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# A Systematic Review of Biomedical and Psychosocial Factors for Suicide: An Islamic Perspective

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**Abstract:** Suicide is a complex public health problem of global dimension with un-even distribution rates. The objectives of this review is to describe the concept of suicide, its causes and preventive measures in the light of the glorious Qur'an and ahadith/sunnah as the principal sources of *Maqasid Al-Shari'ah* in Islam. Descriptive study design was used to review the data collected from published articles, books, news and reports. The findings show that suicide may be caused by social-economic factors; catalysed by psychological problems, mental illnesses, physical illnesses, genetics and medication. Qur'an, 4:29 has strictly forbidden people to kill themselves, while various ahadith have made it clear that whoever kills himself with something, *Allah* (*SWT*) will punish him with whatever he has killed himself with in the Hellfire. The guidelines to prevent suicide include strengthening personal relationships, reciting and comprehending the glorious Qur'an, supplication, *ruqya*, patience and reliance to *Allah* (SWT).

**Keyword:** Suicide, attempted suicide, committed suicide, causes, preventive measures

## 1. Introduction

Suicide is defined as the act of intentionally inflicting one's own death (Turecki and Brentid, 2016). Is a fatal self-injurious act which has become a global public health concern. Suicide behaviours include both attempted and committed suicide. Globally, suicides take a high toll. The World Health Organization (WHO) and the Global Burden of Diseases (GBD) study estimate that each year nearly 800,000 people die due to committed suicide; whereby about 78% of them are completed in the low-and middle-income countries. This corresponds to 1 person dying by suicide every 40 seconds. This makes it the 15th leading aetiology of deaths and accounted for 1.4% of all deaths in 2017. But in 2019, it accounted for 1.3% of all deaths. In some countries this share is as high as 5%. Moreover, in the same year, suicide was the 4th leading aetiology of death among individual's aged 15-29 years old, after tuberculosis, interpersonal violence, and road injury. According to data from the World Health Organisation, there are indications that for each individual who died of suicide there may have been more than 20 others attempting suicide (Bachmann, 2018; https://ourworldindata.org/suicide).

Suicide behaviours affects all age groups in the population; have ripple effect that impacts on families, friends, colleagues, communities, and societies. It is also estimated that at least 6 people are directly affected by each suicide death (WHO, 2017). Suicide mortality rates clearly increase with increasing age. In many countries the highest rates are found among the oldest people aged 80+ (60.1 per 100,000 men and 27.8 per 100,000 women), 70-79 years (42.2 per 100,000 men and 18.7 per 100,000 women), and 60-69 years (28.2 per 100,000 men and 12.4 per 100,000 women) (Bilsen, 2018). There is a little doubt that there are many more men commit suicide than women; with the exception of some few countries such as China and India, where women attempt suicide 2-3 times more often than men (Bilsen, 2018; Bachmann, 2018).

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Among suicide behaviours, attempted suicide cases are much frequent compared to the committed suicide cases. They are about 10-30 times more frequent than committed suicide cases (Bachmann, 2018; Borges *et al.*, 2010); and they are important predictors of repeated suicide attempt as well as committed suicide. The estimated global prevalence of attempted suicide cases is about 3 per 1,000 adults. It is also estimated that, about 2.5% of the population commit at least one act of attempted suicide in their lifetime. However, as will be explained later on, all these suicide data are probably still an underestimation of a real problem (Bachmann, 2018; Bilsen, 2018).

Registering suicide cases is not an easy task. It is a very complicated task which often involves judicial authorities. Unless the phenomena may not be recognised or may be mis-categorized as an accident or another cause of death. About 45% of people who die by suicide consult a primary care physician within one month of death. But still there is rarely documentation of physician inquiry or patient disclosure (Turecki and Brent, 2017). Inadequate knowledge among health professionals may also lead to the misdiagnosing of death as being accidental: Falls, drowning and submersion, assault, exposure to smoke or fire, and accidental poisoning by and exposures to noxious substances (Bachmann, 2018). Sometimes suicide cases may not be identified or reported at all: They may be rooted in stigma, beliefs, legislation, and politics (for-example, prosecution of attempted suicide in certain countries (Bertolote and Fleischmann, 2012).

The present review highlights proper understanding of the suicide behaviours in the light of the glorious Qur'an and Al-Hadith/sunnah as the principal sources of *Maqasid* Al-Shariah in Islam. It will cover the definitions, root causes, epidemiology and prevention techniques.

## 2. Statement of the Problems

The world is at the highest level of social, economic, political, science and technological advancements. These are the highest civilisation achievements that have been reached by human being. As the world civilisation increase, our expectation is that human welfare; in terms of life expectancy, happiness, love, social security, human dignity, respect, and prosperity, will also improve to the maximum. If this is the case, why still there are some people decide to attempt or commit suicide? In fact, the varying trends of attempted and committed suicide cases addresses a negative image to all development achieved by human being. This is quite unexpectedly; it shocks the world and raises the greatest concern to whether these achievements reached by human beings are real or fake?

Suicide behaviours are serious public health concern as the number of both committed and attempted suicide cases are varying; both regionally and worldwide. Different reports have been published that indicate unequal distribution of trends. For Tanzania; in particular, suicide mortality rate dropped from 4.40 (in 2013) to 4.20 (in 2014). It remained 4.20 until 2019 when it raised to 4.30; which showed an increase of about 2.30% of the suicide rate (https://www.macrotrends.net/countries/TZA/tanzania/suicide-rate). Similar increasing trends of suicide mortality rates have been also reported in other regions of the world. However, not only that there are few numbers of reviews that have reported the current status of suicide mortality rates regionally and worldwide, but also there are limited numbers of reviews that have reported the proper understanding and prevention of the suicide in the light of the glorious Qur'an and Al-Hadith/sunnah as the principal sources of *Maqasid Al-Shari'ah* in Islam. Therefore, the specific focus of the present review is to fill this existing gap. The objective of this study is to provide an in-depth description on the concept of suicide, its causes and preventive measures in the light of the glorious Qur'an and Al-Hadith/sunnah as the principal sources of *Maqasid Al-Shari'ah* in Islam.

## 3. Methodology

Documentary analysis methodology was used to review the data collected from published articles, reports and books; including the glorious Qur'an and Al-Hadith books. WHO data from their official websites and literatures were used extensively. This is because their databases cover 194 state members; where data is collected according to the same principles. Hence, their data are the most encompassing and comparable. The biomedical data bank from PubMed was scanned for the literatures related to suicide in the context of medical problems related to the suicide behaviours. These data were then analysed by qualitative content analysis method. This study adopted and modified the Pressure and Release Model (PRM) developed by Blaikie *et al* (2005) to indicate how suicide progresses from root causes to unsafe life and ultimately to suicide behaviours.

## 4. Cause of Suicide

Figure 1 is a simplified model called Pressure and Release Model (PAR) from the disaster management adopted from Blaikie *et al.*, 2005. This model shows the causal relationships between the root causes, dynamic causes and un-safe life conditions that progress to suicide behaviours. Generally, this model comprised of two main sides: (1) Vulnerability factors that include root causes, such as psychosocial factors, dynamic factors, such as biomedical factors, and un-safe life conditions. (2) Suicide itself. Briefly, the root causes normally act as underlying causes; from the society, that are amplified/catalysed/translated by the dynamic factors; through changes in the biological systems, into un-safe life conditions; that consequently may lead to the suicide behaviours. On the other side, dynamic factors may sometimes act as the root causes and progress themselves to unsafe life situations; that consequently lead to the suicide behaviours.

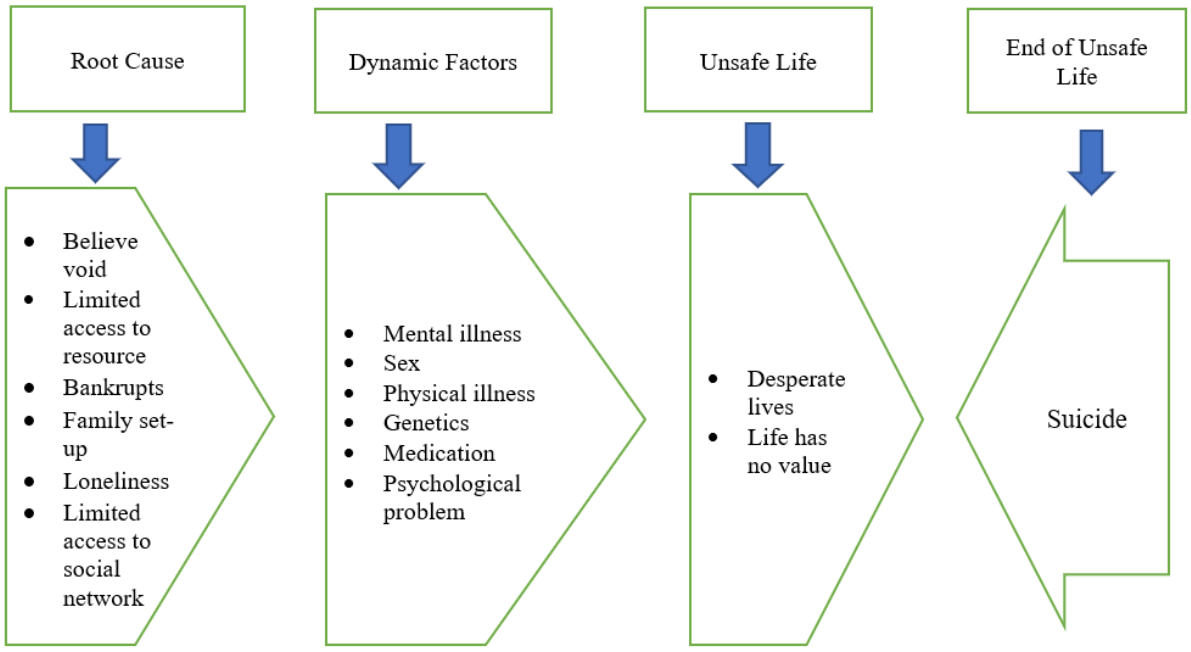


**Fig. 1 - Rooting of suicide (adopted and modified from Blaikie *et al*., 2005)**

## 4.1 Psychosocial Factors

As shown in Figure 1 and based on Figure 2, various psychosocial factors have been reported as the root cause of both attempted and committed suicide. O'Rourker *et al.* (2020) have reported the following psychosocial factors as the root causes of both committed and attempted suicide: A sense of no purpose in life; which is equivalent to the believe gap, a sudden and major change in an individual's life; such as marital status divorced or loss of partner; which is similar to the sex and loss of employment, negative life experience such as substance abuse, financial difficulties, social media; those influencing imitation especially for younger people, family history of suicide, major adverse events; such as sexual abuse and harassments, discrimination; such as for being gay, lesbian, transgender or bisexual, and long history of being bullied.

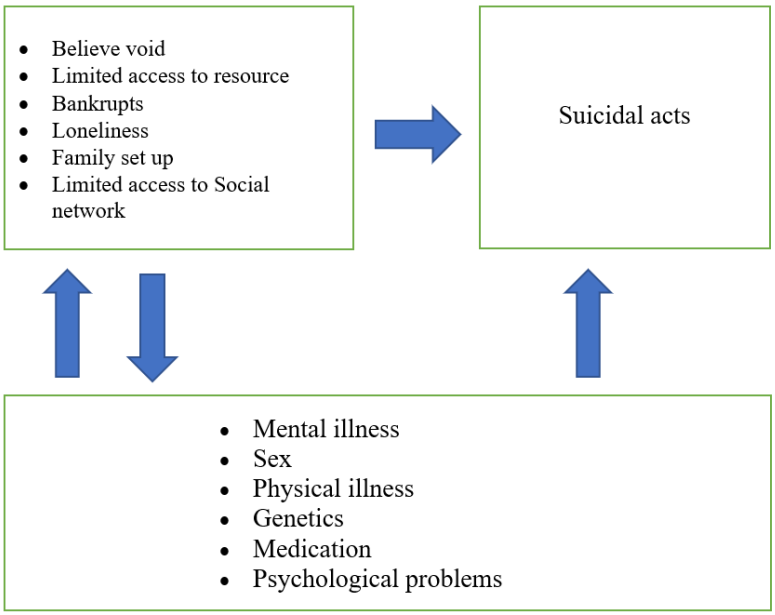


**Fig. 2 - The model showing the causal relationship between depression and other mental disorders, psychiatric factors and suicides (modified from Hegerl *et al*., 2015 in Hegerl, 2016)**

Berardelli *et al.* (2018) have also reported the following lifestyle behaviours as the root causes of both committed and attempted suicides: Sedentary lifestyle (loneliness), family conflicts or isolation; which is also equivalent to family environment, high prevalence of alcohol and cannabis use, interpersonal factors (family conflicts and peer problems); which is also equivalent to the family environment, and lower life satisfaction. All these psychosocial factors; and others not mentioned here, may impact biological systems, and influence suicidal ideation (suicide emotions and judgement); that consequently may lead to the suicidal behaviours. This is how biomedical factors comes in as the cause of suicide.

## 4.2 Mental Illnesses

Mental illnesses are like any other medical illness, i.e., has a biological basis like any other medical illnesses. It refers to health conditions that divert a person's feelings, thinking, behaviour (or all three) and that causes the person distress and difficulty in functioning. There are various mental illnesses that include schizophrenia, attention deficit hyperactivity disorder (DHD), depression, obsessive-compulsive disorder, and autism. Like many other health conditions, mental illness is severe in some of the cases and mild in some other cases. People who are suffering from mental illness do not necessarily look like they are sick, especially if their illnesses are mild (https://www.ncbi.nlm.nih.gov/books/NBK20369/). Other people may present with more explicit symptoms like agitation, withdrawal and confusion. It is reported that about 90% of people who commit, or attempt suicide have suffered from at least one form of mental illnesses (Bilsen, 2018; Gould, 2001 in Bilsen, 2018). Mental illness may stand as independent factor as a root cause of the committed or attempted suicide or; as stated earlier, may have its root from the psychosocial factors (Berardelli *et al.*, 2018; Hegerl, 2016).

Mental illnesses are known to contribute between 47 and 74% of suicide risk (Bilsen, 2018). The reported proportion of committed suicide due to mental illnesses ranges between 60 and 98% (Bachmann, 2018). Many studies have reported that affective disorders (a set of psychiatric or mood disorders) such as depression and bipolar disorders are the disorders most frequently identified in this context. As many as 87% of people who die because of committed suicide meet the criteria for a psychiatric disorder before their death (Bilsen, 2018).

In the beginning of the 21st century, the highest mortality rate of committed suicide globally was due to depression (30%), followed by substance-use related disorders (18%), schizophrenia (14%) and personality disorders (13%) (Bachmann, 2018). In other studies, conducted elsewhere, the evidence for depression were found in 50-65% of committed suicide cases, more often among women than men. Substance-use related disorders; more specifically alcohol overuse, were also strongly linked to the suicide risk, especially in older adolescents and males. This is because, they increase impulsiveness and impair judgment, thereby increasing the risk of attempting or committing suicide. In these studies, among 30-40% of people who died by suicide presented personality disorders, such as antisocial personality disorder or borderline (Bridge *et al.*, 2006; Palmer *et al.*, 2005). Data from the World Mental Health Survey showed that for all countries examined, the risk of first onset of suicide ideation increases sharply during adolescence and young adulthood and then stabilizes in early midlife (Nock *et al.*, 2008).

## 5. Methods of Suicide

It has been reported that high exposure to pesticides such as herbicides, insecticides, fungicides etc, experienced by agricultural workers and rural residents may result in an elevated risk of psychiatric disorders and suicidal behaviours (Koifman & Freire, 2013). In other words, occupation in agriculture has shown a significant association with higher suicide risk than other occupational groups. According to WHO, about 20% of the global committed suicide cases are due to the agricultural pesticide poisoning; most of them occur in rural agricultural areas in low-and middle-income countries (WHO, 2019). For example, in rural China, pesticides poisoning account for more than 60% of committed suicides. Likewise, high proportions of committed suicides are due to pesticides in rural areas of Sri Lanka (71%), Trinidad (68%) and Malaysia (>90%) (Eddleston & Gunnell, 2003). Other common methods of suicide are firearms and hanging. Generally, proper understanding of the most commonly used suicide methods is very important to device prevention techniques that have been identified to be effective.

## 5.1 Epidemiology

A stated earlier, suicide mortality rate varies between countries, regions, and between males and females. In 2015, crude and age-standardized suicide rates according to the WHO regions amounted to 10.7 worldwide; but fall apart in certain regions. The Eastern Mediterranean region had suicide mortality rates of 3.8 and 4.3, the African region 8.8 and 12.8, the Americas 9.6 and 9.1, the Western Pacific region 10.8 and 9.1, South East Asia 12.9 and 13.3, and Europe 14.1 and 11.9 (all crude and age-standardized). The European region reported the highest crude suicide rate; above the global suicide rate of 10.7 per 100,000 for both sexes. This is the case despite the fact that, since 1980, a drop in suicide rates was reached through preventive measures (Bachmann, 2018). With regards to WHO regions, there have been some shifts regarding the highest suicide rates. When WHO initiated systematic study, the highest rates were identified in Japan. The peak shifted to Eastern Europe (from the 1960s to 1980s: Hungary, from the 1990s to the 2010s: Lithuania), and after that to Asia; with India and China accounting for 30% of the crude suicide numbers worldwide. About 54% of all suicides across the globe take place in the two mentioned countries (Bachmann, 2018).

In 2016, committed suicide cases was among of the 10th leading aetiology of death in 5 of the 21 Global Burden of Disease defined regions. Suicide rates in the African (12.0 per 100 000), European (12.9 per 100 000), and South-East Asia (13.4 per 100 000) regions were higher than the global average (10.5 per 100 000). The lowest suicide rate was in the Eastern Mediterranean region (4.3 per 100 000). The South-East Asia Region represented much higher female age-standardized suicide rate (11.5 per 100 000) compared to the global female average (7.5 per 100 000). In males, the regions of Africa (16.6 per 100 000), the Americas (14.5 per 100 000), South-East Asia (15.4 per 100,000), and Europe (21.2 per 100,000), all presented suicide rates which were higher than the global male average (13.7 per 100 000) (WHO, 2016). In 2019, suicide mortality rates in the WHO African (11.2 per 100 000), European (10.5 per 100 000) and South-East Asia (10.2 per 100 000) regions were higher than the global average (9.0 per 100 000). The lowest suicide rate was in the Eastern Mediterranean region (6.4 per 100 000) (WHO, 2021). However, suicide rates dropped in the 20 years between 2000 and 2019, with the global rate decreasing by 36%, with decreases ranging from 17% in the Eastern Mediterranean Region to 47% in the European Region and 49% in the Western Pacific Region. But in the Americas Region, rates increased by 17% in the same time period (WHO, 2019).

Generally, the data reported by the WHO suggest that the global suicide mortality rates increased between 1950 and 2004, especially for men (Bertolote and Fleischmann, 2012), and data-based projections suggest that the number of self-inflicted deaths will increase by as much as 50% from 2002 to 2030 (Mathers and Loncar, 2006). WHO has maintained cross-national data on committed suicide mortality rates since 1950. However, there are inconsistencies in reporting by individual governments, with only 11 countries providing data in 1950, 74 in 1985, and 50 in 1998. In addition to that, the fact that some governments have treated committed suicide cases as a social or political issue rather than a health problem may have decreased the validity of earlier data and resulting estimates. Due to these inconsistencies, it is difficult to generate an accurate cross-national or regional estimate of trends. It is also reported that WHO does not receive data from any country in the world on attempted suicide cases, although at least information from emergency rooms/somatic hospitals and self-reports could be obtained (Bachmann, 2018).

Despite the wide variability in suicide rates, there is a consistently higher rate among men than women, with men more often dying by suicide at a ratio of 3:1-7.5:1. The difference is seen in India and China, where the male to female ratio is 1.3:1 in India, 0.9:1 in mainland China, and 2.0:1 in Hong Kong. The reason for this difference is not known, but it has been postulated that the lower social status of females in the context of disempowering circumstances and the more lethal suicide methods used in these countries; such as self-burning in India and ingestion of pesticides in China, may account for this pattern (Nock, 2008).

## 5.2 Suicide as Stated in the Glorious Qur'an and Al-Hadith /Sunnah

In Islam, glorious Qur'an and ahadith/sunnah are the principal sources of *Maqasid Al-Shari'ah* (goals or objectives or purposes of shariah); which is to protect the five essentials of human wellbeing: *religion, life, intellect, lineage (progeny or offspring) and property* (Saifuddeen *et al.*, 2014). Because both attempted suicide cases and committed suicide cases threatens and destroy human lives respectively, both glorious Qur'an and authentic ahadith/sunnah have strictly forbidden them. In the *Surat An-Nisa*, 4:29 Allah (SWT) has made it clear that:

يَا أَيُّهَا الَّذِينَ آمَنُوا لَا تَأْكُلُوا أَمْوَالَكُم بَيْنَكُم بِالْبَاطِلِ إِلَّا أَن تَكُونَ تِجَارَةً عَن تَرَاضٍ مِّنكُمْ ۚ وَلَا تَقْتُلُوا أَنفُسَكُمْ ۚ إِنَّ اللَّهَ كَانَ بِكُمْ رَحِيمًا

*O you who have believed, do not consume one another's wealth unjustly but only [in lawful] business by mutual consent. And do not kill yourselves [or one another]. Indeed, God is to you ever Merciful (Surat An-Nisa, 4:29).*

On the other hand, many ahadith have been reported on this subject. For-example, Al-Imam Al-Bukhari in his sahih [Sahih Al-Bukhari] has reported a hadith which was narrated by Jundab (Radhiya Llaahu 'anhu) who said that, prophet Muhammad (SAW) said:

كَانَ بِرَجُلٍ جِرَاحٌ فَقَتَلَ نَفْسَهُ فَقَالَ اللَّهُ بَدَرَنِي عَبْدِي بِنَفْسِهِ حَرَّمْتُ عَلَيْهِ الْجَنَّةَ

*A man was inflicted with wounds and he committed suicide, and so Allah said: My slave has caused death on himself hurriedly, so I forbid Paradise for him.*[1]

Likewise, Al-Imam Al-Bukhari has also reported a hadith which was narrated by Thabit bin Ad-Dahhak (RA) who said that prophet Muhammad (SAW) said:

وَمَنْ قَتَلَ نَفْسَهُ بِحَدِيدَةٍ عُذِّبَ بِهِ فِي نَارِ جَهَنَّمَ

[1] Ismail, A. (1997). Sahih Al-Bukhari (M. Khan, Trans). Riyadh. Saud Arabia: Darussalam Publishers and Distributors. Volume 2. Hadith number 1364.

*And whoever commits suicide with piece of iron will be punished with the same piece of iron in the Hell Fire.*[2]

## 6. Prevention of Suicide

### 6.1 Prevention of Suicide According to the Modern Techniques

Even though some countries have placed national suicide prevention strategies, many countries remain uncommitted; with no specified national suicide strategies. Presently, only 38 countries are known to have national suicide prevention strategies. A significant acceleration in the reduction of suicide mortality rates is needed to meet the Sustainable Development Goals (SDG) target of a 1/3 reduction in the global suicide mortality rate by 2030 (WHO, 2020). As shown in Figure 1 and Figure 2, regulating lifestyle behaviours; that are the risk factors for both attempted and committed suicide, is a key component in prevention of suicide behaviours (Berardelli *et al.*, 2018).

According to WHO, 2014, methods of preventing the risks for committing suicides are of three categories: (1) Universal prevention methods that are designed to reach the whole population. These focus on increasing access to health cares, maintaining and promoting mental health, preventing substance abuse, restricting access to the means for committing suicides and promoting media reporting; those do not influence imitation. (2) Selective prevention methods are designed to reach to the vulnerable groups such as people who have suffered from abuse or trauma, people who are affected by disasters and conflicts; including family conflicts, migrants and refugees, people who are bereaved by suicide; deprived of a close relation or friends through suicide, training people who are assisting the vulnerable people, and by providing helping services such as helplines. (3) Indicated methods are designed to target the specific vulnerable people with community support, follow-up for people that are leaving health-care facilities; such as hospitals and rehabs, providing education and training to the health-care providers, and strengthening identification and management of substance use and mental illnesses; such as those mentioned by Barardelli *et al.* (2018): Relevant programs like psycho-educational family treatment, assertive community treatment, psychosocial therapies, and social skills training. Other methods of preventing suicides include; Strengthening personal relationships, strengthening personal believes; which include religious believes, and strengthening positive copying strategies.

### 6.2 Prevention of Suicide According to the Techniques Stated in the Glorious Qur'an and Al-Hadith/Sunnah

Gearing and Alonzo, 2018 have reported that high levels of religiosity decrease the incidence of suicide behaviours. According to Figure 1 and Figure 2, the root causes for both attempted and committed suicide cases are amplified or catalysed by the psychological problems, mental illnesses, physical illnesses, genetics and medication. In the glorious Qur'an and Al-Hadith/sunnah there are various techniques; stated in different contexts, for resolving these problems.

The glorious Qur'an is encouraging people to have faith, patience and reliance to Allah (SWT) (Qur'an, 2:45; 2:153; 2:155; 3:17; 3:186; 3:133, 65:3 etc), to repent (Qur'an, 39:53-54; 3:133), to establish prayers regularly; including *fardh* (obligatory prayers), *wajib* (required prayers), sunnah and *nafl* (voluntary prayers) (Qur'an, 243; 2:210; 4:103; 10:57; 4:103; 22:78; 24:56; 30:31), to treat themselves through Qur'an (*ruqya*) (Qur'an, 10:57; 17:82), to ask help from Allah (SWT) (supplication) (Qur'an, 2:186), to remember Allah (SWT) (*adhkar*) and contemplating on His presence, greatness and glory (Qur'an, 13:28; 2:200; 3:190-191), to fast; both fardh and sunnah fasting (Qur'an, 2:183), and to recite and comprehend the glorious Qur'an regularly (Qur'an, 73:20).

All of these techniques have proven effectiveness in resolving the root causes of suicide such as belief void, bankrupt, family and social conflicts, mental illnesses; that may lead to physiological disorders like depression, anxiety and stress. For-example, Rafique *et al.* (2019) have demonstrated the efficacy of Surah Al-Rehman as a remedy to reduce depression. Furthermore, Mehdipour-Rabori and Nematollahi (2014) have reported that recommended *adhkar* such as *Laa ilaaha illa Llaah* [none has the right to be worshipped but Allah] and others can significantly reduce anxiety, depression, and stress. Generally, large number of suicide cases worldwide are related to psychiatric disorders (mental illnesses). Among these, depression, substance use, psychosis, anxiety, personality-, eating- and trauma-related disorders as well as organic mental disorders constitute the most relevant dynamic factors. Depression is the leading aetiology of death by suicide worldwide. Half of all committed suicides are related to depressive and other mood disorders (Bachmann, 2018).

However, the glorious Qur'an has encouraged people to help one another during times of difficulties such as stress, depression, poverty, diseases, disasters etc. This encouragement is given in the Qur'an, 5:2. In addition to that, Qur'an, 2:182, 8:1, 42:40, 4:128 and 4:35 have commanded human beings to help each other in resolving family and social conflicts. Because conflicts are among of the root causes that may lead to suicide, implementing this command may help in preventing suicide.

The glorious Qur'an has also restricted the use of all things that tend to deteriorate mental health and that lead to anxiety, stress and depression. Qur'an, 5:90-91 and 2:219 have used the word *al-khamr* and *maysir* to prohibit all forms

[2] Ismail, A. (1997). Sahih Al-Bukhari (M. Khan, Trans). Riyadh. Saud Arabia: Darussalam Publishers and Distributors. Volume 2. Hadith number 1363.

of intoxicants; such as alcohol, drugs and substance abuse, that intoxicates the mind, and gambling; that may lead to poverty, depression and stress, respectively. Likewise, because mental illnesses, poverty, depression and stress are among of the root causes of suicide, implementing them may help to prevent suicide. Furthermore, according to Qur'an, 5:91, the use of intoxicants and participating in gambling may excite enmity and hatred between people; that may consequently lead to suicide behaviours.

## 7. Discussion

Generally, the regional data presented in this study shows that, high income regions; such as European and American regions, have high rates of suicide compared to low-income regions; such as Asian and African regions. Similar pattern is seen for countries' data. Developed countries have been reported to have high rates of suicide cases compared to the developing countries. This turns back our attention to the question addressed earlier: The greatest civilisations achievement has reached by human beings; particularly developed countries, then why does a whole creature deliberately takes his/her own life for whatever reason? Responding to this question, the presence of a large number of committed suicide and attempted suicide cases in developed countries addresses a negative image to all development achieved by these countries. Maybe these developments are not real to many people living in these countries. As the world civilisation increases, expectation is to increase human welfare in terms of life expectancy, happiness, social security, increased human dignity, respect and prosperity. If this is not the case, it means that there are some things that are wrong. These things are behavioural risk factors that have been reported in various literatures discussed in this review (Barardelli *et al.*, 2018, Bilsen, 2018, Nock *et al.*, 2018, Turecki & Brent, 2016; Hegari & Koburger, 2015; Borges *et al.*, 2010). To a large extent, these behavioural risk factors are the things that disrupt the expectation stated above. They include: risk factors include loneliness; lack or inadequate social interaction, substance abuse such as excessive alcohol and cannabis, or belief void.

On the other hand, even though the same or similar risk factors for suicides have been reported in developing countries but is only few literatures among of the literatures used in this review that have reported about loneliness; lack or inadequate social interaction, and belief void; which include religious believes, in developing countries. This is among of the basic reasons of why developed countries demonstrates higher rates of both committed suicides and attempted suicides. In addition to that, according to WHO, 2012, developing countries are relatively less equipped to prevent the risk factors for the suicide behaviours. This is also among of the basic reasons of why developing countries demonstrates higher rates of committed suicides. Furthermore, according to WHO, even though suicides continue to remain a serious problem in developed countries, it is the low-and middle-income countries that bear the larger part of the global suicide burden.

## 8. Conclusion

The best data about both attempted and committed suicide cases are updated regularly with WHO; through their official websites. Generally, the available data shows that, suicide rates vary with regions and countries in particular; with the diversity of changing economic, cultural, social, and environmental factors as well as with age and gender. Specifically, suicide mortality rates are increasing to the people who have chronic physical disorders, such as those with disabilities, and mental illnesses; such as those with affective disorders (a set of psychiatric or mood disorders) like depression and bipolar disorders, and in those with the history of attempting suicides; who have already attempted suicide.

However, the quality of suicide data is quiet low to medium because of mis-, under-, or un-diagnosing and reporting. Under these grounds, much less is known about attempted suicide cases. According to Bachmann, 2018, attempted suicide cases might outnumber the committed suicide cases by 30 folds. Prevention of suicides behaviours is possible and highly needed. Therefore, the implementation of the preventive measures addressed in this review; both from the glorious Qur'an, Al-Hadith/sunnah and modern techniques, is warranted.

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