The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 6, Issue 2,DIP: 18.01.072/20180602
DOI: 10.25215/0602.072
http://www.ijip.in | April - June, 2018

The International Journal of INDIAN PSYCHOLOGY

Research Paper

Suicidal ideation: Risk Factor- Vulnerability and Protective Factor — Resiliency among youth of Juvenile Justice System

Dr. Reeta Kumari[1]*

ABSTRACT

Suicide is a leading cause of death for adolescents. A number of problem behaviours associated with youth suicide fall into the purview of law enforcement personnel, and they are therefore in a position to detect risk and prevent suicidal behaviours. The purpose of this study was to examine factors that increase or decrease suicide risk among a group of the juvenile justice system at risk for school dropout, a population known to be at increased risk for multiple problem behaviours. Studies of youth who died by suicide provide information to guide prevention efforts, and there is evidence that a number of youth who died by suicide had contact at some point with the legal system. The literature is sparse with regard to suicidal ideation among Indian women with a history of sexual violence as a minor. Using survey data, this study utilized logistic regression to investigate the roles of a risk factor, criminal justice involvement, and protective factors, and ethnic identity in experiencing suicidal ideation. Findings suggest that criminal justice involvement and the interaction of ethnic identity and spiritual well-being are important factors in understanding which Indian may be at a greater risk of experiencing suicidal ideation. Results are discussed relative to prevention and early intervention programs; particularly the importance of understanding adolescent violent behaviours within a context that addresses stress and distress.

Keywords: *Adolescence, Resiliency, Vulnerability, Juvenile Justice System*

Suicide takes life without regard to age, income, education, social standing, race, or gender. Overall, suicide is the 10th leading cause of death, the 2nd leading cause of death for adults ages 25-34, and the 3rd leading cause of death for youth ages 15-24. The legacy of suicide continues long after the death, impacting bereaved loved ones and communities. The Government of India classifies a death as suicide if it meets the following three criteria:

1. It is an unnatural death,
2. The intent to die originated within the person,

[1] (Asst. Prof., Dept of Psychology, Marwari College, Ranchi, India)
*Responding Author

Received: April 17, 2018; Revision Received: June 4, 2018; Accepted: June 25, 2018

3. There is a reason for the person to end his or her life. The reason may have been specified in a suicide note or unspecified.

If one of these criterions is not met, the death may be classified as death because of illness, murder or in another statistical category. In India, suicide was illegal and the survivor would face jail term of up to one year and fine under Section 309 of the Indian Penal Code. However, the government of India decided to repeal the law in 2014. A four pronged attack to combat suicide suggested in a 2003 monograph was

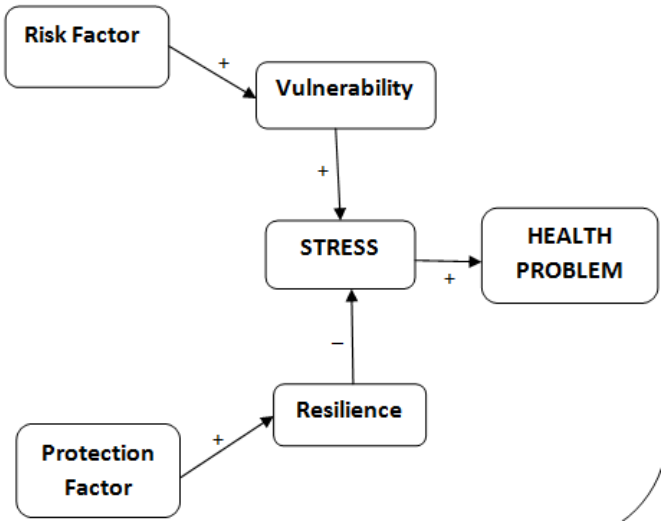
1. Reducing social isolation,
2. Preventing social disintegration, and
3. Treating mental disorders
4. Banning of pesticides & ropes

The southern states of Kerala, Karnataka, Andhra Pradesh and Tamil Nadu along with eastern state of West Bengal, Tripura and Mizoram have a suicide rate of greater than 16 while in the Northern States of Punjab, Uttar Pradesh and Bihar, the suicide rate is less than 4. Pondicherry reported the highest suicide rate at 36.8 per 100,000 people, followed by Sikkim, Tamil Nadu and Kerala. The lowest suicide rates were reported in Bihar (0.8 per 100,000), followed by Nagaland, then Manipur. Poisoning (33%), hanging (31%) and self-immolation (9%) were the primary methods used to commit suicide in 2012. 80% of the suicide victims were literate, higher than the national average literacy rate of 74%. On average, males suicide rate is twice that of females in India. However, there is a wide variation in this ratio at the regional level. West Bengal reported 6,277 female suicides, the highest amongst all states of India, and a ratio of male to female suicides at 4:3.

The reasons that people take their own life are very complex. The many factors that influence whether someone is likely to be suicidal are known as:

1. Risk factors, sometimes called vulnerability factors because they increase the likelihood of suicidal behaviour; and
2. Protective factors, which reduce the likelihood of suicidal behaviour and work to improve a person's ability to cope with difficult circumstances.

This review will explore the prevalence of recent and past suicidal ideation and suicide attempts among juvenile justice-involved youth; gender and ethnic differences; and variables associated with suicidal ideation and attempt.



Risk and protective factors are often at opposite ends of the same continuum. For example, social isolation (risk factor) and social connectedness (protective factor) are both extremes of social support.

Risk and protective factors can occur:

- at the individual or personal level and include mental and physical health, self-esteem, and ability to deal with difficult circumstances, manage emotions, or cope with stress;
- at the social level, which include relationships and involvement with others such as family, friends, workmates, the wider community and the person's sense of belonging; and
- at the contextual level or the broader life environment and this includes the social, political, environmental, cultural and economic factors that contribute to available options and quality of life.

Influencing risk and protective factors

People who attempt to take their own life usually have many risk factors and few protective factors. But risk and protective factors don't explain everything about suicide. Most people with multiple risk factors do not attempt to take their own life, and some who do take their lives have few risk factors and many protective factors. Particular risk factors are more important for some groups than others. For example, the factors that may put a young man at risk are generally quite different to those that increase the risk for a retired, older man. Applying an understanding of risk factors to prevent suicide involves identifying:

- risk factors (individual, social, contextual) that are present for a particular person or group of people;
- individuals who are most likely to be badly affected by these risk factors, and those who are most likely to be resilient; and
- which of the risk factors can be changed (modifiable) to reduce the level of risk.

That there is not a straight one to one relationship between reduced risk and the presence of protective and/or risk factors may be for a number of reasons:

- The same life event can have very different effects on individuals, depending on what else is happening in a person's life at the time and their ability to grow and learn from life's challenges. To assist someone who is feeling suicidal it is critical to understand their sense of self, their ability to cope, and their personal competence.
- People also vary widely in their beliefs about what makes life worth living, and these views may also change over time. Despite many years of research, researchers have not yet been able to explain how and why these differences occur.
- A further challenge lies in the strong relationship between socio-economic factors and health. At present in Australia, there is a strong link between geographic location (regional, rural and remote), socio-economic disadvantage (low socio-economic status) and ill health. This relationship also exists for suicide — suicide rates tend to be much higher in regional, rural and remote locations and in areas of higher socio-economic disadvantage.

SUICIDAL IDEATION

Suicidal ideation or suicidal thoughts has some signs and symptoms to end the life. Some symptoms may include feeling helpless, feeling alone, excessive fatigue, low self-esteem, presence of consistent mania, excessively talkative, intent on previously dormant goals, feel like one's mind is racing and related to poor in education or result. The onset of symptoms like these with an inability to get rid of or cope with their effects, a possible form of psychological inflexibility, is one possible trait associated with suicidal ideation. They may also cause psychological distress, which is another symptom associated with suicidal ideation. Suicidal ideation is generally associated with depression and other mood disorders; however, it seems to have associations with many other mental disorders, life events, and family events, all of which may increase the risk of suicidal ideation. For example, many individuals with borderline personality disorder exhibit recurrent suicidal behavior and suicidal thoughts. For the current paper, we refer to "vulnerability" as an interactive process between the social contexts in which a young person lives and a set of underlying factors that place the young person "at risk" for negative outcomes (e.g., school failure, domestic violence, street children stress, injury). Factors predisposing to vulnerability may be biologic (e.g., chronic illness) or cognitive (e.g., how risk is assessed). Vulnerabilities may result from being reared in disadvantaged environments such as in substance-abusing families, abusive/violent environments, or families with mental illness, and it can result from individual characteristics such as aggressive temperament. In adolescent health, where more than 75 percent of all mortality is related predominantly to social and behavioural factors, there has been extensive research over the past generation that has strived to identify the behaviours that predispose to negative health status both in the short term (during the teenage years) and long term (in adulthood). This stream of research, as Jessor (1991) notes, integrates behavioural epidemiology and social psychology. One refers to risk-taking behaviours (e.g., smoking, drinking and driving, and unprotected sexual intercourse), which in themselves predispose to negative health outcomes (though in themselves they are not synonymous with the negative health outcomes such as emphysema, vehicular injury, and sexually transmitted diseases). Concurrently, we refer to the "at-risk" adolescent, which in

our society too often is code for demographic "disadvantage" (e.g., minority status, poverty, and single-parent families). "At risk" may also refer to other disadvantage. As Rutter (1993), Garmezy (1987), Werner and Smith (1982), and others have shown, disadvantage may be biologic (e.g., diabetes), genetic (e.g., Trisomy 21), familial (e.g., mental illness), social (e.g., violent neighbourhoods), or peer related (e.g., antisocial behaviours).

PROTECTIVE FACTOR — RESILIENCY

Resilience has been defined as the maintenance of healthy / successful functioning or adaptation within the context of a significant adversity or threat. Exposure to domestic violence can have lasting effects on children and teens. Not all young people are affected in the same way, and in fact many children are resilient, able to heal and go on to thrive. Various risk and protective factors among the child, family, and community can impact the ways in which children and teens process and understand the exposure to violence. Protective Factors are the foundation of the Strengthening Families Approach: parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social and emotional competence of children. According to the Center for the Study of Social Policy, research shows that these protective factors are also "promotive" factors that build family strengths and a family environment that promotes optimal child and youth development.

Protective Factors within the family and community that help promote resiliency among children and teens:

- Strong cultural identity
- Access to health care
- Stable housing
- Economic stability—ability to earn a livable wage
- Social support—connections to family and friends
- Affiliation with a supportive religious or faith community

Domestic violence and suicide

Domestic violence is a major risk factor for suicide. The child who are victimized by these heinous crimes feel trapped and confused. The abuser not only physically attacks the child, but also psychologically attacks his/her. The verbal attacks are meant to control the victim, and to try to strip his/her of his/her self-esteem, self-confidence, and self-love. The perpetrator also often wants the child to believe that he/she is at fault for the violence and the verbal abuse. Many domestic violence victims try to change their behavior (even though they are not doing anything wrong) because the horrible attacks leave them hopeless, helpless, and confused. But there really is nothing that the victims can do to stop the violence, because they are dealing with a selfish, cruel criminal who does not have a conscience. All of the blame is on the criminal--the cowardly perpetrator of the domestic violence-not on the victim. The horrible crime of domestic violence often results in a child isolating herself and becoming clinically depressed. Many child feel trapped and powerless, and do not receive treatment for their depression, and thus believe that suicide is the only way out.

However, as a fraction of total suicides, violence against child - such as domestic violence, rape, and incest - accounted for less than 4% of total suicides.

Juvenile Justice System

The Juvenile Justice (Care and Protection of Children) Act, 2000 is the primary legal framework for juvenile justice in India. The act provides for a special approach towards the prevention and treatment of juvenile delinquency and provides a framework for the protection, treatment and rehabilitation of children in the purview of the juvenile justice system. The Act is considered to be extremely progressive legislation and the Model Rules 2007 have further added to the effectiveness of this welfare legislation. However, the implementation is a very serious concern even in 2013 and the Supreme Court of India is constantly looking into the implementation of this law in Sampurna Behrua Versus Union of India and Bachpan Bachao Andolan Versus Union of India. In addition to the Supreme Court, the Bombay and Allahabad High Courts are also monitoring implementation of the Act in judicial proceedings. In order to upgrade the Juvenile Justice Administration System, the Government of India launched the Integrated Child Protection Scheme (ICPS) in 2009-10 whereby financial allocations have been increased and various existing schemes have been merged under one scheme. The Ministry of Women and Child Development started contemplating bringing several desired amendments in 2011. Further Juvenile Justice (Care and Protection of Children) Act, 2015 has been passed by Parliament of India. It aims to replace the existing Indian juvenile delinquency law, Juvenile Justice (Care and Protection of Children) Act, 2000, so that juveniles in conflict with Law in the age group of 16-18, involved in Heinous Offences, can be tried as adults. The Act came into force from 15 January 2016. It was passed on 7 May 2015 by the Lok Sabha amid intense protest by several Members of Parliament. It was passed on 22 December 2015 by the Raj ya Sabha.

The juvenile justice system seeks to deal with children apart from the adult in the matters of investigation trial and correctional process. The children need be separately treated to accord differential treatment to the juvenile delinquents than the adult offenders so that they may not learn the technicalities of the crime commission from the hardened criminals. Juvenile offenders are not to be punished but treated as helpless children in need of care and attention as well as socialization. It is, therefore, necessary to bring them back in society as decent law-abiding citizens through a specialised judicial process.

Despite the Constitutional guarantees and a plethora of child-centric legislations and civil rights, innumerable Indian children, face widespread discrimination and deprivation. The problem of juvenile delinquency is gradually rearing up in its ugly head in the wake of industrialization and urbanization in the country. As a result of various scientific and technological advances during the present century, the structure and functions of our society have undergone a change with the concomitant disorganisation and maladjustment. The growth of cities heterogeneous population, great mobility and fluidity, occupational and cultural variation and over crowed conditions have given rise to new ways of living. Juvenile

are effected in an unusual way by these changing conditions. With rapid changes, rapid increase in social mobility and weakening of the traditional means of social control, are to some extent responsible for the growth of juvenile delinquency in India. In most of the cases social deviation among children is found to have been preceded by various phases of abandonment, destitution, neglect, truancy, vagrancy, abuse or exploitation.

State of Art

Suicide is a complex public health problem involving multiple biological, psychological, family, social, and cultural determinants. The most recent research suggests that an understanding of risk factors in suicide is best used to identify populations or specific groups that might be at risk, rather than attempting to identify individuals at risk. The main reason is that the majority of people who can be categorised as at risk do not and will not ever take their own life. It is extremely difficult to determine from risk factors alone which individuals within an at risk group are more or less likely to become suicidal.

REVIEW & LITERATURE

Despite significant concern over suicidal ideation and behavior among youth involved with the juvenile justice system, no systematic review of the literature on suicidal ideation and behavior among this population exists. In response, this research will focus to:

- Provide a comprehensive review of the available research
- Assess what we know and identify existing gaps, and
- Offer a series of recommendations for future research.

This review will explore the prevalence of recent and past suicidal ideation and suicide attempts among juvenile justice-involved youth; gender and ethnic differences; and variables associated with suicidal ideation and attempt.

A study conducted by the Ministry of Women and Child Development (MWCD) in 2007 found two out of every three children to be physically abused, mainly by the parents. More than half were also victims of sexual abuse. While the states of Assam, Andhra Pradesh, Bihar and Delhi reported the most abuse, the children most likely to be maltreated in this manner were children on the 21 streets, working children and, surprisingly enough, children in institutional care.

Further, any proper study of juvenile justice in India is hampered by a near-total absence of qualitative and quantitative data on both the categories of children addressed by the JJ Act. The only data available are from Crime in India, the annual publication of the National Crime Records Bureau (NCRB), especially the data on "juvenile delinquency", which provide a glimpse of the vast number of children requiring care and justice services. The Ministry of Social Welfare and the Ministry of Women and Child Development provide some data through occasional studies.

METHODOLOGY

Analytic study examines relationships between risk and protective factors and suicide risk.

CONCLUSION

Adolescent suicide in the general population is a national tragedy and a major public health problem. The national survey on juvenile suicide in confinement (Hayes, 2004) found several significant differences between adult suicides and suicide by juveniles. Although the number of reported suicides by juveniles appears low, many juvenile justice clinicians believe the problem is underreported because youth involved in the juvenile justice and child welfare systems have a high prevalence of many risk factors for suicide. Many youth in confinement have experienced physical, sexual, and emotional abuse; substance abuse; and mental disorders prior to incarceration, often resulting in self-injurious behavior. Detention and confinement facilities should maintain comprehensive suicide prevention policies and programming that attempt to circumvent suicide attempts.

Significant findings regarding juvenile correctional suicides included the following:

Timing of Suicides:

Except in detention centres, adult suicides in jails, few suicides occurred within the first 24 hours. Most juvenile suicides occurred during traditional waking hours (4 a.m. to 6 p.m.). Half occurred from 6 p.m. to midnight, and almost some between 6 p.m. and 9 p.m.

Room Confinement Status:

Consistent with other recent research (Gallagher & Dobrin, 2006), half of victims were on room confinement status at the time of death. The reasons for such confinement included failure to follow program rules, inappropriate behavior, and threat of or actual physical abuse by staff or peers.

Prior Suicidal Behavior:

Of those who committed suicide, many had a history of suicidal behavior, most commonly suicide attempt, followed by verbalizing a suicidal ideation and/or threat, suicidal gesture, and self-mutilation.

Suicide prevention

All suicidal prevention programs have a common goal: to prevent suicide, and, if a suicide occurs, to guide evaluation of the event to enable learning that will improve care and enhance preventive actions. This statement presents seven components of a successful suicide prevention program that focuses on recent research and the implications for improved suicide prevention as under:

1. **Staff Training in Suicide Prevention**
   Although there are common elements in such training across all types of correctional facilities, the differences between juvenile and adult inmate suicides support the development of suicide prevention training targeted specifically to juvenile facilities and

based on the latest research on juvenile suicide. Nationwide, suicide prevention training curricula in juvenile facilities primarily rely on information extrapolated from adult inmate suicides. In initial and refresher juvenile suicide prevention training, all direct care, medical, and mental health personnel should receive comprehensive training in the program components outlined in this position statement.

2. **Ongoing Identification of Risk**

Youth can become suicidal at any time during their confinement. Thus, continuous assessment of all juveniles is critical to prevent suicides. Suicide risk screening and assessment needs to be part of the admission process. The intent of a suicide prevention program should provide a system wide process of ongoing identification, management, and stabilization of at-risk or suicidal juveniles. A continuous assessment process alerts staff to consider critical components for identifying and managing risk on a day-to-day basis. The following points are especially helpful when working with adolescents:

- A prior history of suicide attempts and related behaviors is strongly related to future risk. Information should be obtained about the need for suicide precautions during a previous confinement and a history of suicidal behavior or other risk factors while in the community.
- Juveniles who have required special precautions during their current confinement should continue to be assessed frequently, even after active suicide precautions have been removed.
- Staff should not rely solely on the statements of juveniles who deny they are suicidal nor solely on "contracts for safety" because these contracts are unreliable. Research has found that youth who appear manipulative may also be suicidal, and at a minimum suffer from an emotional imbalance that requires a multidisciplinary treatment plan

3. **Communication**

Certain behavioural signs exhibited by incarcerated juveniles may indicate a risk for suicide. The likelihood of a suicide can be reduced by using a multidisciplinary approach and communicating to all staff that signs of risk are present. Communication in preventing suicide involves all categories of staff—for example, between arresting/transporting officers and correctional/direct care staff, among facility staff (including medical and mental health staff), and between facility staff and the at-risk juvenile.

4. **Housing**

Half of all juvenile suicides occur among youth on room confinement status. Further research is necessary to explore the relationship between suicide and isolation.

- Despite the fact that youth are alone in their rooms overnight, with ample opportunity and privacy to engage in self-injurious behaviours, the vast majority of suicides among youth on room confinement occur during waking hours. During these time periods, youth are usually involved in programming or are interacting with staff and peers. These interactive situations provide an opportunity for youth to become

involved in confrontations and inappropriate behavior, resulting in room confinement.

- Youth on room confinement status must be closely observed and receive frequent mental status assessments by qualified mental health personnel. Facility officials should also explore alternatives to room confinement.
- Safe physical environments are critical to prevent juvenile suicides. The vast majority of these suicides occur by hanging, using bedding attached to a variety of anchoring devices, including door hinges/knobs, air vents, and window frames. Housing units and cells must be suicide resistant, and officers must have cutting tools readily available to remove the ligature within seconds of discovering the youth.

5. **Levels of Monitoring**

   The monitoring of at-risk juveniles should be based on their individual clinical needs and not simply on the resources that are said to be available. Medical evidence suggests that brain damage due to strangulation caused by a suicide attempt can occur within 4 minutes, and death within 5 to 6 minutes. Although various levels of monitoring may be used, generally facilities maintain three levels of special observation based on assessment of the immediacy of the suicide risk.

   - Facilities may differ in the requirements for monitoring but it is critical that staff know what is required.
   - Mental health staff should assess and provide timely interventions at least daily for suicidal juveniles.

6. **Intervention**

   A sound and comprehensive suicide prevention program provides early identification and intervention for at-risk and suicidal youth. Multidisciplinary treatment plans, while specifically tailored to monitor and stabilize the juvenile, need to be revised and updated as the youth improves. Even youth who appear stable need intermittent follow-up to monitor progress.

7. **Mortality and Morbidity Review**

   Every completed suicide and serious suicide attempt (e.g., requiring hospitalization) should be examined through a morbidity/mortality review process. Ideally, this review is conducted by a multidisciplinary team including representatives of line and management correctional staff, as well as medical and mental health personnel. A psychological autopsy is also recommended.

REFERENCES

Borum, R., Bartel, P., & Forth, A. (2000). *Manual for the Structured Assessment of Violence Risk in Youth (SAVRY)*. Tampa: University of South Florida.

Brown Ray, K. E., & Alarid, L. F. (2004). Examining racial disparity of the male property offenders in the Missouri juvenile justice system. *Youth Violence and Juvenile Justice*, *2*, 107-128.

Calvert, W. J. (2002). Neighborhood disorder, individual protective factors, and the risk of adolescent delinquency. *ABNF Journal*, *13*(6), 127-135.

Carvajal, S. C., Hanson, C. E., Romero, A. J., & Coyle, K. K. (2002). Behavioural risk factors and protective factors in adolescents: A comparison of Latinos and non-Latino Whites. *Ethnicity and Health, 7*, 181-193.

Douglas, K. S., Ogloff, J. R. P., & Hart, S. D. (2003). Evaluation of a model of violence risk assessment among forensic psychiatric patients. *Psychiatric Services, 54*, 1372-1379.

Hawkins, J. D., Herrenkohl, T. I., Farrington, D. P., Brewer, D., Catalano, R. F., & Harachi, T. W. (1998). A review of predictors of youth violence. In R. Loeber & D. P. Farrington (Eds.), *Serious and violent juvenile offenders: Risk factors and successful interventions*(pp. 106-146). Thousand Oaks, CA.: Sage.

Howell, J. C. (1997). *Juvenile justice & youth violence*. Thousand Oaks, CA.: Sage.

Hsia, H. M., Bridges, G. S., & McHale, R. (2004). *Disproportionate minority confinement 2002 update.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

Juvenile Justice and Delinquency Prevention Act of 2002, Public Law 107-273, 42 U.S.C. 5601 et seq.

Loeber, R., & Farrington, D. P. (2000). Young children who commit crime: Epidemiology, developmental origins, risk factors, early interventions, and policy implications. *Development and Psychopathology, 12*, 737-762.

Moody, K. A., Childs, J. C., & Sepples, S. P. (2003). Intervening with at-risk youth: Evaluation of the youth empowerment and support program. *Pediatric Nursing, 29*, 263-270.

Pope, C. E., & Snyder, H. N. (2003). *Race as a factor in juvenile arrests. Juvenile justice bulletin (NCJ 189180)*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

Scott, L. D. (2003). The relation of racial socialization to coping with discrimination among African American adolescents. *Journal of Black Studies, 33*, 520-538.

Taylor, E. R., Karcher, M. J., Kelly, P. J., & Valescu, S. (2003). Resiliency, risk, and substance use among Hispanic urban juvenile detainees. *Journal of Addictions and Offender Counseling, 24*, 46-64.

Acknowledgments

The author appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interests: The author declared no conflict of interests.

How to cite this article: Kumari, R (2018). Suicidal ideation: risk factor- vulnerability and protective factor — resiliency among youth of juvenile justice system. *International Journal of Indian Psychology*, *6*(2), 118-128. DIP:18.01.072/20180602, DOI:10.25215/0602.072