International Scholars Journals

International Journal of Biochemistry and Biotechnology ISSN 2169-3048 Vol. 8 (2), pp. 001-004, February, 2019. Available online at www.internationalscholarsjournals.org © International Scholars Journals

Full Length Research Paper

Self-destructive ideation in callers to emergency hotline in Mumbai, India

***Pandit Wasim Mishra, Jaffer Chandrakant and Sandeep Patil Tanmay**

Department of Biomathematics, Faculty of Nature and Life Sciences, University of Mumbai, Mumbai, India.

Accepted 10 November, 20118

Suicide is a worldwide public health problem. The stigma associated with suicide often deters people from seeking help. Although, helplines are not rated as very effective therapeutically, they offer an opportunity for intervention for people in crisis. The present study examined the characteristics of people attending an outpatient service after establishing an initial contact during an emotional crisis with a helpline in Mumbai, India. A total of 15,169 clients called the service during the first five years of operation, of whom 9.2% reported suicidal ideation. About half (51.6%) of the callers who were given a referral to the affiliated outpatient clinic kept their appointments. While 38% of the outpatient clients did not have an Axis I or Axis II psychiatric disorder, 25% were diagnosed with schizophrenia and 17% with depression. In addition, 13% had a personality disorder and 7% substance abuse disorders. Female clients more often reported stress arising from financial problems, conflict with their in-laws, and pre-marital relationships than did male clients; male clients more often reported stress arising from employment, loss of reputation, and education than did female clients. The availability of a 24/7 mental health helpline, staffed by mental health professionals with back-up support from an outpatient psychiatric facility, can enhance community mental health services. Some of the problems encountered were mentioned and needed improvements were discussed.

Key words: helplines, suicidal ideation, referrals

INTRODUCTION

Suicide is a major public health problem worldwide, and approximately one million people commit suicide every year, with India contributing about 10% of these suicides (Bertolote and Fleischmann, 2005). In the year 2009, India recorded 127,151 individuals who died by suicide, with a rate of 10.9 per 100,000 per year (//ncrb.nic.in/accdeaths.htm). Suicide is difficult to prevent because of its unpredictable nature. Most individuals experiencing suicidal ideation do not contact health care facilities and, therefore, do not provide an opportunity for intervention and treatment.

*Corresponding author. E-mail: manuscript.submit@ymail.com

Several effective steps for prevention have been proposed, including restricting access to common methods of suicide, adequate treatment of mental disorders (such as depression and substance abuse), and school-based interventions involving self-esteem enhancement, and the development of coping skills (Bertolete, 2004). However no single strategy is sufficient and effective prevention can be achieved only by a concerted and comprehensive approach, based upon multidisciplinary models with a people-centered focus.

If suicidal clients contact mental health services, there is an opportunity for intervention. However, in India, as a result of the stigma related to suicide and also legal issues (since attempting suicide is still a crime in India), people in crisis do not readily seek treatment. Non-government agencies can play a significant role in bridging the gaps in service utilization in India, and many of these organizations work within a public health framework, collaborating with other agencies to provide suicide prevention programs that are responsive to local community needs (Vijayakumar, 1994).

Helplines are one such initiative, and they offer an adjunct to existing services for the intervention and prevention for suicide. For example, a helpline in Karnataka, India, for those with HIV and AIDs has proved to be useful for callers (Alexander et al., 2011). Although helplines are limited in the quality of the therapy provided, research has demonstrated that helplines are valuable. They offer empathic listening and link individuals in crisis to available services (Bleach and Claiborn, 1974; Porter et al., 1997). Research has shown that helpline counselors are effective in evaluating callers for their risk of suicide-related behavior (Karver et al., 2010) and can, therefore, be of great use. However, helplines alone are not sufficient for handling all crisis situations, and helplines require support from other services such as psychiatric hospitals and outpatient counseling clinics that can provide medication and psychotherapy.

The present study attempted to document the benefits of combining a helpline service with psychiatric follow up for diagnosis, suicide risk assessment and treatment. If telephone helplines are supported by a team of professionals offering diagnostic and treatment facilities, the telephone service can respond more effectively to the mental health needs of the callers. This model can also help overcome the limitations of helpline counseling when dealing with acutely suicidal individuals. Since few helpline services ever have a sample of their callers evaluated by a psychiatrist, this study provides important insights into those who call helplines while in a suicidal crisis.

METHODOLOGY

This study was conducted in a counseling center catering for the needs of suicidal clients in a suburban catchment area in Mumbai, India. The center has two components: a telephone helpline operating 24 h a day, 7 days a week, and a psychiatric outpatient facility, both located in a residential community. The psychiatric outpatient clinic offered facilities for the assessment of individuals by psychiatrists and other mental health professionals and also for treatment, including hospitalization. The outpatient clinic operates from 9 am to 5 pm and functions like a walk-in clinic. No prior appointment is required. All clients who contact the helpline and who are experiencing a suicidal crisis are offered further intervention at the outpatient clinic if this is deemed necessary. An attempt to resolve the crisis is always made during this first contact on the telephone, and this was facilitated by the fact that the telephone counselors were qualified psychologists and social workers (rather than volunteer paraprofessionals).

The sample for the study consisted of clients who visited the outpatient clinic after establishing initial contact with the helpline during a suicidal crisis in the years 2001 to 2006. Clients who called and who were in a suicidal crisis were given the opportunity to come for a face-to-face assessment within the next 24 h. If clients failed to appear for their appointment, it was not possible to locate them because of confidentiality; their telephone numbers were not requested. There are no data, therefore, on whether these clients went to other hospitals or clinics.

Qualified psychiatrists at the outpatient clinic examined these clients and developed a plan for their care. These psychiatrists were available from 11 am to 3 pm from Monday through Saturday. If a client required any counseling or medication, this was provided at the outpatient clinic. Those who were judged to require hospitalization were given a choice of affiliated hospitals, government and private, that had agreed to admit and treat clients on a priority basis. Clients were also given the option of follow -up treatment by just “dropping in” at the outpatient clinic when needed.

The helpline was managed by trained clinical psychologists and social workers with masters’ degrees, with experience in psychiatric assessment and treatment.

Data collection was carried using a semi-structured format for the clients who attended the outpatient clinic. All of the clients were evaluated by a psychiatrist.

RESULTS

Of the 15,169 subjects who called the suicide helpline during the five-year study period, only 1,391 (9.2%) reported suicidal ideation. More than half (51.7%) of the clients who were advised to visit the outpatient service did so. In these 718 clients, the frequency of ideation was persistent in 26.5%, significantly more so in women than in men (38.2% versus 18.6%) (Table 1). Some 5.9% reported definite plans for suicide, while another 11.4% had tentative plans. Women more often reported a history of attempted suicide than men (49.3% versus 12.6%).

A report of stress was equally common in men and women, but the nature of the stressors differed by sex. Financial problems were twice as common in women, while men reported more employment and relationship stressors (Table 1). Women reported more stress over pre-marital relationships (including pre-marital pregnancy), conflict with their in-laws and general harassment (especially from husbands who were addicted to drugs and alcohol), while men reported more stress from loss of reputation (A loss of reputation has been consistently reported as a motive for suicide in the national database

Table 1. Clinical characteristics of the outpatient clients.

Characteristic	Total (%) n=718	Male (%) n=430	Female (%) n=288	p value for sex difference
Severity				
Persistent ideation	26.5	18.6	38.2	< 0.001
Plans				
No plans	82.7	80.0	86.8	< 0.001
Uncertain plans	11.4	15.8	4.9	
Definite plans	5.9	4.2	8.3	
Past suicide attempts				
None	72.7	87.4	50.7	< 0.001
1	4.2	3.3	5.6	
2	16.9	5.6	33.7	
> 3	4.6	3.0	6.9	
Stressors				
Financial	46.0	27.9	72.9	< 0.001
Employment	15.6	20.7	8.0	< 0.001
Relationship	33.6	37.2	28.1	0.012
Conflict with in-laws	13.5	5.4	25.7	< 0.001
Harassment	4.7	0.9	10.4	< 0.001
Loss of reputation	7.8	10.7	3.5	< 0.001
Chronic medical illness	3.2	4.7	1.0	0.007
Premarital pregnancy	3.8	0.0	9.4	< 0.001
Premarital relationships	12.1	1.9	27.4	< 0.001
Addiction in husband	12.1	0.0	30.2	< 0.001
Exams/education	32.0	34.9	27.8	0.046
Loans	40.1	53.5	20.1	< 0.001
Psychiatric history				
First contact	28.3	41.9	8.0	< 0.001

of people who commit suicide in India, probably because social reputation is correlated with the success and performance of an individual).

For 28.3% of the clients, this contact was their first mental health contact, and more women than men reported prior mental health contacts.

Among those who visited the outpatient clinic, all of whom were assessed by the staff using DSM-IV criteria, 25% were diagnosed with schizophrenia, 17% with depression, 13% with a personality disorder, and 7% with a substance abuse disorder. Thirty-eight percent had no Axis I or Axis II diagnosis.

Of the 131 clients who were advised to check into a psychiatric hospital, 71 did so. Of those clients treated on an outpatient basis, 43% dropped out of treatment. This high drop-out rate was primarily a result of the lack of available services in the different communities in which they lived and, therefore, the long distances that some clients would have had to travel to the outpatient clinic and not a result of the psychopathology of the clients. The service did have arrangements with ten psychiatric clinics to which it could refer clients who lived near these clinics, but this was not sufficiently close to all of the clients.

DISCUSSION

There were two different types of people who contacted the helpline with suicidal ideation. Some callers felt that they were able to handle the current transient crisis and did not feel the need for further intervention, while other callers continued to be in crisis and wanted further assistance after the initial telephone discussion. The second group contained a higher proportion of women, and these women more often had a history of suicidal

behavior and previous psychiatric contacts. In the absence of the associated outpatient clinic that was available, it is unlikely that these clients would have gone to another hospital or clinic. The helpline offered this opportunity, providing a useful resource for the clients, motivating them to use the service, and bringing them into treatment much earlier than otherwise. Delay in accessing services is common among people suffering from depression who often avoid accepting referrals until the crisis becomes serious and acute.

This study indicates that it is useful, and perhaps important, to have outpatient psychiatric treatment available for those who call a crisis helpline. Roughly 5% of the callers to the helpline were given a referral to the outpatient clinic which they kept, and 60% of these were found to have an Axis I or Axis II psychiatric disorder. The presence of the outpatient clinic provided an opportunity to provide treatment for these clients, and a small proportion was judged to be in need of hospitalization.

Those working on the helpline experienced several problems. The helpline counselors had a high rate of turnover which necessitated recruiting and training counselors on a continual basis. Part of this problem was a result of inability of the service to pay the counselors a good wage, and partly from burn-out as a result of the stressful nature of conducting crisis intervention with callers. A second problem was publicizing the helpline so that people in region knew of its availability. The helpline received a large number of prank and nuisance calls, particularly at night, which tied up the lines and frustrated the counselors. Finally, since this type of service was a new concept, some callers did not understand the service provided. Some wanted information rather than counseling, while others had too high expectations about what the service could provide.

In order to make the service more community-friendly, more coordination with other local agencies is required, as well as sufficient funding to provide a comprehensive service, contacting and talking to community groups in order to publicize the service and explain what it can do, and educating the public through the media (newspapers, magazines, radio, television and the Internet) about the service.

A study of attempted suicides in Mumbai, India, found that 40% did not qualify for a psychiatric diagnosis (Parkar et al., 2008), but studies of completed suicide in India do report a higher incidence of psychiatric disorder (Vijayakumar and Rajkumar, 1999). The present results, indicating that 38% of the clients seen at the outpatient clinic did not have a psychiatric disorder, are consistent with the studies of attempted suicides in India.

However, 62% of the clients seen at the outpatient clinic did merit a psychiatric diagnosis. Services that have suicidal clients need to be equipped for comprehensive and meaningful culture-specific measures for dealing with the psychological and social problems facing the clients and for ameliorating the risk factors present in these individuals. Since there is stigma associated with suicidal behavior and with seeking treatment, programs should be developed to increase the general public's understanding of suicide and the need for treatment in order to decrease this stigma (Manorantjtham et al., 2005).

It would be of interest to explore why some clients dropped out of psychotherapy. It could be that the psychotherapy was successful, and they felt no need for further psychotherapy. On the other hand, it could be that they found psychotherapy unhelpful or because getting to the clinic was too difficult. Future research is required to find out the reasons why clients drop-out of treatment.

Although attempting suicide is a crime in India, having suicidal ideation is not an offense. Thus, clients are not reluctant to call helplines or attend psychiatric clinics, because of any legal issues. Furthermore, despite Indian law, many that attempted suicides attend psychiatric clinics and receive treatment.

The implications of this study are: (1) helplines are helpful for clients in crisis; (2) the model of a helpline supported by a psychiatric outpatient clinic with priority appointments seems to be more useful than helplines alone; and (3) this system offers early identification of psychiatric disorder, with clients evaluated and diagnosed early in the course of their disorder, as well as continuity of care afterwards.

REFERENCES

Alexander G, Kanth C, Thomas R (2011). A descriptive study on the users and utility of HIV/AIDS Helpline in Karnataka, India. Indian J. Commun. Med. 36(1):17-20.

Bertolote JM (2004). Suicide prevention: at what level does it work? World Psychiat. 3:147-151.

Bertolote JM, Fleischmann A (2005). Suicidal behavior prevention: WHO perspectives on research. Am. J. Med. Genet. 133C(1):8-12.

Bleach G, Claiborn WL (1974). Initial evaluation of hot-line telephone crisis centers. Commun. Ment. Health J. 10:387-394.

Karver MS, Tarquin SJ, Caporino NE (2010). The judgment of future suicide-related behavior: helpline counselors' accuracy and judgments. Crisis 31:272-280.

Manorantjtham S, Abraham S, Jacob S (2005). Towards a national strategy to reduce suicide in India. Nat. Med. J. India. 18(3):118-122.

Parkar SR, Dawani V, Weiss MG (2008). Gender, suicide, and the sociocultural context of deliberate self-harm in an urban general hospital in Mumbai, India. Cult. Med. Psychiat. 32:492-515.

Porter LS, Astacio M, Sobong LC (1997). Telephone hotline assessment and counseling of suicidal military service veterans in the USA. J. Advan. Nurs. 26:716-722.

Vijayakumar L (1994). Befriending the suicidal in India. Crisis 15:99-100.

Vijayakumar L, Rajkumar S (1999). Are risk factors for suicide universal? A case-control study in India. Acta Psychiat. Scand. 99:407-411.