शोध संचयन
SHODH SANCHAYAN
ISSN 2249-9180 (Online)
ISSN 0975-1254 (Print)
RNI No.: DELBIL/2010/31292

An Internationally Indexed Refereed Research Journal & A complete Periodical dedicated to Humanities & Social Science Research

Half Yearly

Vol-3, Issue-2
15 Jul-2012

Suicides in India and Its Preventions

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Suicides in India and Its Preventions

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The number of suicide cases is continuously increasing. lt has grown as a server health problem and needs urgent attention. The present paper discusses the causes and cures of this problem.

Key words:- *Suicide, Prevention of Suicide, depression, Personality Disorder*

Suicide uicide has emerged as a global problem. In India the number of suicide cases per year is increasing at an alarming rate. Suicides can be prevented at individual level, family level, community level, and religious level by teacher, councilors and mass media. It is high time to make action plans for preventing suicide on the part of society, government and NGOs. Teachers and psychologist must come up immediately for intervention in sensitive cases. There is a vital need for education, training and specialized techniques to deal with suicidal clients.

"Papa please forgives me, now I don't want to live more." "Gold medal nahi to mai bhi nahi.,"Mai apke ke liye kuch na kar saki , mujhe maaf karna." These are some of excerpts from the suicidal notes from the youngsters. Now suicidal behaviour is very relevant issue in Indian perspective. Everyday we see suicidal incidences are the headlines of the news papers which seriously forces us to think why suicides are increasing at such a high rate? There may be many reasons such as psychological, socio-cultural, neurological or cognitive process.

In India more than one lakh lives are lost every year due to suicides. In the last two decades the suicidal rate has increased from 7.9 to 10.3 per 10000. The southern states of Kerala; Andhra Pradesh and Tamilnadu have a suicide rate of < 15%. Where in the northern states of Panjab and Jammu and Kashmir the suicidal rate is > 3%.[1]

According to National Crime Record Bureau (Government of India, 2010) Bangalore is the suicidal capital of India with 1,778 cases. 15 suicides are committed every hour. 70% of suicide victims in India are married people. West Bengal comes at the second place in suicide cases.[2]

According to National Crime Record Bureau (Government of India, 2005) a large number of suicides (37.8%) in India are by those below the age of 30 years. The fact that 71% of suicides in India are by persons below the age of 44 years imposes a huge social, emotional and economical burden on our society.[3] The almost equal suicide rates of young men and women leading to consistently narrow male: female ratio of 1.4:1 denotes that more Indian women die by suicide than their western counterparts. The common methods used are poisoning (36.6%), hanging (32.1%) and self-immolation (7.9%).[4]

Undoubtedly suicide is a very severe public and mental health problem, which demands urgent intervention or action. The "cry of pain" model sees suicidal behaviour as an attempt to escape from a feeling of entrapment. These individuals believe that they can not escape from an external situation or from their own inner turmoil and that there is no prospect of rescue. Finally they end their life.

The dynamics underlying suicidal behaviour involves more than hostility, feeling of abandonment, helplessness as well as the emotional states of guilt, rage, anxiety and dependency.[5]

Personality variables those are associated with suicidal behaviour:

Impulsivity:

Neurobiological research has studied the connection between the personality dimensions of aggression and impulsiveness in suicidal and violent individuals. Researchers focused on impulsivity together with anger and hostility.[6-7,8] Two personality disorders associated with suicidal behavior are:

1. Antisocial personality disorder
2. Borderline personality disorder

Suicidal individual tend to be controlled by external events rather than moderated by internal stimuli.[9] Perfectionism, tendency to withdraw and aloofness are among some of the personality traits that are also associated with suicidal behaviour. "Extremeness" is

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also responsible for suicidal behaviour. The suicidal individuals are more rigid and extreme in their thinking than non-suicidal persons.[10] Another study reported similar results that suicidal individual are more rigid and inflexible and less able to change their problem solving strategies.[11] Other studies have found similar results, showing that young suicide attempters were more field-dependent (that is, their decisions were more influenced by their environment).

Studies suggest that cognitive deficit make it difficult for a depressed person to generate new or alternative solutions to the problem.[12] Successful problem solving depends largely on the quality of the type of memories individual are able to retrieve. Depressed and suicidal patients are poor at problem solving because they are unable to access specific memories successfully. Specific memories are very useful as a resource in solving problems.[13]

Hoplessness:

If a person feels defeated and there is little chance of escape he/she becomes very vulnerable. Hopelessness is one of the main mediating factors in the relationship between depression and suicidal intent.[14] Lack of positive expectancies a contributing factor in suicidal behaviour and should be taken into account more explicitly in assessments and interventions.

Neurological or Genetic factors for suicidal behaviour:

Serotonin and Dopamine have also been examined by measuring the growth hormone response to apamorphine in depressed persons, some of whom later commit suicide. Alcohol and drugs also have a major influence on attempted suicides. Approximately one million people die by suicide and this is becoming an international public health concern on the same levels as illness such as malaria. Alcohol dependence and abuse were found in 35% of suicide.[15] Alcoholism and drug addiction, with their associated loss of control over emotions and actions, are also associated with suicide.

Personality disorders:

Personality disorders involving an inability to control anger and impulses have also been noted among suicidal patients. The majority of persons who commit suicide have experienced serious difficulties with their parents during childhood. More than half have been rejected, abandoned or physically or psychologically abused. These early adversities may make them more likely to mistrust other people and less able to face difficulties such as marital separation or financial distress. Almost half of suicides clients suffer from severe depression.

Nearly 22% of the suicides in India have been among students caused by non-attainment of expectations.[16] Among the youth major causes are examination failures, parental pressures, high expectations of school and colleges, disappointment in love and conflicts.

India has seen a lot of farmers (15%) die in recent years.[17] Debt and the resulting harassment at the hands of money lenders is a major cause. The reason for suicide is not known for about 43% of suicides were due to illness while family problems contribute to about 44% of suicides.[18]

Divorce, dowry, love affairs, cancellation or the inability to get married (according to the system of arranged marriages in India), illegitimate pregnancy, extra-marital affairs and such conflicts relating to the issue of marriage, play a crucial role, particularly in the suicide of women in India. A distressing feature is the frequent occurrence of suicide pacts and family suicides, which are more due to social reasons and can be viewed as a protest against archaic societal norms and expectations. In a population-based study on domestic violence, it was found that 64% had a significant correlation between domestic violence of women and suicidal ideation (World Health Organization, 2001).[19]

90% of those who die by suicide have a mental disorder.[20] In Chennai, 25% of completed suicides were found to be due to mood disorder. They reported that more than 60% of the depressive suicides had only mild to moderate depression.[21] Media reporting is also an important factor for suicides.

The effects of modernization, specifically in India, have led to sweeping changes in the socio-economic, socio-philosophical and cultural arenas of people's lives, which have greatly added to the stress in life, leading to substantially higher rates of suicide. [22] In India, the high rate of suicide among young adults can be associated with greater socioeconomic stressors that have followed the liberalization of the economy and

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privatization, leading to the loss of job security, huge disparities in incomes and the inability to meet role obligations in the new socially changed environment. [23]

The breakdown of the joint family system that had previously provided emotional support and stability is also seen as an important causal factor in suicides in India.23 lack of belief in God is one of the factor for committing suicide in Chennai. [24] Lack of religious belief was a risk factor. [25]

The actual data on attempted suicides becomes difficult to ascertain as many attempts are described to be accidental to avoid entanglement with police, courts and media.

Suicide Prevention (Coping Mechanism):

For prevention of suicide, the traditional model of intervention is as follows:

(Fig.1 is about to here)

There are some prevention measures, which can be helpful for reducing the rate of suicides:

1. Promoting mental resilience through optimism and connectedness.
2. Education about suicide, including risk factors, warning signs, and the availability of help.
3. Increasing the proficiency of health and welfare services in responding to people in need. This includes better training for health professionals and employing crisis counselling organizations.
4. Reducing domestic violence, substance abuse, and divorce are long-term strategies to reduce many mental health problems.
5. Reducing access to convenient means of suicide (e.g., toxic substances, handguns).
6. Limit the availability of potentially lethal amounts and dosages of prescribed medications.
7. Reducing the quantity of dosages supplied in packages of non-prescription medicines e.g., aspirin.
8. Interventions targeted at high-risk groups.
9. Family is basic unit where emotional bonding, social support and training for resilience building are important for the suicidal prevention.
10. Proper arrangement for general public health measures.
11. In India comprehensive community care services are promoted to provide services to those stricken with mental illness.
12. School intervention programs - emotional education in school children can reduce the incidence of suicide and suicidal attempts.
13. Government policies on employment, school welfare, education, farming, substance abuse, media guidance and public education should be taken in account for suicide prevention.
14. Professional training about assessment, diagnosis and treatment support of high-risk group's detection is required for prompt suicidal intervention.
15. There should be responsible media policy for suicide prevention.
16. Early detection and early treatment of depression and other mental disorders.
17. Enhanced access to mental health services (such as hot/on line services).
18. Attention to those suffering chronic somatic illness.
19. Arrangement for crises intervention.
20. Training gatekeepers like parents, teachers, psychologist, counselors and other professional helpers who must provide emotional support to meet the needs of different age groups.
21. Parents and teachers should not over expect from their children, especially parents should not compel to fulfill their own dreams through children.
22. Parents and other family members should give attention towards changing behaviour of child and provide help and support to handle the difficulties of life especially the teen-age issues and emotional ups and downs.
23. Educating family members or parents regarding the need to monitor their loved oneèkchild and to monitor to communicate observations of change or concern.

Treatment:

• The treatment plan should demonstrate and document a focus toward preventing suicidal behaviours. Treatment planning, based on the clinicians' assessment of suicide risk, must occur at the beginning of treatment.

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- Central to the implementation is attention to building an empathic, supportive and ideally collaborative therapeutic alliance, with particular reference to the patient's (and the patient's family's) cooperation with recommendation treatments.
- Safeguard the patient's environment, particularly with regard to easy access to available firearms and toxic agents.
- Dialectical behavior therapy and Cognitive behavior therapy are useful for suicide prevention.
- Talk therapy has been found to be an effective treatment for many people who struggle with thoughts of harming themselves.
- Antidepressants have been associated with lower suicide rates in adolescents.
- Spiritual counselling will reduce the stress and depression.
- Recent research has shown that Lithium has been found to be effective by lowering the risk of suicide in those with bipolar disorder to the same levels as the general population. Lithium has also proven effective in lowering the suicide risk in those with unipolar depression as well.

Conclusion:

Collaboration, coordination, cooperation and commitment are needed to develop and implement a national plan, which is cost-effective, appropriate and relevant to the needs of the community. The time is ripe for mental health professionals to adopt proactive and leadership roles in suicide prevention and save the lives of thousands of young Indians.

Health professional can play an effective role in preventing, managing or rehabilitating persons with suicidal tendencies, those who have committed a suicidal act. Building value systems, setting acceptable individual aspirations and indicating appropriate goal-setting mechanism are of prime importance for preventing the younger age group from attempting suicide.

In India there should be mental health crises centre in every city and also in rural area so that people who have suicidal thinking can go immediately for help. At last we would say, we simply have to learn to cope better with the increased competition, increased stress, increased loneliness and increased materialism.

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