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Piyush Dholariya

Suicidal tendency in youth in relation to their gender

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Suicidal tendency in youth in relation to their gender

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BY

PIYUSHKUMAR ASHOKBHAI DHOLARIYA

STUDY CENTRE 0901

L.D.ARTS COLLEGE,

NAVARANGPURA, AHMEDABAD – 380009

INDIA

GUIDED BY

HEAD OF THE DEPARTMENT

DEPARTMENT OF

PSYCHOLOGY COORDINATOR

L.D. ARTS COLLEGE

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1. ABSTRACT

Abstract

The suicide rate among children and adolescents in the world has increased dramatically in recent years and has been accompanied by substantial changes in the leading methods of youth suicide, especially among young girls. Much work is currently underway to elucidate the relationships between psychopathology, substance use, child abuse, bullying, internet use, and youth suicidal behavior. Recent evidence also suggests sex-specific and moderating roles of gender in influencing risk for suicide and suicidal behavior.

Suicide is the third leading cause of death among adolescents in the world, accounting for 11% of all deaths to youth ages 12 to 19 between 1999 and 2006 (Minino 2010), and rates of attempting suicide and of suicidal ideation are higher than those of completed suicide. According to the Centers for Disease Control and Prevention (CDC; 2014), each year, 157,000 youth between the ages of 10 and 24 receive medical care at emergency departments for self-inflicted injuries. Data from the 2011 National Youth Risk Behavior Survey show that 16% of youth reported seriously considering suicide, 13% reported creating a plan, and 8% reported trying to take their own life in the 12 months preceding the survey (Crosby et al. 2011). The bulk of existing research on adolescent suicide focuses on psychological explanations and on individual-level risk factors for suicide, including mental health, substance use patterns, and exposure to traumatic life events, such as sexual abuse (e.g., Cash and Bridge 2009; Epstein and Spirito 2010; Hansen and Lang 2011; Molina and Duarte 2006). This work is critical because it identifies individuals who may be at the greatest risk of suicide and provides clear intervention strategies to address individuals'

unique paths to suicidal ideation. However, this approach obfuscates some of the larger (and harder-to-assess) social factors that may be at the root of suicide risk across populations. Social and cultural forces play an enormous role in suicide behaviors (Institute of Medicine 2002)—a perspective dating back to Emile Durkheim's 1897 book Suicide: A Study in Sociology, which characterized the relatively stable rates of suicide within societies as a "social fact" and identified some of the social mechanisms that lead to higher or lower. Suicide is the third leading cause of death among adolescents in the world, accounting for 11% of all deaths to youth ages 12 to 19 between 1999 and 2006 (Minino 2010), and rates of attempting suicide and of suicidal ideation are higher than those of completed suicide. According to the Centers for Disease Control and Prevention (CDC; 2014), each year, 157,000 youth between the ages of 10 and 24 receive medical care at emergency departments for self-inflicted injuries. Data from the 2011 National Youth Risk Behavior Survey show that 16% of youth reported seriously considering suicide, 13% reported creating a plan, and 8% reported trying to take their own life in the 12 months preceding the survey (Crosby et al. 2011).

Keywords: suicide, adolescents, youth, risk factors, epidemiology, attempted suicide

2. INTRODUCTION

Introduction:

Suicide is the taking of one's own life. It is a universal concept and happens all over the world. Ahrens, Linden, Zaske and Berzewski (2000) define suicidal behavior as ranging from feeling that life is not worth living to thoughts of suicide and suicidal acts. According to Durkheim (as cited in Williams, 1997) there are three types of suicide. In other words three categories, which reflect a breakdown in the relationship between the individual and society. Egoistic suicide incorporates the notion that an individual has no concern for their community and no interest in being involved in it. There is a lack of meaningful social interactions and therefore a low level of social integration, as exemplified in urban areas, as opposed to rural areas. Madu and Matla (2003) studied the prevalence of suicidal behaviors among secondary school adolescents in the Limpopo province and found that rates of attempted suicide were highest in urban areas. This fits with the above theory as urban areas and townships are known for low adherence to cultural and traditional values. This causes acculturation, which is the breakdown of family ties and an increase in social misconduct, leading to egoistic suicide. However, this study found no significant relationship between places of residence and plans to commit suicide or attempted suicide. In systems (families) 10 where the boundaries between the system and the surrounding community are impervious, the family becomes isolated from the social environment in which they exist (Barker, 1992). This has potentially negative effects on the adolescent, who is struggling to develop an independent autonomy. Altruistic suicide is when society has a strict hold over the individual, giving the person too little individualism. In this situation the family system has highly permeable boundaries, making the

family and the individuals within the family highly susceptible to events and changes within their wider social environment (Barker, 1992). In both of the above-mentioned cases, the adolescent may have trouble disengaging from the family and developing an independent identity because of either too much or too little influence from the wider social environment. Durkheim defined Anomic suicide as a self-annihilation triggered by a person's inability to cope with sudden and unfavorable change in a social situation (Davison & Neale, 2001). Anomic suicide includes a situation where an individual is socially isolated from significant others. This may occur for reasons including changes in family structures and reduced employment opportunity. The individual does not benefit from societal normative restraints because they no longer participate in society. Although the above are sociological explanations for suicide, they correlate with the reasons and risk factors for suicidal behavior. The above explanations show how the boundaries between the family system and the wider social environment pose challenges to the adolescent living within the family, in terms of building a healthy autonomous identity and disengaging from the family, in order to become an independent individual. The challenges these adolescents face, within the above-11 mentioned scenarios, often result in feelings of hopelessness and helplessness, associated with depression, which in turn is associated with suicidal behavior, including suicide ideation. A study by Huff (1999) identified factors that related to adolescent stress and predicted suicide ideation in these individuals. These factors included depression, family disruption, poor grades and drug and alcohol abuse. These findings are consistent with theory that speaks about the individual being interconnected with their environment and it is a combination of many internal and external factors that bring about stress for the developing

adolescent. Although the link between hopelessness, depression and suicide has been stressed above, it is important to be aware, that the common psychological assumption that depression causes suicide, is more complex than this one-to-one association. Zhang and Jin (1996) speak about a model that integrates individual characteristics (depression and attitudes toward suicide) and social structural characteristics (including gender and family cohesion). This model assumes that suicide ideation is an individual behavior that is influenced by social structure, both directly and indirectly through individual attitudes and behaviors. Suicide ideation is predicted simultaneously by the two characteristics mentioned above. A theoretical model such as this fits quite well with Durkheim's explanations of suicide, involving the individual within a society or community. De Man, Labreche-Gauthier and Leduc (1991, as cited in De Man and Leduc, 1993) found that adolescents from controlling backgrounds reported low levels of self-esteem and high levels of stress, depression and anomie. In a later study by De Man and Leduc (1993) they found that suicide 12 ideation among adolescents was positively related to depression, negative stress, and drug and alcohol abuse and negatively related to self-esteem, satisfaction with social support and school absenteeism. It is evident that risk factors leading to suicide ideation and ultimately suicide, take the form of both individual and environmental factors. It is impossible to isolate one group of factors. The risk factors for suicide ideation among adolescents must rather be seen as interplay of many factors within different areas.

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ideation are higher than those of completed suicide. According to the Centers for Disease Control and Prevention (CDC; 2014), each year, 157,000 youth between the ages of 10 and 24 receive medical care at emergency departments for self-inflicted injuries. Data from the 2011 National Youth Risk Behavior Survey show that 16% of youth reported seriously considering suicide, 13% reported creating a plan, and 8% reported trying to take their own life in the 12 months preceding the survey (Crosby et al. 2011). The bulk of existing research on adolescent suicide focuses on psychological explanations and on individual-level risk factors for suicide, including mental health, substance use patterns, and exposure to traumatic life events, such as sexual abuse (e.g., Cash and Bridge 2009; Epstein and Spirito 2010; Hansen and Lang 2011; Molina and Duarte 2006). This work is critical because it identifies individuals who may be at the greatest risk of suicide and provides clear intervention strategies to address individuals' unique paths to suicidal ideation. However, this approach obfuscates some of the larger (and harder-to-assess) social factors that may be at the root of suicide risk across populations. Social and cultural forces play an enormous role in suicide behaviors (Institute of Medicine 2002)—a perspective dating back to Emile Durkheim's 1897 book Suicide: A Study in Sociology, which characterized the relatively stable rates of suicide within societies as a "social fact" and identified some of the social mechanisms that lead to higher or lower.

Suicide rates across societies. In other words, it is important to recognize that suicide is not only an individual but a societal problem (Stack 2000; Wray, Colen, and Pescosolido 2011). A large body of sociological work has examined compositional and cultural factors unique to particular societies that may help to explain the social determinants of suicide, but few studies

have examined how the gendered social context may enhance or suppress suicidal ideation among adolescents. We aim to build on previous work that documents the influence on suicide mortality of gender composition (Gunnell et al. 2003; Phillips 2013) and the gendered context as a form of social integration (Krull and Trovato 1994; Pampel 1998; Stockard and O'Brien 2002) and in particular on work that considers the impact of the gendered context as a form of social regulation that affects suicide (Aliverdinia and Pridemore 2009; Zhang 2010). In this paper, we use the National Longitudinal Study of Adolescent Health (Add Health) to develop a measure of gendered context that characterizes social differences in the regulating aspects of gender in different U.S. states. We compare this state-level measure to statelevel indicators of suicidal ideation among female and male youth and then examine the differential influence of that context on youth suicidal ideation at the individual level. We find that the most highly gendered states are also those that have the highest rates of suicidal ideation. This suggests a link between overregulation and suicidal ideation and potentially extends Durkheim's thesis beyond enacted behavior to emotional states.

Attempted suicide refers to the failed attempt to take ones life. It is the intention of the individual to take their own life, but for whatever reason, the attempt fails. This differs from parasuicide, which is distress behavior (Pillay and Schlebusch, 1987). It is a cry for help. The individual intends to inflict self-harm upon themselves without fatal injuries. It has been found by, MacLeod, Pankhania, Lee and Mitchell (1997, as cited in O'Connor, Connery and Cheyne, 2000) that individuals who engage in deliberate self-harm irrespective of intention are impaired in their ability to generate

positive future thoughts, when compared to controls drawn from either hospital or non-hospital settings. MacLeod (1992, as cited in Williams and Pollock, 1993) found that while both parasuicide and completed suicide are related to depressive experiences, they differ to the degree of anger expressed. Parasuicide is related to the experience of anger, whereas suicide is more related to giving up. Suicidal people are often poor at solving interpersonal problems. Hopelessness mediates the relationship between depression and suicidal intent within a parasuicide population. Hopelessness has also been found to predict repetition of parasuicide six months later. These results 13 indicate that it is a different population that would commit suicide to those that would commit a parasuicide.

The Suicidality/Depression Link

Psychological autopsy studies have shown a substantial link between clinical depression and suicide in adolescence with up to 60% of adolescent suicide victims having a depressive disorder at the time of death. Similarly, between 40-80% of adolescents meet diagnostic criteria for depression at the time of the attempt Depression is the main predictor of suicidal ideation . In clinically referred samples, up to 85% of patients with major depressive disorder (MDD) or dysthymia (i.e., chronic, but less severe depression) will have suicidal ideation, 32% will make a suicide attempt sometime during adolescence or young adulthood , 20% will make more than one attempt , and by young adulthood, 2.5% to 7% will commit suicide. The association of prior suicidal behavior and depression has been shown to increase the risk for a repeated suicide attempt and suicide.

Recent studies confirm prior research indicating that suicidal thoughts during adolescence significantly increase the adult risk of psychiatric problems, and are the gateway to attempted suicide, and suicide These findings suggest that ameliorating suicidal ideation in adolescence offers hope of reducing acute distress and changing the life course of affected individuals.

Fergusson *et al.* Examined the impact of recurrence of major depression in adolescence on outcomes at ages 21-25 years. Using data from a 25-year longitudinal study of a birth cohort of New Zealand, the authors found a dose-response relationship between the number of depressive episodes between 16-21 years of age and adverse adult outcomes, including suicidal ideation and attempted suicide, even after controlling for potential confounders. These findings suggest that early identification and treatment of major depression may reduce the risk of future suicidal behavior.

Alcohol and Drug Use

Substance abuse (alcohol/drug abuse) disorders contribute substantially to risk of suicide, especially in older adolescent male when co-occurring with mood disorder or disruptive disorders. Recently, Aseltine et al. examined the relationship between heavy episodic drinking (HED) and adolescent suicide attempts. They found that adolescents who were 13 years or younger and who participated in HED were at 2.6 times greater risk of reporting a suicide attempt as compared to those who did not participate in HED. For those youth who were 18 years and older, HED increased their suicide attempt risk by 1.2 times as compared to adolescents of this same age who did not participate in HED. Schilling and colleagues found that drinking while

feeling down resulted in a threefold increase in the risk of self-reported suicide attempts.

Family Factors

Family factors, including parental psychopathology, family history of suicidal behavior, family discord, loss of a parent to death or divorce, poor quality of the parent-child relationship, and maltreatment, are associated with an increased risk of adolescent suicide and suicidal behavior.

Family Constellation

Increasing duration of exposure to a single-parent household before the age of 16 years was significantly associated with higher rates of anxiety disorder between the ages of 21-25 years. Duration of exposure, however, was not significantly associated with suicidal ideation or attempted suicide.

Family History of Suicide Attempt

There is strong and convergent evidence that suicidal behavior is familial, and perhaps, genetic, and that the liability to suicidal behavior is transmitted in families independently of psychiatric disorder. A recent prospective study of early-onset suicidal behavior found a higher relative risk (RR=4.4) of incident suicide attempts in offspring of parents with mood disorders who made suicide attempts, compared with offspring of parents with mood disorders who had not made attempts. Offspring mood disorder and impulsive aggression and parental history of sexual abuse were independent predictors of incident suicide attempts.

Sexual and Physical Abuse

Exposure to child sexual abuse and child physical abuse leads to a significant increase in the occurrence of a variety of poor mental health outcomes, including suicidal ideation and behavior, experienced between ages 16-25. The authors found that exposure to child sexual abuse had a more deleterious effect on mental health outcomes than exposure to only child physical abuse. In another study, approximately 50% and 33% of suicide attempts among women and men, respectively, were attributable to the experience of childhood adversity (physical abuse, sexual abuse, witnessed domestic violence), indicating that even a small reduction in these childhood experiences could have a dramatic effect on reducing the prevalence of suicide attempts in the general population.

When a child experiences both child abuse and parental divorce versus only parental divorce, there is a statistically significant increase in the likelihood of a suicide attempt later in life. This association, however, was attenuated after controlling for parental psychopathology.

Brezo et al. conducted a longitudinal cohort study to determine the relationship between childhood abuse and later suicide attempts. Non-abused children were less likely to have non-fatal suicide behaviors as compared to those who experienced abuse. Sexual abuse by an immediate family member, repeated sexual abuse incidents, and greater severity of abuse conferred an increased risk of suicide attempts.

Salzinger and colleagues followed two sets of urban school children over a period of 4 years (time 1: average age 10. 5 years, n=100 abused and 100 non-abused; time 2: average age 16.5 years, n=78 abused and 75 non-

abused). They found that preadolescent physical abuse was an independent predictor of suicidal ideation and attempted suicide; only internalizing behaviors mediated the robust relationship between physical abuse and suicidal ideation.

Change of Residence

Adolescents aged 11-17 years who frequently moved during childhood were more likely to make suicide attempts during adolescence, and the more often they had moved, the more elevated their risk, even after controlling for potential confounders at birth and during upbringing. There was a dose-response relationship between number of moves and risk of attempted suicide: youth who had moved three to five times were 2.3 times as likely to have attempted suicide compared with those who had never changed residences, while those who had moved more than 10 times were 3.3 times as likely to attempt suicide, controlling for birth order, birthplace, and paternal and maternal factors. Controlling for additional child and parent factors attenuated these specific associations. Analyses of suicide completers revealed a similar association between change of residence and suicide.

Sexual Orientation

Youth who report same-sex sexual orientation are at greater risk than their peers to have attempted suicide, and this risk persists even after controlling for other suicide risk factors, including alcohol abuse, depression, family history of suicide attempts, and prior victimization. A recent study of family response to an adolescent "coming out process" reported that family

rejection or negative family reaction to an adolescent who is gay, lesbian, or bisexual was associated with 8-fold greater likelihood of attempted suicide compared to adolescents who experienced minimal or no family rejection.

Bullying

Klomek and colleagues found that boys who were both bullies and victims of bullying had a higher likelihood of suicidal behavior as compared with those who did not exhibit bullying behaviors or who were only victims. For the girls, there was a different effect of bullying; girls who were victims of bullying were more likely to exhibit suicidal behaviors as compared to those who were neither bullies nor victims. Barker et al. examined the developmental trajectories of bullying and victimization during adolescence on delinquency and self-harm in late adolescence. For both boys and girls, those in the bully-victim trajectory showed significantly higher levels of self-harm than their same-sex counterparts in all of the other trajectories. The girls in the bully-victim trajectory had higher rates of self harm than their male counterparts.

Advances in technology have helped to create a new form of bullying: cyber bullying. Cyber-bullying can occur through emails, texting on cell phones, and posts on internet social sites (e.g., Facebook, MySpace, Twitter) and can be perpetrated by other adolescents or adults, as has been recently reported. At this time, research on cyber-bullying and suicide has not been published.

Rationale:

The rationale behind suicide, which is defined as the intentional taking of one's own life, can be as simple or as complex as life itself. The person who commits suicide may see his or her actions as some sort of solution to a severe physical or psychological dilemma. The Psychology of the suicide is rooted in depression. Therefore, the investigator must take into account the clinical considerations as well as the investigative facts.Oftentimes, a police investigator will find a note indicating that the victim had suffered psychological torment, or was severely depressed. The note might even suggest that he or she believed that suicide was the last resort. Many of the suicide notes I have seen over the years indicate the acute depression of persons who have taken their lives. Depression does not discriminate. It effects the young and old alike. According to Dr. Patrick Cachur of The Centers for Disease Control in Atlanta, Georgia, 30,906 persons committed suicide in 1990. The majority of the cases (approximately 6500) occurred in the age bracket of 25 to 34 years of age. There were 258 suicides among pre-teens ages 10 to 14 years old and there were 6 suicides of children between the ages of 5 and 9 years of age. Ms Sandy Smith, Public affairs Officer for The National Center for Health Statistics, Office of Data Processing recorded 29,760 suicides in 1992 placing suicide as the ninth leading cause of death. Homicide ranked number 10. There are more suicides occurring in the 1990's according to the experts and the rate of suicide among pre-teens and the elderly has significantly increased. Teenage suicides have been described as epidemic in proportion to their representation within society. Periodically, the nation's newspapers and television networks may cover this phenomenon by reporting a series of events including "Teenage Suicide”.

3. REVIEW OF LITERATURE

Review of Literature:

The study concluded that suicidal tendencies of the sample were above average in the present study. In this rapidly changing world and with the growing advancement in science and technology, massive use of social media, mobile phones and due to lack of mature understanding this problem emerged in the society vastly. Minor problems can also force to do something bad to oneself or suicide to rid out from that, instead of finding solution.

- **Study -1: Youth Suicide Attempts in Germany**

The study was done by **Christian Tarchi and Erminia Colucci** on March, 2013. Purpose of the study was the regions showing higher suicide rates for the general population are Sachsen, Sachsen-Anhalt and Thueringen for male; Sachsen-Anhalt, Bayern, Schleswig-Holstein for female (Weinacker et al, 2003; Wiesner, 2004). In Germany, young people with developmental crisis are the fourth group at highest suicidal risk, immediately after people with mental disorders, people with previous suicide attempts and old people isolated and/or affected by chronic illness (Wolfersdorf et al, 2002). Weinacker, Schmidtke and Loehr (2003) reported the highest rates of suicide attempts for the younger groups, especially for young female 15-30 years old. In 1998, 50 children (10-15 years old) and 294 adolescents within the 15-20 years range died by suicide; the attempted suicide rate was eight to ten times higher and attempted suicides were repeated in 25% of the cases (Kirkclady et al, 2004). Blüml (1996) reported that in Germany every day one child and three adolescents take their own life. Furthermore, 40 children and/or adolescents attempt suicide. In the same paper, Blüml showed how youth suicide concerns cities twice more

than the rural areas, affecting especially Berlin and Frankfurt. Moreover, female attempt suicide three times more often than male, but male carry out suicide three times more often than female, mainly because they choose "harder means" (e.g. shooting or hanging themselves). Suicide rates seem to be influenced also by occupation: suicide risk is higher among students than among workers or trainees. In regard to the method, the WHO Multicentre's studies showed that in 25% of the suicidal events recorded in Germany; more than one method was used. The most frequent combination of two methods was drug and alcohol and the most frequent combination of three methods was drug, alcohol and cutting (Michel et al, 2000). 23 YOUTH SUICIDE IN GERMANY World Cultural Psychiatry Research Review 2013, 8 (1): 21-28 Eight out of ten young persons who died by suicide have talked about their decision to someone: therefore Blüml (1996) stated that it is incorrect to think that people who talk about suicide will never do it. The author reported that 85% of people who attempted suicide will attempt it another time, mostly within 12 months; among these attempts, 10% will succeed. Only one young person every ten who suicide leaves a farewell-letter: therefore, it is extremely difficult to explore the reasons for their act.

Conclusion of the study is, the German government has given attention to the topic of youth suicide: the Bundesministerium fuer Bildung und Forschung (Federal Ministry of Education and Research) is carrying out some projects to prevent youth suicide. The most important agency for the prevention of suicide in Germany is the DGS (Note 4), which was founded in 1972 and since then has put efforts to better understand this phenomenon. In 2002, the DGS, in collaboration with the European Network on Suicide Research and Prevention and with the World Health Organization, has

started a National Program to prevent suicide in Germany (Nationales Suizid Praeventions Programm). Although these are very important steps, the causes leading a young German to kill him/herself are still rather unclear, as it is in any other country. In a research on psychosocial wellbeing and psychiatric care in the European community, Carta and colleagues (2004) showed how Germany is last in the ranking of number of child psychiatrist per inhabitants, only 0.9 per 100,000 inhabitants, even though research has shown a connection between suicide and psychiatric disorders .

- **Study – 2 : Gendered Contexts: Variation in Suicidal Ideation by Female and Male Youth**

The study was done by **Kathryn M. Nowotny, Rachel L. Peterson, Jason D. Boardman.** According to Ridgeway and Correll (2004), hegemonic cultural beliefs about gender and their impact on social relations are among the core components that maintain the gender system. The gender system includes social processes that define female and male as different and justifies inequality on the basis of that difference (Ridgeway and Smith-Lovin 1999). When gender is salient, cultural beliefs about gender bias the behaviors and evaluations of women and men in systematic ways. The gender system affects both female and male; though the effects of gender-based regulation may have a greater negative impact on women because of historical and ongoing gender inequalities, the social contexts that youth operate in may not be beneficial for boys, either. There may be more pressure on boys to conform to group masculinity norms to avoid ridicule for nonconformity, so that an adolescent male will act in a manner consistent with gender norms even if those norms do not represent him personally (Chu 2005; Falci and McNeely 2009). Gender nonconformity has many social

consequences, including suicide. For example, Clements-Nolle, Marx, and Katz (2006) found that gender-based discrimination and gender-based victimization were associated with suicide attempts among transgender persons, and Fitzpatrick and colleagues (2005) found that gender roles account for more variation in suicide risk than sexual orientation does.

Conclusion of the study makes a significant contribution by demonstrating the negative consequences for youth who live in contexts defined by restrictive norms about gender attitudes and behaviors. Consistent with feminist literature, we find that restrictive gender norms are more detrimental for female youth than male youth.

- **Study – 3: Youth Suicide Attempts: A Social and Demographic Profile.**

The study was done by **Annette L. Beautrais, Peter R. Joyce, Roger T. Mulder.** Purpose of the study was, the social and demographic characteristics of a New Zealand sample of young people making medically serious suicide attempts were examined and compared with those of a control sample of similar age. The social and demographic characteristics of a New Zealand sample of young people making medically serious suicide attempts were examined and compared with those of a control sample of similar age. Using a case control design, 129 young people making serious suicide attempts were contrasted with 153 randomly selected community controls on a series of social and demographic characteristics including educational achievement, socioeconomic status, income, occupation, religious affiliation and ethnicity. The age and gender distribution of the sample, and the methods of suicide attempt, were examined. Almost equal numbers of young male

(45.7%) and female (54.3%) made medically serious suicide attempts. The clear majority of serious suicide attempts were by overdose or poisoning (78.3%), with tricyclic antidepressants (38.6%) and paracetamol (37.6%) together accounting for three-quarters (76.2%) of all drug overdoses. Young people who were less well educated and who were from lower socio-economic backgrounds had elevated risk of serious suicide attempts. Conclusions: Young people from socially disadvantaged backgrounds have elevated risk of serious suicide attempt.

In many studies suicide is quoted as a leading cause of death among adolescents in the United States. (Kaplan, Feinstein, Fisher, Klein and Olmedo, 2000; Paluszny and Davenport, 1991; Zhang and Jin, 1996). During the past forty years the suicide rate among young people aged between 15 and 24 years in the United States has tripled, while the overall United States population suicide rate has remained stable (Barrios, Everett, Simon and Brener, 2000). In Australia, Frydenburg (1997) states an increase in adolescent suicide in the 15 - 19 age group. In South Africa there exists 14 very little research regarding suicide ideation in adolescents, yet we increasingly hear of suicide amongst adolescents in this country. Figures gathered in 1994 show that in the 15 - 24 age group approximately 8 South Africans (Whites and Indians) per 100,000 commit suicide each year (Wassenaar and Naidoo, 1995). Due to the political situation that existed in South Africa there are no reliable reports of suicide among black or coloured adolescents at that time. Teenage suicidal behavior in South Africa is definitely on the increase (Tshabalala-Msimang, 2003), with an increase of 48 percent in the last ten years (Schlebusch, as cited in Kantiyi, 2003). Shaffer (1986) points out that the stigma attached to suicide and the complex

procedures that lead up to certification may lead to systematic misreporting, especially in the case of children and adolescents. This means that the figures that are reported as suicide rates are merely an indication and that the actual figures are probably higher. The prevalence of suicide and more specifically adolescent suicide within South Africa is high and is increasing at an alarming rate. As pointed out by Peirson (2001) any investigation into suicidal behavior must be extended to suicide ideation as well. It is therefore extremely important that research is conducted to gain a better understanding of adolescent suicide ideation and factors that impact upon it.

Method used in the research was using a case control design, 129 young people making serious suicide attempts were contrasted with 153 randomly selected community controls on a series of social and demographic characteristics including educational achievement, socioeconomic status, income, occupation, religious affiliation and ethnicity. The age and gender distribution of the sample, and the methods of suicide attempt, were examined.

Conclusion of the study was almost equal numbers of young males (45.7%) and females (54.3%) made medically serious suicide attempts. The clear majority of serious suicide attempts were by overdose or poisoning (78.3%), with tricyclic antidepressants (38.6%) and paracetamol (37.6%) together accounting for three-quarters (76.2%) of all drug overdoses. Young people who were less well educated and who were from lower socio-economic backgrounds had elevated risk of serious suicide attempts. Conclusions: Young people from socially disadvantaged backgrounds have elevated risk of serious suicide attempt.

- **Study - 4: Academic stress and suicidal tendency.**

The study was done by **G.S. Venumadhava and Mayuri Sahay**. Amongst the various consequences of academic stress, the most important one is the increased risk to suicidal tendencies. Adolescent suicide is a worldwide problem. (Conner, Duberstien, Conwell, Seidlitz and Caine, 2001). Cole, Protinsky and Cross,(1992), define suicide as "the completed process of a continuum that began with suicidal ideation , followed by an attempt at suicide, and finally completed suicide". The suicide rate in India has been increasing among students. These alarming statistics have stimulated great concern in the public at large and have led social scientists to warn of an impending rise in a number of suicides and suicidal attempts among adolescents.(Watt and Sharp, 2002).

Purpose of the study was what exactly predisposes a child to take a severe measure such as taking one's own life? The search for identity, a neutral stressful demand on youth can be overwhelming to some adolescents and predispose them to thoughts of suicide. Hence, the high incidence of adolescents suicide is assumed to be indicative of societal stress in the lives of young people. (Turner, Kaplan, Zayas and Ross, 2002). Several studies have found that suicide attempts among adolescents tend to increase as stress levels in crease. This may be attributed to academic pressure, work related problems, interpersonal difficulties, death of a loved one, etc. (Butler, Novy, Gagan and Gates, 1994). Poor or an over achieved academic performance can serve as a precursor to stress, subsequent depression and suicide.(Petzel and Riddle, 1981) serious suicide attempts seem to be higher among adolescents who are failing at school. (Henry, Stephenson, hanson and Hargett, 1993). A research was conducted by Petzel and riddle,(2005), to

examine the relationships among stress, self- stress and suicidal ideation late in late adolescents. The study was carried out among a group of college students. The research findings indicated that both stress and self- esteem were significantly related to suicidal ideation; low esteem and stressful life event significantly predicated suicidal ideation.

A. Signs and Symptoms of academic stress including the following:

- A sudden worsening in academic performance
- Isolation; a lack of desire to socialize
- Withdrawal from friends and extracurricular activities
- Open hostility and defiance
- Expressions of sadness and hopelessness, or anger and rage
- A sudden decline in enthusiasm and energy
- Overreaction to criticism
- Lowered self-esteem, or feelings of guilt
- Indecision, lack of concentration, and forgetfulness
- Restlessness and agitation
- Changes in eating or sleeping patterns

B. Conclusion

Whilst we will never be able to eliminate the risk of suicide, we can do some things to reduce the risk:

♣ The Oxford study of student suicide recommended "careful induction upon arrival at university means of alleviating academic stress and worries, and readily available and closely associated student counseling and psychiatric services." Because of these types of counseling it can be prevented.

♣ Counseling facility must be available in every institution their role is important as a teacher.

♣ Avoid making public comments which imply it is 'weak' to seek help

♣ Be sensitive to change in students under your care

♣ Discern the difference between those who are comfortable with being alone, and the isolated or alienated

♣ There is very complex in academic strategy so there is need to work out in that.

♣ By all means challenge and encourage students to achieve their best, but avoid implying that to fall short of some standard (e.g. getting a 1st) would mean utter failure.

- **Study – 5: Suicidal tendency and self-harm among teenagers in the Helsinki metropolitan area.**

The study was done by **Epwene, Samuel**, April 2013 Initially, the adolescents spoke of their fear, anxiety and shame after being referred for a suicide risk assessment. They also indicated the importance of a quick referral and immediate help to deal with their issues, and they indicated that it was important to have one therapist over a consistent period of time in order to establish a sense of trust within the client– therapist relationship

A. Purpose of the study and research question:

1. **Trust:** Initially, the adolescents spoke of their fear, anxiety and shame after being referred for a suicide risk assessment. They also indicated the importance of a quick referral and immediate help to deal with their issues, and they indicated that it was important to

have one therapist over a consistent period of time in order to establish a sense of trust within the client– therapist relationship.

2. **Connection:** The first step in establishing a meaningful relationship with adolescents is connecting with them and engaging them in the relationship. This requires genuine interest on the part of mental health professionals and an ability to set aside their own values and beliefs while allowing adolescents the opportunity to express themselves and tell their story from their point of view. The adolescents' perceptions of what is happening in their lives are vital in determining what their SHB is about. Establishing and maintaining a trusting relationship with adolescents is important in providing an opportunity for adolescents to share their concerns.
3. **Communication:** Active listening requires the therapist to be attentive to the adolescents in order to understand the meaning behind their stories or conversations. It requires listening with an open mind and questioning with genuine curiosity to gain clarity rather than to refute what the adolescent is saying .A non-blaming and non-judgmental approach will gain the respect and cooperation of the adolescent. It is important for the therapist to avoid lecturing, advice giving and nagging .Advice giving often puts people on the defensive and they are less likely to enter into a cooperative relationship (Berg 1994). Lecturing often puts the focus on the problem rather than the solution, and although it may give some relief to the advice giver, it is not likely to accomplish its goal or purpose: changing the behaviour of the adolescent (Corcoran 1998; Mitchell et al. 2003).

4. **Context:** Adolescents bring with them, their own values, believes, hopes, fears and expectations as a result of previous family, social and group experiences. Behaviour is often a means of communication (Halliday & Mackrell 1998), and understanding the message behind the behaviour is vital to guide interventions. Youth are also part of a group or groups within the school and work environment, and membership within these groups also determines behaviour. It is important for mental health professionals to recognize and acknowledge how important membership, and a sense of belonging in a social group within the school environment, is to adolescents and begin to understand their behaviour in context of the expectations of the peer group.
5. **Cooperation:** Behaviour often changes when adolescents have a sense that their opinions, suggestions and recommendations are important. Equally important is recognition of adolescent's hopes and fears in regards to their life aspirations. This recognition promotes an understanding of the challenging behaviour in relation to unmet needs and challenges of the broader environment. A focus on the adolescents' strengths and resources often promotes a shift away from their problems and inappropriate, challenging and self-harm behaviour towards that of participation and cooperation.

B. Findings Result:

The interview with a suicidal person can be a chilling affair. It is not for the faint hearted and clearly is not the job for the novice..... Barker (1997p. 191) Various research methods were used in the studies used these include; Literature review, single blind study, randomized control

trials and questionnaires. Two of the studies published in the Canadian Journal of Psychiatric and Mental Health Nursing. One searched for papers describing randomized and clinical control trials whereas the other reviewed treatment outcome literature including meta-analyses and consultation between practitioners and patients. The purpose of this thesis was to find out how nurses can better assess the risk of self-harm and suicide among teenagers. The four articles reviewed had divergent as well as similar ways on how nurses can intervene on self-harmers. Cutcliff et al(2004, 393–400) projects its ”The Nurses’ Global Assessment of Suicide Risk (NGASR)” as a handy clinical practice assessment tool to help both the experienced and the debutant nurse conduct a better risk assessment of a potential suicide or self-harm patient. They argue that current literature indicates that people with mental health problems are at a higher risk of suicide than the general population. Because suicide is a multifaceted, complex phenomenon, risk assessment within the mental health care system requires a pluralistic, multidimensional and multi professional response. While assessment tools may provide useful guidance, especially guarding against complacency and over confidence, the fundamental basis of risk assessment must involve a thorough examination of the personal, interpersonal and social circumstances of each individ- ual. Such thorough and rigorous assessments, the authors of this paper would add, require a degree of ‘clinical judgment’. As a rule, inexperienced members of mental health care staff should not be charged with the responsibility of conducting suicide risk assessments without sound mentorship. However, with the right support and assessment tool, the novice practitioner might develop the kind of clinical judgment necessary for

this critical task. It is important to point out that as yet, no wide scale, quantitative validation of the tool has been conducted. Therefore, at this point, the tool should be treated with a degree of appropriate caution. In her paper entitled " A brief insight into how nurses perceive patients who self-harm" ,AmyLaura Emerson(British Journal of Nursing, 2010, Vol 19, No 13) points out that self-harming patients attending hospital for problems not relating to self-harm, are perceived negatively (Hawton et al, 2006), and once self-harmers are recognized, their reason for being admitted to hospital is often disregarded. She used some earlier research studies on the perception of nurses towards self-harmers whereby Liggins and Hatcher (2005) and Anderson and Standen (2007) highlighted a major theme: applying the label of mental illness to those who selfharm, with a subsequent negative impact on care delivery. The World Health Organization (WHO) (1993) explains that an act of self-harm does not indicate a mental health risk, and to assume so is politically incorrect. However, the general public still affixes the label of mental illness to someone inflicting pain on themselves. This label of stigma can be destructive and infringe on an individual's life by affecting how they act and how they continue to live their life. It lowers a person's self-esteem, and could result in a more dangerous health concern (Mayo Clinic staff, 2009).Like Nightingale F, said 'The process of repairing the body which nature has instituted, and which we call disease, has been hindered by some want of knowledge or attention' (Nightingale, 1860). Those words of wisdom from the mother of nursing, Florence Nightingale brings me to my core findings of this paper which is buttressed in the works of Murray B & Wright K,(2006) entitled "Integration of a suicide risk assessment and intervention approach: the perspective of youth". They intimated that

inspite of the studies nurses have had, the process of suicide risk assessment is often a challenge for mental health nurses, especially when working with an adolescent population. Adolescents who are struggling with particular problems, stressors and life events may exhibit challenging and self-harm behaviour as a means of communication or a way of coping.

Conclusion

Suicide and Self-harm is common among young adults as in the general population and causes distress and discomfort for them, family, friends and the society as a whole. Necessary service provision should be made available for its management and treatment. Health care professional must be educated well enough to cater for the rising number and cases of self-harm. The hospital management should be organized in a manner that necessary or rather further diagnosis are made by a mental health professional before discharge of a client. Follow up is advised as a way of showing care and encouragement to the client therefore reducing the chances of repeated self-harm. Careful attention should also be given to process evaluation to determine what hinders or helps the delivery of interventions in clinical settings. Addressing methodological limitations inherent in the study of interventions designed to prevent selfharm in young adults will facilitate better practice in the delivery of care in clinical settings.(Burns et al,2009).

Combination of pharmacological and therapeutic interventions is seen to be an appropriate measure only if medication is given during a dangerous situation. Therapeutic interventions should be carried out by trained personnel in order to achieve better treatment. However there maybe

challenges to the self-harmers due to the limited number of trained psychologists and therapists. This is so depending on the location and the need or severity of one's problem. The literature highlights the significance of management and intervention of young people who self-harm and this is an important clinical area hence the need for the clinically valid research-based evidence. Indeed policy makers and public alike need a more clear understanding of self-harm in young people than ever before. (Anderson et al, 2004).

- **Study – 6: Depression and suicidal behavior.**

The study was done by ***M. Wolfersdorf***, *Ravensburg, Germany*. Purpose of the study of the literature dealing with the connections between mental illness and suicidal behavior brings to light the fact that most authors are specialized in the fields of depression research and therapy and only few have examined suicidal tendencies in relation to schizophrenia (e.g. Roy, 1986; Schüttler et al., 1976, Wolfersdorf & Felber, 1995). And this in spite of the fact that most people seem able to correlate the suicidal tendencies of depressive patients with their close proximity to disparagement and sadness. Indeed, people find these tendencies comprehensible within the framework of an inner depressive logic governed by loss, hopelessness and feelings of inviability. Suicidal behaviour in schizophrenic patients, on the other hand, is often regarded as incomprehensible, impulsive and having its origins in psychopathologic factors, thus rendering it unpredictable and impossible to prevent. The important role, however, played by depression in the suicidal tendencies of schizophrenic patients was established by, among others, Roy (1986) and our own group (Wolfersdorf, 1995).

Depressive disparagement, cognitive reduction limiting thoughts to those of insufficiency, worthlessness and guilt, attitudes of despair and helplessness in relation to chances for future improvement are the reason that depressive patients develop stronger suicidal tendencies than all other groups. The question is now raised whether these tendencies develop as a phenomenon independent of the depression itself or whether there is a direct causal relationship. If one assumes the position that suicidal tendencies can be regarded as an attitude and behaviour that are primarily non-pathological and common to all human beings, then it must be possible to identify specific pathogenetical appearance and developmental patterns for these suicidal tendencies. In this case, the role attributed to the depression would be one of an additional psychopathological factor acting to considerably increase the probability that ubiquitous wishes for death and peace are responsible for transforming suicidal ideas into suicidal behaviour.

The suicidal tendencies of depressive-melancholic cases are best analysed using a developmental model incorporating psychophysical triggers, both acquired and constitutional aspects of personality including physical illness, as well as factors originating in the socio-cultural environment. This permits the integration of psycho-dynamic, inside-psychological, psychiatric-biological and social points of view. Current psycho-biological models regard a defective central impulse control as the cause for suicidal behaviour, which is accompanied by serotonin metabolism dysfunction in the central nervous system. Psychiatric and psycho-pathological approaches describe the status of despair and cognitive perception disorders in depression or schizophrenia, but also in crisis-related psychic limitations. Sociological approaches refer to the importance of the aspects of anomie in

society and the difficulties of social integration of the affected groups (for an overview see Maris, 1986; Blumenthal & Kupfer, 1990; Wedler et al., 1992). In the light of aetiopathogenetic and developmental points of view, the following aspects are of importance in the current discussion concerning suicidal tendencies:

- Suicidal ideas: May appear just as well in healthy people, however, acquire a pathological status when they occur in the context of illness, e.g., depression or physical illness.
- Biological readiness to act (impulsivity): This refers to a neurobiochemical and genetic disorder involving impulsiveness and behaviour control, which manifests itself on the neurobiochemical level mainly in a central serotonin disturbance (Praag, van., 1986), peripherally in an electodermal hyporeactivity (Edman et al., 1986; Keller et al., 1991; Wolfersdorf & Straub, 1994). In certain circumstances, this biological readiness to act can also be activated by psycho-social or psycho-dynamical means, however also by biological, i.e., medicamentous means. As an example, see the discussion on ``suicide promotion'' caused by anti-depressants.

Conclusion of the study was If one were to attempt to evaluate the clinical and psychopathological data gathered in studies and from the literature on depression and suicidal tendencies, the following psychopathological phenomena (Table 6) can be retained with a certain degree of certainty as signs of an increased suicidal risk (``risk psychopathology''): thoughts of worthlessness, guilt; pronounced despair (in particular in combination with tendencies of self-punishment and pseudo-altruistic motives of freeing the world of their own person because of being a

burden to others); depressive delusions, in particular delusions of guilt or culpability with self-punishment tendencies; agonising restlessness and psychomotor agitation; panic attacks and generally acute states of anxiety; and altogether strongly pronounced depression (melancholic, psychotic depression). In addition, the occurrence of suicidal behaviour in the current or past case history is equally a sign of a greater risk of suicide.

Depressive patients form a high-risk group for suicidal behaviour. As a matter of principle, one should always presuppose suicidal tendencies in the case of depressive patients until these have been excluded in a comprehensible and credible manner -- as far as this is possible. In the case of insistent suicidal tendencies, it is necessary to apply the correct therapeutic care measures such as reassuring care (in-patient or out-patient treatment and crisis intervention), increased empathetic contacts (control aspects and communication), psychotherapeutical crisis intervention and psycho-pharmaceutical therapy of the underlying illness and anxiolytic-sedative medication.

The psychopharmacological and psychotherapeutical fields that have improved the treatment for people suffering from depression in the last decades that the number of suicide deaths has, on the whole, barely retreated. This is possibly less a therapy-related problem than it is a problem of the timely and correct diagnosis of depressive and suicidal tendencies, and this, more likely than not, at the level of out-patient treatment and general practitioners. Psychologists and psychotherapists, however, cannot be left out here either.

4. SIGNIFICANCE OF STUDY

Significance of study:

Suicide and suicidal behavior among adolescents and young adults is a significant social and psychological problem. In a review of worldwide trends of suicidal behavior, Diekstra (1993) found that the majority of suicide attempts are made by individuals below the age of 35. A study of suicide and suicidal behavior in Canada found that ten percent of adults made a suicide attempt in their lifetime while thirteen percent made plans for suicide (Ramsay & Bagley, 1985). Despite these rates and the amount of research conducted in this field, surprisingly little is known about the experience of being suicidal. While demographic variables may be useful in identifying at-risk groups, they provide little in the way of meaningful understanding of the suicidal individual (Hendin, 1991; Lester, 1994; Shneidman, 1987). Krai (1994) and Strosahl (1999) encourage researchers to focus on the mind of the suicidal in an attempt to understand how suicide becomes an option and to incorporate that information with the identified risk factors associated with suicidal behavior. Although suicide is the fifth leading cause of death across age groups, it is the second leading cause of death after accidents in young people aged 15-24 (Mazza & Reynolds, 1994). Statistics indicate that suicidal risk increases with age until age twenty four at which the highest ratio of attempted to completed suicides occuts (Bland, Newman, & Dyck, 1994). While Canadian suicide rares remained somewhat stable for both males and females between 1985 and 1992, the suicide rate for late adolescents has quadrupled in the past three decades (Health Canada, 1994). Historically, research has focussed on risk factors and prediction of suicidal behavior, (Beck, Steer, Beck, & Newman, 1993; Leenaars, 1990, 1997; Maris, Berman, Maltsberger, & Yufit, 1992;

Shneidman, 1993a) and epidemiological data (Bland et al., 1994; Diekstra, 1993). While this emphasis increases rhe ability to identify factors and patterns associated with suicide at a categorical level, it unfortunately has contributed little to increased accuracy of prediction (Hendin, 1981; Leenaars, 1999; Strosahl, 1999). Unlike completed suicide, no definitive statistics about attempt rates are available as many suicide artempters receive no medical or psychological attention and there is no formal documentation of the attempt (Bland et al., 1994; Diekstra, 1993). Additionally, suicide attempts are often misclassified as accidental. It is estimated that 25 to 40% of persons who complete suicide have a history of a previous attempt (Health Canada, 1994) although the attempt to completion estimates vary from the conservative 10:1 (Bland et al., 1994) to a liberal 600:1 (Health Canada, 1994). Suicidal gestures are also estimated to occur 10 times more often than attempted or completed suicides (Mann, DeMeo, Keilp, &McBride , 1989). Parricularly rare is research focussed at a global level into the suicidal thoughts, behaviors, and affect of young adults (Leenaars, 1997). Understanding suicidal behavior from a singular perspective is likely inadequate because psychological, interpersonal, and existential components contribute significantly to the interpretation and meaning given by an individual to their life experience; interpretations are unique and multifaceted. Understanding suicide and suicidal behavior as multi-determined provides a broader spectrum from which ro develop effective intervenrion strategies and therapeutic interventions. The interaction of personality, environment, and learning processes from which suicidal behavior is developed is increasingly being emphasized (Leenaars, 1997, 1999; Maris, 1981; Shneidman, 1985, 1987, 1993a). Suicidal behavior is hypothesized to be a compilation of a painful situation, a constricred

cognitive state, overpowering emotions, and disturbing relationships, and is conceptualized as adjustive but not adaptive. The distressed individual perceives suicide to be as the last available option. Death provides a solution to end the conscious awareness of pain. Despite these rates and the amount of research conducted in this field, surprisingly little is known about the experience of being suicidal.

Thoughts about death and suicide become more common as children move through early adolescence (Pfeffer, 1997). Since having suicidal thoughts is a predecessor to taking action to attempt suicide, thoughts, if disclosed to others, can serve as warning signs that provide an opportunity for intervention. Because the meaning of thoughts about death and suicide during early adolescence is not always clear, it is difficult for parents, teachers, and care providers to accurately determine the degree of an adolescent's suicidal risk and, in turn, to plan an appropriate response that will assure safety. The response of parents and professionals must balance taking action to ensure safety with encouraging the young person to develop skills to cope more effectively with stress. While studies have shown that past history of suicidal ideation or behavior are the strongest predictors of recurrence or persistence, these findings are drawn predominantly from clinical samples of youth who have come to the attention of mental health professionals. Little is known about the frequency of thoughts of death or suicidal ideation among young adolescents within the population at large. More comprehensive population-based research on the frequency, type, and persistence of thoughts of death and suicide in young adolescents would help to guide parents, teachers, and care providers in their efforts to identify individuals at risk and to intervene effectively to temper the emotional intensity of young adolescents' experiences.

5. OBJECTIVES

Objectives:

The study was carried out with the help of following objectives:

1. To study the suicidal tendency among youth
2. To study the suicidal tendency among male and female
3. Find out the factors of suicidal activities and overcome them.

6. HYPOTHESIS

Hypothesis:

1. **HO_1 -** There is no significant difference between early age youth and middle age youth.

2. **HO_2 -** There is no significant difference between male and female.

3. **HO_3 -** There is no significant difference between male and female early age youth.

4. **HO_4 -** There is no significant difference between male and female in middle age youth

7. METHODOLOGY

Methodology:

(A) Sample and Source of Sample:

The first task of the investigator was to take a representative sample from field of investigation. For this purpose 60 people of early and middle age male and female from society of Ahmedabad. The technique of sampling was incidental and purposive, even random from different regions in nature.

(B) Sample Size:

I. No. of early age male – 15
II. No. of early age female – 15
III. No. of middle age male – 15
IV. No. of middle age female – 15

(C) Variables :-

***Independent Variable*:-**

1. **Age:** Early and middle age of youth
2. **Gender:** Male and Female

***Dependent Variable*:-**

Suicidal Tendency

(D) Research Design of the study:

	Age level of youth	
Gender	Early age (18-24) (30)	Middle age (25-32) (30)
Male (30)	Early age (15)	Middle age (15)
Female (30)	Early age (15)	Middle age (15)

(E) Questionnaire / Tools used:

The following tool was used for the collection of data.

To measure the suicidal tendencies in youth **SUICIDAL IDEATION SCALE** by Dr. Devendra Singh Sisodia and Dr. Vibhuti Bhatnagar was used.

Reliability of the scale:

Test-retest method was applied to obtain the reliability coefficient of the scale. Taking different sets of sample; the administration, of the scale was repeated on several occasions. The result is given below:

Sample	**N**	**Interval**	**r**	**Level of significance**
Early age male	15	4-weeks	.69	.01
Early age female	15	5-6 weeks	.67	.01
Middle age male	15	5-6 weeks	.78	.01
Middle age female	15	5-6 weeks	.79	.01

These coefficients of reliability are sufficiently high and the scale can be considered as reliable for use. Taking into consideration these results, the present scale reliability coefficients but test-retest method for the total group, as well as for the separate male and female groups, are very satisfactory and the scale can be taken as quite reliable for use.

Validity of the scale:

As far as the validity of the scale is concerned, in the first instance the item validity established but the high-low discrimination method was

accepted as the validity of the whole measure. Besides, this scale was also used for validating the projective test of suicide ideation. The coefficient of correlation between the scale and the projective test was observed to be .54 which speaks for the validity of the scale also, the validity being of the concurrent nature.

- **STATISTICAL ANALYSIS:**

  t-test was used for statistical analysis.

8. RESULT AND DISCUSSION

Result and discussion:

This chapter discusses the statistical analysis made on the basis of data collected and gives a brief description of the results obtained.

Here, the results of the present investigation are presented, interpreted and discussed. In order to test the various hypotheses put forward, the following analysis was carried out.

Table: 1 - Suicidal ideation between early age youth and middle age youth

Group	N	Mean	SD	SED	't' value	Level of significance
Early age youth	30	53.5	10.8	1.97	-1.8	NS
Middle age youth	30	59.5	14.81	2.78		

Not significant

Table no.1 shows the suicidal ideation early age youth and middle age youth. For early age youth, the mean is 53.5 and S.D. is 10.8 and for middle age youth, the mean is 59.5 and S.D. is 14.81. For both group, the 't' value is -1.80 which is not significant. The result shows that there is no significant difference in early age youth and middle age youth. Thus, the null hypothesis no-1 which states "There is no significant difference between early age youth and middle

age youth on suicidal tendency", was accepted. This means that suicidal ideation level in early age youth and middle age youth is of same level. In comparison to a study conducted in Taipei Germany, Berlin in 1993 which concluded that middle age youth scored higher than early age youth in the aspect of suicidal ideation, the result of this study differs.

Table: 2 - Suicidal ideation between male and female.

Group	N	Mean	SD	SED	't' value	Level of significance
male	30	58.97	11.56	2.11	1.47	NS
female	30	54.03	14.22	2.59		

Not significant

Table no. 2 shows the suicidal ideation male and female. For male, the mean is 58.97 and S.D. is 11.56 and for female, the mean is 54.03 and S.D. is 14.22. For both group, the 't' value is1.47 which is not significant. The result shows that there is no significant difference in male and female. Thus, the null hypothesis no-2 which states "There is no significant difference between male and female

on suicidal tendency", was accepted. This means that suicidal ideation level in male and female is of same level.

Table: 3 - Suicidal ideation among early age male and early age female

Group	N	Mean	SD	SED	't' value	Level of significance
Early age male	15	59.27	9.6	2.48	2.92	NS
Early age female	15	47.73	11.87	3.07		

Not significant

Table no. 3 shows the suicidal ideation early age male and early age female. For early age male, the mean is 59.27 and S.D. is 9.6 and for early age female, the mean is 47.73 and S.D. is 11.87. For both group, the 't' value is2.92 which is not significant. The result shows that there is no significant difference in early age male and early age female. Thus, the null hypothesis no-3 which states "There is no significant difference between male and female early age youth on suicidal tendency", was accepted. This means that suicidal ideation level in early age male and early age female is of same level.

Table: 4 - Suicidal ideation among middle age male and middle age female

Group	N	Mean	SD	SED	't' value	Level of significance
Middle age male	15	58.67	13.23	3.41	-0.30	NS
Middle age female	15	60.33	16.23	4.19		

Not significant

Table no. 4 shows the suicidal ideation middle age male and middle age female. For middle age male, the mean is 58.67 and S.D. is 13.23 and for middle age female, the mean is 60.33 and S.D. is 16.23. For both group, the 't' value is -0.30 which is not significant. The result shows that there is no significant difference in middle age male and middle age female. Thus, the null hypothesis no-4 which states "There is no significant difference between male and female in middle age youth on suicidal tendency", was accepted.

Finally, we determined the frequency of the methods patients used to treat patients with suicidal ideation or depression as they encountered them in clinical practice. The data analyses were conducted using STATA 13.0 using statistical significance being set at $P \leq 0.05$.

9. CONCLUSION

Conclusion:

The present study was conducted to investigate the impact of the type of study course and gender on suicidal ideation among youth. In view of the analysis and interpretation of data and results drawn from the data, the following conclusions can be made from the present research:

I. There is no significant difference between early age youth and middle age youth on suicidal tendency.
II. There is no significant difference between male and female on suicidal tendency.
III. There is no significant difference between male and female early age youth on suicidal tendency
IV. There is no significant difference between male and female in middle age youth on suicidal tendency.

This systematic review of the scientific literature relevant to youth suicide indicates that suicidal behavior among youth is a complex issue. The evidence suggests that it is not only having a sense of culture that buffers against the negative pathways of suicide, but rather the act of engaging in culturally relevant activities with respected others in the community. This larger process can be theoretically likened to how youth search for and develop a sense of meaning and purpose in their lives. However, there is little to no data that speaks to this theoretical assertion — at present it will have to remain a theoretical speculation. This stringent search of the literature pertaining to youth study identified a small number of studies that were high in methodological rigor. These studies were mostly epidemiological in nature with very few

pertaining to interventions for the prevention of youth study. Although these studies offer insight into the etiology of youth study, additional methodologically rigorous intervention studies are needed to promote and develop an effective program for suicide prevention.

This study showed the prevalence of suicidal ideations and depression in primary care in South Korea. The rates identified in primary care settings are far higher than those in general population which was in agreement with the existing literature from other countries. However, many cases of suicidal ideation and depression might be under-diagnosed and under-treated in primary care. Therefore, physicians in primary care settings should be given education on recognition and management of depression and suicidal ideation in clinical practice.

Only one in twenty had discussed any mental health concerns with their family doctor. Clearly, the onus is on the family doctor to initiate discussions related to depression and suicidal thoughts because teenagers rarely disclose these issues to their doctors without prompting. This study provides a profile of teens most at risk for suicidal ideation, which should improve targeting and outreach to the most vulnerable. In addition to the well-known risk factors of depression and stress, suicidal ideation was highly elevated in adolescents with two or more chronic health conditions, self-reported poor health, migraines, and those whose activities were prevented by pain. Teens with these conditions are likely to be heavier users of family medicine services. Other characteristics significantly correlated with suicidal ideation include lower income, smoking, living alone or in single parent families, having lower levels of social support, and watching excessive amounts of television. Family physicians should regularly screen for suicidal thoughts in their adolescent patients with these characteristics in order to intervene as early as possible.

10. LIMITATIONS

Limitations:

1. This survey is held only on urban students. The same survey may give different result on rural population.
2. Participants would try to imitate answers.
3. Lack of time and lack of interest may have lead to incorrect answers.
4. Sample size was limited to 60, which may have resulted in inability to collect a large pool of youth with varying possibilities.
5. Participants were from just two areas of interests which may have affected the results somehow.

All systematic reviews require that the process focuses on the commonalities across studies at the expense of features that are unique to each study. We have attempted to diminish this limitation by referencing details of each study whenever possible. This review used a scale of quality assessment that may be overly rigorous given the difficulties of performing research on suicide with populations. In an attempt to overcome this problem, we performed a systematic evaluation of all articles deemed moderately rigorous (i.e., all articles scoring a 3 or a 4) and included only those that were found to make an adequate contribution to this review. Selection bias may also have occurred when choosing articles to be cited, this is a problem in systematic review

methodologies. To minimize the potential selection bias we added a third review author, who acted as an independent evaluator to resolve disagreement between other reviewers. Curiously, the literature search did not return a single article that utilized methodologies. One possibility is that such manuscripts exist, but may not be published in English. Thus, they were missed by our database searches as only studies written in English were included. Similarly, the databases searched may not carry more obscure journals, which are likely candidates to publish articles that utilize methodologies. Finally, the studies reviewed often used a pan Indian approach in amalgamating evidence across a large and heterogeneous group of peoples. Localized populations may be distinct and it is unclear as to how well such findings could be generalized at a local level.

However, some limitations have to be pointed out. The Regional Committee for Medial and Research Ethics was concerned that even asking a question about suicidal thoughts might initiate suicidal thinking and did not allow the question in secondary school at the time. Exclusion of adolescents with suicidal thoughts at baseline was thus not possible, so the study is based on lifetime suicidal thoughts reported at follow-up.

11.SUGGESTIONS

Suggestions:

1. The research could be conducted on a major scale in order to get valuable results.
2. The finding that the time used in suicidal ideation is adversely identified with individual's own perspective towards cut the life.
3. Many other factors influence youth to get idea of suicide like job, family, exam pressure, anxiety, low self-esteem, de-motivation, poor emotional and moral support from family and social environment.
4. A superior understanding of the value of life in childhood life may help highlight on what moves may be made to reduces suicidal level.

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