SUICIDE THE UNCONTROLLED EVIL AMONG INDIAN YOUTH:AN OVERVIEW

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Abstract

Suicide has existed for as long as human society, ranking among the top 13 causes of death in all ages across the world and it continues to test our collective wisdom. Suicide is the world's third biggest cause of mortality among young adults. There is an increasing realization that preventative programmes must be adapted to a country's region-specific demographics and conducted in a culturally sensitive way. This study investigates the epidemiological and demographic factors that contribute to suicide in India, as well as suicide prevention strategies. Suicidal conduct is potentially unknown in no civilization. Furthermore, no time throughout history has been observed when this puzzling human propensity was dormant. However, a variety of factors, including biological and sociocultural ones, influence the socio-demographic and other elements of this complicated behavior. Suicide research may represent not just the psychobiological features of suicidal people, but also their societal matrix. As a result, it was thought desirable to conduct a review on suicides in India in order to determine feasible measures and remedies for this self-harming behavior.

Keywords: Suicide, Demographics, Behaviour, Socio-economic deprivation, Marital status, Gender

Introduction

Suicide risk has often been regarded as increasing with age, with older males seen as the group most at risk. However, in certain high-income nations in the 1970s, suicide among young people, particularly young males, became more prevalent (1). Although the emphasis of worry is increasingly turning to middle-aged men, who are the demographic most at risk in many nations, working-age men's reduced life expectancy remains a serious issue (2). Policy measures are required in the light of the global financial crisis and the spread of new suicide tactics. in this study, we hope to give an updated viewpoint on the burden of suicide in young males, particular risk factors, evidence-based therapies, and potential preventive strategies. We selected to focus on data for men aged 19–30 years, which is the most prevalent age group utilized in demographic research for young men.

Epidemiology

Suicide across the globe

Suicide was the eighth biggest cause of potential years of life lost globally (3). In certain nations, suicide is the third leading cause of death among those aged 15-44 years old, and the second leading cause of death among those aged 10-24 years of age; these numbers do not include suicide attempts, which may be up to 20 times more common than committed suicide. Eastern European nations with the highest suicide rates are Belarus, Estonia, Lithuania, and the Russian Federation. According to data from the WHO Regional Office for South East Asia, high rates of suicide have also been observed in Sri Lanka (4). There is an intriguing theory that suicidal rates are affected by latitude and the quantity of sunshine received each day (5). Suicide rates are greater in northern Japan and northern European countries than in southern countries. However, nations in about the same latitude, such as the United Kingdom and Hungary, had significantly different suicide rates (21.6/100,000 and 6.9/100,000, respectively, in 2009) (6). Low rates are observed mostly in Latin America (particularly in Colombia and Paraguay) and in a few Asian nations (eg. the Philippines and Thailand). In 2003, there were no suicides in Haiti. Countries throughout the rest of Europe, North America, and Asia and the Pacific tend to lie somewhere in between these two extremes. Eighty-six percent of all suicides took place in poor and middleincome nations. The global trend of rising suicide rates has been a regular source of worry in recent decades. According to the WHO, suicide rates climbed up by 60% globally between 1950 and 1995. Suicide rates climbed from 10.1 per 100,000 in 1950 to 16 per 100,000 in 1995. In 1995, worldwide male suicide rates and total suicide rates were at their highest levels since 1950. (24.7 and 16 per 100,000, respectively). Surprisingly, the global female suicide rate per 100,000 people fell from 8 in 1975 to 6.9 in 1995 (7). The rise in worldwide suicide rates, on the other hand, should be read with care. Changes in global politics and reporting methods occurred between 1950 and 1995, which may have exaggerated the rates. For example, the period saw the dissolution of the USSR (which had a lower aggregate rate than the average) and its former states began to report separately, inflating the worldwide rate. Second, the 1950 data were based on just 11 nations, but the 1995 estimations were based on 62 countries. These 62 nations are more likely to report on suicide mortality because they have higher rates and are countries where suicide is a serious public health concern (8).

Suicide in India

Suicide rates in India are comparable to those in Australia and the United States, and rising rates in recent decades are consistent with a global trend. The National Crime Records Bureau in India has data on suicide (NCRB; Ministry of Home Affairs). Suicide rates in India increased from 6.3 per 100,000 in 1978 to 8.9 per 100,000 in 1990, a 41.3 percent rise during the decade from 1980 to 1990 and a compound growth rate of 4.1 percent per year. Recent data, on the other hand, paint a different image. Suicide rates decreased from 1999 to 2002, followed by a mixed trend from 2003 to 2006, and then increased from 2006 to 2010 (9). In 2009, the rate was 10.9 per 100,000 people. Since 2008, there has been a 1.7 percent rise in suicides. According to the most current NCRB study, the rate in 2010 increased to 11.4 per 100,000 people, representing a 5.9 percent rise in the number of suicides. The NCRB data is derived from police records. Sociocultural issues call into question the authenticity of these documents. Suicide attempts are criminal under the Indian Penal Code (IPC Section 309), which leads to underreporting. Village headmen ("panchyatdars") certify deaths in rural regions, although all cases are examined by the police. In rural locations, the procedure of recording a death is very inefficient (10). Only approximately 25% of fatalities are eventually reported, and only around 10% are medically certified. To evade police scrutiny, suicide deaths are commonly described as the

result of sickness or accident. Families of suicide victims typically do not want postmortems due to concerns about body mutilation, the time consuming nature of the process, and the associated stigma. As a result, statistics obtained from police records under report suicides. Suicide rates in India vary greatly by state, ranging from 0.5/100,000 in Nagaland to 45.9/100,000 in Sikkim, compared to the national average of 11.4/100,000 in 2010 (11). Some studies have calculated the yearly suicide rate using data from smaller samples and various methodologies, such as hospital based samples, longitudinal cohorts, emergency services, and verbal autopsies (12). Suicide rates are reported to be 23 times higher in research that use verbal autopsy than in other studies. Suicide rates in rural India assessed using verbal autopsy, 19949. The average annual suicide rate reported in these studies ranges from 62 per 100,000 to around 95 per 100,000 for the general population, with age specific suicide rates as high as 148/100,000 and 58/ 100,000 for young women and men, respectively, and 234/ 100,000 and 147/100,000 for elderly men and women (13).

Demographics of suicide in India

Risk factors related with suicide, including suicidal attempts, have traditionally been identified in western literature as being young age (15-24 years), female gender, low educational attainment, unemployment, living alone, and a history of socioeconomic deprivation (14). This section looks at the demographics of suicide in India.

- **Age**

Although older adult males have historically had the greatest suicide rates, rates among young individuals have been rising. Young adults are a particularly susceptible generation, with the highest rates of suicide in the world. Suicide accounts for 6% of all fatalities among young people (15). The senior suicide rate in developed countries has reached a new high (above 60 years). According to an Indian research, the suicide rate was greatest in the 1529 age group (38 per 100,000 people), followed by the 3044 age group (34 per 100,000 population). Suicide rates were 18 per 100,000 in those aged 45 to 59, and 7 per 100,000 in those aged over 60 (16). Because these data are for the entire population rather than the agespecific "population of interest," the increased risk in youth may reflect a higher representation of youth in the population. A similar tendency may be seen in a 2009 National Crime Records Bureau study. Youth aged 15 to 29 years accounted for the highest proportion (34.5 percent) of suicides, followed by those aged 30 to 44 years (34.2 percent). Other research in India reveal that young adults are more vulnerable, with ages 2024 years, followed by 25-29 years, having the greatest rates of suicide in a psychiatric autopsy study, and the 15-39 age group identified as the most vulnerable in another study (17). Two thirds of women who committed suicide were under the age of 25. This pattern can also be noticed in attempted suicides. In one research, the average age of those who attempted was 25.3 years. In a study of suicidal ideators in a general hospital environment, suicidal ideation was also more prevalent in the 16-45 age range (18).

- **Adolescents and young adults**

Suicide is a primary cause of mortality among young people in India, and youth suicide is at an all-time high. - Suicide accounted for around a quarter of all fatalities in men and between 50 and 75 percent of all deaths in females aged 10-19 years in a research that investigated the cause of death among persons aged 10-19 years in a rural community of 108,000 in south India. Girls had a suicide rate of 148 per 100,000, while males had a rate of 58 per 100,000 (19). Suicidal conduct was found to be connected with female gender, not attending school or college, independent decision making, premarital sex, physical abuse at home, lifetime experience with sexual abuse, and potentially common mental problems in young people. Suicidal conduct was linked to both violence and psychological anguish. Gender disadvantage factors enhanced vulnerability, particularly among rural women (20).

- **Elderly**

There is a global trend toward greater suicide in old age, primarily among men. In a 5-year survey of 6312 suicide attempters, just 47 were beyond the age of 60. The elderly in India have a low suicide rate because they are well integrated and respected in the family; children assume responsibility for their care. In addition, the elderly have a lower life expectancy in India than elsewhere, which contributes to the lower suicide rate. In India, the elderly have a completed suicide to attempted suicide ratio of roughly 1:7, which is more than double the ratio of 1:15 in younger age groups (21). This might be due to the elderly's reduced capacity to recuperate from the bodily injury of a suicide attempt. Although research from the West identify social isolation, as defined by 'living alone,' as a risk factor for suicide among the elderly, one early study postulated that for the elderly in India, 'family and social integration' were the main risk factors, even if they were living alone. More recent western investigations tend to back up this claim (22).

- **Gender**

Globally, attempted suicide is more prevalent in women, but completed suicide is more common in males. However, the suicide rate among Chinese women is around double that of other women. To escape discovery, men frequently utilise more dangerous ways and organise their acts more thoroughly. Women, on the other hand, are more spontaneous, less well-planned, and more likely to be discovered and saved. In Australia, Canada, the United States, and the United Kingdom, the male:female suicide ratio is 3.8, 3.9, 4.1, and 3.4, respectively, while it is lower in Asian nations. What are the statistics for India? Although some Indian research have revealed that men commit suicide at a greater rate than women, others have found the opposite (23). In 2008 and 2009, the male-to-female suicide ratio in India was 1.78. The ratio was 1.04 in children under the age of 14 years, indicating that the sexes were about equal. In 1991-1997, the ratio of young men to young women was 1.3, in contrast to the male predominance in industrialised nations. The causes for a higher female suicide rate in India might be societal. Arranged weddings, which are popular in India, put societal and familial pressure on women to stay married even if they are in an abusive relationship; this

may raise the risk of suicide among women. Furthermore, dowry-related stress may cause young brides to commit suicide (24). What about suicide attempts in India? Although attempted suicide was shown to be 1.2 times greater in women than in males in some research, others found a male predominance, with a male: female ratio ranging from 1.13:1 (25). These disparities can be justified by recognising socioeconomic changes in India, such as the trend toward nuclear families and the cultural focus on the masculine archetype, which the individual seeks to meet in vain.

- **Marital status**

Marriage is often protective against suicide in the West; this empirical regularity is referred to as the "coefficient of preservation" after Durkheim's landmark study Le Suicide, published in 1897 (26). Persons who are divorced, separated, widowed, or unmarried are more prone to commit suicide than married people. People who live alone are more vulnerable. Marriage had a greater protective impact on males than on women, and rates of suicide dropped as men progressed from widowers through divorced, single, and married men. Young widowers were particularly vulnerable. Sociological theories based on marital status integration and social integration may explain lower incidence of suicide among married women compared to unmarried women. Marriage is not a major deterrent to suicidal behaviour in poor nations (27). In India in 2009, 70.4 percent of all suicide victims were married, while 21.9 percent were unmarried. Divorcees and separated people made up roughly 3.4 percent of all suicide victims, while widows and widowers made up 4.3 percent. Individual studies suggest that unmarried people have a greater rate of suicide attempts (28).

- **Family structure**

The sociological theory of suicide places a premium on social integration. People who are highly connected into their families and communities have a strong support system during times of crisis, which protects them against suicidal ideation. Parenting style, family history of mental illness and suicide, and physical and sexual abuse as a kid are all risk factors associated with the family. A parenting style defined by low levels of emotional warmth and high levels of parental control or overprotection is connected with a threefold increase in the likelihood of suicide conduct. Even after adjusting for other criteria, suicide attempters with a history of sexual or physical abuse as a kid exhibit greater suicidal behaviour and are at a higher risk for mental problems in adulthood (29). In recent decades, India has seen a shift in family structure, with more individuals shifting away from joint and extended families and into nuclear family forms. The impact of this adjustment on the suicide rate has not been thoroughly investigated. Various study findings may point to a long-term trend. Although a previous study found that more suicide attempters originated from mixed families, the bulk of suicide attempters were from nuclear families, presumably highlighting the significance of social integration. According to a study of burn victims, living in a mixed household was a risk factor for dowry fatalities (30).

- **Urban vs. rural residence**

Suicide rates are often thought to be greater in cities due to a multitude of pressures associated with living and working in cities, such as congestion and social isolation. Although the national suicide rate in India in 2000 was 10.8, the rate in urban areas was somewhat lower at 9.94 (31). Since then, urban suicide rates have risen to 11.4 percent in 2005, approximately 13 percent in 2006 and 2007, and 12.1 percent to 12.5 percent in 2008 and 2009. Suicide and attempted suicide are more prevalent in those who live in cities, according to recent research (32).

- **Occupation**

There is a considerable link between unemployment and suicide, but the nature of this link is complicated. Suicide risk may be increased by variables such as poverty, social hardship, domestic issues, and hopelessness. Furthermore, those with psychiatric illnesses are more likely to commit suicide and are also more likely to be jobless, which might be a double whammy. Adding to the complication is the distinction between recent and long term unemployed; the former is connected with increased risk. The link between unemployment and suicide may be stronger among young individuals. In one study of suicide attempters in India, 46 percent were jobless. In another research, more than half of the patients were employed, 12% were jobless, and others were students or housewives (33). According to NCRB statistics, housewives account for 18.6 percent of all suicides and 52.8 percent of all female casualties. The second largest category is those active in farming and agriculture, accounting for 11.9 percent of all casualties, followed by those working in the private sector (7.8 percent) and the jobless (7.5 percent). Students made up 5.5 percent of all suicides, while jobless people made up 5.5 percent and 7.5 percent, respectively. Employees in the public sector (2.2 percent of all suicides) and government employees (1.3 percent of total suicides) were the groups with the lowest representation (34).

Prevention

Suicide is a significant and generally avoidable public health issue. However, the problem is complex, as Gajalakshmi et al put it: "a complex array of factors such as poverty, low literacy level, unemployment, family violence, breakdown of the joint family system, unfulfilled romantic ideals, intergenerational conflicts, loss of job or loved one, failure of crops, growing costs of cultivation, huge debt burden, unhappy marriages, harassment by inlaws and husbands, dowry disputes, depression, chronic physical illness." (35). Lithium, clozapine, olanzapine, antidepressants, and behavioural therapies such as dialectical behaviour therapy, DBT, have been found to have antisuicidal benefits in psychiatrically sick patients. Because the existence of a past suicide attempt is the strongest predictor of completed suicide, interventions targeting towards suicide attempters may be the most successful in lowering suicide rates. Vijayakumar et al., 2011 (36) investigated the efficacy of short intervention and frequent contact in suicide attempters in a randomised controlled study and discovered that it did lower rates of completed suicide over an 18 month period. Another option is to identify and treat vulnerable groups with risk factors for suicide

early in life. Given the substantial association between traumatic childhood experiences and suicide risk, it is critical to identify groups that have been exposed to traumatic childhood experiences such as sexual/physical abuse and parental domestic violence. Identification of such persons necessitates a multidisciplinary strategy with active engagement from teachers and school officials, health specialists, and the judicial system. Primary preventative techniques include fostering positive health and establishing adaptive coping strategies in children; increasing awareness of child-rearing practices among parents, teachers, and healthcare professionals; and early intervention for maladaptive coping patterns (37). The USI model outlines 'universal' preventive strategies for the general population (e.g., restricted access to lethal means),'selective' strategies for at risk individuals (e.g., the mentally ill, the homeless, and socially excluded groups), and 'indicated prevention' strategies for suicide attempters (eg. emergency outreach). Gatekeeper training focuses on skill development to help community members such as teachers, coaches, and others recognize indicators of depression and suicidal conduct in adolescents. It motivates people to keep a high level of skepticism and to ask directly about discomfort, persuades suicidal people to accept care, and serves as a connection for local referrals. Such techniques would also necessitate the formation of a multidisciplinary team comprised of psychiatrists, general practitioners, psychiatric nurses, psychiatric social workers, and nongovernmental groups (NGOs). The media's position is becoming increasingly important. To limit the harm done to vulnerable persons, a careful balance between press freedom and press accountability must be maintained. The importance of advocacy and legislation cannot be overstated. The WHO has lobbied for laws that limit the availability of deadly agents such as weapons. The proactive stance taken by the NGO Sneha, which discovered that the suicide rate was highest among students who had failed one subject, exemplifies the importance of NGOs in advocacy.

Conclusion

The second and third decades of life appear to be the most dangerous wherein most suicide cases emerge in India. The important reasons include maladjustment with family members as well as marital discord. Furthermore, the event of marriage increases the proclivity for suicide conduct. These findings advocate for the widespread use of family and marital counselling, particularly in the early stages of marriage in India.

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