

Suicide and Suicidality in India: Vulnerabilities and Resiliency

Neha Pathak¹, R.N. Singh^{2*}, Uma Pati Singh³

ABSTRACT

Suicide is a major concern for public health and individual well-being worldwide as it happens to be among the top three causes of death of youths and also a major threat to other age groups. According to estimates, every year, almost one million people die from suicide in the world. One death every 40 seconds is recorded in the world and this trend is on increasing pattern. Thus, it is a major health hazard for our people. It is observed in our country that family problems, illness and relationship problems are relatively more potential predictors of suicide and suicidality. The contribution of various factors to the suicidal deaths varies in intensity and impact, but any prevention programme for suicide must take into account all such factors for making the programme successful. This paper deals with the risk factors for suicide and also suggests the approaches to deal with this epidemic to save our precious human resources and also manage the social and family crisis created by the suicidal deaths.

Keywords: *Suicide, Suicidality, Vulnerabilities, Resilience, India*

The word suicide was firstly used by Sir Thomas Brown (1642) in his treatise “Religio Medici”. This word originated from SUI (of oneself) and CADES (murder). The word *suicide* breaks down into the Latin words *sui* and *caedere*, which together translate to “kill oneself.

Suicide, also called completed suicide, is defined as the act of taking one's own life. There are some related terms also which need to be mentioned in this context. For example, attempted suicide or non-fatal suicidal behavior is self-injury with the desire to end one's life that does not result in death. If a person assists another person indirectly for suicide via providing either advice or the means to the end life, it is known as assisted suicide. This is in contrast to euthanasia, where another person takes a more active role in bringing about a person's death. Suicidal ideation is thoughts of ending one's life but not taking any active efforts to do so. Homicide-suicide or murder-suicide is the type of suicide in which the individual aims at taking the life of others at the same time. Sometimes extended suicides are also noticed,

¹ Research Scholar in Psychology, Magadh University, Bodh-Gaya, India

² Professor of Psychology, Banaras Hindu University, Varanasi, India

³ Professor of Psychology, Magadh University Bodh- Gaya, Bihar, India

*Responding Author

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where after seeing the murdered persons, a person may be motivated for ending his own life (Wasserman, 2009).

Prevalence of the Problem

In India 15 suicides take place every hour in our country, estimating over 1.35 lakh (1,35,445) people ending their lives (WHO, 2012). According to NCRB the suicide rates in India rose from 6.3 per 100,000 in 1978 to 8.9 per 100,000 in 1990, an increase of 41.3% during the decade from 1980 to 1990, and a compound growth rate of 4.1% per year. More recent data, however, reveal a different picture. The rate of suicide showed a declining trend from 1999 to 2002 and a mixed trend during 2003-2006, followed by an increasing trend from 2006 to 2010. During 2009, the rate was 10.9 per 100,000 population. This represented a 1.7% increase in suicides since 2008. In the most recent NCRB report the rate in 2010 rose to 11.4 per 100,000 population; an increase of 5.9% in the number of suicides (2008). As regards patterns, 41.8 per cent people committed suicide by hanging, 26 per cent by taking poison, 6.9 per cent by self-immolation, 5.6 per cent by drowning themselves and 1.1 per cent by jumping off buildings or in front of trains.

Vulnerabilities: Risk Factors

The factors assumed to be associated with suicidal behaviour and deaths may be conceptualized as the risk or vulnerability factors and resiliency or protective factors. Beside there may be some precipitating factors also (Fig.1).

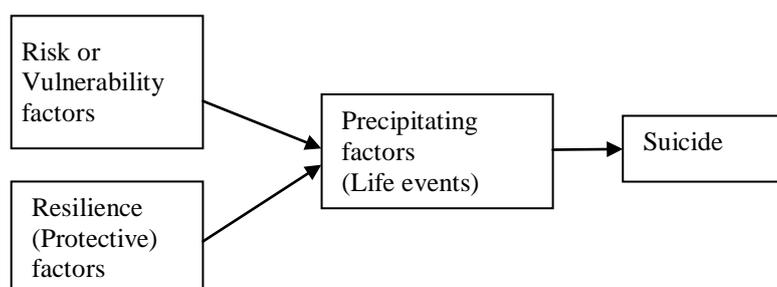


Fig.4: *A model of suicide: Suicide is related to the individual's vulnerabilities and resilience as well as negative life events*

Age

The adolescents and young adults and those over 70 years of age are at the high risk of suicide. Suicide is the third leading cause of death for young people between 15 and 24 years and fourth leading cause of death for children between 10 and 14 years. As the NCRB reports state, out of every three case of suicide every 15 minutes, one is committed by a youth in India of 15 and 29 years and every 90 minutes, a teenager tries to commit suicide in our country. Suicide rate was highest in the 15-29 years age group (38 per 100,000 population) followed by the 30-44 years group (34 per 100,000 population). The rates of suicide was 18 per 100,000 in those aged 45-59 years and 7 per 100,000 in those aged >60 years (Spirito & Overholser, 2003). Pathak and Singh (2016) found that older adolescents scored significantly higher than the younger adolescents on suicidal ideation scale. This suggests

that age is a crucial factor in suicidality and susceptibility of indulging in suicidal thought may increase with progressing age. This trend is also seen in attempted suicides. But in our country the status of elderly is relatively different. They relatively enjoy better life which works as the protective factor.

Gender Disparity

The gender disparity and bias are among the leading risk factor of suicides for young women (Radhakrishnan & Andrade, 2012). Pathak and Singh (2016) also found that females exhibit significantly more suicidality in comparison to their male counterparts. (also, Asthana, Singh and Rai, 2015). Upadhyay and Singh (2006) obtained that males of all the age groups commit suicide at a higher rate than females, although females attempt suicide more often than males. Study revealed that male adolescents scored significantly higher on the measures of suicidal ideation as compared to their female counterparts. Thus the relationship between gender and suicidal ideation seems to be conflicting.

Marital status

The marriage is generally a protective factor against suicide. This empirical regularity is referred to as the “coefficient of preservation” based on Durkheim's (1897). Divorced, separated, widowed, and single people are more likely to commit suicide than married people (Kaposowa, 2000). The scholars speculate that lower rates of suicide among married compared to unmarried women may be the function integration and social integration which individuals feel in family settings (Cutright, Stack & Fernquist, 2007).

But the analyses of suicidal deaths in India present a different picture. In 2009, 70.4% of all suicide victims in India were married and 21.9% were unmarried. Divorcees and individuals who were separated accounted for about 3.4%, while widows and widowers comprised 4.3% of the total suicide victims (NCRB, 2009). In individual studies, some show higher attempted suicides among unmarried persons (Narang, Mishra & Nitesh, 2000 & Kumar, 2006), while others show a higher rate among those who are married (Srivastava et al., 2004; Latha, Bhat & D'Souza, 1996). Thus the marital status appears to be a potential cause of suicide, however in some studies, findings are conflicting.

Personality factors

Some personality traits and other attributes have been reported to be associated with suicidal behaviour. For example, hopelessness and pessimism predict suicides (Beck, Steer, Kovacs & Garrison, 1985). Singh and Pathak (2017) examined the effects of self-esteem on suicidality and it was found that higher the level of self-esteem lower the chances of indulging in suicidal behaviour and vice versa. In another study also, big five factors were found to be associated with suicidality (Singh & Pathak, 2017). The adolescents with higher level of extraversion, agreeableness, open to experience and conscientiousness are significantly less indulged in suicidal ideation in comparison to the adolescents scoring low on the above dimensions. The higher level of neuroticism was found to be a major risk factor for suicidality. The rate of personality disorders among the persons attempting suicide in India

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has been found to range from 7 to 50% and schizoid, borderline, and antisocial personality disorders are the most common disorders. The self-immolators are found to be poor in ego strength, tolerance to frustration, emotionally less stable, and be impulsive (Chandrasekaran et al., 2003).

Mood Disorders

Mood disorder has been found to be a vital risk factors for suicide and suicidality among adolescents (Glowinski et al., 2001). Similarly, the presence of depressive symptoms in the absence of diagnosis is related to increased risk for suicidal ideation and attempts among adolescents (Esposito & Clum, 2002; Sourander et al., 2001; Ramdurg, et al., 2011). Although suicidality is most often associated with affective disorders, anxiety disorders have also been identified as risk factors for suicidal ideation and attempts. In particular, research has shown that, after controlling for major depressive disorder, adolescents with post-traumatic stress disorder (PTSD) are more likely to feel suicidal ideation) and attempts (Mazza, 2000

Life events and Stress

According to WHO, every year in India about 14 thousand students commit suicide and 70% of them are found to be under stress. The students aged 16-18 are often subjected to undue pressure at home to succeed. When they don't, suicide becomes a way out. In 2013 alone, 2,471 suicides were attributed to "failure in examination". In India more than 14,000 students commit suicide per year. This suggests that stressful life events are not related only with depression, they also correlate strongly with suicidal behaviour. The stress-vulnerability model accounts for 30% of the variance in suicidal ideation. Indian society, being sociocentric, lays importance on interpersonal relationships. It is therefore unsurprising that marital conflict is the most potential cause of suicide among women, while interpersonal conflict is the commonest cause among males.

As regards the attempted suicide with interpersonal conflict, similar trends have been reported. The financial stressors and educational burden are said to be the most common triggers of attempted suicide. (Khan et al., 2005; Mohanty el al., 2007). Studies which measured stressful life events found that approximately 90% of suicide attempters reported negative life events (Latha, Bhat & D'Souza ,1996) and about 35% experienced stressful life events in the previous 6 months (Srivastava et al.,2004).

Economic factors

Socio-economic factors including employment status are also among potential causes of suicidal deaths. The highest cases of suicide was seen among the self-employed (19.7%) followed by housewives accounting for 15.3 per cent of the total, daily wagers 12 per cent, salaried persons 7.4 per cent, students 6.1 per cent and retired people 0.7 per cent. As many as 69.7 per cent of those who ended their life had an annual income of less than Rs. 1 lakh while 26.9 per cent had an annual income of between Rs. 1 to Rs. 5 lakh, the report said.

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It is all because of poor economic conditions that farmers commit suicide in large numbers in our country. In majority of cases, farmer suicide happens mainly because of poor economic condition and loss in farming. In India, 182,936 farmers were recorded to have committed suicide between 1997 and 2007. Factors contributing to the high rate of suicide in this vulnerable population include economic adversity, exclusive dependence on rainfall for agriculture, and possibly monetary compensation to the family following suicide (Sarkar, et al., 2006). Singh and Pathak (2016) found that adolescents from agricultural background exhibited significantly higher tendency of suicidality followed by business and service parental occupation (also, Asthana & Singh, 2015). There is fairly a strong association between economic status and suicide, but the nature of this association is complex. (WHO)

Family factor

Analyses of suicidal deaths indicate that family problems are potential risk factors for suicide and it accounts for 84 suicides a day on an average. The researchers are of the view that people who are well integrated with their families and community enjoy good support system during crises, which protects them against suicide. Risk factors related to the family include parenting style, family history of mental illness and suicide, and physical and sexual abuse in childhood. In our country, joint family system has been a very useful support system for the people to cope with negative events in life, but at present more people are moving out of joint and extended families into nuclear family structures. Though the effect of this change on suicide rate has not been systematically studied, yet in majority of suicides, attempters were found to be from nuclear families (Srivastava et al.2004; Latha, Bhat & D'Souza, 1996). Pathak and Singh (2016) also obtained differential effects of type of family on suicidality, as the adolescents from nuclear families were found to be more prone to suicidality than the adolescents from joint families. Ramdurg et al (2011) also found that majority of suicide attempters (86%) had a precipitating event prior to the attempt of suicide. The interpersonal problems with family members other than the spouse were the most common problems behind it (22%) followed by interpersonal problems with the spouse (19%).

Educational level

The data and the findings available about education and suicide indicate that low intelligence increases 2-3-fold risk for suicide and the reason behind it may be that such people are less able to compete for jobs and therefore remain in low SES. Their efficiency in coping with stress is also impaired. The NCRB (2009) data reveal that 25.3% of suicide victims were educated up to primary level, 23.7% had a middle-school education, 21.4% were illiterate, and 3.1% were graduates or postgraduates. In one study of attempted suicide in India, 55.5% were uneducated (Srivastava et al 2004). In another study also, 54% of suicide attempters had received high school education or higher (Latha , Bhat & D'Souza,2004).

Cultural, Religion and Suicide

Does cultural cognition or attitude influence the suicidality and suicide? Although the studies from this point of view are very scarce but indicate some association between the two variables, no doubt. In Japan, suicide is traditionally viewed as culturally appropriate

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behaviour to deal with the feelings of shame and of being personally disgraced, perhaps about failure to achieve or having behaved in an unethical way (Sarason & Sarason, 2011). They probably assume that their unethical behaviour may be the cause for the trouble for their family members. In a comparative study, Japanese students were found to have attempted more suicidal behaviour as compared to their Canadian counterparts, who instead of making for suicides, tried to consult health professionals for dealing with suicidal thoughts (Heisal & Fuse, 1999).

Table 1: Share of different religious and caste groups in suicide in India

SUICIDES IN NUMBERS				
	Rate of suicides*	% share in suicides	% share of population	Number of suicides
RELIGION				
Christian	17.4	3.7	2.3	4,845
Hindu	11.3	83	79.8	1,09,271
Muslim	7	9.2	14.2	12,109
Sikh	4.1	0.6	1.72	848
CASTE				
Scheduled Tribe	10.4	8.2	8.6	10,850
Scheduled Caste	9.4	14.4	16.6	19,019
OBC**	9.2	34	40.2	44,827
General	13.6	43.3	34.6	56,970
All India	10.6	—	—	1,31,666

*Suicides per one lakh population **OBC population calculated on the basis of National Sample Survey data, others on Census 2011 figures.

Table 1 shows the suicide deaths in relation to culture and caste in India. It is obvious from this table that Hindus are more susceptible to suicide and when we talk in terms of caste, we can see that people from general category are relatively more sensitive to suicidal behaviour in comparison to other groups.

CONCLUSION

The analyses of the data and studies regarding suicide make it obvious that suicide is a multifaceted problem and hence suicide prevention programmes should also be multidimensional. So, collaboration, coordination, cooperation and commitment are needed to develop and implement a national plan to manage this epidemic. The people facing family problems and illness, self-employed people, house wife, adolescents, people from poor economic background and persons with psychological problems are relatively at higher risk of committing suicide. The family factors and social supports are the potential variables in coping with the suicidal thoughts and acts.

Action Plans for Preventing Suicide

The problem of suicide no doubt is a multifaceted problem, as a complex array of factors are involved in it, yet attempts can be made to prevent and manage this epidemic. The researchers are of the view that the programmes aiming at the prevention of suicide should also be multifaceted.

It has been found that greatest predictor of completed suicide is the presence of a previous suicide attempt, so interventions aimed at suicide attempters may be the most effective in

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reducing suicide rates (Vijayakumar et al., 2011). The early identification and treatment of vulnerable populations with risk factors for suicide across the life-span is another effective strategy for preventing suicide.

There is greater need of public education programme to identify the symptoms of suicidal behaviour. If the primary psychiatric disorders are detected in the early stage, suicidal deaths can be managed to a great extent. In psychiatrically ill subjects, administering lithium, clozapine, antidepressants, and employing dialectical behavior therapy (DBT) may produce good results.

Stress is a major risk factor for suicide and the people under stress may use suicide attempts as the coping alternative for dealing with the problems of life. There is a genuine need of action programmes to train people to get rid of stress to cope effectively with frustrating events in life.

The action programmes aiming at resolving family problems need to be given high priority as the interpersonal problems within the family are the potential determinant of both, the suicide and attempted suicide.

It has been very obviously concluded that economic factors are also among the potential risk factors for suicide in our country. The development programmes must focus on the economic hardships of the affected groups in order to push and facilitate them for better well-being.

As regards media, it can also have a positive influence on suicidal incidents. The 'Papageno' protective effect of media reporting describes how articles on individuals who adopted coping strategies other than suicidal behavior in adverse circumstances, are negatively associated with suicide. The media can also be a source of information about where to seek help and advice.

There is a greater need of national strategy based on a comprehensive approach that focuses on encompassing the promotion, coordination, and support of activities to be implemented across the country at national, regional, and local levels. The prevention programmes need to be tailored for populations at risk.

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