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AN EMPIRICAL STUDY ON THE ANXIETY LEVELS AND SUICIDE IDEATION IN DIFFERENT CLASSES OF POPULATION

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ABSTRACT

Suicidal ideation is a common medical term for thoughts about suicide, which may be as detailed as a formulated plan, without the suicidal act itself. Although most people who undergo suicidal ideation do not commit suicide, some go on to make suicide attempts. The range of suicidal ideation varies greatly from fleeting to detailed planning, role playing and unsuccessful attempts, which may be deliberately constructed to fail or be discovered or may be fully intended to succeed. What logic allows any victim to engage in actions that cause a dying process in order to achieve death, and whatever that may bring to the victim? Such a choice is made possible by the comparison with life and the conclusion that there will be more satisfaction after the termination. Each victim can specify a condition under which their life has no value and when they would prefer to cease.

Keywords - Anxiety Levels, Suicide Ideation, Youth Anxiety

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INTRODUCTION

A recent Lancet study titled Suicide mortality in India: A nationally representative survey (2012) estimated about 186900 suicide deaths in India in 2010 at ages 15 years and above (114800 men and 72100 women). The study found that 40 per cent among the men (45100 of 114800) and 56 per cent among women (40500 of 72100) who committed suicide in 2010 were aged 15-29 years. The age-standardised suicide rate found in Indian women aged 15 years or older (17.5 per 1 lakh population) is more than two and a half times higher than in women of the same age in high-income countries (6.8 per 1 lakh population) and nearly as high as it is in China.

Throwing light on the Lancet study, Vikram Patel in an op-ed published in The Hindu (dated 22 June, 2012) informs that suicide is the second leading cause of death among the youth, both male and female. Apart from their risk-taking and impulsive character, social and interpersonal factors such as violence and disappointments in relationships coupled with mental health factors, notably depression, and substance abuse made young people especially vulnerable to suicides.

As subjective perceptions of their reality converge on this criterion, the victims experience a wish to return to an earlier state of existence which was more satisfying, or its equivalent, wishes for death. Implicit here is the assumption that after termination some awareness of increased satisfaction will still be present, i.e. continuation.

Carl G Jung (1964) has expressed this as well as any person:
"No one believes in his own death... our own death is indeed unimaginable and whenever we make an attempt to imagine it we can perceive that we really survive as spectators... in the unconscious everyone is convinced of his own immortality."

Shneidman (1981) has written about orientations to death and inferred the difference between interruptions versus cessation of awareness as psychological conditions influencing the choice of suicide. The former refers to transitory states such as sleep and awaking, fainting and revival, anesthesia and

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recovery. Such interruptions of awareness are the only prior experience anyone can have in preparation for the final cessation of awareness implied in the termination of the living body.

It is a relatively universal experience to feel better after a sleep. People have written of positive experiences following a sudden interruption state, such as out of body experiences, or the varieties of religious conversions. The implication here is that victims of suicidal behavior believe they will feel better after termination and that it represents a way of changing their unacceptable awareness of current existence. They find the idea of interrupting consciousness through suicide is attractive. At least partly, they expect to re-awaken after death, like they do after sleep, refreshed, with new ideas, and unforeseen options. The possibility that any change will feel better is itself seductive.

The prospect that awareness will continue past the point of termination, permits potential victim to prefer death. The chance that death may result in cessation rather than interruption of awareness is given much less credence. Such beliefs about the meaning of the afterlife allow victims to consider termination as another option and to wish for its occurrence.

Suicidal events are initiated in order to change the contents of awareness of personal existence. Potential victims regard their lives as having unacceptable values, because their understandings of meanings converge on self defined criteria for when death is preferable. As this convergence approaches congruence, the wish to return to an earlier more satisfying state is approximated by a wish to die. The facts of termination, and the occurrence of a physical death, are expected to change distressing awareness without causing cessation of all awareness. Even those who deny any continuation will imply that nothing will feel better than their present perturbation.

The necessary and sufficient conditions for the occurrence of a self injury event are a wish to die, an act of self and sufficient perturbation to motivate a lethal plan.The time lag within each condition is variable, but additive. There can be long gaps as the potential victim struggles with and surrenders to the seductions of relief from a wish to die. Shorter gaps can occur in the choice and development of a lethal plan. There is an unknown period for the conversion of personal distress to an action oriented perturbation. The time frame for all of these processes is known only by post hoc inquiries or personal speculations of suicidologists. This lack of knowledge reflects the difficulty of accessing the data of

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victims. However, the sum of them all represents the window of opportunity to introduce prevention efforts.

The mental and physical health of the young adults is of utmost importance for the future of the society as a whole. Hence, one can say that the suicide rate is a sensitive measure of psychological and social state. There is no single cause for which suicide can be directly attributed. Environmental factors, childhood upbringing, and mental illness each play a large role. Sociologists today consider external circumstances, such as a traumatic event, as a trigger instead of an actual independent cause. Suicides are more likely to occur during periods of socioeconomic, family and individual crisis. Most people with suicidal tendencies tend to suffer from some mental illness such as depression, bipolar disorder, or some degree of anxiety disorder. These diagnosable mental disorders are associated with more than 90% of suicide victims. As a result, many researchers study the causes of depression to understand the causes of suicide.

HISTORICAL CONTEXT

Certain questions about suicide seem to fall at least partially outside the domain of science, and indeed, suicide has been a focus of philosophical examination in the West since at least the time of Plato. For philosophers, suicide raises a host of conceptual, theological, moral, and psychological questions. Among these questions are: What makes a person's behavior suicidal? What motivates such behavior? Is suicide morally permissible or even morally required in some extraordinary circumstances? Is suicidal behavior rational?

Historically speaking, one does not come across any consistent philosophical belief about suicide. For example, in the Islamic faith suicide is condemned because it hinders the control of Allah over the life and destiny of the person. On the contrary, in Japan seppuku and hari-kari practices are considered honor suicides. In Hindus also, sati practice in which a woman sits on the pyre of her dead husband and sets herself aflame is one example of honor suicide. Saint Augustine was the first to strongly condemn suicide and codify Christian values against it. For Buddhists, since the first precept is to refrain from the destruction of life, including oneself, suicide should be clearly considered a negative form of action. Despite this view, an ancient Asian ideology similar to seppuku called (hara-kiri) continues to influence oppressed Buddhists to choose the act of honor suicide.

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Many questions arise from the ambiguity in defining suicide. From a Buddhist perspective these include questions such as whether nirvana is a kind of suicide. Thus, suicide is justified in the persons of the Noble Ones who have already cut off desire and by so doing neutralized their actions by making them incapable of producing further fruit. From the point of view of early Buddhism, suicide is a normal matter in the case of the Noble Ones who, having completed their work, sever their last link with the world and voluntarily pass into Nirvana, thus definitively escaping from the world of rebirths (Lamotte, 1965).The significant distinction then, is that the Arhat (Noble One) acts without desire whereas the unenlightened person does not. Judaism has traditionally, in light of its great emphasis on the sanctity of life, viewed suicide as one of the most serious of sins. Suicide has always been forbidden by Jewish law in all cases. It is not seen as an acceptable alternative even if one is being forced to commit certain cardinal sins for which one must give up one's life rather than sin. The views on suicide have shifted lately, however.

In the past, the bodies of Jewish people who committed suicide traditionally were buried on the outskirts of a Jewish cemetery, but that is no longer necessarily the case either. Raymond Perlman of Sinai Mortuary in Phoenix says that suicide deaths today usually are dealt with the same as others. "To put (those bodies) in a corner or on the side is really additional punishment for the survivors." Perlman says, "So we would just classify (the suicide) as another death. Unfortunately, a suicide death in most cases punishes the living."

Jewish teachings suggest that those who commit suicide would not face God's punishment, Sherwin says. "Our teachings tell us that when we are in pain, God cries with us," Sherwin says, "If God doesn't judge and condemn, then how can we?"

RISK FACTORS IN SUICIDE IDEATION

Many theories have been developed to explain the causes of suicide ideation. Psychiatric theories emphasize mental illness. Psychological theories emphasize personality and poor coping skills, while sociological theories stress the influence of social and environmental pressures. Emile Durkheim’s theory of suicide (1966) focused on how low degree of social integration and regulation leads to higher rates of suicides. Crises due to lack of prosperity and depression lead to the increase in the number of voluntary deaths. The psychological autopsy studies of consecutive suicides conducted over the long span of 35

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years uniformly suggests that a majority of suicide victims were suffering from mental disorders. Patients with **affective disorders** and **schizophrenia** suffer a greater risk. Genetic or biological factors play a large role in suicide likelihood. Research has shown that suicidal behavior runs in families. Notable examples are the suicides of the Hemingway family in which five members committed suicide. In 1985, the American Journal of Medical Genetics studied an Amish community in Pennsylvania. The studies revealed that four families, representing only 16 percent of the total Amish population, accounted for 73 percent of all Amish suicides. Some scientists claim 10 to 15 genes account for triggering suicide attempts. Similarly how depression is linked genetically, family ties may also have a large effect on one's suicide risk. Research into why individuals become suicidal has identified psychiatric disturbance as the strongest predictor of future suicidality. In particular, **depression**, both unipolar and bipolar, is associated with the greatest suicidal risk, and even in schizophrenics and substances abusers, both groups with high rates of suicide, depression is the strongest predictor of which individuals in those groups will complete suicide. Among the components of depression, the cognitive component, which has been called **pessimism** and **hopelessness** by Aaron Beck and his colleagues (1979), is a more powerful predictor than the somatic components of depression (such as loss of appetite) or the mood symptoms (such as guilt). A study by Jacobs and Teacher (1967) found that progressive social isolation from meaningful relationships has been found in the life histories of adolescent suicide attempters. According to Schrut(1968), chaotic and excessively mobile family life, repeated experiences of rejection prevents a person from making outside contacts and increase the risk of suicidal tendency. Studies also reveal that there is a continuum ranging from suicidal ideas to suicidal behaviors. This contention is supported by Carlson and Cantwell (1982) who found that 425 of the respondents with severe ideation and 34% of those with slight ideation had made a suicide attempt while none of the respondents who reported no suicide ideation had attempted suicide. In the ever-increasing literature describing postmortem studies of suicide victims, the majority of the work has concentrated on the serotonergic system and to a lesser extent on the noradrenergic system. Other neurotransmitter systems, including the **GABAergic system**, cholinergic system, dopaminergic system and peptide modulators and transmitters, have been studied to a far lesser degree, thus preventing definite conclusions. Reduced levels of CSF 5-HIAA appear associated with higher rates of a history of planned, no impulsive suicide attempts, as well as higher rates of suicide attempts resulting in more medical damage.

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Recent epidemiologic studies by Friedman, Jones, Barlow and Chernen(1992) found that 20% of subjects with the diagnosis of panic disorder had attempted suicide. This study sought to determine the prevalence of suicidal ideation and suicide attempts among patients with panic disorder and whether the presence of co morbid borderline personality disorder influenced the prevalence of suicidal thoughts and behavior. Suicide attempts were reported by 2% of the patients with panic disorder, compared to 25% of the patients with both panic disorder and borderline personality disorder. In addition, 2% of the patients with panic disorder, compared to 27% of the patients with **panic disorder** and **borderline personality disorder**, reported suicidal ideation that was judged to be of clinical significance. The rate of suicidal ideation and suicide attempts for psychiatric outpatients with panic disorder was discrepant with the findings of the earlier studies. The increased suicide risk in this group of patients was associated with borderline personality disorder, increased substance abuse, and affective instability. While 61% of the panic disorder patients and 78% of the patients with both panic disorder and borderline personality disorder reported thinking about death, this must be distinguished from actual suicidal ideation and clinical risk of suicide.

Some evidence has been found of an increased risk of suicidal ideation in patients with **cancer, head injury and peptic ulcer** disease. Another study reported that the risk for suicide in patients who are infected with human immunodeficiency virus is not increased at the time of initial screening for the presence of the virus. However, persons with illnesses related to **acquired immunodeficiency syndrome (AIDS)** are 16 to 36 times more likely to die by suicide than persons in the general population. Suicide among medically ill patients, including those with AIDS, rarely occurs in the absence of a comorbid psychiatric disorder, such as major depression, substance abuse or dementia.

Recent research has also focused on whether extremely gifted adolescents are at a higher rate of suicide risk than their counterparts. Cross, Cassady and Miller (2008) found that gifted adolescents did not exhibit heightened rates of suicide ideation as compared to their non gifted peers. However, female students held higher levels of suicide ideation than male students. Female students exhibiting introversion-perceiving (IP) types held higher levels of suicide ideation than those with other types.

Suicidal individuals are found to have experienced a high level of **stress** for a long period of time, and often have an increasing level in the time leading up to their suicidal action. In addition, suicidal individuals are found to have few resources, and the resources that they have are often unavailable (Lester

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2000). For example, the people available to turn to for help may be resented by the suicidal person, or the resources may be hostile toward the suicidal person. The stressful life style and working conditions also increase the risk for suicide. Piennar, Rothman and Vijver(2007) conducted a study on uniformed officers of the South African Police and revealed that the people low in coping skills, emotional stability and conscientiousness were at higher risk for suicide. The family plays a critical role in each of these factors. Physiological and psychological theories of psychiatric disorder stress the role of the parents, either in passing on the genes for the disorder (in physiological theories) or in creating a pathological home environment (in psychological theories) (Maris, Berman, Silverman 2000). Family members are often the cause of much of the stress that suicidal individuals experience, and they are the resources that may be unavailable to the suicidal individual. Also, **childhood sexual abuse and physical abuse** at home significantly raises the suicidal risks for young adults. (Brezo, Paris et al, 2006). Zilboorg(1936), found that the death of a parent during the patient's childhood was a significant factor in suicide. His findings could not be replicated by Barraclough(1987), but his findings revealed that the recent death of a parent or spouse made the patient vulnerable for taking the extreme step. The most common symptoms of suicide include **hopelessness, anhedonia, insomnia, severe anxiety, impaired concentration, psychomotor agitation and panic attacks.** The first risk-factor, and one of the most researched, is family disruption.

Researchers examining the effect of **familial disruption** on adolescent suicide often focus on family histories . Because the family is the first and most important agent of socialization, it is frequently assumed that suicidal tendencies are passed down from parent to child. While examining inadequate family relationships, especially in childhood and early adolescence, some researchers believe that poor parenting leads to negative development and may eventually cause suicidal behavior. Popular family disruption dynamics are parental psychopathy, low social support from family members, child abuse (physical and/or sexual), and neglect . Within the family disruption category, Qin (2003), using a biological approach, addressed the issue of psychiatric illness and familial suicide history. In fact, Qin explains the difficulty surrounding suicidal research by suggesting that because psychiatric illness and suicide co-occur, familial history cannot reflect suicide exclusively or psychiatric illness exclusively. This becomes a basic chicken-or-the-egg argument. Adding further complications to the biological approach to suicide, Qin concluded that an association exists between suicidal behavior and molecular genetics of the

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neurotransmitter serotonin . Therefore, his research focused on biological assumptions of what came first, suicide genes or **psychotic genes**.

While some researchers employ a biological approach to studying family disruption. Others provide a more sociological or learning approach to suicidal behavior caused by family disruption. In their research, Wagner et al. 1998 conclude that aspects of parent-child relationships, child abuse/maltreatment, family loss/separation, and family psychopathy lead to suicidal ideations and behavior in young people. Pelkonen identified both familial psychiatric disorders and situational factors (e.g., comorbidity, abuse, neglect, school problems) as risk factors for child and adolescent suicide. Perhaps one of the most consistent findings with regard to family dysfunction is the occurrence of child abuse (physical and/or sexual) as a predisposing factor to suicidality (Tyler et al. 2003). Another risk-factor used to research suicidal behavior is **loss**. Examples of loss include major losses, such as the death of a parent, spouse, and friend or loved-one and minor losses, such as loss of employment, loss of role status (boyfriend/girlfriend, money), loss of physical capabilities or becoming disabled due to an accident. Final category that suicidal behavior falls into is interpersonal difficulty. According to a number of researchers (Bao et al. 2000; Holden, 1986; King, 1999; Olson et al. 1999; Shagle & Barber, 1993; Smyth & Maclachlan, 2004; Thorlindsson & Bjarnason, 1998) this final category of suicidal risk factors consists of nonconformity, aggression (towards self and others), poor coping skills, low social support leading to **survival-sex, low self-esteem**, **unemployment** and **hopelessness**. The numbers of measurable phenomenon which fall under the interpersonal difficulty category are great.

SUICIDE AND LAW

In the contemporary context, the legal jurisdictions about suicide decide to a great extent as to how a particular country views it. In Australia, suicide itself is no longer a crime, a survivor of a suicide pact can be charged with manslaughter. Also, it is a crime to counsel, incite, or aid and abet another to attempt or commit suicide, and the law explicitly allows any person to use "such force as may reasonably be necessary" to prevent another from committing suicide. In India itself, attempted suicide is a punishable crime by up to one year in prison and/or fine. For a brief while, the courts had repealed the section of the penal code which prohibited suicide but a recent decision of the Indian Supreme Court has upheld the constitutional validity of prohibiting suicide. Under the law of England and Wales, Suicide (and thus also

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attempted suicide) was illegal under English Law but ceased to be an offence with the passing of the Suicide Act 1961; the same Act makes it an offence to assist a suicide. While the simple act of suicide is lawful the consequences of committing suicide might turn an individual event into an unlawful act, as in the case of Reeves v Commissioners of Police of the Metropolis [2000] 1 AC 360, where a man in police custody hanged himself and was held equally liable with the police (a cell door defect enabled the hanging) for the loss suffered by his widow; the practical effect was to reduce the police damages liability by 50%. By 1963, six states in the U.S. still considered attempted suicide a crime (North and South Dakota, Washington, New Jersey, Nevada, and Oklahoma that repealed its law in 1976). By the early 1990s only two US states still listed suicide as a crime, and these have since removed that classification. In some U.S. states, suicide is still considered an unwritten "common law crime".

CONTROVERSY

A recent topic of controversy related to suicide is **Euthanasia.** In modern times, euthanasia "generally refers to the ending of someone else's life for compassionate reasons, when people are terminally ill or their suffering has become unbearable" (Van Bommel, 1986,). There are several different types of euthanasia which have been defined in relation to the specific circumstances surrounding the occurrence of this action. For example, voluntary euthanasia refers to those cases in which an individual has requested his or her own death, whereas involuntary euthanasia refers to cases in which a person is put to death without having given his or her expressed consent beforehand. In addition, an act of euthanasia may be defined as being either passive or active. In passive euthanasia, a patient is simply removed from medical treatment and allowed to die naturally, whereas in active euthanasia, which is also known as "mercy killing," "individuals take an active role in the actual killing of a patient". The issue of euthanasia has important implications for the medical profession. For example, medical ethics are involved in the question of whether or not a doctor or nurse should take part in the request of a patient who wishes to die. The question is related to the huge expenses which are involved in keeping someone alive when there is no hope that the patient will ever regain consciousness. Yet another reason is connected to the idea that a person should be permitted to die if that person's quality of life is no longer worth living. In this regard, it is argued that "individuals have the right to decide when their lives no longer have a quality that they want to live with" (Van Bommel, 1986,). On the other hand, there are many arguments against the

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legalization of euthanasia, as well as against performing it under any circumstance at all--legal or otherwise. For example, some people have argued against euthanasia on religious or moral grounds. These people consider euthanasia to be a form of murder, and as such it is perceived as a sin. Others have argued against euthanasia on the grounds that ongoing medical research may discover cures in the near future for diseases and conditions for which there are no cures today. As such, it would be morally wrong to put a patient to death without knowing whether a remedy for that patient's condition will be discovered while the patient is still alive.

PREVALENCE

Suicidal ideation is more common than completed suicide. Most persons who commit suicide have a psychiatric disorder at the time of death. Because many patients with psychiatric disorders are seen by family physicians and other primary care practitioners rather than by psychiatrists, it is important that these practitioners recognize the signs and symptoms of the psychiatric disorders (particularly alcohol abuse and major depression) that are associated with suicide. Although most patients with suicidal ideation do not ultimately commit suicide, the extent of suicidal ideation must be determined, including the presence of a suicide plan and the patient's means to commit suicide. Suicidal ideation is more common than suicide attempts or completed suicide. A 1995 study found that 3.3 percent of patients in an urban primary care outpatient clinic reported suicidal ideation. In many cases the violence appears to be clearly directed inwardly or outwardly, however a closer examination of the data indicates that this separation is not a strong as it may first appear. First, there are cases involving homicide followed by suicide. In these cases, there are a disproportionate number of multiple homicides before the perpetrators kill themselves. At a less extreme level, examination of murderers shows a significant rate of previous suicide attempts or at least self-destructive acts that have threatened the life of the individual and may be interpreted as suicidal acts. About 30% of violent individuals have a history of self destructive acts. Conversely, 10–20% of suicidal individuals have a past history of violent behavior towards others. As a group, individuals presenting with an episode of major depression or a psychotic illness and having a history of a past suicide attempt are distinguished from individuals with the same psychiatric illness and no lifetime history of a suicide attempt by having a higher level of lifetime externally directed aggression

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and impulsivity. Thus, suicide is a less common form of aggression that is self-directed and, like externally directed aggression, it is a consequence of a lower threshold for acting on strong emotions. This lower threshold can also be termed as the propensity for impulsivity.

MEDIA AND SUICIDE

The boom in the media, both print and electronic has also brought about changes in the patterns and suicidal rates all over the world. Media creates and influences the way people think and react to the phenomena of suicide. Reporting and portrayal of suicidal behavior in the media may have potentially negative influences and facilitate suicidal acts by people exposed to such stimuli. Recent systematic reviews by others and us have found overwhelming evidence for such effects. Evidence for the influence of media on suicidal behavior has been shown for newspaper and television reports of actual suicides, film and television portrayals of suicides, and suicide in literature, especially suicide manuals. The potential for "suicide sites" on the internet influencing suicidal behavior remains to be proved, but anecdotal evidence of negative influences is accumulating. Research on media impacts on suicide has been largely restricted to the United States, a Christian nation marked by moral aversion to suicide. The present study extends the analysis to an Eastern nation, Japan, where people are less critical of those who suicide. Such a cultural definition of suicide might multiply imitative effects. Yule-Walker times series estimates indicate that the imitative effect is restricted to stories concerning Japanese victims. Further, the increase is similar in magnitude to that reported in the American cultural context. The Japanese audience may not be as predisposed to media effects, given a lower divorce rate, low couple centeredness, and a high level of extended family social support. These factors may offset a potentially very high "Werther effect." The model explains 88% of the variance in monthly Japanese suicide rates.(Stack,1996). It has been advised that Psychiatrists should be familiar with the harm that may result from improper reporting of suicide in the media since they may be called upon by reporters or family members following the suicide of one of their patients or following the suicide of a newsworthy person. Following the media guidelines available may prevent such contagion effects from occurring.

DEMOGRAPHIC SURVEY OF THE INDIAN POPULATION

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Since the present study concentrates on the sample taken from an Indian population, its is extremely important to understand the suicidal rates and patterns of occurrences throughout the country. More than one lakh persons take their own lives in India every year, and the problem is assuming alarming proportions. The rate of suicides in India, about 5 per 100,000 persons in the late 1960s, has more than doubled since then. The gravity of the problem is highlighted by the fact that nearly three-fourths of all suicides in India are by people in the socially and economically productive age group of 15 to 49. The increase is particularly striking since the mid-1980s - the number of suicides per 1,000 deaths has doubled from 6 in 1985 to 12 in 1998. While the suicide rates have been decidedly higher in the southern States, the variation across the country has been diminishing in recent years. In other words, States elsewhere have been "catching up" with the southern States in the last few years. While the national average is currently about 11 per 100,000 persons, the southern States together have a rate of 30 for male suicides. The lowest rate for males is in the northern region, about 4 per 100,000 persons. Across the country, the suicide rate for females is consistently lower than that for males, in keeping with the global sex ratios of suicides. But in the younger age group, between 5 and 29 years, the female suicide rate is as high as that for males. Moreover, the rates for educated females - those who have gone beyond primary school - is higher than that for males. The greater vulnerability of women is also associated with the more unstable nature of their livelihoods. The distribution of suicides by marital status reveals some interesting patterns. The rates do not vary much between the sexes for the never married. Among those currently married, while the rate for males is about 17 per 100,000 persons, the rate for females is 11.4 per 100,000. Among those widowed, while the rate for males is 21 per 100,000 persons, the rate for females is also significantly lower, at 6.6 per 100,000. However, among divorced males the suicide rate is 164 per 100,000 persons, but even in this class, among females the rate is only 63 per 100,000. While the suicide rate for separated men is about 167, for females it is only 41 per 100,000 persons. Development by itself does not appear to make societies more secure. For instance, suicide rates are higher in the southern States such as Kerala (30.5 per 100,000 persons) and Karnataka (24.2), Tamil Nadu (18.6) and Pondicherry (58), which has the highest suicide rate in the country. This appears to be paradoxical in the context of the high degree of access that people in these States have to social sector facilities like health and education.

COMPARISON BETWEEN DEVLOPED AND DEVELOPING NATIONS

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There are marked differences in suicidal behavior between developed and developing countries. In developed countries suicide rate is high in the age group of 15 to 24 years and highest in the elderly; the male/female ratio is wider at 3:1 and the divorced/ widowed/separated have a higher risk of suicide. In developing countries the highest rate is found in the young (below 30 years), the male/female ratio is narrower (India 1.4:1, China 1:1.3) and the married women are at a higher risk. The methods used in developed countries are firearms, car exhaust and poisoning, whereas in developing countries they are pesticide poisoning, hanging, and self-immolation. Research in developed countries reveals that above 90% of people who die by suicide have mental disorders, while it is only 60–90% in developing countries. Studies from developed countries reveal that over 70% of those who died by suicide had a diagnosable depressive disorder, whereas it was only 35–40% in China and India . The crucial and causal role of depression in suicide has limited validity in Asia. Only 7–10% of those who committed suicide had ever seen a mental health professional.

The social stressors associated with suicide are loneliness, rejection, and marital conflicts in developed countries, whereas inter-generational conflicts, love failure, and exam failure are found in developing countries. A highly significant relationship between domestic violence and suicidal ideation in women has been found in many developing nations in population-based studies . In Brazil (48%), Egypt (61%), India (64%), Philippines (28%), Indonesia (11%) and Thailand (41%), women who had experienced physical violence by an intimate partner had significant suicidal ideation. Suicide pacts and family suicides are frequent in India, China and Sri Lanka. Women outnumber men in pacts, which are often for social and economic reasons and as a protest against societal norms and expectations. Religious beliefs discourage suicidal behavior. A study in India found that religiosity was a protective factor, and lack of belief a risk factor for suicide.

José Bertolote emphasizes the need to integrate public health and clinical actions to prevent suicide. This is a necessity in developing countries. South East Asia and Africa, which account for 89% of the world population, have only 0.44 and 0.34 mental health professionals per 100,000 population.

The different risk and protective factors and the scarcity of human and economic resources necessitates the development of integrated suicide prevention strategies in developing countries, which function at the individual, family, community and societal level. Specially designed programmes for the women and the

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young, who are the most vulnerable populations, need to be initiated. Forming alliances with non-governmental organizations, native/faith healers and practitioners of alternate medicine would be necessary. More importantly, suicide prevention programmes need to be locally relevant, culturally appropriate and cost effective.

SUICIDE PREVENTION

Suicide prevention in developing countries is more a social and public health objective than a traditional exercise in the mental health sector. In India, The National Strategy for Suicide Prevention (NSSP) recommends the public health approach to preventing suicide as "a rational and organized way to marshal prevention efforts and ensure that they are effective." It distinguishes the public health approach, which identifies patterns of risk and behavior in groups of people, from the medical model, which focuses on individuals. The public health approach to suicide prevention, as presented in NSSP, has five basic steps:

- Clearly define the problem, by collecting data and other information.
- Identify risk and protective factors. Risk factors are associated with (or lead to) suicides and suicide attempts. Protective factors reduce the likelihood of suicide.
- Develop and test interventions. Most interventions seek to reduce risk factors and/or enhance protective factors.

Such preventive measures should be scientifically tested to determine if they actually work before being disseminated and implemented.

Suicide prevention programs should always be evaluated to verify that they are working and to understand how to make them more effective in the particular situation in which they are being used.

Finally, if the interventions are actually having an effect, then additional data collection will help determine how the nature of the problem may be changing in response to those interventions. For example, it may be that an intervention which is successful at reducing suicide by one particular method, such as firearms, is contributing to an increase in the number of suicides by poison. Once the program has been re-defined, the cycle can repeat to address the new situation.

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The Suicide Prevention Triangle model is borrowed from fire prevention education. Fire cannot occur with any one aspect removed or reduced sufficiently.

Similarly, one can juxtapose a triangle composed of three suicidal aspects: a wish to die, a suicidal plan, and sufficient distress to require relief. Together these provide a necessary and sufficient situation for self injury behavior. Self injury behavior can be deterred if one or more aspects are reduced or removed from the social situation of the high risk person. Each is a necessary, but insufficient cause by itself. **The wish to die cannot be altered directly.** Like high fever, it is the result of other conditions. It is experienced when the victim perceives existence as approaching or approximating some implicit standard for when death is preferable. Under some circumstances anyone would rather cease to exist. Given such a perception, the individual is expressing a need to leave an intolerable situation or state of existence. The wish to die when observed reflects a client's desire for an alteration of existence. The health professional can intervene in terms of changing awareness; by either restructuring the definitions of issues or working with perceptions of existence.

People will express the wish to die if they are given social permission by the authority figures in their environment, peers, or have some additional motives not fully recognized by either the victim or others. Regardless the licensed professional can elicit the current state of the wish to die by clinical inquiry. Simply asking, after rapport is established or as part of an ongoing clinical procedure, is sufficient.

The wish to die can come to anyone, although it is relatively rare and transitory compared to it's opposite the more universal wish to live. Sometimes the two coexist and resulting conflict behavior is apparent. This is more familiar as ambivalence.

Deterring any self action has the value of providing opportunities for the wish to live to reassert itself. Because the wish to die can return again, the health professional needs to monitor the current state of the wish to die even after relative stability has recurred.

Self injury methods are over determined by character, previous history and availability (Lester, 1970). Thus one method is usually preferred over all those that are actually available. There are two exceptions to this rule of thumb. People early in the life cycle of their suicidal careers are less committed to one

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method. They tend to prefer two or more less lethal methods, such as wrist cutting and abuse of prescription drugs, often utilized as gestures or threats. The second exception is the behavior of more psychotic people who may act impulsively with methods of availability which provide more lethal opportunities for self injury such as jumping or hanging. The key difference is that there is very little planning and the sheer availability of the method determines the decision to use it by these highly distressed people. Intervention with the first group permits more margin for error. The second requires more vigilance than can be maintained over extended periods of time. Both require priority attention for the underlying distress as the major prevention strategy.

For the larger majority of high risk people who contribute the bulk of deaths by suicidal mode in the U.S., the methods are less random and approach compulsivity (Lester, 1970). This permits the health professional to block access to specific methods rather than the more usual suicidal precautions where access to all methods is denied. The latter creates situations that merely increase the amount of distress experienced by the potential victim while providing protection for short durations of time only. **Selective blocking of a preferred method** takes less effort and is less stressful for the client. It can also be imposed for longer time spans than the usual emergency approach.

Distress and loss of hope is the most visible clinical source of motivation for self injury behavior. It is also the one for which health professionals have the most skill and experience in managing. While vulnerable individuals seem to be most prone for return of distress, over a short interval health professionals are able to do a great deal to reduce or control the experience of personal distress. Crisis intervention, tender-loving-care (TLC), problem solving, constructive listening and opportunities for catharsis, are the usual interventions when clients are identified as in need of emergency care. These are appropriate, short term responses for the prevention of suicide.

However, efforts oriented to distress focused on self injury, or perturbation, are highly restricted. These take the form of supervision and medications for the duration of the emergency. More effort is needed in examining and altering after death orientations, criteria for living, and developing suicide prevention plans that block access to methods.

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The assumption here is that in between suicide attempts, high risk people need intervention that does something for recurring distress, especially when this threatens hope (Beck et al,1975). Usually this is accomplishable through cooperation and planning with significant others, health teams, and the device of a **suicide prevention plan**. The basic element is monitoring the high risk person over the first six months of post hospitalization, and the first year or two following a self injury incident. The use of suicide prevention classes after the acute phase, and letter follow ups during the one or two years post self injury represents longer term interventions that are cost effective. These yield increased support, observation, and stimulate hopefulness. The third figure illustrates the issues in managing distress.

Frequent assessment is implied in longer range interventions. The wish to die, the preferred method and the degree of distress experienced needs to be reviewed with every clinical contact and changes noted. These call for strategies that represent degrees of intervention to match the degrees of lethality and risk; rather than the all or none tactics currently in use.

The wish to die when explicit represents an acute stage calling for immediate steps to block preferred methods, and to deal with distress. The absence of the wish to die, that is the presence of the wish to live, returns the client to pre morbid, but high risk state, even though this may be moments after a self injury act.

The health professional needs to debrief the method used for its continuing availability and lethality. It should be removed or blocked from access. The source and nature of distress are longer term issues that need to be addressed as clinical resources permit.

This overall model permits various clinical skills and procedures to be used optimally over different time frames.

The law recognizes that there are no standards for the prediction of suicide and that suicide results from a complicated array of factors. The standard of care for patients with suicidality is based on the concept of "foresee ability," which includes the reasonable physician's ability to take a thorough history, to recognize relevant risk factors and to design and implement a treatment plan that provides precautions against completed suicide. Courts assume that a suicide is preventable if it is foreseeable, though foresee ability is

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not identical to preventability. (In retrospect, a suicide may appear to have been preventable but not necessarily foreseeable.) In the case of a lawsuit, the chart will be examined to determine whether the physician recognized the risk factors and considered the benefits of exerting greater control over the patient (e.g., hospitalization, calling the family). Although most lawsuits arise over inpatients who commit suicide, documentation of all encounters with suicidal patients should include the entire examination, discussions with family members and consultants, treatment recommendations and ways in which recommended actions were effected.

Most patients who voice or admit to suicidal ideation when questioned do not go on to complete suicide. However, some of these patients will go on to commit suicide; thus, suicidal ideation warrants thorough evaluation--both when suicidality is expressed as well as periodically thereafter. Psychiatric disorders are present in most patients who express suicidal ideation or attempt or complete suicide. The best way to prevent suicide is to ask patients with symptoms of these disorders more specific questions about recent stressors and their thoughts about suicide, and then to treat the patients accordingly. Families must be an integral part of treatment planning. Medication and individual or family therapies are often indicated. Suicidal thoughts provoked by crises will generally settle with time and counseling. Severe depression can continue throughout life even with treatment and repetitive suicide attempts or suicidal ideation can be the result.

Methods for disrupting suicidal thinking include having family members or friends tell the person contemplating suicide about who else would be hurt by the loss, citing valuable and productive aspects of the patient's life, and provoking simple curiosity about the victim's own future.

During the acute phase, the safety of the person is one of the prime factors considered by doctors, and this can lead to admission to a psychiatric ward or even involuntary commitment.

According to a 2005 randomized controlled trial by Gregory Brown, Aaron Beck and others, **cognitive therapy** can reduce repeat suicide attempts by 50%. Even with schizophrenic patients, CBT has been successfully used to reduce suicide ideation. Bateman et al examined whether CBT also changes the level of suicidal ideation in patients with schizophrenia compared to a control group. Ninety ambulatory patients with symptoms of schizophrenia resistant to conventional antipsychotic medication were

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randomized to CBT or befriending. They were assessed using the Comprehensive Psychopathological Rating Scale, including a rating of suicidal ideation at baseline, post intervention, and after 9 months. Post-hoc analysis revealed that CBT provided significant reductions in suicidal ideation at the end of therapy, and sustained at the follow-up.

Alliance based therapy is another upcoming option to treat suicidal patients. This therapy will not work with all patients, but it offers a powerful intervention for many. Patients are engaged in a way that views suicidal ideation and behavior as linked to the transference relationship, particularly the negative transference. This gives psychodynamic therapists a way to establish and maintain a viable therapeutic alliance while helping patients take control of suicidal behavior and allow work related to underlying issues to unfold. Until suicide recedes as an issue, however, other interpretive work is not the principal focus of therapy. Before exploring how their life history, conflicts, and unconscious fantasies may affect them, patients must stay alive to come to sessions. The therapy emphasizes the patient's choice and responsibility and makes suicide an interpersonal event between therapist and patient that can be explored through the lens of the vicissitudes of their relationship. Suicide is not viewed as simply a symptom of an illness.

In numerous short-term randomized clinical trials (RCTs) of **antidepressants** for depression in children and adolescents (<19 years), antidepressants are found to be associated with a slightly higher proportion (0.7%) of patients reporting suicidal ideation or a suicide attempt than control patients receiving placebo (Bridge et al., 2007). The most important test for the role of antidepressants in suicide prevention is real life: In contrast to these randomized clinical trials, observational studies of antidepressant treatment, which typically include abundantly highly suicidal patients, demonstrate a marked alleviation of suicidal behavior in the vast majority of patients. In clinical practice, the benefits of treatment are seen over time as the drug response consolidates. Patient population studies of adolescents report lower rates of suicide attempts and of adults both attempts and completions over time as treatment continues .

Light therapy is also gaining ground in the treatment of suicidal ideation. Not many conclusive results have been reported in it's effectiveness but it has been shown that light therapy improves suicidal ideation in patients with SAD consistent with overall clinical improvement. Emergence of suicidal ideas or behaviors is very uncommon with light therapy.

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INTROVERSION

Introverts have an inward focus and aren't usually the life of the party. They have a strong sense of self that can make them feel highly self-conscious around other people – making walking into a crowded room a little nerve-wracking. Introverts have a hard time being goofy in front of the camera and telling jokes to more than a couple of people at a time, but they can be extremely witty. They're less "Larry, Curly, and Moe" and more Woody Allen - but that doesn't mean introverts' personality traits are neurotic.

Introverts process their emotions, thoughts, and observations internally. They can be social people, but reveal less about themselves than extroverts do. Introverts are more private, and less public. Introverts need time to think before responding to a situation, and develop their ideas by reflecting privately. Introverts' personality traits can be passionate, but not usually aggressive.

Introverts can focus their attention more readily and for longer periods of time, and they aren't easily swayed by other people's opinions. Some introverts aren't stereotypically shy and can strike up conversations with anyone. These introverts enjoy talking and listening to people, and going to parties and events. But most introverts would rather be at home. Introverts can find small talk easy but tiring – and sometimes boring. They'd rather have meaningful conversations about the depths of human souls and minds, but find few opportunities (those aren't your usual conversations at water coolers or dinner parties!).

An introvert's personality traits aren't necessarily tentative or hesitant, but introverts do prefer to think before they act. Introverts tend to get their energy from within, so being with people is draining. After a day filled with people or activities, introverts tend to feel exhausted and empty. To recharge their batteries introverts need to be alone reading, daydreaming, painting, or gardening – any solo activity fills them up again.

Research has found a link between suicide ideation and introversion. Female students held higher levels of suicide ideation than male students. Female students exhibiting introversion-perceiving (IP) types held higher levels of suicide ideation than those with other types. There was a significant between-groups effect for the judging-perceiving analysis. Students identified as perceiving personality types held higher

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levels of suicide ideation than those with the judging personality type. Gender, judging/perceiving, and extraversion/introversion combined to reliably predict approximately 18% of the variance in suicide ideation in this sample. (Cross et al, 2006). Similar results were reported by Allen, Goldberg et al in 2005. Depression was cross-sectionally associated with suicidal ideation in both the attempter and nonattempter groups but made a smaller contribution among attempters. Poor psychosocial adaptation and the personality factor "openness" were stronger contributors to suicidal ideation among prior attempters while anxiety and extraversion appeared protective against ideation. Among nonattempters, depression, anxiety, and neuroticism were the predominant influences on suicidal ideation. Bipolar patients with suicidal ideation may benefit from different treatment strategies depending on their prior attempt status. Charron's (1981) assumption that suicidal thinking is a function of personal characteristics, negative life experiences and social support. These include demographic factors , internal factors that may be found in the personality or physical circumstances of suicidal ideators e.g. self esteem, self image, introversion, anxiety, depression, coping ability, drug abuse etc.

Although suicidal behavior is frequent among cocaine-dependent patients, it has been little studied. Therefore, Alec Roy (2001) examined the characteristics of cocaine-dependent patients who had attempted suicide. Significantly more of the patients who had attempted suicide were female and had a family history of suicidal behavior; they reported significantly more childhood trauma and were significantly more introverted, neurotic, and hostile. The clinical implications are that family, childhood, personality, psychiatric, and physical risk factors contribute to suicidal behavior in cocaine-dependent patients. Comorbidity appears to be an important determinant of suicidal behavior.

ANXIETY

Anxiety is a psychological and physiological state characterized by cognitive, somatic, emotional, and behavioral components. These components combine to create an unpleasant feeling that is typically associated with uneasiness, fear, or worry.

Anxiety is a generalized mood state that occurs without an identifiable triggering stimulus. As such, it is distinguished from fear, which occurs in the presence of an external threat. Additionally, fear is related to

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the specific behaviors of escape and avoidance, whereas anxiety is the result of threats that are perceived to be uncontrollable or unavoidable.

Anxiety is a normal reaction to stress. It may help a person to deal with a difficult situation, for example at work or at school, by prompting one to cope with it. When anxiety becomes excessive, it may fall under the classification of an anxiety disorder. Research into the possible relationship between anxiety disorders and suicidal ideation has yielded mixed results, leading some to suggest that the positive findings between anxiety and suicidal ideation might simply be a by-product of comorbid depression. Recent work has suggested that having an anxiety disorder without history of mood disorder does convey increased risk for suicidal ideation, although the study could not assess for the possible impact of subsyndromal depressiveness. This current study, therefore, examined the relationship between anxiety disorder symptoms and suicidality using continuous scales and controlling for depressiveness. Data regarding the severity of panic, social anxiety, generalized anxiety, and obsessive-compulsive symptoms were obtained from a sample of 166 college students. Results generally supported the conclusions that anxiety disorders convey risk for suicidal ideation above and beyond any co-occurring depressiveness, and anxiety and depression together conveyed an additional interactive risk. Sareen and Cox(2005) conducted a longitudinal study over a 3 year period and found that comorbid anxiety disorders amplify the risk of suicide attempts in persons with mood disorders. Clinicians and policymakers need to be aware of these findings, and further research is required to delineate whether treatment of anxiety disorders reduces the risk of subsequent suicidal behavior. Another study by Asmundson and Cox found that PTSD was the only anxiety disorder that was independently associated with suicide ideation and attempts. In 2007, Michael, Maomi et al conducted a cross sectional research and findings indicate that increased ruminations may mediate the association between anxiety and suicidal ideation/behavior. In men, lower emotional processing may also play a role in this relationship.

EMPLOYMENT AND UNEMPLOYMENT

Employment cannot simply be defined as the number of people with jobs. Such a wide definition would also include children who are too young to work and all those who choose to take up paid employment. In fact, employment refers to all those people who are willing and able to work and are able to find work.

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Employment, therefore, is used in the sense of voluntary employment rather than involuntary decision on the part of someone to choose to work rather than go for leisure.

It is not easy to measure employment. On the other hand, it is easier to measure unemployment. Once we measure unemployment, it has to be subtracted from the total work force and we come to know the total number of employed people. Unemployment is measured differently in different countries. For example, in UK 'the number of people unemployed is measured for official purposes as the number of people claiming unemployment benefits, income support or national insurance credits at unemployment benefit offices on the day of the monthly count, who on that day were unemployed and willing and able to do any suitable work. This official definition of the unemployment rate in the UK is given by the number of the unemployed claimants expressed as a percentage of the estimated total work force (which composes all employees in employment, the self-employed, HM forces, participants in work-related government training programmes, and the unemployed claimants)'.

A prospective longitudinal study between 1980 and 1988 of school leavers entering adulthood examined unemployment and its relationship to suicidal ideation and a number of psychometric variables. The findings did not support an association between unemployment and suicidal ideation in young adults. However, there was an association between dissatisfaction with employment and suicidal ideation. These results suggest that suicidal ideation is related to more enduring personality and health related issues, although it must be acknowledged that individual patients may be distressed by their employment status. In fact, Western countries are facing a general decline in suicide rates that seems unrelated to any national plan aimed at obtaining the desired outcomes in those situations that are known to be associated to suicidal behaviour. General improvement in living conditions, better access to care, and more effective treatments of mental disorders are the most probable reasons for the recent decrease in suicide rates in many countries. However, the most recent financial-economic turmoil and the current threatening climate of permanent war will have a foreseeable impact on the standard of living, the consequences of which are still to be evaluated.

Socioeconomic events are known to produce important fluctuations in suicide mortality. Unemployment, in particular, seems related to suicide risk along direct and indirect pathways. In a study by Anthony Harold Winefield, out of the 340 subjects 32.5 percent of the unemployed and 66 percent of the employed

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people reporting has had suicidal ideation at some point in their lives. There was a trend for more of the long term unemployed to have reported suicidal ideation than the full time employed, but this was not statistically significant. It appeared that the dissatisfied full time employed is more disadvantaged in terms of suicidal ideation than the unemployed. Finally, there were those who reported that they had used a period of unemployment in order to travel and think through their life's ambitions, much in the manner of the more socially condoned " year off". Such an approach is definitely adaptive.

There is no doubt that **unemployment** can affect an individual's psychological well being and this is a uniquely personal experience. However the intensity of emotional arousal which may be seen in susceptible individuals, when one attempts to quantify the broader impact of unemployment as a cause of clinically significant psychological ill health and suicidal ideation, the overall effects are at most quite modest.

CONCLUSION

According to NCRB data, nearly 34 persons out of 100 who ended their own lives fell in the age-group 15-29 years. Coming close to this youth group in terms of number of suicides were persons who belonged to the age-group 30-44 years. The total number of suicides in the age group 15-29 years increased from 38910 in 2001 to 46635 in 2012, demonstrating a jump of 19.9 per cent. The total number of suicides in the age-group 30-44 years increased even more by 26.6 per cent from 36448 in 2001 to 46160 in 2012. Out of 100 persons, who commit suicide and die, roughly 65 are male and 35 are female. The total number of men who committed suicide increased from 66314 in 2001 to 88453 in 2012, displaying a jump of 33.4 per cent in 11 years. The total number of female suicides increased by 11.4 per cent from 42192 in 2001 to 46992 in 2012. The government and NGOs are working in this scenario to reduce the factors involved in this area.

REFERENCES

[1] Apter, Alan., King, R.A. (2003). Suicide in children and adolescents. Cambridge University Press

ISSN (Online) : 2348 - 2001

International Refereed Journal of Reviews and Research
Volume 2 Issue 1 January-February 2014
International Manuscript ID : 23482001V2I101022014-02
(Approved and Registered with Govt. of India)

[2] Asnis, G.M., Zimmerman, J.K. (1995). Treatment approaches with suicidal adolescents. John Wiley and sons.

[3] Beck, Aaron. (1979). Cognitive therapy and the emotional disorders. Plume.

[4] Brezo, Paris et al.(2006). Personality traits as correlates of suicidal ideation, suicide attempts and completions. Acta psychiatrica Scandinavica.

[5] Barraclough(1987). Forensic Psychology. John Wiley and sons.

[6] Bateman. (2000). Introduction to psychotherapy. Routledge.

[7] Burchardt.(2004). Understanding social inequality. Sage.

[8] Carlson . Cantwell(1982). An analysis of adolescent suicide ideation. Springer New York.

[9] Cross, Cassady, Miller.(2006). Suicide ideation and personality characteristics among gifted adolescents. Gifted child quarterly.

[10] Charron. (1981. Correlates of suicide ideation in French Canadian adolescents. Gale group.

[11] Creed and Peter(2002). Career maturity and well being as determinants to occupational status of recent school leavers. Journal of adolescent research.

[12] Conroy, D. (2006). Recovery from depression and suicidal pain. Authors choice Press.

[13] Cottle, Thomas. (2003). Hardest times: The trauma of long term unemployment. University of Massachusetts Press

[14] Durkheim, E. (1966). Critical assessments. Routledge.

[15] Dzuka. Dalbert(2006). Mental health and personality of Slovak unemployed adolescents. Wiley periodicals.

[16] Donnelly, J. (1998). Suicide: Right or wrong?. Prometheus Books.

[17] Eales, M.J. (1994). Depression and unemployment. American journal of community psychology.

[18] Ellis, T.E., Newman. C.F.(1996). Choosing to live. How to defeat suicide through cognitive therapy. New Harbinger Publications.

[19] Eyesenck, H.J. (1953). The structure of human personality. University of chicago press.

[20] Freeman, A.M., Dattilio, F.M. (2000). Cognitive behavioral strategies in crisis intervention. Guilford Press.

International Refereed Journal of Reviews and Research
Volume 2 Issue 1 January-February 2014
International Manuscript ID : 23482001V2I101022014-02
(Approved and Registered with Govt. of India)

[21] Friedman, Jones, Barlow(1992). Handbook on psychology. John Wiley and sons.

[22] Gliatto,M.F., Rai,A.K. (1999). Evaluation and treatment of patients with suicide ideation. American Academy of family physicians

[23] Goodyer, I.M. (2001). The depressed child and adolescent. Cambridge University Press.

[24] Hollis, J.H., Meyers, C.E.(1982) Life threatening behaviours. American association on mental deficiency.

[25] Jung, C. (2007). Introversion. Columbia encyclopedia

[26] Joiner, T.E., Schmidt, N.B., Laurent, Jeff., Pettit, J.W. (2002). Anxiety sensitivity as a specific and unique marker of anxious symptoms in youth psychiatric inpatients. Journal of abnormal child psychology. Volume 30.

[27] Lane, Christopher.(2007). Shyness: how normal behavior became a sickness. Yale University Press.

[28] Lonetto, R., Clare, M. (1980). Death anxiety among university students in northern Ireland and Canada. Journal of Psychology. Volume 104.

[29] Lester, D. (2000). Suicide prevention. Resources for the millennium. Psychology Press.

[30] Lashley, K.S., Stone, Calvin.P. (1932). Studies in the Dynamics of behavior. University of Chicago Press

[31] Northrup, G., Garfinkel, B.D. (1989). Adolescent suicide: recognition, treatment and prevention. Haworth Press.

[32] Peurifoy, R.Z. (1995). Anxiety, Phobias and Panic. Warner books.

[33] Perry, M.S., Charles Ward, L. (1998). Measurement of social introversion. Journal of personality assessment.

[34] Peterson, Anne., Mortimer, J.T.(2008). Youth unemployment and society. Cambridge University Press.

[35] Quinett, P.G. (1989). Suicide: The forever decision. Continuum

[36] Romanczyk,R.G., &Goren,E.R.(1975).Severe self injurious behavior.The problem of clinical control. Journal of Consulting and Clinical Psychology.

[37] Roberts, Albert. (2005). Crisis intervention handbook: assessment, treatment and research. Oxford University Press

ISSN (Online) : 2348 - 2001

International Refereed Journal of Reviews and Research
Volume 2 Issue 1 January-February 2014
International Manuscript ID : 23482001V2I101022014-02
(Approved and Registered with Govt. of India)

[38] Rudd, M., Joiner, T.E.(2000). Suicide Science: Expanding the boundaries. Springer.

[39] Rachman, P.M.(1997) Frontiers of cognitive therapy. Guilford Press.

[40] Reynolds, C.R.(1998). Need we measure anxiety differently for males and females?. Journal of personality assessment. Volume 70.

[41] Segal, D.L., Hersen, Micheal.(2004) Comprehensive handbook of psychological assessment. John Wiley and sons.

[42] Spirito, A., Overholser,J.C.(2002). Evaluating and treating adolescent suicide attempters. Academic Press.

[43] Smith, Richard.(1987). Unemployment and health:A disaster and a challenge. Oxford medical publications.

[44] URL : http://www.indiatogether.org