

## Suicide and Youth: Risk Factors and Prevention

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### ABSTRACT

The current study is aimed at putting the light on the suicide, its prevention strategies and crisis management. Mental health is an indivisible part of public health and significantly affects countries and their human, social and economic capital. Mental health is not merely the absence of mental disorders or symptoms but also a resource supporting overall well-being and productivity. Positive mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and can contribute to his or her community. This mini review gives a short overview of the most important risk factors for late school-age children and adolescents, as established by scientific research in this domain. Key risk factors found were: mental disorders, previous suicide attempts, specific personality characteristics, genetic loading and family processes in combination with triggering psychosocial stressors, exposure to inspiring models and availability of means of committing suicide. Further unravelling and knowledge of the complex interplay of these factors is highly relevant with regard to the development of effective prevention strategy plans for youth suicide. This mental capital is vitally important for the healthy functioning of families, communities and society. Suicide is a complex human behavior with multiple interacting determinants. Clinicians and practitioners often face difficulties in assimilating the evidence base for suicide prevention interventions, evaluating their effectiveness and decoding the best practice elements of each approach. In this article, we do not aim to provide an exhaustive coverage of every approach. Although a number of approaches hold promise, there are difficulties in ascertaining the effective elements under each of them. Innovative research designs are needed to address this knowledge gap as it will facilitate optimal allocation of resources for suicide prevention.

**Keywords:** *Suicide, deliberate self-harm, mental disorders, previous suicide attempts, specific personality characteristics, prevention interventions*

**Y**oung people have to make decisions about important concrete directions in life, for example school, living situation, peer group etc. They must also address new challenges with regard to building their own identity, developing self-esteem, acquiring increasing independence and responsibility, building new intimate relationships, etc. In the meantime, they are subject to ongoing, changing psychological and physical processes themselves. And besides that, they are often confronted with high expectations, sometimes too high, from significant relatives and peers. Such situations inevitably provoke a certain degree of helplessness, insecurity, stress and a sense of losing control. To address

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these challenges and successfully cope with these emotions, young people must have access to significant supporting resources such as a stable living situation, intimate friendships, a structural framework and economic resources. Risk factors can be seen as factors that undermine this support or hinder access to these resources, while protective factors strengthen and protect these resources, or serve as a buffer against risk factors.

Suicide in ancient India has largely been influenced by sacrificial motives, for the sake of honor, religious, and sociocultural beliefs apart from psychiatric and other causes. Ramayana and Mahabharata are the twin epics of India and down centuries they have influenced the thoughts, temper, conduct, and culture of our people. From the pages of Ramayana, it is learned that stung by a baseless accusation that he had accepted his wife after her stay in Ravana's abode, Lord Rama unleashed: "I shall abandon my own life; take my life and should be glad to kill you all." Lord Rama's foremost devotee, Hanuman when his initial search for Sita proves futile, for a moment decides to commit suicide. He would rather give up his life than return without clues or news of Sita.<sup>1-3</sup>

Suicide is a major public health problem worldwide with complex multifactorial origins. More than 800,000 lives worldwide are lost to suicide every year, and Asia accounts for more than 60% of such deaths.<sup>4</sup> India has seen a steady increase in the incidence of suicidal deaths in the last five decades.<sup>5</sup> The estimated suicide-related death rate in India is 21/100,000, which is nearly twice the global average (11.4/100,000) and translates into more than 230,000 lives lost annually.<sup>4</sup>

Since suicide is the outcome of multiple factors including socioeconomic, cultural, religious, and political; the prevalence, causes, and intervention strategies will vary from region to region. Although these are worrying figures themselves, another equally concerning global phenomenon is the changing demographics associated with the malady. There is a clear shift in the predominance of suicides from the elderly to the younger people all over the world and particularly in India.<sup>6,7</sup> Suicide is now the leading cause of mortality in India for those in the age group of 15–39 years.<sup>8</sup> This not only fritters away the advantage of the demographic dividend, provided by the brimming younger population in our country, but also has massive socioeconomic costs and implications. To tackle such a rapidly growing and multifaceted problem, no single strategy is likely to work best. Instead, a systematic, multipronged, collaborative prevention strategy that addresses population level as well as individual level factors is needed.

In the past decade, much new literature had been added in this area. Robust research designs that evaluate these strategies and best practice elements from each strategy need to be synthesized in order to inform policymaking, deliverables, and action plans. The focus of this review is not to exhaustively cover the evidence base for each suicide prevention approach but to provide an overview of representative studies or, more importantly, systematic reviews that have explored each approach and describe the levels of intervention involved.

### MENTAL DISORDERS AND SUICIDE

Mental disorders occupy a premier position in the matrix of causation of suicide. Majority of studies note that around 90% of those who die by suicide have a mental disorder.<sup>11</sup> The number of published reports specifically studying the psychiatric diagnoses of people who die by suicide has been relatively small ( $n = 15629$ ). The majority (82.2%) of such reports come from Europe and North America with a mere 1.3% from developing countries.<sup>10</sup> Two

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case control studies using psychological autopsy technique have been conducted in Chennai<sup>12</sup> and Bangalore in India.<sup>9</sup> Among those who died by suicide, 88% in Chennai and 43% in Bangalore had a diagnosable mental disorder.

Countless experts have found that affective disorders are the most important diagnosis related to suicide. In India, 25% of completed suicides were found to be due to mood disorders. However, the suicide rate increased to 35% when suicide cases with adjustment disorder with depressed mood were also counted. The crucial and causal role of depression in suicide has limited validity in India. Even those who were depressed, were depressed for a short duration and had only mild to moderate symptomatology. The majority of cases committed suicide during their very first episode of depression and more than 60% of the depressive suicides had only mild to moderate depression.<sup>12</sup> Although social drinking is not a way of life in India, alcoholism plays a significant role in suicide in India. Alcohol dependence and abuse were found in 35% of suicides. Around 30-50% of male suicides were under the influence of alcohol at the time of suicide and many wives have been driven to suicide by their alcoholic husbands. Not only were there a large number of alcoholic suicides but also many had come from alcoholic families and started consumption of alcohol early in life and were heavily dependent.

### FACTORS GAINING MOMENTUM IN INFLUENCING SUICIDE IN INDIA

- **Mental Disorders**

Most studies agree that suicide is closely linked to mental disorders. About 90% of people who commit suicide have suffered from at least one mental disorder. Mental disorders are found to contribute between 47 and 74% of suicide risk. Affective disorder is the disorder most frequently found in this context. Criteria for depression were found in 50–65% of suicide cases, more often among females than males. Substance abuse, and more specifically alcohol misuse, is also strongly associated with suicide risk, especially in older adolescents and males. Among 30–40% of people who die by suicide had personality disorders, such as borderline or antisocial personality disorder. Suicide is often the cause of death in young people with eating disorders, in particular anorexia nervosa, as well as in people with schizophrenia, although schizophrenia as such accounts for very few of all youth suicides. Finally, associations have also been found between suicide and anxiety disorders, but it is difficult to assess the influence of mood and substance abuse disorders that are also often present in these cases. In general, the comorbidity of mental disorders substantially increases suicide risk. Especially important here is the high prevalence of comorbidity between affective and substance abuse disorders.<sup>23</sup>

- **Previous Suicide Attempts**

Many studies find a strong link between previous suicide attempts, or a history of self-harm, and suicide. About 25–33% of all cases of suicide were preceded by an earlier suicide attempt, a phenomenon that was more prevalent among boys than girls. Research has shown that boys with a previous suicide attempt have a 30-fold increase in suicide risk compared to boys who have not attempted suicide. Girls with previous suicide attempts have a threefold increase in suicide risk. In prospective studies, it was found that 1–6% of people attempting suicide die by suicide in the first year. The risk of suicide is found to be related mainly to the self-inflicting act as such, and less to the degree of suicidal intention of that act.

- **Substances abuse**

Although substance abuse has been well documented from the pre-Christian era; their role in suicidal behavior has drawn the attention of the researchers only from the previous century.

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One of the earliest reports revealed, 10.3% among the male suicides to be under the influence of alcohol and drug abuse.<sup>13</sup> This observation was strengthened by some of the subsequent studies, although their number was a little less.<sup>14-19</sup> While a few studies have not reported any case of substance abuse in their sample.<sup>20</sup> Some recent studies have reported the alarmingly high proportion of such cases. At any rate, such observations have to be interpreted with caution as there is no uniform policy on alcohol or drug use in different States in India. Many of the substance abusers attempt suicide while under the influence of alcohol. Perhaps, the conflicts regarding various domestic and other problems, feelings of guilt, and death wish come to the fore uninhibited at this stage. That apart, neurobiological changes occurring under intoxication, development of complications such as psychotic disorder, depressive disorder, delirium, and physical illnesses might drive them to this end.

- **Problems with parents-in-law and spouses**

One of the earliest studies on suicide noted domestic problems as an important factor. In the year 1967, when the NCRB first commenced its enumerations, quarrels with parents-in-law and spouses formed 16.3% of all causes, whereas in 2013 this figure has risen to 24%. The problems with parents-in-law and spouses have been the foremost among the causes over several decades. But, more recently there is a spurt in this proportion. The incidence of divorces, separation of the spouses due to interpersonal problems, broken homes, and maladjustment among family members could be cited as some of the important emerging causes.<sup>13</sup>

- **Personality Characteristics**

Suicide is associated with impulsivity. Although we know that a suicidal process can take weeks, months or even years, the fatal transition from suicidal ideation and suicide attempts to an actual completed suicide often occurs suddenly, unexpectedly and impulsively, especially among adolescents. Difficulties in managing the various, often strong and mixed emotions and mood fluctuations accompanying the confrontation with new and ever-changing challenges in different domains is another risk factor for youth suicide, probably partly influenced by bio-neurological factors. Young people who committed suicide were also found to have had poorer problem-solving skills than their peers. Their behavior was characterized by a rather passive attitude, waiting for someone else to solve the problem for them, for simple problems as well as for more complex interpersonal problems. Some researchers indicate defects of memory in this context, with few detailed memories of effective solutions in the past.<sup>21,22</sup>

### VARIOUS SUICIDE PREVENTION STRATEGIES

- **Suicide awareness programs**

The ideal conditions for an effective awareness program include delivery in a relevant setting, having a multifaceted and comprehensive nature inclusive of community-based strategies, and adopting a universal approach while simultaneously ensuring identification of at-risk groups.<sup>24,25</sup>

- **Screening programs for suicide prevention**

Modest evidence shows that the screening tools employed can pick up high-risk adults and older adults at risk of suicide among the community.<sup>26</sup> Notably, the sensitivity and specificity of the instrument play a key role in risk assessment.<sup>27</sup> Contemporary suicide screening programs utilize specialized measures to identify at-risk youth for early referral and intervention.<sup>28</sup> The primary care setting and the emergency department (ED) are key areas where suicide screening must be implemented.

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- **Gatekeeper training**

Gatekeepers refer to individuals who regularly interact with potentially suicidal persons and are available to recognize the key behavioral clues indicating elevated suicide risk.<sup>29,30</sup> Potential gatekeepers include teachers, peers, school support staff, and specifically appointed counsellors. All of them have the common advantage of significant face-to-face contact time with large number of people in the community.<sup>31</sup> Gatekeeper training for students includes elements of informing the suicidal burden, risk factors, warning signs, support system available, signs of depression, communication, and counselling skills to address at-risk population.

- **Restriction of access drugs**

Restriction of access to pesticides, substituting lethal pesticides with less lethal compounds, double-lock boxes, and nonpesticide agricultural movement preventing ready access to dangerous pesticides have been found to be effective. Community locker programs for pesticides where the pesticides are stored in lockers along with community involvement have led to reduced usage of pesticides and decreased suicidal deaths among rural farmers of India.<sup>32</sup>

Other methods tried include analgesic withdrawal from dispensaries, restricting sales of barbiturates and caffeine tablets to reduce overdose suicidal attempts, restricting measures on hanging, erection of barriers at jumping hotspots, and restricting access to charcoal.<sup>33</sup>

- **Suicide hotlines/helplines**

Before embarking on a discussion about the state of evidence of suicide hotlines, it is necessary to understand what constitutes a hotline for suicide. Most available studies have either assessed hotlines among a group of other interventions for suicide prevention, which makes it difficult to isolate the effect of the hotline, or focused on diverse outcome measures such as acceptability, identification, and referral of people at risk as well as service barriers.<sup>33</sup>

- **Media strategies for suicide prevention**

Given the influence of media reporting on public perceptions and attitudes toward suicide, media-based approaches such as responsible reporting represent a population-level strategy for suicide prevention. The Indian Psychiatric Society (IPS) has brought out a position statement on media coverage of suicides, which emphasizes collaboration between media professionals and medical professionals for better dissemination and impact.

## CONCLUSION

Youth suicide constitutes a major public mental health problem. Young people and especially adolescents are by nature a vulnerable group for mental health problems. While suicide is relatively rare in children, its prevalence increases significantly throughout adolescence. And although youth suicide rates are slightly decreasing within the European region, it still ranks as a leading cause of death among the young worldwide and, as such, it is responsible for a substantial number of premature deaths and a huge amount of pointless suffering and societal loss. Each suicide is the result of a complex dynamic and unique interplay between numerous contributing factors, and individual efforts to predict and prevent suicide tend to fail. On the other hand, our knowledge of risk factors is increasing substantially. Mental disorders, previous suicide attempts, specific personality characteristics, genetic loading and family processes in combination with triggering psychosocial stressors, exposure to inspiring models and availability of means of

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committing suicide are key risk factors in youth suicide. The only way forward is to reduce these risk factors and strengthen protective factors as much as possible by providing integrated and multi-sector (primary, secondary and tertiary) prevention initiatives. Key prevention strategies can be population-based (e.g., mental health promotion, education, awareness by campaigns on mental resilience, careful media coverage, limited access to means of committing suicide) as well as targeting high-risk subgroups (e.g., specific school-based programmes, educating gatekeepers in different domains, providing crisis hotlines and online help, detecting and coaching dysfunctional families) or even focusing on individuals identified as suicidal (e.g., improving mental health treatment, follow-up after suicide attempts and strategies for coping with stress and grief).

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### **Conflict of Interest**

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