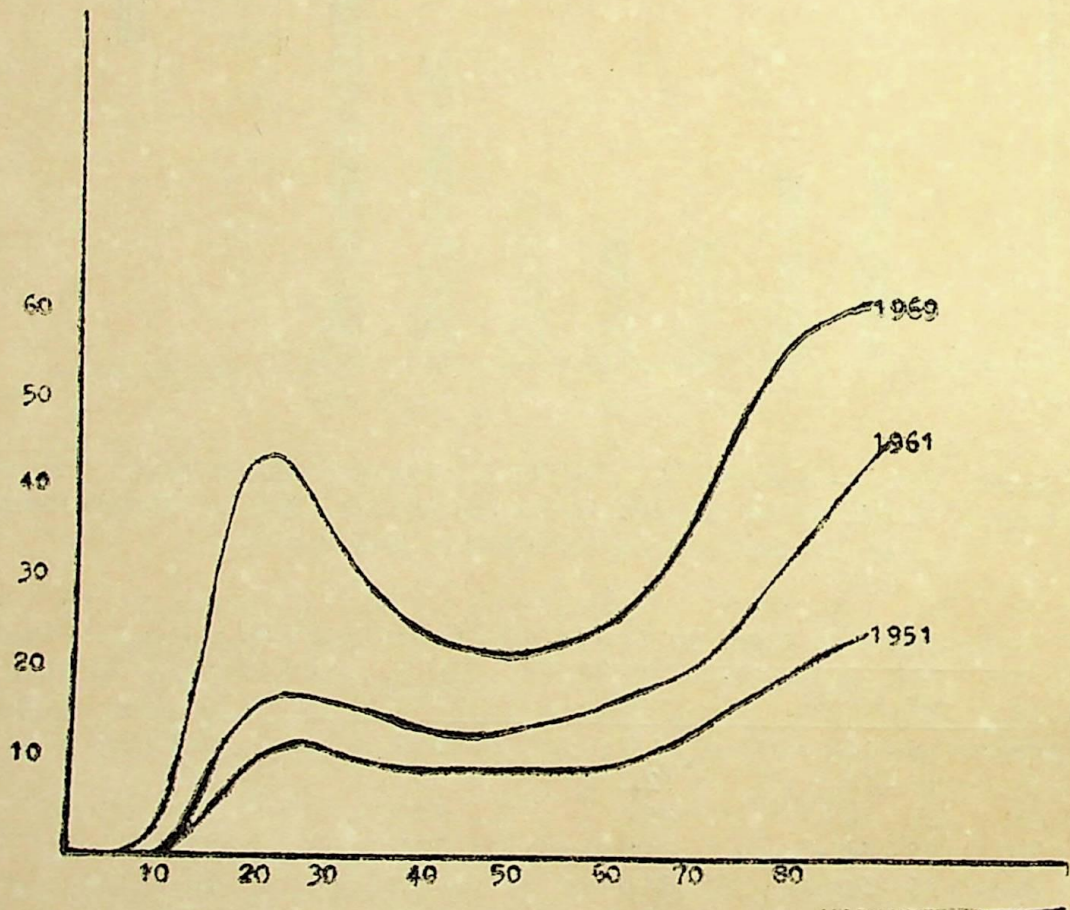


Fig III Suicide Rates (Sri Lanka) — Age Specific for the Years, 1951, 1961 and 1969 (Per 100,000)

Reproduced from "Suicide and Attempted Suicide in Sri Lanka" by Dissanayake and De Silva, Ceylon Journal of Medical Science Vol. 23 Nos. 1 & 2 1974)

Table III
(Suicide Rate -- Age Specific (1951, 1956, 1961, 1966, 1969, 1970 and 1971))

Rate Per 100,000

Year	Age Group								Total Rate
	5 - 14	15 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - above	
1951	0.85	11.63	9.29	9.78	10.18	10.23	17.77	23.07	7.38
1956	0.22	12.59	14.16	9.55	10.81	12.16	25.98	34.61	7.82
1961	0.76	16.18	15.08	12.13	15.12	18.91	24.13	42.37	9.68
1966	1.64	25.88	20.91	16.38	20.30	21.98	34.90	52.94	13.72
1969	2.36	42.77	29.56	21.37	22.44	28.40	53.04	58.66	19.67
1970	1.51	41.20	29.15	23.11	21.20	28.10	46.80	50.50	19.22
1971	1.30	39.10	26.82	21.52	22.24	26.21	41.27	57.80	18.21

Reproduced from "Suicide and Attempted Suicide in Sri Lanka"
 by Dissanayake and De Silva, Ceylon Journal of Medical Science
 Vol. 23 Nos. 1 & 2, 1974.

Kendall (1983) commented that alcoholics have a very high suicide rate and the proportion dying by suicide varies from 8% (Kessel and Grossman 1961) to 21% (Gabriel in 1935) depending on the length of the follow up study. The figure represents a risk 5080 times that of general population. It has been pointed out that alcohol dependence leads to

- (1) Social isolation following social decline, marital failure and occupational failure;
- (2) Loss of self esteem depression and psychological changes predisposing to suicide;
- (3) Intoxication producing increased impulsiveness and weakening of normal restraints against dangerous behaviours.

Table IV

Retrospective diagnosis in 115 suicides

Diagnosis	n	Percent
Depressions and grief reactions	19	17
Chronic alcoholism	19	17
Schizophrenia	2	2
Other mental disorders	5	4
Marital, social and economic stress reactions	26	23
Physical illness	3	3
Impulsive acts	41	36

Reproduced from T. Ganesvarn, S. Subramaniam and K. Mahadevan
Acta psychiatr scand. 1984; 69 : 420-425.

With regard to physical illness Levitan in 1983 showed a higher percentage of suicidal trends in patients with asthma and hypertension as compared with patients of control groups. In 1965 Haberlandt showed that the relatives of completed suicide had a higher suicide rate than the general population. Roy in 1983 found among 243 patients with family history of suicide, almost half attempted suicide. 50% of all patients suffered from a depressive disorder. Zaw (1981) reported a pair of identical twins who committed suicide. Their paternal great grand father and maternal grand father had also committed suicide. There is no doubt that the familial incidence of affective disorder is strong and proven. Many studies have shown identical twins to be highly concordant for affective illness. Suicide is strongly linked to affective disorder.

In 1967 Haberlandt described 98 dizygotic (non identical) twin pairs and 51 monozygotic (identical) twin pairs where in each pair at least one had committed suicide. Amongst the dizygotic pairs no concordance was reported, i.e. there was no reported suicide of both members of a single pair or twins. Amongst the 51 monozygotic twins 9 sets (i.e. 18%) had both committed suicide. In a further 5 pairs (10%) one had committed and the other had attempted suicide. Whether the impulse to suicide is a heritable factor quite apart from depressive illness is still a controversial question.

Depression is a disturbance of mood in the direction of sadness. There is a slowing of physical and mental activity, insomnia, loss of appetite and loss of libido. It is believed to be due to a biochemical disturbance of the mono amines in the brain. The levels of mono amines and 5 HIAA have been examined in the brains of depressed patients after suicide. In one study low levels of 5 HIAA were found when compared with patients dying from natural causes. Traskman et al measured 5 hydroxyindole acetic acid (5 HIAA), homovanillic acid (HVA) and 3 methoxy 4 hydroxyphenyl glycol (MHPG) concentrations in the cerebrospinal fluid of 30 psychiatric patients who had attempted suicide and compared with 45 healthy volunteers. Suicide attempters had significantly lower levels of 5 HIAA in the CSF than the controls. However many such studies have proved to be inconclusive.

Psychologists have constructed scales to measure depression. The Hamilton rating scale has 21 items. Each item is scored in a given range, and the total score of depression is obtained. For example, depressed mood is scored from 0 - 4 and feelings of guilt has the same range. Work and activities of the patient which is decreased in depression is scored from 0 - 2 and so is loss of weight. This scale estimates the degree of sadness. Since every patient suffering from depression does not commit suicide, characteristics other than sadness attracted attention. Beck (1963) Melges and Bowlby (1969) showed hopelessness to be a core characteristic of depression. Feelings of hopelessness have been implicated in suicide. Beck, Weissman, Lester and Trexler (1974) constructed a scale to measure hopelessness. The scale consisted of 20 statements of which 9 would be false for hopelessness and 11 true for hopelessness. For every statement each response was assigned a score of 0 or 1. The possible range of scores would be from 0 - 20. Beck et al showed that depressed patients have unrealistically negative attitude towards the future and seriousness of suicidal intent is more highly correlated with negative expectancies than with depression. It is claimed that statistical association between suicidal intent and depression is an artifact resulting from a joint attachment to a third variable, namely, hopelessness (Minkoff, Bergman, Beck and Beck) (1973). Suicide amongst our young is alarmingly high, if hopelessness is the key factor in suicide, its relevance to our youth deserves careful study in the future.

The study of suicide largely depends on information collected from doctors, relatives and past medical records of the deceased. The chief witness to the drama is not available to give evidence and the feelings that stormed his mind before the fatal act are unknown in the majority of suicides. The people whom we are called upon to see and treat are those who have "attempted suicide". I use the words "attempted suicide" not because of its scientific accuracy but because of common usage. This is not a uniform population with a motive to die; what is common to all these patients is that they have shown an observable behaviour which mimicks suicide. Parasuicide is a more appropriate term. The motives for this behaviour differ. Some are trying to evoke sympathy and attention; others are appealing for help, still others are trying desperately to preserve a broken relationship, or compel or persuade a decision in their favour. Death was least in their minds. But lurking in this population are dangerous men with a will to die, who have only

failed in their present attempt and are waiting for the next, or those with some degree of ambivalence about life. In Western countries only 10% of parasuicides are estimated to be true failed suicides. In a country like ours where the rate of suicide amongst the young is significantly high parasuicides probably include a larger proportion of true failed suicides (Ganesvaran et al) (1982).

The converse is also true: of the 22 suicides we succeeded in interviewing before their death in G. H. Jaffna for the year 1984, 3 said that they did not want to die. One had taken sulphur, other had taken the plant poison - *Thevetia peruviana* commonly called alari seed and the third had taken paraquat. Poor knowledge of the toxic dose or strength of poison was probably the cause in two and in the other was probably a momentary disturbance of the balance between self preservative and self destructive impulses in favour of self destruction. All succumbed to their injuries despite every effort on their part to call for medical attention and cooperate in treatment. It has been pointed out that the population that commits suicide and the population that shows parasuicide are typically two different populations with different characteristics but with some overlap. Parasuicide is more common in the female while suicide is more common in the male. Parasuicide is more common in the young while suicide is common in the elderly. Parasuicides are more often resident with the family while the suicides more often live alone. Parasuicide is more often associated with poverty. A high proportion of parasuicides come from broken homes in which one or other parent was absent during childhood.

The problem of parasuicide is on the increase in both developing and developed countries. It imposes an unbearable burden on the resources of many national health services. Kessel (1965) estimated that more than one in every thousand adult population of Edinburg was admitted for self poisoning every year. In Jaffna a total of 306 were admitted for parasuicide in the year 1984. The number in the general population must be much larger as those without medical risks will not reach hospital.

Follow up studies have shown that a significant number kill themselves in the early years after self injury and eventual suicide rates of 10-20% have been reported (Pierce 1981 Adam et al 1981). It is clearly of importance to be able to identify such patients. It might be expected that a high level of suicidal intent in any act of self injury to be associated with high risk of future suicide. It may not be possible to get this information by directly asking him, as he may not be entirely truthful. He may be ashamed of what took place and may not divulge whether it was a genuine bid at suicide or a manipulative act. He might deny any suicidal ideation because he wants to leave hospital or he may be too confused to remember what he felt.

Pierce constructed a scale to measure intent. It depended on behaviour that can be objectively verified. The behaviour of a patient is a compromise or balance between self destructive and self preservative wishes. A strong wish to die may obscure self preservative wishes or a balance of the two wishes may result in an ambivalent attempt. Pierce's intent scale has three components, namely; circumstances, self report, and assessed medical risk. The circumstances relate to timing, isolation precautions against discovery, acting to gain help during or after the act, final acts of anticipation of death and suicide notes. Self report includes patient's statement of lethality, stated intent, premeditation and reaction to the act (whether glad or unhappy about recovery). The risk is assessed in terms of the lethality of the act and availability of medical treatment. There is a cut off point for the score and it has been validated in a five year follow up study where a group of very high risk patients was identified by repeated use of this scale.

Today the clinician makes use of this data and the psycho social profile already developed to assess the suicide risk of patients seen after parasuicide.

Considerable progress has been made in understanding suicide. Based on the data available, attempts have been made to assess suicidal risk in patient population. The success of these predictions has come under careful examination. Alex D Pokorny (1983) made a prospective research study to identify persons who would subsequently commit or attempt suicide. The sample consisted of 4800 consecutive admissions of a veterans administration hospital in USA. They were examined and rated on a wide range of instruments and measures including most of those previously reported as predictive of suicide. It was found that each test missed many cases of suicide, (ie. sensitivity of test was low) and trials had many false positives (ie. specificity was also low) to be workable in individual cases. The reasons for the reported failure are (a) The base rate of suicide is too low even for a test of high sensitivity and specificity to have a high percent age of prediction. The rate for Pokorny's sample was 286/100,000/yr. The table (V) which was published by Pokorny was adapted from Galen and Gambino and shows the percentage of prediction at three prevalence levels, of tests with varying combination of specificity and sensitivity, (b) tests themselves need improvement (c) suicidal impulse itself varies from time to time. Therefore a single test at a point of time will have low levels of prediction. In practice psychiatrist is involved in predictions over a much shorter period at times of suicidal crisis. Risk is expected to subside and patient usually returns home. This work of the psychiatrist as commented by Pokorny is unresearchable as it would not be ethical to withhold treatment or steps to ensure safety in the plea of conducting a research study. Clinicians will continue to ask the question as to how particular patient resembles the psychosocial profile already described in that community. Suicide prevented at such close quarters will never be known with certainty.

Definition of Sensitivity and Specificity

Sensitivity	$\frac{\text{Number of Cases positive for test}}{\text{Total No. of cases}} \times 100$
Specificity	$\frac{\text{No of normal persons negative for test}}{\text{Total no of normal persons}} \times 100$

Table V

Predictive value of a positive test result at three prevalence levels

Specificity %	Sensitivity %				
	50	70	90	95	99
	A prevalence 1 / 100,000				
50	0	0	0	0	0
70	0	0	0	0	0
90	0	0	0	0	0
99	0	0	0	0	0
99.9	0	1	1	1	1
	B Prevalance 10 / 100,000				
50	0	0	0	0	0
70	0	0	0	0	0
90	0	0	0	0	0
99	0	1	1	1	1
99.9	5	7	8	9	9
	C Prevalence 500 / 100,000				
50	1	1	1	1	1
70	1	1	1	2	2
90	2	3	4	5	5
99	20	26	30	32	33
99.9	72	78	82	83	83

Adapted from Galen and Gambino. Numbers indicate predictive values given as percentages.

Taken from Prediction of suicide in Psychiatric patients by Pokorny Archives of General Phychiatry, 40, 3, 249 — 257.

— (Copyright of American Medical Association)

Methods of suicide vary from place to place and from time to time. The use of a particular method is influenced by many factors such as easy availability, knowledge about its toxicity and current popularity in the area. In the mid sixties government initiated a massive campaign for increased production of food. Dissanayake and De Silva showed how poisoning, mainly agrochemical poisoning was becoming popular in the late sixties. Acetic acid, the popular poison on the estates, was gradually replaced by agrochemicals, and hanging as a method of suicide decreased. Of a total of 145 suicides studied in the area of jurisdiction of the Magistrate Courts Jaffna (Table VI, VII) 70 — 80 % died of agrochemical poisoning. A new trend of poisoning — the use of *Thevetia peruviana* commonly called alari seed began in Jaffna in late 1983 following an article about its toxicity in a Tamil news paper. For the year 1984, a total of 57 were seen in the General Hospital Jaffna for self poisoning with alari seed. Majority of them were females. Four of them died. Agrochemicals of the organophosphates types still remain the chief method of suicide. This raises the question of prevention of suicide by stricter law controlling the sale and distribution of these substances.

Table VII
Methods of suicide in 145 suicides

	n	%	Total suicide % (n = 145)
Self - poisoning (n = 127)			
agrochemicals	116	91	80
other non-drugs	3	2	2
drugs	4	3	3
unknown	4	3	3
Other methods (n = 18)			
hanging	11	61	8
burns	3	17	2
drowning	2	11	1
suicide on railways	2	11	1

Reproduced from T. Ganesvaran, S. Subramaniam and K. Mahadevan — Acta psychiatr. Scand. 1984 : 69 : 420 — 425.

This raises the question of prevention of suicide by stricter law controlling the sale and distribution of these substances.

Table VI
Suicide in Jaffna by poisoning and other methods

	Age										Total
	0-14	15-19	20-24	25-34	35-44	45-54	55-64	65-69	70	70	
Male (79)											
Poison	4	13	17	19	6	7	1	1	4	72	
Other methods	0	1	0	2	0	1	1	0	2	7	
Female (36)											
Poison	0	7	7	7	3	2	1	0	0	27	
Other methods	0	3	1	1	1	0	2	0	1	9	
Total	4	24	25	29	10	10	5	1	7	115	
%	(3)	(20)	(22)	(25)	(9)	(9)	(4)	(1)	(6)	(99)	
Age distribution of population (%)	35.3	10.8	10.2	16.1	10.4	7.8	5.1	1.7	2.6	100	

Stengel has argued that if one method is eliminated the fall in rate would be temporary and other methods would take its place. Burvill's observation in Australia that the drop in suicide from domestic gas after the introduction of natural gas was compensated by proportionate increase in the use, by males, of other gases, such as car exhaust fumes seems to support this view. Mc Clure (1984) has also reported a marked increase in the use of vehicle exhaust gas for suicide between 1975 — 80 in the United Kingdom.

However Krietman attributes the fall of suicide rate since 1960 in the United Kingdom to the increased use of natural gas. Farmer showed that the rise in coal gas suicides coincidental with widespread introduction of coal gas for domestic use, did not appear to cause a compensatory decrease in other methods of suicide. He also demonstrated that, the suicide rates for Australia and USA of which USA has the least restrictive fire arm legislation, did not differ significantly from England and Wales, if suicide by fire arms is discounted.

It is possible that powerful social correlates act synergistically with the factor of availability of a particular method to produce a high rate. We have maintained that the control of Pesticides act No. 33 should be amended to enforce stricter controls on sale and distribution of these dangerous agrochemicals that are freely available over the counter.

Description of psychopathological states leading to suicide have not been the sole province of psychiatrists. Poets down the ages have been keen observers of emotion and human behaviour. The loss of self esteem, when confronted with his injustice and his will to die, is heard in the words of the Pandyan King.

“யானே அரசன் ? யானே கள்வன் !
மன்பதை காக்கும் தென்புலம் காவல்
என் முதல் பிழைத்தது : கெடுக என் ஆயுள்

“Am I the King ? No
The thief I am ; from now
The Pandyan justice, has failed
To preserve and protect the people,
So let my life be lost”.

Grief at the loss of a grown up son has been recognised to be the severest of all grief. We are reminded of Kamban's words on the elderly monarch.

“என்னின் முன்னம் வனம்நீ அடைதற் கெளியேன் அல்லன்
உன்னின் முன்னம் புகுவேன் உயர்வா னகம்யான்” என்றான்.

“Am I so unworthy to see you haste away to the forest first
For I shall see the high heavens before you
my son”, said the King.

No discussion on suicide is complete without reference to the period in which it has been observed.

We have in Jaffna observed social disorder or in Durkheim's words 'Anomic'. Drug addiction and alcoholism have taken toll of many lives by suicide. Homicides and robbery have become the order of the day. But also we observe young men throwing away their lives for a cause which is dear to them. The cyanide self poisonings and suicide squads reported in the newspapers probably are altruistic suicides. We see here today a phenomenon unique in our history. If there is egoism and anomie there is also altruism and self sacrifice for a cause.

If a future historian were to record this period what will he say? Will he in the words of Dickens report "It was the best of times; it was the worst of times; it was the age of wisdom; it was the age of foolishness; it was the epoch of belief; it was the epoch of incredulity; it was the season of light; it was the season of darkness; it was the spring of hope; it was the winter of despair; we had everything before us; we had nothing before us; We were all going direct to Heaven; we were all going direct the other way".

Acknowledgements

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Professor T. Ganeswaran M B B S., D P M., M R C Psych. was born on the 22nd August 1938. He had his secondary education at the Royal College in Colombo. He was admitted to the Faculty of Medicine, University of Ceylon in 1959 and graduated in August 1964. He was then appointed as intern house officer in the General Hospital in Colombo.



Having completed his internship he joined the Department of Health as a District Medical officer in Anamaduwa. The hospital itself was in one of the remotest districts of Sri Lanka, surrounded by jungles and ancient tanks. It was here that he developed his administrative skills while meeting the challenging health problems of a developing district.

In January 1967, he took up to a career in Psychiatry, assuming duties as house officer in Psychiatry at the Mental Hospital in Angoda. Here he came under the influence of leading Psychiatrists of this period like Dr. C. P. De Wijesinghe M D., F R C P., F R C P (E), F R C Psych, (later Professor of Psychiatry in Colombo), Dr. V. Satkunanayagam F R C Psych., D P M Dr. R. Nadaraja M R C Psych., D P M and Dr. A. Sittampalam M R C P., D P M. M R C Psych. He was associated with Dr. T. Arulampalam, M R C Psych., D P M in his pioneering efforts to establish a psychiatric service in the peninsula.

After an initial period of training in Sri Lanka he was trained at the Maudsley Hospital in London. He was appointed Consultant Psychiatrist at the Base Hospital in Matara in October 1970 and has served as Consultant Psychiatrist in the General Hospitals of Galle, Anuradhapura, Jaffna and Kandy. Finally he took up his post as Consultant Psychiatrist at the Mental Hospital in Angoda in 1979.

He was released by the Department of Health to take up the post of Senior Lecturer in Psychiatry in May 1981 in the newly established University of Jaffna. His research interests centred around the peculiar problems of Jaffna. For the first time he established the suicide rate of Jaffna and showed the many factors responsible for the increase since 1970. His studies in suicide and attempted suicide are contributions to the study of changing trends in this behaviour. He was appointed to the Chair in Psychiatry of the Faculty of Medicine, University of Jaffna on the 1st January 1984.