第105回日本精神神経学会総会

シンポジウム

Muslim Suicide : Kashmir Experience

Arshad Hussai (Jquarter Benina Medical College Hospital, India)

Background

Kashmiri language doesn't have a word for suicide and thus speaks volumes about rarity of the phenomenon in Kashmiri society. Kashmir being predominantly a Muslim society had expectedly lowest rates of suicide in whole of India, things have changed and changed for worst, suicidal behavior has become one of the commonest emergencies in medical casualties of Kashmir. The rates are as high as 13/100,000, very close to rate in rest of India i. e. 10.3/100,000. Declining religious values, lack of religious education, nuclearization of families, and ever increasing expectation of performing, unemployment are interacting with chronic conflict stress and ever increasing mental health problems to create a health problem of the magnitude that needs urgent and emergency redressed.

Method

This study was based on data from, longitudinal medico legal registers of S.M.H.S Hospital ; a 1,000 bedded associated hospital of Govt. Medical College Srinagar. The registers were screened and surveyed for all suicide, parasuicide and deliberate self harm (DSH) cases. Medical record number—a unique registration number-was used for identification of case files of suicide, parasuicide and deliberate self harm cases.

Results

The result of the study reveal that on an average 3.5 persons report / day to SMHS causality with suicide, parasuicide and deliberate self harm from list 3 years. Most of the people who complete suicide are males of the age group 25-34. Most of the attempts are made by female, 4 times parasuicides and 7 times more deliberate self harm. Consumption of organ phosphorous like compound is the commonest mode of suicide followed by consumption of other drugs like benzodiazepines, tricyclic antidepressants etc. Violent methods of suicide like cut throat and burning are new phenomenon and predominantly present in people with schizophrenia and severe melancholic depression. All types of suicidal behavior are common in age group 25-34 except DSH in females were 63% are in age group 19-24 years. Major depressive disorder was present in 73% of people with parasuicide, with post traumatic stress disorder as co-morbidity in 15% of them, Substance use disorders were present in 53% of males as a co-morbidity. Cases with DSH-79% did not have any axis I diagnosis this phenomenon was much more common in females 92% of them did not have an axis I diagnosis. In males with DSH 57% did not have any axis I diagno-

sis, 32% of them had substance use disorder and 10% of had diagnosis of borderline personality disorder.

Conclusion

Suicide as health problem has announced its arrival in an unlikely socio-religious scenario and perhaps taking all health planners unawares. And preventive strategies at all levels from primordial to primary to secondary to tertiary need to be taken to address this problem. From maintaining suicide registers to making mental health available and accessible we have a Herculean task on our hands. Religious cognitive reappraisal at community level looks to be an effective maneuver to combat this problem.

（この論文は抄録集より転載しました）