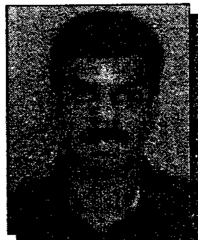
PRESENT SCENARIO OF SUICIDES IN KERALA



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Suicide is a global tragedy. It accounts for 0.4- 0.9% of all deaths. Each and every year at least 5,00,000 people die by suicide. Increasing suicide rate has become an important public health problem in Kerala in recent years. In the print media, visual media as well as in seminars and conferences this problem has been discussed widely. Our state contributes 10.1 percent of all the suicides occurring in India, while our population forms only 3.4 percent of the nation's populace. During the period 1991-2010 suicides peaked in the years 1999 (30.6), 2001(30.1) and 2002 (30.4). According to latest reports (State Crime Record Bureau, 2010) Kerala ranks first in its rate of suicide (25.7 per 100,000), which is almost three times the national average (10.9 per 100,000- National Crime Record Bureau, 2009). Kerala stands first in the rate of suicide among the other states since many years. The annual global suicidal rate is about 14.5 per 100,000 population or one suicidal death about every 40 seconds.

In the year 2010 8586 people committed suicide in Kerala. In Kerala, on an average 24 people are committing suicides per day. Majority of suicide victims are between the ages of 30 to 60 years (62%). In western countries suicide is more common in older age groups. On a closer analysis it is clear that the proportion of young people committing suicide is increasing in Kerala over the years. Younger age for suicide victims has been reported by many studies from Kerala. It could be due to the difficulties in securing stable jobs, financial problems and problems arising out of marriages (suicide is high among the married in Kerala – 78%), which take place increasingly during the early phase of life, might have enhanced the suicidal risk in younger age group.

The male to female ratio in suicide in this state is 2.7:1. The dominance of male in suicide shown in western literature is not seen in Kerala. The diminishing gender difference in Keralite is quite interesting. For the last few years many studies from Kerala, India as well as from other developing countries have also reported an increasing female proportion in suicide.

Suicide statistics is based on data compiled in National Crime Record Bureau and State Crime Record Bureau. Crime Record Bureau data on suicide is based on the information collected from police records. It is possible that there are many suicides that do not get included in the police records leading to gross under reporting. Social stigma, fear of legal actions and scandals, embarrassment etc. will contribute to the tendency of people to keep a suicide a confidential matter and to avoid reporting it. Like wise, there is no way of knowing the number of people who attempt suicide but do not succumb to it. Studies show that the number of people who attempt suicide is about ten times the number of people who actually succeeds in their attempt. By applying this ratio there would be 240 per 100,000 population attempting suicide in Kerala every year. In absolute terms it is approximately 85860 individuals in the year 2010.

Another phenomenon that has attracted public attention in Kerala is increasing family suicide in which often husband and wife commit or attempt suicide after killing their children. Kerala comes third (13) (first Madhyapradesh, second Andrapradesh, NCRB, 2009) in the rate of family suicides. As many as 73 family suicides were reported in the State in the last three years (2007-09). The despair and hopelessness related to family life arising out of severe financial crisis is reported and projected as the reason. The concern towards the children may be making the parents wish that their children should not suffer after their exit from the world. It may also be that their act would gain completion only if children also join in it. Though suicide attempt originates as a purely personal idea, it gains the status of a family act in these cases. Mental health experts, social activists and others blame growing consumerism for this trend.

Districtwise breakup

In the year 2010, Idukki district (38.6 per 100,000 population) had the highest suicide rate closely followed by Wayanad (38.5), Thiruvananthapuram (36.6) and Kollam (36.4) etc. For the last 10 years Idukki and Wayanad, districts have reported higher suicide rates. Interestingly in Thiruvananthapuram district the suicide rate had a steep increase from 17.2 in 1995 to 36.6 in 2010. Like wise there is a sharp rise in suicide rate in Kollam from 32.0 in 1995 to 41.1 in 2004. Some of the districts like Malappuram (12.0 in 1999 and 9.9 in 2010) and Kasargode (24.8 in 1999 and 19.7 in 2010) the suicide rate is decreasing over the years.

The drastic fall in the price of agricultural products might be the reason for high rate of suicides in the farmers dominated districts. Ever increasing rate of alcohol dependence is another reason for this alarming rate. Another reason could be the increasing rate of mental illnesses particularly depression and the influence of migration of Keralite to the Middle East.

Almost every second, family with a relative in the Gulf, has a history of mental illness. The worst victims seem to be women between 15 and 25 years of age. It could be the incompatibility with in-laws that leads to most women developing mental problems.

During the last ten years, lowest suicide rate was reported from Malappuram (9.9 in 2010). Islam clearly forbids suicide, encouraging submission to God's will in suffering and sickness. As a consequence Muslim patients do not readily talk about suicide. Often one finds in clinical practice, depressed Muslim patients, who divulge their suicidal ideas, quickly go on to state that they would not carry out their act because it is against their religion. It takes that much more for a Muslim to cross the bridge and therefore if a Muslim patient mentions suicidal plans he should be taken seriously.

Employment status

According to the recent SCRB report (2010), majority of suicide victims were house wives (15%) followed by unemployed (9.2%), farmers (10%), businessmen (6.8%), private sector employees (5%), students (3.1%) etc. An alarming finding is that over the last few years house wives have occupied number one position in Kerala suicides. The proportion of housewives occupy committing suicides is also very high in Kerala. Unemployment is another important factor in Kerala suicides. Kerala accounts for only 3.4% of India's population but has nearly 16% of the unemployment status among the Indian States. Kerala has the highest rate of unemployment of the educated. It could be the frustrated, educated, unemployed youths who resort to suicide.

Married people (78%) out numbered unmarried (15%) among the suicide victims in Kerala. In Western countries, suicide is more common in unmarried and separated individuals. India in general as well as in Kerala marriage is a social obligation and is performed by elderly irrespective of the individual's fitness for it. Further, marriage is believed to be part of the treatment for mental illness and the mentally ill more likely to get married that is sooner than the mentally healthy. Hence there could be several adjustment problems among the married mentally ill in India. In the West on the other hand, marriage is believed to be a measure of emotional stability and married people have lower rate of mental illness

Suicides more common among married and housewives have been reported by previous Indian studies also. Suicides more common among women below 30 of Indian origin have been reported from Malaysia and Fiji. It is held that females in India are submissive, docile and

non-assertive and these traits have built into their psyche with the result that they find themselves unable to deal with their negative feelings adequately. Among the stresses the marital ones appear to be most frequent in women. Amidst the hostile environment of the families with problems of a difficult husband and dowry demanding in laws, they feel helpless with the threat of loosing their husband's sympathies with none to turn to. This results in the choice of suicide as a way out from psychological pain, anguish and suffering. This calls for measures to cultivate and improve their coping styles to face the domestic conflicts and dowry related problems.

Educational break up

In the recent statistics (2010) 50% were primary and middle class educated, 43% were matriculate and intermediate, 4 % were graduates or diploma holders and 0.5% were postgraduates and above. Only 2% were illiterates.

Mode of attempt

2010 data shows that majority of suicide victims including males and females took their lives by hanging (50%), followed by consuming insecticides and other poisons (32%). Another note worthy point is that a significant proportion of females committed suicide by self- immolation (5.7%) and drowning (6.2%).

Factors like feasibility, accessibility, credibility and rapidity of action and degree of suicide intent could be behind the choice of method for committing suicide. The availability of methods becomes more important when the suicidal act is impulsive in nature. In our state, majority of males are being farmers, they have an easy accessibility to insecticides. Similarly for females because of limited mobility outside home as majority are housewives they have more accessibility to native poisons, medicines, corrosives, kerosene etc. However in both genders stronger suicidal intention might have led them to choose more lethal method like handing as sure means to commit suicide. It has been revealed in Indian studies that domestic burns as a method of completing suicide by young women and most lethal one with a promise of a high degree of success. Burns in general have reported more in younger women.

CAUSES

The causes or the factors that are reported for suicidal attempts differ in police records and in clinical experience. In the clinical situation various problems in the family such as marital problems, difficulties in social life, love affairs, failure in examinations, financial difficulties etc. emerge as the reasons in that order.

According to SCRB data (2010), 40% of suicides were caused by family problems, 18% mental illnesses and 17% physical illnesses. Factors like financial problems, unemployment, love failure, failure in exams and professional/career problems etc have contributed only to lesser extent in Kerala suicides.

Mental illness is identified as an important cause, accounting for 18% of suicides in Kerala, which is far higher than the all-India average of 9%. Among the behavioral disorders depression, alcoholism and schizophrenia score top in the percentage of suicide. Taken together physical and mental illnesses constitute 35% of total suicides in Kerala.

However, on a closer scrutiny it would be observed that mild and moderate difficulties, lack of competence in handling them and the emotional difficulties arising from it are responsible for majority of suicides. This is the real background of many suicides where financial difficulties are projected as the causal factor. More than the gravity of the financial difficulties and genuine, problems in looking after the family, it is the incompetence and lack of confidence in handling these difficulties and the feeling of helplessness emerging from it that are setting the stage for the suicidal behavior. The influence of consumerism, the increasing prevalence of alcoholism, the ruthless and competitive life style, all collaborate to set the tragedy of the individual in the contemporary Kerala society. Aspirations and needs are quite high for an average Keralite but resources are limited. Many tend to buy things through installments. Migration adds to this. People who go abroad (especially to the Gulf) try to inculcate the same living standards and culture here. Moreover, the pampered child rearing practices, geographical over protection of the state from natural calamities, all have made a typical Kerälite an individual without much fortitude or frustration tolerance and emotional immunity.

Media reporting and portrayals have been identified as having an important influence on suicides in Kerala especially copycat suicides. Young people and elderly people appear more vulnerable than those in their middles years to the media related suicide contagion. In adults, a form of social contagion may be operative whereby someone is more likely to harm himself/herself if exposed to someone who has done so. A crucial issue in the social contagion hypothesis is the influence of media. There is a steady and constant exposure to suicide in the television and cinema – often giving tasteless and lurid details of the actual process. The print media often highlights and justifies or even glorifies acts of suicide. Epidemics of suicide following sensational reporting of suicide in the media have been noticed in many parts of the world.

Perhaps teenagers are more vulnerable and impressionable than adults in the face of med influences.

Prevention

Currently available data show that suicidal phenomena, which occur in Kerala, are differe from the west in a variety of ways. Second and third decade seems to be the most susceptib for Kerala suicides. The gender difference in suicide is diminishing. Noteworthy are the importa causative factors such as maladjustment with significant family members and domestic strif Further more the event of marriage in our culture appears to augment the proneness for suicid behaviour. The commonly observed modes of suicide in our country which are hangin poisoning, drowning, burning indicate that apart from the credibility and rapidity of action, th availability and accessibility of particular method is also vital. Hence it is important for our stat to develop locally and culturally relevant and feasible strategies for suicide prevention that ca be implemented along with other state health, education, and welfare programmes. Some o the principles on which suicide prevention strategies are developed are as follows:

1. Detection of treatment of depression and other mental disorders including alcohol and drug abuse.

2. Enhanced access to mental health services

3. Intervention aimed at psychological reaction to physical illness.

4. Assessment and intervention for those who attempt suicide with close liaison with other specialties

5. Intervention after a suicide – postvention

6. Interventions for high risk and special groups

7. Training – health / education / welfare personal

8. Restrict availability of means such as insecticides and medications

9. Training for acute care management of poisoning and establishment of such facility in every community health centres

School based interventions

a) Life skills education (improve self esteem and problem solving skills)

b) School based counseling

c) Training for teachers

d) Close liaison with mental health services

e) Include mental health in curriculum

Crisis intervention

a) Telephone help line

b) Samaritans, Befrienders

c) Suicide prevention centres

10. Public education

11. Collaboration with media for responsible reporting

12. Sensitization of policy makers regarding sustainable development, employment.

Conclusion

Beyond arithmetic and the analysis of data, some of the factors behind the scene of suicide have been presented here. The solution to prevent the alarming suicide rate in Kerala lies both at the individual and at the society level. The individual should make his life more pragmatic and energetic; and the society should contain the socio-economic and socio-cultural forces pulling it in different directions and trying to threaten its stability. The various behavioral disorders like depression, alcoholism, and psychoses should be detected at the earliest and treated before it progresses to an advanced stage. The emotional disturbances in family life should be handled through empathy, understanding and humility. If they grow beyond the level of

being handled and ameliorated with individual or intra-familial initiatives, attempt should be made to avail counseling. Systematic and scientific counseling in a practical and affordable manner is very effective for the prevention of suicide. Establish suicide prevention centre in each hospital. Further, the easy availability means to commit suicide such as organophosphorus compounds and medications without prescriptions should be restricted legally.

References

Government of India (2009). Accidental deaths and suicides in India, National Crime Records Bureau, New Delhi: Ministry of Home Affairs.

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Suicide rate per 100,000 population