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Suicides in Rural Puducherry: Insights from Experiences and Secondary Data

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ABSTRACT: Suicide has many underlying causes. This research sought to investigate the experiences of suicide and gain understanding of suicide methods through secondary data of a specific village.

Methods: This qualitative study explores the experiences of suicide in a specific village between December 2011 and October 2021. After obtaining consent, the in-depth interview explored participants' experiences, needs, and concerns. Purposive sampling method was used for selecting respondents (n=5). The secondary data collected from Sanvi NGO, Puducherry, from December 2011 to October 2021, suicide deaths in a village in Puducherry.

Results: Identified three themes: reaction to a suicide attempt (sub-theme: shock), mental changes after Suicide (sub-themes: Internal conflict, guilt, and suicidal ideation), and social changes after Suicide (sub-themes: social support services, stigma, and financial problems). Secondary data information on 146 suicide deaths was available, 105 were male, and 41 were female. Hanging cases are more prevalent in the village, followed by consumption of poison and self-immolation.

Conclusion: The maladaptive behaviour as a result of substance abuse leads to significant social impairment or persistent interpersonal problems, domestic violence, and arguments with spouse. In rural settings, fostering a supportive family environment, capacity building training as part of the Gram panchayat development plan, and involving the community through trained volunteers, such as ASHA workers, can be adopted.

KEYWORDS: Suicide prevention, Stigma, Community mental health, Substance abuse

INTRODUCTION

Suicide is one of the leading causes of preventable deaths worldwide, making it a significant public health concern (Cerel et al., 2016). Suicide is frequently perceived as an oblivion and terrifying cause of death. Thousands of families lose someone close to them to suicide every year, and the stigma faced by family survivors could make things worse for them and make it harder for them to grieve (Sheehan et al., 2018). These survivors often face unique challenges in their grieving process, which can include feelings of guilt, confusion, shame, anger, and social stigma (Tal Young et al., 2012). An Australian study's findings indicate rural communities had a greater suicide rate than urban ones (Caldwell et al., 2004). Compared to urban areas, there are not as many mental health treatment facilities in rural areas.

Suicide arises from the complex interaction of numerous factors. Suicides in an area are significantly impacted by cultural, religious, regional and social diversity (Kamalja & hangar, 2017). The intake of alcohol is a significant risk factor for suicide and leads to various negative health consequences (Amiri & Behnezhad, 2020). The type of substance used, the accessibility of deadly weapons, and prior suicide attempt history are some of the factors that affect suicide (Datta et al., 2017). Psychosocial and cultural factors impede suicide prevention efforts in rural India by creating barriers to reporting (Raj et al., 2024). NFHS data reveals that compared to urban areas, a higher percentage of men and women drink alcohol in rural areas (Ministry of Health and Family Welfare, 2021). According to 2021 NFHS data, 0.6 per cent of women nationwide who are 15 years of age or older drink alcohol, while 1.6 per cent do so in rural areas. In India's rural areas, 19.9 per cent of men aged 15 and older drink alcohol, compared to 16.5% in urban areas.

In Puducherry, alcohol is more easily accessible than in the adjacent states, mainly due to its French colonial influence and lucrative tourism industry (Mathiyazhagan et al., 2023). Based on the recent NFHS report, 17.3 per cent of women and 30.1 per cent of men aged 15 and above in rural Puducherry drink alcohol, whereas in urban regions, 13.8 per cent of women and 26.7 per cent of men aged 15 and older engage in the same behaviour (Ministry of Health and Family Welfare, 2021). The prevalence of alcohol in Puducherry is 9.87 per cent among those belonging to ≥18 years of age in general and 17.1 per cent among males in particular

(Ramanan & Singh, 2016). Based on the 2011 census, approximately 31.66 per cent of the population in Puducherry resides in rural regions, while the rest of the population is in urban areas. Most suicide victims were male, according to the socio-demographic analysis of suicidal cases at a tertiary care hospital in Puducherry (Subramanyam et al., 2019). Conversely, another study conducted in Puducherry revealed that women were more inclined to participate in non- fatal suicidal actions (Singh et al., 2020).

The rural population of Puducherry has been found to have a higher suicide incidence (Datta et al., 2017). Currently, there are no specific social work studies that address the causes of Suicide within the community context of a particular village in Puducherry. Between December 2011 and October 2021, Tavalakuppam village recorded 146 suicide deaths, and according to the 2011 census of India, the village has a population of 9,212, consisting of 4,472 men and 4,740 women. The objective of the study is to evaluate the perception towards Suicide and to recognize the obstacles to suicide prevention in the Tavalakuppam village.

Participants

All the participants were either family members or neighbours of people died by suicide between December 2011 and October 2021. Twelve individuals were approached, and five (n=5) were selected through purposive sampling. The reasons given for not participating in the study included a reluctance to discuss suicide, concerns about neighbours possibly avoiding them, and a lack of available time. According to the participants, most of the deceased individuals had multiple reasons for their suicide.

METHODS

This research employed a qualitative research methodology to describe the experiences of individuals who have lost their relative or neighbour to suicide. The researcher conducted visits to the village between May 12th and 16th, 2024, as well as from August 13th to 15th, 2024 and participants were selected through purposive sampling. Two local community key informants assisted the researcher in gathering information and establishing rapport with the respondents. The researcher carried out detailed in-depth interviews after obtaining consent from five participants. Three themes emerged after data analysis of the in-depth interview: reaction to a suicide attempt (sub-theme: shock), mental changes after Suicide (sub-themes: Internal conflict, guilt, and suicidal ideation), and social changes after Suicide (sub-themes: social support services, stigma, and financial problems).

Sanvi NGO supplied secondary data concerning the suicides that occurred in Tavalakuppam village from December 2011 to October 2021. This secondary data were analysed in relation to gender, method of Suicide, age, and marital status. By utilising the secondary data, the researcher was able to ascertain the number of suicides that took place in Tavalakuppam village across various age groups during the specified period. The classification of cases as suicides was based on information obtained from the local police station.

Table 1: Socio-demographic characteristics of participants

Socio-demographic characteristics of participants.					
Sl. No.	Gender	Age	Relationship	Academic Credentials	Profession
1	Female	37	Spouse	Primary school	Tailor
2	Female	29	Spouse	Undergraduate	Teacher
3	Female	42	Spouse	High school	Daily wage
4	Male	72	Neighbour	Higher Secondary	Retired
5	Female	54	Neighbour	High school	Unemployed

Ethical consideration

Participants in the study provided their informed consent. Pamphlets were distributed to all participants and their families to increase awareness about suicide warning signs and provide the suicide prevention helpline number. To protect the identities of the study participants, all collected information has been handled with confidentiality. Psychoeducation regarding suicide and methods for preventing it, including identifying warning signs and counselling on reducing lethal means, was offered to five participants in the study.

Reaction to suicide attempt

Shock

When respondents initially learned of a family or neighbour's suicide, their first reaction was shock. The responders found it hard to accept that the individual died by suicide.

Respondents mentioned that they were unsure on how to react to this situation. One of the respondents reacted that "I did not know the reason why he had done suicide? We had a good family life and he left us alone. When I heard the news, I fell down and I became unconscious!" (42 year old spouse)

"It was shock for me! He was in good physical health. It was unbelievable! What was wrong with him? He was addicted to Alcohol. But he only knows the reason for this tragic act" (54 year old neighbour)

Mental changes after Suicide

Internal conflict and guilt

The responders felt that suicidal death was their fault. Additionally, they regret not stepping in immediately. One respondent also attributed suicide to evil spirits or supernatural forces. "The evil spirit attacked my husband. We were having a good family life. Someone had done black magic against us. This resulted in his death. I went outside to my relative's home. If I had there … should not have lost my husband!" (42 year old spouse)

Suicidal ideation

Some respondents stated that they had suicidal thoughts and felt self-depressed.

"I had suicidal thoughts and want to die after the death of my husband. My husband was the major breadwinner in our family. I don't earn much. If I die, who will take care of them (children)? I am living for my children" (42 year old spouse)

"I used to cut my hand. It was painful. My daughters were not eating for weeks after this (suicide of the husband) and they (daughters) became very lean and frail. I realised no one is there to help us. We felt helpless. I live for my children and told them to eat good food. Now stopped cutting my hand. I am concerned about my children. It is important to provide good education to them. We overcame the trauma over the period" (37 year old spouse)

Social change after Suicide

Social support

Social support is the material, ethical, and emotional assistance that neighbours, friends and family provide. The respondents' experiences range from experiencing no support from neighbours, friends and family to good support.

"My husband's friend will purchase groceries and all necessary items for our family. He also supports to sending my daughters to school and college. We get little support from my husband's family or neighbours...other than him (husband's friend), no one supports us" (37 year old spouse)

"Whenever a function happens in the family my in-laws will come with new saree (cloth) and sweets" (29 year old spouse)

Stigma

According to some respondents, they are not invited to family events and marriages. Because suicide occurs in the family, they are characterized as a bad omen. "My family members do not invite me for marriage or other auspicious ceremonies. They treat me as a bad omen" (42 year old spouse)

"Because of shame he died… they say it is due to alcohol! Not because of Alcohol…family is the problem! His wife has an (extra-marital) affair with one person. He (husband) started drinking alcohol and playing cards with his friends. After drinking he takes money from her (wife) for playing cards, if she is not willing to give money he will beat her. There was a regular fight between them" (72 year old neighbour)

Financial Problems

One respondent lost her mother due to suicide after her husband died by suicide. Her mother resided in a distant village, while her husband in the Tavalakuppam village. "They (father and mother) were in dire need of money. They asked for help and they were not able to collect the money within the stipulated time. She (mother) consumed poison and was immediately taken to a nearby hospital. We were not able to save her" (37 year old spouse)

"My elder daughter want to undergo Thyroid operation in a hospital. We needed one lakh rupee…no one helped us" (37 year old spouse)

Secondary data

Between 2011 and 2021, Tavalakuppam village recorded a total of 146 suicides, comprising 41 females and 105 males. There have been no documented instances of suicide among transgender individuals in the village. Hanging is the most prevalent method, with 112 cases reported, accounting for 76.7% of incidents. Additionally, there are 20 cases related to consumption methods, including poison, pesticide, and toxic seeds, which make up 13.7%. Self-immolation accounts for 11 cases (7.53%), while drowning constitutes 2.05% (Table 2). In this village, hanging remains the most common suicide method, regardless of gender. It is also noteworthy that the number of suicides completed by males exceeds that of females.

Table 2: Gender and suicide methods

Suicide methods	Gender		Total	Percentage
	Male	Female		
Hanging	86	26	112	76.71%
Poison/Pesticide consumption	14	6	20	13.7%
Self-immolation	4	7	11	7.53%
Drowning	1	2	3	2.05%
Total	105	41	146	100%

Males account for 71.91% of all suicides, while females make up 28.09% of completed suicides. Incidents of hanging are more frequently reported among younger and middle-aged adults. Both males and females experience hanging cases, with a notably higher incidence among males. A significant 81% of male suicides are attributed to hanging, compared to 63% of female suicides. The consumption of pesticides/poisons is responsible for 13% of suicides among men and 14.6% among women. Additionally, self-immolation accounts for 3.8% of suicides in men and 17% in women (Table 2).

The descriptive statistics presented in Table 3 detail the number of suicides that occurred within various age groups along with their corresponding marital status. Married people accounted for 83.5% of all suicide deaths, whereas single people made up 16.5%. Sixty-three percent of suicides occur in people between the ages of 18 and 45. There is an equal incidence of Suicide among younger adults aged 18-30 years, regardless of their marital status, whether married or unmarried. Married people were involved in all suicides reported in the age groups of 31–45, 46–60, and over 60 years. Additionally, there was one married person reported in the under-17 age category.

Table 3: Marital status and age group of Suicide

Age group	Marital Status		Total	Percentage
	Married	Unmarried		
<17	1	2	3	2.05%
18-30	22	22	44	30.14%
31-45	48	0	48	32.88%
46-60	31	0	31	21.23%
>60	20	0	20	13.7%
Total	122	24	146	100%

The age range of 31 to 45 years accounted for the greatest number of suicides, and all of these cases involved married people. Subsequently, the 18–30 age group had the second-highest number of suicides, with equal numbers for married and unmarried people. All reported suicides among individuals aged 31 years and older were among married individuals. Eighty-four percent of all suicides that are reported occur among the productive age group of 18 to 60 years. There are no recorded cases of Suicide among unmarried individuals aged over 30 years.

DISCUSSION

Suicide trends and prevention strategies

Hanging is the most popular way for people to end their lives in Tavalakuppam village. Hangings typically take place at places of residence or isolated locations in the village because of privacy concerns and the ease with which one can manipulate others without being noticed. The depression among men (15%) were slightly more than women (13.7%) in rural Puducherry (Rajan et al., 2024). The primary breadwinners in rural areas are men, and one major factor that makes them more susceptible to depression and, subsequently, suicide is financial hardship. Negative coping strategies like substance abuse makes them more vulnerable to suicidal thoughts. Despite the fact that marriage is typically viewed as a protective factor against suicide (Chen et al., 2024), 122 married individuals comprise 83.5% of the suicide deaths in Thavalakuppam village.

The potential new trend in youth suicide is contagion using social media, such as "copycat suicides", as well as the use of the internet to obtain lethal means. Harmful unintended consequences can be avoided by limiting access to suicidal means. Preventive measures could also include limiting fictional depictions of hanging Suicide and advocating responsible media reporting of suicide attempts. The ban on highly toxic pesticides has been effective in reducing the number of suicides. India saw a decline in insecticide poisoning suicides as a result of the endosulfan ban (Arya et al., 2021). Centralised storage of pesticides with the assistance of local self-government bodies can limit access to pesticides and is a preventive intervention strategy for reducing suicides, particularly in agrarian areas.

Suicide Prevention: Community-based approaches

Community-based self-immolation preventative programs in Puducherry can be successful if they use local data with the help of gram panchayat representatives to identify target groups. All health evaluations of women should include screening for domestic abuse because it increases the risk of female self-immolation (Campbell & Guiao, 2004). Enhancing access to mental healthcare in rural areas has been linked to community involvement. An island nation with a similar culture to Puducherry, Sri Lanka, saw encouraging results from a community-based participatory intervention in terms of lowering alcohol consumption (Siriwardhana et al., 2013). Campaigns to raise awareness about the importance of preventing suicides by limiting substance abuse can be organized in educational institutions. Students can act as gatekeepers of suicide prevention by sensitising their parents and other community

members about suicide warning signs, limiting access to lethal means, reducing risk factors, and enhancing protective factors like a healthy family environment.

Substance abuse

Alcohol consumption can impair a person's ability to manage stressful situations in a healthy way. Substance abuse is a behavioural risk factor associated with mental health issues. Reducing harmful alcohol use can effectively lower suicide rates, particularly among men (Wasserman et al., 2020; Wasserman & Värnik, 1998; Xuan et al., 2016). Alcohol intoxication results in neglect of children or household, family problems, and repeated absences from the workplace. The attitudes of community members toward alcohol use may have an impact on the interactions between alcohol users, families, and communities. The prevention of substance abuse in Puducherry's rural areas can be significantly enhanced by early detection and treatment of alcohol abuse (Sujiv et al., 2015).

Positive coping and role of family support

A positive family environment is essential for individuals' physical, social, and mental well-being and acts as a protective factor against suicidality. Suicide can have traumatic and long-lasting effects on those left behind. A background of physical abuse contributes to strained family dynamics, resulting in both internal and external issues that can ultimately lead to suicidal thoughts (Wan & Leung, 2010). People in extreme despair and crisis would like to hear supportive responses and love to be reassured by other family members. In many rural households, women are their children's primary caregivers. In the rural area of Puducherry, it was discovered that maternal education and a higher socioeconomic status significantly influenced positive mental health among adolescents (Arikrishnan et al., 2021). Recreational activities and supportive responses in times of difficulty in the family will improve individuals' physical and mental well-being. The results of studies show that family-focused interventions have beneficial outcomes in improving mental health (Das et al., 2016; Shidhaye, 2021). Individual interventions like sending postcards and follow-up phone calls can help individuals feel less alone, which can help them avoid suicidal thoughts and actions in the future. Positive coping techniques, such as yoga, sports, spending time with friends and family, and listening to music, can be used to prevent Suicide, depending on personal preferences.

Suicide stigma

Prior to the Mental Health Act of 2017, Suicide was considered a crime in India, and Suicide is stigmatized in Indian culture. Suicide intervention strategies need to give importance to destigmatizing and decriminalizing Suicide (Yadav et al., 2023). In a study about clinical stigma in India, Patients often feel that the stigma surrounding mental illness in the community is more damaging than their suicide attempt (Weiss & Parkar, 2020). The stigma associated with Suicide can be addressed in Puducherry through community-level suicide prevention and detection systems (Singh et al., 2021). Local self-government bodies like panchayats and village councils have an important role in successful suicide prevention and de-stigmatisation campaigns in rural areas.

CONCLUSION

Suicide does have a detrimental impact on not just the victim but also those in their family, neighbourhood and community. Identification, efficient medical care, and follow-up actions can all help prevent Suicide. Residents in the village do not receive enough mental health care and social support. The appropriate and responsible portrayal of suicides in the media, especially celebrity suicides, is an effective suicide prevention strategy. Particularly for vulnerable people, celebrity suicides may lead to "Copycat suicides," or the social learning of suicide-related behaviours. The public's awareness of suicide prevention will increase through responsible media reporting.

Community-based interventions and the support of a trained mental health workforce at the grassroots are necessary to address the suicide risk among the rural population.

Reaching out to the friends, family, and neighbours of suicide victims through self-help groups, bereavement support groups, and accredited social health activists in rural areas can enhance social support. Strengthening the primary healthcare system facilitates budget-friendly mental health care, particularly in villages where the availability of trained mental health specialists is limited. To save lives and prevent suicide attempts in Puducherry's rural areas, an efficient, quick, and inexpensive suicide intervention is needed. Thoughtful planning of community involvement initiatives and if community volunteers were acknowledged, trained, given tasks, supervised, and supported by local self-government and health system personnel, they were seen as a significant support for community-based suicide prevention in rural areas.

LIMITATIONS

This study is limited to a specific village in Puducherry and cannot be generalised. Size of the sample size is less and it is conducted in a limited area. Given that participants were questioned about earlier episodes, recollection bias might exist. A few years ago, suicide attempts were illegal in India. Suicide attempters in India are still stigmatized, and some people might not even be prepared to use the word "suicide" or speak about it. Suicide and suicidal behaviour are still considered taboo, which makes social desirability bias possible.

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CONFLICT OF INTEREST

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