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CAUSES AND PREVENTION OF SUICIDE: AN INDIAN PERSPECTIVE

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ABSTRACT

Suicide is the third leading cause of death among young adults world wide. In India, young people are vulnerable to suicide which is a major health problem today. The reasons for committing suicide are not much clear but, in general, family problems, physical and mental illnesses, unemployment, love affairs, drug abuse, failure in exams, bankruptcy or sudden change in economic status, poverty, dowry-dispute, infertility, sexual assault are seen as motives behind suicide. Understanding reason from a suicide survivor's perspective may lead a step forward in taking preventive measures against suicide. Survivor's perspective can provide valuable insights into concerns that are unique to young people and preventive measures can be directed towards these concerns. Some individual and environmental factors that increase vulnerability, emotional and cognitive states that lead to suicidal ideation and some intervening factors that facilitate the transition from distress to the suicidal attempt are important in understanding the journey of suicide. Shortly, before the suicidal attempt, a stressor is present in the form of a trigger associated with longstanding problems which had already produced intolerable distress over time. Distorted cognitions and overwhelming emotions, usually anxiety or anger leads to impulsivity which turns into the act of suicide. The socio-cultural norms are responsible to make females much vulnerable to commit suicide. Over the past years, India has witnessed an increase in suicide rate. In India, women are not necessarily protected by marital status and thus marital stress leads to suicide. Competition in all walks of life make young people more vulnerable to stress and this may lead to suicide. The motives and mode of suicide in India are different from

Western countries. Prevention of suicide should be implemented at family and community level and vulnerable persons must be identified in order to save their lives and teach them to live life in a constructive manner. Suicide prevention programs in India, may be helpful in fostering life skills among young people, engaging with high-risk groups and restricting access to harmful substances. Families must take care of their members who are vulnerable to stress and suicide. Preventive programs can be made successful by the involvement of both family and society.

Key Words: Suicide, Survivor, Suicidal ideation, Cognitions, Emotions, Prevention.

The act of killing oneself intentionally can be termed as suicide. It is an act of intentionally causing one's own death. Government of India classifies a death, as suicide, if it meets three criteria- it is an unnatural death, the intent to die originated within the person, there is a reason (specified in a suicide note or unspecified) for the person to end his/her life. If any ot these criteria is not met, the death may not be termed as suicide. Many risk factors lead to suicide- mental and physical illnesses, hopelessness, loss of a loved one, sexual assault, experiencing bullying or trauma, facing prejuidice and discrimination and the like.

Suicide has been glorified, romanticized, bemoaned and even condemned through ages. Suicide is probably an age old story world wide. The universality of suicide transcends religion and culture (Evans and Norman, 1988). Understanding suicide in the Indian context, needs an appreciation of the literary, religious and cultural ethos of the sub continent because Indian tradition is intact even today in the lives of its citizens. Ancient Indian text contains stories of valor in which suicide was glorified and taken as a means to avoid shame and disgrace. Suicide was understood as sacrificing life, in the great epic of Ramayana and Mahabharata. Bhagavad Gita condemns suicide for selfish reasons and posits that suicidal death cannot have "Shraddha", the all important last rites, Brahamanical view had held that those who attempt suicide should fast for a stipulated period. Upanishads, the Holy scriptures condemn suicide and state that 'he who takes his own life will enter the sunless areas covered by impenetrable darkness after death.' However, the Vedas, permit suicide for religious reasons, and consider that the best sacrifice was

that of one's life. Suicide by starvation also known as "Sallekhana" was linked to the attainment of "moksha" (liberation from the cycle of life and death), and is still practiced to this day (Braun, 2008). Sati, where a women immolated herself on the pyre of her husband rather than live the life of a widow and Jauhar (Johar), in which Rajput women killed themselves to avoid humiliation at the hands of the invading Muslim armies, were practived unitl the early half of the 20th century; stray cases continue to be reported (Bhugra, 2005).

Suicide Around the World

WHO indicated that suicide in 2004 was the eighth leading cause of death world wide, among persons 15-44 years of age (WHO, 2004). In some countries, suicide was found to be the second leading cause of death in the 10-24 years age group. High rates of suicide has been reported in Sri Lanka, based on data from the WHO Regional Office for South-East Asia (Gururaj & Issac, 2001). It was found that 86% of all suicides occurred in the low and middle income counties (WHO, 2002) Suicide rates increased by 60% world wide from 1950-1995. The average rate increased from 10.1 per 100.000 in 1950 to 16 per 100.000 in 1995 (WHO, 1999). The period from 1950 to 1995 witnessed changes in world politics and in 1950 estimates were of only 11 countries whereas in 1995 there were 62 countries to give estimates. This shows that these 62 countries might be facing suicide as a major health problem and were hence more likely to report on suicide mortality (Bertolote and Fleishmann, 2002)

Suicide in India

Data on suicide in India are available from the National Crime Records, Bureau, Ministry of Home Affairs, An increase of 41.3% during 1980-1990 and a compound growth rate of 4.1% per year was noticed (NCRB, 1992). Recent data shows that from 1999 to 2002, the rate of suicide showed a declining trend, a mixed trend during 2003-2006, followed by an increasing trend from 2006 to 2010 (NCRB, 2008)

NCRB data are based on police records. Socio cultural factors undermine the truth of these records. Since suicide attempt in a punishable offence under the IPC Section 309, so suicide cases result in under-reporting. In rural areas death registration process is inefficient. Death

caused by suicide is frequently reported as due to illness or accident to avoid police investigation. Families hide suicide because they feel social stigma in postmortem and all other processes. Thus, police records under-report the suicide data.

Suicide is an emerging and serious public health issue in India. 164,033 Indians committed suicide in 2021 and the national suicide rate was 12 per one lakh. In 2021 Maharashtra recorded highest number of deaths by suicide (22,207) followed by Tamil Nadu (18,925), Madhya Pradesh (14,965), West Bengal (13,500) and Karnataka (13,056). These five states together accounted for almost half of the total suicides recorded in India in 2021. In 2019, these five states collectively contributed to 49.5% of Indian suicides. Nagaland reported only 41 suicides. These five states have consistently shown higher suicides from 2017 to 2019. Among Union Territories, Delhi reported the highest number of suicide followed by Puducherry, Lakshadweep reported zero suicides. Bihar and Punjab reported a significant increase in the percentage of suicide in 2019 over 2018.

Demographics of Suicide in India

Risk factors associated with suicides include young age (15-24 yrs), female gender, low educational level, unemployment, living alone and history of socio-economic deprivation.

Young adults are a particularly vulnerable group and currently show the highest rate of suicide the world over. Suicide is responsible for 6% of all deaths among young people (Patton, et. al., 2009). An Indian study showed suicide rate to be the highest in 15-29 yrs age group (38 per one lakh), followed by 30-44 yrs group (34 per one lakh), 45-59 yrs age group (18 per one lakh) and above 60 years it was 7 per one lakh (Gururaj & Isaac, 2001) Youth is a period of heightened risk of suicide (Vijayakumar, et. al., 2005) and suicide is a leading cause of death among young people in India. In a study which evaluated the cause of death among those aged 10-19 years, in a rural population of 108,000 in south India, suicide accounted for about a quarter of all deaths in males and between 50-75% of all deaths in females aged 10-19 years. The average suicide rate for girls was 148 per one lakh and for boys it was, 58 per one lakh (Aaron, et. al., 2004) Among young people, suicidal behaviour was found to be associated with female gender, who were not

attending school or college, were not taking independent decisions, had premarital sex, physical abuse at home, lifetime experience of sexual abuse and also probable common mental disorders. Violence and psychological distress were independently associated with suicidal behaviour. Rural girls were more affected by these factors (Pillai, et. al., 2009)

There is a global trend seen towards increased suicide in late life, mainly in men. In a 5-years study of 6312 suicide attempters only 47 were above the age of 60 years. (Rao & Madhavan, 1983). The low prevalence of suicide among the elderly in India may be because the aged are well integrated and respected in the family and children take responsibility for their care. Also, life expectancy in the elderly is lower in India than elsewhere, contributing comparatively to the lower suicide rate (Shukla, et. al., 1990)

Globally, attempted suicide is common among women and completed suicide is common among men. Although some Indian studies have found a higher incidence of suicide in men than women, others have found the contrary. For each suicide, at least 20 people make a suicide attempt (Bostwick etal, 2016). A prior history of such attempts is one of the most established risk factors for subsequent death by suicide (Beautrais, 2003) Suicide attempts are at least 15 times more common than complete suicides. Young women in particular seem to be at increased risk, reporting them more frequently than men. Marriage is generally protective against suicide in Western Countries but in developing countries, like India, it is not a strong protective factor (WHO, 2002). In 2009, 70.4% of all suicide victims in India were married and 21.9% were unmarried. Divorcees and separated individuals accounted for about 3.4%, while widows and widowers comprised 4.3% of the total suicide victims (NCRB, 2009). This shows that the quality of marital relationship, emotional warmth, extended family support, ability to handle stresses related to marriage and child rearing are more important than having a marital status only. Education, in general makes a person to think and analyze well. Moreover it may sharpen intelligence also. Low intelligence results in a two-three fold increased rate of suicide. Possibly persons with low intelligence are less capable to compete and therefore acquire lower income and social status. They may be less efficient in coping with stress and, finally neurodevelopmental vulnerabilities may increase their risk of committing suicide (Gunnell,

Magnusson, Rasmussen, 2005). Family structure, if cohesive is a protective shield against suicide. People who are well integrated with their families and community have a good support system during crisis, protecting them against suicide. India has witnessed a change in family structure during recent decades, with more people moving out of joint and extended families into nuclear family structures. Some studies show more suicide attempts in nuclear families (Srivastava, et. al., 2004; Latha, et. al., 1996). An earlier study show that more suicide attempts occurred in joint families (Adityanjee, 1986; Gupta & Srivastava, 1988). Moreover, burn victims, from joint family were at greater risk for dowry deaths in India. Family and marital conflict were found to be the major reason for suicide (Kar, 2010). It has been observed that urban life is more prone to commit suicide because of a variety of stressors present, as, overcrowding and social isolation. In India in 2000, the suicide rate in urban areas was slightly lower at 9.94% (NCRB, 2000) In 2005, it increased to 11.4%, in 2006 and 2007 it increased to around 13% and in 2008 it was 12.1% and 12.5% in 2009 (NCRB, 2009). Studies in recent years, show an increasing trend in suicide rates and attempted suicides were found to be more common in persons living in urban areas (Khan, et. al., 2005). Association between unemployment and rates of suicides is found to be strong enough, but suicide risk is high to related factors, as, poverty, social deprivation, domestic problems and most important hopelessness. Loss of employment is a high risk factor for suicide (WHO, 2000). Young adults are again at higher risk of suicide due to unemployment (Pritchard, 1992). In India, NCRB (2010) data shows that housewives account for 18.6% of total persons committing suicide and 52.8% of the total female victims. The least represented group was of employed persons in public sector (2.2% of total suicides) and government servants (1.3% of total suicides)

Precipitating causes of Suicide

Suicide is an expression of rent up negativity in a person. Negative life events, being stressed mostly, losses of significant persons and objects, negative interactions are some of the general causes of suicide. But most important cause is the vulnerability and coping skills present in a person. Rich and Bonner (1987) found in a stress-vulnerability model that negative life events and stress accounted for 30% of the variance in suicidal ideation. Indian society gives

importance to interpersonal relations, so, here marital conflict is the most common cause of suicide among women, while interpersonal conflict is the most common cause of suicide among men (NCRB, 2010) (Banerjee et al, 1990)

Factors contributing to suicide in India as studied in 2019, NCRB report is presented in Table –I

Table-I : Factors contributing to suicide in India

Contributing Factors	**Percentage (%)**
Family problems	32.4
Illness	17.1
Drug Abuse (Alcoholism)	5.6
Marital Issues	5.5
Love Affairs	4.5
Bankruptcy/Indebtness	4.2
Failure in Exams	2.0
Unemployment	2.0
Professional /career problems	1.2
Property Dispute	1.1
Death of Dear Person	0.9

Poverty	0.8
Suspected/ illicit relation	0.5
Fall in social reputation	0.4
Impotency/ Infertility	0.3
Other causes	11.1
Unknown causes	10.3

Source : NCRB, 2010

Some common suicide triggers are – physical illness, bankruptcy, illicit relations, drug intoxication. High rate of suicide in India was found to be associated with sexual abuse and illegitimate pregnancy (NCRB, 2010). This reflects the cultural boundaries related to sexuality in India. Chronic pain and illness was also found to be common reason for suicide (Srivastava, et. al., 2004). Stressful life events were found to be the cause for 90% suicides (Latha, et. al., 1996) 35% people who committed suicide experienced stressful life events in the previous 6 months (Srivastava et. al. 2004). These data need further investigation to establish these figures with more evidence.

Motives for Suicide

The motive for suicide may be diverse. An Indian study of suicide attempters classified motivation into 'the wish for change' and 'the wish to die' groups and found that farmer group had low lethality, lack of planning, more likelihood of rescue and were not intoxicated during the attempt. The latter group utilized more drastic measures, such as hanging and was more likely to have a psychiatric disorder with comorbid alcoholism (Unni, et. al., 1995).

In India, some general causes of suicide do exist which reflect the unique social structure of our

society and the social pressures that an individual face. They are- illict or suspected relation, cancellation or non-settlement of marriage, impotency or infertility, death of a dear one, dowry-dispute, divorce, ideological cause or hero worship, illegitimate pregnancy, physical abuse (rape, incest etc), poverty, professional or career problems. (NCRB, 2009).

Suicide-note reports a last wish in 30% cases (Bahtia et al, 2006) Mass suicides occur due to pacts in couples or families (NCRB, 2010). Suicide pacts almost always involve people well known to each other, mostly childless and spouses (Bardale & Dixit, 2007). There is an emerging trend for cyber-based internet-facilitated suicide pacts which involve two or more strangers who meet on the internet and share similar world views (Rajagopal, 2004). Such cases have been reported but remain uninvestigated. Different modes of suicide exist worldwide. Common methods used in developing nations include firearms, car exhaust asphyxiation and poisoning. In developing nations, pesticides, poisoning, hanging and self-immolation are the modes seen. In India, during 2009, consumption of poison (33.6%) hanging (31.5%) self-immolation (9.2%), drowning (6.1%) were the commonest modes of suicide found. Jumping from building accounted for 1.5% (NCRB, 2010). Qualitative studies on young survivors, have revealed the importance of several factors in suicide- stressful family environments, mental and emotional problems, substance abuse, romantic disappointments, fragile peer relationships, poverty, sexual abuse, chronic health problems past suicidal behaviors, social contagion, and so on. Also the combination of intrapersonal and interpersonal factors in transitioning from suicidal ideation to suicide attempts are also being revealed. (O'Brien et. al., 2021) Two studies are worth mentioning in this direction. First, explored family-level factors in persons between 13-29 years of age and highlighted the role played by dysfunctional relationships in suicide attempts (Mathew et al, 2021) The second study assessed the explanatory models of 15-24 yrs olds, and emphasized the importance of interpersonal issues and emotional dysregulation, the financial issues in men and social stigma in women (Aggarwal, et. al., 2020). While these studies give valuable information on risk factors but does not give information on the complete range of potential factors – for eg., spanning both individual –level constructs or well as environmental influences, their complex interactions with one another, the pathways by which they lead to suicide attempts and on factors unique to young women which make them more valuable to

commit suicide.

Prevention of Suicide

General measure to prevent suicide may include – reducing social isolation, preventing social disintegration, treating mental disorders, regulating the sale of pesticide and ropes, promoting psychological and motivational sessions, meditation and yoga practice (Singh & Singh, 2003) Enforcing state-led policies to decrease the high suicide rate may be a good measure to prevent suicide.

Losing young people to suicide is a tragedy, with devastating emotional and economic consequences for families and communities, which is indicative of the urgent need to address the suicidal behaviours in youth. With 17% of the world's population living in India and nearly 30% being 15-29 years of age, preventing suicidal behaviours among young people in India is crucial in achieving the targeted reduction of premature deaths due to suicides. To develop preventive programs, it is necessary to understand the reasons among youth which lead them to commit suicide. Subjective perspective here is very important. Such perspective can provide valuable insights into concerns that are unique to young people and direct the focus of such efforts towards these specific factors.

Preventing suicide is not easy, but consistent efforts can certainly lead to good results. (Gajalakshmi, et, al., 2007), took a view of the numerous causes to commit suicide and thus declared it a difficult problem to solve. The view runs as, "a complex array of factors such as poverty, low literacy level, unemployment, family violence, breakdown of the joint family system, unfulfilled romantic ideals, inter-generational conflicts, loss of job or loved ones, failure of crops, growing costs of cultivation, huge debt burden, unhappy marriages, harassments by in-laws and husbands, dowry disputes, depression, chronic physical illness, alcoholism/drug addiction and easy access to means of suicide." In 2000, WHO launched the multiside intervention study on suicidal behaviour which aimed to increase knowledge about suicidal behaviour and about the effectiveness of interventions for suicide attempters in culturally diverse places around the world. Psychiatric disorders need early detection and adequate treatment which

may be helpful in reducing suicidal behaviour. Since the greatest predictor of completed suicide, is the presence of previous suicide attempt, interventions aimed at suicide attempters may be the most effective, in reducing suicide rates (Vijayakumar, et. al., 2011) A study revealed that 24% of suicide completers had consulted a psychiatrist or physician before the event and family of the victim was aware of the suicidal intent in 68% of cases.(Khan , et. al, 2005). This means that adequate training of general practitioners in detection and referral of patients with common mental disorders, can be a preventive measure, to get a significant decline in suicide rates.

The early identification and treatment of vulnerable populations with risk factors for suicide across the life-span can be an important preventive measure. In this direction, the first step is to identify populations with childhood traumas, may it be physical abuse or parental domestic violence. A multi level approach with active participation of teachers health professionals, parents and legal system is required. Primary prevention requires promoting positive health and teaching coping strategies to children, promoting awareness about child rearing practices in parents and early intervention for maladaptive coping styles. At the community level, the establishment of social programs, such as, child and family support programs aimed at achieving gender equality and socio-economic balance, may be useful in this direction (Sharma, et. al., 2007)

The role of media is also important. A balance is required between freedom and responsibility of press, to minimize the harm to vulnerable individuals. The task of suicide prevention is not that easy. Although suicide attempters are at increased risk of completed suicide, about 10% of attempters persistently deny suicidal intent, this group may continue to be vulnerable, though restricting availability of lethal means appears to be a possible solution (Vijayakumar & Satheesh–Babu, 2009). Interestingly an early study in India in West Bengal, where legislation was introduced to restrict sale of a pesticide found no reduction in the overall suicide rate, but only a change in the modes of suicide was observed (Nandi, et. al., 1979) Thus, it seems no hyperbole that suicide prevention is a great challenge in India and sometimes it appears to be more complex than the problem of suicide itself. Hope lies in a consistent effort made in all walks of life in suicide prevention and developing a humanity sensitive approach in the family

and society. The causes of suicide need a serious attention and they must be solved. Moreover, life is precious and struggle is a part of life, so we must try hard to fight. In this journey we all must join hands together to achieve good results.

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