

A STUDY OF THE ORGANISED TEACHING SCHEME ABOUT SUICIDE PREVENTION FOR SCHOOL CHILDREN WORKED

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Abstract

Understanding and perspective on suicide among students were shown to improve after participating in an organized educational program, according to the intervention research. Many nations are still very concerned about the need to reduce suicide rates, which is a clear worldwide public health issue. Suicide prevention and support services may benefit from an understanding of risk and protective variables.

Keywords: Suicide, students, concerned, secondary institutions

Introduction

Life is a gift from Mother Nature, and we should savor every moment of it. By taking one's own life, a person misses out on the one chance nature has given them to live each moment to the fullest. Unfortunately, not everyone has a fairytale existence, and when they do, people's reactions vary widely. While some people are resilient enough to bounce back from setbacks, others give in to feelings of hopelessness and despair until they take their own life.

Major suicidal conduct begins with suicidal thoughts. Suicidal ideation, suicidal thoughts, and severe self-injurious conduct are the specific characteristics of this domain. It is composed of ideas that are intimately associated with the actions, preparation, and result of suicidal thoughts, especially with regard to the final portion, which deals with ideas of how other people would react. A subset of suicidal behaviors, researchers have concentrated on suicidal conduct as a separate mental health disorder. While it's true that not everyone who has suicidal thoughts will really try to end their lives, for many people, these ideas serve as a precursor to more severe suicidal acts. Many things, including the stresses of everyday life, individual and cultural issues, and the interplay between these, may lead to suicide thoughts among adolescents. In addition, most countries have just lately acknowledged suicide and intentional self-harm as a public health concern, despite the fact that these phenomena have long been seen as primarily a cultural or societal phenomenon.

"Sir Thomas Brown" first used the term "suicide" in his 1642 work "Religioned." Many people's opinions on the document have been divided. These feelings are distinct from wrath, sadness, contempt, anxiety, tension, fear, melancholy, and shame. The definition of suicide is "a deliberate decision to terminate one's life, an unexpected means of death, in which the desire to die arises from inside the individual and there are known or unknown factors contributing to this decision." When someone attempts, completes, or even contemplates suicide, they never take into account the available choices or future possible consequences. The word "suicide" has always meant something different to various individuals. "An act of despair whose

result is not known, occurring after a battle between an unconscious death wish and a desire to live better," "to love and be loved," "to live or not to live," "nothing less than a (soft of) exit," "an end to psychic conflicts," "a conscious act of self-inflicted cessation," and many more are among the many accepted definitions of the term. No matter how you slice it, it's certain to be a devastating social loss and an act of self-destruction.

Literature review

Júnior, Alceu Ramos (2020) Worldwide, More and more people are committing suicide., and it is now the second worst killer of young adults (those aged 15–29). Consequently, it is crucial to identify and comprehend the variables that put this group at risk for suicide. This evaluation primarily focused on 30 papers, the majority of which were published in economically developed nations. Included were analytical studies that used a random or quasi-randomized design, as well as cohort, case-control, or cross-sectional designs, and whose populations ranged in age from 10 to 25. Possible risk factors included things in a person's social surroundings and life events, mental health problems, and their sociodemographic profile. Even though the writers say that suicide isn't caused by just one thing, they do provide the risk variables under several studies. Suicide is a multi-faceted problem that affects global public health due to the interplay of several elements, including biological, psychological, social, cultural, and familial contexts.

Rauf, Khalida & Parvaiz, Naiza. (2022). One definition of suicide is the intentional ending of one's own life. It is a big problem for public health as it is a significant leading cause of death. The purpose of this qualitative research was to identify factors that may contribute to suicidal ideation and behavior. Thirty people who tried to kill themselves and were taken to Jinnah Hospital were in the group. The data was gathered through semi-structured qualitative talks with individuals, who were picked through a process called "purposive sampling." We used the tried-and-true method of text analysis to spot codes, categories, and themes in our data. The present study's findings revealed four overarching themes: family, society, the environment, and the person. In terms of suicide prevention, these findings are very significant. All of the aforementioned should be part of any comprehensive evaluation tool used by mental health professionals or preventative initiatives.

Bilsen, Johan. (2018). Suicide does happen more often in older people, but... it remains one of the top killers of children and teenagers across the globe. This has devastating psychological, social, and economic repercussions in addition to the obvious loss of life among the young. Addressing the problem of youth suicide is a top priority in the area of mental health for the people. Because of this, a lot more knowledge is needed about why teens try to kill themselves. A number of danger factors have been found through research in this area for children and adolescents in their late school years, and this brief review summarizes such risks. Mental diseases, suicidal ideation or behavior, certain personality traits, genetic predisposition, family dynamics, exposure to suicidal role models, and easy access to lethal methods were identified as major risk factors. When it comes to creating successful measures to

prevent suicide among young people, more understanding of the complicated relationship between these variables is crucial.

Jha, Smriti & Chan, Gerry & Orji, Rita. (2023). Nearly 700,000 individuals throughout the globe succumb to suicide every year. Previous research on suicide risk factors contains a broad variety of areas of risk variables, does not account for the majority of nations, and lacks statistical connections. The purpose of this comprehensive research and meta-analysis is to identify the most significant risk variables for suicidality in order to close knowledge gaps in this area for suicide and how these variables might inform the design of technology treatments to reduce suicide rates. After a thorough search across these are PsycINFO, PubMed, IEEE Xplore, and the ACM Digital Library are the four databases concerned. A total of twenty-five papers met the inclusion requirements. Being female, having a history of sexual trauma, having a low education level, being lonely or very isolated, having bipolar disorder, despair, many chronic health issues, and a history of suicide in the family ideas or attempts, and any diagnosed mental disorder are all factors that are statistically linked to suicide. Factors most strongly linked to suicide include domain-wise mental health issues, co-occurring illnesses, and behavioral risk factors. To better understand suicide and its causes, we provide a novel hierarchical model of suicide risk variables. Lastly, we discuss some of the factors to think about and unanswered questions about the development of technology to prevent suicide.

Sahoo (2016) In India, suicide claims over 100,000 lives annually. In the last 30 years, the number of suicides has gone up by 43%. from 1975 to 2005. Rapidly expanding and home to people of many different ethnicities, Jamshedpur is an industrial town. Suicide attempts have been on the rise recently, affecting people of all ages; annually, Tata Main Hospital admits around 300 patients with suicidal thoughts or behaviors. Determining what variables may raise the risk of suicide is the primary objective of this research. Methods: In Jamshedpur, researchers visited Tata Main Hospital to conduct their study. We hired 101 people who had tried to kill themselves and were sent to us by the emergency room., surgical units, and casualty departments to participate in the research over the course of six months. In order to gather information on additional risk variables, a unique pro forma was created. Findings: This research favored female patients over male patients, those in their twenties and thirties, those from lower-middle income brackets, those from metropolitan areas, those with some college education but no job, and those without health insurance. Despite the prevalence of mental disorders, only a small percentage of patients have received therapy in the past. Potential danger signs include an increase in arguments within families, marital strife, money problems, and feelings of shame. Finally, in order to effectively design and execute suicide prevention initiatives, identifying those at risk at an early stage and providing ongoing treatment to them is of the utmost importance.

Research methodology

In the Indore district of Depalpur, there are two secondary institutions: Depalpur's School for Government Higher Secondary and the Government Higher Secondary School in Hyderabad.

Those in the eleventh graduate from Depalpur's Government Higher Secondary School as well as another institution.

One group consisted of 43 students from Government Higher Secondary School, Depalpur (the Intervention group), whereas the other group consisted of 40 students from the same class and age range (the Control group).

Verbal permission was gained after the investigator described the study's goal to the students at both institutions. Over the course of four weeks, data was gathered. During the first week, a pre-test was administered utilizing case vignettes and knowledge and attitude assessments. During the first week, the experimental group was given a structured curriculum (Appendix-VII) to educate them about suicide. The post-test was administered in the fourth week after a two-week vacation. In both ensembles, the drums and strings were identical.

Data analysis

Table 1 Individuals' socio-demographic details (n = 83)

Variables	Intervention (n = 43) N (%) / Mean (SD)	Control Group (n = 40) N (%) / Mean (SD)	$\chi^2 / t, df$	P value
Gender				
Boys	9 (20.9)	19(47.5)	6.54, 1	0.01
Girls	34(79.1)	21(52.5)		
Age in years	16.19 (0.39)	16.05 (0.64)	-1.18, 81	0.24
Type of family				
Nuclear	32(74.4)	28(70.0)	0.20, 1	0.65
Joint	11(25.6)	12(30.0)	0.20, 1	0.90
Single parent home	8(18.6)	7(17.5)	0.02,1	0.90
Having two or more siblings	28(65.1)	21(52.5)	1.36,1	0.24
Monthly family income (in INR)	1879(1443)	2121(1328)	0.79,81	0.43

Only the gender distribution of the intervention and control groups varied substantially (Table 1). There were 20.9% men and 79.1% females in the intervention group, compared to 47.5% men and 52.5% females in the control group. In terms of age, socioeconomic position, family type, and number of siblings, Between the control group and the assistance group, there was no change that was statistically significant. The young people in the control group were 16.05 years old, while the kids in the intervention group were 16.19 years old on average. Among those who received the intervention, 28% had more than two siblings, compared to 21% in the

control group. In both groups, only 7% of children were born to a single parent. Unfortunately, that figure increased to 8% in the group that received the intervention. Those in the control group made up 70%, like the intervention group (74.4%), was mostly made up of kids from one-parent homes. Every month, the people in the intervention group made INR 1879 and the people in the control group made INR 2121.

Table 2 The experimental (intervention) group and the control group were compared on the mean score of knowledge, attitude, and case vignettes (severity identification) related to suicide

Variables		Control group (n = 43)	Intervention group (n = 43)	t*	p
Knowledge regarding suicide total score	Baseline [mean (SD)]	15.65 (4.80)	16.67 (4.16)	-1.04	0.30
	Post [mean (SD)]	15.60 (4.49)	20.05 (5.56)	- 3.99	0.001
	tb	0.16	- 5.63		
	p	0.88	0.001		
Knowledge regarding Mental Health Disorders for suicide	Baseline [mean (SD)]	57.25 (14.43)	58.33 (13.07)	- 0.36	0.72
	Post [mean (SD)]	59.00 (16.20)	70.09 (11.96)	- 6.07	0.001
	tb	-0.76	-6.07		
	p	0.45	0.001		
Knowledge regarding warning signs of suicide	Baseline [mean (SD)]	1.32 (1.12)	1.26 (1.24)	0.23	0.82
	Post [mean (SD)]	1.58 (1.47)	1.95 (1.34)	-1.20	0.23
	tb	-1.08	-3.93		
	p	0.29	0.001		

Table 2 demonstrates that following the structured education program, there was an important change in the intervention group's average scores on tests of general knowledge, attitude towards suicide, and ability to judge how serious a case story was ($p = 0.001$). If you look at the control group's mean scores on tests of general information and approach towards suicide, and capacity to determine the seriousness of a case vignette without the structured instruction program were not significantly different between the two sets of tests.

Prior to the organized instruction program, there wasn't a big contrast between the two groups' training and control sessions when it came to basic information, mood, and capacity to use case vignettes to determine the seriousness of suicide. Nevertheless, after the organized instruction program, out of the two groups, the control group and the intervention group in how much they knew about suicide and how they felt about it ($t = -6.07$, $p = 0.001$ for each).

Table 3 Statistical analysis of the difference in knowledge between the Experimental (Intervention) and Control groups with respect to some suicide-related topics.

Variables		Control group (n = 43)	Intervention group (n = 43)	t ^a	p
Knowledge regarding suicide total score	Baseline [mean (SD)]	15.65(4.80)	16.67(4.16)	-1.04	0.30
	Post [mean (SD)]	15.60(4.49)	20.05(5.56)	-3.99	0.001
	tb	0.16	-5.63		
	p	0.88	0.001		
Knowledge regarding Mental Health Disorders for suicide	Baseline [mean (SD)]	6.15(1.96)	6.40(1.76)	-0.61	0.54
	Post [mean (SD)]	6.20(2.13)	8.05(2.17)	-3.92	0.002
	tb	-0.36	-6.52		
	p	0.72	0.001		
Knowledge regarding warning signs of suicide	Baseline [mean (SD)]	3.82(1.06)	3.84(0.97)	-0.09	0.93
	Post [mean (SD)]	3.60(1.17)	4.81(1.30)	-4.45	0.001
	tb	1.55	-6.06		
	p	0.13	0.001		
Knowledge regarding beliefs or myths about suicide	Baseline [mean (SD)]	3.60(1.50)	3.84(1.31)	-0.78	0.44
	Post [mean (SD)]	3.32(1.21)	4.16(1.63)	-2.65	0.01
	tb	1.92	-1.64		
	p	0.06	0.11		
Knowledge regarding interventions to prevent suicide	Baseline [mean (SD)]	2.35(1.27)	2.60(0.93)	-1.03	0.31
	Post [mean (SD)]	2.40(1.17)	3.02(1.19)	-2.39	0.02
	tb	-0.50	-2.95		
	p	0.62	0.005		

Table 3 reveals that prior to the organized instruction program, there was no difference in the groups' understanding of Mental Health Disorders, warning indicators, ideas or lies, and ways to keep people from committing suicide. Even so, after the planned schooling programme, there were substantial differences in the two groups' understanding of suicide Mental Health Disorders, warning signs, attitudes, myths, and treatments.

When comparing the control group's pre- and post-test scores on multiple-choice questions on suicide prevention strategies, warning signs, Mental Health Disorders, and myths and misconceptions, there was no change that was statistically important. The group that was involved, however, showed substantial improvement in knowledge following the structured instruction program in areas such as Mental Health Disorders, warning signals, and measures to prevent suicide.

Table 4 Assessment of the intervention and control groups' knowledge, attitudes, and ability to identify the severity of suicidal thoughts and behaviors by regression analysis

Variables	β^a	95% CI	SE	t	p
Overall knowledge regarding suicide	4.99	2.71-7.28	1.15	4.35	0.000
Knowledge regarding Mental Health Disorders for suicide	2.00	1.02-2.98	0.49	4.07	0.000
Knowledge regarding warning signs of suicide	1.36	0.80-1.91	0.28	4.86	0.000
Knowledge regarding beliefs or myths about suicide	0.95	0.30-1.61	0.33	2.89	0.005
Knowledge regarding interventions to prevent suicide	0.72	0.19-1.25	0.27	2.68	0.009
Attitude	9.35	3.01-15.70	3.19	2.94	0.004
Case Vignettes	0.50	-0.14-1.13	0.32	1.55	0.13

took into account the effect of gender, which showed a difference at the start. Information on mental health disorders and suicide ($p=0.000$), warning signals ($p=0.000$), opinions ($p=0.005$), and behavior ($p=0.009$) are all included in Table 4 are still significant after gender is taken into account improved significantly as a consequence of the organized education program. Even after controlling for gender, the organized instruction program led to a change in attitude that is statistically significant as compared to the control group ($p=0.004$). Case stories helped both the training and control groups get better at figuring out how bad a problem is, but the difference wasn't statistically significant.

Conclusion

According to the results of the qualitative research, many members of the local community saw suicide as a way out of the problems that persons with mental illness and those without it faced, including problems with family, finances, and interpersonal relationships. Few of the people who committed suicide had serious mental illness, according to the psychological autopsy research. Psychosocial stress and social isolation were also identified as Mental Health Disorders for suicide in the area, according to the psychological autopsy research.

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