A Buddhist Approach to Suicide Prevention

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The majority of the Thai population is Buddhists and Buddhism has a great deal of influence on their mind, character, way of life, and health, particularly mental health. According to the Four Noble Truths (Cattāri ariyasaccani), suicide is a form of suffering that is originated from craving (Taṇhā). Therefore, human beings cannot avoid suffering by taking their own lives, nor do they escape from "the wheel of suffering" by doing so. Moreover, the consequence of suicide is a rebirth in the woeful planes of existence, and hence further suffering endlessly.

From the present study, the Buddhist approach to suicide prevention can be considered in the following areas: 1) Buddhist attitude toward suicide, 2) faith and confidence in life after death, 3) providing monks with general knowledge and understanding about suicide and life after death, 4) early identification of mental disorders, persons at risk of suicide and prompt referral to appropriate mental health professionals, 5) control of access to instruments of suicide, 6) control of alcohol and drug abuse, 7) prevention of HIV infection, 8) responsible media reporting and 9) practice of meditation.

Keywords: *Four Noble Truths, Suicide, Suffering, Craving, Woeful planes of existence, Meditation*

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Buddhism has been regarded as the national religion of Thailand from time immemorial. Almost 92 percent of Thai people are Buddhist, and the monarchy must be Buddhist in accordance with the national constitution. Buddhism has been the philosophy of life for Thai people for more than a thousand years and it has a strong and significant influence upon their mind, character, way of life, and mental health. The Buddhist institution also has a profound impact on Thai traditional culture and civilization as well as the creative forces behind language, literature, architecture, painting, sculpture, fine art, drama, song, and music[1].

Suicide Rate in Thailand

The suicide rate in Thailand is now 7-8/100,000 population per year. It began showing a tendency to increase in 1983 and reached a peak in 1999, although since then it has been declining gradually. Data from 1991 to 2001 indicates that the suicide rate in Thai men has increased while the rate in women remained unchanged. The most common age group in men for suicide has been 20-29 years, but during 1998-2002 an increasing tendency to commit suicide has been noted in older persons (Fig. 1).

The highest suicide rate was found in the Northern region of Thailand, especially in Chiang Mai, Lamphun, Chiang Rai, and Phayao provinces, where there are also a high number of HIV-infected persons. It is speculated that these two factors are related[2].

Suicide is Suffering

The heart of the Buddha's teaching lies in the Four Noble Truths (Cattāri Ariyasaccāni), which he expounded in his very first sermon entitled "The Great Discourse on the Turning of the Wheel of Dhamma (Dhammacakkappavattana Sutta)" to the five ascetics at Isipatana (modern Sarnath) near Benares. The Four Noble Truths are 1) suffering 2) the origin of suffering 3) the cessation of suffering and 4) the way leading to the cessation of suffering[3,4].

The word suffering is translated from the Pali word "Dukkha", which means suffering, pain, sorrow, or misery. It is generally thought that the term Dukkha

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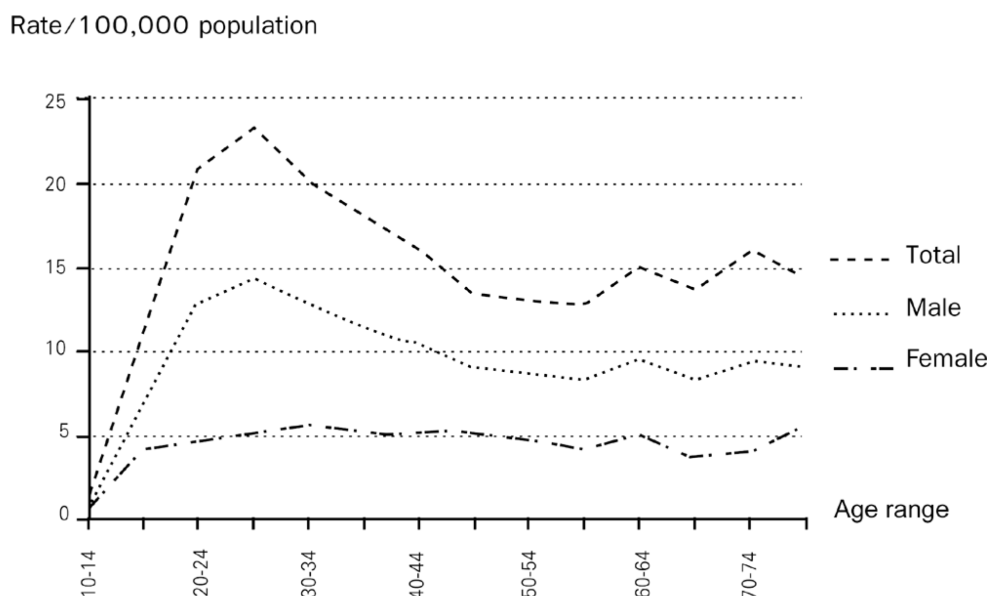

Fig. 1 The suicide rate classified by age range between 1998-2002[2]

in the First Noble truth contains not only the ordinary meaning of "suffering", but also deeper philosophical ideas such as "unsatisfactoriness", "unpleasantness" or "unendurability". Therefore, it is difficult to find one word to embrace the whole conception of the term "Dukkha"[5].

The concept of Dukkha can be viewed from three aspects: 1) Dukkha as ordinary suffering (Dukkha-dukkha), 2) Dukkha as produced by change (Vipariṇama-dukkha), and 3) Dukkha as conditioned states (Saṅkhāra-dukkha)[6]. Birth, old age, sickness, death, sorrow, lamentation, physical pain, grief, despair, association with unpleasant persons and conditions, separation from loved ones, and not getting what one wants are included in Dukkha as ordinary suffering[3,4,6]. According to this viewpoint, it can be seen that suicide is associated with ordinary suffering.

Everything in this world is subject to change. A happy situation in life, which eventually leads to unpleasant feelings, is not permanent or everlasting. It changes sooner or later. When it changes, it produces pain, suffering, unhappiness, dissatisfaction, low self-esteem, feeling of emptiness, and even suicide. This is suffering as produced by the change or impermanent nature of existence. In addition, feelings of happiness require a constant condition for maintenance, but in reality, they are subject to continual rising and falling. The third form of suffering is related to the oppressive nature of all formations of existence. All conditioned or compounded phenomena are impermanent, unsatisfactory, and selfless. Therefore, everything is subject to the three universal characteristics, namely, the impermanence (Anicca), the suffering (Dukkha), and the egolessness (Anattā) Strictly speaking, suicide is related to the three aspects of suffering as mentioned.

The Origin of Suicide

Since suicide is a form of suffering, its origin, according to the Four Nobel Truths, must derive from craving or desires (Taṇhā). Craving is divided into three types, namely, 1) craving for sensual pleasure (Kāma-taṇhā), 2) craving for existence (Bhāva-taṇhā), and 3) craving for non-existence (Vibhāva-taṇhā)[7,8]. Craving for sensual pleasure arises from a desire for attractive and desirable objects regarding forms, sounds, odors, tastes, and touch. Human beings are often compelled to search for and preserve this type of craving, such as a luxurious and comfortable house, new model cars and new fashion clothes and the like. However, sometimes we feel very disappointed and desperate when we cannot get what we want. Craving for existence refers to desire to have and to be; for example, in this very life, everybody wants to be endowed with good luck, dignity, praise, and happiness. Craving for non-existence, which is contrary to the second type, denotes the negative aspects that are expressed by the desire

not to have and not to be. Nobody wants to encounter bad luck, disgrace, blame and suffering in his or her daily living[4].

The third type of craving may be accompanied by the wrong view, which holds that "nothing remains after death; there is complete annihilation of life"[4,9,10]. In Sanskrit, the meaning of Vibhāva-taṇhā also includes " craving for power" which is the power to control or even to destroy other people and oneself. In other words, some people believe that suicide is the final solution or the end of all suffering. Thus, a suicidal or homicidal impulse can be considered as a type of craving for non-existence. Of these three types, craving for non-existence is closely related to a suicidal impulse. In fact, suicide can be the outcome of any type of craving.

Conceptual Models

Suicide is the act of killing oneself, which is deliberately initiated and performed by the person concerned in full knowledge or expectation of its fatal outcome. Suicidal acts with a non-fatal outcome are labeled suicide attempts, attempted suicides, parasuicides or acts of deliberate self-harm. There is a growing tendency among experts in the field to broaden the concept of suicide, and the term "suicidal behavior" is used instead[11].

Conceptual models relevant to prevention of suicide consist of 1) the medical model, 2) the sociological model, and 3) the human-ecological model[11]. According to the most widely accepted medical model, suicide is a sign or consequence of a mental disorder; in other words, a mental disorder acts as the agent, and suicide is the outcome and target for preventive action. Successfully treating a person for this type of mental disorder would consequently reduce or prevent suicide[12].

Regarding the socio-cultural model, Durkheim categorized suicide as anomic, altruistic, egoistic, and fatalistic[13,14]. He considered anomic suicide, the result of weak or absent norms or standards, as a prototype of suicide. An analysis of social categories indicates that the high-risk group for suicide includes men, the elderly (and more recently, young people in some places), ethnic minorities, people living alone, the unemployed and migrants[15]. Preventive activities, therefore, first need to identify various variables that may lead to suicide. Perhaps one of the most widespread measures taken so far has been the setting-up of suicide prevention centers, but their effectiveness has yet to be demonstrated[16,17].

The human-ecological model sees suicide as the final step in a series of independent but interrelated factors i.e. socio-cultural and physical environment. According to this model, the primary prevention of suicidal acts emphasizes on reducing or restricting access to the means of committing suicide by focusing on this potentially lethal act and its immediate personal and environmental circumstances[11]. For instance, a reduction in the availability of firearms should be attempted, as these weapons are one of the most efficient means of committing suicide[18].

Risk Factors

The presence of a psychiatric disorder, including alcohol and drug abuse, is the strongest risk factor for suicide. In a study of 5,412 hospitalized psychiatric patients, the risk of suicide was between 11 and 67 times higher than a control population for patients with acute or chronic schizophrenia, affective disorders, or a problem with alcohol or other drug abuse[19]. Mood disorder is the most frequently observed diagnosis[20-24]. The relation between a mood disorder, completed suicide, and attempts at suicide is shown in Fig. 2[21].

Other risk factors for suicide include being male, over 50 years old, living alone and having a physical illness. For alcohol-dependent people, the recent loss of someone close is a risk factor[25]. Previous suicide attempts are associated with an increased risk of suicide in psychiatric patients[26,27]. The loss of a parent when a child is between the ages of 6 and 14 is an especially common risk factor in later suicides[28].

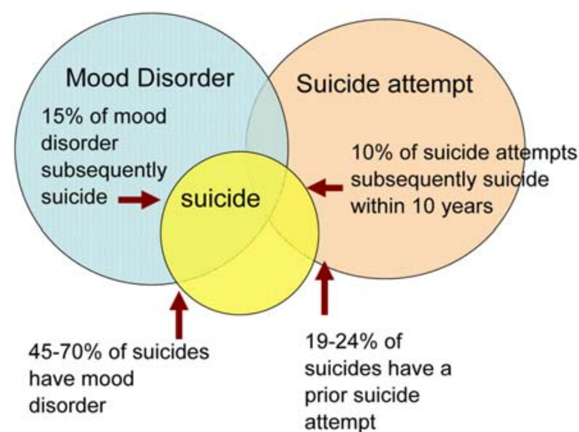

Fig. 2 Diagram summarizing suicide data and its relation to mood disorder and suicidal attempts[21]

Suicide rates may be related to access to instruments of suicide. For instance, suicide rates were found to decrease among people aged between 15 and 24 when access to handguns was restricted[29,30]. On the contrary, a recent study found that the presence of one or more guns in the home was associated with an increased risk of suicide[31].

Buddhist Prevention Measures

Mental health organizations in Thailand have developed different programs of suicide prevention for the nation. They are designed to encourage or empower groups or individuals to work together. From the authors' viewpoint, a Buddhist approach to suicide prevention can be taken in the following areas:

1) Buddhist attitude toward suicide.

2) Faith and confidence in life after death.

3) Providing monks with general knowledge and understanding about suicide and life after death.

4) Early identification of mental disorders and persons at risk of suicide and prompt referral to appropriate mental health professionals.

5) Control of access to instruments of suicide.

6) Control of alcohol and drug abuse.

7) Prevention of HIV infection.

8) Responsible media reporting.

9) Practice of meditation.

1. Buddhist attitude toward suicide

According to the code of monastic discipline (Vinaya), a monk should not attempt suicide or encourage another person to commit suicide[32-35]. In fact, suicide or suicidal behavior is motivated by cravings, particularly craving for non-existence or destruction (Vibhāva-taṇhā). Buddhist morality usually begins with the Five Precepts (Pañca-sīla) that people are strongly advised to observe if they wish to make spiritual progress. The first precept is to abstain from killing other beings. This precept also includes the act of murdering and suicide.

However, according to Buddhist doctrine, human beings cannot avoid suffering by taking their own life, nor do they escape from the "wheel of suffering" by doing so. Suicide is the outcome of the desire to annihilate oneself and the fruit of that act is a rebirth in the woeful planes of existence, and hence further suffering endlessly[36-38].

2. Faith and confidence in life after death

Life is not just limited to one single lifetime, but it is subject to the cycle of death and rebirth (Saṁsāra). Death is due to four causes, namely (1) expiry of life-span, (2) the cessation of action (kammic) forces, (3) a combination of the above two, and (4) untimely death due to interrupting action of kammic force (Upacchedaka kamma). An apt analogy of the four causes of death is extinguishing the flame of an oil lamp. The possible causes are (1) exhaustion of fuel, (2) a burnt out wick, (3) a combination of (1) and (2), and (4) external cause such as a sudden gust of wind or someone intentionally blowing the flame[37].

Untimely death (Upaçchedaka or Upagkādaka kamma) is associated with a powerfully evil kammic effect. Among the four classes of death, untimely death is common nowadays because most people live without, mindfulness (Sati) and clear comprehension (Sampajañña). In other words, their lives are closely associated with heedlessness (Pamāda). Suicide is also considered as a kind of untimely death.

In Abhidhamma Pitaka, when a person is approaching death, he or she needs good quality of mind. If a wholesome thought process, in the form of unconscious impulses, prevails to the moment of death that person will be reborn in the blissful planes of existence, which include the human world, realm of the gods (celestial beings) and realm of divine beings of the Form or Formless Spheres[36,37].

On the contrary, if a person has unwholesome impulses at the moment of death, they will be reborn in the woeful planes of existence, which consist of hell (Niraya), hungry ghosts (Peta), demons (Asurakāya), and the animal kingdom (Tiracchāna)[37]. Hence, suicide is not the way to end suffering. Since suicide is a form of craving and craving is the cause of suffering, any person who commits suicide cannot escape suffering and they have to be reborn in the woeful planes of existence.

Pertaining to Buddhist psychological viewpoint, any person who tries to attempt suicide is usually motivated by anger or aggressive impulse (Dosa). This concept is strikingly supported by the psychodynamics of suicide in psychiatry. For instance, in his paper "Mourning and Melancholia", Sigmund Freud postulated that suicide results from displaced murderous impulse against the self. In other words, suicide represents aggression turned inward against an introjected, ambivalently cathected love object[39,40]. Karl Meninger, in "Man against himself", believed at least three wishes might contribute to a suicidal act: 1) the wish to kill, 2) the wish to be killed, and 3) the wish to die. He conceived of suicide as inverted homicide because of a patient's anger toward another person. This retroflexed

murder is either turned inward or used as an excuse for punishment.

According to Buddhist doctrine, any person who makes a suicide attempt due to anger or aggressive impulses is bound to be reborn in the realm of hell (Niraya) or other woeful planes of existence after death. Some suicidal persons may have fantasies, which often include escape or sleep, rescue, rebirth, reunion with the dead or even a new happier life. Such fantasies or beliefs cannot become true because they are contrary to the Buddhist viewpoint.

3. Providing monks with general knowledge and understanding about suicide and life after death

Buddhism has become so integrated with the Thai way of life that the two are hardly separable. Buddhist influence can be detected in Thai character, traditions, arts, literature, architecture, language, and all other aspects of Thai culture[1,42,43]. In Thai society, monks or Sangha members play a significant role in the field of mental health. Most Thai people tend to consult monks when they have personal or psychological problems, including some persons with suicidal thoughts or impulses. Many monks are capable of giving good advice and counseling to these persons in dealing with their stress, anxiety, and emotional problems.

The monks usually use the Buddhist doctrine and their own experience to console and teach those who are afflicted with different kinds of mental problems. Therefore, in order to help suicidal persons effectively, they must have the general knowledge and understanding about suicidal persons, particularly with regard to risk factors, etiology, and suicide prevention[11,44]. Additionally, they must have good knowledge about the processes of death and life after death according to Buddhist psychology. They must realize the fact that any kind of suicidal acts is not the right way to escape or end mental suffering.

4. Early identification of mental disorders and persons at risk of suicide and prompt referral to appropriate mental health professionals

Since the presence of a psychiatric disorder, especially in association with alcohol and drug abuse, is the strongest risk factor for suicide, prevention and early treatment of psychiatric disorders would undoubtedly have a significant effect on the number of suicides[11,21,44]. Educational programs should be provided to teach monks how to recognize or detect mental disorders as early as possible and promptly refer patients to mental health professionals for effective treatment. This approach is an important strategy in the prevention of suicide.

Several Buddhist universities, institutes and temples have developed this kind of educational program or mental health curriculum so that monks can learn about mental disorders, alcohol and drug abuse, and risk factors associated with suicide as well as early intervention focusing on primary and secondary prevention. After graduation, a large number of monks returned to their hometowns or villages and establish the programs in the temples or villages to promote mental health and to reduce the rate of suicide in their communities.

5. Control of access to instruments of suicide

In the doctrine of the Noble Eightfold Path (Aṭṭhaṅgika-magga), particularly with regard to Right Livelihood (Sammā-ājīva), there are five kinds of trade with that described by the Buddha as wrong. They include dealing in weapons, human beings, meat, liquor, and poison. Avoiding these kinds of trade and earning a living by a blameless trade is called Right Livelihood[6,8,45]. Buddhists are advised to abstain from a livelihood that brings harm to other beings, such as trading in arms, intoxicating drinks, and poison. Therefore, the practice of Right Livelihood is related to the primary prevention of suicide, as it has a great deal of impact on the control of guns, other weapons, poisons and toxic substances which are all commonly used for committing suicide.

6. Control of alcohol and drug abuse

To refrain from the heedless use of alcohol, intoxicants, and drugs is one of the Five Precepts commonly practiced among lay Buddhists[3]. Alcohol and drug abuse are major risk factors associated with suicidal behavior[11,44]. If Sangha members or monks try to encourage people to observe the basic Five Precepts and follow the Right Livelihood strictly and regularly, indulgence in alcohol and drug abuse would be significantly reduced.

7. Prevention of HIV infection

One of the Five Precepts is to refrain from committing adultery or sexual misconduct. The Five Precepts (Pañca-sīla) are commonly observed together with the Five Ennobling Virtues (Pañca-dhamma). One of the Five Ennobling Virtues is sexual restraint[45]. Any person who refrains from sexual misconduct and has sexual restraint is guaranteed against involvement in

sexual promiscuity and HIV infection. Hence, practicing the Five Precepts and Five Ennobling Virtues can contribute to the primary prevention of HIV infection, which is a major risk factor of suicide.

8. Responsible media reporting

Sangha members or monks have the responsibility of propagating Buddhist teaching through different forms of media, such as radio, television, newspapers, and magazines. The doctrines of the Four Noble Truths, Law of Kamma, rebirth, wheel of suffering (Saṁsāra) and others should be taught to lay Buddhists through these media[9,46-48]. This kind of approach can minimize the unnecessary reporting of suicide in the popular media and may be helpful in reducing suicide rates, particularly with regard to "copycat" suicides[11].

Newspaper reports of suicides in the subway system of Vienna have been correlated with subsequent suicide rates, thus confirming studies done in Canada, the Netherlands, the United Kingdom, the USA, and other countries[49,50]. The media could therefore undertake the responsibility of reducing the suicide rate by limiting graphic and unnecessary depictions of suicide and instead promoting appropriate and relevant religious teaching.

9. Practice of meditation

In Buddhism, there are two forms of meditation or mental development, namely, (1) concentration meditation (Samatha bhāvanā) and (2) insight meditation (Vipassanā bhāvanā)[51]. The purpose of concentration meditation is the development of calmness, tranquility, peacefulness, and stability of the mind. This form of meditation is conducive to non-distraction and one-pointedness of the mental state. Loving-kindness (Metta) meditation is a form of concentration meditation that is commonly practiced to control anger or aggressive defilement (Dosa), which is closely associated with suicide[36].

Contemporary suicidologists believe that suicidal persons usually have fantasies associated with wishes for revenge, anger, aggression, power, control, or punishment. Suicidal persons tend to act out suicidal fantasies because of a loss of loved objects or a narcissistic injury; they may experience overwhelming affects like rage and guilt, or identify with a suicide victim[21]. These persons can be advised to practice the extension of loving-kindness (Metta bhāvanā) to themselves and others in order to counteract the destructive effect of introjected aggressive impulses.

Another form of meditation is insight meditation, which is essentially a Buddhist contribution to the spiritual wealth of the world. This is a method of analysis in which the emphasis is placed on the development of mindfulness (Sati) and wisdom (Paññā) of Ultimate Reality. The words, Ultimate Reality, refer to the Three Universal Characteristics (Tilakkhaṇa) of compounded things, which include Impermanence (Anicca), Suffering (Dukkha), and Egolessness or Non-self (Anattā). All things in this world are characterized by the Three Universal Characteristics and in the ultimate analysis, there is nothing that should be attached to as "I", "Mine", "Ego", or "Self". This kind of wisdom and insight can lead someone to understand the concept of non-attachment[51]. Through this understanding, the craving that is the primary cause of suicide will be significantly reduced. Insight meditation helps to purify the mind of defilements, such as greed (Lobha), anger (Dosa), and delusion (Moha), and it can free the mind from suicidal thoughts and impulses. In general, meditation helps to create will power, and increase self-confidence and self-esteem. Meditation not only promotes mental health, but it is also an effective means for the primary prevention of various mental disorders and suicide.

To the contrary, it should be aware that there might be some negative aspects of meditation. For example, in the Tipitaka, Book of Vinaya, Parajika, many monks committed suicide, asked, or even hired other persons to kill them after the Buddha had taught Asubha Kammaṭṭhāna which is the meditation of corpses at different stages of decay. After the Buddha had left, many monks had developed the intense feeling of disgust toward their bodies to the point that they decided to kill themselves[52]. In addition, there are some people who developed various kinds of behavioral change or psychotic symptoms, which were induced by the meditation[53].

In conclusion, the World Health Organization has developed steps to prevent suicide in many areas, such as identification and treatment of people suffering from mental disorders, restriction of access to instruments of suicide, control of alcohol drugs and toxic substances, and responsible media reporting[11]. The authors have presented the Buddhist approach to suicide prevention by trying to integrate the relevant doctrines of the Buddha with those topics as mentioned.

References

1. Chandra-ngarm S. Buddhism and Thai people. 2nd ed. Chiang Mai: Ming Muang Printing Press; 2000.

2. Lortrakul M. Suicide. In: Udomratn P, editor. Epidemiology of mental health problems and psychiatric disorders in Thailand. Songkha, Thailand: Linbrother Printing; 2004: 61-81.
3. Sayadaw M. The great discourse on the turning of the wheel of dhamma (Dhammacakkappavattana Sutta). Bangkok: Buddhadhamma Foundation; 1996.
4. Disayavanish C. Psychology of the extinction of suffering. Chiang Mai: Klangweing Printing Press; 2001.
5. Rahula W. What the Buddha Taught. New York: Grove Press Books; 1974.
6. Mahathera N. Buddhist dictionary: manual of Buddhist term and doctrines. 4th rev. ed. Kandy, Sri Lanka: Buddhist Publication Society; 1988.
7. Bhikkhu Bodhi. The Buddha and his dhamma: two lectures on Buddhism. Kandy, Sri Lanka: Buddhist Publication Society; 1999.
8. Gunaratana BH. Eight mindful steps to happiness: walking the Buddha's path. Boston: Wisdom Publication; 2001.
9. Venerable Ledi Sayadaw. The manual of dhamma. Maharastra: Vipassana Research Institute; 1999.
10. Phradhammapidok (P.A. Prayutto). Buddhadhamma. 6th ed. Bangkok: Mahachulalongkaranarajvidhayalai Printing Press; 1995.
11. World Health Organization. Primary prevention of mental, neurological, and psychosocial disorders. Geneva: WHO; 1998: 75-90.
12. Diekstra R. The epidemiology of suicide and parasuicide. In: Diekstra R, Gulbinat R, De Leo D, Kienhorst I, editors. Preventive strategies on suicide. Leiden, Netherland: Brill; 1995: 1-34.
13. Charon JM. The meaning of sociology. New Jersey: Prentice-Hall; 1980.
14. Durkheim E. Le suicide (Suicide). Paris: Presse Universitaire de France; 1990.
15. World Health Organization. Prevention of suicide. (Public Health Paper, No. 35). Geneva: WHO; 1968.
16. Ettlinger R. Evaluation of suicide prevention after attempted suicide. Acta Psychiatr Scand Suppl 1975; 260: 1-135.
17. Barraclough BM, Jennings C. Suicide prevention by the Samaritans. A controlled study of effectiveness. Lancet 1977; 2: 237-9.
18. Lester D. Preventing suicide by restricting access to methods for suicide. In: Diekstra R, Gulbinat R, De Leo D, Kienhorst I, editors. Preventive strategies on suicide. Leiden, Netherland: Brill; 1995: 163-72.
19. Black DW, Warrack G, Winokur G. The Iowa record-linkage study. I. Suicides and accidental deaths among psychiatric patients. Arch Gen Psychiatry 1985; 42: 71-5.
20. Sudak HS. Suicide. In: Sadock BJ, Sadock VA, editors. KAPLAN & Sadock's comprehensive textbook of psychiatry. Vol. 2. 8th ed. Philadelphia: Lippincott Williams & Wilkins; 2005: 2442-53.
21. Sadock BJ, Sadock VA. Synopsis of psychiatry: behavioral sciences/clinical psychiatry. 9th ed. Philadelphia: Lippincolt Williams & Wilkins; 2003.
22. Puri BK, Laking PJ, Treasaden IH. Textbook of psychiatry. 2nd ed. Edinburgh: Churchill livingstone; 2002.
23. Maris RW. Suicide. Lancet 2002; 27: 319-26.
24. Lagomasio IT, Stern TA. The suicidal patient. In: Stern TA, Herman JB, Slavin PL, editors. Guide to primary care psychiatry. 2nd ed. New York: McGraw-Hill; 2004: 127-35.
25. Murphy GE, Wetzel RD, Robins E, McEvoy L. Multiple risk factors predict suicide in alcoholism. Arch Gen Psychiatry 1992; 49: 459-63.
26. Goldstein RB, Black DW, Nasrallah A, Winokur G. The prediction of suicide. Sensitivity, specificity, and predictive value of a multivariate model applied to suicide among 1906 patients with affective disorders. Arch Gen Psychiatry 1991; 48: 418-22.
27. Kerkhof AJ, Diekstra RF. How to evaluate and deal with acute suicide risk: guidelines for health care workers. In: Diekstra R, Gulbinat R, De Leo D, Kienhorst I, editors. Preventive strategies on suicide. Leiden, Netherland: Brill; 1995: 97-128.
28. Lester D. Experience of parental loss and later suicide: data from published biographies. Acta Psychiatr Scand 1989; 79: 450-2.
29. Rich CL, Young JG, Fowler RC, Wagner J, Black NA. Guns and suicide: possible effects of some specific legislation. Am J Psychiatry 1990; 147: 342-6.
30. Sloan JH, Rivara FP, Reay DT, Ferris JA, Kellermann AL. Firearm regulations and rates of suicide. A comparison of two metropolitan areas. N Engl J Med 1990; 322: 369-73.
31. Kellermann AL, Rivara FP, Somes G, Reay DT, Francisco J, Banton JG, et al. Suicide in the home in relation to gun ownership. N Engl J Med 1992; 327: 467-72.
32. Pio E. Buddhist psychology: a modern perspective. New Delhi: Abhinav a Publications; 1988.
33. Bhikkhu Pesala. The debate of King Milinda. Delhi: Motilal Banarsidass Publishers PVT; 1991.
34. Mendis KNG. The questions of King Milinda: an

abridgement of the Milindapanha. Kandy, Sri Langka: Buddhist Publication Society; 1993.
35. Ericker C. Buddhism. London: Hodder Headline PLC; 1995.
36. Narada Maha Thera. A manual of Abhidhamma. (Abhidhammattha Sangaha). 4th rev. ed. Jakarta: Yayasan Dhammadipa-Arama; 1979.
37. Janakabhivamsa A. Abhidhamma in daily life. Yangon: The Religious Affairs Department Press; 1997.
38. Sayadaw M. A discourse on dependent origination. Bangkok: Buddhadhamma Foundation; 1999.
39. Freud S. Mourning and melancholia (1917). In: Strachery J, editor. The standard edition of the complete psychological works of Sigmund Freud. Vol. 14. London: Hogarth Press; 1963: 237-60.
40. Gabbard GO. Psychodynamic psychiatry in clinical practice. 3rd ed. Washington, DC: American Psychiatric Press; 2000.
41. Menninger KA. Psychoanalytic aspects of suicide. Int J Psychoan 1933; 14: 376-90.
42. Plamintr S. Getting to know Buddhism. Bangkok: Buddhadhamma Foundation; 1994.
43. Dhammananda DS. Buddhism for the future. Taipei: The Corporate Body of The Buddha Educational Foundation; 2000.
44. Bostwick JM. Suicidality. In: Wise MG, Rundell JR, eds. Textbook of consultation-liaison psychiatry. 2nd ed. Washington, DC: American Psychiatric Publishing; 2002: 127-48.
45. Phradhammapidok (P.A. Prayutto). Dictionary of Buddhism. Bangkok: Mahachulalongkoranarajavidhayalai, 1995.
46. Mahathera N. Karma and rebirth. Kandy, Sri Langka: Buddhist Publication Society; 1982.
47. Malasekera GP. Aspects of reality as taught by Theravada Buddhism. Kandy, Sri Langka: Buddhist Publication Society; 1982.
48. Thittila A. Essential themes of Buddhist lectures. Yangon: Department of Religious Affairs; 1996.
49. Etzersdorfer E, Sonneck G, Nagel-Kuess S. Newspaper reports and suicide. N Engl J Med 1992; 327: 502-3.
50. Phillips DP, Lesyna K. Suicide and the media: research and policy implications. In: Diekstra R, Gulbinat R, De Leo D, Kienhorst I, editors. Preventive strategies on suicide. Leiden, Netherland: Brill; 1995: 231-62.
51. Disayavanish C. Insight meditation and emotional quotient. Chiang Mai: Sangsilpa Printing Press; 2006.
52. The Tripitaka, Book of Vinaya (Discipline), Parajika (Thai Version) Book 1: 339.
53. Disayavanish C, Disayavanish P. Meditation-induced psychoses. J Psychiatr Assoc Thai 1984; 29: 1-12.

แนวปฏิบัติเชิงพุทธต่อการป้องกันอัตวินิบาตกรรม

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ส่วนใหญ่ของประชากรชาวไทยเป็นพุทธศาสนิกชนและพุทธศาสนามีอิทธิพลอย่างมากต่อจิตใจ อุปนิสัย วิถีชีวิต และสุขภาพโดยเฉพาะอย่างยิ่งสุขภาพจิต ตามหลักอริยสัจจ์ 4 อัตวินิบาตกรรมหรือการฆ่าตัวตาย ถือว่าเป็นความทุกข์ อย่างหนึ่งซึ่งมีสาเหตุมาจากความอยาก (ตัณหา) ดังนั้นมนุษย์จึงไม่สามารถหลีกเลี่ยงความทุกข์ได้ โดยการฆ่าตัวตาย หรือ ไม่สามารถหลีกหนีจาก "วงจรของความทุกข์" ด้วยการกระทำเช่นนี้ ยิ่งกว่านั้นผลของการฆ่าตัวตายคือการเกิดใหม่ใน ทุคติภูมิ และยิ่งทำให้เกิดความทุกข์ยืดเยื้อต่อไปอีกไม่มีสิ้นสุด

จากการศึกษาแนวปฏิบัติเชิงพุทธต่อการป้องกันการฆ่าตัวตาย มีเรื่องต่าง ๆ ที่สามารถพิจารณาได้ดังต่อไปนี้ 1) เจตคติเชิงพุทธต่ออัตวินิบาตกรรม 2) ศรัทธาและความเชื่อในเรื่องชีวิตหลังความตาย 3) การถวายความรู้ และความเข้าใจเกี่ยวกับอัตวินิบาตกรรมและชีวิตหลังความตาย แด่พระภิกษุสงฆ์ 4) การตรวจหาความแปรปรวนทางจิตใจตั้งแต่แรก ผู้ที่เสี่ยงต่อการฆ่าตัวตาย และการส่งต่อผู้ที่มีปัญหาอย่างทันท่วงทีไปพบผู้เชี่ยวชาญทางสุขภาพจิตที่เหมาะสม 5) การควบคุมการใช้อาวุธเพื่อทำลายตนเอง 6) การควบคุมการใช้สุราและสารเสพติด 7) การป้องกันการติดเชื้อเอดส์ 8) การรายงานทางสื่อที่ต้องมีความรับผิดชอบ และ 9) การเจริญกรรมฐาน

1. On suicide and assisted suicide in antiquity see van Hooff, Anton J. L., From Autothanasia to Suicide: Self-Killing in Classical Antiquity (Routledge, 1990). 2. A.iii.451. 3. Buddhism believes in reincarnation or rebirth.Â 5. A noteworthy exception to this is Florida, Robert E., Buddhist Approaches to Euthanasia 22 Studies in Religion/Sciences Religieuses 35 (1993).Â A broader discussion of suicide will be found in a forthcoming book on Buddhist ethics by Peter Harvey to be published by Cambridge University Press entitled An Introduction to Buddhist Ethics: Foundations, Values and Issues, and I am grateful to the author for sight of an advance copy of the relevant chapters. Developing an integrated approach to preventing suicide. Suicide is a significant issue globally5 and understanding of effective suicide prevention interventions has expanded considerably in the past few years.Â However, in recognition that a systems approach to suicide prevention extends beyond the delivery of health and medical services, guidance is provided about engagement with government and community groups. responsible for broader aspects of suicide prevention. These include groups who provide services under commonwealth and state government departments, such as family and community services, police and justice, education and NGOs.