A FIVE YEAR RETROSPECTIVE STUDY OF SUICIDE IN PRIZRENI REGION

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ABSTRACT

According to the World Health Organization (WHO) in 1999, suicide is among the top ten causes of death for all age groups in North America and the majority of northern and western European countries; it represents 1 to 2 percent of total mortality. This research is a five years retrospective study of all suicidal cases in Prizreni region that had happened from January 2010 up to December 2014. It is an archive type and it was done by analyzing of the data that I had got from Prizreni Regional Unit of heavy Crimes Database, Regional Hospital "Prim Dr. Daut Mustafa" in Prizren and the daily newspaper "Express", and whenever was possible the information from the relatives of the ceased ones or the one who attempted suicide. Thus all the above mentioned data were gained from the aforementioned resources for the frame time, January 2010 up to December 2014. The descriptive statistics were used to analyze personal data to find the frequency, percentage, mean and standard deviation (SD). All data were analyzed by using a statistical package SPSS for windows version 21.0. Statistical significance was considered at p-value < 0.05. The group age with the highest number of cases was 21-30 and the average age was 29 with a standard deviation of 1.16. Males commit suicide 3.12 times more than females, but females attempt suicide 3.5-4 times more than males. Hanging was the main method used, respectively 40 % of the cases, fire arms 30 % of the cases. The highest frequency was during day time 9-12 a.m. and in the evening 5-8 p.m., and when it comes to season, it was mainly in summer and spring, more respectively in May and July. Rural areas lead versus urbane ones with greater number of cases, 65.7 % versus 34. 3 %. The victims of suicide are mainly single. Notes were found only in 2 cases.

Keywords: Suicide, methods, risk factors, suicide attempts, prevention.

INTRODUCTION

Suicide is one of the causes of death in adults in the industrialized countries. Globally, estimated 815,000 people killed themselves in the year of 2000, making suicide the 13th leading cause of death. The highest rates of suicide are in the East European countries. The lowest rates are mainly in Latin American and a few countries in Asia [20]. At present, suicide is an important problem in forensic science because it is an unnatural death and not easy to separate from homicide and accident. Two points need to be considered: First, evidence of the death scene or anything found at the scene, such as knife or gun. Second is autopsy of death body to define a cause of death. Nowadays, suicide is a problem in every country and men are higher than female. In most countries of the western world, the suicide ratio of male to female is 3:1 [9]. Many studies showed that males are three times more likely to commit suicide than females [8]. The age range was 9-70 years with a mean age of 33.4 years [4].

LITERATURE REVIEW

According to the World Health Organization (WHO) in 1999, suicide is among the top ten causes of death for all age groups in North America and the majority of northern and western

European countries; it represents 1 to 2 percent of total mortality. Analysis of the mortality figures reveals important differences in the mortality rate between various countries and age groups. [3] The suicide rate in industrialized countries has increased since the beginning of the twentieth century and reached very high levels in many European countries and North America. The rise in suicides parallels the gradual increase in urbanization and education. It is also known that a major part of the increase in the suicide rate can be attributed to those people under forty years old. [14] Epidemiological knowledge about suicide in the world is limited to countries that report suicide statistics to WHO. The majority of countries in Africa, the central part of South America, and a number of Asian countries do not report data on suicides. What epidemiological data are available can often vary in quality. According to Ian Rockette and Thomas McKinley, the misclassification of suicide leads to underreporting. Classifying suicides as unintentional poisonings, drownings, or undetermined deaths is not unusual. [3]

Underreporting and misclassification can be explained by social attitudes toward suicide, religious disapproval, and recording procedures. Some countries have a system whereby coroners can investigate unnatural deaths. In other countries a certificate is simply signed by the doctor. Autopsies also vary from one country to the next. For example, the autopsy rate is very high in Australia but very low in Germany. When there is no stigma associated with suicide, those close to the deceased are more likely to reveal information and characteristics about the deceased that would lead to a more accurate classification. [6] In almost all countries for which statistics are available, suicide is more frequent among men than women, a trend that prevails in most age groups. In a number of countries, a trend toward an increase in suicide has also been observed among men but not women. The gap in rates between men and women is smaller in Asian countries. Contrary to other countries, the suicide rate in China is higher among women than men in both rural and urban areas. However, the male-female suicide ratio is lower than in most countries. [11] Women's resistance to committing suicide may be explained by the strong role they play in family life, even if they work outside the home; their tasks prevent them from becoming socially and emotionally isolated. Women also seek medical treatment more often than men, increasing their chances of having any psychiatric problems detected and treated early. Conversely, men seem more vulnerable to losing their professional identity, a calamity often aggravated by solitude and loss of contact. Certain harmful behaviours linked to suicide, such as alcoholism and drug addiction, are especially common among men. [5]

According to David Lester, the suicide rate increases with age among men and varies with age among women. In industrialized countries, the rate is higher for women in their middle ages. In poor countries, the suicide rate is higher among young women. In many industrialized countries and even in small communities, statistics show an increase in suicide among young people, especially among young men. In many areas, namely North America, suicide is the leading or second leading cause of death among young males. Suicide among children under the age of twelve is rare. The incidence of suicide rises sharply at puberty; the highest youth suicide rates occur during adolescence or early adulthood. The increase in suicide among youth dovetails with an overall rise in youthful depression. In addition, the earlier onset of puberty induces adult stresses and turmoil at an earlier age, including sexual activity and the abuse of alcohol, tobacco, and drugs. [20] Methods of suicide vary greatly among different countries, depending on cultural traditions and social and political conditions. According to Canetto and Lester, the use of firearms in suicide deaths is definitely higher for both men and women in the United States than in Canada. This is mainly due to the large number of firearms in circulation and the absence of restrictions on access to them.

In many countries, the use of firearms in suicide deaths is higher in rural areas than in urban ones because there are more hunters in rural areas. Another interesting example of the link between methods and their availability is that of domestic gas in England used for exhaust poisoning. When England lowered the toxicity of domestic gas, suicide by this method was eliminated in the country and suicides decreased by one-third. Other countries such as Switzerland, Ireland, and Scotland have also reported changes in the suicide rate following the detoxification of gas. [21]

There are also major differences in how men and women in Western countries commit suicide. Many men shoot and hang themselves while women tend to poison or hang themselves. In industrialized and developing nations, women most frequently use chemical products intended for agriculture. [23] Suicide may be associated with various pathologies. In Western societies, for example, suicide is considered to be a reflection of the social ills associated with crises such as unemployment, insecurity, weakness, or the loss of income, all of which contribute to the breakdown of family ties and the mental and physical isolation of individuals. Suicide often leads to various forms of exclusion in Western societies, in particular social isolation. In addition to social factors, individual and biological factors are also associated with suicide, notably the presence of psychiatric problems. People who suffer from depression or other mental problems are statistically more at risk of suicide than the rest of the population. However, though mental disease is a risk factor that increases the probability of suicide, it does not itself explain the occurrence of suicide. Other individual syndromes associated with suicide are antisocial behavior and the abuse of drugs and alcohol. More recent studies have also linked genetic and biological factors to suicide, such as gender and serotonin production problems.

To counter the problem of suicide, many countries have set up prevention programs that focus on early detection of mental disease and more adequate treatment of potential victims. Other programs seek to purvey more accurate information about the problem through the media. Legislation restricting the use of firearms, the restriction and control of toxic substances, and the detoxification of domestic gas are the most common and successful preventive measures in advanced industrialized countries. [23]

METHODOLOGY

This research is an archive type and it was done by analyzing of the data that I had got from Prizreni Regional Unit of heavy Crimes Database, Regional Hospital “Prim Dr. Daut Mustafa” in Prizren and the daily newspaper “Express”, and whenever was possible the information from the relatives of the ceased ones or the one who attempted suicide. Thus all the above mentioned data were gained from the aforementioned resources for the frame time, January 2010 up to December 2014.

The descriptive statistics were used to analyze personal data to find the frequency, percentage, mean and standard deviation (SD). Chi-square test was used to test the association between properly variables in each group. All data were analyzed by using a statistical package SPSS for windows version 17.0. Statistical significance was considered at p-value < 0.05. The data were analyzed within the frame of the available information, such as:

- Demographic characteristics of the victims
- The circumstances of the committed action (method, time, location, police reports)
- Toxicology (only for the cases the hospital might have information)

- Possible contacts with psychiatrists and general practitioners etc.

Data analysis

Statistical analyses were conducted for all the suicidal cases in Prizreni Region for the time frame, January 2010 up to December 2014, and variables, such as: gender, age, time, methods, weather, season, etc were analyzed, along with other possible suicidal components:

- Age group with dominant cases
- Age group regarding males and females
- Average age and standard deviation,
- The ratio of suicidal cases male vs female
- The ratio of suicidal attempts male vs female
- Preferred methods,
- The frequency of the cases within time, weather, month, season etc.
- Urban vs rural zones
- The incidence level in municipality and region

RESULTS

The group age with the highest number of cases was 21-30 and the average age was 29 with a standard deviation of 1.16. Males commit suicide 3.12 times more than females, but females attempt suicide 3.5-4 times more than males. Hanging was the main method used, respectively 40 % of the cases, fire arms 30 % of the cases. The highest frequency was during day time 9-12 a.m. an d in the evening 5-8 p.m., and when it comes to season, it was mainly in summer and spring, more respectively in May and July. Rural areas lead versus urbane ones with greater number of cases, 65.7 % versus 34. 3 %. The victims of suicide are mainly single. Notes were found only in 2 cases. Self-poisoned, based on the data offered by the Regional Hospital "Daut Mustafa" in Prizren, were 15 cases. One of the risk factors, often mentioned on the police reports, was high stress that is linked with psycho-social and economical factors.

From this study results that the incidence level is 0.039 (/1000 inhabitants), whereas when it comes to municipalities, Rahoveci leads with a level of 0.072 and the last ranked or lowest level is in Dragash 0.029. In region level, the prevalence level is 0.018 (/100 inhabitants), and in municipalities, Rahoveci again leads with a level of 0.036, and Prizreni has the lowest one, 0.036. According to the last registration, Kosova has a population of 1733872 inhabitants, and within a ten year period, 2000-2010, there were 624 cases of suicide and the average of the cases per year would be 62.4, respectively 3.6 cases in 100.000 inhabitants. Thus, if we compare it with our neighbour countries like Albania, which has a rate of 4.0, Macedonia 8.0, Bosnia and Herzegovina 11.8 or Serbia 19.5 cases (100.0000 inhabitants) [1] Or if we compare with the global rate of suicide 16/ 100.000[2], we can conclude that Kosova has the lowest rate of suicide compared to our neighbor countries or even the global rate of suicide.

DISCUSSION

In the post war period in Kosova, there is an increased number of divorces, unemployment and pretty worse economical situation. As mentioned in the research, this might be one of

[1] http://www.worldlibrary.org/articles/list_of_countries_by_suicide_rate (taken on January 18th 2012)
[2] http://www.who.int/mental_health/prevention/suicide/charts/en/ (taken on January 24th 2012)

very influential factors that can impact the incidence and prevalence rate of suicide, factors that were considered carefully in this research. Factors vary also from age, socio-economical status they have in kosovar society etc.; in middle age people, factors might be unemployment, desperation in marriage and in profession, dull perspective of the future, whereas after fifties factors might be a bit different, like diseases that might be of psychological and physical nature, losing the partner, not being able to adapt with the life after being retired, etc. However, apart from the factors mentioned above, there are a lot of other factors that might lead to intensifying fatal suicidal cases, such as war traumas, transition period and rapid changes in families and society as a whole. We also think that fading of social values such as solidarity, social support, individualization and so on might have a great impact on the phenomenon of suicide. It is scientifically confirmed that the feeling of being hopeless, is one of the main factors regarding suicide incidence, and this is also confirmed by diagnostic criteria according to DSM IV and ICD 10.

All the aforementioned factors make people feel pessimistic, lose the meaning of life and make them go through a psychological stressful phase, which eventually make them see suicide as the only possible solution. Being incapable of solving economical and social difficult problems and the pressure to be successful are considered as two of the main reasons that lead to suicide in our country.

CONCLUSIONS

Even though the rate of suicide in Kosova seems to be the lowest in region, the situation remains worrying especially when we consider the growth of the incidence comparing to previous five years. This requires a professional and multidisciplinary engagement to build a strategy in country level, based on the experiences of other countries, so we are capable to deal with such phenomenon and decrease the incidence level. Unfortunately, Kosova doesn't have the commodity of national suicide preventive programs, which requires a solid financial and professional infrastructure. As a country that has just come out of a recent war with a lot of catastrophic psychological and economical consequences, being in transition, lacking financial resources, and without proper socio-economical studies of the phenomenon in question, cannot be able to build up a strategy in the required level, but nevertheless this should not prevent the efforts to reach this level gradually.

It is the duty of the Ministry of Health, the Ministry of work and social welfare and the whole society to engage all the necessary and possible human resources, academics, doctors, psychologists, social workers, health service workers, especially mental health service workers, to share their opinions and experiences and to make together a plan of action to prevent this increasing phenomenon. We are fully aware, and this is shown by the experience of other countries, that for such national strategies, only a good will is not enough, as this can be achieved only if it is supported financially, by starting decreasing the high level of unemployment, opening new work places, having a systematic psycho education of the society, building up a strong and effective social network, and consequently decreasing the level of poverty and aiming a better and more qualitative life.

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