Family Suicide in Kerala : An explorative study into pattern , determinants and consequences.

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INTRODUCTION:

Kerala shows serious draw backs with respect to mental health status, though achieved targets for health for all by 2000 A.D. High suicide rate is one indicator. With annual suicide rate as 27/100,000 population, Kerala represents one of the geographical areas with highest rate.

Clinical conditions (Eg: Depressive Disorder). Socio Economic Factors (Eg: migrations, debt traps) and Socio-Cultural settings (Eg: disintegrating traditional social support systems, aspirations disproportionate to resources) contribute to suicide intentions along with the other hitherto unknown causes. Hence only a wholistic approach can be expected to have any significant effect for any prevention programmes.

Suicide of entire family members appears to be a new phenomenon in our state. Even the reports appearing in mass media points to an alarming rise in the figure. No scientific study has so far been conducted to illuminate neither the magnitude nor the causes of this problem. No intervention models hence exist at present in the state within the specific socio-culture context. This study is the first attempt in that direction.

'Development' is intended to improve the quality of life either directly or indirectly. Any activity with an objective to preserve life cannot be considered as separate from Developmental activity. Attempt to evolve a suicide prevention strategy, which is locally workable, is hence relevant.

FACTS AND FIGURES ABOUT SUICIDES IN KERALA.

The rate of suicide per lakh population in a year was gathered from the crime records beuro of National and state level. The figures are given in table 1.

Table 1 : Rates of suicides in India and Kerala per lakh population

Year	India	Kerala
1973	7.1	19.83
1974	7.8	17.40
1975	7.1	18.22
1976	6.8	14.8
1977	6.3	14.7
1978	6.3	14.5
1979	5.9	14.4
1980	6.3	14.9
1981	5.8	16.1
1982	6.8	18.2
1983	6.4	19.8
1984	6.8	20.9
1985	7.1	22.1
1986	7.1	21.9
1987	7.5	23.6
1988	8.1	24.7

1989	8.5	24.5
1990	8.9	26.3
1991	9.2	28.9
1992	9.2	27.3
1993	9.5	27.0
1994	9.91	28.2
1995	9.74	26.1
1996	9.47	26.0
1997	10.03	28.1
1998	10.80	29.4
1999	11.20	30.48

In 70s the suicide rates I India was between 5.9 to 7.8 . The figures for Kerala for corresponding period was 14.4 to 19.8 . For both the regions there was a tendency of fall from the beginning of the decode to end of the decode.

In 80s the suicide rates in India was between 5.8 to 8.5 and for Kerala it was 14.9 to 24.5. The rates in both the regions showed a tendency to rise to wards the end of the decade.

In 90s the rates in India varied between 8.9 and 11.20 and for Kerala, varied between 26.3 and 30.5. The figures for both India and Kerala showed a definite rise from the beginning to the end of the decade.

It is frequently quoted that Kerala is unique to have a higher suicide rates when compared to the corresponding figures of India. However three observations appear relevant. Pondichery showed very high fignes for suicide ranging from 29.0 to 72.5, topping list almost every year during last 3 decades. The city of Bangalore showed an incidence rate of 35.17 during 1999 (Gururaj & Mohan isac 2001). Suicide rates for the byear period as in 85 villages of Kaniyanbody block when verbal autopsy method was used to collect data instead of police records. The country of srilanka had a rate of 31.0 in 1985, Pondichery a State, Banglalore a city and Kaniyambodi as a region are all in south India and Srilanka is the neighbour to Kerala. All there are geographically neighbour hood region.

If at all a high rate of suicide is seen in Kerala, it is not specific to Kerala, but of a geographical area comprising the whole south Indian peninsula.

A STUDY OF SUICIDE IN KERALA BASED OF REPORTS APPEARE IN PRINT MEDIA

INTRODUCTION.

While issues of Socio-economic development in Kerala gather much attention trends in the reverse direction (eg: rising suicide rates) are rarely the focus of scientific attention (HALLIBURTON 1998). Suicide rates in Kerala is consistently higher than the National figures at least for past two decades (PRAVEENLAL & MANOJKUMAR 2000). Importance of suicide prevention programmes are appreciated by professional community in Kerala (PRAVEENLAL ET AL 1998.) Though scanty, a few reports are available on the attempted suicides (PRAVEENLAL 1999) while studies on completed suicides are rate.

While formulating for the study of family suicides in Kerala, it was decides to gather information regarding the suicides happening in Kerala in general. It is in this context, the present study was conducted. The aim of the study was to gather demographic details, method adopted and causes of the completed suicides happened in Kerala during a period of 6 months.

Methodology:

The news paper in local language having largest circulation was selection for the study. Papers of all days for 6 months - 1st January to 30th June 2000 - were scanned for any reports of completed suicide. Details of the suicide victims as appeared in the reports were collected. Gender, Age, Method adopted and reported reason were collected in to the master sheet directly. The collected information was compiled manually and converted into table format.

Observation and Results:

Malayala Manorama was the news paper selected for the study. Having established in 1888 and successful in sustaining publication for past 112 years it is the leading daily in Kerala at present. This paper has nearly 11 lakhs copies every morning as the current circulation. 112 reports of suicide appeared in 182 issues of the news paper thus scanned belonging to the predecided period of 6 months. Thus one has more than 50% chance (61.5%) of reading a report of the suicide if one opts to read the leading news paper in the language of the state.

The age and gender distribution of the suicide victims are given in Table.1. Maximum number of suicides happened for the age group was 20-39 years. This was followed by 40-59 group, above 60 and the least was from the age group below 19. For males the highest were from 40-59 age group, the others remaining the same as for the whole group. For females, first and second highest groups were similar to that of the whole group, while below 19 qualified for 3rd place and above 60 years had the lowest rank.

Distribution of suicide victims according to the mode of attempt is given in Table.2. Out of 112suicides victims, 40 preferred to die by poisoning, which was the highest preferred mode. This was followed by burns, hanging, drowning, rail track and jumping from height. For males, burns had fifth rank after rail track. Most females preferred burns (59.1%). This was followed by poisoning, hanging and drowning. None selected rail track or jumping from height as a method to commit suicide.

Distribution of suicide victims according to the reason for suicide is given in Table 3. News paper reports didn't mention the reason for suicide in 76 cases (67.9%), out of the remaining 36 cases where the reason was mentioned, death of near one was the commonest. This was closely followed by committing murder and then suicide (family suicide), marital disharmony and scolding by parents. Death of a dear one, committing murder, financial difficulty, unemployment and trouble with police were reported in case of males only, while failure in exam, eve teasing, can't have children, mental illness and patients objection to desired mariage were reasons exclusively for females.

Discussion:

The age and gender distribution of the suicide victims from the data gathered from news papers is comparable with similar data gathered from forensic records (PRAVEENLAL et al 2000). This justified the use of newspaper reports as a source of reference for studying the phenomenon of suicide.

Smaller number of suicides are appearing in the news papers when compared to forensic records. It could be due to under reporting as a news items. Another possible explanation is that the Forensic department of a Medical college may be offering services to more than one district while news papers by and large restrict to reporting district wise information in the inner pages. 62% of the issues of the news paper carried a report of completed suicide. This means, if we select any 2 issues of a news papers at least one will carry a report of suicide. This appears important on the basis of enough evidence to suggest that wide and glorified coverage of suicide in newspapers and television one associated with a statistically significant excess of suicides (WHO 2000). It is well appreciated that utilization of media is beneficial for the promotion of mental health (SRINIVASA MURTHY 1994).

The age distribution of those who commit suicide is different when compared to National diagues. The figures of teenagers in Kerala (9%) is strikingly lower than that of Indians as a whole. In the National Crime Records Buero reports of 1993, 9469(11.29%) of all suicide victims (84244) in India were

teenagers. The corresponding figures were Kerala were 351(4.3%) and 8124 respectively. This lower contribution by teenagers could be explained in terms of difference in demographic profile.

. Male predominance over females in the overall suicide rates are in accordance with established figures elsewhere. The 1993 National figures showed a Male to Female ratio of 689.9 for all suicide victims while it was 422.3 for Kerala. The corresponding figures for teenagers were 1074.7 and 1166.7 for India and Kerala. Reasons for this reversal of male predominance for teenagers is not explainable. Why this reversal is more prominent in Kerala inspite of a favourable sex ratio for females (1036) needs further exploration.

Preference for poisoning followed by burns and hanging were the most frequently reported mode of attempt. Selection of poisoning may be due to it's availability acceptability and lesser "Violence" controlling the availability of pesticides and poisons and improving the medical management of poisoning are strategies considered in Sri Lanka (EDDLESTON et al 1998). Which can be adopted in Kerala as a prevention strategy. Women's tendency to avoid going out alone at odd hours may be the reason for none of them preferring rail track, while their preferance for self immolation may be due to their familiarity with setting five and accessibility.

Unlike forensic data, the majority of reports in the news paper failed to mention the reason. This could be due to their inability gather relevant information or their self restraint. Over simplified approach can lead to attributing sole responsibility to one single factor in a multifactoral problem. In such cases usually popular reasons in broad terms will be assumed, which have more chance for false generalisations and negative impact. In that limited sense, nonreporting of the reason could be viewed as a welcome step from the media.

The gender difference in the cause s are evident as financial and occupation related problems contributing for male suicides, while that role is for interpersonal problems in case of females. As one assumes financial responsibility at middle ages and interpersonal problems are more likely in teenage, the gender difference in age groups could be appreciable (PRAVEENLAL ET AL 2000). Unemployment was cited as a cause in only one case. This could be due to the possibility of truth remaining unappreciated when it is too familiar or it may be due to underemployment (HALLIBURTON 1998) not unemployment which is really the problem. Dowry related issues were not reported, perhaps due to reluctance of media in reporting issues carrying legal significance.

Table1 Number and 1% of suicide victims according to age and gender

Age Group	Total N(%)	Male N(%)	Female N(%)	M.F.Ratio.
Below 19	10 (8.9)	3 (4.0)	7(16)	2333
20------39	48 (42.9)	24(35.3)	24(54.6)	1000
40------59	40(35.7)	31(45.6)	9(20.5)	290
Above 60	14(12.5)	10(14.7)	4(9.1)	400
	112(100.0)	68(100.0)	44(100.0)	

Table: 2 Distribution of suicide victims according to mode of attempt

Mode of attempt	Total N(%)	Male N(%)	Female N(%)
Poisoning	40 (35.7)	32(47)	8(18.1)
Burns	30(26.8)	4(5.9)	26(59.1)
Hanging	26(23.2)	19(27.9)	7(15.9)
Drowning	10(8.9)	7(10.3)	3(6.8)
Rail track	5(4.5)	5(7.3)	(0)
Jumping from height	1(0.9)	1(1.5)	(0)
Any method	112(100.0)	68(100.0)	44(100.0)

Table:3 Distribution of suicide victims according to the reason for suicide

Reason	Male N%	Female N%	Total N%
1. Death of dear one	8(11.8)	----	8(7.1)
2. Committed murder and them suicide	6(8.8)	----	6(5.4)
3. Marital disharmony	3(4.4)	2(4.5)	5(4.5)
4. Parents scolded	1(1.5)	3(6.8)	4(3.6)
5. Physical illness	2(2.9)	----	2(1.8)
6. Failure in exam	----	2(4.5)	2(1.8)
7. Eve teasing	----	2(4.5)	2(1.8)
8. Can't have children	----	2(4.5)	2(1.8)
9. Financial difficulty	1(1.5)	----	1(1.9)
10.Unemployment	1(1.5)	----	1(1.9)
11.Mental Illness	----	1(2.3)	1(1.9)
12.Marriage objected by parents	---	1(2.3)	1(1.9)
13.Trouble with police	1(1.5)	----	1(1.9)
14. Not mentioned	45(66.2)	31(70.5)	76(67.9)
All reasons	68(100.0)	44(100.0)	112(100.0)

A STUDY OF COMPLETED SUICIDES FROM THE POSTMORTEM RECORDS OF THRISSUR MEDICAL COLLEGE

INTRODUCTION .

Suicidal behaviour was neither known to any society and nor dormant during any period of history (PONNUDURAI 1996). Suicide is paradoxical as man has a tendency to cling to life even under most adverse and painful conditions (SHUKLA 1990). Suicide rates in India have shown a gradually increasing trend; which is 9 per 1,00,000 in 1996. States like Kerala and Goa and cities like Pondicherry and Bangalore having rapid social change are associated with higher suicide rates (SARINIVASA MURTHY 2000). In spite of these facts, very few studies on suicides were conducted in India, when compared to attempted suicides. This study was done in this context to gather information regarding completed suicides in Kerala.

Methodology

All the postmortem conducted in the Department of Forensic Medicine of Thrissur Medical College from 1st January 1998 to December 1998 formed the universe of the study. All the diagnosed cases of suicide were identified. Details like socio-dermographic profile, method of attempt and reason for attempt were connected using a specially designed proforma. Thus dervised data was compiled and analysed.

Observations and results

Out of a total number of 1737 cases on which postmortem examination was conducted at the Forensic Department of Thrissur Medical College, 800 were suicide victims. This formed 46.1%. Out of this, 13 were the victims of family suicide (1.6% of suicides).

The distribution of committed suicides according to sex and age is given in Table.1.

Out of the reported 800 cases 330 were from age group 20-39 forming 41%. This was followed by 40-59 age group (34%), 60 and above (16%) and up to 19 age group (9%). This was almost true for females. In case of males the highest representation was from 40-59 age group, followed by 20-39 age group, 60 and above and upto 19. More males committed suicide when compared with females. This trend was highest in 40-59 age group, followed by 60 and above age group and 20-39 age group. In the up to 19 age group, this ratio reversed drastically in 'favour' of females, which showed a 250% higher rate when compared to males.

The distribution of committed suicides according to method of attempt and sex is given in table.2. Methods adopted to commit suicide varied widely. Majority of them opted for poisoning, followed by hanging, burns and drawing. This remained true for both males and females except for the relative status for burns and drowning. With respect to burns, females out numbered males by 200% as a method of preference while in stabbing, the sex ratio was equal. Male dominance were higher in using methods like drowning, hanging, poisoning and rail track. The sole gun shot was the method adopted by a male.

The distribution of suicide according to reason for attempt and sex is given in table 3. Various causes were identified by the investigating police officer, which was leading the individual to commit suicide. Major recorded causes were disappointment in life and financial crisis. This was closely followed by physical illness and psychiatric illness. Marital disharmony and alcoholism ranked next. This was the order observed for male, except alcoholism which had a higher position than marital disharmony. Among females, psychiatric illness and marital disharmony qualified for 2nd and 3rd ranking, while financial crisis was below that of physical illness. With respect to broken love affair, failure in exam, death of a family member, marital disharmony and family conflict; females out numbered males. Alcoholism and unemployment were recorded only for male suicides only, while marriage not getting fixed was recorded for females. For 149 cases, no cause was recorded. This amounted to 19%. It was 16% for males and 22% for females.

Table.1

Distribution of committed suicides according to sex and age

Age Group	Total N %	Male N %	Female N %	M.F.Ratio N %
Up to 19	700(8.8)	20(4.1)	50(16.3)	2500
20-39	330(41.3)	180(36.5)	150(48.9)	833
40-59	275(34.4)	209(42.4)	66(21.5)	316
60 and above	125(15.6)	84(17.0)	41(13.4)	488
Total	800(100.0)	193(100.0)	307(100.0)	623
Kerala Population	29098000			

Table - 2

Distribution of committed suicides according to sex and method

Method of attempt	Total N%	Male N%	Female N%	M.F.Ratio
Poisoning	395(49.4)	276(56.0	119(38.8	431
Hanging	225(28.1)	140(28.4	85(27.7	607
Burns	89(11.1)	29(5.9	60(19.5	2069
Drowing	82(10.3)	42(8.5	40(13.0	952
Rail track	6(0.8)	5(1.0)	1(0.3	200
Stab	2(0.3)	1(0.2)	1(0.3	1000
Gun shot	1(0.1)	1(0.2)	0(0.0	0
Total	800(100.0)	493(100.0)	307(100.0)	623

Kerala Population	29098000

Table -3

Distribution of committed suicide according to sex and reason for attempt

Reason for attempt	Total	Male	Female	M.F.Ratio
Disappointment in life	166	101	65	644
Financial crisis	119	100	19	190
Physical Illness	107	74	33	446
Psychiatric Illness	98	55	43	782
Marital disharmony	63	22	41	1864
Alcoholism	36	36	0	--
Unemployment	10	10	0	--
Family conflict	17	8	9	1125
Failure in exam	5	3	2	667
Can't have children	8	2	6	3000
Death of a family member	7	2	5	2000
Broken love affair	10	1	9	9000
Marriage not getting fixed	5	0	5	--
Unidentified	149	79	70	886
Total	800	493	307	20604

DISTRICT BASED SUICIDE PREVENTION PROGRAMME FOR THRISSUR

Back Ground

Mahathma Gandhi had a clear vision about how democracy should function. He advocated for administration by the people in the locality and named it Panchayathiraj. Bold initiative for implementation of this system came from Late Prime Minister RAJEEV GANDHI and actual implementation tried by Left Democratic Government in Kerala. ' Peoples' Plan Campaign for IX th Five year Plan ' under the leadership of late Sri E.M.S. NAMPOOTHIRI- PAD gave opportunity for the Common man to formulate developmental plans; which could be worked out, as 40% of state budget was transferred to Local self Governments. Mental Health Programmes happened at Ponnani Block Panchayath-one of the most backward areas of the state-are the best example. Based on public demand and pressure, a two days workshop of subject experts, mental health professionals, grass root level activists and peoples' representatives were convened and a document (Appendix) was prepared listing 10 action programmes. (MANOJ KUMAR THERAYIL & PRAVEENLAL 2000).

Suicide rates are high in Kerala in past decades (Table 1) Family suicides in which the entire family committing suicide is a recent phenomena perhaps noted only in Kerala. Kerala Research Programme on Local Level Development, supported a study of this phenomena (NAIR.K.N. 2001) and the review literature and gathering of secondary data enabled a group of Mental health professionals to prepare back ground papers and draft programmes for the activists to deliberate upon.

On several socio -demographic factors and health profile, Kerala is different from India as a whole (PRAVEENLAL 2000). The ' user- provider combined initiative' (SHAJI et al 2001) for getting the Government declare a Mental Health Policy is unique in itself. Mental health professionals as a whole enjoy a good acceptance among public.

Triggering event.

On 7th July 2000, 7 members of family died of suicide using cyanide. Members included grand mother to children. Shock waves passed through the peoples on realising it. Media men initiated a small gathering which was attended by then District Collector (Mr. ALKESH KUMAR SHARMA) on his own. It was decided on 'actions against suicide' and called a meeting of 'people with concern'.

Launch of the programme.

The programme was launched on 18.8.2000 formally. But for an appeal to the public through newspapers and local cable TV net-work, there was no mobilisation. Even then, the town hall, where the meeting held, was fully packed. Mr. V. R. KRISHNA IYER, former Justice of Supreme Court of India inaugurated the meeting. Leaders and activists from all the areas ranging from relegious leaders to Scientists, artists to critics and leaders to common men. The massive gathering resolved to enter into activities to counter the rising suicide rates.

Following the programme, a core committee was formed which decided on three objectives-increase public awareness, increase case identification and referral and gear up the Health care and N G O sectors to receive the referrals and offer care.

Action plans.

The following specific action plans were decided .

1. To train family doctors.

A family doctor should be able to identify high risk group, recognise warning signs, start initial interventions, decide on cases for referral and manage depression by himself/herself. Appropriate training to be given to family doctors inorder to achieve these targets.

2. To train public Health nurse.

A public nurse should be able to identify high risk group, recognize warning sign, refer to appropriate agency, ensure follow up and do postvention where suicide took place. Appropriate training to be given to public health nurses to achieve these targets.

3. To train school teachers.

A child spends lot of time in the school and teacher is able to interact with child regularly at least for 10 months. A teacher should be able to recognize warning signs, decide on referal at appropriate time and impart life skill education. Approprite training to be given to school teachers to achieve these targets.

4. To organise campaigns.

General awareness compaigns to be organised at as many places as possible in order to raise a public opinion against suicide. Encourage as many organisations as possible to include suicide prevention activities in their agenda.

5. To organise a workshop for media men to encourage positive reporting.

Influence of media and style of reporting on the suicide is without any doubt .Mediamen are concerned about the issue. It was decided to encourage a procees by which 'self - restraining guide lines for positive reporting' comes from within the media

Activities done

Activities on all the targetted areas did happen with varying coverage. Six work shops were conducted in which teachers, policemen,christian life community leaders, social activists, youth leaders and women's leaders were trained (table-2). Family Physicians (70), Public Health Nurses (263) and Nurse's tutors (23) were trained.(Table-2)

11 public meetings were organised at different regions of the district. Those had participations of relegions leaders, Cine superstars, Novelists etc.

Based on opinion survey among general public, a group of media men and mental health professionals worked together and prepared a draft proposal. This was presented as back ground paper in a one day work shop of media men and a set of suggestions were prepared.

Nine Hospitals (of which six in private sector) started suicide prevention centres. A committee was formed in the collectorate to help those in extreme debt trap.

Uniqueness of the programme

This District Based Suicide Prevention Programme is not a Government programme. It is not an NGO initiative or a research project. There is no strict organisational set up and no resources were mobilised for the sake of it except small contributions then and there; as and when the activity happens.

Peoples felt need and silent demand; professional's willing involvement; administration's patronage and leadership-- when these three simultaneonsly existed, it was just a natuaral happening.

Impact.

The impact of the programme on suicide rates are not yet analysed . An evaluation was not predesigned and it may be too early to measure the impact. A crisis management centre in the district head quarters who run a telephone service (Maithry) reported more callers and volunteers contacting them. Local self Governments had more demands for programmes in their area. Police had organised a compaign in their area on their own ;following a family suicide and reports they have not registered any similer incident after that. Reports on suicide in news papers now retracted to inner pages without any fine details and glorification. In group meetings, especially in women's groups, participants started expressing openly their post suicide attempts and experiences surrounding it Perhaps stigma is becoming thinner.

TABLE 1 : SUICIDE RATE/LAKH POPULATION.

YEAR	INDIA	KERALA
1975	7.1	18.22
1980	6.3	14.9
1985	7.1	22.1
1990	8.9	26.3
1995	---	26.1

TABLE-2: ACTIVITIES DONE. (TRAININGS)

S;NO	PARTICIPANTS	DATE	NUMBER
1	TEACHERS	26.8.2000	160
2	POLICEMEN	2.9.2000	94

3	CLC LEADERS	16.9.2000		38
4.	SOCIAL ACTIVISTS	19.9.2000		69
5.	YOUTH LEADERS	8.10.2000		98
6.	WOMEN LEADERS	--.11.2000	*	481(8Centers)
7.	FAMILY PHYSICIANS	20.9.2000		70
8.	PUBLIC HEALTH NURSES	22.9.2000		263
9.	NURSES TUTORS	18.12.2000		23

* Different days in the month of November.

METHODOLOGY

An act of ending life involving more than one person in a family secondary to the desire to end life by atleast one person is the working definitions used in this study.

The incidents of family suicides happening in three districts of Kerala during the period of 1st January to 31st December 2000 was scanned through three sources. The media reports were followed, the forensic sources were monitored and on NGO net work with grassroot level workers in Kerala (Kerala Sasthra Sahithya Parishath) were in touch regularly.

On receiving any information, a field assistant had gone to the site at the earliest. He had traced the route properly, contacts were established with key persons in the locality and preliminary information's were collected.

The field investigator then visited the scene within a period of 14 days and collected information's using specially designed proforma (Appendix).

It collected event details, prior warning signs, possible causes, socio-economic status, family integration, personality disorder, possibility of mental and physical disorders.

The collected data were compiled and analyzed. As the numbers are too small and no controll groups are available, any statistical analysis were not attempted.

OBSERVATIONS AND RESULTS.

The information about Family suicides were collected from the Kerala State Crime Records Beuro. The data for the year 1998 and 1999 were available. No separate data were complied or collected prior to 1998 regarding the family suicide. Hence it cannot be commented when was the first incident happened in Kerala.

Table - 1

Incidence of Family Suicides in Kerala

Year	No. of Incidents	No.of persons involved	No.of Males involved	No.of females involved
1998	25	68	30	38
1999	20	59	29	30

The details available in the Kerala State Crime Records Buero is presented in Table 1. In the year 1998, 25 incidents of family suicides happened in Kerala involving 68 persons. Among the people involved, 30 were males and 38 were females. In the year 1999, 20 incidents happened, involving 59 persons among whom 29 were males and 30 were females.

The present study was carried out during the year 2000 from 1st January to 31st December. Three districts were considered for this study, primarily considering the convenience. Ernakulam, an industrial district, Thrissur, the cultural capital and Palakkad one of the backward districts of Kerala were included for the study. During the study period, 31 incidents of family suicide happened in these districts. Details are given in Table II.

Table II : An over view of family suicides studied.

Period of study	1st January to 31st December 2000
Study Area	3 out of 14 districts.
Total incidents	32

Distribution of Persons involved in family suicides according to gender and age are given in Table III.

Table III. Distribution of persons involved in family suicides according to gender and age.

Age group	Total	Male	Female	M.F.Ratio
Up to 19	36(36.4)	19 (40.4)	17(32.7)	894.7
20-39	35(35.4)	11(23.4)	24(46.2)	2181.8
40-59	22(22.2)	13(27.7)	9(17.3)	692.3
60 and above	6(6.1)	4(8.5)	2(3.8)	500.0
All. ages	99(100.0)	47(100.0)	52(100.0)	1106.4

A total of 99 persons were involved of which 47 were males and 52 were females. Those below 19 years constituted the highest proportion followed by 20 to 39 age group. 40 to 59 age group were comparatively smaller and those above 60 years were very few. For males, below 19 years were very high proportion while for females it was 20-39 age group. The MF ratio indicates a general trend towards higher figures for females, but this was evident in group 20-39 only. For all other age groups males outnumbered women.

Distribution of persons involved in Family Suicides according to gender and mode of attempt is shown in table IV. Poisoning showed the highest frequency (69.1) This was true for both males and females. Drowning followed (14.4%). This was true for both the genders.

Table IV: Distribution of persons involved in Family suicides according to gender and mode of attempt.

Mode of attempt	Total	Male	Female	M.F.Ratio
Poisoning	69(69.1)	32(71.7)	35(66.7)	1096.8
Drowning	14(14.4)	6(13.1)	8(15.7)	1333.3

Burns	8(8.2)	3(6.5)	5(9.8)	1666.7
Hanging	6(6.2)	4(8.7)	2(3.9)	500.0
Wrist slashing	2(2.1)	0(0.0)	2(3.9)	---
All methods	99 (100.0)	47(100.0)	52(100.0)	1108.7

For other methods, the figures were single digit numbers. There is a difference in gender as more men selected hanging while females selected burns. Wrist slashing was resorted by females only.

Distribution of Family Suicides according to presence or absence of suicide notes are given in TableV. In about half of the incidents, suicide notes. were left by the persons involved in the act

Table V: Distribution according to the presence of suicide note

Status of suicide notes	N	%
Present	16	50.0
Present	16	50.4
Total	32	100.0

The Distribution of family suicides according to presence or absence of Mental Illness is given in Table VI. 0nly In 5 instances, (15.6%), there was evidence for the presence of any previous mental illness. In 27 instances (84.4%) there was no evidence for the presence of any mental illness.

Table VI: Distribution according the presence of Mental Illness.

Mental Illness	N	%
Present	5	16.1
Absence	27	83.9
Total	32	100.0

The distribution of family suicides according to presence or absence of physical illness is given in table VIII. In 7 instances (21.9%) at least. one person had a physical illness.

VII: Distribution according to presence of physical illness

Physical illness	N	%
Present	8	22.6
Absent	24	77.6
Total	32	100.0

However for 25 instances (78.1%) , there was no such finding.

Distribution of family suicides according reported or to percieved causes is given in table VII. Financial crisis formed the main reason as it was appreciated as reason in 11instares (34.4) .

Table VII: Distribution according to causes

Causes	N	%
Financial crisis	11	34.4
Family Problems	8	25
Mental Illness	5	15.6
Physical Illness	4	12.5
Objection to Marriage	2	6.3
Wish to die together	1	3.1
Unwed Pregnancy	1	3.1
All reasons	36	--

In 8 instances (25%) family problems were the cause. In 5 instances (15.6%) it was mental illness, while for 4 instances (12.5%) it was physical illness. In 2 instances (6.3%) relatives' refusal to approve wish to marry were quoted as the cause for committing suicide. Wish to die together and unwed pregnancy were quoted as reason in one each instances.

Distribution of family suicides according the change in socio-economic status when compared to prior generation is given in table VIII. It shows in 30 instances (93.8%)

Table VIII: Distribution according to change in socioeconomic status when compared to prior generation.

Status of SES	N	%
Changed	2	6.2
Not changed	30	93.8
Total	32	

the socio-economic status of the deceased were same as those of their parents only in two instances (6.2%) there was a decline in the socio-economic status of those who died in comparison with the respective status of their prior generation.

Distribution of family suicides according to status of living is given in table IX. According to the information received from key informants in 16 instances, (50%) family was leading a life at the optimum level. In 3 instances (9.7%) the index family was leading a life which is lower in status than could be afforded.

Table IX: Distribution of family suicides according to status of living.

Status of living	N	%
Optimum	16	50
Higher than could be afforded	13	40.6
Lower than could be afforded	3	9.4
Total	32	100.0

Distribution of family suicides according to presence or absence of warning signals are given in table X. In 12 instances (37.5%) warning signals were given by atleast one of those who involved in the act. This was in terms of active expression of the suicide intent to near and dear. In 20 instances (62.5%) there was no such signals were evident.

Table X: Distribution according to status of warning signals

Warning Signal	N	%
Given	12	37.5
Not given	20	62.5
-Total	32	100.0

Distribution of family suicides according to the persons who decided on the act is given in table XI. In 17 instances(53.1%), both father and mother took decision jointly. In 10 instances (31.3%) it is mother who took the decision and in 4 instances (15.6%) it was father.

Table XI: Distribution according to the persons who decided on the act

Instigator	N	%
Both father and mother	17	53.12
Only mother	10	31.25
Only father	5	15.6
Total	32	100.0

Distribution of family suicides according to the death and survival of involved persons is given in table XII. Out of the total 99 persons involved 84 died (84.8 %) and 15 survived (15.5%)

Table XII: Distribution of family suicides according to death and survival of involved persons.

Status	Total N %	Died N %	Survived N %
Instigator	49(100.0)	43(87.8)	6(12.2)
Victim	50(100.0)	41(82)	9(18)
All involved	99(100.0)	84(84.8)	15(15.2)

Among the total of 49 instigators 43 died (87.8%) and 6 survived (12.2%). Among the total of 50 victims, 41 died (82%) and 9 (18%) survived.

There was a time gap between the incident of committing suicide and others coming into the knowledge about it. Details of its is given in the table Table X111. In most of the instances (56.3%) the incident came to the knowledge of some body within 6 hours. In quarter of instances, it took more than 6 hours for identification of the incident. There is no report that it took more than one day for the recognition. However, in 6 instances (18.8) the time gap could not be clearly calculated, as the exact time of death is unknown. Only the Postmortem would give the answer. But due to Medico-legal reasons, the postmortem reports were not available for the study.

Table: X111 Distribution of incidents according to the interval between time of act and others recognising it.

Duration of Interval	Number of incidents N	%
Less than 6 hours	18	56.3
More than 6 hours but less than 24 hrs	8	25.0
More than 24 hours	0	0.0
Unspecified	6	18.8
Total	32	100.0

Distribution of incidents according to the persons who identified the act is given in table X1V. In 18 instances, it was a relative who identified the fact (56.3%). In 12 instances (37.5%) it was a neighbour and on 2 instances it was a servant or workers in the hotel who identified it. Relatives or neighbours went to the house to check as the family members were not seen outside.

Table XIV: Distribution of incidents according to the persons who identified the act.

Person identified	Number of incidents	
	N	%
Relatives	18	56.3
Neighbour	12	37.5
Others	2	6.2
Total	32	100.0

Table XV: Distribution of incidents according to the presence of warning signals

Status of warning signals	Number of incidents	
	N	%
Present	12	37.5
Absent	20	62.5
Total	32	100.0

Distribution of incidents according to the presence or absence of warning signals is given in table. In 12 instance (37.5%) , there was clear warning signal atleast to one persons who. But either they rejected it as a silly joke or ignored as non important. In 20 instances (62.5%) , there was no warning signals. The details of warning signals is given in table. Out of 12 incidents of family suicide, where warning signals were identified, in 8 of them direct expression about the desire to commit suicide was mode to a relation (66.7%) . In 3 of the incidents (25%), it was direct communications to neighbours friends. In I case (8.3%) it was indirect communications to the auto driver who was lived immediately prior to the act. HC was told that there wait be any further chance of meeting again.

Distribution of family suicides according to the nature of home environment and interpersonal relationship pattern represented in tables. (home environment) and part B (interpersonal relations at home) were used. Responses on all the items were not available for all the respondents, and for many a cases responses available on more than one item.

Table XV11 Distribution of incidents according to the reported attitude towards home by involved elders.

Attitude.	N	%
1. Inability to be happy at home	20	62.5
2. No peaceful place at home	16	50.0
3. Over work at home	2	6.3
4. Financial strain causing distress	15	46.9
5. Not happy to invite other to home	8	25.0
6. No bore don at home	10	31.3
7. Relations influence have decisions	4	12.5
8. Waits house to be more clean	0	0

9. Consider neighbors as good people	17	53.1
10. Ashamed of one's home	10	31.3

Table XV111.Distribution of incidents according to the reported information regarding inter personal relatives in the home.

Inter personal relations.	N	%
1. Quarrelling parents	12	37.5
2 Difficulty to get along with siblings	4	12.5
3. Consider spouse not understanding	1	3.2
4. Happy and playful family	15	46.9
5. Friends of children not forbidden from being invited	8	25.0
6. Frequents quarrels away in matter	12	37.5
7. Not expressive of love and affection towards each other	3	9.4
8. Only weaknesses are considered and strengths of other in the family	2	6.3
9. Fights everyday at home	10	31.3
10. All members take food together	9	28.2.

In 20 instances, it was reported that it was unable to be happy at home (62.5%). In 17 instances, it was reported that neighbours are considered as good people(53.1%). Have was not reported to be a peaceful place in 16 instances (50%). Financial strains were causing distress in the home in 15 instances(46.9%). It is reported that there was no peace at home in 10 instances(31.3%), and equal number of instances where are was ashamed of one's home. In 8 instances, (25.0%) it was reported that they were not happy to invite other to their home. In 4 homes, it was reported relatives who are not living with them influence the home decisions. Only in 2 homes (6.3%), other reported there is evidence for over work.

It was reported that 15 homes involved in the incident was thought to be happy and playful among themselves. In 12 families parents were reported to be quarrelsome And the used to be frequent quarrels. Were, almost in every day affair in 10 families (31.3%). In a families (28.2%) it is reported that all the members took food together regularly. But in 8 families (25.0%) children of the household is instructed against inviting their friends home. In 4 families (12.5%) there was obvious difficulty in getting along with siblings and in 3 families it appeared to other that they are not expressive of love and affection towards each other(9.4%). It is reported that in two families, only weakness of others are considered and strength of other in the family are overlooked(6.3%). In one family the head of household was considering the spouse not understanding him.

Table X1X Distribution of incidents according to immediate impact onsurvivors and relatives.

Status of impact	No;of incidents Total	survivor	relative
Worry about stigma attached	5	4	1
Worry about withdrawal of one self due to shame	1	1	-
Worry about lack of support in future	4	4	-
Guilty (couldn't realise warning sign)	1	1	-
Guilty (could not help to avoid it)	6	5	1
Guilty (didn't realise seriousness of stress)	2	1	1
Angry as even children not spared	5	3	2
Angry as ruined the whole family	6	4	2

The impact on the survivor and relatives are given in table. Responses on this aspect was not available in all the cases. Only in 10 incidents, the data was available. In 22 of them, the information was not

available as the appropriate responder was not traceable, available or unable to co-operate with a response. 6 of them were angry as the whole family is received. 6 of them (5 survivors and 1 relative) feltguilty as the responder could not help the instigator to avoid the incident. 5 respondents (4 survivors and 1 relative) were married about the stigma attached to it. 5 were angry (3 survivors and 2 relatives) as even the young children were not spared. 4 survivors were married about future support from other due to death of near and dear ones including the wage earner and the possibility of others distancing from the survivor due to taking part in the act. 2 of the responders(1 survivor and 1 relative) were guilty as they and they did not realise the seriousness of the stressor. One was feeling shame and was warned about the resulting withdrawal and another was guilty as the person could not realise the warning signs.

Discussion:

No information regarding the incidence of family sucide could be gathered from official data bases. From the available sources family suicides happened in Kerala since 1998. Either it could have been the first report or perhaps there was no practice of collecting data under the category of family suicide. A literature search showed no reports regarding family suicides from anywhere in the world. There are reports about suicide parts or collective suicide of masses on extreme (religious) beliefs (eg: follows of Jim Jones in USA). During the study period there was one report in print media from Bombay description suggestive family suicide.

However this incident was about a Malayalee family. It can be presumed that family suicide is a phenomena seen in people of kerala origin only.

During 1998 and 1999 there were 25 to 20 incidents in the whole state of Kerala. However during the study period of the year 2000, 31 incidents happened in the study area which comprised only 3 districts out of a total of 14 districts of Kerala. The rise in the number of incidents appear alarming.

The overall M:F ratio was 1:1:1, this is similer to corresponding figures of suicides in Kerala. As the figures include both commiters and attemptors, it is difficult to comment whether it is closer to figures of commiters or attempters. A look into the gender ratio across various age groups revealed on finding. For all the age groups involved females tends to be lessor, ranging from 1:0.5 to 1:0.8, except for 20-39 age group which showed a M.F.ratio of 1:2.9. It appears women in the age group 20-39 readily acted on the decision to end life without hesitation. They would have either decided on their own or agreed to their spouses decision. This willingness to consider suicide as on option is less marked in the females of all the other age groups.

Poisoning was the most common mode of attempt. Lack of any policy for pesticides, easy availability and no violence involved could be the reason for this preference. Ease in mixing with tasty eatables or drinks make it each to administer to children. Drawing followed in the order of frequency though for believed. Only very few resorted to burns, hanging and wrist slashing. Though it may appear very difficulty, a mother hand hanged her child before she herself commit suicide by same method. Gender differences are evident as the highest ratio inn favour of women was for burns, followed by drowning and poisoning. Hanging had a M:F ratio in the reverse direction. Now firm conclusions could be drawn from this observation as the selection of the mode of attempt would have been the decision of instigator rather than the victims of suicide.

In about half of the instances, the diseased had left suicide notes. This had made identification of causes easy. But in other half suicide notes were not left, the reasons leading to the suicide were at least to be assumed from the circumstantial evidences and perceptions of key informants.

Only in 16.1.% of instances there were evidences for the presence of mental illness in at least one who was involved. This appear important. Mental illness is unable to explain the phenomena of family suicide. This should be appear important. Mental illness is unable to explain the phenomena of family suicide. This should be a pointer while planning intervention strategies. Similar is the status of physical illness. It is the absence (77.6%) of it which was prominent.

Financial crisis formed the most frequently reported cause (35.5%). This was followed by Family problems (25.86), Mental illness and physical illness combined formed the cause in 25.8% of instances. In two instances, it was objection to marriage. The conditions with highest frequency forms a pointer towards the possible non biological causation for the occurrence of the phenomena of family suicide. Lack of presence of mental illness in the study instances supports this finding. The financial crisis could arise from economic factors existing in the society. Financial mismanagement at the individual level also could be a reason. Family problems in kerala families is even other wise evident, from the rising figures of divorces in Kerala. Strain on the kerala women who has to take up the triple role of working women, homemaker and cover of children could be a factor behind it. Kerala women gaining shoulder to shoulder status with men in literacy could be giving confidence for women to rebellion instead of succumbing.

In great majority of instances(93.5%) the socio-economic status of the index family was not below the socioeconomic status of their parents. It is noteworthy as the most commonly encountered cause is financial crisis. Perhaps the discrepancy between desired and attained socioeconomic status may be important rather than the actual status. It appears the involved persons were not ready to be satisfied with the socio-economic status of their own families of origin. Only in 15 instances (48.4%) they were maintaining a living status based on the affordability. In 3 instances, they were maintaining a living status higher than could be afforded. Living standards were not tailored according to the extend of income, but set at a desired level ignoring the available resources. Perhaps there two observations - setting a desire well beyond the level of family of origin and maintaining a higher living status above the affordability level - are the most important especially when the financial crisis emerged as the most frequently mentioned cause for committing suicide.

Warning signals were evident in 16(51.6%) instances. Before the attempt, at least in half of the instances, the distress was presented before others perhaps as a last resort to seek help. The people around either did not appreciate the actual meaning or ignored it. For example in one incident, when people in the locality come to know about an incident they instantly knew which family was informed. They were expecting this to happen one day.

From the preliminary findings, bread winner of the house and his jointly took decision in 17 instances (54.8%), while body of the house hold took decision in 10 instances (32.3%). A male member above took decision only in 4 instances (13.0%). Where as 21 males were involved in the decision to end life, the corresponding figures was 27 for the women. It happens, which it comes to the decision of ending life only oneself, role of women is prominent. This prominence may be one factor which explains the involvement of children in the act. A mother insisting to caring the child wherever she goes is part and parcel of child rearing in our region. Perhaps during the period of strain, woman may be regressing to a state when she was looking after her toddler. Regression at the time of stress is an ego defuse mechanism.

Out of 97 persons involved 82(84.5%) died. This is no major difference in the death rates among instigators or victims. When survival rates depend on the lethality of the method used, time to reach medical care facility and the efficiency of the care delivery system; the status of instigator or victim has no role in the outcome.

In most of the instances (18 instances 56.3%) the incident was recognised by others within six hours. Another 8 instances were recognised later than six hours, but before 24 hours. In six instances the exact time gap could not be ascertained as the time of death was not evident. However in no cases it took more than 24 hours. In all cases the incident was identified before passing of a day. Only the night time was elapsed. This indicates that the index family was not totally sealed off from others and other felt the freedom to enter into the house where familiar family members were not observed to be engaged in family chares as usual. The observation that relatives (18 instances 56.3%) neighbour (12 instances 37.5%) and other (2 instances 6.2%) were the persons who identified substantiates the above.

Warning signals were evident in 12 instances (37.5%). The involved persons had presented their distress before other and perhaps as a last resort to seek help. The studies from else where had reported that warning signals are expressed to family physicians many a times as a nonspecific symptom without any evidence for specific illness. In this study no information is available regarding this aspect. A system where each family is registered with a medical practitioner is not available in our country. It was unable to locate

any family physician, regularly who is approached by the index family for any medical help. In the present study the warning signals were direct expression of the intend to commit suicide. No expression was remembered by others regarding the plan for ending life of the entire family. In the instances, where the desire was expressed, the people around either did not appreciate the actual meaning or ignored it. Perhaps this points to a possible positive effect in reducing the suicide rates, by the Campaigns increasing the general awareness of the public at large and gate keepers of the society in specific.

No firm conclusions can be drawn on the information received on the house environment and interpersonal relations at home. The impressions of others (who responded to the investigations enquiry) could be their perceptions and need not be the actual. In situations where the index individual is non existing, there is no way to get exact information except if there is prerecorded information (as anyother situations).

The index homes were considered as unhappy homes and not considered as a peaceful place. They are ashamed of one's home and unhappy to invite other to their home. On the other hand it is reported that they considered neighbours as good people and the financial strain was causing distress. Relatives living away influencing the family decisions were also reported. If these reports are true, that indicates even the close information about domestic environment is shared with others.

Regarding the interpersonal relation at home, conflicting data is forth coming. They were happy and playful at home (15) and as a habbit all the family members take food together at home(9). On the other hand they were quarrelsome parents (12) quarrels among inmates were frequent (12) and domestic quarrels were a daily affair (10). Friends of children appeared forebidden from entering the house. These contradictory data points to the fact that no generalisable pattern of interactions between family members were evident in the families who committed suicide. Another possibility is that two data is not representative of the actual situation, being influences by the personal biase of the responder. d relatives were angry because the whole family is received. They considered anyone who is related to the died will have to face the bad effects. Some of them felt guilty as they thought if they had taken proper steps at the appropriate the incident could have avoided. Stigma was a cause for concern. History of suicide in the family will lead to others distancing from them. Death of wage earner and near and dear ones, especially in the Context stigma was posing

The survivors an wary for the survivor about one's own future. These were the immediate impacts and could be only a perception of the future. Only a reevaluation after a period of 3 to 5 years is going to give the exact picture of the impact.

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APPENDIX.

PONNANI DOCUMENT.

LIFE SKILL EDUCATION IN SCHOOLS.
PRO-LIFE MESSAGES IN CURRICULAM.
COUNSELLING CENTRES IN COLLEGES.
CME PROGRAMMES FOR GPS BY LOCAL SELF GOVERNMENTS
SENSITISATION FOR THOSE WHO MEET PEOPLE IN DISTRESS.
MEDIA GUIDELINES BY JOURNALISTS.
SUICIDE PREVENTION CENTRES IN DISTRICTS.
NGO INITIATIVES.
AVOID DEBTTRAP & CONTROLL UAFC *

CATALYSE FIGHT AGAINST POVERTY,PAIN & IGNORANCE.

* UAFC-Unauthorised Financial channels.

15,16 JANUARY 2000 THAVANUR
PONNANI BLOCK PANCHAYATH
PEOPLES PLAN CAMPAIGN FOR 1Xth 5YR PLAN

MANOJKUMAR, PRAVEENLAL,
ARAVINDAKSHAN & UNNI.