Medicine and Society

Suicide in India: Part perceptions, partial insights, and inadequate solutions

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ABSTRACT

Suicide is a complex phenomenon, often linked to environment. Despite the identification of many social, cultural, economic and political correlates and risk factors, psychiatry continues to argue for curative solutions based on the reductionistic biomedical model, rather than support public health measures to manage the larger sociocultural, economic and political context. While psychiatry and curative medicine help many people, survival of the human body is best explained by the materialist explanation that locates the variation in health and longevity to tangible resources. There is no single, simple or straightforward solution to reducing population suicide rates; specific mental health interventions are unlikely to impact secular trends in the rates of suicide.

Natl Med J India 2017;30:155–8

INTRODUCTION

Suicide has been recognized as a major public health problem.[1] WHO acknowledges that suicide is a global problem affecting all nations, particularly low- and middle-income countries. Suicide has an adverse impact on not just those who kill themselves but also on families, communities and on society. WHO recognizes that many deaths are impulsive and require effective, comprehensive, multisectoral responses and national strategies for prevention. It supports restricting access to means including pesticides, firearms and certain over-the-counter medications. It recognizes the need to manage mental health concerns including alcohol and substance use. It supports the need for de-stigmatization of mental illness and mental healthcare in the community. It mandates the need to incorporate suicide prevention as a core component of health and champions early intervention.

The Mental Health Gap Action Programme (mhGAP)[2] of WHO includes the identification of suicide risk as a health priority. It has developed an intervention guide to recognize and manage mental illness, substance use and people with suicidal ideation and plans and a history of deliberate self-harm. The WHO Mental Health Action Plan 2013–2020[3] foregrounds the prevention of suicide and has included indicators that measure progress. These include (i) percentage reduction in the suicide rate; (ii) number of suicide prevention interventions successfully implemented; and (iii) a decrease in the number of hospitalized suicide attempts. The plan aims at a 10% reduction in suicides by 2020.

WHO has also initiated a multisite intervention study,[4,5] which attempts to increase awareness of the issues, reduce stigma and influence national policies. It includes suicide mortality surveillance, technical support to countries, regional and national workshops, production and dissemination of resources, advocacy and randomized treatment trials of brief interventions for suicide attempts.

Nevertheless, suicide periodically comes into Indian consciousness, particularly when the National Crime Records Bureau (NCRB) releases statistics. The country has an annual ritual of discussing suicide, debating issues, criticizing current approaches, scoring political points and highlighting particular solutions. The short attention span of the population and the fickleness of the media, mean that suicide forms a regular part of the media cycle.

MEASUREMENT CHALLENGE

Most researchers recognize that the official national suicide rate of 11/100 000[6] under-estimates the magnitude of the problem. The criminalization of attempted suicide, its legal implications, police investigations, postmortems in under-resourced settings, the absence of detailed coroner's reports and stigma complicate issues. Higher rates recorded in localized regions using accurate methods of data collection[7] have now been confirmed in a nationally representative sample.[8] Yet, the country's only estimates of suicide are based on police records and NCRB statistics, whose authors disclaim veracity of their figures and distance themselves from the data collection process.[6]

CORRELATES AND FOCUS

Part perceptions, which highlight particular correlates, argue for specific solutions while ignoring others, are partial responses to a complex, multidimensional problem. Psychiatry continues to focus on the individual, when the need is for change in contexts, environments and populations. The issues are briefly mentioned.

Gender

The narrowing of the gender gap and higher rates of suicide among young women[9] is widely acknowledged. Nevertheless, issues related to gender justice, which often drive such attempts, are not the focus of interventions within our patriarchal society. Attempting to address cultural and religious biases for the second-class status of girls and women is taboo, does not receive much traction, let alone approval and resources.

Age

Despite the recent focus on young people who kill themselves, older individuals have much higher rates of suicide.[10] However, Indian law has shifted the responsibility of support for senior citizens from governments to their children and heirs.[11] The lack of pensions and social security for much of the population and the weakening of the joint family system result in isolation and impoverishment for many older people and provides a fertile context for suicide. In addition, despite good intentions, the law is rarely used to secure justice and financial security for older people.

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Alcohol use

A higher risk of suicide among people who are dependent on alcohol has been documented. However, such use is seen as a moral failing. The explanation deflects from the fact that governments are addicted to tax revenue from the sale of alcohol;[12] they rarely get credit for their contribution to high rates of suicide.

Farm suicides

Suicides among farmers have focused on the crisis in agriculture.[13] The debate acknowledges the role played by the introduction of cash crops in semi-arid regions, which traditionally employed sustenance farming. However, variable monsoon, poor irrigation, government apathy, increased costs of cultivation, intensive use of fertilizers, extensive usage of pesticides, low prices for farm produce, family stressors, and addictions compound problems. The major reduction in farm loans by large banks and the rise of private lenders, who also provide seeds, fertilizers and pesticides, result in debt and death traps, add to the toxic mix.

Sale of pesticides

Ingestion of pesticides is a common method of suicide.[7] It has led to research, encouraged by manufacturers of pesticides, which focused on evidence that providing safer methods of storage (e.g. a double-locked box[14]) and the use of pesticide banks (i.e. secured central storage facility[15]) to reduce impulsive suicidal attempts and fatality. Nevertheless, such focus belies the fact that extremely lethal pesticides, banned in high-income countries, are sold by multinational corporations and are freely available in India. These strategies shift the responsibility for suicide from large businesses, which refuse to change practice in order to maximize profits, to individuals. While selective approaches such as banning of lethal WHO class I organophosphorus insecticides in Sri Lanka has reduced hospital admissions, the use of class II compounds means continued deaths by pesticide poisoning.[16]

Life skills education

Many experts have correctly identified the need for life skills education, particularly among high school students, in order that people learn resilience and are able to cope with the stress.[17] However, the Indian educational systems continue to prize book knowledge. The examination season often sees a spurt in suicide and suicide attempts as unrealistic aspirations and expectations of family and society make it extremely difficult for children who do not fit the mould. Changes in curriculum, although rare, have a non-significant impact as the traditional examination systems continue to test rote learning.

Disease versus distress

Recent investigations from India into completed suicide have shown that the vast majority of people who kill themselves are distressed rather than suffer from severe mental illness.[18] However, psychiatric models of mental illness, with their symptom counts sans context medicalize all personal and social distress. The discounting of contexts results in people with social and personal distress receiving psychiatric labels. The mechanical application of this approach increases the prevalence of mental disorders across settings. The validity of psychiatric diagnoses, yet to be established, has been questioned both from a primary care perspective[19] and from a neuroscience framework.[20]

Holistic care

Psychiatry also argues for holistic care and emphasizes the biopsychosocial model, which demands assessments and managements of biological, psychological and social causes and contributors to mental disorders. However, the lack of expertise in psychological therapy and the fact that social interventions are outside the psychiatrist's therapeutic armamentarium mean that the biopsychosocial approach is often praised but it is the reductionist biomedical model, with its predominant focus on pharmacological medication, which is practised.[21]

Help-seeking

Many individuals in emotional distress seek help from diverse sources of cure and healing; medical, traditional and faith healers compete to provide a variety of services using assorted and contradictory concepts, frameworks, and therapies. Many metropolitan cities also have telephone counselling helplines (e.g. 'Sneha' in Chennai). Despite the fact that such services help many people contemplating suicide, research evidence suggests that suicide rates, which are often stable over time, seem impervious to such interventions.[22]

Training

People in distress often seek help from their physicians; those who attempt suicide are commonly seen in emergency departments and are admitted to intensive care units. Yet, psychiatric training in India continues to remain mainly on paper.[23] Skill and confidence to recognize and manage suicidal risk is scarce. Similarly, training of gatekeepers (e.g. teachers, prison wardens, traditional healers, priests, etc.) who can identify vulnerable individuals is non-existent. The diverse skills required for recognition of distress, identification of suicidal risk, provision of psychosocial support, counselling and managing mental disorders and substance dependence require a comprehensive education programme, not just for the transfer of knowledge but the acquisition of necessary skill and confidence. The inability to upscale such interventions to a national level limits their impact.

Legal issues

The recent Mental Health Act 2017 has decriminalized attempted suicide and recommends mental healthcare. However, the fact that domestic violence and discrimination based on caste are common causes of severe mental distress, existing laws to manage these situations are rarely implemented.

Economic systems

Nations with economies in transition (e.g. Russia, Ukraine, Estonia, Latvia, Lithuania) seem to have much higher rates of suicide than those with stable markets.[24] Yet, the gross domestic product drives all economic discussion with a complete neglect of the more holistic human development index. The Gini coefficient, which emphasizes inequity within nations, is rarely highlighted. The displacement of people from their ancestral lands for development projects, rural poverty, unemployment and migration to urban areas are indicative of structural violence, which has been normalized in India. Social security nets and universal healthcare are now seldom part of the dialogue of social justice as capitalism has mesmerized our governments, bureaucracy and upper classes.

Culture

Although suicide is stigmatized in Indian culture in general, there is also acceptance of such an option for people in severe distress. Indian films portray non-fatal suicidal attempts as an indication for true love, which often helps resolve family tensions. The level

of acceptance of suicide as an option for individuals to overcome interpersonal, family and financial stress in the general population is high.[25] People perceive poverty, lack of empowerment, a materialistic society, and the inefficient social and economic support system as major factors that push individuals towards taking their own lives. Understanding the complex sociocultural and economic issues that modulate and increase the incidence of suicide deserves serious consideration. Subtle cultural sanction is not easy to displace from people's imagination and will require concerted campaigns to change local beliefs.

Religion and philosophy

The country's current fascination and embrace of capitalistic systems of thought and economy, which worships material wealth, has also resulted in subtle and not so subtle changes in the population's philosophy and outlook. India's path to modernity seems to be able to accommodate, compromise and compartmentalize its ancient philosophy, religions and culture, which often emphasize simple and austere lifestyles. The emphasis on individualism has also resulted in a reduction in traditional support systems, which increase social isolation. Rapid urbanization and massive migration from rural areas also leaves many without community supports.

Politics

The release of the NCRB 2013 statistics and a Union minister's response of fixing the blame on love affairs and impotency sparked a furious debate.[26] The response to suicide is coloured by political perspectives, which are often used to shift blame and score political points rather than seriously engage with issues.

Media

The mass and social media, with their wide reach, can have a beneficial impact on knowledge, attitudes and practice related to suicide and suicidal attempts. However, the 24 (7 news cycle and the focus on television rating points makes issues related to suicide popular with the media. Details of suicide are often emphasized increasing the risk of copycat suicides among the vulnerable. Despite the beneficial impact of restraint, the suggested self-imposed ban on such messaging is often violated in practice.

Public health

Many experts have correctly argued that suicide is a major public health problem. They demand that viewing suicide through the public health lens will remove it from the political arena, with its penchant for shifting responsibility. While on the surface this appears to be a good solution, the reality is much more complex.

NEED FOR A COMPREHENSIVE APPROACH

Suicide as a behaviour is a final common pathway for a variety of predisposing, precipitating and perpetuating factors. In addition, each of the risk factors and conditions described is neither necessary nor sufficient for suicide. Consequently, there are no single or simple solutions to preventing suicide. Attempting to reduce a single risk factor or a group of related factors, while preventing death in a proportion of people, may not have a major impact on population rates. This calls for a comprehensive and broad-based approach to suicide prevention, which should necessarily be multisectoral. Medicalizing suicide or reducing it to a psychiatric label will prove inadequate for the task.

There is strong evidence to link health to the social and economic environment and longevity to improved living standards.[27] Many inputs—political, financial, social, cultural, engineering, science, educational, religious and legal in addition to medical—are part of efforts to improve population health. The public health perspective draws on a wide variety of disciplines and consequently is not a discipline in the traditional sense.[28] The multiple disciplines and the many stakeholders and actors involved and their divergent frameworks, language and cultures have muddied the waters. The medical fraternity and the pharmaceutical industry advocate the biomedical model and curative treatments. Financial institutions argue for and insist on the capitalistic model, which focuses on profits than on prioritizing population health. Social science perspectives are marginalized. Political leaderships prefer electoral language to retain power. Civil servants concentrate on planning, budgets and targets. While many disciplines share public health objectives, their diverse frameworks clearly support their divergent agendas.[29]

SUICIDE AND PUBLIC HEALTH

Poor public health standards in India and low- and middle-income countries are a result of major problems related to ownership of the public health goal.[28] Medicine currently owns the goal but cannot deliver and other disciplines lack the sense of ownership. The context of public health demands a different framework. There is a need to differentiate public health as a discipline, a goal, an agenda and as practice.[29] The differentials in power between stakeholders and actors need to be acknowledged and all issues should be scrutinized under the public health lens. Public health should be located within society and politics rather than within medicine. There is a need for a people's movement that champions public health issues as basic rights. The challenge is to integrate public health goals into the diverse disciplinary frameworks.

The poor health status of populations in the poorest countries is related to chronic poverty working through lack of basic needs and access to health services, social discrimination, economic insecurity and political exclusion. Suicide is also associated with many of these sociodemographic, cultural, and economic correlates and demands comprehensive population-based strategies.[29] Many of the risk factors associated with suicide require a social security net provided by the state. Without a social security net many vulnerable individuals face significant socioeconomic distress, which can easily propel them towards the option of suicide. The egalitarian society promised in the Indian Constitution requires the provision of basic needs such as clean water, nutrition, housing, healthcare, education and employment. In addition, it should provide gender justice and protect against social exclusion. Without such public health approaches, suicide prevention would remain on paper with the medical and psychiatric approaches currently advocated completely inadequate for the task of reducing suicide rates. Multidimensional problems such as suicide require large-scale public health interventions to reduce suicide rates of populations.

CONCLUSION

India's ritualistic debate on suicide ignores the elephant in the room, for most parts of the year. India has one of the highest suicide rates in the world. However, experts, like the blind men of Hindustan, who function within their disciplinary straightjackets and with their part perceptions, fail to recognize the big picture. They identify causal mechanisms operating in a minority of suicides and suggest single and simplistic solutions to manage the complex individual and social phenomenon of suicide. They rarely push for comprehensive national responses.

Many risk factors associated with suicide are neither necessary nor sufficient for death making the search for single and direct solutions impossible. Comprehensive solutions demand a package of macroeconomic policies that reduce the impact of free-markets, schemes which meet basic human needs and rights, psychosocial interventions that organize local support within communities, an essential pesticide list that excludes lethal compounds, gender justice, universal primary healthcare, legal and social protection for the vulnerable and increasing awareness and education through the mass media.

The reductions in suicide reported in some countries have more to do with secular trends and improvements in living standards than specific suicide prevention programmes.[30] While interventions have shown a reduction in method-specific or site-specific rates, there is no firm evidence to suggest an overall reduction in suicide. A national strategy encompassing diverse approaches needs to be in place to achieve any degree of success.[31]

We need the wisdom to recognize that suicide is a final common pathway for diverse kinds of people who choose this extreme option when faced with difficult life situations related to the sociocultural, political and economic environment, within which they live. Rates of sociocultural and economic change within society have a differential impact on people based on their different histories, backgrounds, contexts and opportunities. India's ability to carry all its people to a more prosperous future will require a vision to see the big picture, reduce inequity and provide support for those who started with contextual disadvantages.

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