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Suicidal Behavior Disorder: A Repertorial Study of Relevant Rubrics in Homoeopathy

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Abstract: ***Suicidal Behavior Disorder (SBD), recognized in recent psychiatric discussions, refers to repeated suicidal attempts or ideation independent of major psychiatric diagnoses such as depression or psychosis. Conventional management often emphasizes crisis intervention, pharmacotherapy, and psychotherapy, yet many patients continue to experience underlying susceptibility that predisposes them to recurrence. Homoeopathy, with its holistic and individualized approach, offers a complementary perspective in addressing the dynamic causes behind suicidal tendencies. This paper explores the scope of Homoeopathic Repertory in the management of Suicidal Behavior Disorder. Repertorial rubrics such as "Suicidal disposition," "Despair of life," "Desire for death," and "Impulsive to suicide" are examined across standard repertories including Kent's, Synthesis, and Complete Repertory. Homoeopathy, integrated with supportive psychiatric care, may contribute to reducing suicidal impulses, improving resilience, and restoring balance in patients predisposed to self-destructive tendencies.***

Keywords: Suicidal Behavior Disorder, Homoeopathy, Repertory, Suicidal disposition, Mental health management

1. Introduction

Suicide continues to be one of the greatest challenges faced by mental health clinicians and researchers, an issue made worse by increasing trends in the global suicide rate. Suicide behavior disorder (SBD) was introduced in DSM-5 as a disorder for further consideration and potential acceptance into the diagnostic system. There are numerous positive developments that would arise from the addition of a suicide-related diagnosis. Utilizing the 2009 guidelines established by Kendler and colleagues, the present review examines the evidence for SBD's validity and discusses the diagnosis' potential clinical benefits and limitations. Altogether, growing evidence indicates that SBD has preliminary validity and benefit. SBD presents with several significant limitations, however, and possible alternative additions to future DSMs are highlighted. (1)

2. Definition

This condition is characterized by a **suicide attempt within the past two years**, where the act was carried out with a **clear expectation of death**. SBD reflects a **paradigm shift** in psychiatric thinking, recognizing suicidal behavior as a **distinct clinical entity**, rather than solely a symptom of other mental disorders like depression.

Suicidal ideation is the consideration of or desire to end one's own life. Suicidal ideation typically ranges from relatively passive ideation (e.g. wanting to be dead) to active ideation (e.g. wanting to kill oneself or thinking of a specific method on how to do it) (2)

Traditionally, suicidal ideation and behavior have been conceptualized as **secondary features** of mood or psychiatric disorders. However, research suggests that this model may be overly simplistic. For example, **approximately 10% of individuals who die by suicide reportedly have no diagnosed mental illness**. On the other hand, **most individuals with mood disorders never attempt suicide** (Reardon, 2013).

3. Epidemiology

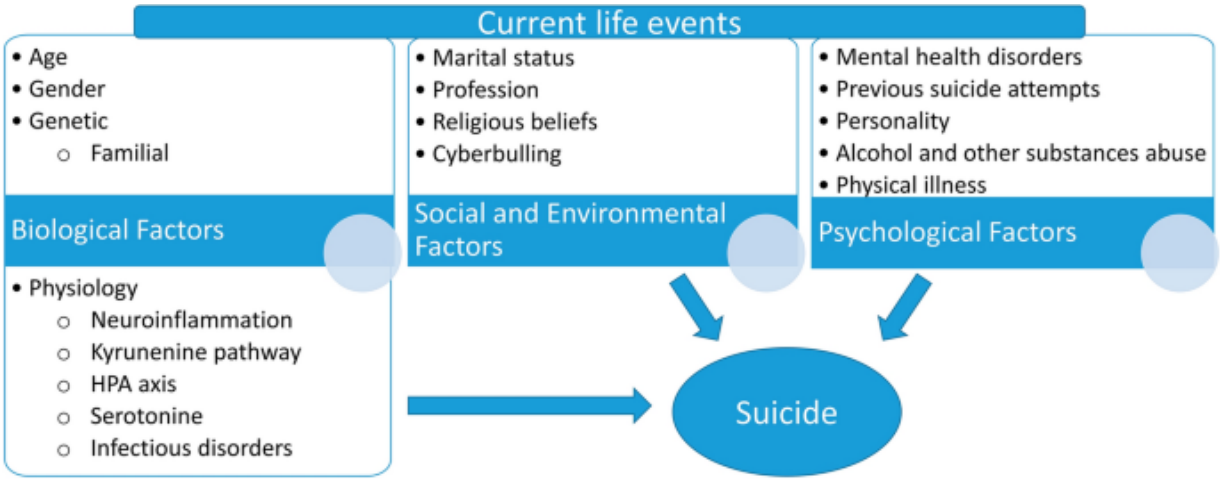
- Suicide is a worldwide phenomenon. As such, it has continued to be addressed by the World Health Organization (WHO) since 1950, i.e., only two years after its foundation (3). Obviously, the WHO and its coworkers have presented the most comprehensive and unbiased data from its member states, which serve as a basis for this paper.
- Globally, suicides are the second leading cause of premature mortality in individuals aged 15 to 29 years (preceded by traffic accidents), and number three in the age-group 15–44 years (4). Upsettingly, in 2015, the vast majority—namely 78% of suicides—were completed in low- and middle-income countries (LMIC) (WHO 2015).
- The global suicide mortality rate amounts to 1.4%, ranging from 0.5% in African regions to 1.9% in the South-East Asia region —please be aware of the fact that the WHO defines regions which do not completely overlap with geographic regions, e.g., the African region excludes the Eastern Mediterranean region/the Arabic countries.
- With respect to WHO regions or to continents, there have been some shifts regarding the highest suicide rates. When WHO initiated documentation, the highest rates were detected in Japan. The peak shifted to Eastern Europe (from the 1960s to 1980s: Hungary, from the 1990s to the 2010s: Lithuania), and to Asia thereafter (5) with China and India accounting for 30% of the absolute suicide numbers worldwide. (6)

3.1 Gender Differences in Suicide

There is a **well-documented gender disparity** in suicide rates:

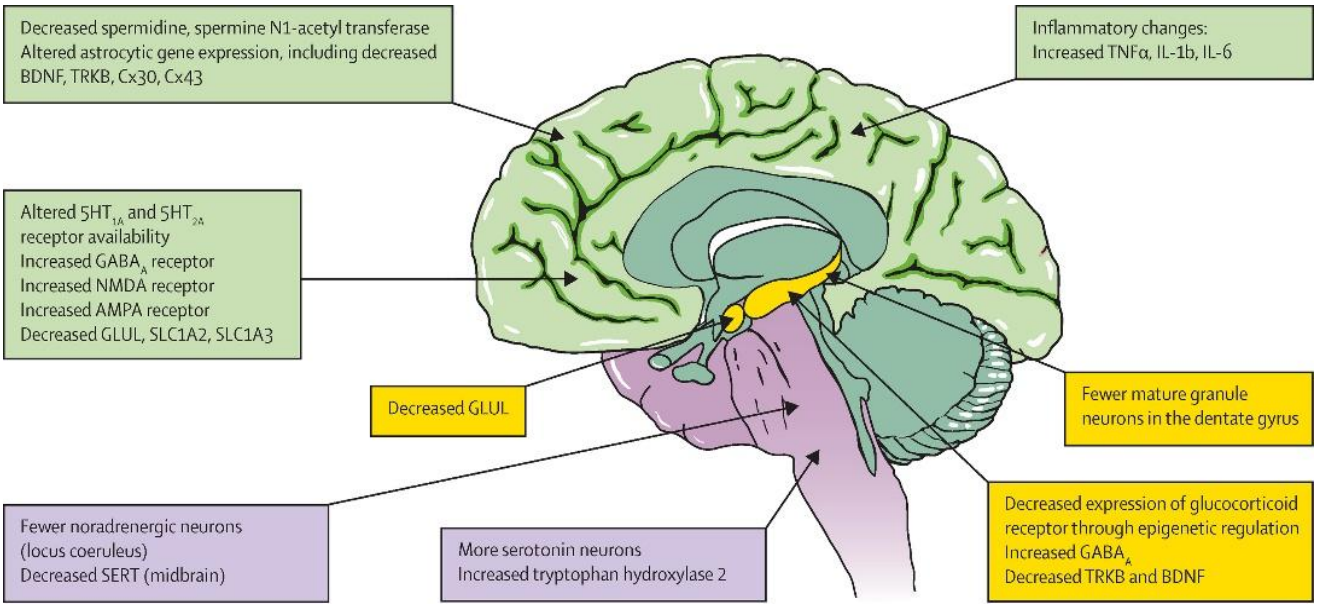
- **Men** are more likely to **complete suicide**, often using **more lethal methods** such as firearms or jumping from heights.
- **Women**, in contrast, are more likely to attempt suicide through **less lethal means**, such as cutting or drug overdose.

4. Etiology and Risk factors of Suicide



1) Severe sexual harassment and rape
2) Being jolted in love
3) Death of a over done
4) Acute financial crisis Interpersonal
5) Conflict with parents
6) Conflict with lover interpersonal
7) Rejection
8) Loneliness
9) Insult in a public place
10) After an immoral act
11) Incurable disease
12) Academic and Career Related
13) Failure in the examination
14) Lower marks than expected [7]

5. Pathophysiological changes in the Brain



6. Phases of Suicide

The four-phase model:
Suicide also has its own dynamics, which can be described in four phases as follows. In the first phase, suicidal ideation takes place, which may be expressed verbally or non-verbally. The second phase is the planning of the suicide, a stage of ambivalence that leads to the strategy to be used for the suicide. Once the decision has been made, this is the third phase or the suicide attempt, which fails. Thus, the last phase would be suicide, where the person would finally end his or her own life.

The three-phase model:
These four phases are not the only ones that have been proposed to try to explain this phenomenon, and thus the three-step theory of suicide has emerged. In this theory, the concepts of grief, hopelessness, suicidality and connectedness are important.
Firstly, there is the desire to commit suicide. Studies suggest that this arises from a combination of hopelessness and feelings of intense pain. However, if a person is suffering emotionally but has hope for an improvement in the future, he or she will try to overcome the situation and show an effort to try to remain committed to life.

Secondly, there is an intensification of suicidal desire, which is mostly moderate. While pain takes away the feeling of wanting to live, there is also a connection that binds the person to wanting to go on living. If a person has a higher level of pain compared to their level of connection to life, their desire for suicide will be increased.

The last step of this phenomenon is the occurrence of suicide attempts. At this stage, people have an intense desire to commit suicide.

However, not all those who are suicidal in their approach finally commit suicide. Experts point to fear of death as one of the main factors influencing not ending life by suicide. A possible ability to cope with fear and pain through previous experiences such as sexual abuse, the health profession or having experienced non-suicidal self-harm could reinforce this idea. This three-step theory would also be supported by the influence of factors such as personality, genetics of the individual or access to knowledge about methods of suicide. [8]

7. Methods of Committing Suicide:

1) Active Methods:
   a) Hanging or Strangling
   b) Cutting or Stabbing
   c) Drowning
   d) Shooting
   e) Jumping from a height
   f) Train by standing in a Railway track

2) Passive:
   a) Gases
   b) Barbiturates
   c) Aspirin
   d) Strychnine
   e) Lysol
   f) Cyanide
   g) Phosphorous [9]

8. Warning signs of Suicide

Ideation-Thinking about suicide
Substance use-problems with drugs or alcohol
Purposelessness-feeling like there is no purpose in life or reason for living
Anxiety-feeling intense anxiety or feeling overwhelmed and unable to cope
Trapped-feeling trapped or feeling like there is no way out of a situation
Hopelessness or helplessness-feeling no hope for the future, feeling like things will never get better
Withdrawal-avoiding family, friends or activity
Anger-feeling unreasonable anger
Recklessness-engaging in risky or harmful activities normally avoided
Mood change-a significant change in mood

9. Proposed DSM-5 Criteria for Suicidal Behavior Disorder

The DSM-5 outlines **five criteria** for diagnosing Suicidal Behavior Disorder, along with **two specifiers**:

Diagnostic Criteria:
1) The individual has made a **suicide attempt within the past two years**.
2) The criteria for **non-suicidal self-injury (NSSI)** are **not met** during the attempt.
3) The diagnosis is **not applicable** in cases involving **suicidal ideation** or **planning alone** (i.e., no attempt made).
4) The attempt was **not made during a state of altered consciousness**, such as **delirium or acute confusion**.
5) The act was **not ideologically motivated**, such as being driven by **religious or political beliefs**. [10]

10. Management

- **Acute care:** Outpatients may be managed if no active plan, means, or intent, with strong social support and crisis planning. Inpatient admission is indicated when a patient has a plan and means, or if risk is uncertain. Safety measures include removing lethal means, frequent monitoring, and in some cases involuntary hospitalization.
- **Pharmacotherapy:** Lithium reduces suicide in mood disorders; clozapine is effective in psychotic disorders. Antidepressants can help but require caution due to overdose risk and FDA warning for youth. Ketamine shows promise for rapid relief, though more research is needed. Combining medication with psychotherapy is most effective.
- **Long-term care:** Ongoing follow-up with mental health services lowers risk. Patients with personality disorders need vigilant evaluation of suicidal threats, coping strategies, and timely referrals.

- **After a suicide:** Families and caregivers need empathetic support, education about causes, space for grieving, and access to support groups. [11]

11. Rubrics in different repertories:

1) Kent Repertory:
a) Mind-Suicidal disposition-dread of an open window or a knife,with
b) Mind-Suicidal disposition-fright, often
c) Mind-Suicidal disposition-intermittent, during
d) Mind-Suicidal disposition-lacks courage, but
e) Mind-Suicidal disposition-pains, from
f) Mind-Suicidal disposition-thoughts-drive him out of bed
g) Mind-Suicidal disposition-thoughts-throwing himself from a height
h) Mind-Suicidal disposition-thoughts-windows, from
i) Mind-Suicidal disposition-thoughts-waking on
j) Mind-Suicidal disposition-weeping, amel
k) Mind-Suicidal disposition-twilight, in

2) Knerr Repertory:
a) Mind-Suicide-Anxiety, driving her to
b) Mind-Suicide -Attempted
c) Mind-Suicide -Mania, in
d) Mind-Suicide-Blood on a knife, when seeing
e) Mind-Suicide -Courage, but lacks
f) Mind-Suicide -Despair about his miserable existence
g) Mind-Suicide-Night, gets up in the, and takes his pistol
h) Mind-Suicide-Religious despair, with
i) Mind-Suicide-Uterus, prolapsus or induration of (pregnancy)
j) Mind-Suicide -Window, whenever he sees an open, or a cutting instrument (after suppressed foot sweat)
k) Mind-Suicide-Pregnancy, during
l) Mind-Suicide-Mind, determined to commit, but cannot make up, her how
m) Mind-Suicide-Phosphorus, tried to end sufferings by eating, from matches, after business embarrassment
n) Mind-Suicide-Razor, to cut his throat with
o) Mind-Suicide-Sharp weapon, wants to kill himself with

3) Analytical Repertory of Symptoms of Mind by Dr.Hering
a) Mind-Irresistible inclination to commit suicide
b) Mind-Inclined to suicide
c) Mind-Phrenitis with inclination to suicide
d) Mind-Driving to despair, to suicide by drowning
e) Mind-Burning, cramp-like pain, driving to despair; would like to commit suicide by drowning
f) Mind-Cramp-like contraction, with longing for death
g) Mind-Melancholy, constantly thinks of suicide, ovaritis
h) Mind-dwells on suicide
i) Mind-Depression, disposition to suicide
j) Mind-Wishes for solitude
k) Milk scanty; very sad and depressed, says she will die, despairing sadness
l) Mental derangement, thoughts of suicide
m) After midnight with violent palpitation and inclination to commit suicide
n) Conations. Palpitation, with depression of spirits, thoughts of suicide
o) In twilight anxiety, with inclination to commit suicide

4) Synthesis Repertory:
a) Mind-Anguish-suicide; attempts to commit
b) Mind-Delusions-suicide; attempts to commit
c) Mind-Delusions-suicide; attempts to commit-drowning; by
d) Mind-Delusions-suicide; attempts to commit-knife; on seeing a
e) Mind-Fear-suicide; of-knife; on seeing a
f) Mind-Suicidal disposition-anger driving to suicide
g) Mind-Suicidal disposition-talks always of suicide, but does not commit
h) Mind-Suicidal disposition-thinking about suicide amel
i) Mind-Suicidal disposition-thoughts-meditates on easiest of committing suicide
j) Mind-Thoughts-persistent-suicide; of

5) Phatak Repertory:
a) Suicidal Disposition, weary of life
b) Suicidal Disposition, weary of life-Blood, seeing on
c) Suicidal Disposition, weary of life-Brooding
d) Suicidal Disposition, weary of life-By dagger
e) Suicidal Disposition, weary of life-By drowning
f) Suicidal Disposition, weary of life-By hanging
g) Suicidal Disposition, weary of life-By poison
h) Suicidal Disposition, weary of life-By shooting
i) Suicidal Disposition, weary of life-Cars, under
j) Suicidal Disposition, weary of life-Love disappointment, from

6) Synthetic Repertory:
a) Suicidal disposition
b) Suicidal disposition-axe, with an
c) Suicidal disposition-despair, from
d) Suicidal disposition-drunkenness, during
e) Suicidal disposition-fire, to set oneself on
f) Suicidal disposition-gassing, by
g) Suicidal disposition-hypochondriasis, by
h) Suicidal disposition-seeing blood or a knife, she has horrid thoughts of killing herself, though she abhors the idea
i) Suicidal disposition-shooting, by
j) Suicidal disposition-throwing himself from a high

7) Repertory of Psychic Remedies with Materia Medica-Jean Pierre Gallavardin:
a) Suicide-by fire arms
b) Suicide-being crushed under a carriage
c) Suicide-by drowning
d) Suicide-by hanging
e) Suicide-stabbing, by
f) Suicide-poisoning
g) Suicide-jumping from a high place
h) Suicide-asphyxiation by a coal gas
i) Suicide-cutting throat by a razor blade

8) Murphy Repertory:
a) Mind-Suicidal disposition-acute, depression, from
b) Mind-Suicidal disposition-anxiety, agony, from
c) Mind-Suicidal disposition-axe, with an
d) Mind-Suicidal disposition-car, run over by a
e) Mind-Suicidal disposition-cancer, with or family history of
f) Mind-Suicidal disposition-children, in

g) Mind-Suicidal disposition-night, gets up in the, and takes his pistol
h) Mind-Suicidal disposition-menses, during
i) Mind-Suicidal disposition-perspiration, during
j) Mind-Suicidal disposition-poison, by
k) Mind-Suicidal disposition-pregnancy, during

9) BBCR Repertory:
a) Mind-Suicidal-Drowning, by
b) Mind-Suicidal-Hanging, by
c) Mind-Suicidal-Homesickness, from
d) Mind-Suicidal-Knives, seeing, on
e) Mind-Suicidal-Shooting, by
f) Mind-Suicidal-Starving, by
g) Mind-Suicidal-Throwing himself-from a height or window
h) Mind-Suicidal-Throwing himself-under the cars
i) Mind-Suicidal-Tired of life

10) Boericke Repertory:
a) Mind-Mood-disposition-Suicidal
b) Mind-Propensity to-Commit suicide

12. Conclusion

The management of Suicidal Behavior Disorder through the Homoeopathic Repertory provides a systematic and individualized approach to address one of the most critical challenges in mental health. By utilizing rubrics that encompass not only suicidal thoughts but also underlying causative factors, emotional states, and concomitant symptoms, homoeopathy extends beyond symptomatic relief to target the patient's constitutional susceptibility. Integrating repertorial analysis with miasmatic understanding and holistic case management can help reduce relapse, restore balance, and support patients in achieving mental stability. While homoeopathy should be considered as a complementary system alongside conventional psychiatric care, its individualized, non-invasive, and holistic methodology offers promising potential in the comprehensive management of Suicidal Behavior Disorder.

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