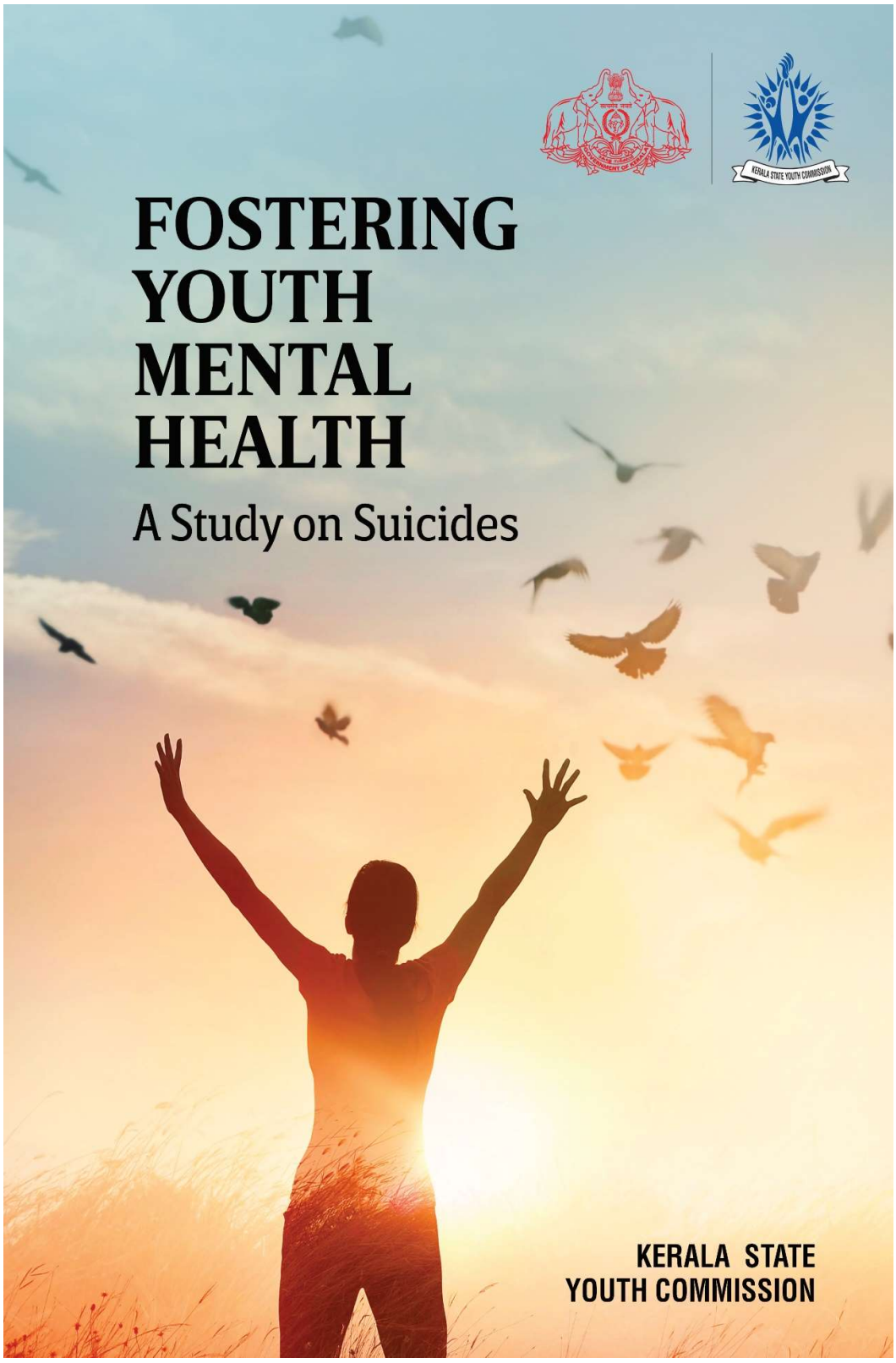
FOSTERING
YOUTH
MENTAL
HEALTH
A Study on Suicides
KERALA STATE YOUTH COMMISSION
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FOSTERING YOUTH MENTAL HEALTH

A Study on Suicides

Research Report

KERALA STATE YOUTH COMMISSION

കേരള സംസ്ഥാന യുവജന കമ്മീഷൻ

FOREWORD

Due to the advantage of demographic dividend, Kerala has a significant share of youngsters in its population that can be effectively translated into the development of the state. In this context, the Kerala State Youth Commission (KSYC) is all set to play a proactive role to ensure the wellbeing of this young population. In addition to the policies and programmes it has been framing and implementing, the KSYC is all set to take up relevant research projects on various issues related to the youth in Kerala. It has identified various issues that fall into the priorities and scope of the commission.

The occurrence of suicide is a symptom of mental ill health of any society that is related with social transformation. This appears to be true in the case of Kerala as well. However, the tremendous enviable achievements the state has made in terms of social and human development, on par with even the most developed nations, problematise rather than normalise the situation. The preponderance of youth population too is a significant factor contributing to the issue. It is in this pressing context that the KSYC has taken up the research project "FOSTERING YOUTH MENTAL HEALTH: A Study on Suicides". This is not only the maiden research project of the KSYC that marks a turning point in its functioning but also a seminal and extensive study on suicide and youth mental health in the state. The output of the study certainly will attract the attention of academia and policy makers to shift their focus on the life and wellbeing of youth in the state who are the enormous source energy that can be mobilised for achieving the sustainable development goals of the state.

Kerala State Youth Commission upholding the slogan "ZERO SUICIDE" will frame pertinent policies and carryout effective interventions to foster the mental health and wellbeing of our youth brigade.

SHAJAR M
Chairman
Kerala State Youth Commission

ACKNOWLEDGEMENT

The research project titled "Fostering Youth Mental Health: A Study on Suicides", is the maiden research project executed by the Kerala State Youth Commission (KSYC). The success of this project is the result of the sincere efforts of many.

I put on record my sincere gratitude to the research team that includes Dr. MS Jayakumar *(Assistant Professor, Department of Sociology, University of Kerala)* as Chairperson and Dr. Lima Raj *(Assistant Professor, Department of Psychology, Sree Sankaracharya University of Sanskrit)*, Mr. Praveen Parameswar (*Chief Executive Officer at Lifology.com & Chief Lifologist)*, Ms. Daliya R Chandran *(Assistant Professor on Contract, Master of Social Work, Department of Sociology, University of Kerala)* and Dr. Anil Chandran S *(Head, Department of Demography & Director, Population Research Centre, University of Kerala)*, as members for their untiring efforts to complete the project within the short time.

I extend sincere thanks to Adv. Mr. M Randheesh and Adv. Mr. P Rahul Raj *(State Coordinators, KSYC*) who have efficiently coordinated the study. Thanks are also due to all District Coordinators of the Commission for their diligent efforts.

I am grateful to Ms. Darly Joseph (*Secretary*), Mr. Prakash P Joseph (AO) Mr. C Ajithkumar (*Finance Officer*) and other staffs of KSYC for their administrative support.

I express my gratitude to Mr. Vishnu V J, Ms. Ashly Mariam Punnoose and Ms. Santhra Sunil for their tireless assistance to the project.

I am grateful to all the field investigators for their voluntary service to the project.

Most importantly, I am indebted to all the respondents for their kind and sincere cooperation with this research project by providing the required data.

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EXECUTIVE SUMMARY

- The present study shows that the highest number of suicides is found in the age group 36-40.
- Male suicide rate is higher than female suicide rate. While majority of the male victims belong to the age group of 31-35, majority of the female victims belong to 18-20 age group.
- The youth with low education (SSLC and plus two) show higher tendency to commit suicide.
- The rate of suicide among the employed youth is much higher than the unemployed youth.
- Majority of the employed who committed suicide were working in unorganized sector.
- There is a strong relationship between income of the person and suicide. The majority of those committed suicide had either low income or no income at all.
- Studies and statistics show that suicides in India are higher among married individuals (among both males and females). But the situation in Kerala is different as suicide is more among unmarried youth than married.
- The rate of suicide among religious groups is almost proportional to their size in the population of the state.
- Suicide is higher among Other Backward Communities (OBC) followed by SC/ST and General category.
- The highest rate of suicide is reported in Grama Panchayaths followed by Municipality and Corporation.
- Hanging is adopted as method of suicide by the overwhelming majority followed by poisoning, drowning and jumping from heights.
- There is gender difference in the method of committing suicide. While more males adopt hanging, more female use of poisons, drugs or substances.

- A notable percentage of individuals who committed suicide had a history of suicide among their relatives.
- Even those with strong family and friendship relations committed suicide. This points to the fact that the causes of youth suicides are more associated with other factors that need to be studied.
- A substantial percentage of suicides are associated with toxic relationships followed by relationship breakup, blackmailing, rejection and other reasons.
- A larger portion of respondents, acknowledged that financial crisis contributed "to some extent" to suicide.
- The study found that a major percentage of suicide victims had addiction towards alcohol, illegal drugs, narcotic substances and other items.
- A significant percentage of victims experienced psychological distress and feeling of hopelessness. This underscores the importance of fostering mental well-being of youth.
- The rate of diagnosed depression is slightly higher among male victims than the females while females have a higher rate of diagnosed mood disorders than males.
- Majority of the survivors experience prolonged grief and strong sense of loss.
- Majority of the survivors pointed that emotional distress is the most negative impact of suicide on family. This is followed by lack of support and financial crisis.
- Some of the survivors shifted their residence to a new place, probably to escape from disturbing surrounding.
- Majority of the victims' family members recovered from the impact of suicide only to some extent.
- Majority of the victims from both genders is included in OBC category (51.4 percent males and 58.6 percent females).
- Majority of the victims are lived in rural areas (Grama Panchayath).

- In Grama Panchayath female victim population is higher (71.7 percent) than the male victim population (69.3 percent). When it came to municipality majority of victims are males (19.6 percent).
- More than half of the victims (51.0 percent) (Male 53.1 percent and female 42.8 percent) are in the pink ration card colour category signifying Priority or Below Poverty Line (BPL).
- Female victims are better educated than males (in degree, post-graduation and above, professional, medical engineering and law). While the majority of the males (42.2 percent) studied up to SSLC, the majority of females upto Plus two (28.9 percent).
- More than half of the victims (68.9 percent) does not have any financial crisis at the time of suicide.
- It shows that employed victims have financial crisis than the unemployed victims (36.4 Percent).
- There is visible difference between the employment status of male victims (72.7 percent) and female victims (29.6 percent). Also, more female victims are unemployed (39.5 percent) than males (10.3).
- Among the unmarried victims, the majority (60.5 percent) are males whereas among the married, the majority (64.5 percent) were females.
- In all religious groups, more males committed suicide than females. The majority of the male victims (81.7 percent) belongs to Hindu religion and majority of females (32.4) belongs to Muslim religion.
- Both male and females have the problem of addiction. In the case of alcohol consumption majority of the male victims (48.9 percent) are addicted to that. On the other hand, drugs are mostly use by females (16.1 percent) than the males (11.2 percent).
- 21.6 percent victims who had mental health issues like personality disorder, mood disorder, and depression but more than three fourth (87.9 percent) did not seek any health care service at all

- A significant portion (12.3 percent) of the victims had given some or other signal to the family members about their suicide.
- For the majority (84.7 percent), it was the first attempt and the remaining (15.3 percent) made multiple attempts.
- 3.2 percent of the victims had committed murder/s before committing suicide.
- The unmarried victims were more (81.1 percent) closer to family
- Both male (79.1 percent) and female (66.9 percent) victims mostly chose the method of hanging for committing suicide followed by poisoning (8.7 percent). The method of poisoning is comparatively higher among the females (9.5 percent) than the males (8.5 percent).

CONTENTS

CHAPTER 1
YOUTH SUICIDES

"Life is no brief candle for me. It is a sort of splendid torch which I have got hold of for the moment, and I want to make it burn brightly as possible before handing it on to future generations"

-George Bernard Shaw

1.1 Introduction

Suicide is the second leading cause of death worldwide and it is a major public health problem with far-reaching social, emotional and economic consequences. It is estimated that more than 700,000 suicides occur every year worldwide, and each suicide profoundly affects many more people (WHO, 2023). In the world, the rates of suicide have greatly increased among youth over the years, and youth are now the group at highest risk in one-third of the developed and developing countries. Suicide is nevertheless a private and personal act and a wide disparity exists in the rates of suicide across different countries (Radhakrishnan and Andrade1, 2012).

Suicide is a complex and multifaceted phenomenon, and its causes are usually the result of a combination of various factors. It is important to note that each individual's situation is unique, and what might contribute to one person's suicidal thoughts or actions may not be the same for another. Some common factors associated with suicide risk include, mental health disorders, previous suicide attempts, family history, chronic illness or pain, substance abuse, isolation and lack of social support, traumatic life events etc.

1.2 Youth Suicide in India

India has one of the highest suicide rates in the world. According to the National Crime Records Bureau (NCRB), a total of 1,64,033 suicides were reported in the country in 2021 showing an increase of 7.2 percent than the previous year (2020) and the rate of suicides has increased by 6.2 percent in 2021 over 2020.

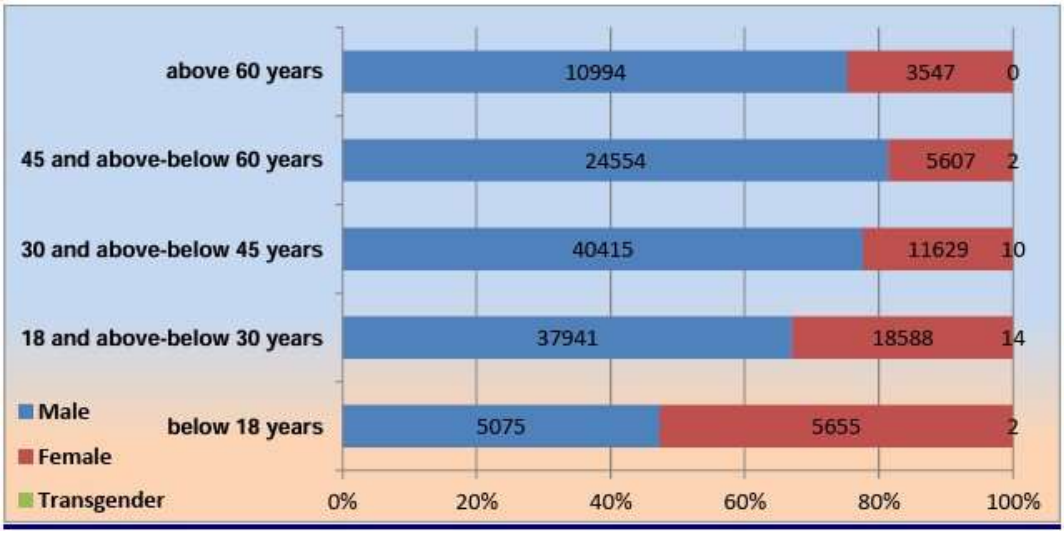
Table 1.1 Number of Suicides, Growth of Population and Rate of Suicides (2017–2021)

Sl. No.	Year	Total Number of Suicides	Mid-Year Projected Population (in Lakh*)	Rate of Suicides (Col.3/Col.4)
(1)	(2)	(3)	(4)	(5)
1	2017	1,29,887	13091.6#	9.9
2	2018	1,34,516	13233.8#	10.2
3	2019	1,39,123	13376.1#	10.4
4	2020	1,53,052	13533.9$	11.3
5	**2021**	**1,64,033**	**13671.8$**	**12.0**

Source: National Crime Records Bureau, 2021

The age groups between 18 and below 30 years and between 30 years and below 45 years of age were the most vulnerable groups resorting to suicides in India. These age groups accounted for 34.5 percent and 31.7 percent suicides respectively. Among these two groups, male suicide rate is significantly higher than their female counterparts.

Figure 1.2 Suicide Victims by Sex and Age (2021)



Source: National Crime Records Bureau, 2021

1.3 Youth Suicide in Kerala

Among the Indian states, Kerala performs well in human development, especially with enviable levels of education and healthcare infrastructures. However, there are some issues that still grapple the state, mental health being one of them, with suicide as a significant indicator.

Table 1.2 States/UTs with Higher Suicide Rate (2019-2021)

Year					
2019		**2020**		**2021**	
A & N Islands	45.5	A & N Islands	45.0	A & N Islands	39.7
Sikkim	33.1	Sikkim	42.5	Sikkim	39.2
Puducherry	32.5	Chhattisgarh	26.4	Puducherry	31.8
Chhattisgarh	26.4	Puducherry	26.3	Telangana	26.9
Kerala	24.3	Kerala	24.0	Kerala	26.9
National Rate	**(10.4)**	**National Rate**	**(11.3)**	**National Rate**	**(12.0)**

Source: National Crime Records Bureau, 2021

According to national crime records statistics (2021), Kerala is in the fifth position in terms of suicide rate (24.0) after Andaman & Nicobar Islands (39.7), Sikkim (39.2), Puducherry (31.8) and Telangana (26.9). These figures speak only on suicides committed, not attempted. Studies have pointed out that the attempts are 20 times more than the reported suicides in the country.

Table 1.3 Number and Rates of Suicides in Kerala (2017-2021)

Year	No. of suicides	Suicide rate/lakh population
2017	7870	22.9
2018	8237	23.8
2019	8556	24.6
2020	8500	24.3
2021	9549	27.2

Source: Kumar, 2022

The statistics during 2017-2021 show an increase in the number of people dying by suicide in Kerala. In 2017, 7,870 people committed suicide in Kerala. In 2021, it increased by 21.3 percent to reach 9,549 people (National Crime Records Bureau, 2021). Looking closer, while 22.86 people/one lakh population took the extreme step in 2017, 27.20 did

it in 2021. This is despite Kerala achieving most of the targets the World Health Organization (WHO) has set. The situation raises serious questions on whether the State has achieved the desired goals in case of suicide prevention and mental health (Kumar, 2022).

These numbers point to the fact that Kerala needs to take further steps towards mental health and suicide prevention. The suicide rate of Kerala is more than the national average rate. The are still many who attempt suicide but fail. As a result, developing action plans to address this issue is crucial. Suicide is caused by a variety of factors, including financial commitments, illnesses, family issues, love affairs etc.

Among the districts, Thiruvananthapuram, has been reporting the greatest number of suicides over the past five years (36.8 suicides per lakh in 2017, 42 in 2021) while Malappuram reporting lesser number of suicides for the past few years (7.6 in 2017, 11.5 in 2022). Data, however, points at a gradual increase in the number of suicides in Malappuram as well. As per the national suicide trend, the highest number of suicides in Kerala happen in the young and middle-aged groups (20.2 percent among 15-29 age group and 24.3 percent among 30-45 group) (Kumar, 2022).

Another notable fact is that more males commit suicides than females in Kerala, according to the NCRB (2021), the suicide rate among males in the state was 26.7 per 100,000 people in 2020, compared to 11.7 among females. The Annual Vital Statistics Report of Government of Kerala, 2020 also shows the same trend as out of the total suicides reported in the state during 2019-20 (5186), the majority of the victims were males (4130). The same trend is reflected in different age groups as well (Table 1.5).

Table 1.4 Suicide Death by Age (Medically Certified or Not) in Kerala

Gender	Age Group									
	5-14	15-24	25-34	35-44	45-54	55-64	65-69	70+	Not	Total
Male	31	374	600	765	837	762	285	488	8	4130
Female	31	234	171	117	112	140	62	168	3	1056

Total	62	608	771	882	949	902	347	654	11	5186

Source: Vital Statistics Report of Government of Kerala, 2020

Annual Vital Statistics Report of Government of Kerala 2021 shows that suicide contributes 1.87 percent (1.49 percent males and 0.38 percent females) of total deaths in Kerala. Addressing the issue of suicide requires multifaceted and comprehensive approach focusing on the overall well-being of the population. Since Kerala has enviable achievements in human development that includes physical health and wellbeing, comparable to even the most developed nations, it cannot afford to have even a narrow rate of prevalence of suicide that reflects mental ill health. Due to demographic dividend, Kerala has significant proportion youths in its population. Therefore, suicide among the youths is important not just as a mental health issue, but also as a development issue.

In this pressing context, the present research investigated into the causes and consequences of youth suicides in Kerala.

1.4 Objectives

1. To identity the causes and consequences of youth suicide in Kerala
2. To analyse the social, economic and psychological dimensions of suicide
3. To capture the effects of youth suicides on survivors
4. To make suggestions for appropriate policies and programmes to address the issue.

1.5 Concepts and Definitions

Youth -Youth in the present study is defined as an individual in the age group of 18-40.

Suicide -WHO defines suicide is the act of deliberately killing oneself (WHO).

1.6 Population and Sampling

Both primary and secondary data were used in the study. Details of suicide victims in the age group 18-40 years for the period 2018-22 were obtained from the State Crime Records Bureau. Primary data (quantitative) were collected from the immediate survivors of the suicide victims using a structured interview schedule. The sample size for the primary

survey was estimated as 680, which is 30 per cent of the average annual number of suicides (an average of 2258 youth suicides were reported in Kerala per year during the 2018-22 period; the total number of suicides during the period being 11294). In order to account for non-response and casualties, the sample size was increased by 20 per cent, i.e., 816 suicides. The final achieved sample size was 745. The data were collected during 5-20 December 2023 covering all the districts.

1.6 Data Collection

A structured interview schedule was prepared in English for data collection and was translated into Malayalam. Data were collected by the Post Graduate students from various universities and colleges across the state who volunteered to participate in the data collection process and were trained by the faculty members involved in the study. The data were collected using the digital platform and analysed using appropriate software.

CHAPTER 2
SOCIO ECONOMIC PROFILE

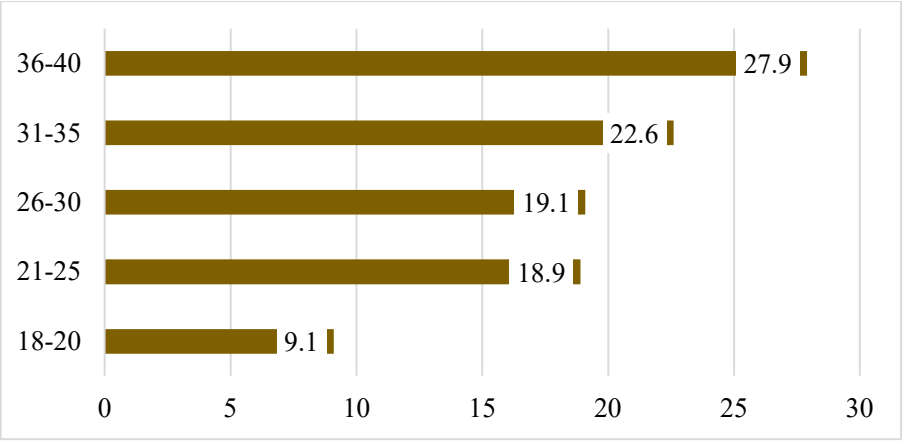
2.1 Introduction

This chapter represents the profile of the victims covered in the study. Creating a profile of victims entails summarizing and analysing demographic, psychological, social, and other pertinent characteristics of individuals like age, gender, education, occupation, monthly income, marital status, religion, social category etc. This information is essential for tailoring preventive measures, interventions, and support systems for reducing suicide rates and aiding vulnerable populations.

2.2 Age

Age has an important relationship with suicide. As people get older, their concept of death gets mature, and suicide rate goes up as well. Presence of depressive disorder, alcohol abuse, use of lethal methods, loneliness, social detachment, hopelessness, financial crisis, physical illness etc tend to increases with age. According to *The Suicidal Career Theory* developed by Edwin Shneidman, the eventual suicides are dependent on time and life experiences in order to acquire the ability to cause self-injury (Orden, 2010). The most reliable 'age data' for suicide states that across all age categories, there is a consistent trend of higher numbers of suicides among males compared to females.

Figure 2.1 Age of Victims



The present study also shows that the highest number of suicides (27.9 percent) for both is found in the age group 36-40, followed closely by 31-35 (22.6) 26-30 (19.1) 21-25 (18.9) and 18-25 (9.1) indicating that individuals in their later adulthood are more prone to committing suicide.

Individuals in 36-40 age group have significant life stressors such as career pressures, financial responsibilities (e.g., mortgages, supporting a family), and relationship issues (marital problems, divorce). Some individuals in this age range might have undiagnosed or untreated mental health conditions like depression, anxiety, or substance abuse disorders, which can escalate during this phase of life. The 36-40 age range is also often associated with a "midlife crisis," where individuals may reassess their achievements, goals, and life satisfaction. This period of introspection might lead to emotional turmoil and existential questioning. With increased maturity and independence, individuals in this age group might have greater access to lethal means too, potentially increasing the risk of completed suicides.

Erikson (Cherry, 2022) considered young adulthood to be a longer stage than the previous ones, extending from the end of adolescence to about the age of 35. During this period we experience *intimacy versus isolation.* We undertake some form of productive work and establish intimate relationships, typically close friendships and sexual unions. Individuals who struggle to form these close connections during young adulthood might experience feelings of isolation. They tend to avoid social interactions, distance themselves from others, and might even display aggression towards them. Preferring solitude, they fear intimacy as something that could challenge or undermine their sense of self-identity. Mental health struggles, of relationships complexities, abuse, of substances, exploration of identity, and role confusion, social pressures and expectations, contribute to suicidality.

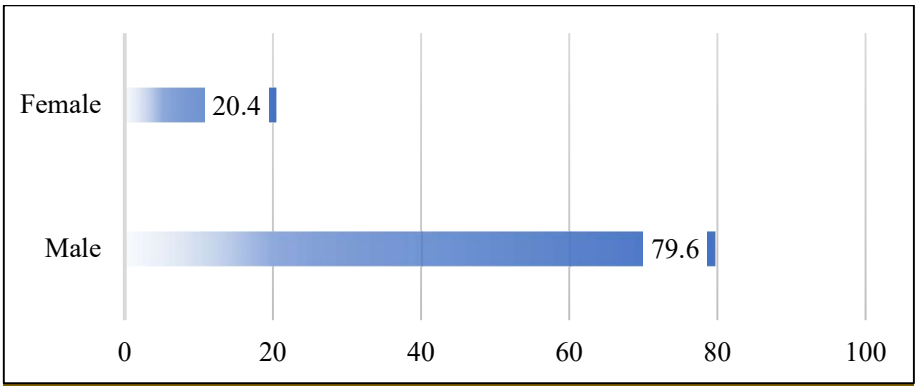
2.3 Gender

Gender is one of the most repeatedly reproduced predictors of suicide. The relationship between gender and suicidal behaviours have been intelligibly analyzed. Recent studies corroborate that male suicide rate exceed those of females. However, women are more likely to attempt suicide than men (Kaplan and Sadock, 2003). Interestingly this leads to what has been called *gender paradox in suicide* (Canetto and Sakinofsky, 1998). High

suicide mortality rate in men can be due to various factors like socioeconomic risk factors, occupational factors, demographic factors, psychiatric and psychological factors, lethality, family factors, substance abuse, socio-cultural differences, help seeking patterns, gender role, etc. (Richardson.et.al, 2021).

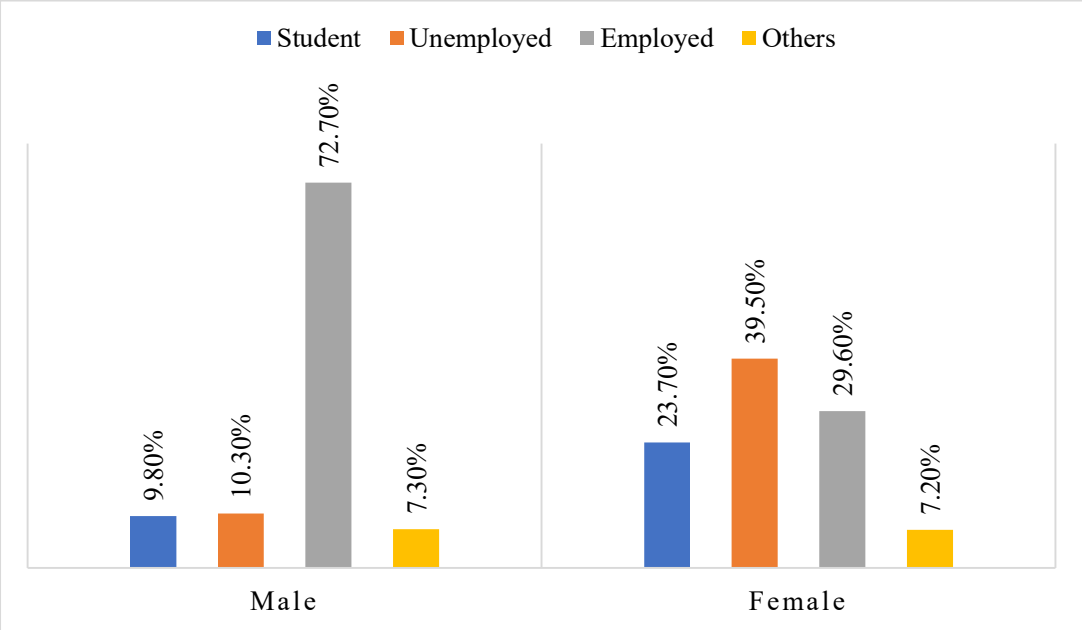
Women on the other hand have higher suicide attempts and rates of depression but lower suicide mortality rate (Vijayakumar, 2015). A total of 448 women committed suicide in 2018 while the number dropped to 431 in 2022 (Kallungal, 2023). This may result from the fact that women tend to seek appropriate help. Moreover, the traditional female roles like fragility, emotionality, family, marriage, and children, tend to protect women from suicide regardless of postpartum and other depressions (Ghodke, et.al, 2023). Other suicide risk factors more prevalent in women are sexual abuse, presence of personality disorders and the fallacies created by the *phallocentric* and *gynocentric* perspectives on suicide. The present study also shows (table 2.2) that males over high (79.6 percent) females (20.4 percent) in committed suicides.

Figure 2.2 Gender of Victims



The figure (2.3) shows that while around three fourth (72.7 percent) of the male victims were employed; the corresponding percentage among females was only less than one third (29.6 percent). So also, while only 10.3 percent of males were unemployed, 39.5 percent of females were unemployed. This can be read along with the education status as around one fourth (23.7 percent) of female victims were students. This is also related to the low age at suicide among females. Female work participation in Kerala is considerably low and there is a felt need for programmes to ensure female work participation overriding the structural barriers.

Figure 2.3 Gender and Employment status

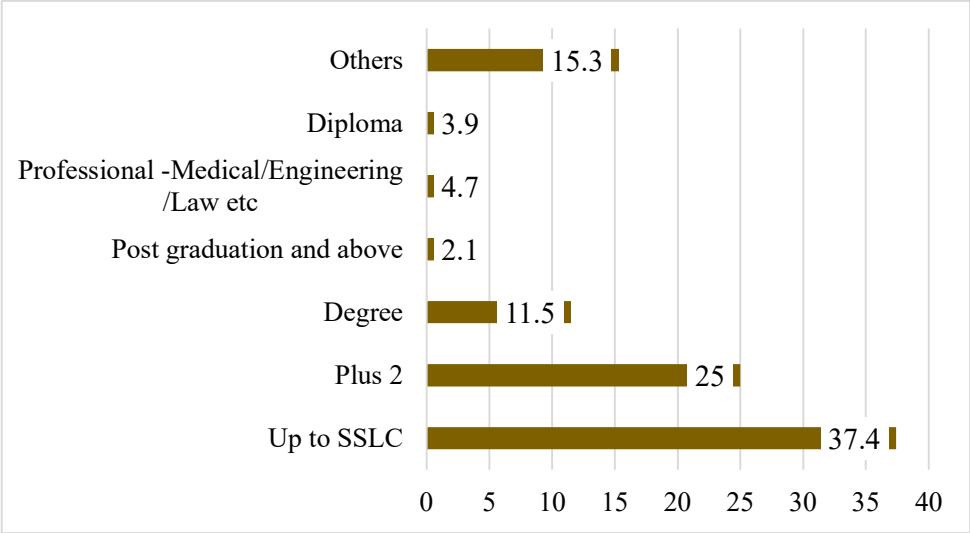


2.4 Education

The relationship between education and suicide is complex and multifaceted. Research has shown varying correlations between educational attainment and suicide rates across different populations and contexts (Pompili, M. et al. 2013). Higher educational attainment usually exhibits a negative correlation with suicide risk. This association could be attributed to various factors linked to higher education, such as enhanced cognitive abilities, improved access to resources, elevated socio-economic status, fortified social networks, and heightened mental health literacy (Rosoff, et.al, 2020). These facets potentially foster more effective coping strategies and heightened resilience in managing stressors, thereby diminishing the propensity for engaging in suicidal behaviours.

Conversely, certain stressors associated with educational settings, such as academic pressure, competition, and performance expectations, can also contribute to mental health challenges and increase the risk of suicide among students. Additionally, in some cases, marginalized groups might face barriers to accessing higher education, which can exacerbate feelings of hopelessness and contribute to increased suicide risk.

Figure 2.4 Educational Status of Victims



The connection between education and suicide is shaped by many things—individual, societal, cultural, and economic factors. While more education often links to lower suicide rates, it is not a fixed rule and changes a lot depending on situations. Recognizing these differences is vital for creating effective suicide prevention plans that cater to diverse populations' needs. Figure 2.3 presents the education of victim. The majority fall in the low education categories (37.4 percent in up to SSLC and 25 percent in plus two).

Table 2.1 Gender and Education

Gender	Education							Total
	Up to SSLC	Plus 2	Degree	Post graduation and above	Professional - Medical/Engineering /Law etc	Diploma	Others	
Male	42.2%	23.9%	8.8%	0.7%	4.2%	4.4%	15.9%	100.0%
Female	19.1%	28.9%	22.4%	7.9%	6.6%	2.0%	13.2%	100.0%
Total	37.4%	25.0%	11.5%	2.1%	4.7%	3.9%	15.3%	100.0%

Table 2.1 represents the relationship between gender and education. It shows that female victims are better educated than males (in degree, post-graduation and above,

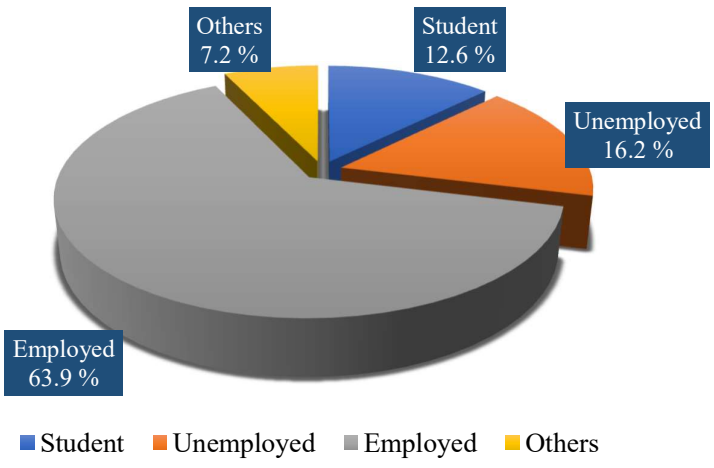
professional, medical engineering and law). While the majority of the males (42.2 percent) studied up to SSLC, the majority of females did up to Plus two (28.9 percent).

2.5 Occupational Status

Moreover, occupational stress, persistent exhaustion, inadequate equilibrium between work and personal life, and restricted availability of mental health resources within specific sectors can intensify mental health challenges, augmenting susceptibility to suicidal ideation and actions. Initiatives aimed at enhancing mental health provisions, destigmatizing mental health issues, and instituting comprehensive workplace wellness schemes are pivotal in attenuating the likelihood of suicide risks prevalent across diverse occupational domains. These efforts involve creating robust support systems, promoting mental health literacy, integrating accessible mental health services, and implementing holistic programs that foster psychological resilience and well-being within occupational settings.

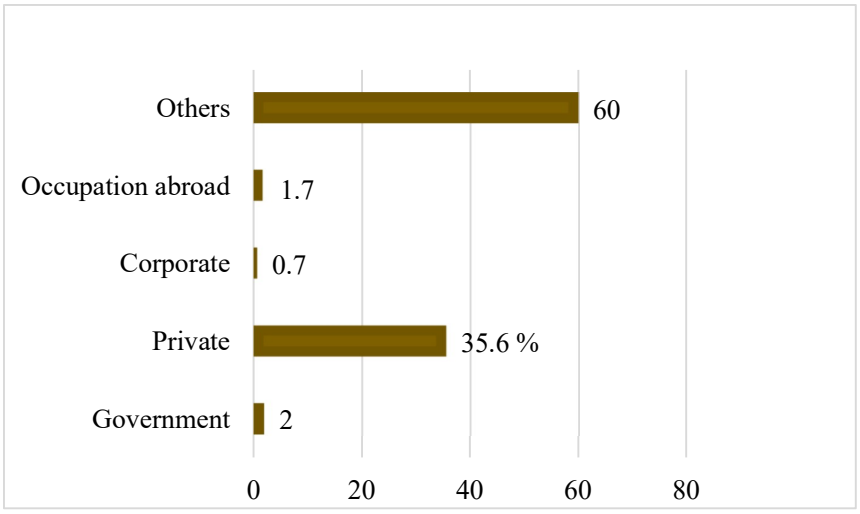
Occupation can significantly influence suicide rates due to various factors within the work environment, especially for men (Roberts, et.al, 2013). Increased occupational instability, absence from the work, occupational content of gender role stereotypes have been proposed as the major factors behind increase in male suicides. Some jobs have higher stress levels, job insecurity, long hours, or exposure to traumatic experiences, all of which can contribute to increased physical and mental weakness that lead to low self-esteem and confidence.

Figure 2.5 Employment Status of the Victims



While being unemployed or experiencing job-related stress can contribute to the causes of suicide. So, the employment status of the victim is related to the cause of suicide. Employment often plays a significant role in shaping one's identity and self-worth. Unemployment or problems in job can lead to feelings of inadequacy, hopelessness, and despair. Employed category constitute greater rate of suicide. (63.9 percent). Jobs with high levels of stress, pressure, and burnout may contribute to mental health challenges, potentially increasing the risk of suicide. Also, unemployment is a significant cause to suicide. (16.2 percent). unemployment can lead to financial strain, creating stressors that contribute to mental health issues and increase the risk of suicide.

Figure 2.6 Sector of Employment of the Victims



Certain professions may be associated with higher stress levels, increased job demands, or exposure to trauma, which could elevate the risk of suicide. 35.6 percent of the victims were worked in private sector. 60 percent constitute the other sector of employment.

Table 2.2 presents the relationship between employment status and financial crisis of the victims. It is found that the employed and unemployed victims experienced almost the same level of financial crises. It is also notable that student victims were the least affected with financial constraints.

Table 2.2 Employment Status and Financial Crisis of the Victims

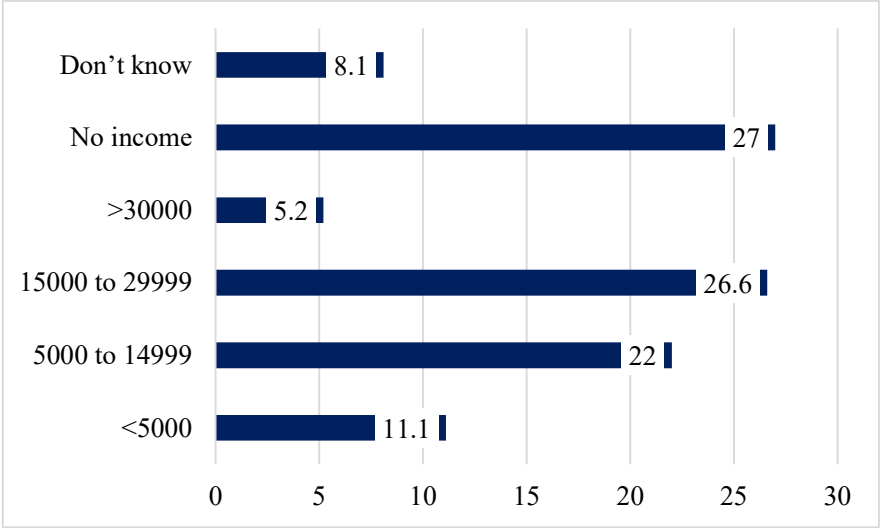
Employment status of the person (at the time of committing suicide)	financial crisis at the time of suicide			Total
	To a great extent	To some extent	Not at all	
Student	2.1%	4.3%	93.6%	100.0%
Unemployed	9.9%	23.1%	66.9%	100.0%
Employed	11.8%	24.6%	63.7%	100.0%
Others	7.4%	16.7%	75.9%	100.0%
Total	9.9%	21.2%	68.9%	100.0%

2.6 Income

Individuals facing financial instability due to lack of income may experience increased stress, hopelessness, and a sense of despair, which can contribute to higher suicide risk. The 2021 NCRB data records higher suicide rates in those working as daily wage earners (25.6 percent), rather than the unemployed (8.4 percent). A ten year trend analysis shows a sharp increase in deaths amongst the daily workers (12 percent in 2014), making daily labourers the commonest occupational group associated with suicidal death in 2021.

Research has shown that people who experience stress from financial issues are 20 times more likely to attempt suicide than those who do not experience it. (Elbogen et al, 2020). Living with low income can be associated with various stressors, such as inadequate access to education, healthcare, and social support, all of which may contribute to an elevated risk of suicide. Lower income individuals may face challenges accessing mental health resources, including therapy and medications, which can impact their ability to manage mental health conditions and cope with stressors. There is a strong relationship between income of the person and suicide

Figure 2.7 Income of Victims

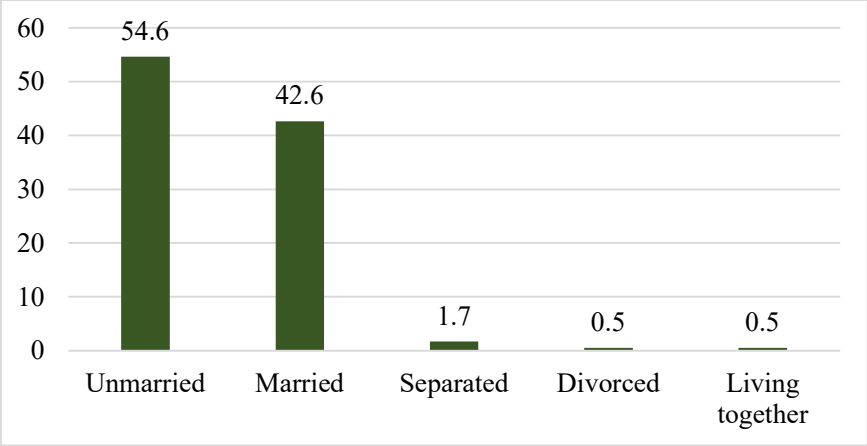


The present study too shows similar results. The majority fell in the lowest income category (27 percent) of the victims did not have income. Also, among those had income, the majority (22 percent had 5000-14999 and 11.1 percent had less than 5000.

2.7 Marital Status

Studies and statistics state that suicides in India are higher in married individuals (both male and female), in contrast to the western pattern of higher death rates in 'loners' or individuals without families. The Indian pattern contradicts sociological theories of connectedness as a protective factor against suicide, as married individuals are expected to be more integrated into the society and family. Indeed, according to the NCRB data, "family problems" accounts for as much as 32.4 percent of all deaths by suicide. In Indian women suicide rates are higher among home matters (compared to students or working women), suggesting family to be the primary source of stress. Domestic violence, dowry and demands by the husband's family, substance use by husband, coupled with lack of economic independence and subservient family role, exerts tremendous stress on women, resulting in increased suicide rates in the first 5 years of marriage. The commonest officially reported cause "family problem" subsumes, oversimplifies and dehumanizes a very complex and layered social inducer of death, unique to the Indian culture.

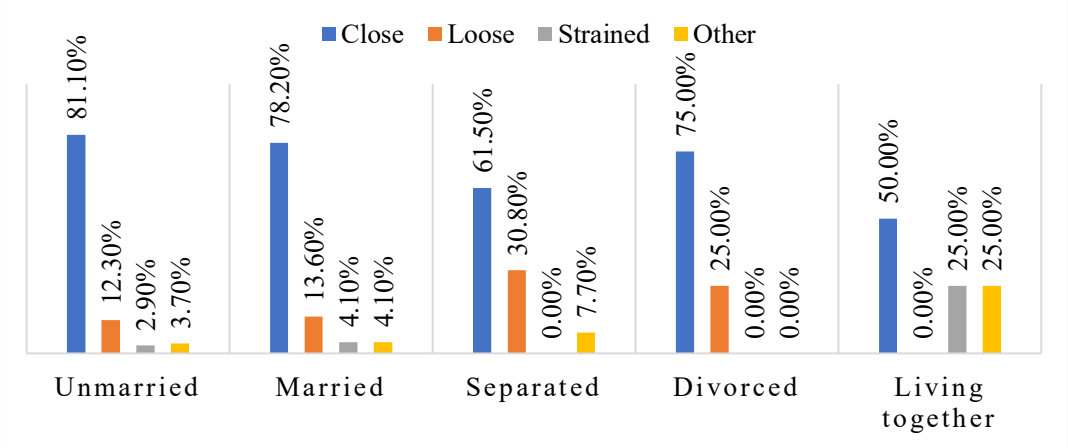
Figure 2.8 Marital Status of the Victims



Numerous studies have shown that unmarried people are more likely to consider or attempt suicide. Others have found that people who had been divorced, widowed or married in the preceding five years were at higher risk of committing suicide relative to those who had no change in marital status over the same time period (Evans, 2015).

The percentage of suicide is greater in unmarried people (54.6 percent) than married people (42.6 percent) in Kerala. According to this findings, unmarried individuals, may have a higher risk of suicide compared to married individuals. Social isolation, lack of support, and feelings of loneliness are factors that may contribute to this association. The emotional support, companionship, and sense of belonging that can come with a stable marital relationship may contribute to lower suicide risk.

Figure 2.9 Marital Status and Nature of relationship with family

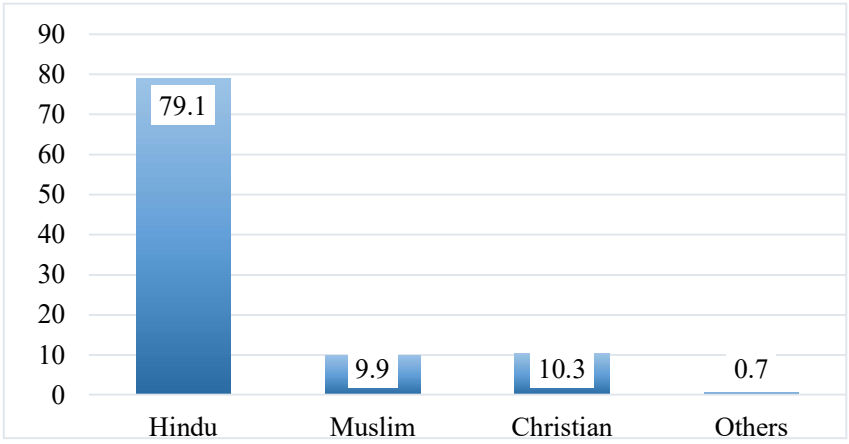


Marital status is one of the important variables that affects the nature of a person's relationship with family. It is found that the majority of victims across all marital statuses maintained close relationship with their family (figure 2.9). The unmarried victims were more (81.1 percent) closer to family followed by the married (78.2 percent), divorced (75.0 percent), separated (61.5 percent) and living together (50 percent). The separated victims have higher percentage (30.8) of loose family ties followed by the divorced (25.0 percent). The victims who were living together had more strained (25 percent) family relations than all others.

2.8 Religion

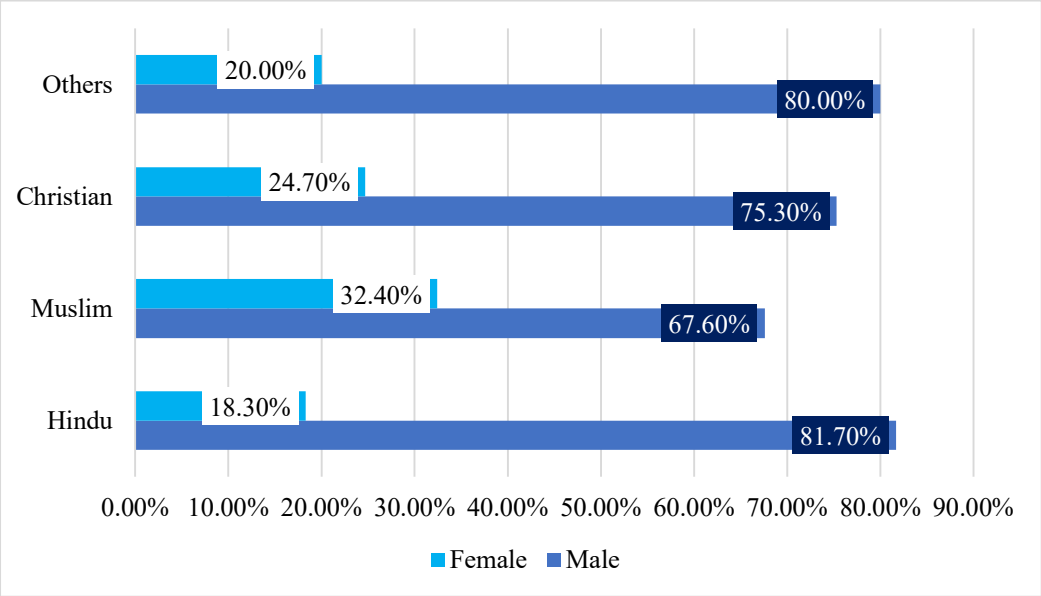
Although religion is reported to be protective against suicide, the empirical evidence is inconsistent. Research is complicated by the fact that there are many dimensions to religion (affiliation, participation, doctrine) and suicide (ideation, attempt, completion). Studies found that religious affiliation does not necessarily protect against suicidal ideation, but does protect against suicide attempts. Whether religious affiliation protects against suicide attempts may depend on the culture-specific implications of affiliating with a particular religion, since minority religious groups can feel socially isolated. After adjusting for social support measures, religious service attendance is not especially protective against suicidal ideation, but does protect against suicide attempts, and possibly protects against suicide (Lawrence et al, 2020).

Figure 2.10 Religion of Victims



The rate of suicide among Hindu religions is 79.1 percent. The rates of suicide among Christians and Muslims are 10.3 percent and 9.9 percent, respectively.

Figure 2.11 Religion and Gender

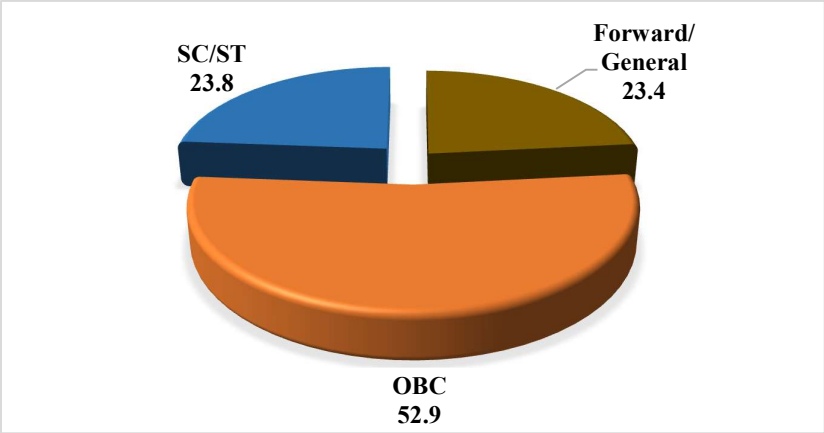


In all religious groups, males committed the greatest number of suicides (figure 2.11). While the males in Hindu (81.7 percent) registered the highest proportion of victims, females in Muslims recorded the highest percentage of (32.4).

2.9 Social Category

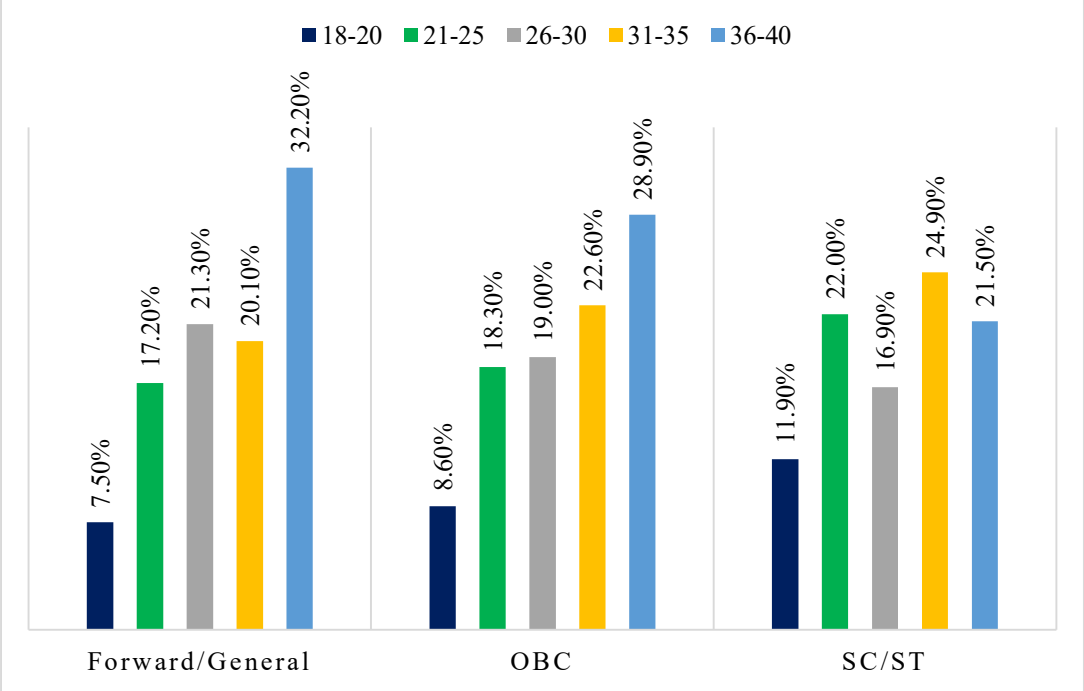
The relationship between social categories and suicide is complex. It is influenced by various factors. In the Indian sociocultural scenario, the social category is defined on the basis of caste. The findings of the present study show (figure 2.12) that suicide is high among the other backward communities (OBC) (53 percent) followed by SC/ST (23.8 percent) and general (23.0 percent).

Figure 2.12 Social Category of the Victims



The increased rate of suicide in the OBC may be due to include economic challenges, lack of educational opportunities, and limited access to resources. Mental health issues and social stigma can also contribute. The present study too shows that the social category of the individual is also a factor contributing to suicide.

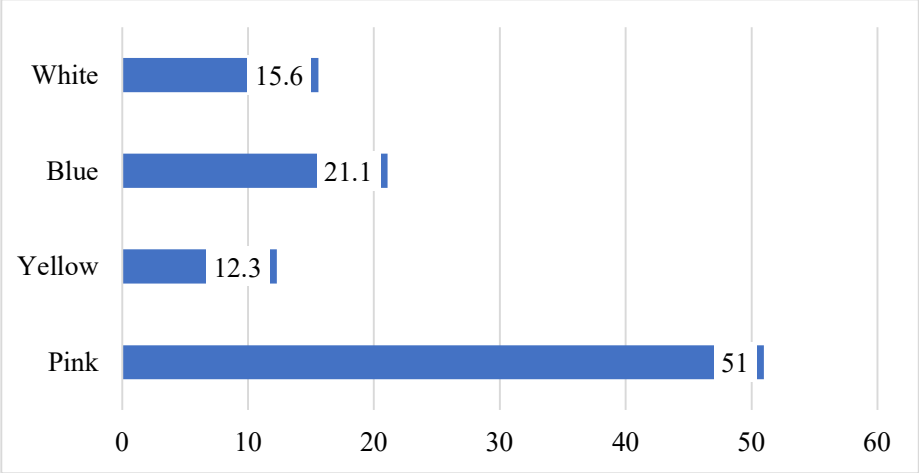
Figure 2.13 Social Category and Age



When analyzing the relation between social category of the victims and age, it is found that the majority of the victims in the forward/general (32.2 percent) and OBC (28.9

percent) fell in the age group 36-40. It is notable that the proportion of youngsters committing suicide are higher among the SC/STs than that in other groups.

Figure 2.14 Colour of Ration card of Victims (in %)



The Figure (2.14) shows the distribution of the samples across the categories (colours) of ration cards they fell in. Under the public distribution system, beneficiaries are categorized into four colours; White, Blue, Pink and Yellow. More than half of the victims (51.0 percent) are in the pink category signifying Priority or Below Poverty Line (BPL), followed by Blue/ Non-Priority subsidy/Above Poverty Line or APL (21.1 percent), White (15.6) and Yellow/ most economically backward section (12.3 percent).

Table 2.3 Age and Employment Status

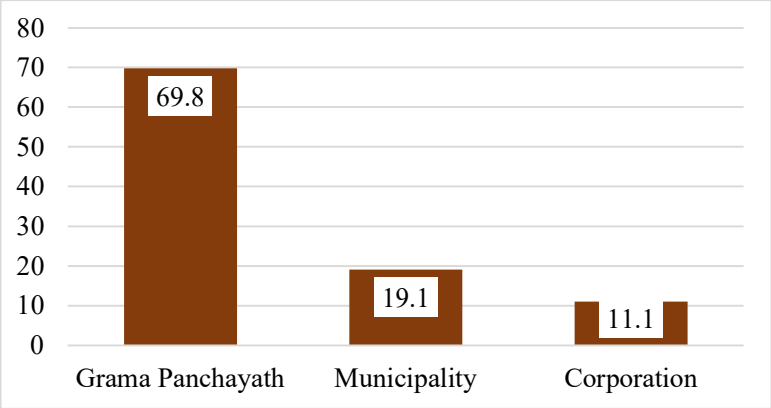
Age Group	Employment status				Total
	Student	Unemployed	Employed	Others	
18-20	73.5%	8.8%	13.2%	4.4%	100.0%
21-25	26.2%	23.4%	45.4%	5.0%	100.0%
26-30	3.5%	16.9%	73.9%	5.6%	100.0%
31-35	0.6%	14.9%	79.2%	5.4%	100.0%
36-40	0.0%	14.4%	73.6%	12.0%	100.0%
Age unknown'	5.6%	16.7%	66.7%	11.1%	100.0%
Total	12.6%	16.2%	63.9%	7.2%	100.0%

In the age group 31-35, 79.62 percent were employed followed by 26-30 (73.9 percent), 36-40 (73.6 percent) and 21-25 (45.4 percent). whereas in 18-20, it was just 13.2 percent. Also in the 18-20 group, 73.5 percent were students. Unemployment decreases from the age 26 years.

2.10 Place of Residence

The place of residence, can significantly affect suicide rates as usually urban areas experience higher stress due to competitive lifestyles, work pressure, and social demands, potentially contributing to higher reported suicides. Rural regions might face different stressors like agricultural challenges, socio-economic disparities, and limited access to mental health resources. This might explain why districts like Wayanad, Kasargod, and Idukki, which are comparatively rural, report lower suicide rates. Semi-urban areas may exhibit a blend of urban and rural challenges, possibly reflecting intermediate rates compared to purely rural or urban districts. Some districts might fall in this category, such as parts of Thrissur, Kozhikode, and Palakkad. Disparities in access to mental health facilities, support groups, and awareness programs could be more pronounced in rural areas, potentially affecting reported suicide rate. Disparities in access to mental health facilities, support groups, and awareness programs could be more pronounced in rural areas, potentially affecting reported suicide rates.

Figure 2.15 Place of Residence



2.11 Method of Suicide

The choice of method varies significantly across individuals and cultures. The choice of suicide method is influenced by accessibility, cultural factors, and the individual's intent.

Methods range from self-poisoning, such as medication overdoses or ingestion of toxic substances, to more violent means like hanging, firearm use, jumping from heights, drowning, or self-immolation. Each method varies in lethality and fatality rates, influencing the chances of survival.

The distribution of suicide methods, depicted by their percentages, offers insight into the diverse ways individuals choose to end their lives. Hanging emerges as the predominant method, representing an overwhelming majority at 76.6 percent. Its prevalence likely stems from its accessibility and lethality. Poisoning follows as the second most common method at 8.7 percent, highlighting the significance of self-poisoning through the ingestion of toxic substances or medications.

Table 2.3 Methods of Suicide

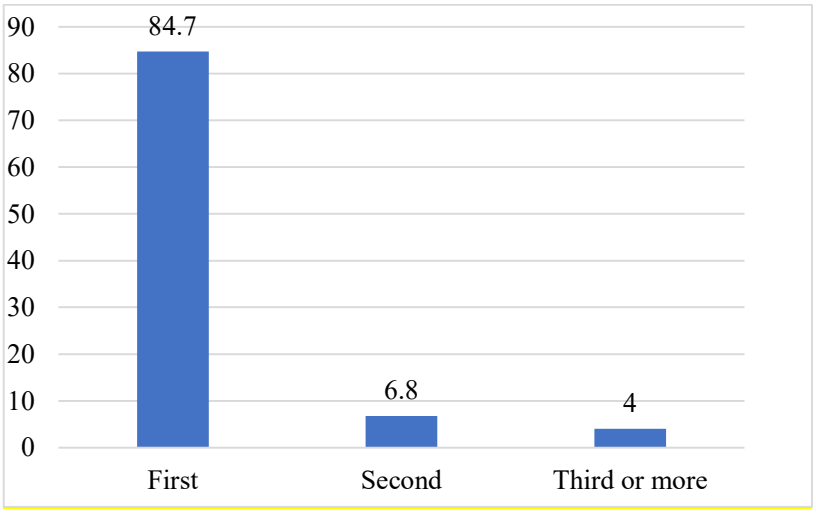
Method of Suicide	Percentage
Hanging	76.6
Poisoning	8.7
Drowning	3.6
Burning	0.8
Jumping from height	2.8
Jumping on to moving train etc	1.5
Bleeding	0.3
Overdose of medicines	0.8
Other methods	4.8
Total	100.0

Meanwhile, drowning, jumping from heights, and other less frequent methods collectively contribute to the remaining percentages, each presenting unique challenges in terms of prevention and intervention due to their often-severe consequences. Understanding the distribution of these methods emphasizes the diversity and complexity of suicide prevention strategies needed to address the accessibility and risks associated with each method, particularly focusing on the most prevalent means of suicide.

However, generally, there are gender disparities in the choice of suicide methods. Men often opt for more immediately lethal means like firearms, hanging, or jumping from heights, leading to higher completion rates. Women, while attempting suicide more

frequently, often choose methods with lower fatality rates initially, such as drug overdoses or self-poisoning. Understanding these gender differences in method preference is crucial for tailored prevention and intervention strategies.

Figure 2.16 Number of attempts



The figure (2.16) represents the number of suicide-attempts the victims made. For the Majority (84.7 percent), it was the first attempt and the remaining (15.3 percent) made multiple attempts. While 6.8 percent made two attempts, 4.0 percent made three or more attempts. Since both single attempts and multiple attempts are highly significant on their own, they deserve serious attention as proper interventions can prevent them in future.

CHAPTER 3
CAUSES OF SUICIDE

3.1 Introduction

Suicide, a deeply complex phenomenon, is influenced by a multitude of causes spanning social, economic, psychological, gender, spatial, and youth-specific aspects. Each dimension brings its own set of challenges and influences, underscoring the need for a comprehensive understanding to formulate effective prevention and support strategies. It involves community engagement, improved access to mental health services, education and awareness campaigns, and the destigmatization of seeking help. By embracing a holistic approach that acknowledges the complexity of these dimensions, societies can better support individuals at risk and work towards effective suicide prevention.

3.2 Social Causes

3.2.1 Lack of Social Support and Suicide

Among the numerous factors influencing suicidal behaviour, the impact of social support stands as a significant protective element against suicide risk. Social support encompasses a spectrum of interpersonal relationships, including emotional, instrumental, informational, and appraisal support, each contributing uniquely to an individual's resilience against suicidal ideation and behaviour. Emotional support, characterized by empathy, care, and companionship, serves as a crucial buffer against the psychological distress that often precedes suicidal thoughts. Instrumental support, involving tangible assistance and resources, acts as a practical aid in alleviating stressors that may contribute to suicidal tendencies. Moreover, informational support, disseminating guidance and advice, and appraisal support, fostering a sense of self-worth and validation, collectively fortify an individual's coping mechanisms, thereby reducing their susceptibility to suicidal inclinations.

The table provided indicates the percentage of suicide associated with various experiences of discrimination.

Table 3.1 Experience of Discrimination

Experience of Discrimination	Percentage
Gender	0.4
Physical appearance (body shaming)	0.8
Religion	0.1
Colour	0.3
Disability	0.1
Any other (specify)	3.0
No discrimination	95.3
Total	100.0

A slightly higher percentage (0.8 percent) of suicides are linked to experiences of discrimination related to physical appearance, specifically body shaming. This suggests that negative perceptions or comments about one's body may contribute to distress and suicidal thoughts. A small percentage of suicides (0.4 percent) are associated with experiences of gender-based discrimination. This may include discrimination based on one's gender identity or expression. The highest percentage (3.0 percent) is associated with discrimination categorized as "Any Other." This category is unspecified, and further information is needed to understand the specific forms of discrimination included.

3.2.2 Youth Suicide and Family Problems

The dynamics of family structure can significantly influence an individual's mental health and, in some cases, contribute to increased suicide risk. Changes in family structure, such as divorce, separation, or the loss of family members, can introduce stressors that affect individual's emotional well-being.

When parents get divorced or separated, it can create instability, emotional distress, and conflict in the family. Children may experience feelings of abandonment, guilt, or loneliness, which can contribute to depression or suicidal thoughts. Single-parent households may face economic challenges, time constraints, and increased stress for the parent, which can affect the emotional support available to children. This lack of support might contribute to feelings of isolation or distress in children.

While blended families can provide support and care, they might also introduce complexities in relationships, conflicts, and adjustments that can be stressful for children or adults adapting to new family dynamics. The death of a family member, especially a parent or a sibling, can lead to profound grief and emotional distress. Coping with such loss might be challenging and increase the risk of mental health issues or suicidal ideation. In cases where individuals feel disconnected or unsupported by their family due to issues like rejection, discrimination, or lack of understanding (e.g., in LGBTQ+ families), the lack of acceptance and support can contribute to higher vulnerability to mental health issues and suicide.

Family relationships and dynamics significantly influence an individual's mental health. Dysfunctional family environments, abuse (physical, emotional, or sexual), neglect, conflict, or strained relationships can profoundly impact an individual's well-being. Lack of support, feeling misunderstood, or facing discrimination within the family context can exacerbate feelings of isolation, hopelessness, and despair, elevating the risk of suicidal behaviour.

Table 3.2 History of Suicide

History of suicide (Multiple answers possible)	Percentage
Relatives	8.8
Friends	1.9
Neighbours	0.8
Lover /partner	0.6
Other (specify)	0.7
No such incidences	87.2
Total	100.0

Family history can play a significant role in influencing an individual's risk of suicide. The data provided indicates the percentage of individuals who died by suicide and whether there was any history of suicide among different relationships. A percentage of individuals who died by suicide (8.8 percent) had a history of suicide among their relatives. This suggests that there may be a familial component or influence on suicide risk. A smaller percentage (1.9 percent) had a history of suicide among their friends. The

influence of peer relationships on suicide risk is evident, though to a lesser extent compared to relatives.

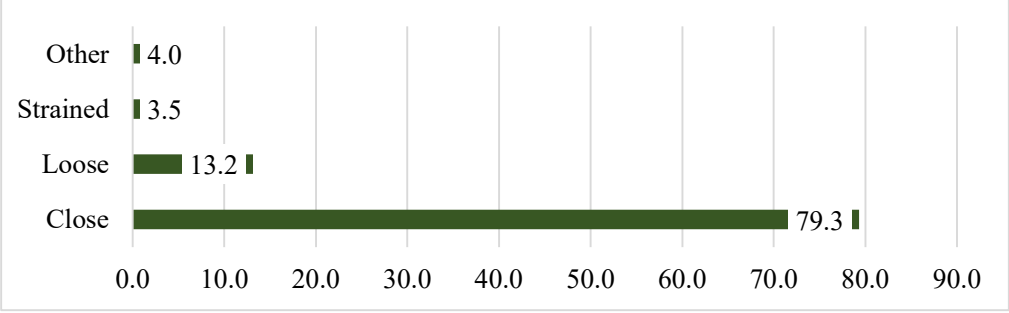
The dynamics of family structure can significantly influence an individual's mental health (Jabbari, 2023) and, in some cases, contribute to increased suicide risk (Oppenheimer, et.al, 2018). Changes in family structure, such as divorce, separation, or the loss of a family member, can introduce stressors that affect an individual's emotional well-being.

When parents' divorce or separate, it can create instability, emotional distress, and conflict within the family (Trichal, 2021). Children may experience feelings of abandonment, guilt, or loneliness, which can contribute to depression or suicidal thoughts. Single-parent households may face economic challenges, time constraints, and increased stress for the parent, which can affect the emotional support available to children. This lack of support might contribute to feelings of isolation or distress in children (D'Onofrio and Emery, 2019).

While blended families can provide support and care, they might also introduce complexities in relationships, conflicts, and adjustments that can be stressful for children or adults adapting to new family dynamics. The death of a family member, especially a parent or a sibling, can lead to profound grief and emotional distress. Coping with this loss might be challenging and increase the risk of mental health issues or suicidal ideation.

In cases where individuals feel disconnected or unsupported by their family due to issues like rejection, discrimination, or lack of understanding (e.g., in LGBTQ+ families), the absence of acceptance and support can contribute to higher vulnerability to mental health issues and suicide.

Figure 3.1 Nature of Person's Relationship with Family



Family dynamics, communication patterns, support systems, and the overall environment at home can contribute to a person's emotional and psychological state. Positive family relationships can act as a protective factor against suicide. A supportive and nurturing relationship with family members can provide emotional support, understanding, and a sense of belonging, which are crucial for an individual's mental health. Strong family bonds can serve as a buffer during challenging times, helping individuals cope with stress, anxiety, and depression.

Conversely, dysfunctional family relationships or lack of support can contribute to feelings of isolation, alienation, and despair, potentially increasing the risk of suicidal thoughts and behaviours.

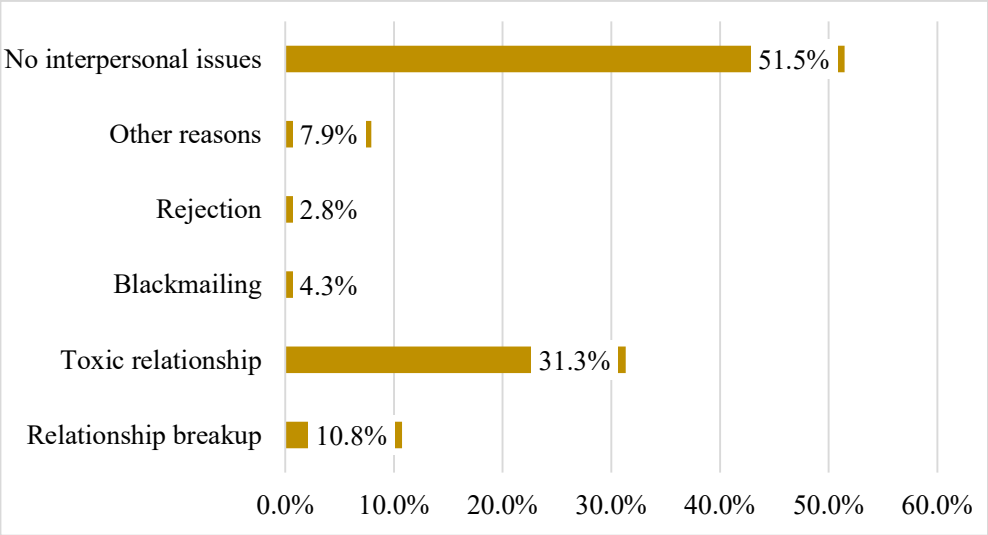
This study observes a trend that even people who have a strong bond with their family commit suicide. A higher number of individuals who commit suicide (79.3 percent) have close relationships with their family. This contradiction with the existing data proves that the causes of youth suicides in Kerala are more associated with other factors than family.

3.2.3 Friendship/ Love Affairs and Suicide

Scientific evidence consistently underscores the profound influence of friendships and romantic relationships on shaping individuals' mental health trajectories, significantly impacting their vulnerability to suicidal ideation and behaviours. Strong friendships serve as protective factors against suicide. Studies, such as a longitudinal analysis by Klomek et al. (2009), have shown that adolescents with close friendships exhibit lower rates of suicidal ideation and attempts. Supportive peer relationships provide emotional solace, a sense of belongingness, and opportunities for open communication, reducing feelings of isolation and hopelessness. Conversely, social isolation or conflicts within friendships can heighten suicide risk. Research by Reinherz et al. (2006) underscores that social alienation or the absence of close friendships during adolescence can elevate the likelihood of suicidal behaviours in later years.

Interpersonal issues can significantly contribute an impact suicidal thoughts and behaviours. These issues involve difficulties in relationships and interactions with others, and they can manifest in various ways.

Figure 3.2 Interpersonal Issues of Victims

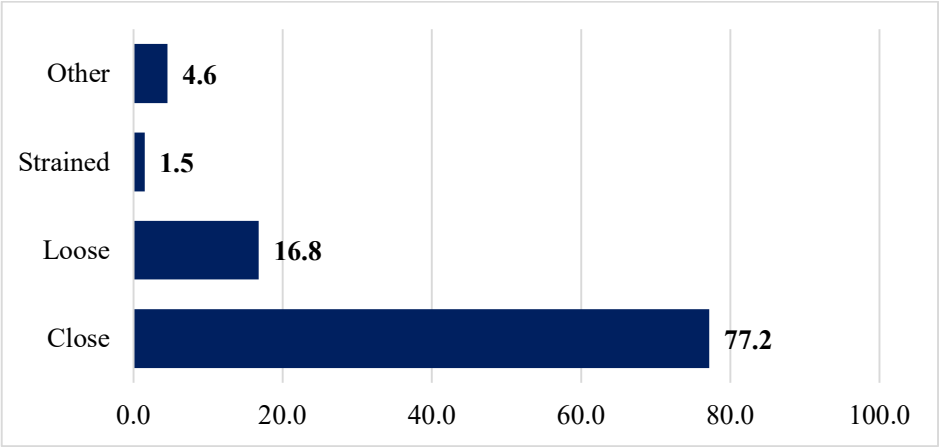


A substantial percentage of suicides (31.3 percent) are associated with toxic relationships. This underscores the impact of unhealthy, harmful, or abusive relationships on mental health and highlights the need for awareness, intervention, and support in such situations. The data also shows that relationship breakup is associated with 10.8 percent of suicides. The end of a significant relationship can be a highly distressing experience, contributing to emotional pain and vulnerability associated with loss of companionship, shared experiences, future plans, identity crisis, sense of loneliness as they navigate a changed social landscape, and physical health implications. A difficult breakup and toxic relationship may influence an individual's ability to trust and engage in future relationships.

Positive romantic relationships also offer significant protective effects against suicide. A study by Josephson et al. (2015) found that strong emotional support and satisfaction in romantic partnerships were associated with lower suicidal ideation and attempts among young adults.

Feelings of dejection among females are intricately linked to their mental health, societal influences, and personal experiences, creating a complex correlation with a heightened risk of suicide. Studies consistently reveal a greater prevalence of depression and dejection among females, amplifying their vulnerability to suicidal behaviour. World Health Organization (WHO), indicates that females are more likely to experience conditions like depression and anxiety compared to males.

Figure 3.3 Nature of the Person's Relationship with Friends



Positive relationship with friends provides emotional support, creating a network where individuals can share their feelings and experiences. Healthy friendships contribute to a sense of belonging and connectedness, reducing feelings of isolation and loneliness. On the other hand, certain dynamics within friendships or the absence of supportive relationships can be risk factors for suicidal thoughts and behaviours.

Notably, in Kerala, the majority of people who commit suicide have close relationships with friends. (77.2 percent). This may because of unhealthy nature of relationship. Lack of open and honest communication within friendships leads to complicated relationship. Unresolved conflicts, betrayals, or toxic dynamics within friendships may exacerbate mental health challenges. Experiencing bullying or harassment from close friends can significantly impact an individual's mental health and increase suicide risk. Friends engaging in unhealthy coping mechanisms, such as substance abuse, may contribute to a negative environment. It is essential for persons in close relationship to be aware of each other's well-being and to foster an environment of trust and support.

3.2.4 Education and Suicide

The relationship between education and suicide involves intricate dynamics influenced by various factors. Academic pressure, characterized by intense competition and high expectations, can contribute to elevated stress levels among students. Bullying and peer pressure within educational environments may exacerbate mental health challenges, fostering feelings of isolation and distress. Transition periods between educational levels

can pose significant challenges, potentially leading to heightened stress and mental health concerns.

The provided table presents the percentage distribution of suicide cases based on educational qualifications and age groups. A striking observation is the higher prevalence of suicides in the 31-35 age group across all educational qualifications. This suggests that this particular age bracket may be more vulnerable to suicide, emphasizing the need for targeted interventions and mental health support for individuals in this demographic.

Table 3.3 Educational Qualification and Age of the Victims

Educational qualification	Age					Total
	18-20	21-25	26-30	31-35	36-40	
Up to SSLC	5.9%	15.6%	31.7%	47.6%	56.7%	37.4%
Plus 2	64.7%	34.8%	27.5%	17.3%	10.1%	25.0%
Degree	13.2%	24.1%	8.5%	10.1%	6.7%	11.5%
Post-graduation and above	1.5%	2.1%	5.6%	1.2%	1.0%	2.1%
Professional -Medical/ Engineering /Law etc.	7.4%	5.0%	9.2%	3.6%	1.9%	4.7%
Diploma	2.9%	7.8%	4.9%	3.0%	1.9%	3.9%
Others	4.4%	10.6%	12.7%	17.3%	21.6%	15.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Additionally, the Up to SSLC category exhibits a gradual increase in suicide percentages with age, peaking in the 31-35 age group. Conversely, the Plus 2 category displays a different pattern, with a peak in the 18-20 age group followed by a general decline in older age groups. The Degree category demonstrates a fluctuating trend, reaching a peak in the 21-25 age group. These variations highlight the diverse dynamics at play within different educational strata.

The Degree category displays a fluctuating trend with a peak in the 21-25 age group. Post-Graduation and above, as well as Professional categories, show relatively lower

percentages across all age groups. Diploma and Others categories exhibit varying patterns with peaks in different age groups.

In conclusion, the analysis of suicide rates based on age and educational qualifications reveals nuanced patterns that warrant further investigation. While the data provides valuable insights, it is essential to acknowledge the limitations and complexities inherent in studying such a sensitive topic. A more comprehensive approach, involving additional demographic and socioeconomic factors, is necessary to gain a holistic understanding of the interplay between age, educational qualifications, and suicide rates.

Table 3.4 Disturbing Experiences from Academic Institution

Disturbing experiences from academic institution	Age					Total
	18-20	21-25	26-30	31-35	36-40	
Rejection from peers	0.0%	0.7%	0.7%	0.0%	0.0%	0.3%
Harassment from teachers/authorities	0.0%	0.7%	0.0%	0.0%	0.0%	0.1%
Failure in Examination	1.5%	2.9%	0.0%	0.6%	0.0%	0.8%
Academic pressure	1.5%	1.5%	0.7%	0.0%	0.0%	0.6%
Dejection due to poor academic performance	0.0%	0.0%	0.0%	0.6%	0.5%	0.3%
Disciplinary action	0.0%	5.1%	0.7%	1.9%	0.0%	1.5%
Any other	97.0%	89.0%	97.8%	96.9%	99.5%	96.4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Disturbing experiences in academic institutions can sometimes contribute to mental health challenges and, in some cases, may be linked to suicide risk. Data shows that failure in examination (2.9 percent), academic pressure (1.5 percent), and disciplinary action from academic institutions (5.1 percent) can contribute to the causes of suicide in the age group 21–25. This pointed to the critical need for academic institutions to prioritize mental health support and create inclusive and respectful environments.

3.2.5 Work Pressure

Work pressure, constitutes a significant factor influencing mental health in the workplace (Rajgopal, 2010). In the realm of societal influences, the demands and stresses of the workplace exert profound effects on mental health and well-being, often leading to increased susceptibility to suicide. The contemporary work milieu, marked by competitiveness, strict performance standards, job instability, and extended work hours, fosters an atmosphere where long-term stress prevails. This ongoing stress from work obligations, coupled with the fear of job loss or falling short of high-performance expectations, significantly affects mental health.

Table 3.5 Age and Occupation of Victims

Employment status of the victims	Age					Total
	18-20	21-25	26-30	31-35	36-40	
Student	73.5%	26.2%	3.5%	0.6%	0.0%	12.6%
Unemployed	8.8%	23.4%	16.9%	14.9%	14.4%	16.2%
Employed	13.2%	45.4%	73.9%	79.2%	73.6%	63.9%
Others	4.4%	5.0%	5.6%	5.4%	12.0%	7.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

From the data, a clear trend emerges between the employment status of the victim and the age group to which they belong. People who are employed commit more suicide (63.9 percent), and there is a significant increase in the suicide rate of employed people with an increase in age. 79.2 percent of the individuals in the age group 31–35 who commit suicide are employed.

Table 3.6 Disturbing Experiences at Work Place

Disturbing experiences at work place	Age					Total
	18-20	21-25	26-30	31-35	36-40	
Insult/ rejection from colleagues	0.0%	0.8%	1.4%	0.6%	0.5%	0.7%
Verbal/physical/sexual harassment	0.0%	0.0%	0.7%	0.0%	0.0%	0.1%
Professional incompetency	0.0%	0.0%	0.0%	0.0%	0.5%	0.1%
Dissatisfaction in job	0.0%	0.8%	2.9%	2.5%	0.5%	1.4%
Discrimination in promotion, transfer	0.0%	0.0%	0.0%	0.6%	0.0%	0.1%
Disciplinary/downgrading actions	0.0%	0.0%	0.0%	0.0%	0.5%	0.1%
Work pressure	0.0%	0.0%	1.4%	0.0%	3.0%	1.1%
Other	3.2%	1.6%	2.2%	0.6%	3.5%	2.4%
No such experience	96.8%	96.9%	91.3%	95.6%	91.5%	93.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

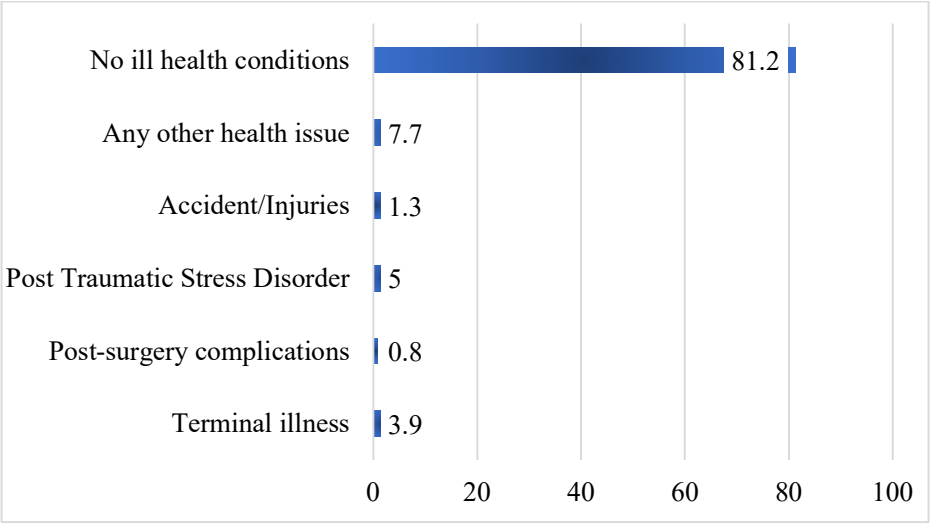
Work-related stress and disturbing experiences in the workplace can contribute to suicides. The data do not show highly significant relationship between disturbing experiences in the workplace and suicide. Dissatisfaction in the job (1.4 percent), work pressure (1.1 percent) and some other work-related factors (2.4 percent) caused suicides. In the age group 36–40, 3.5 percent suicides were because of work pressure.

3.2.6 Health and Suicide

The association between health and suicide involves a complex interplay of physical and mental health factors. Physical health conditions, especially chronic illnesses or severe pain, significantly impact mental well-being. Coping with prolonged health issues can evoke feelings of hopelessness and distress, elevating the risk of suicide. Additionally, certain medications or treatments may induce mood-altering side effects, further

influencing susceptibility to suicidal thoughts. Mental health disorders are also strongly correlated with suicidal tendencies. These conditions distort perception, intensify emotional turmoil, and impair coping mechanisms, heightening the risk of suicidal ideation and actions. Integrating mental health care into primary health care systems and eradicating the stigma around seeking mental health support are critical steps in promoting well-being and averting suicide.

Figure 3.4 Health Condition of Victims



The table provides insights into the distribution of suicide rates based on different health conditions. The majority of individuals who died by suicide did not have any reported health conditions (81.2 percent). This may suggest that a significant portion of suicides is not directly associated with specific physical health issues. A smaller percentage of suicides (7.3 percent) are linked to various other health conditions not specified in the data. These conditions could encompass a range of physical or mental health issues that are not explicitly categorized. A relatively low percentage of suicides (1.3 percent) are attributed to accidents or injuries. This category may include instances where individuals intentionally harmed themselves, leading to fatal consequences. Post-Traumatic Stress Disorder (PTSD) is identified as a factor in 5% of suicide cases. This suggests a connection between a history of trauma and the risk of suicide, highlighting the importance of mental health support and intervention for individuals dealing with PTSD.A small percentage of suicides (0.8 percent) are associated with post-surgery complications. This could imply that some individuals may struggle with the physical and

emotional challenges following surgery, contributing to the decision to end their lives. A notable percentage of suicides (3.9 percent) are linked to terminal illness. Individuals facing a life-limiting health condition may experience significant emotional distress and may choose suicide as a response to their prognosis.

Strategies for suicide prevention should address not only individuals with diagnosed health conditions but also consider the broader context of mental health and well-being. Further research and analysis, incorporating additional variables and demographics, may provide a more nuanced understanding of the interplay between health conditions and suicide rates.

Access to quality health care services is pivotal in suicide prevention. Prompt identification, effective management, and appropriate treatment of both physical and mental health issues are crucial in reducing suicide risk. By fostering supportive environments, promoting healthy lifestyle choices, and imparting stress management techniques are integral in mitigating risk factors associated with health challenges. Addressing both physical and mental health concerns, comprehensive approaches can significantly contribute to suicide prevention efforts.

3.3 Economic Causes

Economic conditions can play a crucial role in suicide. Proponents of a classic economic theory of suicide (Hamermesh and Soss, 1974; Marcotte and Zejcirovic, 2020) argue that the decision to suicide is framed in terms of a cost-benefit analysis, where the discounted lifetime utility perceived by an individual is below a desired minimal threshold. Given that suicide rates rise and fall with economic changes such as the business cycle, unemployment, economic growth, level of economic development, suicide is not seen as fully irrational behaviour (Hamermesh and Soss, 1974; Ying and Chang, 2009). In this view, a full understanding of suicide needs to focus on more than individual psychological morbidity.

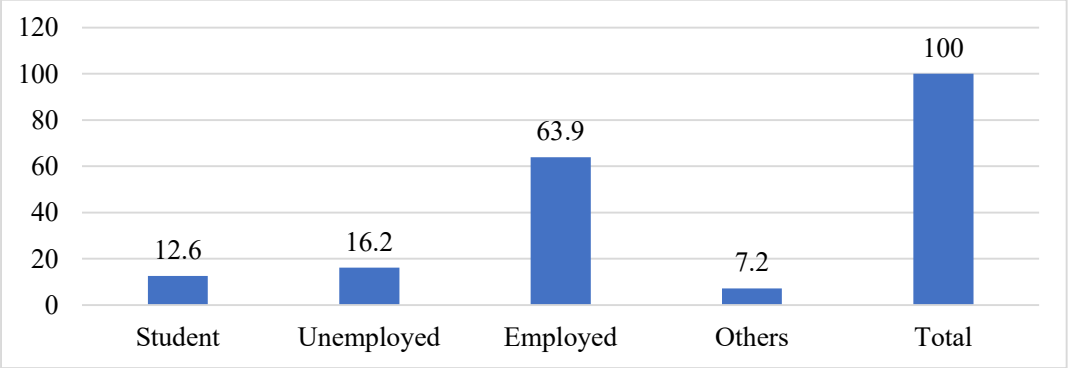
High levels of unemployment and financial instability can contribute to increased stress and anxiety, which may, in turn, be associated with higher suicide rates. Individuals facing job loss or financial difficulties may experience feelings of hopelessness and despair, which are risk factors for suicidal thoughts and behaviours. Economic recessions and

downturns can have a negative impact on mental health. The loss of jobs, housing, and financial security during such periods can lead to an increase in suicide rates. A study published in the Lancet Psychiatry Journal in 2014 found that economic recessions were associated with an increase in suicide rates in multiple countries.

3.3.1 Unemployment and Youth Suicide

Unemployment can increase the risk of suicide by such mechanisms as promoting financial strain, and loss of the meanings of and human connectedness at work. Individual level data generally show a significant association between unemployment and suicide risk (Denney et al., 2015; Kposowa, 2001). However, the present study shows a different picture as the majority (63.9 percent) of the total sample of victims who suicide was employed. They were followed by Students (12.6 percent), and unemployed (16.2 percent).

Figure 3.5 Employment Status of Victims



The study also showed a relationship between the education and employment status of the victims at the time of committing suicide. Out of the total highly educated victims (postgraduate or above). 37.5 percent were unemployed. The percentage of unemployed people committed suicide is higher in the age group 21–25.

Table 3.7 Educational Qualification and Employment Status

Educational Qualification	Employment status of the person (at the time of committing suicide)				Total
	Student	Unemployed	Employed	Others	
Up to SSLC	0.7%	13.3%	81.4%	4.7%	100.0%
Plus 2	25.3%	19.4%	51.6%	3.8%	100.0%
Degree	27.9%	23.3%	44.2%	4.7%	100.0%
Post-graduation and above	6.3%	37.5%	37.5%	18.8%	100.0%
Professional - Medical/Engineering /Law etc	31.4%	20.0%	48.6%	0.0%	100.0%
Diploma	17.2%	3.4%	75.9%	3.4%	100.0%
Others	3.5%	12.3%	61.4%	22.8%	100.0%
Total	12.6%	16.2%	63.9%	7.2%	100.0%

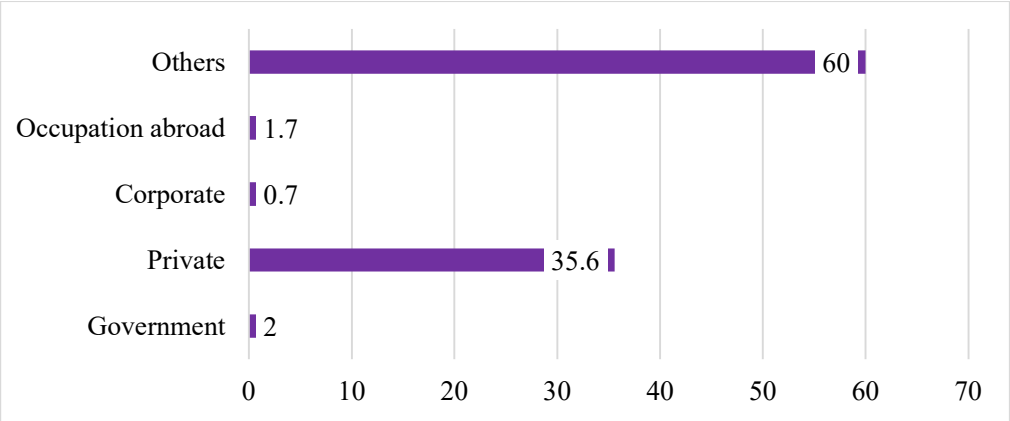
The state of unemployment create stress in individuals. Especially in young adults, unemployment creates existential crisis. This leads to suicidal thoughts. If unemployed persons find a similar job quickly, perhaps in a few weeks, the impact on economic and psychological health is assumed to be less than if the bout with unemployment is much longer (Stack, 2000). Two studies based in Denmark found that the longer the period of unemployment, the greater the risk for suicide (Agerbo, 2005; Qin et al., 2003).

In a time-series analysis of data from 1991 to 2011, for 20 European nations, a 1 percent increase in unemployment was associated with a 0.72 percent increase in male suicide and a 0.95% increase in female suicide rates (Reeves and Stuckler, 2016). The level of gender equality was found to be a moderator of this association. In nations very high in gender equality there was no association between unemployment and suicide. Such equality was viewed as a protective factor for men. Gender equality lessens the stress for males by reducing pressures to adhere excessively to “breadwinner” culture in the traditional male role. Equality had no effect, however, on female suicide rates.

3.3.2 Economic Instability and Financial Issues

Specific economic problems impact probability of suicides. It is often mediated by other individual-level factors, mainly psychological and physical, whose negative influence is exacerbated by reductions in the availability of health and social care during an economic crisis. Financial instability tends to be associated with increases in suicide rates. The number of people who commit suicide in the private and other sectors of employment is higher than in the government sector. No monthly income category commits more suicide.

Figure 3.6 Sector of Employment



Apart from negative financial events that have already materialized (e.g. recessions and unemployment), uncertainty about future events may also have a detrimental effect on mental health. Job insecurity or fear of job loss (a source of economic uncertainty) are associated with adverse health outcomes. Economic uncertainty can also have an immediate impact on health outcomes.

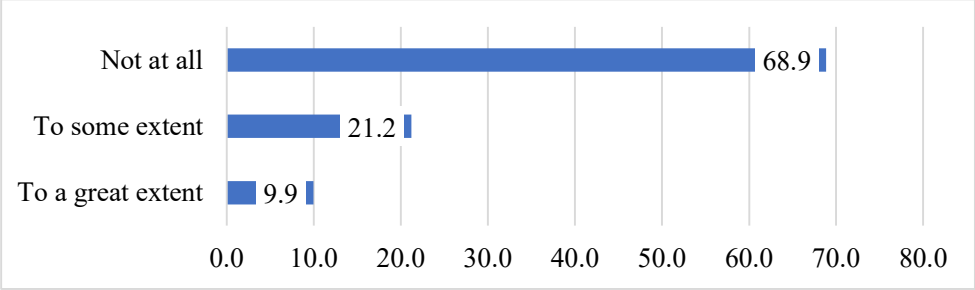
3.3.3 Debt

The relationship between debt and suicide is a complex and multifaceted issue that involves various factors. While it's essential to approach the topic with sensitivity and recognize that not everyone experiencing financial difficulties considers or attempts suicide, there is evidence to suggest a correlation between debt and mental health challenges, including an increased risk of suicidal thoughts and behaviours.

The figure indicates the perceived correlation between financial crisis and suicide, with respondents providing their assessment of the extent to which a financial crisis contributed to the act. The subset of respondents who indicated that a financial crisis

contributed to the suicide "to a great extent" represents 9.9 percent of the total. This suggests that, for nearly 10 percent of individuals, there is a strong perceived link between financial crisis and the decision to end their lives.

Figure 3.7 Financial Crisis at the Time of Suicide



A larger portion of respondents, 21.2 percent, acknowledged that a financial crisis contributed "to some extent" to the suicide. This group perceives a connection between financial difficulties, which may include debt, and the act of suicide, albeit to a lesser degree than the first group. The majority, comprising 68.9 percent of respondents, did not attribute the suicide to a financial crisis at all. This suggests that, for a substantial portion of individuals, factors other than financial issues, such as mental health, relationship problems, or other personal struggles, played a more dominant role in the decision to end their lives.

3.4 Psychological Causes

The psychological causes of suicide encompass various mental health factors that significantly influence an individual's vulnerability to suicidal thoughts and behaviours. Exponents of *diathesis -stress* perspectives argue that the risk of suicide is determined by the interaction of predisposing vulnerabilities and the experience of stress (e.g., Joiner and Rudd,1995; O'Conner and O'Conner,23; Schotte and Clum,1987). these vulnerabilities can take many forms like; biological, cognitive, or personality/individual factors.

The Kinderman Model of Suicide (2005), conceived by psychologist Peter Kinderman, offers a fresh perspective on understanding and preventing suicide. Departing from traditional approaches that heavily rely on diagnosing mental disorders, this model places

a strong emphasis on psychological factors contributing to suicidal behaviour. This model uses three key factors in explaining the aetiology of suicidal behaviour.

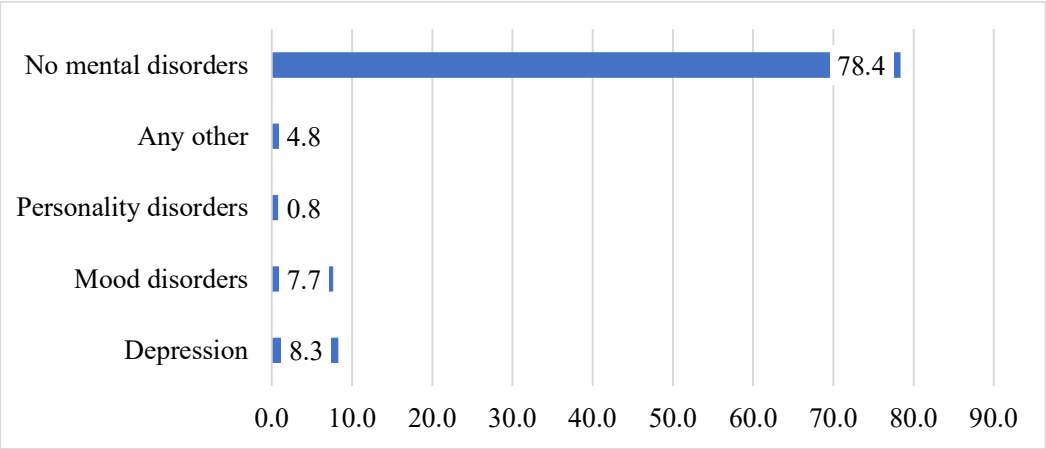
Firstly, "*Feelings of Defeat*" encompass a sense of being overwhelmed, trapped, or defeated by life circumstances. This emotional state often leads to a pervasive sense of hopelessness and helplessness, significantly increasing the risk of contemplating suicide. Secondly, "*Entrapment*" refers to the feeling of being caught in an untenable situation with no perceived way out. This perception of incapability amplifies emotional distress and contributes substantially to thoughts of suicide. Thirdly, the model underscores the influence of "*Negative Emotions*" on suicidal behaviour. Intense psychological pain and an array of negative emotions heighten the risk of suicide, especially when coupled with feelings of defeat and entrapment.

3.4.1 Mental Health Issues

Mental Health Issues are critical contributors of suicide. They create emotional turmoil, distort thinking patterns, and reduce the ability to cope with life's challenges. Addiction also amplifies suicide risk. Societal Pressure and Family Dynamics play a pivotal role in fostering a sense of despair and inadequacy. The absence of Psychological Well-being contributes too. A lack of purpose, self-esteem, or fulfilment in life can lead to contemplation of suicide as an escape from emotional pain. Work Pressure is a significant factor in elevating the risk of suicidal thoughts. Parental Pressure can heavily impact adolescents and increase the risk of suicide among young individuals. Moreover, Other Pressures such as academic stress, financial difficulties, discrimination, or relationship problems compound emotional distress, augment mental health issues, and escalate the risk of suicidal behaviour.

Most suicide victims never see a mental health professional, nor even actually get diagnosed with a mental disorder. But it is salient to look closely at mental health issues. But to say that many suicides have mental disorders is not the same as saying that they are “crazy”, psychotic, or confused (Joiner, 2010). studies recommends that only about 5-10 percent of suicides have schizophrenia (Maris, 2015), and roughly a third of suicides are intoxicated when they are eventually suicide.

Figure 3.8 Mental Health Issues of Victims



The data presents information on the mental condition of individuals who died by suicide, categorized into different mental health conditions. The majority of individuals who died by suicide, 78.4 percent, did not have any reported mental disorder. This may indicate that a significant portion of suicides occurs in individuals without a clinically diagnosed mental health condition as there may be diverse conditions not explicitly categorized in the provided data. A small percentage, 4.8 percent, of individuals who died by suicide had a mental disorder not specified in the categories of personality disorder, mood disorder, or depression. This category may encompass a range of mental health conditions not explicitly mentioned. A small percentage, 4.8 percent, of individuals who died by suicide had a mental disorder not specified in the categories of personality disorder, mood disorder, or depression. This category may encompass a range of mental health conditions not explicitly mentioned. A slightly higher percentage, 8.3, is specifically associated with individuals diagnosed with depression. Depression, a common mental health condition, is characterized by persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities.

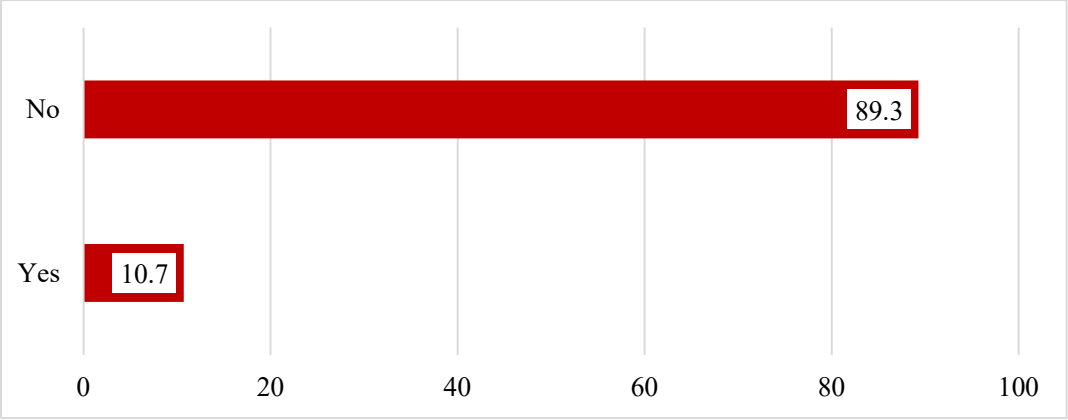
The data does not capture the nuances of undiagnosed mental health conditions or the potential presence of subclinical symptoms that might contribute to suicide risk. Factors such as life events, stressors, and interpersonal relationships, not explicitly covered in the data, also play crucial roles in suicide risk.

3.4.1.1 Depression and suicide

The relationship between depression and suicide is a well-established, intricate association deeply rooted in psychological research. The studies put forward a causal relationship between suicide and depressive disorder. According to the neuro biological aetiology, the main biological hypothesis sates that the brain and CSF of suicide victims show lower serotonin level than do healthy nondepressed controls, especially in the prefrontal cortex of the brain (Asberg et al.,1976; Mann & Currrier, 2012). many antidepressants try to correct this chemical imbalance by enhancing and boosting the serotonin system along with other mechanism. Many medical model of mental disorders assume that depressive disorders arises from various neurochemical dysfunctions of brain which involve the neurotransmitters like dopamine, serotonin, epinephrine, nor epinephrine, cholinergics, GABA and so forth.

Suicide can be a tragic consequence of endogenous depression, that appears to arise internally, often due to biological factors rather than external triggers or life events. Therefore, it is characterized by a profound and persistent sense of sadness, emptiness, or low mood that does not seem to have an identifiable cause. People experiencing endogenous depression might not find relief from their symptoms even if their life circumstances improve.

Figure 3.9 Seeking Mental Health Support



Seeking mental health support is of utmost importance when dealing with suicidal thoughts or feelings. 89.3 percent of the individuals didn't seek mental health support. The stigma and taboos that exist in society about mental health make it difficult to seek help. Seeking the support of mental health professionals provides an opportunity to

explore and navigate the underlying issues contributing to suicidal thoughts. This data indicates the importance of raising awareness about mental health and the various systems that provide mental health support.

3.4.2 Addiction

Numerous studies have reported a consequential association between substance abuse addiction and suicidal behaviour, especially in youth (Fowler et al.,1986; Neeleman & Farrel,1997). Individuals struggling with addiction often face a multitude of challenges, including psychological distress, social isolation, and a sense of hopelessness, which can exacerbate suicidal tendencies. While mood disorders are among the most important risk factors for suicide, comorbidity with alcohol and substance use disorders vastly increases vulnerability to suicidal ideation, attempts and deaths.

Substance abuse affects brain chemistry and can lead to changes in mood regulation, exacerbating mental health conditions like depression or bipolar disorder. The impact of drugs or alcohol on decision-making and impulse control can also increase the likelihood of engaging in self-harm or suicidal behaviours. In fact substance abuse itself viewed as a form of self-destructive behaviour by some researches (Meninger, 1938). According to a 2004 WHO study, substance-related disorders are involved in 17% of completed suicides (Bertolote et al., 2004).

The table provides insights into the prevalence of substance abuse or addiction across different age groups. The percentages represent the proportion of individuals within each age group who had been abusing or addicted to various substances, including alcohol, illegal drugs, narcotic substances, and any other items. The prevalence of alcohol abuse varies across age groups. It is relatively low in the 18-20 age group (3.1 percent) and gradually increases with age. The total percentage for alcohol abuse across all age groups is 39.2 percent. The 18-20 age group exhibits a high percentage of illegal drug abuse (23.4 percent), which decreases in subsequent age groups. The lowest percentage is in the 'Age unknown' category (0.0 percent). The overall total for illegal drug abuse is 12.2 percent.

Table 3.8 Age and Problem of Abuse or Addiction

Age	Problem of Abuse or Addiction				Total
	Alcohol	Illegal drugs	Narcotic substances	Any other item	
18-20	3.1%	23.4%	3.1%	70.3%	100.0%
21-25	21.1%	18.8%	4.5%	55.6%	100.0%
26-30	36.6%	14.2%	3.0%	46.3%	100.0%
31-35	50.9%	8.6%	3.1%	37.4%	100.0%
36-40	53.8%	6.7%	2.1%	37.4%	100.0%
Total	39.2%	12.2%	3.1%	45.5%	100.0%

The percentages for narcotic substance abuse are generally low across all age groups, ranging from 2.1 percent to 5.6 percent. The total percentage for narcotic substance abuse across all age groups is 3.1 percent. The category 'Any other item' encompasses a broad range of substances or items subject to abuse. The percentages vary across age groups, with the highest in the 18-20 age group (70.3 percent) and decreasing in older age groups. The total percentage for abuse of any other item is 45.5 percent.

This data doesn't provide any significant relationship between obsession or addiction and suicide. The majority of the respondents were unaware of this (51.6 percent). It is notable that 7.4 percent and 8.8 percent of suicides in the age group of 18–20 were because of obsession with internet and social media, respectively.

Table 3.9 Age and Problem of Obsession or Addiction

Age	Obsession or Addiction						Total
	Online Gaming	Internet use	Social media	Others	No addiction	Unaware about this	
18-20	0.0%	7.4%	8.8%	1.5%	38.2%	44.1%	100.0%
21-25	5.2%	5.2%	3.0%	3.0%	31.9%	51.9%	100.0%
26-30	0.0%	2.2%	2.9%	4.3%	35.3%	55.4%	100.0%
31-35	0.0%	1.2%	1.8%	6.0%	36.1%	54.8%	100.0%
36-40	1.0%	1.0%	1.5%	6.4%	41.2%	49.0%	100.0%
Total	1.2%	2.6%	2.7%	4.9%	36.8%	51.6%	100.0%

3.4.2.1 Alcohol

Alcohol consumption and its association with suicide represent a complex interplay of behavioural, psychological, and neurological factors that profoundly impact mental health outcomes. Several studies across the world have consistently reported a high prevalence of alcohol use disorders among people who committed suicide. George Murphy (1992) argued that alcohol dependent suicides tend to have years of heavy drinking, (refers to as ‘’the acquired ability to inflict lethal self-injury’’), to have poor social support, to live alone, to have talked to others about committing suicide, to have serious medical complications of alcoholism, and to be unemployed. Certain other variables associated with suicidal behaviour among alcoholics are; suicidal behaviour has been more strongly associated with alcohol use among males than among females, suicide attempts among alcoholics are younger age, lower socio-economic status and family history of alcohol abuse (Roy et al., 1990).

3.4.2.2 Opiates and Narcotics

Opiates, including substances like heroin, prescription painkillers (e.g., oxycodone, morphine), and synthetic opioids (e.g., fentanyl), interact with the brain's opioid receptors, modulating pain perception and inducing feelings of euphoria. The use and abuse of opiates are intricately linked to an increased risk of suicidal behaviour. It is important for suicidology that opioids affect GABAergic neurotransmission, which is related to mood; they tend to worsen or induce depression. Most of the adverse effects of opiates are related with depressed mood, and that depression elevates suicide risk.

The psychiatric diagnosis related to opiates are problematic drug patterns related to use or abuse leading to addiction like opioid use disorder, opioid intoxication, and opioid withdrawal.

3.4.3 Lack of Psychological Well-being

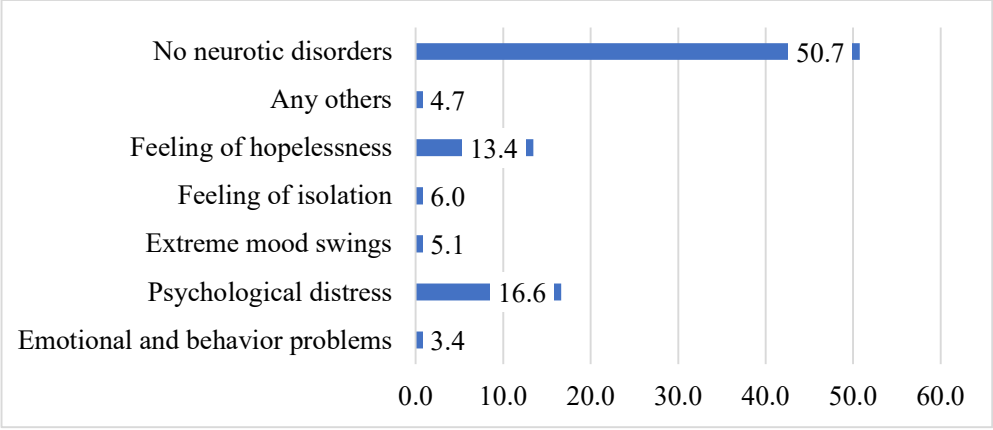
Lack of psychological well-being is deeply intertwined with the heightened risk of suicide, marking a critical intersection within the realm of mental health. Psychological well-being encompasses various facets, including emotional balance, resilience, a sense of purpose, and positive relationships. When individuals lack emotional balance and resilience, it often leads to conditions like depression and

anxiety, amplifying thoughts of suicide. This absence diminishes a sense of purpose, leaving individuals feeling disconnected and isolated, increasing vulnerability. Without coping mechanisms, stress becomes overwhelming, contributing to suicidal thoughts. Inadequate coping mechanisms make stress overwhelming, fostering thoughts of suicide as a means of escape. Addressing this involves ensuring accessible mental health services, educating to combat stigma, and implementing programs to bolster resilience. These measures not only aim to prevent suicide but also strive to cultivate more resilient and supportive communities, fostering better mental health for all.

The table provides insights into the presence of neurotic disorders among individuals who died by suicide, categorizing the individuals based on different types of neurotic disorders. The majority of individuals who died by suicide, at 58.7%, did not have a diagnosed neurotic disorder. This indicates that a significant portion of suicides occurred in individuals without a recognized neurotic condition.

A small percentage, 4.7%, of individuals who died by suicide had neurotic disorders not specified in the categories of feeling of hopelessness, feeling of isolation, extreme mood swings, psychological distress, or emotional and behavioural problems. This category may include a range of specific neurotic conditions not explicitly mentioned. Feeling of hopelessness is reported in 13.4 percent of cases, suggesting a significant association between this specific neurotic symptom and suicide.

Figure 3.10 Problem of Neurotic Disorders

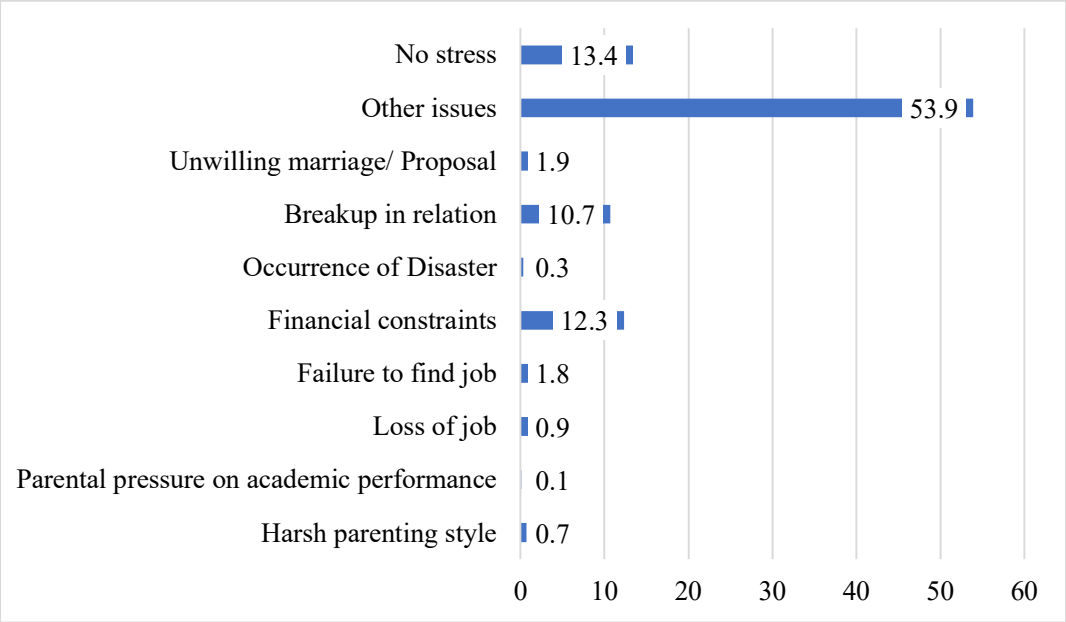


Hopelessness is a known risk factor for suicide and is often linked to a lack of positive expectations for the future. Feeling of isolation is reported in 6.0 percent of cases,

indicating that a sense of social disconnection or loneliness may contribute to suicidal ideation and behaviour. Extreme mood swings are associated with 5.1 percent of suicides, emphasizing the impact of mood instability on psychological well-being. Conditions like bipolar disorder may manifest with such mood swings.

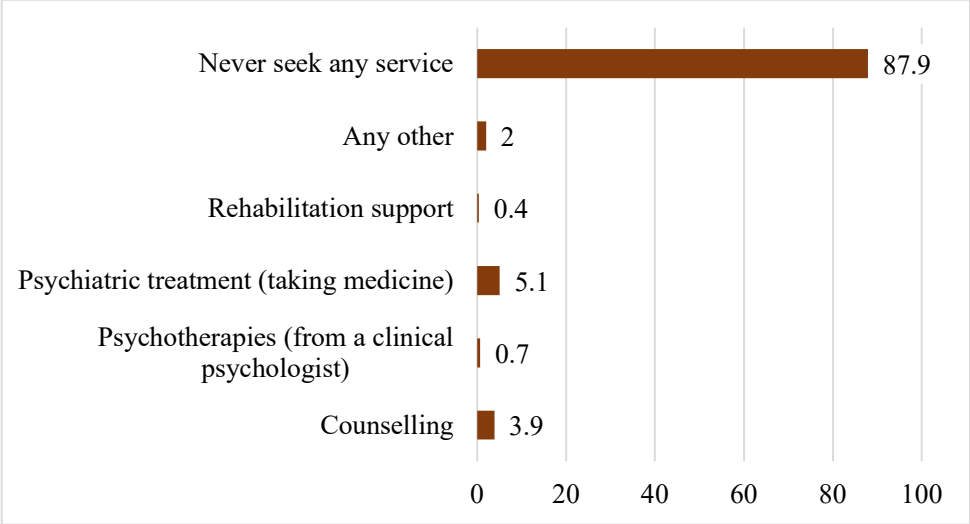
A substantial percentage, 16.6 percent, of individuals who died by suicide experienced psychological distress. This broad category encompasses a range of mental health challenges, and its association with suicide underscores the importance of addressing general mental well-being. Emotional and behavioural problems are reported in 3.4 percent of cases. This category suggests a variety of challenges that may impact both emotional regulation and behaviour.

Figure 3.11 Problem of Prolonged Stress



Persistent stress can lead to mental health conditions such as anxiety and depression, which are known risk factors for suicide. According to this data, Prolonged stress caused by financial constraints (12.3 percent), breakups in relationships (10.7 percent), and other issues that create persistent stress (53.9 percent) can significantly contribute to the causes of youth suicide. Long-term stress can cause a sense of hopelessness, making individuals feel as if there is no way out of their challenging circumstances. This hopelessness is a key factor in suicidal ideation (Rosiek et al, 2016)

Figure 3.12 Seeking Mental Health Service



Out of the 21.6 percent victims who had mental health issues like personality disorder, mood disorder, and depression, more than three fourth (87.9 percent) did not seek any mental health care service at all (figure 00). This points to the need of effective interventions for the mental health of youth.

Figure 3.13 Signaling Suicide

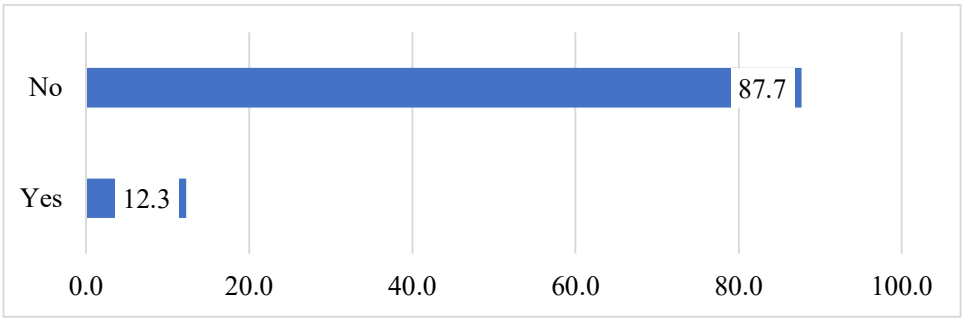


Figure 3.13 clearly shows that a significant portion (12.3 percent) of the victims had given some or other signals to the family members about suicide. However, the latter failed to prevent suicide and protect the victims, inviting attention to the necessity of awareness campaigns for early detection of suicidal tendencies and effective interventions to prevent the act.

3.5 Conclusion

The causes of suicide are intricate and multifaceted, encompassing social, economic, and psychological factors that collectively contribute to this complex phenomenon. Socially, the absence of a robust support system, family problems, and challenges within friendships and love affairs can significantly impact an individual's mental health. Educational and workplace pressures further exacerbate the risk, necessitating reforms and policies that prioritize mental well-being in these environments. Economic factors, including unemployment, financial instability, and debt, also play a substantial role, emphasizing the need for comprehensive strategies to address economic challenges. Additionally, psychological causes, such as mental health disorders, addiction, societal pressures, and the absence of psychological well-being, underscore the interconnectedness of individual and societal factors influencing suicide risk. To effectively prevent suicide, holistic policies must be implemented, spanning social support systems, educational and workplace environments, economic stability measures, and mental health initiatives, acknowledging the complex interplay of these elements in shaping mental well-being.

CHAPTER 4

GENDER DIMENSION OF YOUTH SUICIDE

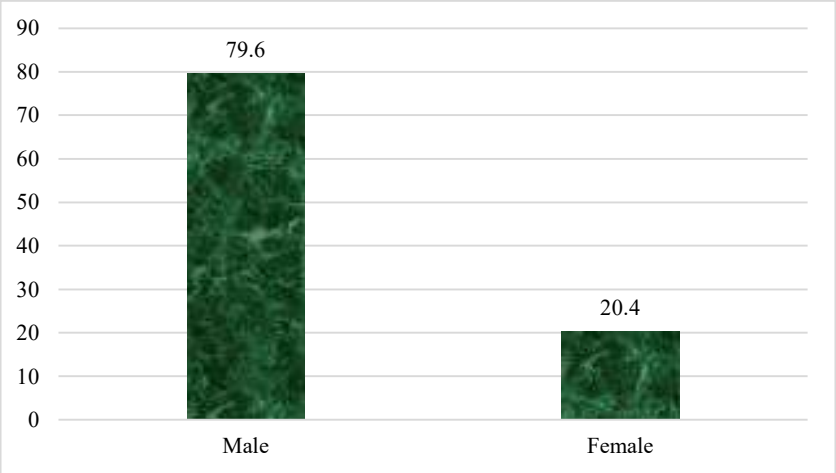
4.1 Introduction

Gender plays a significant role in shaping patterns and risk factors associated with suicidal behaviour among young individuals. Within the context of suicide research, gender differences in suicidal behaviour rates are known as the "Gender Paradox" (Canetto and Sakinofsky 1998). In adolescents and young adults, this paradox changes according to age (Canetto 2008; Rhodes et al. 2014a). Female suicide attempt rates increase with age, peaking in mid-adolescence (Lewinsohn et al. 2001; Boeninger et al. 2010; Thompson and Light 2011), whereas male suicide rates increase until early adulthood (WHO, 2014).

4.2 Gender Gap and Youth Suicide

Suicide rates are typically higher in males than females, while the converse is true for suicide attempts. The present study also supports these findings. There is a enormous difference between the number of males and females who have committed suicide.

Figure 4.1 Gender of Victims



Gender differences in suicidal behaviour may be explained by differences in emotional and behavioural problems (Kaess et al. 2011). The higher rates of suicide deaths among male youths may be associated with a higher prevalence of externalizing disorders (e.g., conduct disorder, substance abuse disorder, deviant behaviour) (Mergl et al., 2015) and a preference for highly lethal methods (Värnik et al., 2008). In contrast, females are more prone to show internalizing disorders (e.g., anxiety, mood disorders) (Fergusson et al.

1993). These disorders may mediate the association with suicidal thoughts and behaviours (Peter and Roberts 2010; Mars et al. 2014).

Gender differences are observed not only in the overall rates but also in the methods chosen for suicide. Males tend to choose more lethal and violent methods, such as firearms or hanging, which can contribute to the higher completion rates compared to females. Females are more likely to choose less immediately lethal methods. There is evidence to suggest that female suicides may be underreported, as some suicides may be misclassified as accidents or attributed to other causes. Cultural and social factors can influence the reporting and recording of suicides.

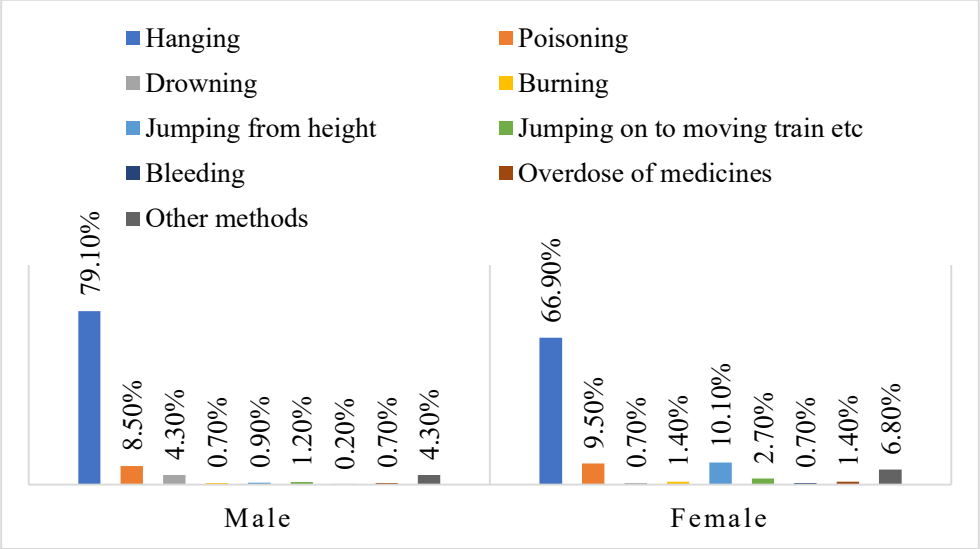
There are differences in factors contributing to male and female suicides. Societal expectations regarding masculinity, the stigma around mental health issues, and a reluctance to seek help may contribute to higher suicide rates among males. Females, on the other hand, may face different risk factors, such as higher rates of attempted suicide, which may not result in death but are indicative of distress. Issues such as relationship problems, family conflicts, and mental health challenges can contribute to suicide risk in females.

Table 4.1 Age and Gender

Age	Gender		Total
	Male	Female	
18-20	60.3%	39.7%	100.0%
21-25	76.6%	23.4%	100.0%
26-30	81.0%	19.0%	100.0%
31-35	84.5%	15.5%	100.0%
36-40	81.3%	18.8%	100.0%
Total	79.6%	20.4%	100.0%

The gender gap in suicide rates can vary across different age groups. In the present study, the gap is more pronounced in older age groups. 84.5 percent of suicides in the age group 31–35 is committed by males. 81percent and 81.3percent are the rate of male suicides in the age groups 26–30 and 36–40 respectively.

Figure 4.2 Gender and Method of Suicide



Both male (79.1 percent) and female (66.9 percent) victims mostly chose the method of hanging for committing suicide followed by poisoning (8.7 percent). Poisoning is comparatively higher among the females (9.5 percent) than males (8.5 percent). Drowning, another method, was adopted by more males (4.3 percent) than females (0.7 percent). Another method 'jumping from heights' is found more (10.1 percent) among the females than males (0.9).

4.3 Societal Pressure and Gender Norms

Social pressure and gender norms play significant roles in shaping individuals' behaviours, identities, and experiences. Societal expectations regarding gender roles and norms can contribute to both positive and negative impacts on individuals, influencing their mental health, well-being, and overall quality of life. Societal expectations often dictate that males should be self-reliant, strong, and less emotionally expressive. This can create a barrier for males to admit vulnerability or seek help, as doing so may be perceived as a deviation from traditional masculinity. they may be more prone to internalizing their struggles and less likely to share them openly, which can hinder timely intervention and support.

Table 4.2 Seeking Mental Health

Gender	Seeking mental health		Total
	Yes	No	
Male	10.1%	89.9%	100.0%
Female	13.2%	86.8%	100.0%
Total	10.7%	89.3%	100.0%

The data highlights that, regardless of gender, the majority of the victims did not seek mental health care within one year immediately before the incident. This indicates a huge gender gap in mental health support and intervention prior to suicides. More females (13.2 percent) sought mental health care than males (10.1 percent). This emphasizes the need to understand and address the barriers preventing individuals, irrespective of gender, from accessing mental health support. The decision to seek mental health care is complex and may be influenced by various factors, including stigma, perceived self-sufficiency, cultural beliefs, and the availability of mental health services. Understanding these factors is crucial for developing targeted interventions.

Traditional gender norms often prescribe specific behaviours and expectations for boys and girls. The pressure to conform to these norms can lead to internal conflicts for individuals who do not fit neatly into prescribed roles, contributing to stress, anxiety, and depression. Societal expectations around masculinity can promote the idea of "toxic masculinity," where boys are discouraged from expressing vulnerability, seeking help, or showing emotions other than anger. This can create a sense of isolation and contribute to mental health struggles, potentially increasing the risk of suicide. Unrealistic beauty standards and body ideals portrayed in media can contribute to body dissatisfaction, eating disorders, and self-esteem issues, which may impact mental health and contribute to suicide risk.

4.4 Family and Gender Norms

Family plays a crucial role in shaping individuals' understanding of gender norms and expectations. Family is often the primary socializing agent, where individuals learn about cultural and societal expectations regarding gender roles and behaviours.

Table 4.3 Nature of the Person's Relationship with Family

Gender	Nature of the person's relationship with family				Total
	Close	Loose	Strained	Other	
Male	77.2%	14.3%	4.0%	4.4%	100.0%
Female	87.5%	8.6%	1.3%	2.6%	100.0%
Total	79.3%	13.2%	3.5%	4.0%	100.0%

The table (4.3) suggests a correlation between the nature of the person's relationship with their family and the gender-specific suicide rates. Both males (77.2 percent) and females (87.5 percent) demonstrated higher percentage of suicides despite having close relations with their family. This points to the fact that even those individuals in close-knit families are not immune to mental health challenges, and also that the factors within the family could contribute to distress and suicide. A close relationship with family can be either supportive or burdened. Supportive relationships may provide a safety net and emotional support, reducing the risk of suicide. On the other hand, burdened relationships with high expectations or conflicts might contribute to distress. Paradoxically, individuals in close relationships might feel more isolated if they perceive that they cannot share their struggles with their family members. This isolation can contribute to a higher risk of mental health issues and suicide. That is a close-knit family with positive dynamics may act as a protective factor, while a dysfunctional family may contribute to distress.

Males have a higher percentage of suicide attempts (14.3 percent) in loose relationships compared to females (8.6 percent). This might imply that a more distant or less supportive family environment could be a contributing factor for males. Strained family relationships affect the males more than the females.

Strict adherence to traditional gender norms within the family may exert pressure on young individuals to conform to specific roles and expectations. This pressure can contribute to stress, anxiety, and feelings of inadequacy, potentially increasing the risk of mental health challenges, including suicidal ideation. If a family environment is not supportive of diverse gender expressions and identities, the youth who do not conform to traditional gender norms may experience rejection, isolation, and discrimination. This lack of support can be a significant risk factor for mental health issues, including suicide.

The way parents and other family members model coping mechanisms and emotional expression can influence how youth manage stress and emotional challenges. If traditional gender norms discourage certain expressions of vulnerability or seeking help, it may contribute to a reluctance to reach out for support. Conflicts within the family related to gender expectations, identity, or other issues can create a stressful and potentially harmful environment for young individuals. Ongoing family conflict can contribute to mental health challenges and increase the risk of suicidal behaviour. To address the intersection of family dynamics, gender norms, and youth suicide, it is crucial to foster open communication, acceptance and support.

Table 4.4 Gender and Social Category

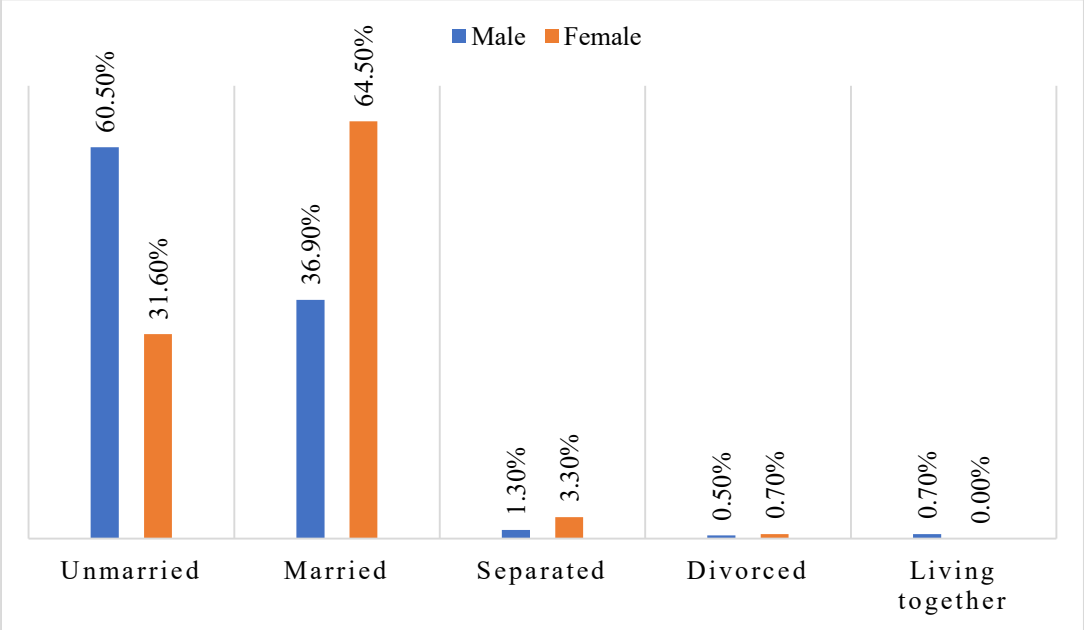
Gender	Social Category			Total
	Forward/General	OBC	SC/ST	
Male	23.3%	51.4%	25.3%	100.0%
Female	23.7%	58.6%	17.8%	100.0%
Total	23.4%	52.9%	23.8%	100.0%

Caste is an important method of social categorization of people in India under three broad categories such as Forward/General, OBC, SC/ST. Table (4.4) represents the relationship between gender and social category of the victims. The majority of the victims from both genders fall in OBC category (51.4 percent males and 58.6 percent females), that reflects the general population trend of Kerala. Among OBCs, female victims are more than the males. The least percentage of victims belong to the forward/general category which is almost equally distributed among males (23.3 percent) and females (23.7 percent). The number of victims among SC/ST categories is also significantly higher (23.8 percent) compared to others. Among them, majority are males (25.3 percent).

Figure 4.3 Gender and Employment Status

The figure (4.3) shows that there is visible difference between the employment status of male (72.7 percent) and female victims (29.6 percent). Also, more female victims are unemployed (39.5 percent) than males (10.3). So also, while 23.7 percent of female victims were students, only 9.8 percent among were students. Unemployment is more (36.5 percent) visible among the female victims.

Figure 4.4 Gender and Marital Status



It is interesting to note that among the unmarried victims, the majority (60.5 percent) are males whereas among the married, the majority (64.5 percent) are females. This points to

the fact that marital status has contrasting effect on males and females in choosing the extreme option. Among the separated, females (3.3 percent) are ahead of males (1.3 percent).

4.5 Cultural Norms and Values

Certainly, cultural norms and values wield profound influence on the perception, understanding, and response to suicide within societies. These aspects are crucial in the comprehensive examination of how societal beliefs, traditions, and perceptions shape attitudes towards mental health and suicidal behaviour.

The social construction of masculinity and femininity significantly influences the manifestation of suicide rates and behaviours. Traditional masculinity expects men to be tough, hide their emotions, and avoid asking for help. This pressure often makes men reluctant to admit vulnerability or seek support for mental health issues, which raises the risk of under reporting and can lead to a higher chance of suicide. Additionally, the belief that being a successful provider is tied to masculinity can worsen feelings of failure and hopelessness, especially during job loss or financial struggles, contributing to higher suicide rates among men.

Traditional femininity expects women to be nurturing and prioritize others' needs over their own mental well-being. This pressure can cause women to suppress their emotional distress. While it might make them more likely to seek help for mental health issues, it can also lead to feelings of guilt or shame for not meeting societal standards of being caring enough, which can affect their risk of suicidal behaviour. The socially constructed feminine roles offer them to fulfil the sociocultural stereotypes based on traditional gender roles (Payne et al., 2008). Women, despite having higher rates of suicide attempts, exhibit a lower suicide mortality rate due to their adherence to religious beliefs and negative attitudes toward suicide, serving as protective factors in reducing the actual occurrence of suicide among them.

Suicide rates among gender minority groups are influenced by cultural attitudes and values. Many cultures uphold strict ideas about gender, which can make it hard for gender minorities to express themselves. Discrimination and exclusion based on these cultural norms add stress and can lead to mental health challenges. The pressure to conform to

traditional gender roles and facing prejudice can deeply affect mental well-being. Gender minorities often feel marginalized and struggle with anxiety, depression, and thoughts of suicide due to societal rejection.

In many cultures, mental health remains stigmatized, often viewed as a taboo subject. This stigma surrounding mental health issues leads to reluctance in acknowledging and addressing psychological distress. Consequently, individuals facing mental health challenges may internalize feelings of shame and isolation, deterring them from seeking help or expressing their struggles openly. Cultural values, religious beliefs, and social expectations also play pivotal roles in shaping attitudes towards suicide. Some cultures may consider suicide as a moral or religious transgression, leading to condemnation or ostracization of individuals and their families. Conversely, in certain historical or cultural contexts, suicide may be perceived as an honourable act in specific circumstances, complicating perceptions and responses to suicidal behaviour.

Dowry-related suicides have been a longstanding issue in several parts of India, including Kerala. Kerala, known for its relatively higher literacy rates and social indicators compared to some other Indian states, has unfortunately not been immune to dowry-related issues. Dowry-related deaths or suicides occur when a woman faces harassment, abuse, or extreme pressure due to demands for dowry from her marital family.

Despite legal prohibitions, dowry-related social pressure persists, subjecting women to stress, emotional trauma, and abuse. Government and non-governmental efforts focus on awareness, law enforcement, and support services. However, deep-rooted cultural norms pose challenges in combating dowry practices. Solutions involve gender equality advocacy, law enforcement, counselling, and community awareness initiatives.

4.6 Gender and Psychological Vulnerability

The link between gender and psychological vulnerability in the context of suicide is a complex and multifaceted issue. Research indicates that gender plays a significant role in shaping patterns of mental health and emotional well-being, influencing the chance of individuals to experience psychological distress and, in extreme cases, engaging in suicidal behaviour.

Risk factors for suicide, including access to lethal means and interpersonal conflicts, may interact differently based on gender. Protective factors, such as social support, also vary

in effectiveness. Recognizing intersectionality and tailoring suicide prevention strategies to address gender-specific aspects of psychological vulnerability is essential for promoting mental well-being and reducing suicide risk**.**

Table 4.5 Gender and Diagnosis of mental disorders

	Diagnosis of mental disorders					Total
Gender	Depression	Mood disorders	Personality disorders	Any other	No mental disorders	
Male	8.6%	7.1%	1.0%	4.7%	78.6%	100.0%
Female	7.2%	9.9%	0.0%	5.3%	77.6%	100.0%
Total	8.3%	7.7%	0.8%	4.8%	78.4%	100.0%

The table (4.5) shows the percentage of individuals who died by suicide and whether they had been diagnosed with specific mental disorders, categorized by gender. The rate of diagnosed depression is slightly higher among males (8.6 percent) compared to females (7.2 percent). Females have a higher rate of diagnosed mood disorders (9.9 percent) compared to males (7.1 percent). These differences could be due to societal expectations and gender norms can affect how individuals share their emotional struggles.

Females might feel more encouraged to seek help or talk about their mood, influencing diagnosis rates. Depression and mood disorders may show up differently in males and females. Females might express emotions more openly, making it easier to diagnose mood disorders. Males might internalize their struggles or show different symptoms that are less recognized. Stigma around mental health, especially for males, may discourage open discussions. Expectations about how males should express emotions can contribute to underreporting and affect diagnosis rates. This affects access to mental health services.

Table 4.6 Gender and Place of Residence

Gender	Place of Residence			Total
	Grama Panchayath	Municipality	Corporation	
Male	69.3%	19.6%	11.1%	100.0%
Female	71.7%	17.1%	11.2%	100.0%
Total	69.8%	19.1%	11.1%	100.0%

The table (4.6) represents the gender and place of residence of the victims. The majority of the victims lived in rural areas (Grama Panchayath) than in urban areas. In grama panchayths, female victims are higher (71.7 percent) than the males (69.3 percent). In municipalities, males (19.6 percent) outnumbered females (17.1 percent).

Table 4.7 Gender and Colour of Ration Card

Gender	Colour of Ration card				Total
	Pink	Yellow	Blue	White	
Male	53.1%	11.8%	21.2%	13.8%	100.0%
Female	42.8%	14.5%	20.4%	22.4%	100.0%
Total	51.0%	12.3%	21.1%	15.6%	100.0%

The table (4.7) shows the relationship between gender and colour of ration cards of the victims. Under the public distribution system of Kerala, beneficiaries are categorized into four colours, While, Blue, Pink and Yellow. More than half of the victims (51.0 percent) are in the pink category signifying Priority or Below Poverty Line (BPL), followed by Blue/ Non-Priority subsidy/Above Poverty Line or APL (21.1 percent), White (15.6) and Yellow/ most economically backward section (12.3 percent). Among both ganders, the majority fell in Pink (BPL) category (Male 53.1 percent and female 42.8). Thus, there is a connection between poverty and suicide.

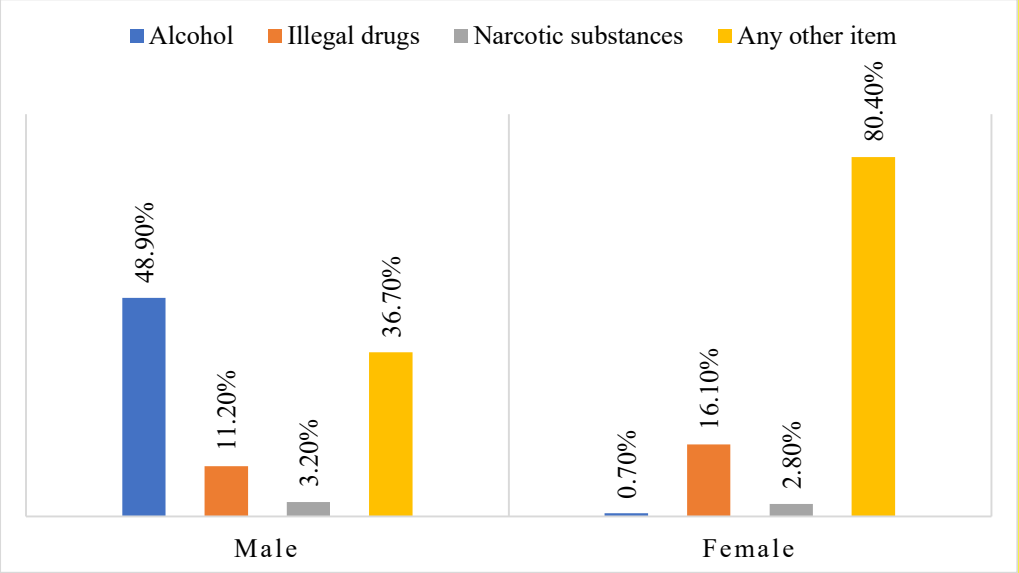
Table 4.8 Gender and Financial Crises

Gender	Had the person faced any financial crisis at the time of suicide?			Total
	To a great extent	To some extent	Not at all	
Male	10.5%	23.3%	66.3%	100.0%
Female	7.9%	13.2%	78.9%	100.0%
Total	9.9%	21.2%	68.9%	100.0%

Table 4.8 says that more than half of the victims (68.9 percent) did not have any financial crisis at the time of suicide. Regarding gender, female victims are more free from financial crisis than males.

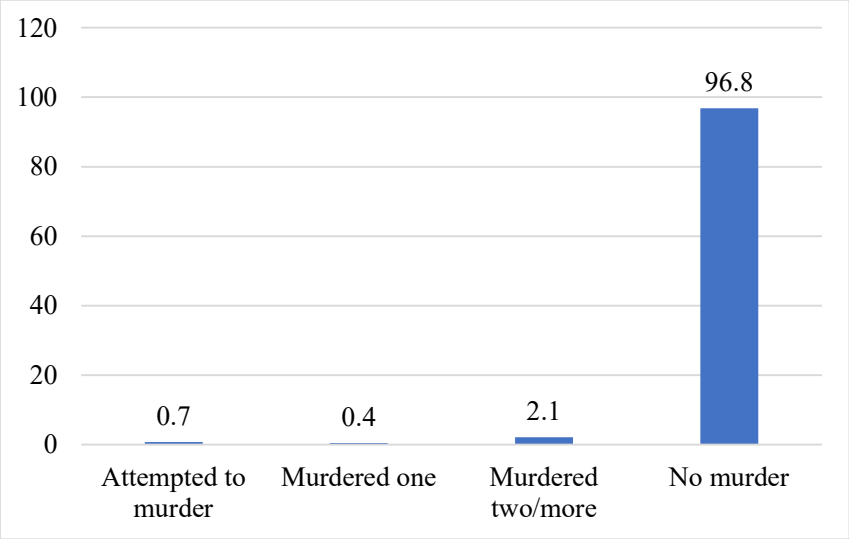
4.7 Gender and abuse/addiction

Figure 4.5 Gender and Addiction



The figure (4.5) represents the relationship between gender and abusing or addiction of the victims to addictive substances. Both males and females have addiction. In the case of alcohol consumption, male victims (48.9 percent) outnumbered the females (0.7 percent). On the other hand, illegal drugs are used by more females (16.1 percent) than males (11.2 percent). The abuse of narcotic substances is reported to be negligible among both genders. However, abuse of other substances is reported to be high among the females (80.4 percent) than the males (36.7 percent). This demands further investigation.

Figure 4.6 Commission of murder/s before suicide



The incidences of suicides after committing murder are increasingly being reported in the state. Figure 4.6 shows 2.5 percent of the victims had committed murder/s before committing suicide whereas 0.7 percent attempted to kill others before suicide. Though the numbers of such events are very small, they deserve serious attention as they are indications of an extremely hazardous mental illness.

Table 4.9 Gender and Types of service the person received

Gender	If yes, which of the following service the person received?						Total
	Counselling	Psychotherapies (from a clinical psychologist)	Psychiatric treatment (takimedicine)	Rehabilitation support	Any other	Never seek any service	
Male	3.4%	0.5%	5.1%	0.5%	2.2%	88.4%	100.0%
Female	5.9%	1.3%	5.3%	0.0%	1.3%	8it6.2%	100.0%
Total	3.9%	0.7%	5.1%	0.4%	2.0%	87.9%	100.0%

The present study found that 21.6 percent of victims did have some sort of mental health issues including personality disorder, mood disorder, depression etc (Table 4.9). But interestingly, the

majority (87.9 percent) of these victims had never sought any mental health care services. This is either due to the lack of knowledge of and nonaccess to mental health care or due to the social stigma attached to mental ill-health. There is not much difference in mental health seeking behaviour between males (11.6 percent) and females (13.8 percent).

4.8 Conclusion

The gender dimension of youth suicide reveals a nuanced interplay of societal expectations, family dynamics, and psychological vulnerability. Traditionally, a gender gap exists, with males exhibiting higher suicide rates, while females tend to attempt suicide more frequently. This discrepancy is closely tied to societal pressures and gender norms, emphasizing the need to challenge and redefine traditional expectations imposed on both genders. Family dynamics contribute significantly, with both males and females facing higher suicide attempts in close relationships. The complex link between gender and psychological vulnerability underscores the importance of recognizing and addressing mental health issues, with men being identified as more vulnerable. In conclusion, combating youth suicide requires a holistic approach that challenges societal norms, fosters supportive family environments, and acknowledges the distinct psychological vulnerabilities faced by different genders. This involves destigmatizing mental health discussions, encouraging open communication within families, and tailoring interventions to address the unique challenges faced by both young men and women.

CHAPTER 5

EFFECTS AND COPING

5.1 Introduction

Youth suicide is a complex and tragic phenomenon that has profound and far-reaching effects on individuals, families, communities, and society at large. The aftermath of youth suicide has profound effects on individuals, families, and communities, influencing psychological, social, and educational dimensions. The psychological impact includes grief, guilt, and mental health risks, while social dynamics may be disrupted, leading to stigmatization and isolation. Coping strategies involve grief counselling, community support groups, and postvention programs to address immediate needs. Public health initiatives and comprehensive policies are essential for preventing youth suicide and supporting affected individuals. This scientific exploration emphasizes evidence-based interventions and community resilience as crucial elements in addressing the complex repercussions of youth suicide.

5.2 Effects and Coping Strategies

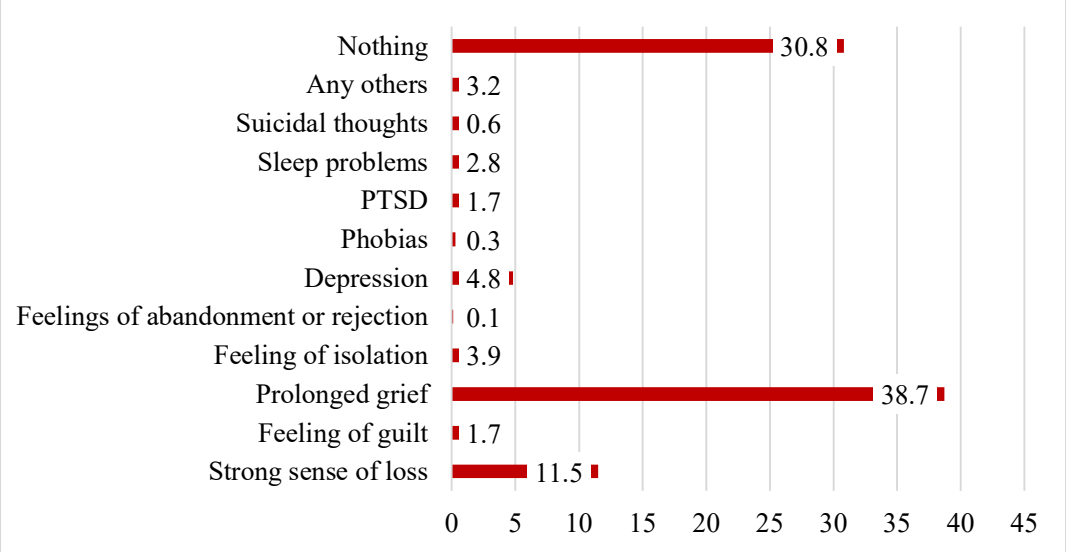
The loss of a young life to suicide can lead to intense grief and a range of psychological consequences for family members, friends, and peers. Survivors often grapple with feelings of guilt, shame, and profound sadness, contributing to the risk of developing mental health disorders.

The social fabric of communities is significantly affected by youth suicide. Stigmatization, social isolation, and strained relationships may arise as individuals struggle to comprehend the complexities surrounding suicide, leading to a pervasive impact on community dynamics. Within educational institutions, the suicide of a young person can create a sombre and challenging atmosphere. Peers, teachers, and school staff may experience heightened stress, and the overall educational environment may be disrupted, impacting academic performance and emotional well-being.

The family structure undergoes profound changes following a youth suicide. Parents and siblings may experience disruptions in communication, increased familial tension, and alterations in roles and responsibilities, as they attempt to cope with the loss and make sense of the circumstances.

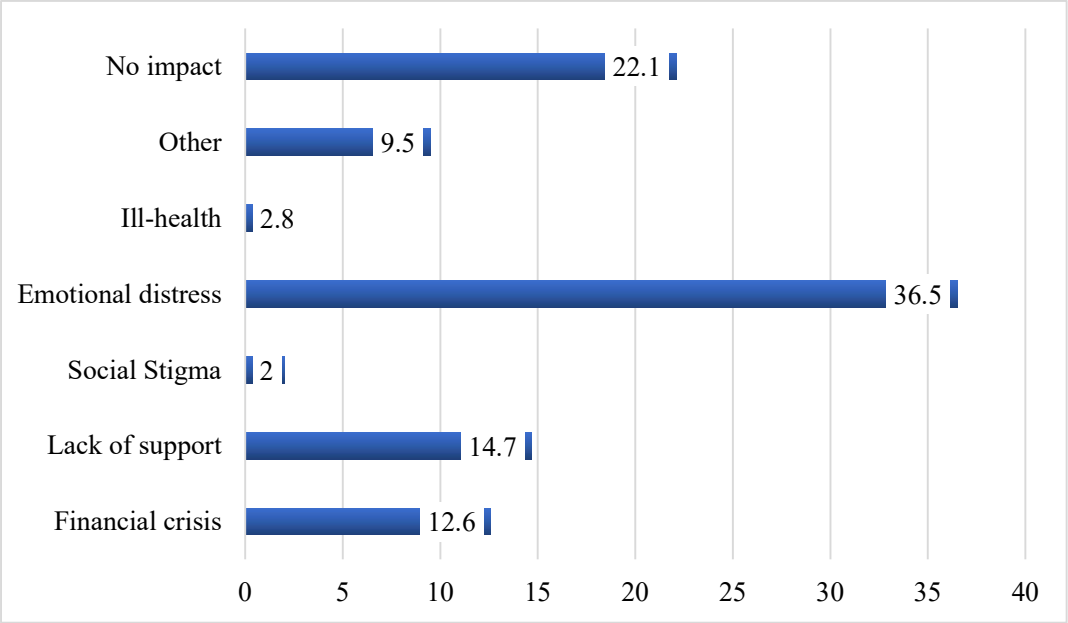
The occurrence of youth suicide may trigger a phenomenon known as suicide contagion, wherein individuals who are closely connected to the deceased are at an increased risk of suicidal ideation or behaviour. This presents significant challenges for suicide prevention efforts and underscores the need for targeted interventions.

Figure 5.1 Experience of Following Conditions among the Family Members after the Death of the Person



Experiencing the suicide of a family member is an incredibly traumatic and have lasting effects on the surviving family members. 38.7 percent of the survivors experienced prolonged grief. The grief experienced by family members may grapple with feelings of profound loss, sadness, and emptiness. 30.8 percent of the survivors experienced nothing related to the suicide of their family member. 11.5 percent of the survivors experience strong sense of loss. It can be difficult to comprehend and accept the reality of the situation.

Figure 5.2 The Most Negative Impact of Suicide on the Family



The impact of suicide on survivors is profound and far-reaching, causing emotional, psychological, and social repercussions that can be long-lasting. In the opinion of 36.5 percent of survivor's emotional distress is the most negative impact of suicide on family. The aftermath of a suicide can be traumatic for family members. The trauma can manifest as intrusive thoughts or heightened anxiety. It affects the emotional wellbeing of the family. 14.7 percent of the survivor's face problems due to lack of support. Families dealing with suicide may face societal stigma and judgment. Misunderstandings about mental health and suicide can lead to isolation and feelings of shame within the community. The most important consequence of suicide for 12.6 percent of survivors are financial crisis. Loss of income or financial stability due to the suicide can create additional stress and hardship for the surviving family members.

5.3 Coping Strategies

Grief Counselling and Therapy: Professional mental health support, including grief counselling and therapy, is instrumental in helping individuals navigate the complex emotions associated with youth suicide. Evidence-based therapeutic approaches aim to address grief, guilt, and trauma while fostering resilience and coping skills.

Community-Based Support Groups: Community support groups provide a vital network for individuals affected by youth suicide. These groups offer a safe space for shared

experiences, mutual support, and coping strategies. Facilitated by mental health professionals or trained peers, these groups contribute to the healing process

Postvention Programs: Tailored postvention programs, implemented in educational settings and communities, aim to address the aftermath of youth suicide. These programs focus on providing immediate support, disseminating accurate information, and fostering a supportive environment to prevent suicide contagion and support recovery.

Public Health Initiatives: Public health initiatives play a pivotal role in preventing youth suicide and supporting those affected. Awareness campaigns, educational programs, and community outreach efforts contribute to destigmatizing mental health issues, promoting help-seeking behaviour, and building resilient communities.

Policy Development and Mental Health Services: Comprehensive policies that prioritize mental health services, suicide prevention, and intervention efforts are essential. Adequate allocation of resources, training for professionals, and the integration of mental health support within educational and community settings contribute to a proactive approach in coping with youth suicide.

Community Engagement and Advocacy: Engaging in community advocacy and awareness initiatives can empower individuals to turn their grief into positive action. Advocating for mental health resources, suicide prevention programs, and destigmatization efforts can contribute to broader societal change.

Professional Support Services: Accessing a range of professional support services, beyond traditional therapy, can be beneficial. This may include psychiatric evaluation, medication management, and specialized counselling services tailored to the unique needs of individuals and families.

Crisis Hotlines and Helplines: Accessing crisis hotlines and helplines offers immediate support for individuals struggling with the aftermath of youth suicide. Trained professionals provide confidential assistance, guidance, and resources to help cope with emotional distress.

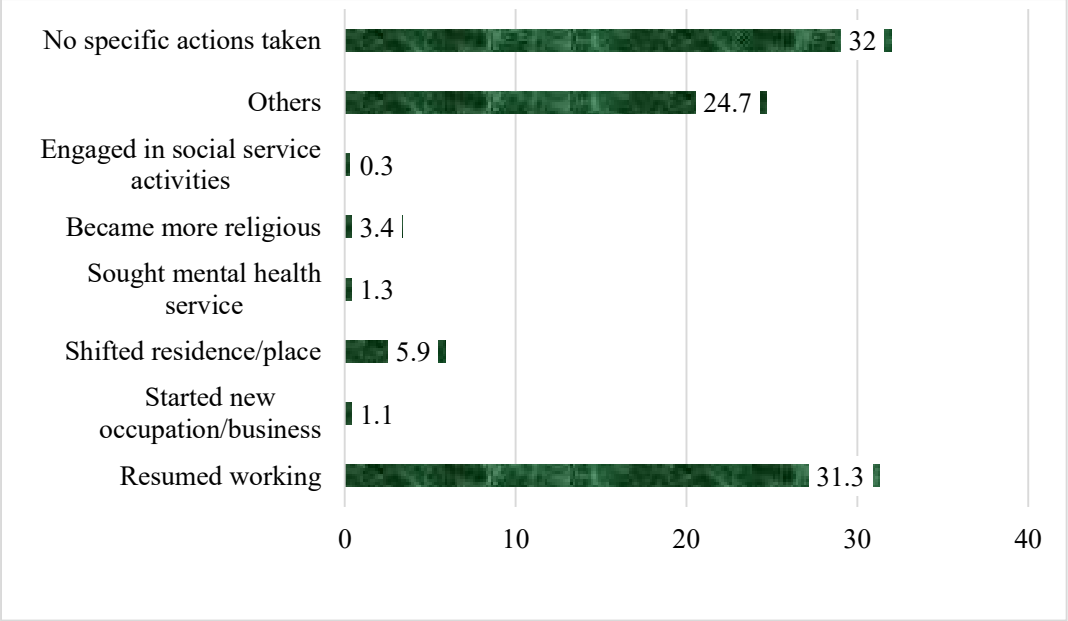
Peer Support Networks: Establishing peer support networks, especially for individuals who share similar experiences, can be invaluable. Peer support provides a sense of

understanding, empathy, and shared coping strategies, fostering a supportive community for healing.

Education and Awareness: Promoting education and awareness about mental health and suicide prevention is crucial. Programs that focus on destigmatizing mental health issues and providing accurate information empower individuals to recognize warning signs and seek help proactively.

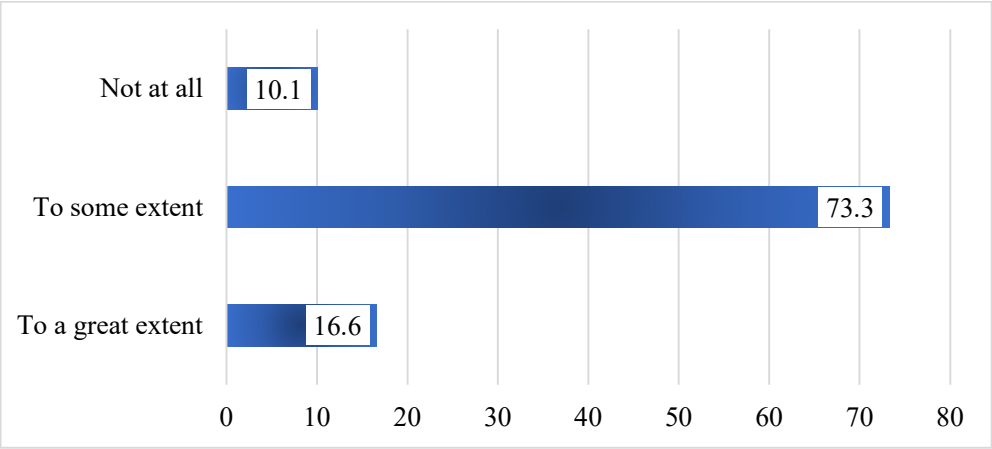
Mindfulness and Meditation: Incorporating mindfulness and meditation practices into coping strategies can enhance emotional well-being. Mindfulness techniques, such as deep breathing and meditation, promote self-awareness, stress reduction, and overall mental health

Figure 5.3 Coping Strategies of Family Members after the Suicide



The coping mechanisms adopted by the family members to cope up with the loss are different. 32 percent of the survivors doesn't take any specific action to deal with the situation. Resumed working is the way adopted by 31.3 percent. It helps to go back to normal life. Following the suicide of the family member, 5.9 percent of the survivors shifted their residence to a new place. It may be for avoid the judgement or discrimination from others.

Figure 5.4 Could Family Members Recover from the Impact of Suicide



73.3 percent of the family members of victim recover from the impact of suicide only to some extent. Only 16.6 percent recovers to a great extent. This trend clearly proves that the multidimensional effects of suicide is long lasting. This figures clearly depicts the prolonged effects of suicide on family members. Coping with suicide is a unique journey for each family member. Seeking help from mental health professionals, leaning on support networks, and allowing oneself the time and space to grieve are crucial components of the coping process (Wiedermann et al, 2023).

5.4 Conclusion

In conclusion, the effects of youth suicide are profound and multifaceted, impacting individuals, families, and communities. Coping strategies, grounded in scientific evidence and informed by a comprehensive understanding of the psychological, social, and educational dimensions, are crucial for mitigating the aftermath of youth suicide and fostering resilience among those affected. This scientific exploration aims to contribute to create a comprehensive and individualized support system that addresses the specific needs of those affected, fostering resilience and promoting long-term healing .This study aims to contribute to the ongoing discourse on youth suicide prevention and support, emphasizing the importance of evidence-based interventions and community resilience to the ongoing discourse on youth suicide prevention and support, emphasizing the importance of evidence-based interventions and community resilience.

CHAPTER 6
MAJOR FINDINGS

- The present study shows that the highest number of suicides is found in the age group 36-40.
- Male suicide rate is higher than female suicide rate. Among the male's majority of the victims belongs to the age group of 31-35. And among female's majority of the victims belongs to the age group of 18-20.
- The suicide is higher among people those who belongs to low education categories (SSLC and plus two).
- The rate of suicide is much higher among people those who have employment than the unemployed. Majority of the employed people are working in un organized sectors.
- There is a strong relationship between income of the person and suicide. The majority fell in the lowest income category of the victims did not have income.
- Studies and statistics state that suicides in India are higher in married individuals (both male and female). But the percentage of suicide is greater in unmarried people than married people in Kerala.
- The rate of suicide among Hindu religion followed by Christians and Muslims. Which reflects the general population trend of Kerala.
- The relationship between social categories and suicide is complex. It is influenced by various factors. In the Indian sociocultural scenario, the social category is defined on the basis of caste. The findings of the present study show that suicide is high among the other backward communities (OBC) followed by SC/ST and General category.
- The place of residence, can significantly affect suicide rates. The highest rate of suicides occurring among people those who reside under Grama Pachayaths followed by Municipality and Corporation
- The choice of method varies significantly across individuals and cultures. The choice of suicide method is influenced by accessibility, cultural factors, and the individual's

intent. Hanging emerges as the predominant method, representing an overwhelming majority followed by poisoning, drowning and jumping from heights.

- There is gender difference in method of committing suicide. Male use method such as hanging and more female death of suicide is due to the use of poisons or substances.
- Family history can play a significant role in influencing an individual's risk of suicide. A notable percentage of individuals who died by suicide had a history of suicide among their relatives.
- This study observes a trend that even people who have a strong bond with their family and friends commit suicide. This contradiction with the existing data proves that the causes of youth suicides in Kerala are more associated with other factors than family and friends.
- Interpersonal issues can significantly contribute an impact suicidal thoughts and behaviours. A substantial percentage of suicides are associated with toxic relationships followed by relationship breakup, blackmailing, rejection and other reasons.
- The relationship between debt and suicide is a complex and multifaceted issue that involves various factors. The present study also founds the same. A larger portion of respondents, acknowledged that financial crisis contributed "to some extent" to the suicide.
- Numerous studies have reported a consequential association between substance abuse addiction and suicidal behaviour, especially in youth. The present study also states the same. The study found that a major percentage of suicide victims has an addiction towards alcohol, illegal drugs, narcotic substances and other items.
- A substantial percentage of individuals who died by suicide experienced psychological distress and feeling of hopelessness. This broad category encompasses a range of mental health challenges, and its association with suicide underscores the importance of addressing general mental well-being.
- The rate of diagnosed depression is slightly higher among male victims compared to females. Females have a higher rate of diagnosed mood disorders compared to males.

- Experiencing the suicide of a family member is an incredibly traumatic and have lasting effects on the surviving family members. Majority of the survivors experienced prolonged grief and strong sense of loss.
- The impact of suicide on survivors is profound and far-reaching, causing emotional, psychological, and social repercussions that can be long-lasting. Majority are pointed that emotional distress is the most negative impact of suicide on family. Followed by lack of support and financial crisis.
- The coping mechanisms adopted by the family members to cope up with the loss are different. Majority of the survivors resumed working to escape from the mental condition and a limited number of survivors shifted their residence to a new place. It may be for avoid the judgement or discrimination from others.
- Majority of the family members of victim recover from the impact of suicide only to some extent. This clearly depicts the prolonged effects of suicide on family members.

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