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A Free Open Access Peer-Reviewed Interdisciplinary Quarterly Journal

Sambhāṣaṇ, a free open access online journal was launched on the occasion of Dr. Babasaheb Ambedkar's 129th birth anniversary on 14th April 2020 by Dr Rajesh Kharat the Office of the Dean, Faculty of Humanities, University of Mumbai. This interdisciplinary journal carries the vision of bringing diverse disciplines in dialogue with each other through critical reflections on contemporary themes. Since it's inception, the journal has been responding to contemporary issues, the first year focussing on myriad of discourses around the pandemic and it's reshaping of the world into a new order. It also carried a special issue on Gandhi's philosophy and relevance in contemporary times. Subsequently, the journal carried volumes on the theme of syncretic traditions of India, special issues on John Rawls, volumes on the theme of environment and sustainability, mental health, art, technology and Indian society and disability and Indian society. In it's initial phase there were guest lectures organised too. The journal continues to evolve in content and bring to conversations new themes of contemporary relevance.

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illustration provided

Sambhāṣaṇ or conversation as an art of dialogue has been crucial to the development of both national and world philosophies. Thinkers such as Mohandas Karamchand Gandhi, Rabindranath Tagore, Sarojini Naidu, David Bohm, Hans Georg Gadamer, Anthony Appiah and Martha Nussbaum have projected shared dialogue as a way of understanding the relationship between the individual and society. While Jyotiba Phule, Savitribai Phule, Bhimrao Ramji Ambedkar, Pandita Ramabai, Jürgen Habermas, Paul Ricoeur, Patricia Hill Collins and Judith Butler, to name a few, have started out a new through ruptures in conversations. The inevitability of conversation in academic life emerges from its centrality to human development and ecology. Conversations are not restricted to any single territory, but are enacted between global and the local topographies. This online English Journal aims at continuing and renewing plural conversations across cultures that have sustained and invigorated academic activities.

In this spirit, Sambhāṣaṇ an open access interdisciplinary peer-reviewed online quarterly journal endeavours to:

- be an open platform, where scholars can freely enter into a discussion to speak, be heard and listen. In this spirit, this journal aims at generating open conversations between diverse disciplines in social sciences, humanities and law.
- preserve and cultivate pluralism as a normative ideal. Hence, it attempts to articulate a plurality of points of view for any theme, wherein there is both a need to listen and to speak, while engaging with another's perspective.
- act as a springboard for briefly expressing points of view on a relevant subject with originality, evidence, argument, experience, imagination and the power of texts. It hopes that these points of view can be shaped towards full-fledged research papers and projects in the future.

Framework

- This journal is open to contributions from established academics, young teachers, research students and writers from diverse institutional and geographical locations.
- Papers can be empirical, analytical or hermeneutic following the scholarly culture of critique and creativity, while adhering to academic norms.
- Commentaries and reviews can also be submitted. Submissions will be peer-reviewed anonymously.
- Some of the issues will publish invited papers and reviews, though there will be a call for papers for most issues.
- There would be an occasional thematic focus.

Guidelines for Submission

- Original, scholarly, creative and critical papers with adequate references.
- All references to the author should be removed from the submission to enable the anonymous review process.
- There can be a limit of approximately 3500-4000 words (for papers) and 1500-2000 words (for commentaries) and 1000-1200 words (for reviews).
- Essays should follow the Times New Roman font in size 12 with double space, submitted in MS Word format.
- All contributions should follow the author-date referencing system detailed in chapter 15 of The Chicago Manual of Style (17th Edition). The style guidelines in this journal can be consulted for quick reference.
- Authors should submit a statement that their contribution is original without any plagiarism. They can also, in addition, submit a plagiarism check certificate.
- The publication of research papers, commentaries and book reviews is subject to timely positive feedback from anonymous referees.

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This journal accepts original essays that critically address contemporary issues related to social sciences, humanities and law from an interdisciplinary perspective.

"In an ideal society there should be many interests consciously communicated and shared... In other words there must be social endosmosis."

Dr. B.R. Ambedkar

Editorial Note

Suicide and the Fractured Self – Interrogating the Social, Cultural, and Psychological Complexities of a Global Emergency

Suicide is not only the tragic cessation of life—it is often a final expression of pain unheard, burdens unshared, and disconnection unaddressed. It forces us to confront the fragility of our modern societies, the silences of our institutions, and the profound loneliness that can take root in even the most seemingly connected lives. That the current moment demands a renewed, uncompromising engagement with the question of suicide is beyond dispute. According to the World Health Organization (2023), over 700,000 people die by suicide annually, with many more attempting it. Suicide is now among the leading causes of death worldwide, particularly in low-and middle-income countries and within specific vulnerable groups such as students, the elderly, LGBTQ+ individuals, and rural populations experiencing chronic distress. The Supreme Court of India recently referred to the rise in student suicides as a "suicide epidemic," highlighting

the stark reality that over 13,000 young lives are lost every year due to overwhelming pressure to succeed. The alarming rise in these cases points to a need for systemic change, not only in how academic success is measured but also in how mental health is addressed within educational institutions. A more supportive environment- one that values emotional well-being just as much as exam scores- is vital to avoid the loss of valuable young lives. A recent headline, '*Social Media Influencer Dies by Suicide After Losing Followers*', points to a growing concern that can no longer be overlooked. It draws attention to how digital pressures are beginning to affect mental health in adverse ways, especially when it comes to young people. The stress that comes from constantly managing one's image, chasing numbers, and fearing public failure is becoming more common. This is adding to existing challenges like academic stress, unemployment, and the social stigma around mental illness. To address the issue of suicide in India effectively, we need to acknowledge these changing realities and build a more open, supportive environment where mental health is taken seriously, both offline and online. The rise of cyberbullying, reflected in tragic suicides globally, is also becoming a growing issue in India, where online harassment is contributing to a rising mental health crisis among young people. The anonymity of the internet often enables harmful behaviour, while the emotional impact on the person targeted is very real. Unfortunately, most people suffering from such abuse feel they have nowhere to turn, as support systems are either lacking or not taken seriously. As our lives become increasingly digital, it is essential to treat online abuse as a legitimate mental health risk and to ensure that both awareness and legal protections evolve to meet this new reality.

What accounts for this rise? Why, in an age of unprecedented technological connectivity, wellness movements, and global advocacy, are increasing numbers of individuals finding themselves unable to go on? In posing this question, we must

resist the oversimplification that attributes suicide solely to mental illness. While depression, bipolar disorder, and substance use are undeniably risk factors, reducing suicide to clinical pathology obscures the broader, more insidious forces at work. Suicide must be understood as a multidimensional phenomenon that intersects with economic despair, cultural alienation, identity-based oppression, and the emotional costs of living in a fast-moving, hyper-individualized world.

The sociological imagination offers valuable insight here. Émile Durkheim's landmark study *Le Suicide* (1897) remains disturbingly relevant. His categorization of suicide into egoistic, anomic, altruistic, and fatalistic types provides a lens to explore the tensions between the individual and society. In contemporary life, the prevalence of egoistic and anomic suicides is glaring. Urbanization, labor precarity, disintegration of traditional support systems, and weakening community bonds create a sense of isolation so profound that it undermines the will to live. Today's societies increasingly valorize self-sufficiency and success, while offering little in terms of collective responsibility, emotional solidarity, or communal healing.

These conditions have only intensified in what sociologist Zygmunt Bauman termed "liquid modernity," where everything—relationships, identities, meanings—is fluid, transient, and increasingly commodified. In such a world, individuals are rendered responsible not just for their material well-being, but for their emotional resilience, productivity, and relevance. Failure is internalized. Suffering is privatized. Within this framework, suicide often becomes a desperate act of protest against a society that demands much but listens little.

From a psychological standpoint, the frameworks have evolved, though not always in tandem with social realities. Sigmund Freud, in his early work *Mourning and Melancholia* (1917), theorized

suicide as an expression of self-directed aggression, rooted in ambivalence and loss. While contemporary psychodynamic thinkers have built on this, newer models such as Thomas Joiner's Interpersonal Theory of Suicide (2005) offer a more empirically testable framework. Joiner identifies thwarted belongingness and perceived burdensomeness as core components driving suicidal desire. When these intersect with an acquired capability for self-harm—often shaped by trauma, habituation, or access to means—the risk escalates. Yet even this model, while valuable, must be situated within broader social ecologies. Who is made to feel like a burden? Who is denied belonging, and why?

Cultural scripts further complicate the picture. In many societies, the language available to express despair is limited, shrouded in stigma, or completely unavailable. In such cases, suicide becomes a tragic form of communication—a way to say what cannot be said in life. Anthropologists like Arthur Kleinman and Nancy Scheper-Hughes have documented how suicide, especially in contexts of poverty and marginalization, can be a culturally saturated act, entangled with ideas of honor, shame, and existential protest. In India, for instance, the alarming rates of farmer suicides must be read not just through an economic lens but as a collapse of identity, dignity, and moral selfhood. Similarly, the suicides of students struggling with academic pressure, caste-based discrimination, or familial expectation underscore how structural violence can operate through psychological pathways.

Technological change presents a paradox. On the one hand, social media and digital platforms offer avenues for mental health awareness, crisis support, and community building. On the other, they have introduced new sources of distress—cyberbullying, performative comparison, and the addictive pursuit of online validation. Research by Twenge et al. (2017) has shown correlations between increased screen time and elevated rates of anxiety, depression, and suicidal ideation among adolescents. Young

people, constantly tethered to their devices, are paradoxically more disconnected from meaningful human connection than ever before. The internet age has thus birthed a generation that is both hyper-visible and profoundly unseen.

Even as we turn our gaze to survivors—those who have attempted suicide and those left behind—we find silences that are deafening. Survivors of suicide loss often encounter stigma, blame, and disenfranchised grief. Suicide attempt survivors, too, navigate shame, medicalization, and institutional neglect. Despite growing awareness, most health systems still lack robust postvention protocols. The WHO's *Live Life* guidelines (2021) and models such as Zero Suicide offer valuable frameworks, yet implementation remains uneven, particularly in resource-scarce settings. It is imperative that the lived experiences of survivors inform our prevention and care efforts—not as afterthoughts but as central narratives.

Prevention, therefore, cannot be reduced to a checklist of risk factors or a campaign of awareness days. It must be embedded in systemic change. This includes investing in community mental health services, integrating psychosocial education into schools and workplaces, training frontline professionals in trauma-informed care, and critically—reweaving the social fabric. Societies must learn to listen—not only to cries for help, but to the quieter, chronic expressions of fatigue, alienation, and loss of meaning. The work is cultural as much as it is clinical; ethical as much as it is infrastructural.

To face suicide honestly is to confront uncomfortable truths about the world we have built and the values we uphold. It is to admit that progress can be dehumanizing, that freedom without solidarity can be suffocating, and that success without compassion can be lethal. It is to question whether the systems that govern our lives—

education, labor, healthcare, family—still serve our deepest needs or exacerbate our silent suffering.

This issue of the journal is not simply a collection of articles. It is a collective attempt to bear witness—to the pain, the complexity, the stories that are too often lost in statistics. It draws on voices across disciplines and geographies, acknowledging that no single framework can capture the totality of suicide's meaning. And yet, through this multiplicity, it affirms one core belief: that every life matters not just in its achievement, but in its vulnerability.

As we continue the vital work of suicide prevention, research, and advocacy, let us remember that compassion is not a luxury—it is a lifeline. And in a world where suffering is too often silent, let our scholarship, policy, and practice echo with the radical clarity of care.

OVERVIEW OF THE CURRENT ISSUE OF SAMBHASHAN

The current issue includes three main sections following by a tribute to Dr. Anita Ghai. Section I features papers and articles that explore various dimensions of suicide, addressing its psychological, social, cultural, and ethical aspects. The first article by Tama Dey advocates for the adoption of critical suicidology in India, emphasizing the need to contextualize suicide within broader socio-political, economic, and cultural frameworks. It highlights how marginalized groups disproportionately suffer and calls for a shift beyond individual-focused approaches. The second article by Abhina Jose explores Kerala's high suicide rates—particularly in the marginalized district of Wayanad—despite its strong social indicators, dentifying key vulnerabilities among tribal, male, and agrarian populations. In the following article by Shreya Kurnool and Lata Dyaram, they address the rising suicide rates among Indian workers and critique the lack of scholarly attention to workplace-

related suicide. The next article by Jeevan Jyoti., Mehmood Ahmad and Rabia Choudhary presents a conceptual study synthesizing literature on various dimensions of techno-stress. It explores their physiological impacts, shifting focus from psychological to bodily outcomes. Following this, Ankita Singh and Moitrayee Das review literature on elderly suicide, emphasizing overlooked risk factors like loneliness and illness, and call for culturally sensitive, policy-driven interventions. Dave Sookhoo, in his article, advocates for a sociocultural perspective in understanding suicide, highlighting the need to integrate social context into prevention, assessment, and treatment strategies. Nisha Yadav, in the following article, analyzes the root causes of farmer suicides in India, emphasizing income insecurity and risk exposure, and proposes policy reforms to enhance resilience and sustainability. The article by Srishti Sharma, Juhi Deshmukh and Aparna Satpute explores the link between binge gaming in adolescents and emotional distress, highlighting vulnerability factors and proposing preventive strategies grounded in psychology and community support. Biraj Mehta Rathi reviews Abbas Kiarostami's *Taste of Cherry*, examining how the film uses the protagonist's search for a burial to explore themes of ethics and human connection. Lakshmi Muthukumar and Saniya Gonsalves' article analyzes the representation of suicide ideation in *If Tomorrow Doesn't Come* by Jen St. Jude and *Me (Moth)* by Amber McBride, using Vulnerability Studies to show how mental health issues are shaped by broader social and relational factors.

Section II features a Case analysis by Anjali Joshi, exploring the journey from suicidal thoughts to rational living through Rational Emotive Behavior Therapy (REBT). Section III features a movie review by Tina Chakravarty of Not Today (2021), directed by Aditya Kriplani, analyzing the film's portrayal of suicide and mental health. The section also includes a book review by Aishe Debnath of *Why Physicians Die by Suicide* by Michael Myers (2017), exploring the mental health challenges faced by medical professionals. The

following book review by Wilbur Gonsalves presents a review of The Anxious Generation by Jonathan Haidt (2024), examining how the shifting nature of childhood is contributing to a rise in mental health issues. This is followed by a review by Aishe Debnath of Left Behind – Surviving Suicide Loss by Nandini Murali (2023), offering a poignant exploration of coping with suicide loss. Tanvi Upadhyay reviews *A Book of Light: When a Loved One Has a Different Mind* by Jerry Pinto (2016), an anthology that provides intimate narratives from caregivers of individuals with various mental health conditions, fostering open dialogue and compassion. Anuradha Bakshi reviews Saving Lives: A Review of the National Task Force on Mental Health and Well-being of Medical Students, highlighting the report's focus on addressing systemic failures and providing essential mental health support to medical students in India.

This issue also features a tribute by Biraj Mehta Rathi commemorating Dr. Anita Ghai's invaluable contributions to advancing disability rights in India. The issue concludes with a list of suicide prevention mental health helpline numbers.

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Editorial Team

We are gratefully acknowledge the constant support from
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Dedicated to Survivors of Suicide Loss

SECTION I: ARTICLES

SECTION I

PAPERS & ARTICLES

‘An Invitation for Critical Suicidology’: Examination of the Need for Critical-Political Analysis to Understand Suicide in Indian Context

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Abstract

A recently evolved field of study, critical suicidology, aims to understand suicide and suicidal behaviours by examining the political, economic, social, cultural, and historical contexts in which they occur. This approach adopts a social justice perspective and addresses the socio-political drivers and forces underlying the social issues that contribute to suicide deaths. It conducts a critical-political analysis of social determinants and explicitly focuses on the ethical and political contexts of the relationships between social issues and suicide. The current paper investigates whether suicidologists in India need to employ such critical-political approaches to comprehend suicide and suicidal behaviours based on the existing literature. The review underscores four crucial aspects. Firstly, it suggests that the prevalence of suicide and suicidal behaviours is disproportionately higher among certain groups, such as youth, young women, and farmers. Secondly, the nature of risk factors indicates that suicide is deeply embedded within socio-cultural-economic-political contexts and is linked to issues of oppression, marginalisation, and other forms of injustice. This creates disproportionate suffering for these groups, leading to higher suicide rates. Thirdly, the cultural-historical roots of suicide, often associated with sin and crime, underscore the need to employ newer methodologies to gain an in-depth understanding of this issue with profound historical significance. Fourthly and finally, the review highlights that the rising globalisation of neoliberal ideology also needs to be examined while understanding suicide in India. These findings highlight the need for researchers to move beyond individual-focused and problem-oriented approaches and embrace critical suicidology to arrive at a more nuanced and enriched understanding of this complex phenomenon.

Keywords:

Critical suicidology, suicide prevention, social justice, suicide in India

An Introduction to Critical Suicidology

If we take a look at the theories that dominate contemporary suicidology, we will observe that it is a cluster of theories that highlight the role and importance of various person-centric factors which are cognitive, perceptual, and dispositional in nature. They formulate suicidal behaviours in terms of deficient, distorted cognitive-perceptive processes (e.g., Baumeister, 1990; Pollock & Williams, 2001; Beck et al., 1985, 1990; Rudd, 2006). Disordered dispositional characteristics are said to increase the vulnerability toward developing suicidality (e.g., Wenzel & Beck, 2008). Also, the Interpersonal Theory of Suicide, which is also one of the most prominent theories, underscores the importance of perceived burdensomeness, perceived sense of low belongingness, and low fear of death in conceptualising suicidal behaviours (Joiner, 2005). Although the theory supposedly attempts to focus on the 'interpersonal' factors as evident in its name, it explicitly emphasises the individual's perception. The majority of these theories and models understand suicidal behaviours through person-centric factors leaving aside larger cultural, social, environmental, and ecological contexts (Hausmann-Stabile et al., 2021).

Departing from this vantage point, a school of thought has evolved which tries to understand suicide and suicidal behaviours by focusing on the political, economic, social, cultural and historical contexts within which they occur. This school of thought is often referred to as critical suicide studies or critical suicidology (Marsh, 2016, 2019). Rather than understanding suicidality free from the context, the approaches try to theorise the relationship between suicide and the broader contextual factors (Marsh, 2019; White & Kral, 2014). The theorists draw heavily from the broader social justice approach of studying mental health and illness which proposes that experiences of mental distress, regardless of its origin, occur within social, cultural and historical contexts that produce an environment of discrimination and social inequality, placing a disproportionate burden on some group people over another (Morrow & Weisser, 2012). More interestingly, the environment of discrimination and social inequalities is argued to be structured through legal, medical and mental health practices and policies. This is evidenced by several instances of psychiatric diagnoses being disproportionately applied to certain groups like women and the psychiatrisation of normal life experiences (Metzl, 2009; Ussher, 1991). LeFrancois (2013) uses the term 'psychiatrisation,' which

is viewed as the practice and result of sanism. Sanism and psychiatrisation not only address the discrimination against people diagnosed with mental illness but also unsettle several assumptions about rationality, normality and madness. Taken together, it can be contested that there are various ways in which social and structural inequities in mental health operate that represent how power is distributed in the mental health system.

Similarly, White and Kral (2014) highlight social issues like adverse living conditions, socioeconomic disadvantage, unemployment, economic hardship, poverty, and social fragmentation as well as racism, prejudice, and discrimination can increase the likelihood of suicide and suicidal behaviours. The researchers also confirm minority communities like sexual minority youth are at an increased risk of suicidal behaviour. Drawing from these pieces of evidence, they claim suicide is intertwined with social inequalities and injustice. The relationship between social issues and suicide has long been recognised by researchers (Durkheim, 1951) but studies addressing the socio-political drivers and forces like colonialism, racism, patriarchy, heteronormativity and capitalism behind the social issues having a direct effect on suicide rate are fairly new. (Kral & Idlout, 2016; Mills, 2017; Reynolds, 2016; White, 2017; White & Kral, 2014). The social justice approach distinguishes itself from traditional conceptualisations by its primary and overt focus on the ethical and political contexts of relationships between social issues and suicide. In this context, White and Kral (2014) argue that traditional psychological theories provide excessively individualistic and technical accounts of suicide that de-contextualize the act and strip away its inherently relational, ethical, historical, and political nature of it. Button (2016) states that a political analysis of suicide should move beyond sociological explanation. Instead, he argues, "The 'social facts' of suicide (the patterns and trends of suicide rates in certain populations) also tell a political story – a story (or a series of stories) that is frequently punctuated by marginalisation, persistent neglect, cultivated indifference, and bad faith" (Button, 2016, p. 274). Hence, the author asserts that there is an obligation to ameliorate the socio-cultural conditions correlated with higher rates of suicide through suicide prevention intervention.

Various thinkers and researchers in critical suicidology have drawn ideas from post-structuralist philosophers like Michael Foucault, Judith Butler, and Margarite

La Caze. Marsh (2010) adopts various principles and strategies of analysis guided by Foucault's studies e.g. Madness and Civilization; Discipline and Punish, and The History of Sexuality. The author asserts that Foucault's ideas can usefully be employed to scrutinise the underlying presumptions and certainties inherent in the attitudes, beliefs, and practices surrounding suicide and suicidality. Foucault's work can guide the mapping of the intricate connections between the production, dissemination, and circulation of authoritative knowledge, specific power dynamics related to knowledge, and 'truth effects' that influence the construction of knowledge. Marsh (2010) analyses such relations concerning how suicide and suicidality are most commonly conceptualised and responded to in practice. On the other hand, Jaworski (2020) draws from the philosophical works of Michel Foucault, Judith Butler, and Margarite La Caze to conceptualise critical suicidology's standpoint of ethics and morality of suicide.

The three challenges of critical suicidology

Taking an ethical and critical lens, the proponents of critical suicidology suggest that three problematic assumptions dominate research and practice, which are, 1. Suicide is individual, 2. Suicide is pathological and 3. Suicidology is science.

Suicide is individual: The first and foremost important assumption that underlies most suicide research and practice is the belief that suicidality arises from and is located within the individual. Suicidality is popularly thought to originate from a disordered psychic space or disturbance in neurobiological mechanisms, or a combination of both. Kral (1998) says that there is an implicit notion in mainstream suicidology that the ultimate origin of suicide lies within the person. As a result, mental health professionals look out for 'ahistorical' and 'acultural' signs and symptoms of suicidality.

Suicide is pathological: Drawing from several accounts claiming an inevitable link between mental disorders and suicide, Marsh (2010, 2016) states that another commonly held assumption in suicidology is that 'People who kill themselves are mentally ill'. With the emergence of the psychiatric profession and broader medicalisation movement, responsibility for the care and management of persons with suicidal behaviours also fell onto psychiatry and related disciplines.

As a result, suicidality has been predominantly studied through the psychiatric lens. Despite the lack of convincing empirical findings (Hjelmeland et al., 2012), the aetiological link between underlying psychopathology and suicide has been established, leading to a compulsory ontology of pathology around suicide and suicidal behaviours (Marsh, 2010).

Suicidology is a science: The final assumption in suicidology is that suicide must be studied 'scientifically'. The assumption may not seem problematic when 'what is scientific' is defined more broadly. Nevertheless, within suicidology, the meaning of scientific rigour has reduced to research procedures that use fully experimental quantitative research designs, ensure hypothesis testing, use inferential statistical analysis, and the like. Consequently, important journals prioritize the publication of only those research works that comply with the mentioned qualities (Joiner, 2011; Marsh, 2016). The hegemony of quantitative approaches and marginalisation of various other research approaches are considered problematic, for instance, White (2012) posits that such a narrow definition of scientific rigour may not provide a deep and sufficient understanding of the fluctuating, historically contingent and relationally constructed nature of youth suicide.

These assumptions prevail worldwide as can be seen in the dominance of psycho-centric theories around the globe (Hausmann-Stabile et al., 2021). Similarly, these are reflected in major epidemiological studies where researchers claim that approximately 95 per cent of people who die by suicide experience mental disorders at the time of death (Joiner, 2005) or that a review of 98% of suicide cases has ICD-or DSM-defined mental disorder at the time of death (Kapur & Gask, 2006).

Is suicidality essentially related to person-centric factors and pathology?

In this section, recent Indian studies are reviewed to map the sociocultural contexts in which suicidality and suicidal behaviours occur in India. Following this, an argument is placed on whether these prevailing assumptions need to be dismantled by suicidologists in India and whether researchers should take a

social justice lens to understand suicide and suicidal behaviours. The discussion focuses broadly on four aspects, viz., the disproportionate burden of suffering on certain groups, the complex nature of the risk factors associated with suicide and suicidality, the rich history of suicide in India and the context of neoliberal globalisation. All of these aspects highlight how suicide is intertwined with issues of injustice and politics.

The disproportionate burden of suffering: A review of the empirical research in India indicates that the prevalence of suicide and suicidal behaviours are discrepant among people belonging to certain age groups, geographical regions, communities, and so on. For instance, suicide among the youth has consistently been reported higher all over India, including South Indian states, Hyderabad, Odissa, West Bengal, Jharkhand, and northeast Indian States (Aaron et al., 2004; Kar, 2010; Kosaraju et al., 2015; Majumdar et al., 2021; Sahoo et al., 2016). A nationally representative study in India also reflects that a large proportion of suicide deaths occur among youth and adolescents, especially in young women (Patel et al., 2012). The National Crime Record Bureau data also depicts that the rate of suicide death has been highest among persons aged 15 to 29 years during the last 3 decades (Swain et al., 2021). Researchers have consistently indicated that although the suicide death rate is higher in men, suicide attempts in women are much higher as compared to men in India (Vijayakumar, 2015). Additionally, a nationally representative study indicates that the suicide rate is much higher in women than in men among young adults (Patel et al., 2012). Alongside, regional studies indicate that the suicide rate is notably higher among women as compared to men in certain areas of South India and Arunachal Pradesh (Aaron et al., 2004; Joseph et al., 2003; Singh et al., 2013). However, a much higher underestimation of the reporting of the suicide rate among women has been observed (Patel et al., 2012), while studies on suicidality in women are also limited, primarily because suicidal behaviours in women are considered 'manipulative' and 'non-serious' (Vijayakumar, 2015). Comparable observations are made among farmers, daily labourers, and gender minority groups, where the suicide rate is disproportionately higher in these groups, but their experience remains significantly less researched (Behere et al., 2021; Majumder et al., 2021). Similarly, several discrepancies could be observed across various geographical regions, such as various south Indian and northeastern regions. Researchers show that

although suicide in a tribe of Arunachal Pradesh is significantly higher than the national suicide rate, there is a severe underestimation. Moreover, suicide in the region is ignored and under-studied in the region (Mene, 2013; Singh & Rao, 2018). This higher occurrence of suicide in certain groups makes it important to understand the sociocultural, systemic, and structural factors that produce environments of discrimination and inequality in certain groups over others. Rather than looking at the personal incapacity of these groups as often highlighted by researchers, it is equally important to look at systemic disadvantages and marginalisations that the communities undergo and their relationship to the suicide rate in the communities. The following section highlights that it is not just the higher prevalence that underscores the issues of injustice, but also the complex nature of the associated risk factors.

The complex nature of risk factors: The nature of risk factors associated with suicide indicates that suicide is deeply embedded in the socio-cultural-economic-political contexts and is again tied to issues of oppression, marginalisation, and other forms of injustice. There are studies that have looked into the experiences of these groups with a narrowed and in-depth focus. Studies attempting to understand women's experience revealed that women are found more likely to experience domestic violence and other forms of violence and have greater barriers to seeking help which makes them vulnerable to suicidal behaviours (Colucci & Montesinos, 2013; Gururaj et al., 2004; Indu et al., 2017; Lasrado et al., 2016; Vijayakumar, 2015). Furthermore, women are often held accountable for the failure of their marriages, their identity is attacked, and divorce is viewed as detrimental to the family's reputation (Lasrado et al., 2016). The preference for male children and dowry expectations are also associated with suicide rates in women in India (Kumar, 2003). Hence, it can be contended that women contemplating suicide are subjected to gender-based violence, discrimination and other oppressive practices in India. Comparably, farmers' suicide is often related to agrarian crisis, indebtedness, economic downfall, dent in social status, the marriage of female family members, crop failure and the like. This indicates an inordinate socioeconomic stressor for the farmers (Bhise & Behere, 2016; Mishra, 2006). In this context, Das (2011) highlights the need to go beyond the asocial-medical model and attend to the macro-social and political paradigm to introduce social reforms to bring down suicide among farmers

effectively. Also, suicide among youth is reportedly associated with factors like childhood maltreatment, bullying, ethnicity-caste-gender-based discrimination, and stressful life events (Gupta & Basera, 2023). Several reports have associated youth suicide within institutional spaces with systemic oppression, caste violence, institutionalised discrimination, cultures of shaming, harassment in the college, and academic distress (Sarveswar & Thomas, 2022; Sasikumar, 2023; Shantha, 2019). Reviewing extensive research on risk factors of suicide, it can be argued that higher rates of suicide in specific communities are tied to various forms of oppression, marginalisation, and inequities. The sociocultural contexts produce environments of discrimination and social inequality, which place a disproportionate burden of suffering on some groups of people. This calls for framing the issue in terms of injustice and politics. While studies unfolding the social determinants are countless, there are only a handful of studies attempting to understand why and how these social determinants exist. As Hjelmeland (2016) writes, "We now have thousands of risk factor studies, yet we still understand very little about when, where, how (if at all), and for whom the found risk factors are related to suicide and why it is that the vast majority displaying one or more of them do not kill themselves." (p. 32). Very few Indian researchers attempted to understand the complexities by attending to social identity, professional identity, social positioning, gender-based expectations, cultural imperatives, and broader contexts of power and structural inequalities (Lasrado et al., 2016). It is important that Indian researchers go beyond merely stating the social determinants where there is a redundancy of literature and conduct a political analysis of the factors to understand why and how these social determinants prevail. A social justice perspective can help to excavate the ethical and political context of relationships between the social determinants and suicide.

The rich history of suicide in India: What does it say about the essential scientific approach to understanding suicide and suicidal behaviours?

Suicide has variously been studied from theological, philosophical, moral, ethical, sociological, psychological, literary, autobiographical, psychiatric, epidemiological and medical perspectives over time. It would be an enormous task to map all these perspectives and the related practices. Nevertheless, it is

important to look back at the ways suicide has been historically constructed in India to initiate the discussion on how it should be studied.

In India, suicide has been historically associated with practices to avoid shame, preserve honour, offer sacrifices, express protest, or commit a sin, depending on religious and cultural customs. Holy scriptures of the Hindu religion, such as Bhagvad Geeta and Upanishad, have condemned suicide. Bhagavad Geeta deems an act of suicide selfish and posits that a death by suicide cannot have 'shraddha,' the important last rite. Upanishad states, "He who takes his own life will enter the sunless areas covered by impenetrable darkness after death" (Radhakrishnan & Andrade, 2012, p. 305). Similarly, Quoran proscribes suicide as a cardinal sin. The Muslims believe that those who die by suicide are forbidden from entering paradise (Shoib et al., 2022). On the other hand, Buddhism considers actions that lack compassion towards self and others 'unskillful' actions and suffering or 'Dukhha' inevitable in life. Thus, it contends that a desire to end suffering through suicide is 'unskillful' and would trigger substantial uncertainties for further rebirth (Kelly, 2011). Suicide is framed as immoral, or a sin against community and God worldwide. Influenced by Plato and Aristotle, suicide is viewed as a sin against oneself in the same vein as murder against another person. Suicide is seen as a phenomenon that damages communities and their members, because human beings have a natural tendency to live, form and belong to communities (Battin 1995, 2015; Critchley 2015).

Nevertheless, contrasting perspectives are also found in Indian religious scriptures such as the Vedas, which permit suicide for religious reasons and embrace it as the best form of sacrifice. Also, few other religious scriptures allow persons to end life in some situations, such as to expiate for sin. Sallekhana, the Jain religious ritual of fasting to death, is linked to the attainment of 'moksha', signifying liberation from the cycle of life and death (Vijayakumar 2004). Two controversial ancient Indian practices are essential to mention in this context. The practice of Sati refers to the suicide of Hindu widowed women on the funeral pyre of the husband or after cremation. The other one is Jauhar, which was a form of mass suicide of Rajput women to avoid humiliation at the hands of the invading Muslim armies. Both of the practices are seen as altruistic suicide. However, whether the practices are suicidal or homicidal remains debatable to date (Vijayakumar, 2004). Alongside,

suicide has been associated with diverse social, environmental and political movements where it is used in the mobilisation of efforts. The tactic of suicide is used to transcend a movement and as an act of protest (Lahiri, 2015; Nooraeen & Croarkin, 2023). Nonviolent movements like fasting to death, grounded in the Gandhian philosophy of satyagraha, have been observed at various junctures throughout Indian history. Martyrdom, suicide bombing and self-immolation similarly represent extreme forms of protest by taking one's own life for collective causes (Biggs, 2005). So, it can be asserted that the history of suicide in India is multi-storied, complex and dynamic. However, one can argue that the majority of the religious and cultural practices consistently framed suicide as immoral, sinful or against nature and the community worldwide as well as in India.

At this point, it also becomes important to understand the way suicide is framed historically and its effects on suicidology. In an attempt to avoid the moral judgments which are historically associated with suicide, the pioneering authors in suicidology introduced an obligation to study suicide 'scientifically' through logical positivism and structural determinism, insisting that such a study must be based on empirical observations (Jaworski, 2020). This notion that suicide must be studied scientifically is termed 'scientism'. Fitzpatrick (2015) argues that although scientism has some social benefits, it primarily serves to maintain professional interests and has damaging implications for suicidology. The stance is problematic, particularly because "what constitutes a 'scientific' approach within suicidology has come to be defined in a very narrow way" (Marsh 2016, p.19). Drawing from the statements of the editors of key suicide journals, the author underscores that scientific rigour has been conceptualised by its ability to study suicide objectively and quantify the phenomenon. Only positivist scientific ventures which utilise quantitative approaches, search for objectivity and are grounded on empirical facts of suicide-related facts are deemed legitimate, fundable, and publishable. This leads to the marginalisation of other research approaches which do not promise such certainties. Hjelmeland and Knizek (2015) show how this narrowed conceptualisation of scientific rigour has resulted in repetitive, uncreative, reductionist publications in major suicide and related journals that highlight the already known risk factors of suicide. The review studies in India and South Asia similarly represent a predominance of quantitative methodologies like psychological autopsy studies, survey methods,

and analysis of police records, mortality records, and case records. The studies predominantly aimed at unravelling the suicide mortality rate, the prevalence in certain groups, common means of attempting suicide, and the various risk factors associated with suicide (Jordan et al., 2014; Rane & Nadkarni 2014; Rappai et al., 2020; Vijayakumar, 2010). The use of qualitative approaches like in-depth interviews, semi-structured interviews, focus group discussions and other novel methodologies are significantly marginalised. White (2012) argues that such narrowly defined scientific approaches to studying suicide may not provide a sufficient understanding of a phenomenon that is fluctuating, historically contingent, and relationally constructed. Such a stance undervalues the importance and unavoidability of researchers' interpretation and subjectivity. Also, it is not beneficial to study a phenomenon which has such rich historical meaning associated with it (Jaworski, 2020). Finally, it is important to move beyond the linear cause-and-effect explanation of suicidal behaviours and understand "why that particular person at that particular time in his or her life is considering to or actually has carried out a suicidal act" (Hjelmeland & Knizek, 2010). This kind of understanding should consider the complex cultural-religious-historical scripts while making sense of suicide or suicidal behaviours.

The context of neoliberal globalisation: The everyday living in this world is slowly turning towards globalisation, meaning there is an upsurge in 'global connectedness' in terms of economic, political and sociocultural environments. The globalisation has been defined as a process by which the world is being moulded into a shared social space by economic and technological forces where developments in one region of the world can have profound consequences for the lives of individuals or communities on the other side of the globe" (Held et al., 1999). Authors have argued that globalisation is not a politically neutral phenomenon, but it propagates neoliberal ideologies. Thus, they have labelled it as neoliberal globalisation (Roberts, 2020). As Harvey (2005) highlights, neoliberalism espouses individualism and personal responsibility and dismisses the accountability of the broader social and systemic factors. Taking a Marxist lens, authors contend that capitalism supports exploitation and class struggle, leading to various forms of social inequalities wherein the bourgeoisie upper class profits from the proletariat lower class's work. In this context, globalisation is understood both as a by-product of the capitalist system and a method of

expansion of neoliberal capitalist values (Moustakis, 2024; Roberts, 2020). The globalisation of neoliberalism intersects with mental health in three ways, viz., the economic impacts, the cultural ideological changes and the impacts in the medical-psychiatry sphere. In terms of economic impacts, neoliberal globalisation contributes towards greater income inequalities. Income inequality is associated with serious mental illnesses, poorer community cohesion, increased rates of depression and schizophrenia, especially in low- and middle-income countries (Burns et al., 2014; Messias et al., 2011; Pabayo et al., 2014; Pickett et al., 2006; WHO and Calouste Gulbenkian Foundation, 2014; Wilkinson, 2005). It has also been seen as a risk factor for suicide (Machado et al., 2015). The economic impact of neoliberal globalisation is also manifested through recession and austerity. Recession, which is defined as a year in which the gross domestic product of a country falls below zero, has commonly occurred in capitalist economies (Martin, 2015; Ormerod, 2010). Austerity is a societal impact of recession, and it signifies a reduction in public spending that brings down national debt and benefits a country's economic growth. A substantial amount of literature has shown that recession and austerity contribute to poorer mental health outcomes and common mental disorders in countries like the United Kingdom, Greece, Spain, and Hungary (Cooper, 2011; Martin-Carrasco et al., 2016; Van Hal, 2015). Mills (2017) contends that suicide is a symptom of austerity. She shows that suicide in the United Kingdom is associated with punitive welfare retrenchment, the stigmatisation of welfare claimants, and the internalisation of market logic that assigns value through 'productivity' and understands welfare entitlement as an economic 'burden'. Similar observations are made in Spain, Greece, Ireland and the United States, where a greater number of suicide deaths have been observed during the recession years (Corcoran et al., 2015; Isabel et al., 2017; Kentikelenis et al., 2011). In a parallel line, poverty and unemployment have been seen as key drivers of suicide in low and middle-income countries. In India, a higher suicide rate is observed among males in states with higher levels of unemployment (Arya et al., 2018). Alt (2018) tried to understand farmers' suicide in India at the backdrop of neoliberal politics and contends that, "the farmer suicides have functioned to legitimate intervention into the lives of those who remain by either treating them as subjects with mental health problems or educating them on how to embrace a neoliberal entrepreneurial mentality" (p. 1). The author also

argues that farmers' suicide functions to dispose of a population that is seen as a surplus in the contemporary development vision.

Other than the economic impacts, there are also cultural-ideological impacts of the globalisation of neoliberal ideology. The neoliberal ideology reorients a society's purpose and values towards materialism and individualism. The globalisation-driven cultural change has been observed to be a cause of concern for the Inuit Canadian community and was a driver of an increased number of suicides among them. Lastly, the impacts in the medical and psychiatric spheres encompass the privatisation of mental health care, globalisation of pharmaceutical industries and movement towards global mental health in which Western knowledge are exported globally (Moustakis, 2024; Roberts, 2020).

Conclusion

In conclusion, it can be argued that the burden of suicide and suicidal behaviours is disproportionately higher in certain groups in India. Moreover, a review of the associated risk factors highlights the complex socio-cultural, economic, and political contexts in which these phenomena arise. Suicide is also linked to various forms of oppression, marginalisation, and inequities, indicating that it is intertwined with issues of injustice and politics. Hence, it necessitates a political analysis of the social determinants. The cultural-historical roots of suicide, often associated with sin and crime, underscore the need to employ newer methodologies to gain a richer understanding of this problem with profound historical meanings. Lastly, the rising neoliberalism around the globe is significantly contributing to the burden of suicide deaths. Hence, it is important to go beyond the current mainstream theories, which often take an individual-focused and problem-oriented approach. Instead, researchers should critical suicidology to conduct a critical-political analysis to gain a more nuanced and richer understanding of this issue.

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Beyond the Kerala Model: A Multidisciplinary Revisit of Kerala Suicides through the Lens of Wayanad Distress

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Abstract

Suicide is a potential health hazard with durable socio- cultural, economic and psychological implications. The article examines the paradoxical pervasiveness of high suicide rates in the State of Kerala- a region well acclaimed for its flawless social indicators including health and education- through a multidisciplinary lens, with a focus on socio-economically marginalized district of Wayanad. Despite Kerala's achievements in high literacy rate, health and gender equality the steep increase in self kills stimulates reasonable curiosities. It is analyzed that men, tribal communities and agrarian population are the vulnerable categories reporting a higher rate of suicide. Combing the quantitative data analysis (2011-2024) and qualitative insights from police interviews the study identifies underlying suicidal causalities such as alcoholism, drug abuse, mental health disparities, agrarian distress and other cultural factors. Wayanad indigenous tribal communities encumbered by systematic exclusion, economic instability and human wildlife conflicts emerge as severely vulnerable. The article critiques Kerala mental health infrastructures, highlighting the gaps between policy and implementation and underscores the need for context specific preventive strategies. It advocates for integrating mental health education, strengthening community based interventions and addressing socio-economic inequities to mitigate the public health crisis.

Key words:

Suicide, Kerala paradox, Socio-spatial analysis, Agrarian distress, Wayanad, Mental Health

Introduction

Suicide, the act of intentionally killing oneself, or in other words, the avoidable, self-executed death, is emerging as a global health crisis or a potential epidemic, often remaining an area of study for traditions though avowedly distinct in their paradigms and traits. Edwin S. Shneidman (1918-2009), an American Clinical Psychologist who is considered the founder of modern Suicidology, the scientific study of suicidal behaviours, causes of suicidality and suicide prevention, defined suicide as the 'conscious act of self-induced annihilation, best understood as the multidimensional malaise in a needful individual who defines an issue for which suicide is perceived as the best solution.' (Shneidman, 1998)

Suicides have an undulating legacy, which the ancient Egyptian, Greek, and Roman impressions can validate. Throughout its historical progression, suicides are contradictorily associated with shame and honour. In the ancient Greco-Roman cultures, Plato, Aristotle, and Pythagoras defined suicide as a disgraceful act, yet viewed it as justifiable when it is done for the fatherland, for upholding honour, as well as in situations like chronic illness, where death is viewed as more attractive than life. It is worth underlining the polarized ancient and pre-modern class-oriented attitudes towards suicides, where the low economic class associated self-death with fear and the high class maintained a more liberal outlook. (Vessey, 2021)

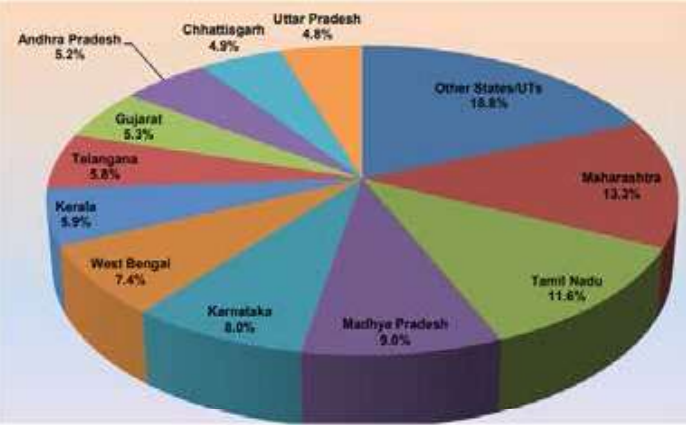
Both in their underlying causes and executions, suicides are essentially spatial and temporally dependent. The modus operandi diversifies with the Americans, Indians and Finnish! (Farberow, 1975) Despite national and international initiatives to abort suicides, the trend shows a steep increase. It serves as the 17th leading cause of global deaths and the third most wanting cause of young (15-29 years) deaths globally (WHO, 2023). Every year, 726000 people globally commit suicides and many attempt suicides, serving as a potential social epidemic for low and middle-income countries. The alarming rate of suicides among the 15-29-year-old young population of developing countries is a no-joke socio-economic concern (WHO, 2023). Though low and middle-income countries have a high suicidal vulnerability, it's unsuccessful to skip the strong correlation between mental disorders such as depression, loneliness, relationship disputes, etc., in

developed countries and potential self-kills. Therefore, it is high time to encounter suicides as a public health problem secured with its durable links to sociocultural, political and economic dynamics, which demand a public health response.

It is a timely desirability to assess the suicidal situations of India, with a total population of 1.2 billion (as per the 2011 census). Every year, more than 100000 people commit suicide in the Indian subcontinent for multiple reasons ranging from professional/career problems, a sense of isolation, abuse, violence, family problems, mental disorders, addiction to alcohol, financial loss, chronic pain, etc. India ranks 49 with a suicide rate of 12.4. The following table shows the annual suicide trend for 2018-2022.

Table 1: Total Number of Suicides and Rate of Suicides in India, 2018-2022

YEAR	TOTAL NUMBER OF SUICIDES	RATE OF SUICIDES
2018	134516	10.2
2019	139123	10.4
2020	153052	11.3
2021	164033	12.0
2022	170924	12.4



Source: Accidental Deaths and Suicides in India 2022, NCRB

Suicides, no doubt, constitute a significant health concern where states like Maharashtra, Madhya Pradesh, West Bengal and Uttar Pradesh in the northern region and Tamil Nadu, Kerala and Karnataka in the southern region contribute the maximum victims. The following figure represents the share of national suicides for the year 2022 by the top states.

Figure 1: State Wise Percentage Share of Suicides in India, 2022
Source: Accidental and Suicide Deaths in India, 2022, NCRB

Amongst all the aforementioned states, it is noticeable that Kerala, being one of the 'Top 10' Indian states with a significant share, remains a true paradox which initiated much scholarly attention from time immemorial. Being an irresistible state with high-performing social indicators that even earned the world's attention, the Kerala suicides raise reasonable curiosities which are strived to address.

Aims

The research article aims to analyze the socio-spatial aspects of suicides in Kerala with special reference to Wayanad.

Objectives

1. To analyze and understand the socio-spatial aspects of suicides happened in Kerala.
2. To analyze and understand the underlying reasons for Kerala suicides
3. To analyze and understand the dynamics of Kerala suicides with special reference to the district of Wayanad
4. To analyze the role of availability and accessibility of mental health infrastructures in limiting the number of suicides.

Study Area

The study area selected for the research is Wayanad, which is considered the 12th district of Kerala in the sequence of formation of the districts. This northeastern district lies between north latitude 110 26'28'' and 11o 48'22'' and east longitude 75o 46'38'' and 76o 26'11'', sharing boundary with the states of Tamil Nadu and Karnataka, comprising a total geographical area of 2132 sq.km, which is about 6% of total state geographical area and 40% of the district area is under the category of protected forest (PLANNING BOARD, 2024). The district with the lowest population, 817420, contributes the highest tribal population of the State (18.5% of the total district population) and ranks 12th in the sex ratio, which is 1035 females. The district, with a literacy rate of 89.03 % is ranked 14th respectively and is viewed as the poor performing district among the socio-economic indicators including health and education. The Socio-Economic Caste Census report (SECCS) of 2011

suggested Wayanad for the Central Government uplift plan as the district among the 115 other backward Indian districts accounts 75 in the poverty rank and 114 and 112 in health and education, respectively (INDIA, 2017). The district's backwardness is aggravated by the lack of transportation facilities, as this is one among the few districts with the absence of a rail network or air route, and Wayanad being a landlocked district, largely connected by the road network, there are many areas still not favored with the bus routes either! The prolonged struggle of human-wild conflicts and triggers is an added burden and irresistible predicament to the Wayanadan lives. The lack of better education and health facilities and bare developmental exposures are potent in explaining the vulnerabilities faced by the Wayanadan residents. The inclusion of the district into the aspirational districts' list under Aspirational District Programme (ADP) of NITI Aayog, 2018 is propitious.

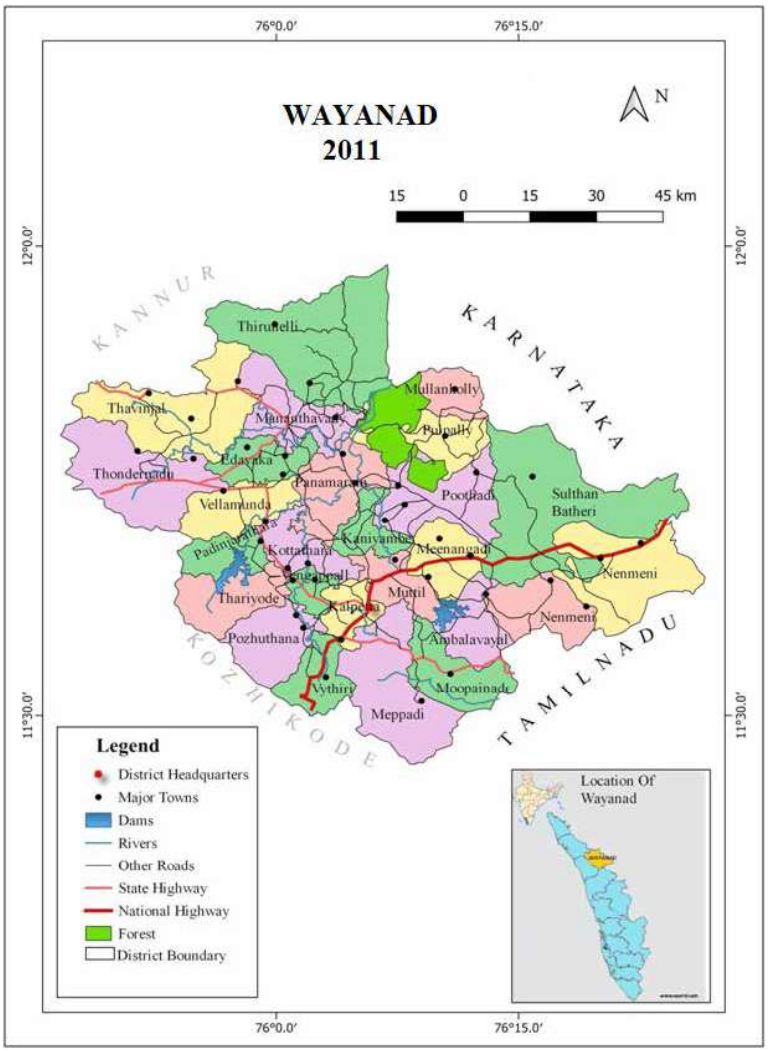


Figure 2 Study Area
Source: Map made using QGIS using the data gathered from the official website of Wayanad

Data and Research Methodology

The data for the research fall into the categories of quantitative and qualitative. The quantifiable figures, personal opinions, and statements were also collected via primary and secondary data collection methods for an inclusive understanding of the respective topic.

Thematic Analysis (T.A), the method of identifying and analyzing the patterns and themes of qualitative data, is used for analyzing the narrations gathered via primary surveys such as both face-to-face interviews and telephonic interviews of 15 police officers with a record of more than 10 years working experience and 15 officers with a recent working history, belonging to 17 police stations of Wayanad had been done to understand the socio-spatial and cultural aspects of suicides along with the established efforts in suicide prevention. A schedule of 25 questions divided into eight subdivisions was used to gather the responses accordingly. The result gathered is presented through succeeding sub-sessions.

The quantifiable data elucidating the regional trend of suicide across the district of Wayanad for the past five years (inclusive of present year) with the bifurcation of sex had been collected in person from the DCRB (District Crime Records Bureau) Kalpetta office, Wayanad with the approval of District Head of Police, Kalpetta, Wayanad under the order no, G1-22230/2024/W dated 7-06-2024. The collected data is presented using various graphical representations relevant to the findings.

OBSERVATION & DISCUSSION

Suicides: A Paradoxical Account of Kerala Model

It is noticeable that Kerala has earned wider recognition due to its ineffable performance in social indicators such as health, education, literacy and equality. According to the recent documentation of SDG performance in India (Baseline Report 2018), Kerala is ranked first. The top rank for Kerala is attributed to its achievements in providing good health and quality education, reducing hunger and achieving gender equality. The score of performance of the SDGs of Kerala could be read as follows;

Figure 3: SDG Index Scores of SDG Goals for Kerala

GOAL	SCORE
SDG 1. No Poverty	83
SDG 2. Zero Hunger	80
SDG 3. Good Health and Well being	72
SDG 4. Quality Education	80
SDG 5. Gender Equality	63
SDG 6. Clean Water and Sanitation	89
SDG 7. Affordable and clean energy	100
SDG 8. Decent Work and Economic Growth	62
SDG 9. Industry, Innovation and Infrastructure	60
SDG 10. Reduced Inequalities	69
SDG 11. Sustainable Cities and Communities	75
SDG 12. Sustainable Consumption and Production	65
SDG 13. Climate Action	69
SDG 14. Life Below Water	-
SDG 15: Life on Land	77
SDG 16: Peace, Justice and Strong Institutions	16

Source: Sustainable Development Goals Nation Indicator Framework Progress Report, 2020

An immense and efficient health support system with physical and mental health considerations guided by the then ruling communist party during Covid 19 pandemic got appreciated as a KERALA MODEL, thereby setting an epitome for more pandemics on the queue nationally and globally.

The universal literacy rate achieved by the State makes the region profoundly denser with literate human capital. Kerala is characterized by an economy supported mainly by primary activities, including agriculture, plantations such as rubber, pepper, coconut, etc, fishing, mining, and the service sector, including Tourism, Healthcare, and Information Technology. The State also has a strong tradition of Gulf remittance dependency. The trend continues with more outflows of the young population to foreign countries such as the UK, USA, Canada, and Germany, and so on, for both education and employment. Generating inland job opportunities remains always a challenge for the government. Kerala was also criticized for its resistance against industrialization, as the majority went with left ideologies.

Culturally, Kerala could be viewed in the postmodern ideologies of pluralistic thinking, critique of central power & ideology, cohesion towards subjectivity, etc., marking the state dynamic in its progress. The art and culture of the land are so in tune that they grant much exposure to the younger and older generations.

With all these indicators, parameters, and aspects adding to the pride, the paradox of the land continues with the highest number of reported suicides in the districts of high literacy and health care are perplexing and no less triggering. The following table supplements the explanation of the increasing trend in Kerala.

Table 2: Number of Suicides and Suicide Rate in Kerala, 2011-2021

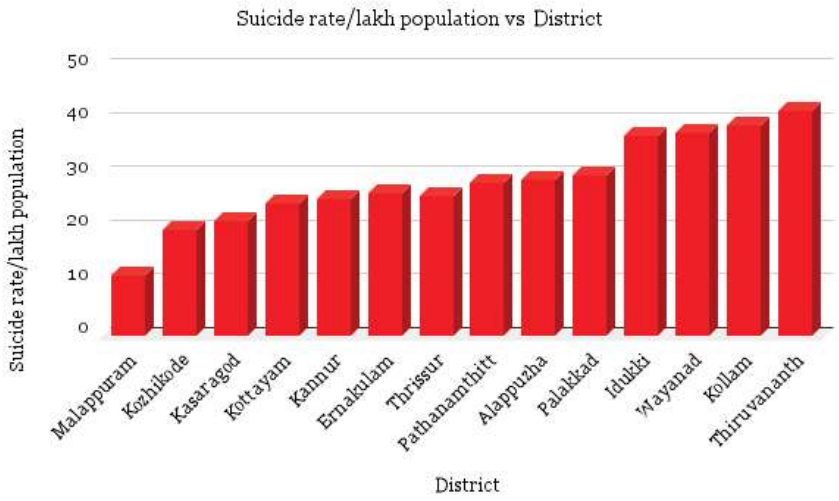
YEAR	NUMBER OF SUICIDES	SUICIDE RATE/ LAKH POPULATION
2011	7870	22.9
2018	8237	23.8
2019	8556	24.6
2020	8500	24.3
2021	9549	27.2

Source: Kerala Youth Commission Report on Suicides, 2022

Regional Distribution

The following figure shows the district-level rate of suicides in the 14 districts of Kerala for the year 2021.

Figure 4: Kerala District Wise Rate of Suicides in Kerala, 2020-2021



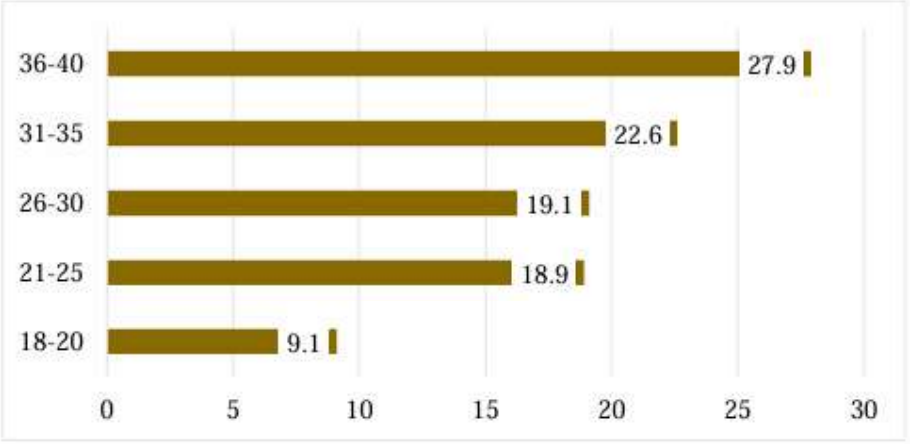
Source: Suicides in Kerala: A Critical Analysis by Dr. P.N. Suresh Kumar

The capital districts Thiruvananthapuram, Kollam, Wayanad, and Idukki are the districts that contribute the most significant number of suicides.

Age

As per the study conducted by the Kerala Youth Commission on suicides in the year 2021, on a sample size of 745 gathered from various districts all around the State, it is noticeable that in Kerala, the most vulnerable category of suicides falls into the age category of 26-40 in general.

Figure 5: Age Group of Suicide Victims in Kerala, 2021



Source: Source: Kerala Youth Commission Report on Suicides, Kerala, 2021

It is worth noticing that Kerala is the State with both adolescent and old age populations committing suicides, as these categories deal with polarized phases of life, that is, intimacy versus isolation (Commission, 2021). Adolescence is a delicate phase where the members of the same deal with enormous psychological as well as social issues. The adolescent suicides in Kerala could be viewed as the output of the increasing distress caused by interlinking social and personal problems. The members in their early 20s and 30s could be viewed as a recipient body of attention, success, commitments, and reasonable settlements; any serious setback at the same time can result in malicious outputs such as suicides.

Gender

Suicides and gender maintain an indispensable relationship with each other. Thinking holistically, one could say that Keralites belong to a sex-negative society that is highly gender sensitive, leading to accumulated atrocities against women, including domestic violence, IPV or Intimate Partner Violence, and other unfavourable situations contributing to loaded disappointment and disheartening. Still, the decision to end a life is more vested with men. The same aligns with the gender paradox of suicides (Benjamin J. Sadock, 1972) that, in Kerala, similar to the national trends, it is men who commit suicide, amongst whom married men commit more suicides than married women. From 2018 to August 2023, 6,244 men in the age group of 18-30 committed suicide in the State. The figure was 2,471 among young women. (Hindu, 2023). This diversity could be read as part and parcel of increased female education and the mindfulness to seek proper help where the biased gender role might have hampered Kerala men from being emotionally expressive and thereby not having any mental health support system. In contrast, women stay duty-free in being emotional, which is an obvious circumstance!

Education and Employment

Kerala, with the highest literacy rate in the country, possesses the highest number of suicides, with an increasing trend that has often been discussed widely. Better education facilities and efficient educational systems are inversely related to suicides, as better education supplements large cognitive coping mechanisms and potential resilience. But in the State of Kerala, there is a complete picture of a literate and educated young population committing suicide mercilessly. Here comes the inseparable amalgamation of education, employment, and mental postures. Keralites indeed crave education and employment, but the jobless youth suffering from the inadequate job opportunities elevated by societal expectations can often lead to mental distress. Taking the hot seat of educated joblessness is an actual pain in which many compromise via small jobs with minimum satisfaction, where a few surrender themselves to ultimate disappointment, ending in suicides often. When we think about the inputs from

education that apply to daily life, it is valid to suggest that there is a need for chapters with more humane subjects. The inclusion of mental health awareness and sex education by the Kerala government can be considered promising.

The Kerala paradox is reflected in the occupational status of suicide victims, too. As per the Youth Commission report, 63.9% of suicide victims are employed, where the share of unemployed victims is 16.2%, and that of students is around 13%. (Commission, 2021). The 'Employed Suicides,' similar to 'Married Men Suicides' and 'Educated/ Literate Suicides,' are multilayered. The employed suicide victims could also be viewed as the victims of a deadly working environment, stressed about the pay scale, and anxious about an unbalanced personal and professional life.

Religion

Kerala is a secular and communist state, with Hindus forming a majority in almost all the districts (54.73%) except the district of Malappuram, which is a Muslim-majority region with a share of 26.56 %, and Christians are the second majority in the State, accounting for a proportion of 18.38%. The direct relationship between suicides and religion is that, in broader aspects, any religion should work for the betterment of its followers. But the case histories of suicides reveal the fact that it is not an adhesive force but rather is the impetus in self-death. A perfect example of this could be cited from the district of Malappuram, with the highest majority of Muslim communities expanding the increasing rate of suicides of Muslim girls within the age limit of 25 years old. Rigid religious expectations, caste discrimination, young marriages, lack of girls' education and other deepened stigmas can potentially cause vicious outputs like suicides.

Caste

After analyzing the Youth Commission report on suicides as well as based on data collected through interviews, it came to notice that Kerala have a share of 9.10% SC, 1.45 %ST population and an estimated OBC population of 42%, among which it is OBC, ST and SC population are viewed as the most suicide vulnerable group. Wayanad district, with the largest share of the ST population, takes the majority of SC/ST suicides in Kerala.

Suicide Methods Employed

Like the myriad options to craft one's life, there are many methods to end the life, too. From hanging to drug overdose, Kerala has witnessed distinguished methods. The following table indicates the primary suicide methods employed in Kerala.

Table 3: Methods of Suicides and Percentage of Suicides

METHODS	PERCENTAGE OF SUICIDES
Hanging	78.4
Consuming poison	9.4
Drowning	4.7
Immolation	3.9
Jumping before moving vehicles	1.5
Drug overdose	0.3

Source: Suicides in Kerala: A Critical Analysis by Dr. P.N Suresh Kumar

Most people find hanging and consuming poison as reliable methods to end their lives.

Causes of Suicides

Suicide is multifaceted in its causes, as there is serious overlapping between social, economic, cultural, political and psychological concerns. It is examined that the primary causes of suicides in Kerala as a whole include;

Table 4: Suicide Causes and Sex-Wise Number of Suicides

ISSUE/ CAUSE OF SUICIDES	MALE	FEMALE	TOTAL
Bankruptcy or Indebtedness	220	22	242
Causes Not Known	239	61	300
Death of Dear Person	127	63	191
Drug Abuse/Alcoholic Addiction	1043	4	1047
Failure in Examination	29	17	46
Fall in Social Reputation	52	6	58
Ideological Cause/Hero Worshipping	0	1	1
Illegitimate Pregnancy (Other than Extra Marital Affairs)	0	1	1
Illness (Cancer)	183	48	231
Illness (Insanity/Mental)	492	197	689
Illness (Other Prolonged Illness)	828	340	1168

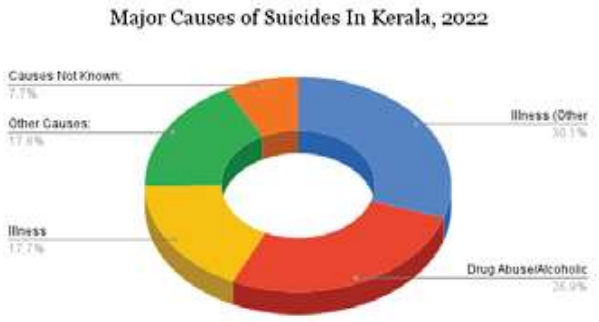
ISSUE/ CAUSE OF SUICIDES	MALE	FEMALE	TOTAL
Illness (Paralysis)	27	13	40
Impotence/Infertility	7	14	21
Love Affairs	196	96	292
Marriage Related Issues (Divorce)	9	4	13
Marriage Related Issues (Dowry)	9	0	9
Marriage Related Issues (Extramarital)	17	17	34
Marriage Related Issues (Non-Settlement)	17	13	30
Marriage Related Issues (Others)	21	9	30
Marriage Related Issues (Total)	64	52	116
Other Causes	671	112	683
Physical Abuse (Rape, etc.)	0	4	4
Poverty	2	2	4
Professional Career Problem	90	10	100
Property Dispute	6	4	10
Suspected/Illicit Relation (Other than Extra Marital Affairs)	2	1	3
Unemployment	108	9	117

Source: Accidental Deaths and Suicides Report, NCRB,2022

The above table reveals that irrespective of any leading causes, male suicides outnumber female suicides. There is a popular saying that women think about suicide but never commit it!

Delving into the leading causes, it is clear that more people in Kerala commit suicides due to prolonged illness, Drug Abuse, Mental Issues, and Other Causes and a striving majority for unknown causes.

Figure 6: Leading Causes of Suicides in Kerala, 2022



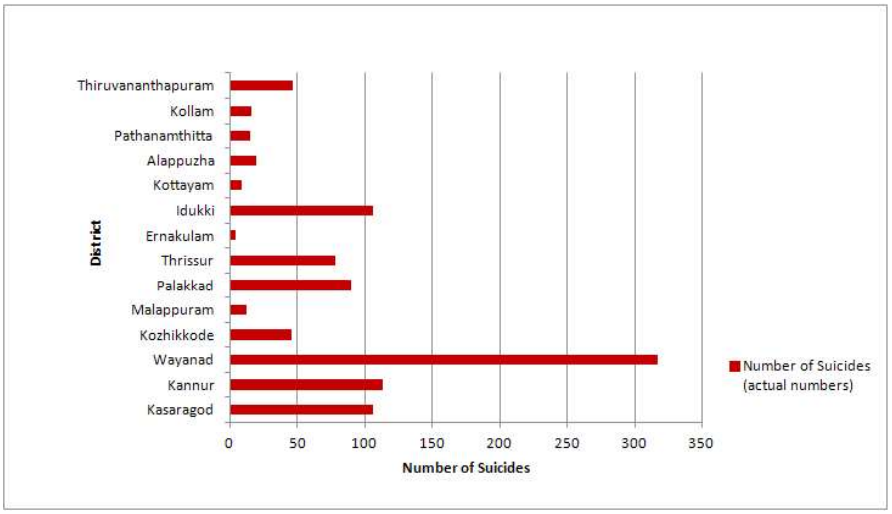
Source: Graph made using the data gathered from the ' Report on Accidental Deaths and Suicides in India,' 2022, for the State of Kerala

Though the primary concerns are shared based on data collected, an in-depth study of the Kerala Model contextualized with a promising sociocultural environment equips one to identify the legacy of farmers' suicide, which was a 'big think' before a decade ago. Though the national counting of farmer's suicides is often taken broader and is included in the employment and economic issues, it is worth understanding the crisis with more empathy, requiring a bit much effort.

Agrarian Distress & Farmers' Suicides

Kerala is a mixed economy supported mainly by agriculture and other primary activities, including fishing, mining and tertiary or service sector activities such as tourism. The Gulf remittance also boosts the economy. However, agriculture remains the hotspot, serving a larger population share. The 2009 report on Farmers' suicides in Kerala states that a majority of farmers in districts such as Wayanad, Kannur and Thiruvananthapuram have the largest share of farmers' suicides, as shown in the following figure.

Figure 7: District Wise Number of Farmers' Suicides in Kerala, 2009



Source: Report on Farmers' Suicides in Kerala, Department of Economics and Statistics, 2009

The monsoonal fall, along with climatic uncertainties following crop decline, bank loans and inadequate subsidiaries, could be the potential causes for the fatal trend. An essential dynamism associated with farmers' suicide is the family suicides or group suicides. It is a visible trend of farmers' family suicides due to severe agrarian distress.

‘In-Doubt’ Mental Health Posture of Kerala

Covid 19 the pandemic has made the world standstill, and the entire human community is dealing with claustrophobic episodes in their life where people get exposed to a lot of intra-inter conflicts leading to an open space and the need to protect the mental health capabilities of human capital to have a post covid healthy world. Though mental health discussions were associated mainly in recent times with COVID-19, it is noticeable that the Indian Lunacy Act in 1912, replaced by the Mental Health Act of 1987 and 2017, were considered the initiating steps in promising the idea of mental health as important as physical health.

Under the Mental Health Act of 1987, the State Mental Health Authority was constituted by the Government of Kerala in 1997 with two sector functions: its regulatory and developmental roles. The former includes licensing and regulating the functioning of mental health infrastructures. At the same time, the latter deals with creating more programmes and implementing the same to eliminate the intellectual and mental burden of the state population by raising untiring awareness, extending NGO support and other comprehensive initiatives.

Kerala is nowhere different from many other parts of the country, with a well-written mental policy and no state action plans! The same highlights the usual case of theory without practice. As per National Mental Health Survey (NMHS) 2015-2016, There were a total of 626 mental health professionals within the State (psychiatrists: 400, clinical psychologists (211, and psychiatric social workers: 15). Thus, for every 100,000 population, there would be 1.2 psychiatrists, 0.63 clinical psychologists and 0.04 psychiatric social workers. (National Institute of Mental Health and Neuro Sciences Banglore, 2015-2016)

There are three mental hospitals, seven medical college psychiatry departments and 18 general hospital psychiatry units in the government sector. The number of beds available for patient admission in the government sector is 1962 (5.87 beds for 100,000 population). In addition, several psychiatry hospitals, clinics and psychiatry units are in private hospitals. The District Mental Health Program is being run in all districts. There are 22 mobile mental health units, 43 daycare

centres, 66 de-addiction units, 10 vocational training centres, six sheltered workshops and 146 long-stay homes. (National Institute of Mental Health and Neuro Sciences Banglore, 2015-2016)

There are District Mental Health Programmes that run in 14 districts where villages are placed as the core component of the National Mental Health Programme (NMHP) adopted by Kerala. Like other Indian states, community health centres (CHCs) function on a more local level, amplifying the decentralized Kerala Model. Besides, there are ventures such as THALIRU (focusing on the mental health of the students), MUKTHI (community-based substance prevention programme), SANTHWANAM (occupational therapy unit), MANASS (tele-mental health services) targeting specific vulnerable categories can be viewed.

The Yuvajana Commission or Kerala Youth Commission raising the slogan of 'ZERO SUICIDE' and other geriatric mental health services aimed at the old age population are also in the long run.

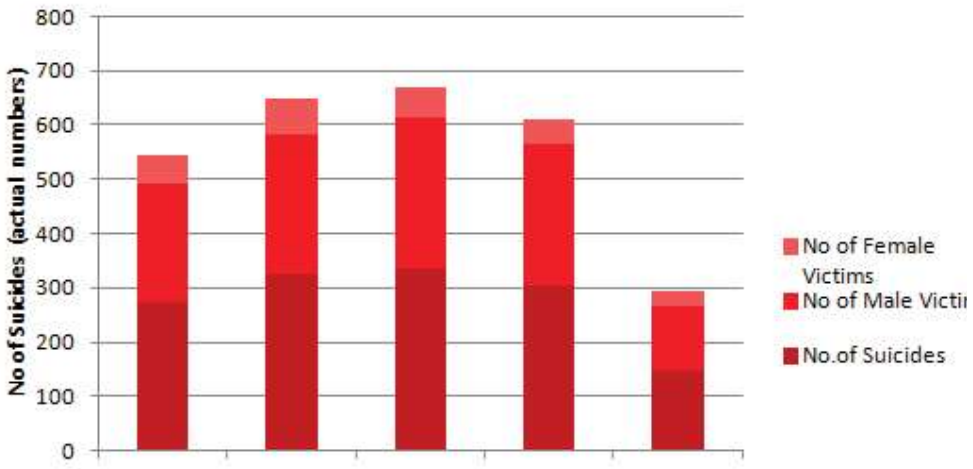
But the present mental health disorders and their malicious effects, such as suicides, poignantly signify the debatable efficiency of all the programmes at varying levels. The NMHS reported that the allocation of funds for mental health care and the efficient use of allocated funds remain a latent huddle to overcome.

SUICIDES IN WAYANAD

The following could be viewed as the discussion of the data collected through interviews of the police officers of Wayanad district about suicides, causes, ideations and related aspects.

Trends and Patterns: Wayanad as a whole is experiencing a declining trend in conventional farmers' suicide, whereas the tendency of child suicides, even at the youngest age of 6-10 years, is a pristine potential trend to overlook in the future. Likewise, the number of SC/ST suicides remains a significant challenge with a slightly declining trend.

Figure 8: Suicide Trend in Wayanad, 2020-2024



Source:Office Database, District Crime Records Bureau(DCRB), Wayanad, Kerala,2024

Interpretation:

General Trend: The stacked bar graph illustrates the number of suicides, broken down by gender, in Wayanad from 2020 to 2024. As shown, the total number of suicides for each year is represented by the entire height of the stacked bar. The sum value shown includes the total number of male and female suicides for each year. Unfortunately, there seems to be an increasing trend in the overall number of suicides over these years.

Specific Observations:

- **2020**: We see a relatively lower number of suicides compared to subsequent years.
- **2021**: There's a noticeable increase in the number of suicides compared to 2020.
- **2022**: The number of suicides continues to rise, reaching the highest point in the given period.
- **2023**: While still high, there's a slight decrease in the total number of suicides compared to 2022.

- **2024**: The data till June signifies the potential rise of suicides. But it is worth noting that a period witnessed by natural calamities like the Wayanad landslides may also show a stagnant or declined trend.

Gender Breakdown:

- **Male Victims**: The number of male victims seems to be consistently higher than female victims throughout the years.
- **Female Victims**: While the number of female victims also shows an increasing trend, it remains lower than that of male victims.

Suicide Methods: The primary suicide methods, as per the observations and years of field visits of the officers, include hanging, in particular outside hanging and poison consumption. They stated that hanging outside the house happens mainly because of crowded interiors where the houses are comparatively thatched ones with only a few feet in height. The SC/ST suicides have the central tendency of hanging outside the home, over a tree or near forest areas. The 'hanging outside' method has also resulted in wild animal vulnerability, where the victim remains half-eaten and the human is missing. Another primary method includes poison consumption, which is common in the case of farmers' suicides and victims belonging to categories other than SC/ST.

Figure 9: A hanging suicide scene

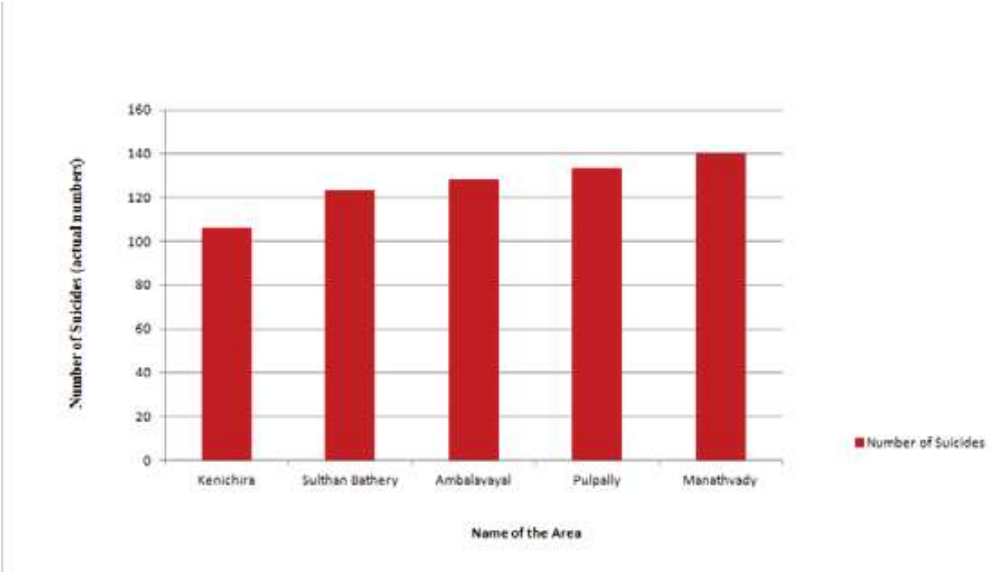
Source: Manorama News Report dated 3 January 2021, Kozhikode, Kerala

Spatial and Demographics

Areas with the highest number of suicides: When asked about the areas with the highest number of suicides, though void of the custom of recording the total number of deaths recorded over the entire Wayanad district, it has been shared that;

1) Sulthan Bathery
2) Ambalavayal
3) Kenichira
4) Pulpally
5) Mananthavady

Figure 10: Areas with suicide Vulnerability, 2020-2024



Source:Office Database, District Crime Records Bureau(DCRB), Wayanad, Kerala,2024

Interpretation

Suicide Rates: Mananthavady has the highest number of suicides, followed by Pulpally, Ambalavayal, Sultan Bathery, and Kenichira.

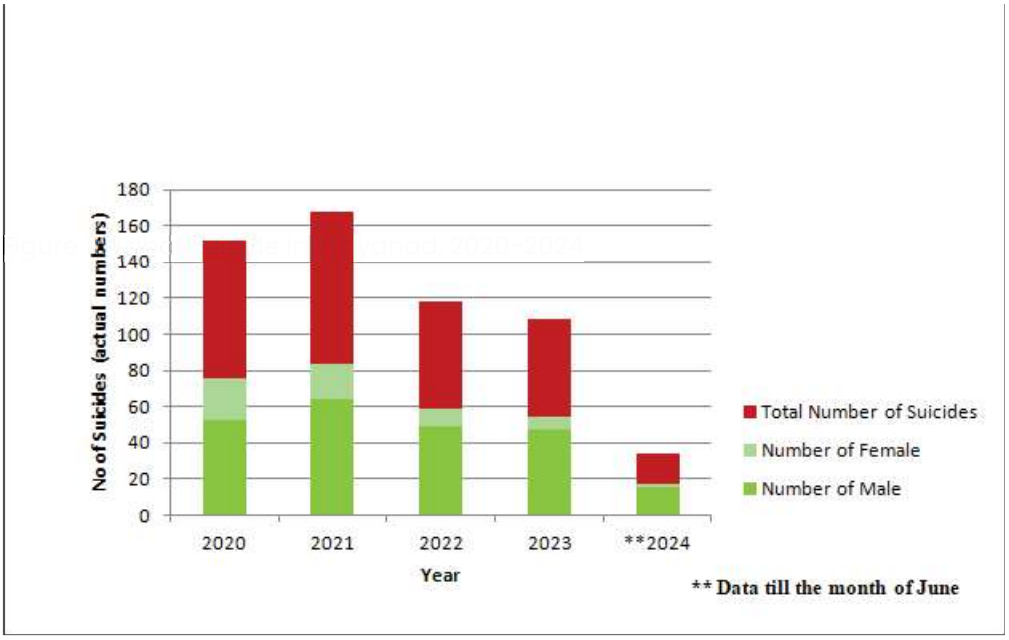
- **Increasing Trend:** The number of suicides seems to be increasing over time in most areas, as indicated by the upward slope of the linear trend line.

- **Variability**: There is significant variation in the number of suicides between the different areas.

From the interviews carried out, it came to known that Kalpetta subdivision has the highest number of child and teenage suicides that happen mainly due to academic stress, relationship issues, and gadget and substance addiction such as mobile phones and drugs, respectively.

The category of the population with maximum suicide vulnerability: Around 40-45% of the total geographical land is forest, and the district has 18.5 percentage of the tribal population, contributing 36% of the state tribal population. Tribes belonging to the major categories of;

1) Paniya
2) Kurumas
3) Adiyars
4) Kurichyas
5) Ooralis
6) Kattunayikkas



Source: Office Database, District Crime Records Bureau (DCRB), Wayanad, Kerala, 2024

Interpretation

- **Declining Trend**: There is a noticeable increase in the total number of suicides from 2020 to 2021, following there is a decreasing trend of tribal suicides for the years 2022 and 2023. The total number of suicides for each year is represented by the sum of the number of male and female suicides in the stacked bar diagram.

- **Male Dominance**: The number of male suicides is consistently higher than female suicides in all years represented.

- **Gender Disparity**: The gap between male and female suicides seems to be widening over the years, particularly noticeable in 2021 and 2023.

The tribes, most of the time, end their lives on momentary thoughts, for example, over the share of alcohol distributed among the family members or over drug disputes. The respondents claimed that people here (tribes in particular) do not understand the meaning and value of their lives as they cannot have any futuristic thoughts. Most are daily wage workers, with less than 1% in low-status government jobs. The daily wage workers initially spend a significant share of their money on the consumption of alcohol and drug abuse (alcohol consumption is more common among the tribal sects of Paniya, Kattunayikkas and Adiyas), resulting in bare savings. Since many government policies and programmes support tribal child education and accessibility of food products at the lowest costs or free of cost, the bare savings work!!

Tribal populations with a high cultural diversity believe in life after death, making death a celebration, especially in communities like Paniya. The human authority to end life is part of community rights, whereas initially, the state perspectives viewed it as a crime. Suicides or self-deaths made by age-old people are viewed with immense respect as they make the lives of the non-dependent population easy. A novel cultural shift or the mass conversion of tribes to Pentecostalism, a Protestant Charismatic Christian Movement, has the potential in the making to check inappropriate lifestyles such as alcohol and drug consumption, sexual harassment, child marriages, IPVs, etc, eventually ceasing the cases of suicides.

The police officers have the opinion that the conversion has culturally succeeded in making few communities aware not to end the life granted by the Almighty

Vulnerable age group: Among the total number of suicides recorded in the past five years in Wayanad, it is essential to notice that more than half of the SC/ST victims belonged to the age category of 30-40 years among men and 18-25 years among women. The general category of suicides includes the age groups of 22- 28 among women and 25-35 among men. Whereas among child suicide, it is the age categories of 14- 18 years have the highest number of victims.

Contributing Factors

Major causes or contributing factors: When asked about the relevance of death concerning the contributing factors or major causes, it became clear that alcohol consumption (both active and passive), drug abuse, and dysfunctional family relationships are the major contributing factors of SC/ST suicides whereas the cases of depression, substance or material addiction, intimate partnership issues and academic failures serve as the major causes for suicides among the non-SC/ST categories and children below the age of 18. Farmers' suicides due to financial losses, crop failures and wild animal conflicts remain another major set of causation factors among the suicides reported in Wayanad (with a separate database). Let us sum up the causes of suicides;

1. Alcohol Consumption
2. Drug Abuse
3. Dysfunctional Family relations
4. Intimate Partner Violence
5. Academic failures
6. Sexual Harassment
7. Crop failures and wild animal vulnerability
8. Economic Crisis
9. Mental Health Issues (mainly depression)
10. Post Mental Health treatments

The following chart can be used to substantiate the understanding.

Alcoholism: A potential threat: Alcoholism in Wayanad district, particularly among the tribal populace, is so intense that it causes a serious threat to the increase in the number of suicides.

A case history shared by one among the police officers includes the suicide of two brothers on the festival time of Onam, a local Keralite festival on the share of alcohol. Similar to this, Pulpally had witnessed a significant suicide of 22 solely due to suicide in the year 2022.

Case Reporting and Crime Statistics Comparison

Case and Reporting

A view on the high number of suicides in Wayanad and Kerala can be viewed as a possible outcome of the high Crime Reporting Rate, too, which is a positive take on the crime awareness of the public. All the benefitting social developments in the State have also equipped individuals to report even the slightest atrocities they face. In Wayanad, the officials and their involvement with the public is pleasing that the government workers, including teachers, ASHA workers, and other public workers and their local networks are enabled to have the maximum reporting of the crimes happening in the district, including suicides. Therefore, mere numbers do not mean the crime intensification or severity but rather a well-established reporting rate.

Suicide Acts and Decriminalization:

The question of including suicide as a crime is debatable, perhaps a decadal domain. Still, the Indian Penal Code (IPC) 309, Attempt to Suicide states that, 'Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year [or with fine, or with both.].'

Whereas IPC Section 306, Abetment of suicide, states that 'If any person commits suicide, whoever abets the commission of such suicide, shall be punished with

imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.'

A landmark change occurred with the enactment of the Bharatiya Nyaya Sanhita (BNS) in 2023, which replaced the Indian Penal Code (IPC). This new legislation explicitly decriminalized attempted suicide. The anticipated implications of decriminalization include;

1) **Reduced Stigma:** The removal of criminal liability is expected to reduce the stigma associated with suicidal thoughts and encourage people to seek help.
2) **Focus on Mental Health:** This shift allows for a more holistic approach to addressing the underlying causes of suicidal behaviour.
3) **Effective Prevention Strategies:** With decriminalization, resources can be allocated towards prevention, early intervention, and mental health support services.

Suicide data bank:

The research on the suicides happening in the districts of Kerala would help to highlight the regional distribution of the phenomenon, for which the primary limitation is the absence of provision of uploading suicide data on the website of DCRBs or the District Crime Records Bureau. Any intended research on the field is carried down primarily via offline mode, making things accessible. This situation was handled as part of the debate on 'Suicide vs Mental Crime,' i.e., usual crime data that is uploaded to the website helps in generating a crime data bank across the country. Still, since suicide is not under the perimeters of An IPC crime, the data is preserved with confidentiality.

Limitations of the study

The significant limitations of the study include;

1. **Data Availability & Representation:** As suicides are barely viewed as a potential crime for which data is to be reserved, and there is no suicide data bank available online either in the State Crime Record Bureau or District Crime Record Bureau.

2. **Time-Consuming & Expensive:** The inaccessibility of suicide data curtails further research to a larger extent, and many times, in-person meetings and physical data collection involving research are consuming and expensive.
3. **Data Periodicity:** A significant challenge of relying on secondary data sources are that many governmental and non-governmental organizations claiming the publication of annual reports publishing have hardly made efforts to continue the legacy. Many reports date back to 2017, 2015 and 2009.
4. **Biased Responses:** As the primary data collection is done through face-to-face interviews, there are potential biases and prejudices

Concluding Remarks:

Suicide, or the act of deliberately killing oneself, is a multifaceted health concern that triggers the socio-cultural-economic set-up of a world. Though viewed primarily as a mental health concern, it's come to precision that suicides are many a times the unavoidable responsive mechanism to many appalling social, economic, cultural and political scenarios. It is a comprehensive call to induct into the circumstances making suicides inevitable and the best solution as defined by Edwin Shneidman. In a state with high-performing social indicators such as education, health and gender equality, the never-stopping trend of suicides with due specifications of the adolescent and elderly male population due to career setbacks, academic expectations, drug abuse & alcohol consumption, familial and other relationship problems is a wakeup call to understand the heart of the problem!

A theory without well-defined action plans, including implementation and surveillance, can generate many paradoxes demanding restriction and reassurance to the members of the society who deserve social security and prosperity by all means. The post-suicidal approaches in Kerala as a whole and Wayanad, in particular, should be replaced with preventive measures fundamentally focusing on schools and nursing homes. Humans are the capital!

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Work and Suicide: Towards Exploring Workplace Morbidities

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Abstract

In recent years, there has been a rise in the number of fatalities that occur in the workplace, which has raised issues over the mental health of employees as well as the accountability of businesses. As suicide rates can be seen as indicating mental health within the society, there is a rising awareness and acknowledgement of the significance of mental health in the workplace. Despite a substantial volume of contemporary organizational literature that attends to employees' well-being and occupational health, scholarly works particularly on suicide behaviours among employees, are abysmally poor. The dearth of scholarly as well as practitioner's attention to this issue is concerning, given that suicide deaths among Indian workers are only on the rise. In order to promote the examination of work and suicide with the goal of ultimately curbing mortality rates, we present a perspective that underscore an interdisciplinary approach, thereby providing insights for comprehending the prevailing trends associated with work and suicide in India. We emphasise power dynamics, politics and social relational elements around suicidal ideation and or behaviour in an organizational context, and highlight strategies for employers to construct a work environment that ensures psychological safety and is conducive to employee well-being. Taken together, we amalgamate various domains particularly through a biopsychosocial lens while tackling a critical mental health crisis that stems, in part, from employees' work and workplace experiences.

Keywords:

Self-harm, workplace suicide, stress, morbidities, biopsychosocial

Background

This work presents reflections and insights on the significant transformations experienced by businesses and organizations in recent decades owing to

technological advancements. It also recognizes the various crises that have impacted our societies, affecting the operational dynamics, sustainability, and viability of these entities. Several unprecedented phenomena, such as the Covid-19 pandemic, industry 4.0 and the emergence of advanced technologies such as the internet of things (IoT), generative artificial intelligence (AI), and machine learning (ML) have conquered business and organisational life in a way that few were prepared for.

The increasing incidents of humanitarian crises and global conflicts, such as those on the lines of devastation in Syria and Ukraine, have exacerbated the unsteady global economic landscape. While within an organizational context, change is seen as the only constant, creating both risks as well as opportunities, what is not clear is business and workplace drivers that escalate to a state of self-harm leading to public health and a humanitarian crises.

While researchers in organizational studies have historically prioritized the well-being and occupational health of employees, there has been comparatively less emphasis on the specific issues such as self-harm and suicidal behaviours within the workforce. Suicide in the workplace is a tragic phenomenon that has been more prevalent in India over the past few years. People of working age make up the majority of those who take their own lives. Despite this, many business entities are clueless on how to support and or assist employees who are at risk of committing suicide or to respond to a suicidal death. The scarcity of research in this area is particularly concerning given that people dedicate a substantial or whole of their waking hours and life building their careers via work and professional environments building their , alongside the alarming increase in suicide rates among Indian workers. While individuals often prioritize their life, health, and well-being, how must employers and organizations prioritize the work, workplace, or occupational health and well-being of their employees? Modern day workplace morbidities, hazards, threats to safety of workers continue to raise the question of what can we learn from these violations and extortions to translate them into prospective positive and sustainable change to initiate.

Despite many progressive organisations being cognizant about the fact that it actually makes good business sense to focus on people and potential preventative measures that can curb occupational hazards, more often than not they adopt a reactive approach to address these issues. Perhaps what is not clear at a ground level for organizations could be how do they have a 'duty of care' to ensure 'all' employees work in a safe and healthy working environment, and not harmed by they conducting their duties. Particularly, with respect to issues like workplace suicide, it becomes extremely pertinent to approach this with at most sensitivity, accuracy, and with a focus on preventing future tragedies. Workplace suicide is a serious issue that affects innumerable individuals, families, organizations and the nation. Perhaps what is not known could also be how do one go about drawing boundaries and define workplace suicide? Is suicide a work issue or workplace issue? Is it that self-cessation occurs directly owing to work itself, or is it risk factors in the workplace, or within the larger context of a person's employment i.e., either on-site, during work hours, or as a direct result of work-related stress or pressures? In recent years, the issue of corporate liability in cases of employee suicide has garnered increased scrutiny. With the rise in suicides and stressed employees, firms are urged to consider their responsibility of care towards their workforce.

This problem is intensified by many legal decisions that set precedents about employer liability for an employee's suicide. The Supreme Court recently dropped a criminal case against a prominent international firm concerning the suspected suicide of one of its employees. The degree to which firms can be held liable for an employee's suicide remains unclear. Prosecuting company officials for complicity in a suicide would represent an improper application of the court system, considering the ambiguous comprehension of suicidal fatalities. Workplace occurrences, such as coercing employees to resign or demoting them, do not demonstrate that the firm compelled employees to the point of suicide. Section 306 of the Indian Penal Code, presently known as the Bharatiya Nyaya Sanhita (2023), specifies that an employer can only be tried for abetting suicide if there is clear provocation that compels workers to resort to self-harm. The Supreme Court's decision to dismiss the complaint against the company executives highlights the requirement for significant evidence indicating an intent to provoke employee suicide, rather than mere claims of

workplace pressure or harassment. To determine an employer's obligation in cases of employee suicide, it is essential to clarify these critical facts, as they may influence organizations in the future. This is essential as it safeguards businesses and employers from wrongful prosecution for a crime due to unclear information, underscoring the necessity for the establishment of pertinent statutes, rules, policies, and regulations.

While suicide is a global phenomenon and is a significant public health issue wherein the World Health Organization (WHO) indicates that 700,000 people die by suicide each year worldwide, suicide rate has increased to 12.4 per 100,000 people compared to global average, the highest rate recorded in India. Specific data on workplace suicide globally is limited (Howard, 2022) as it is often challenging to accurately track suicides directly attributed to work pressure and other work-related factors. With India State-Level Disease Burden Initiative Suicide Collaborators (2018) and National Crime Records Bureau (NCRB, 2022) reporting over 1.71 lakh suicides in India, India seem to set a dubious distinction of having the highest number of suicides in the world. This is particularly concerning when suicide became the largest public health crisis facing people, both young and old in India. While some of these estimates are marred by incomplete reporting and inefficient civil registration systems (Arya et al., 2021; Snowdon, 2019), NCRB pegs suicide as having far reaching socio-economic, emotional, and political consequences (NCRB, 2022). Also, some of the important considerations must be noted on the reporting of the incidents and other data limitations. This is so as often suicide statistics are underreported due to social stigma. In addition, more significantly, there is increasing evidence that points to a greater association between detailed media portrayals of suicide and imitative suicidal behaviour. Media reporting's of suicide in India is poorly adherent to international reporting guidelines, keen to sensationalizing with very little focus on its role in suicide prevention efforts and creating awareness or educating the public. Hence, readily linking a suicidal deaths to work and workplace factors can be complex, challenging and misleading.

Understanding Work and Suicide

Numerous firms continue to struggle with maintaining workplace well-being, which is critical for organizational sustainability (McKinsey, 2022). This is despite the fact that there has been significant advancement and growth in employment scenario across a variety of industries. Workplace suicidal and morbid feelings can set off by several workplace components (ILO, 2022; McKinsey, 2022).

Employee morbidities can be of multiple nature such as musculoskeletal vulnerabilities and disorders affecting nerves, tendons, spinal disc among others, respiratory conditions including, asthma, pulmonary disorders, allergens, and poor air quality among others, prior mental health conditions such as anxiety, depression, hyper tension, often interacting and exasperated by workplace factors such as poor ergonomics, crowded office setting, repetitive motions and exertions, workplace isolation, exclusion, bullying, lack of support, high work load can be seen as contributing to the incidents of workplace suicides (McKinsey, 2020). Likewise, workplaces all too often become breeding ground for infections, particularly affecting hygiene and health care activities of workers, sedentary works, eye injuries and disorders, poor diet and food service quality and care, all contributing to cardiovascular issues, infectious diseases, high stress, increasing auto immune concerns. Personal and family issues, alcohol and substance abuse concerns can get to the brink with increased stress and long hours spent at work or can get exasperated by workplace injuries sustained while carrying out duties or falls/trips/equipment related injuries. Some of the research evidence points out that workplace stress is the number one reason for incidents of employee committing suicide. However, it is important to conduct pertinent investigations and research to understand the work and working conditions, across industries and work environments to contain the triggers of such mental states of workers and suicidal tendencies. More importantly, it is pertinent to note that some occupations have been found to have higher suicide rates than others. Workers in service occupations with a higher risk of suicide may include caring and service sector workers such as police, and law enforcement personnel, construction workers, some health care personnel, veterinarians, and so forth (ILO, 2020).

We argue that the workplace stress can be seen as an individual's physical emotional and psychological response to the actual and expected job demands. The person capabilities and resources, are often to be aligned towards both internal need satiation as well as to match the expectations of the external environment propelling adaptation. Job or work related stress can be seen as one of the leading causes of individual's mal adjustment, stress, self-doubt and self-cessation thoughts. Far too often, with lack of direct or specific records and documents on workplace suicide (Office of the Registrar General of India, 2020), there is no way that one can readily correlate and or attribute work-related stress, job insecurity, and long working hours as independently and solely triggering mental health issues and employee suicide in India. However, in the recent past for instance, specifically in 2024, there emerged a significant outcry and extensive criticism, with social media serving as a catalyst for debates and discussions regarding how overwork and its intense pressures have exacerbated the decline of both physical and mental health among highly educated knowledge workers and technology professionals. The detrimental work culture was cited often within the prominent organizations and multinational companies in India. Some of the esteemed consulting firms known for their works, reports and publications on workplace mental health also have tragically lost their young professionals to suicide, with attributions pointing to excessive workload, toxic work culture and burnout. In such instances, firms do convey their sympathies and highlight their dedication to fostering a healthy workplace; however, they frequently refute the assertion that work-related stress directly contributes to instances of suicidal deaths. Hence, the effects of work on suicide are complex. While, work can be protective shield against suicide and several other human vulnerabilities, as a source of personal satisfaction and meaning, interpersonal contacts, and financial security, it is only when work is ill organized or when workplace risks are not managed or mismanaged, work can raise suicide risk in some workers. As correlation is not causation, although heavy workload, long work hours, uncertainty and job insecurity, harassment, bullying, discrimination, lack of support can all contribute to increase work related as well as workplace stress, it cannot be concluded that these have caused worker suicides.

It is social factors such as taboo and stigma around psychological problems and mental health issues at workplaces, which prevent many from seeking timely

help. Most businesses and organizations uphold productivity, competence, extraversion and business like persona with emotional stability as virtues at workplaces. Silence around issues pertaining to mental wellbeing at organizations contribute to workplace stress. Expressions of hopelessness or worthlessness, substance abuse, long periods of withdrawal, sickness, absenteeism, workplace errors and blunders, reduced activity and productivity, changes in the looks and appearance, could all serve as cues towards risk factors that may increase the likelihood of workplace suicide (McKinsey, 2022).

Risk factors such as a biological makeup and history of mental illness, previous suicide attempts, and or experiencing traumatic events often serve as contributory factors that augment the risks of workplace suicide. Beyond presence of some biological aberrations, present article highlights social relational factors at work that may carry a vulnerability to develop worker suicidal thoughts, feelings and action. Human frailties often get pronounced when driven to the brink. Substantial research evidences that bullying and in-group favoritism to adversely impact employees that may push the staff and employee base to the brink (Leach et al., 2017). Complaints and displeasure expressed owing to bad politics and cronyism behind the rise of various employees through the ranks marks the value organizations and business place on human rights and social governance. Power and pay disparities and consequent status inequalities, capitalistic greed, corporate corruption, managerial and executive narcissism; lip service to righteousness; obedience to the authority, norm of the compliance to loyalty; fraternity; seniority, leadership and supervisory bullying, all aid in elevating the levels uncertainty and the risks individual members often perceive and help explain the employee actions that either sub serve, or withdraw from such organizational context.

The discourse surrounding work and work culture in India has intensified recently, as senior leaders across various sectors emphasize the importance of prioritizing work over work-life balance. Despite the current trend of global companies implementing four-day work weeks, Indian workplaces continue to prioritize long work hours, often associating them with a strong sense of dedication and commitment. Besides, there exists a distorted view that employees extended working hours as signifying greater productivity. This perspective often measures

productivity solely by the amount of time spent working, rather than by the actual results accomplished. The glorification of long work hours and workaholism in India establishes a detrimental cycle, resulting in a situation where neither employees nor employers derive respective benefits. There are several such nuanced administrative, management, supervisory expectations and pressures that have been shown to adversely affect mental health at work, and directly or indirectly impacting suicidal thoughts, behaviors, and death. We reiterate that many of these workplace factors do often interact with non-workplace factors to further increase suicide risk.

Social-relational Lens to Work and Workplace suicides

Aforementioned is only a growing body of data that suggests that psychosocial variables, in addition to physiological and biological factors, play a role in the aetiology of a variety of mental and physical health stressors that are seen in modern workplaces. Back in 1977, George Engel, was the one who initially proposed the biopsychosocial model, was largely accurate in his predictions on what he believed was going to happen in the future. These workplace fatalities are the clear demonstrations of the roles that multiple factors take, including biological, psychosocial, and socio-political factors, which combine in complex ways to determine exposure, prevalence, an individual's quality of work life, and mortality. These fatalities are particularly relevant in the contemporary workplace context and corporate world.

Therefore, we contend that the biopsychosocial model is an appropriate lens for understanding certain non-communicable health conditions, such as suicide thoughts, attempts, and fatalities within work settings. In light of increasing employee suicidal deaths, we allude to the investigation of the significant bearing that particularly social relational and political context within the organizational settings may have on the employee experiences at work and the overall workforce well-being.

It is not surprising that researchers in the social sciences have shown a large amount of interest in investigating the factors that contribute to suicide, given that suicide is one of the leading causes of death on a global scale as well. Suicide is the most significant reality depicting poor biological and psycho-social

health. Nevertheless, there exists a notable deficiency in scholarly inquiry into the relationship between occupation, employment, work, and suicide, despite some academic curiosity and the recognized significance of work in our daily existence. Hence, we argue that this body of research has not yet gained momentum within Indian organizations and that it has to be thoroughly examined by combining the biopsychosocial model, in particular by weaving key social factors into the discourse surrounding work and work design literature at the same time. We assert that the qualities of work and work design, which include nature of the job, compensation and rewards of the job, autonomy and physical or cognitive demands of the job and more, are all constantly evaluated and contrasted in reference to societal and social standards which ascribe prestige, relative dignity and social status to the work and jobs. In light of this, consequently the societal norms and conceptions that surround the terms "occupation," "profession," "work," and "career" are inextricably connected and shape the employee experiences within the world of work. Depression, suicide ideation, and suicide attempts are all too often the lived experiences that employees have while navigating the weight of societal conceptualization of work, job and career.

A significant number of young employees in today's workplaces have a tendency to avoid socio-political engagements because they often believe them as negative, see exchanges and interactions as superfluous with hidden agendas, and as devoid of morals or integrity. Nevertheless, they do demonstrate a heightened vulnerability to its ill effects, which include unhappiness with their jobs, resignation, and a decrease in their overall well-being (Goel, A et al., 2024). Moreover, according to the works of Jaiswal and Dyaram (2019), the immediate work environment has a significant impact on employees. As a result, it is seen as crucial by employees to acquire the skills necessary to negotiate socio-political challenges within the realm of work environment in order to advance one's career and improve one's overall well-being.

The existence of extensive evidence suggests that a number of complex socio-political variables have an influence, both directly and indirectly, on job autonomy, possibilities for advancement, promotions, the type of projects, work-family conflict, and levels of job satisfaction. These factors are all also influenced significantly by the nature and status of the job as pegged within

the organizational hierarchy as well as by the societal yardstick. Social mobility allows individuals to keep their positions within the workforce, rather of relying entirely on their knowledge, skills, and work competences. This is because social mobility enables and allows individuals to go up within the organizational structures and work environment as well. Consequently, the perceptions and experiences that employees have within the complex social-relational power dynamics of the workplace and working environment have a significant impact on their sentiments of who they are, workplace inclusion or alienation, as well as their intentions about the continuation of their line of work. The result of this is that it has the potential to have a detrimental impact on their sense of self-worth and self-image, which may ultimately result in their withdrawing their participation. The intricate interplay of political and power dynamics, coupled the social relational features that continuously review and scrutinize employees on many dimensions of their professional and personal life, leads individuals to engage in self-evaluation filled with dread (Goel, A et al., 2024). It is usual for this to lead to feelings of self-doubt and a sense of disconnection from one's surroundings, which ultimately leads in effects that are more severe than those that are typically discussed in the existing body of research. While the bio-psychosocial model is not a therapy but can be seen serving as both a care philosophy and a practice guide.

The biopsychosocial model is a perspective that explains health and illness as a result of the interplay between biological, psychological, and social factors suggesting that all three of these factors contribute to the development and maintenance of health or illness, and that none of these factors can be understood in isolation from the others. The biopsychosocial model can serve in prevention and intervention towards treatment of mental health conditions, as it emphasizes the importance of considering the whole person in their context and position, rather than just their physical symptoms.

Perspectives for Suicide Prevention Strategies

India's relative contribution to global suicide fatalities is substantial and rising. India has a higher than anticipated rate of suicide deaths, with significant regional differences in the number of victims and the proportion of men to

women. India has consequently formulated a suicide prevention strategy that considers these disparities to tackle this significant public health issue, while also establishing a new benchmark in mental health through the Tele Mental Health Assistance and Networking Across States (Tele-MANAS), an initiative by the Union Ministry of Health & Family Welfare. While India accounts approximately 28% of worldwide suicides, the occurrence of suicide arises from a complex interplay of societal, economic, and individual factors just as in many countries worldwide. In response to this increasing fatalities, India's national suicide prevention policy introduced in 2022 follows the concept advocated by the WHO, utilizing a multi-sectoral approach to suicide prevention. While it includes a combination of prevention strategies we emphasize on targeting entire worker communities such as workforce or community of working professionals , than mere 'high-risk,' individuals and tertiary preventive strategies that assist those affected by suicide (Vijayakumar et al., 2022)

Well-being, suicide, mental health issues have been traditionally underrepresented in the workplace health and safety efforts. However things are evolving and this is changing for good. In France as well as in some European countries, there are workplace standards that curb workplace psychosocial hazards that put workers at risk for suicide and employers have been made accountable for toxic workplaces and management practices that precipitates worker suicides. Promoting mental health and wellness in the workplace will not only support suicide prevention but also increase productivity and well-being among workers. Many workplaces already have resources in place that can be used to support suicide prevention.

While the Supreme Court's intervention safeguards against potential misuse of legal provisions and underscores the necessity of fairness in addressing sensitive matters such as mental health and workplace dynamics, employers may find it challenging to address such issues; therefore, it is prudent for firms to implement safety measures. Possible solutions include examining the company's internal regulations to ensure a safe and ethical workplace, initiating educational programs, providing managerial training on workplace issue resolution, establishing ethics hotlines, among others. Post higher incidents of worker suicides and greater identification of several workplace psychosocial

hazards that put workers down and/or at self-risk, seeking help and support from employee resource groups, buddies at work in terms of trusted colleagues, managers, or mental health professionals as well as support and resources via hotlines connecting to suicide prevention champions, organizations, and other assistance programs have gradually spruced up in contemporary organizations

Moreover, several modern day organizations are wanting to turnaround the image of toxic workplaces and management practices by assuming more responsibility and accountability to create healthy workspaces for everyone and creating a culture that prioritizes open communication as well as build employee resource groups (ERG), and other support/assistance programs including provisioning for mental health awareness and training with aid of mental health professionals. These generally aid in bringing down the taboo or stigma attached to speaking up issues pertaining to mental health at work. Besides these, practical strategies that reduce workload, increase workplace safety including psychological safety via curbing discrimination, harassment, bullying to uphold diversity, equity, inclusion, and belongingness that promotes employee work life integration.

A variety of physical and mental health disorders that are prevalent among the workforce, in addition to the increasing number of suicides that are occurring among working professionals, have contributed to an intensification of the discourse regarding stress in the workplace. There is a large amount of cause for concern over the dangers that are linked with professional stress, which appears in a variety of physical and psychological health problems. Increased workloads, stringent deadlines, and a lack of work-life harmony have been related to a variety of health problems, including hypertension, cardiovascular disease, and depression. If not causation, this linkage however has been shown through research. It is possible for employees to experience burnout or even significantly more severe consequences if they are subjected to significant stress and leadership does not provide adequate support or understanding for mental health. India's corporate landscape has undergone significant changes more recently with the introduction of hybrid work culture; however, traditional perceptions of work-life balance remain, leading to concerns regarding burnout and employee attrition. Several Indian companies may need to reassess their strategies in light of the significant number of work-related suicides. With some

of the Indian corporate stalwarts encouraging and emphasizing on long work hours and a hustle culture, it may be seen as posing significant risks to employee well-being and retention rates. Work design experts recommend a transition to goals centered on productivity, utilizing technology effectively, and fostering work-life balance to achieve sustainable success. Besides, establishing trust, selecting appropriate talent, and cultivating a balanced work culture are critical measures for disrupting the detrimental cycle of linking work with worker suicide. As high stress and burnout undermines both creativity and productivity over time, the emphasis ought to be on enhancing productivity—identifying methods to achieve greater output with an equivalent level of effort. Rather than prolonging workdays, a focus on improving processes, adopting advanced technologies, and fostering skill development can significantly boost efficiency. This approach ensures that employees are recognized for the value they generate, rather than merely the hours they contribute.

The complexities of occupational well-being are being increasingly investigated by regulatory bodies around the world. A number of nations, like Japan and South Korea, have enacted rules with the intention of reducing excessive overtime, while a number of European nations and Australia have maintained restrictions that permit workers to disconnect from their jobs beyond the usual working hours.

It is possible that India will rethink its labor regulations and implement ways to safeguard workers from overwhelming demands and the severe repercussions that come with them as a result of the inquiry that the government is now actively doing into untimely death of young professionals from top consulting firms and corporates of India. This is important as there is widespread underreporting of suicide deaths, which occurs because suicide is documented as a criminal offense. Likewise, the insufficiency of injury statistics in the National Crimes Record Bureau (NCRB) for suicide prevention planning, are well known (Arya et al., 2021; Dandona et al., 2017). These challenges needs to be addressed in order for the data to be used to advise appropriate activities and track the impact of India's National Suicide Prevention Strategy (NSPS) over time. National Suicide Prevention Service can bring to the fore, the issue of the robustness of the number of deaths by suicide in the context of the larger inadequacy of the vital registration system in the country given that suicide accounts for 2% of all deaths in India and only 22·5%

having a medically certified cause of death (India State level Disease Burden Initative, Office of Registrar General of India). The NSPS would be able to achieve its goal of reducing suicide fatalities by situating necessary strategy within a more nuanced use of the data on the biopsychosocial dimensions of suicide in India, as well as addressing the key data gaps associated with identifying workforce at high risk of attempting suicide. It would mean that for prevention of worker suicide in India, it is crucial for NSPS to identify lesser known risks of suicidal behaviors in the work settings. We need more nuanced studies to scan the varied work setups that up the risk of self-harm including work spaces with lack of surveillance and vigilance, availability and accessibility of heights, substances to self-harm, and so forth. Addressing some of the employee morbidities certainly require multi-domain expertise to design and implement comprehensive health and wellness initiatives and programs that promote human centric and humane work culture in contrast to lopsided economic and business centric work culture. Workplace interventions must integrate mental health care physicians, psychologists, psychiatrists and social sustainability champions to be able to effectively screen for depression, substance abuse disorders, and suicidal ideation which would also help prevent the stigma around the topic. In addition to focusing on vulnerable segments in the workforce, a multi-faceted approach would aid in carving more effective workplace suicide prevention strategies that promote more surveillance and awareness, anti-stigma, healthy work culture, psychological safety to seek help. More importantly, public awareness and training to improve sensitization on this issue, role of media and how to portray worker suicides appropriately and responsibly can help create problem solving approach than sensationalism. The NSPS must look at measures that can work at a large scale and are accessible to the wider workforce who do not wish to or in contact with mental health services. This way NSPS could develop and improve effective interventions within the work context.

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Strain in the Digital Era: Understanding Techno-Stress and Its Physiological Outcomes

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Abstract

In an era of rapid technological advancements, the impact of techno-stress on individuals has become a critical area of research. This study presents a conceptual analysis that synthesises existing literature on techno-stress dimensions (techno-overload, techno-invasion, techno-complexity, techno-insecurity, and techno-uncertainty) and links these dimensions to physiological outcomes. The research enhances the techno-stress literature by consolidating fragmented findings and redirecting attention from well-researched psychological outcomes to the less explored physiological ones. Additionally, the study suggests future research directions to validate the framework through empirical testing and the development of intervention strategies.

Keywords:

Physiological outcomes, techno-complexity, techno-insecurity, techno-invasion, techno-overload, techno-stress, techno-uncertainty.

1. INTRODUCTION

In the contemporary digital era, technology has become deeply embedded in daily life, fundamentally altering the way employees interact with their work and personal environments (Kraus et al., 2021). While technological advancements have markedly enhanced productivity and connectivity, they have simultaneously introduced novel stressors, collectively referred to as techno-stress (Tarafdar et al., 2024). Techno-stress encompasses various dimensions such as techno-overload, techno-invasion, techno-complexity, techno-insecurity, and techno-uncertainty (Nastjuk et al., 2023). These dimensions, also called techno-stressors,

refer to the technology-induced demands that lead to strain responses, which can be psychological (such as anxiety, exhaustion, or burnout) or behavioural (absenteeism and turnover) (Nastjuk et al., 2023).

Despite extensive research on techno-stress, previous studies have predominantly emphasised psychological and behavioural responses, often overlooking the physiological effects associated with different techno-stress dimensions (Sonnentag & Fritz, 2014; Borle et al., 2021; Marsh et al., 2022). Understanding the impact of techno-stressors on employees' physiological well-being is imperative, as prolonged exposure to technology-induced stress has been linked to adverse health outcomes, including cardiovascular issues, hormonal imbalances, and emotional disturbances (Tams et al., 2020; Mishra & Rašticová, 2024). Furthermore, the meta-analysis by Nastjuk et al. (2023) highlighted that numerous studies have investigated the association of techno-stress with psychological and behavioural outcomes. However, the physiological impact of various techno-stress dimensions has not been thoroughly explored (Nastjuk et al., 2023). Addressing these gaps is crucial for a comprehensive understanding of techno-stress and its broader implications for health (Day et al., 2012; Galluch et al., 2015).

This research is a conceptual article that synthesises existing literature on techno-stress and strain outcomes. The study aims to bridge the research gaps by developing a conceptual framework that integrates techno-stress with physiological outcomes. Specifically, the paper investigated how techno-overload, techno-invasion, techno-complexity, techno-insecurity, and techno-uncertainty influence physiological markers, offering a foundation for future empirical validation. By providing an in-depth analysis of these relationships, the study seeks to advance theoretical knowledge of techno-stress as a multi-systemic phenomenon and offer practical insights into managing its physiological impacts (Tams et al., 2018). Furthermore, the research examined the effectiveness of various interventions and coping mechanisms designed to mitigate these effects.

The structure of this paper is as follows: The next section provides a comprehensive literature review of existing research on techno-stress, highlighting the

dimensions of techno-stress and its physiological outcomes. This is followed by the development of a conceptual framework and a discussion of the methodology used to measure techno-stress in the existing literature. Thereafter, both theoretical and practical implications have been discussed. Furthermore, the next section proposes recommendations for addressing the study's limitations and exploring new avenues for research. Lastly, the study provides the conclusion.

2. LITERATURE REVIEW

2.1 Technostress

Technostress is a type of stress that individuals experience due to their inability to keep up with the rapid advancements and demands of Information and Communication Technologies (ICTs) (Tarafdar et al., 2007). Craig Brod introduced the term in 1984, describing it as a "modern disease of adaptation caused by an inability to cope with new technologies in a healthy manner" (Brod, 1984, p. 16). The concept was further revised by Weil and Rosen (1997), who describe technostress as an adverse impact technology has on people's attitudes, beliefs, behaviours, or psychology. Techno-stress is driven by various factors, known as techno-stress creators or stressors, which arise from the interaction between individuals and ICTs (Tarafdar et al., 2024). Based on the literature review, Tarafdar et al. (2007) and Ragu-Nathan et al. (2008) identified five critical dimensions of techno-stress, which include: techno-overload, techno-invasion, techno-complexity, techno-insecurity, and techno-uncertainty. (1) Techno-overload refers to situations where ICTs force users to work faster, more intensively, or longer (Thurik et al., 2023). (2) Techno-Invasion describes the pervasive nature of technology that blur the boundaries between work and personal life, leading to the encroachment of work into personal time and space and creating a sense of constant pressure (Tarafdar et al., 2007). (3) Techno-complexity refers to the complexity of ICTs that makes users feel inadequate or overwhelmed by their skills (Marsh et al., 2022). It forces users to invest significant time and effort in learning and mastering new technologies, which can lead to frustration and stress (Tarafdar et al., 2014). (4) Techno-insecurity is the fear of losing one's job or relevance due to rapid technological advancements or being replaced by more tech-savvy employees (Thunberg et al., 2023). This dimension highlights the anxiety associated with staying updated and competitive in a constantly evolving digital landscape

(Tarafdar et al., 2014). (5) Techno-uncertainty reflects the continuous changes, updates, and modifications in ICTs that create uncertainty for users. It requires them to continually learn and adapt, which can lead to feelings of instability and stress (Ragu-Nathan et al., 2008).

2.2. Physiological Outcomes

Techno-stress induces significant physiological responses, manifesting through various bodily reactions to technology-related stressors. These responses include cardiovascular, biochemical, and gastrointestinal symptoms, as evidenced by elevated cortisol levels, increased heart rate, and heightened skin conductance (Riedl et al., 2013; Weinert et al., 2020). The perception of technology as a stressor leads to both psychological and physiological reactions. Specifically, stressors such as system unreliability led to increased emotional sweating and elevated levels of stress hormones (Weinert et al., 2020). While physiological strain may occur subconsciously, its implications for long-term health are significant. Prolonged exposure to such stressors can lead to serious health issues, such as cardiovascular problems, underscoring the importance of addressing these physiological outcomes, as they often reflect immediate, involuntary responses driven by external stimuli rather than conscious cognitive evaluation (Riedl, 2013; Tams et al., 2014).

3. CONCEPTUAL FRAMEWORK: TECHNO-STRESS AND PHYSIOLOGICAL OUTCOMES

Based on the literature review, the study introduced a Conceptual Framework of Techno-Stress and Physiological Outcomes (see Figure 1), which extends the existing techno-stress framework by explicitly linking techno-stress dimensions to physiological outcomes. The model has been built upon the five techno-stress dimensions proposed by Tarafdar et al. (2007) and Ragu-Nathan et al. (2008) and incorporates physiological response mechanisms from stress research (Mishra & Rašticová, 2024; Riedl et al., 2012; Weinert et al., 2020). Prior studies have established relationships between techno-stress dimensions and various negative outcomes; however, these findings remain fragmented across disciplines (Nastjuk et al., 2023), underscoring the need for empirical research recommendations. Furthermore, the Conceptual Model is grounded in the

Person-Environment (P-E) Fit Theory (Edwards & Cooper, 1990), which posits that stress arises when there is a misalignment between an individual's abilities and the demands of their environment. In the context of techno-stress, this misfit occurs when employees struggle to adapt to rapid technological advancements, resulting in physiological strain. Figure 1 illustrates the pathways through which each dimension of techno-stress triggers specific physiological responses. A detailed explanation of each conceptual relationship has been discussed as follows:

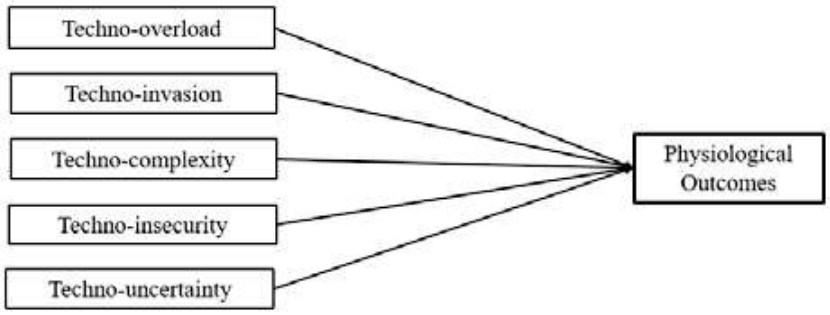

Figure 1: Conceptual Framework
Source: Author's Own

3.1. Techno-Overload and Physiological Outcomes

Techno-overload arises when employees are overwhelmed by the sheer volume of technology-related tasks, leading to excessive cognitive processing and mental fatigue (Thurik et al., 2023). This cognitive overload triggers the body's stress-response systems, leading to physiological responses such as elevated cortisol levels, increased heart rate, and increased skin conductance (Riedl, 2013). Elevated cortisol, a key stress hormone, is commonly associated with increased arousal and prolonged activation of the hypothalamic-pituitary-adrenal axis, contributing to chronic stress if the overload persists (Riedl et al., 2012; Sonnentag & Fritz, 2014; Mishra & Rašticová, 2024). Muscle tension is another common symptom, often manifesting in the neck, back, and shoulders, as employees constantly work with technology (Riedl, 2013). Chronic activation of these physiological markers may lead to immune system suppression, increased fatigue, and long-term health risks such as hypertension and cardiovascular disease (Riedl et al., 2012; Ayyagari et al., 2011).

3.2. Techno-Invasion and Physiological Outcomes

Techno-invasion refers to the constant intrusion of technology into personal and professional lives, eroding boundaries between work and leisure (Tarafdar et al., 2014). This continuous connectivity disrupts regular routines and extends exposure to stress. Consequently, physiological outcomes such as sweating, gastrointestinal disturbances, and elevated blood pressure emerge from the persistent pressure to respond to technology-driven demands (Riedl, 2013; Mishra & Rašticová, 2024). Over time, these sustained physiological responses can lead to more serious health problems, such as cardiovascular issues, including hypertension and increased risk of heart disease (Riedl et al., 2012; Riedl et al., 2013).

3.3. Techno-Complexity and Physiological Outcomes

Techno-complexity involves the cognitive challenge of understanding or using intricate technological systems, which places significant mental demands on employees (Borle et al., 2021). The complexity of these systems often results in frustration, confusion, and mental fatigue, triggering the activation of physiological stress responses. As users struggle to navigate complicated technologies, the body responds by releasing stress hormones like cortisol and adrenaline (Riedl, 2013). Elevated cortisol levels are a marker of the activation of the hypothalamic-pituitary-adrenal (HPA) axis, a key system involved in the body's stress response, while adrenaline triggers immediate physiological changes, including increased heart rate and blood pressure (Riedl et al., 2012). Furthermore, techno-complexity has been linked to increased skin conductance, a physiological indicator of sympathetic nervous system activation (Mishra & Rašticová, 2024). These physiological markers not only indicate immediate stress but, if the complexity persists over time, may lead to chronic stress-related health issues, such as cardiovascular diseases and impaired cognitive functioning (Weinert et al., 2020).

3.4. Techno-Insecurity and Physiological Outcomes

Techno-insecurity arises from fears of being displaced by technological advancements or becoming irrelevant in the workforce, which can significantly heighten stress levels (Fischer & Riedl, 2017). This fear often triggers physiological

stress responses, such as increased heart rate, muscle tension, and elevated blood pressure, as employees grapple with anxiety over their professional futures (Schellhammer et al., 2013). Research suggests that these physiological responses are primarily driven by the activation of the body's fight-or-flight system, particularly the sympathetic nervous system, leading to an increase in adrenaline and cortisol (Riedl, 2013; Adam et al., 2016). Over time, prolonged exposure to techno-insecurity can contribute to chronic health conditions such as hypertension, elevated blood pressure, and stress hormones, which place a strain on the cardiovascular system (Sonnentag & Fritz, 2015).

3.5. Techno-Uncertainty and Physiological Outcomes

Techno-uncertainty refers to the continuous and unpredictable changes in technology, creating uncertainty about the future and leading to difficulties in adapting to new systems or software (Marsh et al., 2022). Techno-uncertainty results in significant psychological and physiological outcomes as employees struggle to meet ever-evolving technological demands (Borle et al., 2021). Physiologically, techno-uncertainty triggers stress responses, such as elevated cortisol levels, increased heart rate, and heightened blood pressure, reflecting the body's reaction to perceived instability and the constant need to adapt (Riedl, 2013; Peters et al., 2017). The uncertainty about effectively using or managing new technologies also leads to increased cognitive load, resulting in mental fatigue, which further activates the body's stress-response systems (Ayyagari et al., 2011). Prolonged exposure to techno-uncertainty can lead to chronic physiological issues such as headaches, muscle tension, and gastrointestinal problems, as the stress experienced in response to constant technological change strains the nervous and musculoskeletal systems.

4. METHODS OF ASSESSING TECHNOSTRESS

Previous research on techno-stress employed two methods for measuring the degree of stress experienced by participants. First is the questionnaire (psychometric method), and second is the biomarker method (Mishra & Rasticova, 2024). Both methods offer distinct strengths and weaknesses, making them complementary in understanding the multifaceted nature of techno-stress (Tams et al., 2014).

Questionnaires are widely used for assessing technostress, particularly in capturing subjective experiences. Questionnaires collect information from the participants about how they felt in stressful situations. They rely on self-reporting and allow researchers to measure specific dimensions of technostress, such as techno-overload, techno-invasion, techno-complexity, techno-uncertainty or techno-insecurity (Tarafdar et al., 2007). One of the primary advantages of questionnaires is their ease of administration; they are more cost-effective to implement on a large scale and are relatively straightforward to analyse. Moreover, these instruments allow individuals to reflect on their emotional and psychological responses to technology, providing detailed insights into their personal coping mechanisms and perceived stress. However, questionnaires are inherently subjective, which can introduce biases such as social desirability or memory recall issues. Participants may underreport or overreport their stress levels based on personal factors that do not reflect their true physiological state (Mishra & Rašticová, 2024). Moreover, while questionnaires provide valuable information on the psychological impacts of technostress, they do not capture the body's biological response, which can limit the understanding of how stress affects physical health.

On the other hand, biomarkers offer an objective measure of the physiological effects of technostress by assessing changes in biological systems (Riedl et al., 2012; Riedl, 2013). Biomarkers such as cortisol levels, heart rate variability, blood pressure, and skin conductance provide direct evidence of the body’s stress response (Mishra & Rašticová, 2024). Cortisol, for instance, is a well-known marker of stress hormone in humans, and elevated levels have a detrimental effect on health (Riedl et al., 2012). By measuring these physiological outcomes, researchers can gain insight into the impact of technostress on the autonomic nervous system, revealing how it affects cardiovascular health, immune function, and overall well-being (Riedl, 2013; Riedl et al., 2013). Unlike questionnaires, biomarkers are free from subjective reporting biases and provide real-time, quantifiable data on how the body responds to stress. However, collecting biomarkers is often more complex, requiring specialised equipment and expertise, which can increase costs and limit the size of study samples.

In comparing the two, it becomes clear that questionnaires and biomarkers assess different facets of technostress. Questionnaires are well-suited for measuring the perceived psychological effects of technology use, allowing employees to express how they feel about the impact of technology on their work and life, for example, the techno-stress questionnaire developed by Tarafdar et al. (2007). Biomarkers, in contrast, provide a physiological lens, demonstrating how the body responds to technology demands at a biological level (Tams et al., 2014). The choice between questionnaires and biomarkers depends on the research goals. If the objective is to understand the psychological perceptions of technostress and how individuals feel about their interaction with technology, questionnaires are an appropriate tool (e.g., Ayyagari et al., 2011). However, if the research aims to explore how technostress impacts physical health or to measure chronic stress responses, biomarkers offer a more precise and objective method (e.g., Riedl et al., 2013; Tams et al., 2018). In practice, some studies combine both methods to obtain a more comprehensive picture of technostress, integrating subjective experiences with physiological data to better understand how techno-stress affects both the mind and body (Wineart et al., 2020). Using both approaches, researchers can develop a more nuanced and holistic understanding of the complex relationship between technostress and overall well-being (Tams et al., 2014). Furthermore, the previous literature also lacks a well-established psychometric scale for measuring the physiological outcomes of techno-stress.

5. IMPLICATIONS

5.1. Theoretical Implications

The study highlights several important directions for future research. There is a need to further explore the physiological mechanisms underlying techno-stress. Future studies should focus on linking distinct dimensions of techno-stress, such as techno-overload, techno-invasion, techno-uncertainty, techno-insecurity, and techno-complexity, to physiological outcomes such as heart rate, blood pressure, skin conductance, and cortisol levels. The current research broadens the scope beyond traditional psychological responses and offers a more comprehensive understanding of how both conscious and unconscious physiological outcomes affect overall well-being. Furthermore, there is potential to create advanced dual-level models of techno-stress that encompass both psychological and

physiological outcomes, recognising that they may not always be in harmony. This approach would involve considering situational factors, such as the specific type of technology being used or the context of its use, which have the ability to influence the intensity of physiological stress responses. Additionally, future research could broaden the theoretical framework to include other dimensions such as techno-addiction, techno-unreliability and techno-anxiety, offering deeper insights into the prolonged effects of technology use on mental health and well-being. The current study also warrants the development and empirical validation of the physiological outcome scale. Such an effort would help to bridge the gap between techno-stress and physiological outcomes. Lastly, examining individual resilience and coping mechanisms, such as emotional intelligence and psychological flexibility, could offer a better understanding of why some employees are more physiologically resilient to techno-stress than others.

5.2. Practical Implications

The research suggests innovative strategies for managing the physiological impacts of techno-stress. One promising avenue is the use of biofeedback and wearable technologies that enable employees to monitor real-time physiological stress indicators such as cortisol levels, heart rate, and blood pressure. The reliance on self-reported data for psychological and behavioural outcomes may introduce subjective bias and social desirability effects. To enhance the robustness of future findings, incorporating objective measures, such as wearable devices that track real-time physiological responses, is recommended to reduce the subjectivity associated with stress assessment. These interventions could play a crucial role in mitigating the long-term effects of chronic stress in the workplace.

Additionally, the study highlights the importance of adaptive technology design, where user interfaces are personalised to adjust complexity or reduce task overload based on physiological feedback. Such adaptive systems could significantly improve user comfort and reduce stress, particularly for employees dealing with techno-overload or techno-complexity.

Furthermore, Organizational policies should go beyond basic digital detox strategies to include structured physiological recovery periods where employees engage in activities such as mindfulness, relaxation techniques, or physical exercise. Public health initiatives should also emphasise education about the physiological effects of techno-stress, promoting healthier technology use habits across the population. Longitudinal studies are also needed to investigate the long-term health impacts of techno-stress, particularly concerning chronic conditions such as cardiovascular disease and mental health issues. These practical interventions and future research directions are essential for addressing the broader implications of techno-stress on both employee well-being and organisational and societal health outcomes.

6. LIMITATIONS AND FUTURE RESEARCH DIRECTIONS

Despite the valuable insights provided by this study, several limitations must be acknowledged. First, while the study effectively highlights the physiological outcomes of techno-stress, it does not extensively address the long-term effects of these physiological changes on overall health and well-being. To address this gap, future research should consider longitudinal studies that examine the cumulative impact of sustained techno-stress on chronic health conditions such as cardiovascular disease, metabolic disorders, and mental health challenges. Second, the study may not capture the complete sets of stressors in varied technological environments due to its concentration on specific techno-stress dimensions: techno-overload, techno-invasion, techno-complexity, techno-insecurity, and techno-uncertainty. Future research should explore additional stressors and investigate their contributions to physiological outcomes. Third, the study does not fully account for individual differences in stress resilience or coping mechanisms. Future research should examine how personal traits, such as emotional intelligence, cognitive flexibility, or psychological capital, moderate the relationship between techno-stress and physiological outcomes. Investigating these personal factors may help explain why some employees experience more severe physiological outcomes from techno-stress while others demonstrate greater resilience. Fourth, although the study proposes interventions like biofeedback-based stress management and adaptive technology design, it does not evaluate the effectiveness of these solutions in real-world settings.

Future research should assess the practical implementation of such technologies and policies and conduct experimental or field studies that track stress levels and health outcomes before and after implementing these interventions. Finally, future research should replicate this research by empirically testing the relationship between techno-stress dimensions and physiological outcomes using validated psychometric scales.

7. CONCLUSION

The usage of computers, the internet, smartphones, and other technologies has greatly benefited users, organisations, and society. However, using technology can also lead to noticeable stress perceptions, a condition known as technostress, which can harm users' health (Riedl et al., 2013). The study explores that techno-stress dimensions increased physiological arousal and strain, which must not be ignored in techno-stress research. The present study is an essential step towards a better understanding of techno-stress dimensions in stress perceptions. Comprehensive research is necessary to reduce the detrimental impacts of techno-stressors on health outcomes. We draw the conclusion that by concentrating on the conscious part (i.e., psychological or self-reported outcomes) "tip of the iceberg," the research on technostress has missed a significant portion of techno-stress research. Thus, testing the unconscious part of technostress (physiological outcomes) is a perfect way to start researching the underwater portion of that "iceberg." In order to completely comprehend the effects of technology on people, it may eventually be necessary to use both measures and combine the insights they bring to produce a more comprehensive picture of the psychological and physiological outcomes of technology.

Conflict of Interest

The authors declare no conflicts of interest relevant to this article.

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Loneliness, Loss, and Life: A Scoping Review of Elderly Suicide in Developing Countries

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Abstract

Elderly suicide is a subject that does not gain appropriate attention in psychological literature, particularly when compared to substantial research done on the younger age groups. Older adults comprise a significant portion of the global population, yet their challenges often go overlooked, creating critical gaps in understanding and intervention. This article aims to review the literature established so far regarding suicide among older adults, focusing on risk factors, prevention, the social environment, and interventions. Moreover, this article underscores that loneliness, grief, illness, and lack of adequate psychosocial resources should be considered significant risk factors. In addition, it identifies protective factors such as family support, community engagement, and some targeted interventions as being able to mitigate the risks of suicide. The findings highlight significant research gaps, including the need for culturally sensitive, longitudinal studies and effective policy-driven solutions. This paper intends to provide a comprehensive literature review to inform policymakers, healthcare providers, and scholars about effective strategies to decrease suicide rates among older adults and to foster a more supportive environment for elderly groups.

Keywords:

Elderly suicide, risk factors, mental health, India, intervention strategies, public health

Introduction

Elderly suicide represents a multifaceted public health issue with profound implications for individuals, families, and societies. With the world's population continuously ageing, especially in countries such as India, the mental health of older people and their general well-being have become a critical concern. The World Health Organisation (WHO) predicts that by the year 2050, the number of

elderly persons aged 60 years or more will double to approximately 2.1 billion people (World Health Organization, 2024). Thus, a proper understanding and response to the specific mental health needs of this age group become necessary. Suicide among the elderly is not only an individual tragedy but also reflects gaps in health care, social support, and community resources in the system. Mental health is an understudied but critical part of older adults' well-being.

Mental health remains a critical but underexplored component of overall well-being in older adults. Despite a growing awareness of the mental health needs of this demographic, there remains a disproportionate focus on younger populations. Issues such as depression, anxiety, and cognitive decline often go unaddressed in older adults, contributing to an increased risk of suicide. Other factors that contribute to this complex interplay include chronic health ailments, social isolation, bereavement, and financial difficulties.

Additionally, mental health issues are, in most cases, taboo among older people, thus making the problem even worse as patients are discouraged from seeking help. This article aims to fill a crucial gap in the literature by providing an extensive review of elderly suicides, focusing on risk factors, protective mechanisms, and intervention strategies within the context of developing countries like India. By synthesizing current evidence, this paper aims to identify effective strategies and provide pragmatic recommendations aimed at reducing suicide rates among seniors.

Research Question

What are the primary risk factors, protective measures, and effective intervention strategies for preventing suicide among the elderly in developing countries, and how do societal contexts influence these factors?

Research Objectives

1. To identify and categorize the primary risk factors contributing to suicidal behavior in elderly populations.

2. To explore protective measures that can mitigate the risk of suicide among older adults.
3. To assess current intervention strategies and their effectiveness in preventing elderly suicide.
4. To highlight research gaps and propose areas for future study.
5. To provide recommendations for policymakers and healthcare providers to better address the mental health needs of the elderly.

Methodology

This scoping review was conducted following the methodological framework proposed by Arksey & O'Malley (2005), with additional enhancements as suggested by Tricco et al. (2016). The review was carried out in five stages:

1. Identifying the research question.
2. Identifying relevant studies.
3. Study selection.
4. Data charting.
5. Collating, summarizing, and reporting the results.

To ensure a systematic approach, the research question guiding this review was 'What are the primary risk factors, protective measures, and effective intervention strategies for preventing suicide among the elderly in developing countries, and how do societal contexts influence these factors?'

Data Collection

To identify relevant studies, an extensive search was conducted across multiple databases, including PubMed, Scopus, and Google Scholar. The search focused on peer-reviewed articles published between 2000 and 2024 to ensure the inclusion of recent and relevant data. Keywords such as 'elderly suicide,' 'risk factors,' 'protective measures,' 'intervention strategies,' and 'mental health in older adults' were used. Both qualitative and quantitative studies were considered.

Study Selection

The study selection process involved an initial screening of titles and abstracts, followed by a full-text review to confirm the relevance of the articles. Data charting was then employed to extract key information, such as study objectives, methodologies, findings, and limitations. Finally, the collated data was analysed to identify common themes and research gaps.

Inclusion Criteria

The inclusion criteria for this scoping review were meticulously designed to ensure that the selected studies would provide a comprehensive understanding of the factors influencing elderly suicide. The criteria encompassed several key aspects:

1. Peer-Reviewed Articles: Only peer-reviewed articles published between 2000 and 2024 were included. This time frame was selected to capture the most current and relevant research findings, reflecting recent trends and developments in the field. Peer review serves as a quality control mechanism, ensuring that the studies included in this review have undergone rigorous evaluation by experts in the field.
2. Focus on Elderly Populations: The review specifically targeted studies that focused on elderly populations, defined as individuals aged 60 years or older. This age threshold was chosen based on demographic definitions commonly used in gerontology and public health research. By concentrating on this age group, the review aims to address the unique challenges and risk factors associated with suicide among older adults.
3. Research Addressing Risk Factors or Protective Measures: Studies included in this review had to address either risk factors or protective measures related to suicide among the elderly. This criterion ensures that the review encompasses a broad spectrum of literature, highlighting both the vulnerabilities that increase suicide risk and the factors that may help mitigate these risks. Understanding both sides is crucial for developing effective intervention strategies.

4. Language of Publication: Only articles published in English were considered for inclusion. This criterion was established to facilitate a thorough understanding of the research findings and methodologies, as well as to ensure that the review could be effectively communicated to an English-speaking audience.
5. Qualitative and Quantitative Studies: Both qualitative and quantitative studies were considered for inclusion. This approach allows for a richer understanding of the issue at hand, as qualitative studies can provide in-depth insights into personal experiences and contextual factors, while quantitative studies can offer statistical evidence of trends and correlations.

Exclusion Criteria

To refine the scope of this review further, specific exclusion criteria were established to filter out studies that would not contribute meaningfully to the objectives of this scoping review:

1. Focus on Youth or Middle-Aged Populations: Studies that focused solely on youth or middle-aged populations were excluded from this review. While these groups are undoubtedly important in discussions about mental health and suicide prevention, they do not align with the specific focus on elderly populations that this review seeks to address.
2. Non-Peer-Reviewed Articles or Grey Literature: Non-peer-reviewed articles, including opinion pieces, editorials, and grey literature (such as reports from non-academic organisations), were excluded from consideration. This exclusion was necessary to maintain a high standard of scientific rigour and reliability in the evidence presented.
3. Research Not Specifically Addressing Suicidal Behavior or Related Mental Health Issues: Studies that did not specifically address suicidal behaviour or related mental health issues were also excluded from this review. This criterion ensures that all included research directly contributes to understanding the complexities surrounding elderly suicide, thereby enhancing the relevance and applicability of findings.

Literature Review

Elderly suicide is a growing public health concern that urgently needs focused research and intervention. Despite the increasing prevalence of this issue, it often takes a backseat to studies on younger populations. This literature review aims to synthesize recent findings and identify gaps in understanding the complex factors that contribute to suicide among the elderly in India.

Prevalence and Statistics

Recent studies indicate that elderly suicide is on the rise globally, with India being no exception. According to the National Crime Records Bureau (NCRB) of India, individuals aged 60 and above accounted for 11% of total suicides in the country in 2022 (National Crime Records Bureau, 2022). This trend is concerning, given the limited attention and resources allocated to the mental health of older adults. Furthermore, a study by Rana (2020) highlighted a significant increase in suicide rates among older adults in India, particularly during the COVID-19 pandemic. This emphasises the urgent need for targeted mental health interventions and support for this vulnerable group.

The World Health Organization (WHO) also emphasizes that the elderly population is particularly vulnerable to suicide due to various psychosocial factors. Globally, it is estimated that about 800,000 people die by suicide each year, with older adults representing a substantial proportion of these cases (World Health Organization, 2019). In India, the cultural stigma surrounding mental health issues further complicates the situation, as many elderly individuals may not seek help or report their struggles.

Demographic Context

The elderly population in India is increasing as a result of improved healthcare and a longer life expectancy. As of 2021, there are approximately 138 million elderly persons aged 60 or older in India (Ministry of Statistics and Programme Implementation, 2021). This demographic shift underscores the need for a targeted approach in addressing mental health issues specific to older adults.

Despite this, studies focusing on mental health challenges, including suicide among the elderly, remain limited.

A report by the United Nations indicates that by 2050, one in six people globally will be aged 60 years or over (United Nations, 2019). This demographic transition necessitates a reevaluation of mental health services and policies to ensure they are equipped to address the unique needs of an ageing population.

Risk Factors and Contributing Elements

Understanding the multifaceted risk factors contributing to elderly suicide is essential for developing effective prevention strategies.

Social Isolation and Family Structure

Social isolation is a significant risk factor for elderly suicide, especially in the context of urbanisation and the breakdown of traditional family structures. Motillon-Toudic et al. (2022) discuss how the erosion of the once-common joint family system, which acted as a crucial safety net for older adults, has led to an increased sense of loneliness and abandonment. This social isolation, coupled with limited emotional support, significantly exacerbates feelings of depression, and thus heightening the risk of suicidal behaviour among the elderly.

Research suggests that social isolation can lead to a decline in mental health and increase suicidal ideation among older adults (Morgan et al., 2019). A study by Cattan et al. (2005) supports this notion by demonstrating that social engagement significantly reduces feelings of loneliness and improves overall well-being among seniors.

Moreover, social networks play a crucial role in providing emotional support and companionship. A study conducted by Victor et al. (2000) found that individuals with larger social networks reported lower levels of depression and anxiety. The absence of such networks can lead to a sense of purposelessness among older adults, further increasing their vulnerability to suicidal thoughts.

Loss of a Spouse

The emotional impact of losing a spouse is profound, especially for older women who statistically outlive men. Research indicates that widowhood is a major precipitating factor for suicidal ideation. Scocco and De Leo (2002) found that the risk of suicide rises sharply during the bereavement period, a trend that has been consistently observed in studies from various cultural backgrounds.

A longitudinal study by Utz et al. (2013) further underscores this relationship by showing that widowed individuals exhibit higher rates of depression and suicidal thoughts compared to their married counterparts. The loss of companionship and emotional support during such a critical life transition can leave older adults feeling isolated and hopeless.

Additionally, widowhood often leads to significant lifestyle changes that can exacerbate feelings of loneliness. A study by Morgan et al. (2019) found that widowed individuals frequently experience disruptions in daily routines and social interactions, contributing to their mental health decline.

Chronic Illness and Physical Decline

Physical health plays a crucial role in mental well-being. Research by Kułak-Bejda, Bejda, and Waszkiewicz (2021) highlights the chronic illnesses, such as dementia and cardiovascular diseases, significantly contribute to feelings of helplessness and despair, thus increasing the likelihood of suicidal thoughts and behaviours among older adults. In India, where healthcare resources for the elderly are often stretched thin, effectively managing chronic conditions remains a significant challenge

Studies also emphasized that depression, often linked with chronic pain and physical limitations, is a key risk factor for suicide among older adults (O'Connell et al., 2004). The interplay between physical health conditions and psychological distress highlights the need for integrated healthcare approaches that address both physical and mental health needs simultaneously.

Furthermore, chronic conditions such as diabetes or heart disease can lead to increased dependency on caregivers or family members, which may further

exacerbate feelings of inadequacy or loss of autonomy among older adults (Berkman et al., 2000). This dependency can create additional stressors that contribute to suicidal ideation.

Mental Health and Stigma

One major barrier to addressing elderly suicide is the stigma surrounding mental health issues. Elderly individuals are less likely to seek help for psychological distress due to deeply ingrained cultural attitudes (World Health Organization, 2023). This reluctance to engage with mental health services often leads to underdiagnosis and inadequate treatment.

Moreover, research indicates that the limited availability of geriatric mental health professionals significantly exacerbates this issue. The shortage of trained professionals equipped to address the unique mental health needs of older adults creates substantial barriers to accessing essential care (Miller 2022). This lack of access is especially problematic in rural areas, where many older adults have limited options for mental health treatment.

The stigma associated with mental illness can also manifest as internalized shame or guilt among seniors who struggle with suicidal thoughts but feel unable to discuss their experiences openly (Corrigan, Druss, & Perlick, 2014). This internal conflict can lead to increased isolation and despair.

Socioeconomic Status and Financial Stress

Economic stability is another crucial factor influencing mental health among older adults. Older individuals without secure financial safety nets face heightened stress levels which can trigger mental health issues. Financial dependency, especially in societies that place a high value on self-reliance, can result in feelings of inadequacy and burden.

Research suggests that economic hardships, such as financial strain and unemployment, are closely linked with increased rates of anxiety and depression among seniors, conditions that further elevate suicide risk (Avery, 2020). This

study found that financial stressors like high debt and low income significantly correlate with suicidal ideation and attempts, especially in the context of economic downturns.

Moreover, financial insecurity can limit access to healthcare services necessary for managing both physical and mental health conditions effectively (Marmot et al., 2008). Older adults facing financial difficulties may prioritize basic needs over seeking help for psychological distress, further exacerbating their vulnerability.

Community and Social Support Systems

While challenges are substantial, community support and intervention programs offer promising pathways forward. Morgan et al. (2019) highlight the importance of social programs that facilitate engagement and reduce isolation among seniors. In India, however, such programs are not yet widespread or well-funded.

A systematic review by Pitkala et al. (2009) highlighted that group activities, community centres, and social gatherings are vital in reducing feelings of isolation among older adults. Their findings demonstrated that structured social programs significantly improve mental health and lower suicide risk by fostering a sense of belonging and connectedness.

Research conducted by Cattan et al. (2005) indicates that participation in community activities can enhance social networks among seniors, thereby fostering resilience against feelings associated with loneliness or despair. Additionally, community-based interventions have been shown to improve the overall quality of life for older adults while reducing instances of depression. A systematic review by Ho et al. (2023) highlights that complex community-based interventions, including holistic assessments and care planning, can effectively sustain independence and improve health-related quality of life for older adults living in the community.

Policy and Public Health Implications

Addressing elderly suicide in India requires a multi-pronged approach encompassing policy changes, enhanced healthcare infrastructure, and targeted research initiatives. Increased investment in geriatric mental health services alongside public awareness campaigns can help reduce the stigma surrounding mental illness while encouraging help-seeking behaviour.

The development of community-based programs aimed at improving access to counselling services tailored specifically for older adults is essential for addressing rising trends in suicides within this demographic group (Lapierre et al., 2011). Policymakers must prioritise creating supportive environments where seniors feel empowered to seek help without fear or shame.

Furthermore, integrating mental health services into primary healthcare systems could provide more accessible support for older adults struggling with suicidal thoughts or behaviours (Patel et al., 2018). Training primary care providers on recognising signs of mental distress among seniors would enhance early intervention efforts, ultimately saving lives.

In conclusion, understanding the complex interplay between various risk factors contributing to elderly suicide is vital for developing effective prevention strategies tailored specifically towards this vulnerable population group within India's rapidly changing socio-economic landscape.

Collating, Summarizing, and Reporting Results

A comprehensive approach to synthesising and presenting findings is critical for understanding the complex issue of suicide among the elderly in India. This section emphasises the importance of systematic thematic analysis, identifying gaps in current research, and effectively reporting findings.

Thematic Analysis

Thematic analysis enables the identification of patterns and recurring themes across the literature. This method facilitates a deeper understanding of the multifaceted factors contributing to elderly suicide in India.

One recurring theme is social isolation, which is a major risk factor exacerbated by urbanisation and the breakdown of traditional family structures. As younger generations migrate to cities in search of better opportunities, many older adults are left to live alone, which can lead to profound loneliness. A study by Motillon-Toudic et al. (2022) highlights how the erosion of familial support systems has amplified feelings of abandonment among the elderly, contributing to mental health challenges such as depression and suicidal ideation. Furthermore, research by Victor et al. (2000) underscores that older individuals with limited social networks are significantly more likely to experience depression and anxiety, emphasising the critical need for community-based interventions to foster social connections.

Another key theme is health challenges, particularly chronic illnesses and physical decline. Conditions such as diabetes, arthritis, and cardiovascular disease not only reduce the quality of life but also lead to dependency on caregivers, which can cause feelings of inadequacy and helplessness. Morgan et al. (2019) found a strong correlation between chronic illness and suicidal ideation among older adults. This is particularly concerning in India, where limited access to quality healthcare for seniors exacerbates these challenges.

Economic insecurity also emerges as a critical stressor. Older adults without stable financial support often experience heightened anxiety and depression, which can escalate to suicidal thoughts. In India, many elderly individuals lack adequate pensions or savings, leaving them reliant on family support or public assistance. Rana (2020) highlights that financial dependency can create a sense of burden among older adults, further contributing to mental health decline.

Lastly, the pervasive stigma surrounding mental health in India prevents older adults from seeking help. Studies such as those by Kafczyk & Hämel (2022) show that elderly individuals are less likely to discuss their mental health struggles due

to cultural attitudes that equate seeking psychological support with weakness or failure. This stigma often results in delayed or insufficient care, further worsening their mental health outcomes.

Identifying Gaps

Despite the growing body of literature, significant gaps remain in the research on elderly suicide in India. One major gap is the lack of focus on cultural nuances. India's diverse cultural landscape means that the experiences of elderly individuals can vary significantly based on factors such as religion, language, and regional practices. Research that examines these variations is sparse but crucial for developing tailored interventions.

Another gap is the lack of intervention studies. While several risk factors have been identified, few empirical studies have tested the effectiveness of programs aimed at mitigating these risks. This gap limits the ability of policymakers and practitioners to implement evidence-based solutions.

The gendered nature of elderly suicide also remains underexplored. For instance, widowed women, who statistically outlive men, face unique challenges such as economic dependency and societal neglect, yet little research looks into their specific experiences. Similarly, studies often overlook the experiences of rural elderly populations, focusing disproportionately on urban settings where data is more accessible.

Reporting Findings

To make the findings of this review meaningful, they are presented in a way that is both accessible and actionable. Key findings include:

1. Prevalence and Risk Factors: Elderly suicide is an urgent issue, driven by factors such as social isolation, health challenges, and economic insecurity.
2. Barriers to Care: Stigma and inadequate access to geriatric mental health services prevent timely intervention.

3. Potential Solutions: Evidence suggests that enhancing social networks and community engagement can significantly reduce suicidal ideation among the elderly.

These findings must be communicated clearly to researchers, healthcare professionals, and policymakers to drive meaningful change.

Future Research Directions

Longitudinal Studies

Long-term studies are essential for understanding how factors like health decline, social changes, and policy interventions influence suicidal ideation over time. These studies can also assess the long-term effectiveness of prevention programs, providing valuable data for scaling up successful initiatives.

Culturally Sensitive Interventions

Given India's cultural diversity, future research must focus on developing interventions that respect local traditions and practices. For instance, incorporating yoga and meditation into mental health programs could appeal to older adults familiar with these practices. Collaborations with religious leaders and community elders can also help destigmatise mental health issues and encourage help-seeking behaviour.

Impact of Policy Changes

Research should examine how policy changes, such as the introduction of universal pensions or increased funding for geriatric healthcare, affect elderly suicide rates. Comparing regions with different policy implementations can offer insights into what works and why.

Discussion

The findings of this scoping review underscore the multifaceted and deeply rooted nature of elderly suicide in India, revealing critical insights into its risk factors, barriers to intervention, and potential prevention strategies. This discussion

synthesises these elements, evaluates their implications, and proposes a way forward to address the gaps in research, policy, and practice.

Interplay of Risk Factors

The review highlights that elderly suicide is rarely the result of a single factor but rather the culmination of intersecting vulnerabilities, including social isolation, health challenges, financial insecurity, and cultural stigma. Each of these factors is deeply influenced by India's socio-economic and cultural context. For example, the erosion of the joint family system, driven by urbanisation and migration, leaves many older adults without the traditional safety nets they once relied on. The resulting loneliness and lack of emotional support are particularly pronounced in a country where social identity is often closely tied to familial roles (Pitkala et al., 2009).

Health challenges, particularly chronic illnesses and physical decline, also play a significant role. Physical ailments not only affect the quality of life but also lead to increased dependency on caregivers, exacerbating feelings of helplessness and burden (Scharf & de Jong Gierveld, 2008). This dependency is often further compounded by inadequate healthcare infrastructure for the elderly, especially in rural areas, where access to mental health services is severely limited. Financial insecurity adds another layer of vulnerability, with many older adults lacking pensions or savings to support their basic needs, let alone access quality healthcare.

Barriers to Intervention

A major finding of this review is the pervasive stigma surrounding mental health in India, which serves as a formidable barrier to seeking help. Despite recent efforts to raise awareness about mental health issues, deeply ingrained cultural attitudes continue to equate mental illness with personal weakness, particularly among older generations (Kafczyk & Hämel, 2022). This stigma often manifests in feelings of shame or guilt, discouraging elderly individuals from openly discussing their struggles or accessing support services.

Additionally, the limited availability of geriatric mental health professionals further hampers intervention efforts. Kafczyk & Hämel (2021) emphasise that the shortage of trained professionals capable of addressing the unique needs of older adults is a critical gap in India's healthcare system. This gap is particularly stark in rural areas, where mental health services are either nonexistent or inaccessible due to financial and logistical constraints.

Policy and Community Interventions

The findings also point to the urgent need for policy-level interventions and community-based programs. Current policies often fail to address the specific mental health needs of the elderly, focusing instead on physical health and financial support. While these are important, a more holistic approach is required to address the psychological and emotional well-being of older adults. For instance, integrating mental health screenings into routine healthcare check-ups could help identify at-risk individuals early and provide them with the necessary support.

Community-based interventions, such as social engagement programs and support groups, have shown promise in reducing feelings of isolation and loneliness among seniors (Cattan et al., 2005). However, such programs are currently underfunded and poorly implemented in India. Expanding these initiatives and tailoring them to local contexts, such as incorporating culturally relevant activities or engaging local community leaders, could significantly enhance their impact.

Cultural and Gender Considerations

The review also highlights the importance of considering cultural and gender dynamics in understanding elderly suicide. For instance, widowed women, who often face compounded challenges of economic dependency and societal neglect, are particularly vulnerable. Despite this, their experiences remain underexplored in the literature. Similarly, the role of cultural practices, such as the stigma attached to widowhood or the social expectations of elderly men as family providers, requires further investigation. Addressing these cultural

and gender-specific issues is crucial for developing targeted interventions that resonate with the affected populations.

The Role of Research and Evidence-Based Solutions

Another critical discussion point is the need for robust, evidence-based solutions to address the issue of elderly suicide. The review reveals a significant lack of intervention studies, particularly those that test the effectiveness of community-based or policy-driven programs. Longitudinal research that tracks the impact of interventions over time is essential to understand what works and why. Additionally, comparative studies across different regions or cultural contexts within India could provide valuable insights into the diverse experiences of the elderly and inform more targeted approaches.

Moving Forward

To address the issue of elderly suicide effectively, a multi-pronged approach is necessary. This includes:

1. Raising Awareness: Efforts must focus on destigmatising mental health issues through public awareness campaigns that are culturally sensitive and specifically tailored to older adults.
2. Improving Access to Care: Expanding mental health services, particularly in rural areas, and training primary healthcare providers to recognise and address signs of distress among the elderly is crucial.
3. Strengthening Social Networks: Community programs that encourage social engagement and foster a sense of belonging among older adults should be prioritised.
4. Policy Interventions: Policymakers must allocate more resources to geriatric mental health and develop targeted programs to address the unique needs of the elderly.

Conclusion

Elderly suicide is a pressing public health issue in India that demands immediate and sustained attention. This discussion has highlighted the interplay of risk factors, barriers to intervention, and the potential of policy and community-

based approaches to mitigate this crisis. Addressing this issue requires a comprehensive and culturally nuanced strategy that integrates research, policy, and practice. By prioritising the mental health and well-being of older adults, India can take a significant step towards ensuring a dignified and fulfilling life for its ageing population.

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Suicide:
A Socio-Cultural Perspective

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Abstract

Understanding suicide to devise and implement plans for prevention, treatment and sustained agenda for reduction of risks and enhancing protective mechanisms requires an approach that gives equal attention to the sociocultural elements of aetiology and predisposition. The prevailing mental health disorders affecting potential suicidality are embedded in the social context of lives at risk, therefore, the sociocultural perspective can offer an explanation that might elucidate the personal, community and societal elements of suicidal tendencies and their likely solutions as part of a larger holistic perspective. This paper describes with relevant evidence the factors that are known to influence suicidal ideations, behaviour and the act of suicide. Setting the scene for a sociocultural perspective in broad terms rather than specific countries or global regions, the paper draws from a range of sources that provide a thematic narrative to capture the essence of the sociocultural elements informing knowledge about suicide. In conclusion, it asserts that the social underpinning of the explanation of suicide is of equal significance in assessment, treatment and prevention.

Keywords

Suicide, sociocultural, stigma, social justice, cultural

Introduction

Suicide is recognised as a major public health concern worldwide. Death, because of self-injurious behaviour, is classified as suicide (Posner et al., 2014). According to the World Health Organisation (2025), the global rate of suicide is staggering, represented by more than 7,20,000 deaths every year. Additional data suggest that seventy-three per cent of suicides happen in people in low- and middle-

income countries (LMICs) (WHO, 2025). Suicide rates vary across countries and show variations in incidence among gender and age groups. Suicide behaviour is complex, and the reasons people attempt suicide or succeed in killing themselves are postulated to involve a wide range of personal, biopsychosocial, cultural, and environmental factors. The presence of mental and physical health disorders is a risk factor for suicide and has been reported extensively in the literature. However, other factors such as social isolation, discrimination, violence, unemployment and abuse act as determinants that influence suicidal behaviours. In this paper, I explore the social and health-associated factors that predispose and lead to suicide from a socio-cultural perspective.

Suicide has been defined as a self-destructive, wilful act of killing oneself (WHO, n.d.). It identifies intent as a conscious motivation and self-directed behaviour. Suicide is a personal and unique human act, the reasons and consequences of which can be unravelled only after the event. Factors associated with suicide have been extensively examined and documented, particularly in relation to mental health and substance misuse, with a focus on mental health disorders. For instance, mental disorders such as depression (Too et al., 2019; Yeh et al., 2019), physical disorders (Nafilyan et al., 2023; Onyeka et al., 2020), and substance abuse are risk factors (Esang & Ahmed, 2018; Rizk et al., 2021) that have been reported extensively. Whilst the associations between various mental health disorders, physical illness and substance use are used to inform treatment and prevention strategies which can be tailored to reduce self-harm and attempted suicide, data suggest that rates of suicide are increasing and continue to support trends in variability and differences among age groups, gender and specific social groups (Carrett et al., 2023; Kar et al., 2024; Radhakrishnan & Andrade, 2012; Yadav et al., 2023). Our understanding of suicide has stemmed from disease-oriented approaches, which focus primarily on mental health disorders along with their prevention and treatment strategies, which align with evidence from a medical perspective. However, a more holistic approach to understanding suicide requires exploring the social and cultural factors that influence an individual's thoughts and behaviours (Digviijay et al., 2023; Kirmayer, 2022; Lester, 2008).

Social perspectives of suicide

Suicide is the outcome of complex interactions between biopsychosocial and environmental factors (Rane & Kulkarni, 2014). Throughout their lives, people encounter events that significantly shape how they perceive themselves, their circumstances, and their outlook on the future. Chew & McLeary (1994) suggest that suicide risk is a product of both motivation and opportunity, exposing individuals to varied life paths. Each person's life course comprises transitional phases during which they may face experiences that heighten their vulnerability to suicide risks. (Johns et al., 2023). Transitional phases in childhood, adolescence, student life, adulthood, and later years have been shown to impact social relationships, sometimes acting as protective factors and at other times, as risk factors. Social events and interactions shape the person's attitudes, thinking and behaviours in the context of rules and standards within the society. Societies are characterised in part by the formal and informal institutions around the individual and family. The family unit acts as a social support and a safety net in protecting the individual from harm and suicide across the lifespan. The wider societal context raises concerns about the stability of the family structure, the changing nature of social relationships within households and highlights various negative risk factors for suicide, such as marriage and divorce, domestic violence, alcohol consumption, and substance abuse (Frey and Cerel, 2015; Maloku & Maloku, 2020). Thus, social relationships with meaningful reciprocity, a sense of belongingness and healthy interdependence and an optimistic viewpoint can act as protective factors.

At any time during their life course, an individual may be vulnerable to factors that adversely affect their health and well-being. Suicide-related mortality can be influenced by a range of determinants, which may operate alone or in combination with other factors. Contributing factors identified in the literature include being involved with the criminal justice system, exposure to suicide within one's social or familial network, divorce, unemployment during midlife, and the availability of firearms (Na, Shin and Kwak et al., 2025). Notwithstanding the predominant stance from the mental health perspective on suicide and its influences in shaping prevention programmes, social aspects of attempted suicide and suicide ought to have an equally important position in explaining

the significance of social factors in lethal suicide. In a review of meta-analyses, Llamocca et al. (2023) reported a higher likelihood of suicide among those with a family history of alcoholism or drug addiction, being a victim or perpetrator of abuse, other primary support group problems, employment or occupational maladjustment problems, housing or economic problems, legal problems, and other psychosocial problems. The societal impact of illness and suicide is profound and cannot be fully captured through fragmented or incomplete data alone. Social relationships are important for the development of healthy attitudes and behaviours towards oneself and others, and provide social support and community connectedness. Societal expectations will be that the individual's family stands as a source of support and nurturance. At different stages in the life course, issues about family relationships, the dynamics of the psychosocial and cultural values may emerge as challenging and harm the health and well-being of an individual. Psychological distress resulting from such adverse experiences does not manifest in the form or severity of a diagnosable mental illness. However, it can leave a lasting impact on one's capacity to deal with and regulate personal emotions. Such distress may also result in suicidal ideations and influence suicidal behaviours, especially among adolescents (Yang et al., 2022) and is often rooted in emotional maltreatment such as lack of cohesion among family (Hari et al., 2023). Family conflicts, humiliation, and economic hardships have been identified as significant contributors to suicidality. Notably, experiencing shame has been strongly associated with non-suicidal self-injury (NSSI) (Sheehy et al., 2019).

Social connectedness acts as a protective factor. The more connected the family members are, the solidarity and support act as a protective factor against suicidal ideations and suicidal behaviours (Matchell, Rallis & Esposito-Smythers, 2016; Peláez-Fernández et al., 2024). Relationships between family functioning and suicidal ideation in adolescents have been shown to moderate behavioural outcomes (Yang et al., 2022). On one hand, family connectedness is found to be a significant protective factor against suicidal ideation and behaviours among young individuals (Merai et al., 2025; Randell et al., 2006) and older adults (da Silva et al., 2015) across societies and cultures. On the other hand, it is also a major source of conflict and violence. Family conflict and suicidal behaviours among young children have been shown to have a strong association (Zhang

et al., 2023; Assari et al., 2021). Family history of suicide and unstable behaviours mitigate the ability to create stable and lasting relationships (Rajalin et al., 2017) and may precipitate suicidal thoughts and acts. Lopez-Castroman et al. (2015) reported an additive effect for the age at the first attempt in suicide attempters with both a family history of suicidal behaviour and either physical or sexual abuse. Thus, a family history of suicide may act as a risk factor with inherent predictive features that family members would have an awareness of and put them on guard, in addition to environment-related anxieties and stress. Health professionals should be equally alert to these possibilities when encountering individuals who exhibit suicidal behaviours.

Considering the role of socioeconomic status and poverty in suicide, Lee et al (2021) reported that poverty attribution showed a permissive attitude to suicide. Iemmi et al (2016) reported a positive relationship between poverty and suicide, concluding that there was a consistent trend at an individual level. Poverty, in the form of worsening socio-economic status, reduced wealth and unemployment, was found to be associated with suicidal ideations and behaviours. Similarly, financial hardship is associated with a significant risk of suicidal ideations (Choi et al., 2021). Factors such as unemployment, occupation (Milner et al., 2012), financial hardship, social isolation, discrimination, and cyberbullying can be factors to consider in the context of modern-day living. Social disparities limit the choices available to people living in disadvantaged and resource-constrained communities, where inequalities persist through generations within familial networks.

In arguing for a population-level intervention in the prevention of suicide, Caan (2020) cites Marmot in emphasising the role of society – 'suicide is an individual act, but the suicide rate is a property of the community'. Suicide is a community issue that needs to be considered in the relevant frameworks of shared life experiences and responses (Armstrong, 2020). At a community level, this suggests that there should be actions indicative of acceptance and collective responsibility.

At an individual level, Marks & Albernathy (1974) suggested considering a 'suicide threshold'; once that particular level is reached, the suicidal process develops

and ends in the person's self-inflicted death. Elsewhere, Capron et al. (2022) have proposed the construct of unacceptable loss thresholds, explaining that they are a person's tolerance limit for a negative life event, which, if violated, results in an increase in suicide risk. These useful concepts help advance our understanding of how a person comes to commit suicide, the processes that are involved in times of crisis and how the person ends their lives. When a person is bereaved through the suicide of a family member, aside from the impact on the immediate bereaved family members, the community around whom the person lived and interacted would be equally affected emotionally. Again, statal and charitable organisations exist that support families and friends following the suicide of a loved one. Interestingly, in communities where there are higher levels of access to the internet, home insurance and income, the rate of suicide tends to be lower (CDC, 2024) compared to low- and middle-income countries where resources are limited and hard to access.

Social media influences

Social media is embedded in society and has influenced a great many positive outcomes in communication, entertainment and creative opportunities, and holds great potential for suicide prevention (Robinson et al., 2016). Luxton et al. (2012) examined the literature on the use of internet and social media platforms and suicide rates in the general population. They concluded that though the results of studies showed a positive correlation between the prevalence of internet use and suicide rates, caution needed to be exercised because of the designs of studies and ecological fallacy.

The internet provides information about the 'how' and the means to commit suicide. Social media use among young people has increased, and problematic internet or social media usage particularly contributes to increased vulnerability to suicide attempts (Sedgwick et al., 2019). Menon et al. (2018) concluded that exposure to social media promoting self-harm and emulating and adoption of self-injurious behaviours of others were affecting the well-being and self-worth of young people. In contrast, Christiansen et al. (2024) have argued that the evidence supporting the role of social media in influencing suicidal ideation and behaviours was weak. The time spent on social media, negative influences

of others may nevertheless point to mental health concerns that may lead to distress, suicidal thoughts and suicide attempts (Young et al., 2024). No causal relationship between heavy use of the internet and suicide could be claimed based on the current evidence. However, problematic use of the internet and social media represents a social problem that adversely affects individuals and various segments of society.

The positive influence of social media can also be harnessed by using it to inform the public about the risks of suicide, involving messages through the medium appropriate for people of all ages and protected characteristics.

Social identity and group solidarity

Identities are shaped and perceived socially. Community engagement influences identification with a social group, promotes a sense of belonging and is associated with the subculture, which has profound implications for the attribution of values and beliefs. A stable sense of personal identity contributes to a continuity in one's self-perception over time. However, this stability can be shaken by negative life experiences, which may impact mental health and increase the risk of suicidal thoughts and behaviours (Sokol & Eisenheim, 2016). While personal identity reinforces self-worth, suicidal thoughts and tendencies diminish self-continuity with poor self-concept and self-blame. Group identification, on the other hand, has been shown to encourage help-seeking behaviours (Kearns et al., 2015).

In their study of suicide prevention among construction workers in Australia, Gallestrup et al (2024) identified four themes. These included a strong sense of belonging, connection and solidarity among workers and their industry; how specific context and roles impacted identity while existing within an overall sense of identity and solidarity; how industry mateship supported engagement in suicide prevention; and how the role of lived experience, mateship and responsibility provided hope for change. These themes add to the understanding of peer support, building social relationships over time, trust, and reciprocity can act as protective mechanisms against suicide. The prevention of suicide requires a comprehensive approach with the commitment and involvement of statal and parastatal bodies with professionals skilled in preventive work.

Gender, as a form of social identity, is complex and multifaceted, including identities beyond the male-female dichotomy. Gender as a social construct has many domains that influence health and relationships (Barr et al., 2024). Payne, Swami and Stanistreet (2008) have outlined definitions of gender referring to 'masculinity' and 'femininity' and argued that societal roles and expectations about behaviours are socially constructed, so that gender is more dynamic and not fixed or static, manifest in the enactment, in interactions with others. According to Payne, Swami and Stanistreet (2008; p.4), a 'gender analysis offers a powerful means of understanding differences in suicidal behaviour among men and women'. The differences in suicidal ideations, the impact of mental illness, domestic issues and methods used in suicidal acts are gendered. Jaworski (2010) has discussed the held perceptions about the differences in reasons for suicidal acts between men and women. Women's suicide is often seen from the perspective of a breakdown in a relationship due to emotional issues, whilst suicide in men is seen as a struggle against personal situations such as physical illness and economic failures. The methods of suicide have also been critiqued to show differences between men and women, which may be accounted for by the availability and access to the means of inflicting harm and death, with men choosing more violent means than women (Kumar et al., 2017). Interpretations about the differences between male and female suicide are also often shaped by gendered perspectives.

Stigma

Stigma is a social phenomenon that affects the health and social conditions of the population in general. Bolster-Foucault et al. (2021) reviewed the literature, mostly reporting studies from developed countries and identified ten domains of structural determinants of stigma, which included welfare policies, healthcare practices and policies, and public health interventions. In giving prominence to these domains as key areas for consideration in health and social care practice, one can emphasise the need for intersectoral collaboration in addressing suicide and suicide prevention.

Stigma impacts the quality of life of individuals, delays in help-seeking and treatment adherence among people with mental illness. Stigma can lead to discrimination and social isolation, thus making the individual vulnerable to suicidal behaviours (Oexle et al., 2018). Stigma associated with sociodemographic characteristics has been shown to exert an impact on the choices individuals make to access services or not, predominantly opting to harm themselves or commit suicide (Kučukalić and Kučukalić, 2017). Stigma can intensify feelings of shame, hopelessness, isolation and rejection in someone who is suicidal and experiencing difficulty in making a decision about seeking help from mental health professionals. Stigma impacts help-seeking attitudes and behaviours towards suicide. It has been found that in countries where suicide rates are low, people experience less shame and are more positive about seeking help for mental health services (Reynders et al., 2013). The association between stigma and suicide is highly suggestive of the risk of suicide among those with mental disorders and for minority groups (Carpiniello and Pinna, 2017). Interventions to reduce structural stigma in society need the collaboration of stakeholders and leadership in policy making so that the risk of suicide among those who perceive themselves as marginalised can feel empowered to face their personal challenges.

Culture and suicide

Suicide is viewed differently across cultures (Range et al., 1999). Traditionally held values and beliefs surrounding suicide are usually linked to disruptions in the social and cultural foundations that typically offer protection against such acts. Perceptions about suicide and those who commit suicide vary equally and are influenced heavily by social and cultural norms. Suicide may or may not be acceptable in the culture. However, suicide ends in a fatal outcome - death of the person, and consequences suffered by families and friends, bearing testimony to emotional and social hurt, guilt and stigma. Yet, there may or may not be shared grief and a sense of loss. The level of engagement, empathy and compassion can have a huge impact on the family's ability to comprehend and avert suicidal acts. Family involvement in providing a safe environment, reducing access to means of self-harm, and making needed adjustments to enable family involvement in

preventive and therapeutic modalities can be significant in informing suicide prevention (Gorman et al., 2023).

Ongeri et al (2022) conducted 25 interviews with key community informants, including health professionals, about sociocultural factors that may influence suicidality. Their findings supported 4 themes that inform understanding cultural perspectives related to suicidality: (1) the stigma of suicidal behaviour, with suicidal victims perceived as weak or crazy, and suicidal act as evil and illegal; (2) the attribution of supernatural causality to suicide, for example, due to sorcery or inherited curses; (3) the convoluted pathway to care, specifically, delayed access to biomedical care and preference for informal healers; and (4) gender and age differences influencing suicide motivation, method of suicide and care seeking behaviour for suicidality. The context and background of acculturation into modes of thinking and behaviours shape the experiences and attitudes of people. Social perceptions

Individualistic and collectivist values, beliefs and attitudes towards suicidal ideations and individuals differ as might be expected (Eskin et al., 2020). In a study across 12 countries, Eskin et al. investigated the associations between suicidal behaviour and the moderating effects of value orientations towards suicide and suicidal individuals. They found that intermediate levels of individualism protect against suicide across countries. They reported that collectivistic values were uniformly associated with less permissive attitudes to suicide. By comparison, individualistic values were associated with a more stigmatised view of suicidal behaviour.

Eskin et al. (2020) found that both individualistic and collectivistic value orientations were associated with socially accepting attitudes to a suicidal peer, helping a suicidal friend, and emotional involvement, indicative of compassion and supportive solidarity. In Bangladesh- a country usually characterised as a collectivist country- Khan (2023) suggested that indices of cultural life showed an association between attitudes toward suicide and prevailing manifestations in society. Many collectivist countries may not have been able to develop a positive culture of help-seeking in the event of suicidality, like Bangladesh. A strong sense

of collective stigma and shame towards suicide might impact early intervention. To counter the associated shame and stigma, professionals must approach to adopt culturally sensitive interventions to appropriately address such a serious sociocultural problem as suicide. Professional education and training often overlook the importance of equipping trainees with culturally competent skills and practices. However, Vinuprasad, Sharadha, and Eskin (2020) suggest that integrating exposure to suicide-related topics into the undergraduate curriculum can lead to positive shifts in attitudes toward suicide.

Culture, religion and opinions about suicide

Countries worldwide have religion as one of the social planks on which they have built their constitutional rights-based freedoms. Recognised as a fundamental human right, people are free to choose and practice and celebrate their religion. Boyd and Chung (2012) explored opinions about the relationship between religion and suicide across 43 countries. They analysed variables such as religious affiliation, religious importance, and church attendance (Boyd and Chung, 2012). They concluded that the individual's opinions about suicide are influenced by personal beliefs as much as cultural values and religious characteristics of their country. Individuals who reported more religious importance have lower levels of suicide acceptability (Boyd and Chung, 2012). The evidence supporting an association between religious affiliation and opinions about suicide is not consistent. As far as religious affiliation and practices are concerned, Lawrence, Oquendo and Stanley (2016) reported that religious affiliation did not protect against suicidal ideation but did protect against suicide attempts. Furthermore, they suggested that protection against suicide attempts depended on the culture-specific implications of affiliating with a particular religion and that 'religious service attendance protected against suicide attempts and possibly protects against suicide'.

Agoramoorthy and Hsu (2017) described views about suicide from the Hindu religion tenets and suggested that the ancient practice of Sati, when widowed wives would throw themselves on their deceased husband's funeral pyre, was in the belief that they would be reunited with their husband in the other realm. However, they point out that Hindu scriptures do not mandate. Similarly, in

Islam, the Qu'ran forbids suicide. In an analysis of age-standardised suicide rates in Muslim-majority countries, using data from 2000 to 2019, Lew et al (2022) concluded that these countries had lower suicide rates than the global average, which might reflect religious belief and practice or could be due to underreporting due to the legal frameworks. Gearing and Alonzo (2018) asserted that high religiosity has been associated with decreased suicide risk.

Social justice and prevention strategies

Westefeld (2020) has argued that suicide prevention is a social justice issue, suggesting that the intersection between suicide (suicide prevention) and social justice requires healthcare professionals to be engaged with the people at risk of suicide. In defining social justice and its parameters, such as multiculturalism, equality, justice and reduction of suffering, and goals of social justice, Westefeld is targeting what Hochhauser et al. (2020) considered as the societal dimensions in a socioecological framework, focusing on among others, government policies and decisions, the legal regulations of lethal means of suicide. To Westefeld (2020), suicide and suicide prevention are social justice issues that should be of concern for health and social care workers, counsellors and policy makers.

Social determinants of suicide include a range of social, cultural and political factors that contribute to suicidal ideations and suicidal behaviours (Fitzpatrick 2018). Stack (2021) has discussed the effects of four sets of factors on suicide risks and predictability, namely, political, social, cultural and economic factors. In providing evidence for the impact of each set of factors, Stack (2021) advanced the comprehensive understanding and explanation of the relationships between factors within in set that contribute to the risks of suicide and prevention strategies.

When considering the goals of suicide prevention programmes, the concept of social capital would be worth considering in the context of individuals, their family, communities and the wider society. From the sociocultural perspective, the resources available within the social relationships and social networks can influence positive health outcomes and possibly moderate social inequalities. In the wider context of the quality and amount of these resources would also influence outcomes, as people in social relationships might have diverse and

mixed capacities in skill sets and ability to engage. Zhai, Kishan and Showalter (2022) provided supportive evidence that social capital is a statistically significant influential factor of suicide rates. They have further argued that changes in social engagement and interpersonal connectedness can impact suicide rates. Social justice as a goal requires health professionals to change their attitudes, which can be barriers to interactions and beneficial, effective therapeutic relationships.

Prevention programmes and activities can be categorised at 3 levels, namely, universal, selective and indicated (Goldsmith et al., 2002; Stone and Crosby, 2014). Universal programmes and activities refer to activities addressed at informing the public, enhancing awareness, reducing barriers and promoting social support. School-based programmes are universal in approach and can reach large numbers. Selective level interventions target at-risk groups, whilst the indicated level has as its population those who are at high risk, for example, with who have previously attempted suicide. To add to the evidence of the effectiveness of community-based intervention in suicidal behaviour prevention, Hegerl et al. (2021) have reported on 4-level community-based interventions implemented in countries in and outside Europe with a focus on depression and suicide. The interventions highlight the engagement and responsibilities at each level of participants, involving 1) primary care, 2) the public, 3) Community facilitators and gatekeepers, and 4) patients, individuals at high risk and relatives. This approach extends the focus on suicide prevention to a global audience, including laypersons, service providers, and health professionals. Evidence supporting the efficacy of the 4-level intervention has shown positive outcomes in preventing suicidal acts, with the sustainability of these effects also demonstrated.

Culturally sensitive programmes of prevention need to have social acceptance and address minority mental health at the community and societal levels (Zhai et al., 2022). Pirkins et al (2024) have argued that we need to change the way we think about suicide and emphasised the role of social determinants of suicide as target goals for prevention strategies, with the structural inequalities and social justice as core elements to address.

Conclusion

Suicide is a growing social concern, increasingly recognized as a significant issue for health and wellbeing, and can be approached from multiple perspectives. Here, a sociocultural approach was adopted to understand and explore the underpinning social concepts that advance understanding of the manifestations of suicide in society. Sociocultural factors that influence the susceptibility and predisposition to suicide need a holistic and ecological approach to prevention, that takes cognisance of the social and societal influences that threaten an individual's self-worth and trigger suicidal behaviours. Strategies for prevention have to take into consideration the social determinants of conditions that represent social values, strategies and actions to reduce suicide at an individual level, collective and societal levels. Therapeutic approaches including individual counselling and supportive peer strategies, can be used to help reduce suicide-related mortalities. Sustained actions are needed if risks are to be reduced and protective factors increased, and mortality rates decreased.

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Farmers' Suicide in India: Causes and Policy Interventions

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Abstract:

India's agrarian economy, while vital to food security and rural employment, is marked by persistent vulnerabilities. Farmers, who constitute the backbone of the sector, grapple with fluctuating market prices, climate uncertainties, and rising input costs—all of which erode their economic stability. One of the most tragic manifestations of this distress is the escalating rate of farmer suicides. This study aims to analyse the underlying causes of farmer suicides and evaluate the effectiveness of existing policy interventions. Although indebtedness and crop failure are widely recognized as key triggers, the root causes lie in the low income of farmers and their limited capacity to absorb risks. To mitigate the crisis, agricultural policies must focus on enhancing farmers' income, strengthening risk management strategies, and improving financial security. Based on the findings, the study proposes targeted policy recommendations to build resilience and ensure sustainable livelihoods.

Keywords:

Farmers' suicide, indebtedness, crop failure, agrarian crisis

Introduction

Agriculture is a cornerstone of the Indian economy, providing livelihood to nearly 42.3% of the population and contributing about 18.2% to the gross domestic product (Press Information Bureau, Ministry of Finance, 2024). Despite its crucial role, the sector is affected by a deepening crisis, leading to a catastrophic rise in farmers' suicides. The National Crime Records Bureau (NCRB) data indicates that nearly 4,02,757 farmers took their lives between 1995 and 2022. Studies suggest these figures may be underreported due to factors such as stigma, restrictive

definitions of "farmer" (often excluding women), and incomplete reporting, with some states recording zero cases (Nagaraj et al., 2014).

The issue of farmers' suicides in India was first brought to national attention by journalists and media in the mid-1990s. The NCRB publishes comprehensive data on crime, suicide, and accidental deaths in India. These reports include suicide statistics categorized by profession, specifically documenting suicide deaths among individuals engaged in farming activities. In 2014, the NCRB published its first detailed report on farmers' suicides, which analysed the causes of these suicides. The report presents distinct data on farmers and agricultural labourers, identifying indebtedness as a primary factor contributing to farmer suicides.

In response to the issue of farmers' suicides, the government has implemented several policy initiatives, including farm loan waivers, the Pradhan Mantri Safal Bima Yojana, and increases in the Minimum Support Price (MSP), among others. However, the figures in the latest NCRB report indicate that these measures have not significantly reduced the incidence of farmers' suicides - data from 2020 onward shows an upward trend in the number of cases.

Farmers' suicides are not just individual tragedies, it has long-term economic, social and psychological consequences. Families of victims are left with unpaid loans, pushing them further into poverty. Children and widows of victims become vulnerable to stigma and social discrimination. Compensation to families and debt waivers create further fiscal pressure on the state and the centre. Hence, it is important to understand the underlying causes of farmers' suicide so that corrective actions can be taken to prevent the same. Toward this end, this paper aims to study the following objectives.

1. To analyse the causes of farmers' suicide in India.
2. To evaluate existing policy interventions and
3. To propose some policy recommendations.

Agriculture Statistics

According to the Situation Assessment Survey (SAS) conducted by the National Statistical Office (NSO), the estimated number of agricultural households is

93.094 million, which comprises 54% of the rural households, of which 2.6% are landless households. It can be seen in the table below that more than 88% of agricultural households are small and marginal.

Table 1: Distribution of Agricultural Households and Land Ownership by Size Category in India

Size category of ownership holdings (in ha.)	Landless (<= 0.002)	Marginal (0.002 – 1.0)	Small (1.0 – 2.0)	Semi-medium (2.0 – 4.0)	Medium (4.0 – 10.0)	Large (> 10.0)
Percentage distribution of agricultural households	2.6	70.4	16.4	7.9	2.4	0.2
Percentage distribution of area owned by agricultural households	0	31.5	25.7	22.8	15.7	4.3

Source: National Statistical Office (NSO), Government of India, Situation Assessment of Agricultural Households and Land and Holdings of Households in Rural India, 2019

Review of Literature

Farming is one of the most high-risk and stressful occupations, associated with elevated suicide rates not only in India but also in countries such as the USA, Canada, Sri Lanka, England and Australia (Behere & Bhise, 2009).Agricultural labourers were identified as a high-risk occupational group, alongside labourers and cleaners, in a meta-analysis of 34 studies (Milner et al., 2018). Farming is a high-risk occupation in India as well, and the high incidence of farmer suicides in India underscores that the issue is not solely psychological but is largely driven by socio-economic factors rooted in the state of agriculture.

Reddy (2010) examines the crisis in agriculture and farmers' suicide in India, highlighting the structural challenges faced by small and marginal farmers in India. He differentiates between agrarian crisis and agricultural crisis, emphasizing that the former stems from policy failures leading to the marginalization of

farmers, whereas the latter results from declining agricultural productivity. He highlights how post-1991 economic reforms led to the withdrawal of state subsidies, reduced agricultural investment, and declining institutional credit availability to the agricultural sector.

Mishra (2014) has computed suicide rates of male farmers in India from 1995 to 2012 based on data provided by the NCRB. He finds that the suicide rate of male farmers at the aggregate level spiked twice in 2004 and 2009 before starting to decline. However, analysis of state-wise data revealed that for states like Maharashtra and Andhra Pradesh, where farmers' suicides were high, suicide cases have been increasing. His study specifically focused on seven states, viz Andhra Pradesh, Chhattisgarh, Karnataka, Kerala, Madhya Pradesh, Maharashtra and Uttar Pradesh, where the suicide rate for male farmers is higher than that for male non-farmers. While highlighting the trend of suicide rates in these states, Mishra has pointed out state-specific causes of suicide. He points out that a higher suicide rate among farmers in India is an indication of a larger socio-economic crisis. He outlined that the crisis has two dimensions -production and distribution.

Merriott (2016) states that, unlike developed countries where suicide is associated with mental illness, farmers' suicide in India has factors that have socioeconomic characteristics like indebtedness and cultivation of cash crops. However, no significant relation between the introduction of Bt. Cotton and suicides were found in his study. He contends that reduced agricultural credit flows, declining public investment in rural infrastructure, and trade policies that adversely impacted agriculture's terms of trade have collectively contributed to the agrarian crisis.

Manjunatha & Keshava (2012) cite deceleration in agricultural growth, decline in public sector investment in agriculture, reduced or almost stagnant flow of credit to the agricultural sector from PSUs, and fall in share of total exports as some of the reasons for the current state of agriculture and consequent incidence of farmers' suicide in India. They recommend a comprehensive agricultural policy and strengthening of infrastructure.

Vasavi (2009) explores the structural and systemic factors contributing to agrarian distress in India, particularly focusing on farmer suicides. The study

critically examines existing literature on rural distress, emphasising how neoliberal economic reforms, declining state support, and socio-cultural vulnerabilities have exacerbated the crisis. The paper discusses the role of debt, input costs, market volatility, and policy neglect in pushing farmers into distress. It also engages with sociological and anthropological perspectives, highlighting how caste, class, and gender intersect with economic vulnerabilities. The literature reviewed underscores the need for a comprehensive, multi-disciplinary approach to understanding and addressing agrarian distress beyond economic determinism. The green revolution and commercialisation of agriculture have led to the individualisation of agriculture, wherein the entire burden of farming is on a single individual.

Nagaraj et al. (2014) provide an analysis of the magnitude and trend of farmers' suicide at a nationwide level from 1997 to 2012. They also delve into an analysis of gender composition and regional patterns of suicide cases. Their study finds that the suicide rate among farmers is higher than the suicide rate among the general population. Additionally, nearly 85% of farmers' suicides are by males. Without underscoring the significance of the long-existing agrarian crisis as a cause of farmers' suicide, the authors emphasize that suicide is a complex phenomenon having socio-economic and psychological dimensions.

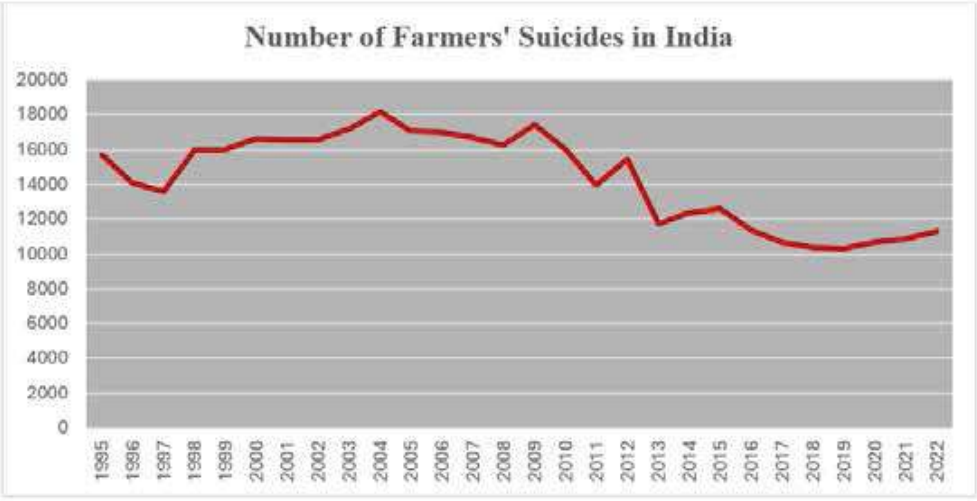
Mohanty (2005) evaluates farmers' suicide in Amravati and Yavatmal districts of Maharashtra, attributing these acts to social and economic causes. Mohanty establishes that farmers' suicides are embedded in a larger crisis of agrarian transformation under neoliberal reforms. His study links farmers' suicide to cropping patterns, land holding size and credit structure.

Incidence and Causes of Farmers' Suicide in India

Data on farmers' suicides in India is available from 1995. Analysis of the trend of farmer suicide indicates that the number of incidents reported by the NCRB increased consistently till 2010. An average of more than 16,000 cases were recorded every year for almost two decades since the New Economic Policy was implemented in 1991. Since 2010, a decline in the number of suicide cases has been observed for over a decade, with an average of 12,314 cases every year. However, recently, it has been observed that the number of suicide cases has

been increasing (see Figure 1). State-wise analysis of suicide cases indicate that the six states - Maharashtra, Karnatake, andhra Pradesh, Tamil Nadu, Madhya Pradesh and Chhattisgarh, comprise almost 75% of the suicide cases in India.

Figure 1: Number of Farmers' Suicides in India



Source: Various reports from the National Crime Records Bureau

This study identifies two primary factors contributing to farmer suicides in India. First, the failure of the New Economic Policy to prioritize agriculture, making it unviable for many farmers. Second, the issue of high indebtedness, particularly among small and marginal farmers.

Reforms introduced under the New Economic Policy in 1991 neglected agriculture, as there was no official policy for agriculture until the National Agricultural Policy of 2000. However, agriculture was not insulated from broader changes—it experienced indirect consequences due to reforms in the industrial and financial sectors. These included a fall in public sector investment in agriculture due to fiscal prudence, reduced credit delivery to agriculture and declining terms of trade as agricultural goods were exposed to the volatile global market.

Share of public sector in gross capital formation (GCF) in agriculture dropped steeply from 29.6 % in 1990-91 to 17.1% in 2002-03. The decline in the share of the agriculture sector's capital formation as a percentage of GDP from 2.0 per cent in the 1990s to 1.7% in 2004-05 was mainly due to the decline or stagnation of public investment in agriculture. Inadequate capital formation post-liberalisation has adversely affected infrastructure development in agriculture.

Under liberalisation as a part of banking and financial sector reforms, interest rates were deregulated, and the volume of direct credit requirement for agriculture was eased. The focus was on the profitability of banks, thereby increasing competition within banks and between banks. This led to a decline in rural credit. Credit to small and marginal cultivators as a percentage of total direct agricultural credit declined in the 1990s and even in the first half of the 2000s (Chavan 2014). This further affected private investment in agriculture.

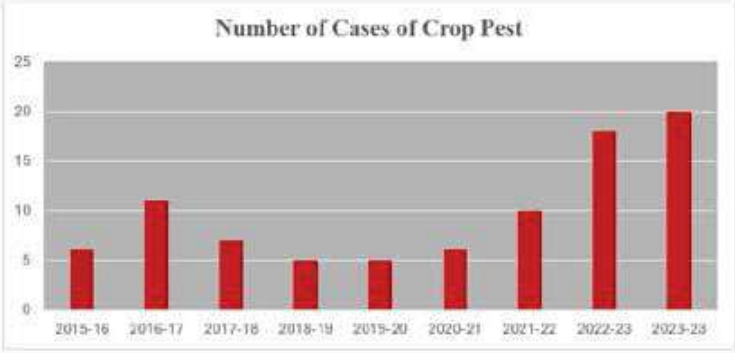
Crop failure and Indebtedness are other major causes of farmers' suicide. According to the 'All India Financial Inclusion Survey (NAFIS)' report 2021-22 by NABARD, 55% of the agricultural households are indebted. According to NCRB 2015, 'Bankruptcy or Indebtedness' is reported as a major cause of suicides among farmers or cultivators, contributing to 38.7% of suicides (3,097 out of 8,007 suicides). Does higher indebtedness contribute to the larger incidence of farmers' suicides? Indebtedness becomes a direct trigger for suicide when declining earnings make repayment impossible. Indebtedness is not inherently problematic—financially stable households often take loans to invest in productive assets, boosting capital formation and income. The crisis arises when debt is coupled with systemic risks (crop failure, price volatility) and a lack of safety nets. Small and marginal farmers with limited access to institutional credit frequently depend on informal sources (moneylenders, friends, and relatives) to take loans at extremely high interest rates. With their constrained repayment capacity, these debts can quickly spiral out of control, reaching unsustainable levels. This financial burden, coupled with the absence of viable solutions, can push farmers into extreme distress, sometimes culminating in suicide.

Crop failure is the second major cause of farmers' suicide in India, as reported by the NCRB. Loss of crop is defined as crop failure. Two main factors that can cause crop failure are adverse weather conditions and pest infestation. Indian agriculture is vastly dependent on monsoons and is thus susceptible to crop failure. With only 55.8% of the gross cropped area being covered by some source of irrigation, timely rains play a very crucial role in Indian agriculture. According to the National Disaster Management Authority (NDMA), due to its unique geo-climatic and socio-economic conditions, India is vulnerable to natural calamities like floods and droughts. 68% of the cultivable land in India is vulnerable to drought (NDMA, 2022). This affects crop yields as well as production, leading to

a reduction in farmers' income. According to a report released by the Forum of Enterprises for Equitable Development (FEED), 80% of marginal farmers in India have been impacted by crop losses resulting from adverse climatic events in the past five years. It also showed that the major cause of crop damage was drought (41%), followed by factors like irregular rainfall with excessive or untimely rains (32%), and the early departure or delayed onset of the monsoons (24%) (Financial Express, 2024). According to the Department of Agriculture, Government of Maharashtra, over the past five years, the state has experienced a loss of 36 million hectares of crops attributed to the climate crisis (Deshpande, 2023). Erratic climatic conditions, including cyclonic storms, floods, flash floods, droughts, unseasonal rains and cloudbursts, were identified as the cause for the loss (Deshpande, 2023).

Since the beginning of cultivation, farmers have been facing problems from several organisms like insects, mites, rodents, slugs and snails, nematodes, birds, plant pathogens, and weeds. Crop losses due to pests could be either qualitative (reduced productivity and lower yield) or quantitative (lower quality affecting market value). In India, losses in crop yields caused by insect pests, diseases, weeds, nematodes, and rodents are estimated to range between 15% and 25%, leading to an annual economic impact of approximately ₹90,000 crore to ₹1.4 lakh crore (e-pest surveillance in selected crop ecosystem, 2012). It has been observed that the number of cases of pest infestation has increased in the last few years. Year-wise incidence of crop pests as reported by the Directorate of Plant Protection, Quarantine and Storage, Ministry of Agriculture and Farmers' Welfare of the Indian Government, is shown in the table below.

Figure 2: Number of cases of crop pests in India



Source: Chart based on data from the Directorate of Plant Protection, Quarantine and Storage

Policy Measures for Farmers' Welfare

The Government of India has implemented various welfare schemes to assist farmers. The below section discusses some of these to assess their role in income stabilisation and risk mitigation for farmers

Pradhan Mantri Kisan Samman Nidhi (PM-KISAN): The PM-Kisan scheme, launched in 2018, is a 100% centrally funded scheme to support farmers with a supplementary income of ₹6,000 per year paid in three equal instalments through the Direct Benefit Transfer (DBT) mode. The scheme originally covered only small and marginal farmers; it was later extended to all landholders. The scheme was launched as a commitment to fulfilling the promise of doubling farmer's income by 2022. Under this scheme, the Central Government has transferred a total of ₹3.46 lakh crores to 9,58,97,635 farmers in 18 instalments. The scheme is commendable for its successful implementation and its wide coverage within a short period. The assured income of ₹6000 per year helps cover some part of the expenses, especially during the lean season. However, it has certain inefficiencies and gaps. One, it does not cover landless labourers and tenants, who form a substantial portion of the rural poor and are highly vulnerable to suicide. Second, there are leakages in the scheme as several fake and bogus beneficiaries have been registered under the scheme. Additionally, ₹6,000 per year (₹500 per month) is too meagre to affect farmers' income given the rising cost and inflation. A major criticism of this scheme is the misallocation of fiscal resources due to its universal approach rather than need-based targeting, thus failing to address the agrarian distress.

Minimum Support Prices (MSP): The Minimum Support Price (MSP) refers to a predetermined rate at which the government agrees to buy agricultural produce from farmers, regardless of the prevailing market price. Currently, the Government fixes MSPs for 22 crops in accordance with the recommendations of the Commission for Agricultural Costs & Prices (CACP). Since 2018-19, MSPs have been fixed at 1.5 times the cost estimated by CACP. Procurement of crops is facilitated by the State Government agencies and the Food Corporation of India (FCI). The grains procured at the MSP are distributed to identified beneficiaries through a targeted Public Distribution System (PDS) and other Welfare schemes at subsidized prices. The difference between the expenditure on the procurement

of crops at MSP and the storage cost for buffer stock and the revenue received from the distribution of grains at subsidized prices comprises the food subsidy.

Despite guaranteeing price stability for 22 crops, India's MSP regime suffers from crippling limitations - it has limited coverage (primarily in Punjab-Haryana), incentivizes ecologically ruinous rice-wheat monocropping, and excludes high-risk crops like pulses. Procurement remains plagued by delays, corruption, and massive fiscal costs. Additionally, the absence of legal backing renders MSP ineffective for most farmers who sell to private traders below mandated rates. This system perpetuates regional disparities and fails to address the core vulnerabilities of small and marginal landholders.

Pradhan Mantri Fasal Bima Yojna (PMFBY): PMFBY, launched in 2016, aims to offer crop insurance to farmers against various risks like yield losses due to natural calamities and pest infestation, post-harvest losses and localised calamities at affordable rates. By capping premiums at 2% (Kharif), 1.5% (Rabi) and 5% (Horticulture) to be paid by farmers and the rest subsidised by the government, it seeks to mitigate agrarian distress through risk coverage. While PMFBY's affordable premiums (1.5-5%) and comprehensive risk coverage (from sowing to post-harvest) represent significant progress, its implementation remains deeply flawed. The scheme has disbursed ₹1.5 lakh crore in claims since 2016 and adopted tech-driven assessment tools, yet delayed payouts (2- 6 months), low farmer enrolment and insurer malpractices, lack of awareness about the procedure among farmers have severely undermined its effectiveness.

Kisan Credit Card (KCC): Introduced in 1998, the Kisan Credit Card Scheme aimed to provide credit for agricultural purposes like cultivation of crops (purchase of seeds, fertilisers, etc), post-harvest expenses, working capital for maintenance of assets, credit to household for consumption requirements as well as investment credit for allied activities in agriculture. The scheme covers not just farmers but tenant farmers and sharecroppers as well. The beneficiaries of this scheme are issued smart cards or debit card to transact their operation. Farmers receive credit under this scheme at a subsidised rate of 7% per annum, and the security required under this scheme is hypothecation of crop or mortgage of land. For more than two decades since its implementation, as of December 2024, 7.72 crore farmers have benefited from this scheme, amounting to ₹10.05 lakh crore.

Despite its transformative reach, the KCC scheme suffers from deep structural flaws. While it ambitiously covers tenant farmers, it systematically excludes landless labourers, the most vulnerable agrarian group. The collateral requirement (land mortgage or crop hypothecation) disproportionately disadvantages smallholders, forcing many back into the clutches of informal moneylenders. Worse, the scheme's design lacks safeguards against debt traps, evidenced by rising NPAs and cases of coercive loan recovery. By focusing solely on credit access without addressing market risks or price volatility, the KCC often adds to farmers' money troubles instead of solving them.

Has the farmer's income doubled?

In February 2016, the Indian Government announced the ambitious target of doubling the farmers' income by 2022. It is evident that the target has not been attained. The table below analyses the data from the NABARD All India Rural Financial Inclusion Survey for 2016-17 and 2021-22. It provides data on the average monthly income of agricultural households for the years 2016-17 and 2021-22. As can be seen in the last column of the table, the percentage of targeted income (which double of income of 2016-17) achieved in five years ranges between 68.28% and 85.32%, implying that the farmers' income did not double in the five years (see Table 2).

Table 2: Percentage of targeted income achieved by agricultural households from 2016-17 to 2021-22.

Size Classes (in ha.)	Average Monthly income of agricultural households (in rupees) for the year 2016-17	Average Monthly income of agricultural households (in rupees) for the year 2021-22	Percentage of targeted income achieved by 2021-22
< 0.01 ha	8136	11110	68.28
0.01- 0.40 ha	6650	11347	85.32
0.41-1.00 ha	8171	13509	82.66
1.01-2.00 ha	9990	16548	82.82
> 2.00 ha	14682	21177	72.12

Source: Calculations based on NABARD All India Financial Inclusion Survey reports for the years 2016-17 and 2021-22.

Policy Recommendations and Conclusion

The study finds that low income, indebtedness of farmers, crop failure and inability to absorb risk are some of the major causes leading to farmers' suicide. Policies aimed at mitigating farmers' suicide must address these issues. The study makes the following recommendation.

1) Remove Leakages from Farmers' Welfare Schemes: Government welfare schemes aimed at supporting farmers often suffer from inefficiencies, corruption, and misallocation of resources. Addressing these issues is crucial to ensuring that benefits reach the intended beneficiaries. Using satellite imagery and AI-based land records, the government can accurately identify eligible farmers, preventing fraudulent claims and misuse of funds. Simplifying the application and disbursement process for subsidies and insurance claims will ensure timely assistance to farmers, reducing financial distress.

2) Increase Public Investment for a Stronger Agricultural Infrastructure Base: While the Second Five-Year Plan focused on industrial expansion, a similar large-scale initiative is needed to strengthen India's agricultural base. Investing in critical agricultural infrastructure can significantly reduce farmers' vulnerability to economic and environmental risks. Expansion of Irrigation facilities by constructing new canals and promoting watershed management can enhance water security for farmers. Inadequate storage leads to distress sales, forcing farmers to sell their produce at low prices. Expanding cold storage, rural godowns, and grain banks will enable farmers to store their produce and sell it at remunerative prices. Investing in better road networks and rural transport will facilitate access to mandis (wholesale markets), reducing transportation costs and post-harvest losses. Further, Investment in climate-resilient agriculture, including drought-resistant seed varieties, soil health management, and agroforestry, will enhance the sector's ability to withstand extreme weather events.

3) Prevent Diversion of Agricultural Loans to Non-Agricultural Uses: Farmers often take loans intended for agricultural purposes but use them for non-productive expenses, such as household consumption, medical emergencies, or social obligations (marriages, festivals). This diversion of funds exacerbates indebtedness and financial distress. Financial institutions should ensure that

loans disbursed for agricultural purposes are utilized as intended. Strengthening credit monitoring mechanisms through regular audits and farm visits by banking officials can help monitor loan usage.

4) Increase the reach of MSP procurement: The Minimum Support Price (MSP) mechanism is intended to provide farmers with a safety net against market fluctuations. However, a large proportion of farmers, especially in states with weak procurement infrastructure, fail to benefit from MSP. Increasing the number of procurement centres, particularly in remote and tribal areas, will ensure that farmers can sell their produce at MSP without having to rely on private traders. Many farmers experience delays in MSP payments, which increases their financial vulnerability. Ensuring prompt payments through digital transactions and grievance redressal mechanisms will make MSP more effective.

Addressing these policy gaps through targeted interventions can significantly reduce agrarian distress and prevent farmer suicides. By plugging leakages in welfare schemes, strengthening agricultural infrastructure, preventing credit misallocation, and expanding MSP coverage, policymakers can make the agriculture sector more resilient and sustainable.

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Disconnected: Risk of Suicide Among Adolescents with Binge Gaming

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Abstract

The present research article emphasizes binge gaming, particularly during the late childhood and adolescent phases, and its alarming connection to emotional distress and suicidal ideation. Gaming can become a maladaptive coping mechanism for underlying loneliness and unmet emotional needs, creating a cycle of isolation. Binge gaming is observed as deeply intertwined with emotional well-being, particularly in this tender age. With this regard, important vulnerability factors in adolescents have been explored, including personal and socio-cultural risk factors. Proposed preventative strategies are rooted in psychological principles and community support to foster healthier engagement with technology and address the root causes of binge gaming.

Keyword

Internet Gaming, Adolescence, Loneliness, binge gaming

Introduction

Addiction is a silent, insidious force. It rarely announces itself as danger—instead, it disguises itself as relief, escape, even joy. But beneath the surface, it erodes connection, purpose, and hope. Among the many forms addiction can take, binge gaming has become one of the most pressing and underrecognized issues, especially among young people (Balhara et al., 2021; Gupta et al., 2021; Hern, 2021; Associated Press, 2021).

For children—particularly those whose emotional needs go unmet—gaming offers more than just entertainment. It provides a temporary retreat from the

complexities of life, a realm where they feel control, reward, and stimulation. What begins as innocent play can quickly evolve into an obsession. Over time, this seemingly harmless escape becomes a self-perpetuating cycle: the more emotionally isolated a child feels, the more they turn to gaming for comfort, and the more they game, the deeper their isolation becomes.

This loop mirrors the emotional mechanics of loneliness. As David Foster Wallace once said, "It is the loneliness that kills a person, not the pain." Loneliness is not merely the absence of social interaction—it is a profound emotional void that distorts one's perception of reality. It convinces people they are fine, even as they quietly deteriorate. Addiction, in this sense, is an offshoot of loneliness. It tricks the mind into believing it has found a solution while silently severing ties to real-world support and healing. Binge gaming, in particular, creates a mirage of excitement, action, and connection. But this illusion is fragile. In truth, it drags individuals—especially children—further into emotional desolation. Relationships strain, mental health declines, and the ability to seek help diminishes. In severe cases, the consequences can be devastating.

In July 2024, a tragic case near Pune, India, made national headlines. A 16-year-old boy, reportedly addicted to an online game, died by suicide after jumping from the 14th floor of a residential building in Pimpri Chinchwad city. According to Deputy Commissioner of Police Swapna Gore, the boy had shown signs of deep engagement with an online game—possibly identified by the initials "XD"—and left behind a chilling message in his notebook: the words "log out," alongside sketches that resembled building maps and instructions describing how to die by suicide. The boy was a class 10 student. His father worked overseas in Nigeria, and his mother, an engineer by training, was a homemaker. Investigators found that the boy had been spending significant time on his laptop, which has since been handed over to cyber experts. His parents confirmed his binge gaming, adding that they had grown increasingly concerned about his emotional withdrawal in the days leading up to the incident.

The boy's death underscores the destructive power of unchecked digital addiction—how it can distort reality, sever ties with the outside world, and ultimately lead to an irreversible act of despair. This was not merely a case of

excessive screen time. It was a harrowing collapse into emotional isolation, masked by the virtual thrills of an online universe.

Such incidents are not isolated. They are a warning. Addiction—particularly when it intersects with loneliness—must be treated as a profound psychological crisis. It calls for open conversations, compassionate parenting, mental health support in schools, and systemic awareness of the emotional toll of virtual escapism.

Left unchecked, what appears to be a harmless distraction can become a deadly silence.

Binge gaming has become a growing concern, especially among children and adolescents, with alarming connections to suicidal ideation and behaviour. A systematic literature review of 12 studies involving 88,732 participants found that 11 out of 12 studies reported a positive association between problematic gaming and suicidal thoughts, with some studies also linking binge gaming to suicide attempts (Xie et al, 2023). This suggests that binge gaming doesn't just impact daily functioning but can escalate to severe emotional distress, contributing to a heightened risk of suicidal behaviour.

Further evidence from a study with 1,693 participants revealed that 16.95% of individuals were diagnosed with Internet Gaming Disorder (IGD), and 43.06% of these individuals reported experiencing suicidal ideation (Yu et al, 2024). The study showed that those with IGD were 2.42 times more likely to experience suicidal thoughts compared to non-IGD participants, indicating a strong relationship between binge gaming and mental health issues like depression and suicide (Yu et al, 2024). This highlights the vulnerability of children and adolescents who struggle with binge gaming and the urgent need for intervention.

Why are Adolescents More Vulnerable to Binge Gaming?

Adolescents are particularly vulnerable to suicide due to binge gaming because of the complex interplay of developmental, emotional, and societal factors.

Adolescence is a critical period for brain development, especially in areas related to impulse control and emotional regulation.

Several studies have examined adolescent screen time in India. Chaudhry et al. (2018) found that 68% of adolescents exceeded two hours of daily screen time, averaging 3.8 hours per day. Similarly, Kumar & Gupta (2024) reported that 83.2% of secondary school children in rural India engaged in excessive screen time, primarily using mobile phones.

This makes teenagers more susceptible to addictive behaviours, such as excessive gaming (Steinberg, 2014). A study found that attention problems, self-esteem, and social vulnerability are the chief predictors of gaming disorder (Wartberg et al., 2021). These problems are especially dominant during adolescence.

As Gabor Maté (2010) aptly states,

> From the Latin word vulnerate, 'to wound,' vulnerability is our susceptibility to be wounded. This fragility is part of our nature and cannot be escaped. The best the brain can do is to shut down conscious awareness of it when pain becomes so vast or unbearable that it threatens to overwhelm our capacity to function. The automatic repression of painful emotion is a helpless child's prime defence mechanism and can enable the child to endure trauma that would otherwise be catastrophic.

Adolescents are particularly vulnerable to using gaming as an escape mechanism when they experience emotional pain, such as bullying or family issues. While gaming may initially provide a temporary escape, over time it deepens emotional isolation and can exacerbate feelings of hopelessness, leading to suicidal ideation (Kaur et al., 2023).

Studies have consistently shown that binge gaming in adolescents is linked to an increased risk of suicide. A study found that adolescents with internet gaming disorder are more likely to experience mental health issues such as depression and suicidal thoughts (Przybylski & Weinstein, 2017). Furthermore, a scoping

review by Darvesh et al. (2020) found that the prevalence of gaming disorder and Internet gaming disorder ranges between 0.7% and 27.5% in different populations, with adolescents being particularly at risk. The review highlighted that individuals diagnosed with gaming disorder frequently experience psychological distress, including depression and suicidal ideation.

As Gabor Maté wisely states, "The question is never 'Why the addiction?' but 'Why the pain?'" (2008). This perspective is crucial to understanding the dynamics of binge gaming in children. It suggests that the addiction itself is a symptom, not the core issue. Binge gaming often stems from deeper emotional pain-whether it's neglect, trauma, or unaddressed mental health struggles-that children are trying to escape. Until we recognize and address these root causes, binge gaming will continue to affect more children, leading them further into emotional isolation and despair.

Why Binge Gaming?
Why are Adolescents more vulnerable?

Binge gaming is defined as the prolonged, uninterrupted playing of video games over extended periods, 5 hours or more (Marmet et al., 2023). It has emerged as a significant concern, particularly among adolescents and young adults. While gaming can offer entertainment, cognitive engagement, and even social interaction, excessive gaming is increasingly associated with a wide range of physical, psychological, and social problems.

One of the most immediate dangers of binge gaming is its disruption of healthy daily routines. Long hours spent gaming often come at the expense of sleep, physical activity, and proper nutrition. Studies have linked excessive gaming to poor sleep quality, sedentary behavior, and a higher risk of obesity (Lemola et al., 2011; Vandewater et al., 2004). Moreover, the immersive and rewarding nature of games can foster compulsive behaviors, making it difficult for individuals to regulate their playtime (Kuss & Griffiths, 2012).

Psychologically, binge gaming has been linked to increased rates of depression, anxiety, and loneliness. Many individuals turn to gaming as a coping mechanism to escape real-world stressors or emotional pain, but this often results in a

harmful cycle—temporary relief gives way to deeper isolation and worsening mental health (Gentile et al., 2011).

Social consequences are equally concerning. As players increasingly prioritize virtual achievements over real-life responsibilities, their relationships with family and peers may deteriorate. This often leads to social withdrawal, declining academic performance, and interpersonal conflicts (Anderson et al., 2017).

In recognition of these patterns, the World Health Organization (WHO) has officially classified Gaming Disorder in the International Classification of Diseases (ICD-11). The disorder is defined by impaired control over gaming, increasing priority given to gaming over other activities, and continuation of gaming despite negative consequences (WHO, 2018).

The addictive potential of video games is not accidental. Many are intentionally designed to keep players engaged through psychologically persuasive techniques. Reward systems such as achievements, level-ups, and loot boxes foster a cycle of constant reinforcement, encouraging players to keep playing in pursuit of the next dopamine hit (King & Delfabbro, 2019). Online multiplayer games deepen this engagement by creating social obligations—players feel compelled to log in regularly to maintain their in-game status and relationships, reinforcing compulsive habits that interfere with daily life (Andreson, 2004).

Another alarming aspect of modern video games is the frequent inclusion of violent content. Many popular titles feature intense depictions of combat, crime, and aggression. Repeated exposure to such content can desensitize players to violence, reinforce aggressive thoughts, and reduce empathy—particularly in younger audiences (Anderson et al., 2010; Carnagey et al., 2007). Although not all gamers exhibit aggressive behavior, the combination of high-adrenaline action and reward-based violence may contribute to unhealthy emotional and behavioral patterns, especially when consumed excessively.

Additionally, the unpredictable nature of in-game rewards—such as random loot drops or victories—further fuels addiction. This variable reward system mimics the mechanics of gambling, keeping players engaged in the hope of a “win”

(Cudo et al., 2020). Features like daily login bonuses, limited-time events, and in-game purchases heighten this effect by creating a sense of urgency and fear of missing out (King & Delfabbro, 2019).

Although video games are not inherently harmful, their design and overuse can lead to serious physical, mental, and social consequences. Binge gaming, particularly among vulnerable populations like adolescents, should be approached with awareness, boundaries, and support to mitigate its long-term risks.

Understanding binge gaming and Suicide

Personal Risk Factors

When we delve into the individual causes of suicide and binge gaming, it is essential to recognize that various psychological factors, beyond just social influences or environmental stressors, play a significant role. The intricate relationship between binge gaming and suicidal tendencies can be understood by exploring the unique psychological distress that occurs in those struggling with these issues. The Interpersonal Theory of Suicide, as proposed by Joiner (2005), offers a crucial framework for analysing this relationship, but individual psychological causes, such as mental health disorders, emotional neglect, and coping mechanisms, also contribute to this tragic outcome.

1. Neuropsychological Predispositions

Binge gaming alters key neurobiological pathways, increasing suicide risk in children. Excessive gaming dysregulates the brain's reward system by overstimulating dopaminergic pathways, leading to anhedonia and emotional numbness—both linked to depression and suicidal ideation (Weinstein & Lejoyeux, 2020; Zhou et al, 2021). Neuroimaging studies reveal reduced grey matter volume in the anterior cingulate cortex, a region critical for emotional regulation, further exacerbating suicide risk (Yuan, 2013).

Moreover, binge gaming disrupts stress response mechanisms, elevating cortisol levels and heightening emotional reactivity (Wang et al., 2023). Understanding

these mechanisms is essential for developing targeted interventions addressing both addiction and mental health risks.

2. Mental Health Disorders

Binge gaming often exists in tandem with underlying mental health disorders, which play a significant role in both the development of binge gaming and the risk of suicide. Research consistently shows that individuals involved with binge gaming frequently struggle with conditions such as depression, anxiety, and post-traumatic stress disorder (PTSD) (Marmet et al., 2023; Snodgrass et al., 2014). These co-occurring mental health issues can intensify feelings of isolation, hopelessness, and despair, pushing individuals toward gaming as an escape from emotional pain (Singh & Raut, 2022).

Internet Gaming Disorders (IGD) are associated with anger control problems, emotional distress, self-esteem problems, hyperactivity/inattention and parental anxiety (Wartberg et al., 2017). For those already experiencing depression or anxiety, gaming becomes a way to disconnect from their negative thoughts, but it also exacerbates their sense of isolation by withdrawing them from real-world social interactions. This isolation is a key element in increased suicide risk, as the individual may feel hopeless and misunderstood, unable to access the support they need.

3. Escape Coping Mechanisms

When it comes to binge gaming, the coping mechanism becomes both the cause and the effect. For individuals suffering from high levels of stress or trauma, gaming offers an outlet—albeit a temporary and ultimately harmful one—to numb emotional pain. This initial use of gaming as a means of escape can quickly spiral into a full-blown addiction, especially when coupled with the inability to cope with real-world challenges.

According to a study by Kuss and Griffiths (2017), the primary reason individuals engage in excessive gaming is to cope with negative emotions such as stress, boredom, and loneliness. Gaming, especially online multiplayer games, offers a pseudo-social world where individuals feel a sense of accomplishment,

belonging, and control. However, this coping mechanism is maladaptive, as it provides short-term relief at the cost of long-term psychological health. Over time, this escape into virtual worlds can lead to a reduced sense of agency in the real world and an increased emotional numbness, which is a significant risk factor for suicide.

4. Emotional Dysregulation

Emotional dysregulation is a core factor driving binge gaming, particularly among adolescents, and often plays a tragic role in the path toward self-harm and suicide. Many children and teenagers who become deeply immersed in gaming are not simply seeking entertainment—they are searching for an escape from emotional pain. Emotional neglect, whether from distant parenting, social exclusion, or an inability to form meaningful connections, creates a void that gaming temporarily fills. Online games offer instant gratification, a sense of achievement, and the illusion of community. For a young person starved of emotional validation, this digital refuge can feel like the only place where they are seen, valued, or in control. But over time, it isolates them further, deepening their disconnection from real life and exacerbating feelings of loneliness and worthlessness.

Research supports this harmful dynamic. Liu et al. (2024) found that individuals who experienced emotional neglect or childhood trauma were significantly more likely to adopt maladaptive coping mechanisms such as excessive gaming. Rather than soothing emotional distress, this kind of escapism reinforces the very pain it attempts to numb, creating a cycle of avoidance, isolation, and psychological decline. Without proper intervention, the emotional weight becomes unbearable, and in some cases, leads to suicidal ideation.

Parental neglect further compounds the issue. Many parents underestimate the severity of binge gaming or fail to monitor their child's screen habits closely. In some households, video games serve as a digital babysitter, allowing parents to disengage while their children retreat deeper into the virtual world. Gentile et al. (2011) showed that low levels of parental supervision are directly correlated with increased risk of binge gaming, which in turn affects academic performance, emotional well-being, and social development. Lemmens et al. (2009) also

observed that poor parental engagement creates an environment where gaming becomes the default mode of emotional regulation.

Crucially, the seriousness of excessive gaming is often ignored until the consequences become visible—poor grades, aggression, social withdrawal, or deteriorating mental health. Kuss and Griffiths (2012) highlight that many families only seek help when the damage has already taken root. By then, the individual may have already developed a deep dependency on the virtual world, lacking the emotional tools to cope with real-life stress. The more they rely on gaming to manage their emotions, the more difficult it becomes to form healthy coping strategies. When even their digital escape can no longer mask the pain, and they feel trapped between emotional chaos and addictive behavior, suicide may tragically appear as the only way to find peace.

Socio-Cultural Risk Factors

The rise in binge gaming and its link to suicide is not only a result of individual psychological vulnerabilities but also societal pressures that exacerbate emotional distress, particularly in children. As discussed by Byung-Chul Han in Burnout Society (2015), society's increasing focus on constant productivity, achievement, and instant gratification creates an environment where children, especially those with emotional vulnerabilities, turn to gaming as an escape. This escape, however, often leads to a dangerous cycle of addiction and isolation, which can increase the risk of suicide.

1. Validation in Gaming

One major societal pressure is the need for constant attention and validation, which is particularly evident in online gaming. Virtual worlds like Fortnite and Minecraft provide children with an opportunity to gain recognition through in-game achievements and social media. The desire for attention, often tied to emotional neglect or bullying, leads children to prioritize gaming over real-life connections, deepening their isolation and fueling the cycle of addiction. Han (2015) suggests that in a society that thrives on attention, children are increasingly disconnected from real-world relationships, making them more vulnerable to emotional distress.

2. Bullying Within and Outside of Games

Binge gaming is also closely linked to bullying, both within and outside the gaming world. Many children experience cyberbullying within online games, where they face harassment, name-calling, and exclusion from gaming communities (Kowalski et al., 2014). This bullying amplifies feelings of emotional isolation and thwarted belongingness, a key factor in Joiner's Interpersonal Theory of Suicide. Additionally, many children turn to games as a way to escape traditional bullying in schools or social settings. Virtual worlds provide an alternate reality where they can feel a sense of belonging and escape the pressures of real-life bullying, creating a vicious cycle that traps them in both emotional distress and addiction (Kuss & Griffiths, 2017).

3. Hedonic Pleasure

The pursuit of hedonic pleasure, or immediate gratification, is another societal factor that exacerbates binge gaming. Han (2015) argues that modern society's focus on constant pleasure-seeking aligns with the behaviours seen in binge gaming. Children, particularly those struggling with emotional or social issues, find temporary relief in the instant rewards offered by games. The rush of completing levels or earning in-game achievements provides immediate validation and distraction from real-world problems. However, this short-term satisfaction often leads to neglect of long-term well-being, exacerbating mental health issues and increasing vulnerability to suicidal thoughts (Ainslie, 2012).

4. Conspicuous Consumption and Virtual Status

In today's society, conspicuous consumption extends beyond individuals to family dynamics, where parents may use their children to showcase social status. Parents often buy expensive gaming items, high-end consoles, or exclusive in-game content to signal their wealth and success to others. This practice reflects Veblen's (1899) concept of conspicuous consumption, where material goods are used to display status. In the context of gaming, children may become symbols of their parents' social aspirations, as these purchases are not only for the child's benefit but to demonstrate the family's perceived success.

Parents often consider it better for the child to be online rather than roaming on the streets (Kuss & Griffiths, 2017). In turn the pursuit of digital validation consumes children. This can exacerbate feelings of alienation, increasing the risk of binge gaming and mental health issues as children internalize these external pressures (Przybylski & Weinstein, 2013).

Moving Towards Preventative Methods

In order to address binge gaming effectively, we must focus not only on psychosocial and biological factors, but also on the psychological principles that shape behavior. Such as impulse control, emotional regulation, reward sensitivity, and habit formation. Since many video games are designed to exploit these very mechanisms, our interventions must reverse that impact by building healthier mental patterns and real-world coping skills.

Here are some targeted prevention strategies shaped by key psychological principles-

1. **Digital Detox Programs-** Structured digital detox retreats, inspired by the ancient Gurukul system, can help reset overstimulated brains. Practices like yoga, journaling, and mindfulness enhance impulse control and emotional regulation by training the brain to slow down and tolerate discomfort without reacting immediately. These environments promote delayed gratification, helping adolescents shift from needing instant digital rewards to appreciating long-term emotional satisfaction (Sharma et al., 2021).

2. **"No-Screen Days" in Schools & Colleges-** State-mandated no-screen days can replace digital stimulation with real-world engagement like physical activity, storytelling, or creative arts. These practices activate intrinsic motivation and provide natural reinforcement, which supports mental health without needing a screen. Structured offline time also reduces dependence on external validation, training students to enjoy effort and process over instant feedback (Kuss & Griffiths, 2017; Tawankanjanachot et al., 2023).

3. **Reviving the "Chaupal"-** Modernized Chaupals—community hubs for discussion, games, and learning—promote positive social reinforcement and reduce emotional isolation. Offline interaction satisfies the basic psychological need for connection while reinforcing habits of listening, patience, and empathy. These spaces encourage repetition of healthy social behaviors, which strengthens real-world bonds and decreases reliance on virtual worlds (Przybylski & Weinstein, 2013).

4. **Digital Well-Being Tools**- Built-in digital well-being features on phones (like screen time tracking, usage limits, and do-not-disturb modes) create friction against compulsive habits and encourage self-monitoring. These tools leverage the principle of environmental design—where controlling access to stimuli helps reduce overuse. When used intentionally, they support children in building self-discipline and recognizing when it's time to stop, especially with parental guidance (University of South Florida, 2025).

5. **Parental Digital Literacy Programs**- Parents often underestimate how easily compulsive gaming develops. Literacy programs can teach parents how to apply routine reinforcement, structure consistent tech rules, and encourage offline bonding habits. These habits not only limit screen time but also make real-life interaction more rewarding. Practical strategies—like tech-free meals or shared hobbies—help build behavioral alternatives to screen use (Crouch, 2017; Hiniker, 2016).

6. **School-Based Counselling & Peer Support-** Psychological counselors in schools can guide students through stress management, goal-setting, and recognizing unhealthy coping habits. Early intervention teaches kids how to recognize emotional triggers that lead to binge gaming, and how to respond with healthy coping strategies. Peer groups also provide social accountability, where shared experiences build trust and reduce stigma around asking for help (Kosa & Uysal, 2020).

7. **Policy-Level Action & Industry Regulation-** Some policy level suggestions could include-

a. **Regulate In-Game Purchases & Loot Boxes-** These exploit variable-ratio rewards, the most addictive form of reinforcement. Removing such mechanics protects users from financial stress and compulsive engagement (King & Delfabbro, 2019).

b. **Mandatory Screen Time Caps-** For minors, enforcing daily screen limits aligns with the principle of structured limitation, helping shape consistent habits while executive function is still developing (Liu et al., 2024).

c. **Device Linking & Age Checks-** Features like linking a child's device to a parent's allow for external control during the early stages of habit formation—supporting better boundaries while young users are still learning self-regulation.

d. **No Smartphones Before a Certain Age-** Delaying access reduces early exposure to dopamine-reinforcing loops, preserving children's capacity to engage in unstructured, imaginative play—a key part of emotional development.

8. **Encouraging Boredom as a Skill-** Boredom is a natural emotional state that promotes creativity, self-reflection, and problem-solving. Teaching kids to sit with boredom—without instantly turning to a screen—helps them develop frustration tolerance and internal motivation. These moments of stillness train the mind to enjoy simplicity and reduce over-reliance on digital stimulation for emotional comfort.

Conclusion

Binge gaming among adolescents is not merely a case of excessive screen time—it is a complex behavioural and emotional issue rooted in deeper psychological wounds, such as emotional neglect, low impulse control, loneliness, and the lack of meaningful real-world connections. It manifests not only in disrupted routines but also in deteriorating mental health, strained relationships, and, in the most tragic cases, suicide. To address this growing crisis, we must recognize

that addiction is a symptom, not the cause. The true causes lie in emotional dysregulation, social disconnection, and unmet psychological needs.

As Johann Hari (2018) insightfully puts it, “The opposite of addiction is not sobriety. The opposite of addiction is connection.” This simple truth underscores the importance of real human bonds in healing what digital escapism masks. Adolescents who fall into the spiral of binge gaming are often seeking validation, autonomy, and emotional safety—needs that are sometimes absent from their immediate environments. The digital world, while providing a temporary refuge, ends up becoming a trap when it replaces rather than supplements real-world engagement.

Combating this issue demands more than enforcement or digital bans—it requires a cultural and psychological shift in how we nurture young minds. By fostering emotional resilience through school-based counseling, rebuilding social bonds via offline community spaces like the Chaupal, and educating parents on recognizing and responding to early signs of addiction, we can shift from reaction to prevention. At the same time, using psychological principles—such as reinforcing healthy habits, building delay of gratification, and creating friction against compulsive behaviors—can reshape the way adolescents engage with technology.

Practical interventions like digital detox retreats, screen-free school days, and digital literacy programs, when grounded in empathy and behavioral science, offer more sustainable solutions than punitive restrictions alone. Furthermore, encouraging adolescents to embrace boredom and rediscover intrinsic motivation helps them build inner resources that no screen can provide.

If we are to ensure a balanced, mentally healthy future for India’s youth, we must choose to engage, educate, and empower—not merely restrict. By addressing the emotional root causes and building environments where young people feel connected, capable, and seen, we can transform gaming from a coping mechanism into what it should be: just one of many forms of entertainment in a rich, meaningful life.

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The Ethics of the Face: Levinas, Suicide, and Kiarostami's *Taste of Cherry*

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Abstract

This article explores how Abbas Kiarostami's *Taste of Cherry* (1997) visually articulates Levinas's ethics of the face through its narrative of the protagonist's search for someone to bury him after his planned suicide. Through three crucial encounters with potential assists, the film transforms suicide from a philosophical abstraction into an ethical confrontation with alterity.

Drawing on Levinas' ethics and concept of the "...face-to-face..." encounter, this analysis demonstrates how the film challenges traditional philosophical approaches to suicide, suggesting that ethical engagement with suicidal suffering requires acknowledging an unresolvable responsibility to the Other that transcends conceptual understanding. Rather than seeking philosophical closure, both Levinas and Kiarostami suggest an ethics grounded in the infinite demand presented by the suffering face.

Key Words:

Otherness, Ethics of the face, Philosophical unresolvability, Infinity

Introduction:

The article attempts to review Abbas Kiarostami's Palme d'Or-winning film *Taste of Cherry* (1997) as a visual articulation of Levinasian ethic of the face. The film is a narration of a desperate man bent on committing suicide. The film follows Mr. Badii (revealed later) in his search for a compassionate man to do him this favour in exchange of a large monetary reward. The review discusses three primary encounters, first with a Kurdish soldier, second with an Afghan seminary student and lastly, with a Turkish taxidermist. These encounters presents to

us a cinematic exploration of what Levinas would call "...the face-to-face..." (*Totality* and *Infinity*, 80)" encounter that disrupts and transcends traditional philosophical discourses on suicide. Thus, the film *Taste of Cherry* viewed through the lens of Levinas' ethics; repositions suicide from an abstract philosophical problem to an embodied ethical relation to the Other, thereby revealing why philosophical discourses on suicide remain fundamentally unresolvable. The first section explains the philosophical positions of suicide, with focus on Levinas' philosophy of ethics of face that changes the characterisation of suicide from an abstract philosophical issue to a lived ethical confrontation with otherness. The second section articulates a Levinasian reading of *Taste of Cherry*, suggesting that the most ethical response to suicide may not be philosophical resolution but rather an acknowledgment of unresolvability, an openness to the infinite ethical demand presented by the suffering face that precedes and exceeds all conceptual systems.

I
Levinas and the Ethics of Face

Traditional philosophical treatments of suicide have historically oscillated between prohibition and permission, with various traditions offering seemingly definitive answers to the question of voluntary death. The Greek tradition starting with Socrates offers a prohibition based on divine ownership of human life (Plato 62d) and Stoic permissiveness that views rational suicide as a legitimate exercise (Cicero 60–61). The existentialist tradition, particularly through Camus, positions suicide as the "...one truly serious philosophical problem..."(4), this that tests the value of existence itself. Characterising of suicide within the non- European traditions too present a complex picture. Hinduism and the Dharmaśāstras (legal texts) would be seen as discouraging suicide as impure/sinful as it interferes with one's karma cycle, yet certain practices of honour and devotion included self-immolation of the widows (this was not necessarily prescribed in Hindu scriptures). Similarly, Buddhism's primary injunction emphasizes non-violence (*ahimsa*) and the preservation of all life, including one's own, yet, in Japanese Buddhism, particularly within Samurai culture, ritual suicide (seppuku) became accepted despite seeming to contradict Buddhist non-violence principles. These competing perspectives on suicide often exist in tension between philosophical

principles of absolute moral prohibitions and contextual exceptions based on intention, circumstances and cultural adaptations. They also illustrate a certain negative subtext of suicide, alternate terms and frameworks are created for morally approved self-chosen deaths, these include conceptual terms like sacrifice, transcendence, spiritual disciplining (in case of fasting), ritual passages (to name a few). They get codified within practiced religious traditions that continue to maintain boundaries around acceptable and unacceptable forms of death, even while making exceptions to their general prohibitions against suicide in specific moral contexts. These diverse traditions share a common limitation; they approach suicide as a philosophical abstraction that can be systematically resolved. Whether condemning, condoning or contextualizing suicide, traditional philosophical frameworks attempt to provide definitive answers through rational argumentation or moral doctrine. Yet, the act of suicide fundamentally resists such systematic resolution because it involves the radical particularity of a suffering subject whose experience exceeds categorical understanding. Levinas' ethics offers a radical philosophical re orientation of understanding suicide. Levinas positions suicide within the domain of the ethical relation to the Other. For Levinas, ethics precedes ontology and epistemology, it is "...first philosophy..." (*Totality*, 47) that emerges not from rational deliberation but from the pre-cognitive encounter with the face of the Other.

Levinas explains the Other as essentially different, infinitely transcendent, foreign, and inhabiting a completely different world. The Other is transcendent in the sense that it is beyond one's categories of thought or beyond one's world (Levinas *Totality*, 194-196); the face of the Other becomes a ground of interpersonal contact that resists all attempts of the self to have knowledge of it, to consume it or enjoy it. Yet, the self reduces the unfamiliar to a recognizable Other in order to control and manipulate it, thus doing injustice to the other. Levinas describes this as the murder of the Other as it paralyses the power of the absolutely independent being.

Levinas presents a radical understanding of ethics based on our encounter with the Other. The Other paradoxically has no physical capacity to resist being harmed, yet presents an infinite ethical resistance through their face, which silently commands "thou shall not commit murder" (Levinas, Totality, 199). This

creates a fundamental paradox: we can physically harm the Other, but their defenselessness makes an ethical appeal that paralyses our power. This proximity creates responsibility toward the Other that transforms our subjectivity (Levinas, Totality, 197-200). The self doesn't simply know or comprehend the Other. Instead, a new understanding emerges where the self exists primarily in relation to the Other; the self becomes "...that which is for the Other..." (Levinas, *Totality*, 200-201). In essence, Levinas suggests that subjectivity means being held hostage by the Other. The self only finds meaning through this forced commitment to respond to the Other. Ethics emerges precisely from this situation where the self must sacrifice itself for the Other (Levinas, Otherwise, 127)

The face, in Levinasian terms, is not merely a physical visage but the manifestation of infinite alterity that confronts the subject with an ethical demand prior to any philosophical comprehension. The demand of not being annihilated is a prohibition that extends to oneself too. For Levinas, the impossibility of killing is not real, but moral. The fact that the vision of the face is not an experience, but a moving out of oneself, a contact with another being and not simply a sensation, is attested to by the purely moral character of this impossibility (Levinas *Totality*, 199). Applying Levinas' ethics of face, suicide represents a particular ethical problem that cannot be reduced to questions of autonomy or meaning. In *God, Death, and Time*, Levinas criticizes Heidegger's *Dasein* (13) and suggests that death is not to be understood as something that solely concerns the self; rather explains that the personal relation with death is based upon the emotional and intellectual reaction to the knowledge of the death of the other (Levinas God 16). Thus, death is that which can only be experienced through the Other. The Other, who expresses one's own self through the face, at death, becomes a mere masque. Since the face does not respond or express anymore, it is death that is then expressed through the face. Being affected by the death of the Other is having a relation with someone who will not respond to the self anymore. Hence, death presents an ethical demand of responsibility towards the Other (Levinas *God* 12-13). Applying this to the understanding of suicide, while suicide attempts to assert sovereignty over being one's own being, yet paradoxically, it fails to escape responsibility to the Other. In suicide, the self is not liberated from the Other; on the contrary, it is bound to the Other. This tension between the apparent autonomy of suicide and the inescapable responsibility to otherness places

suicide beyond philosophical resolution. Understanding suicide as an exercise of sovereign choice or authentic decision-making would involve a fundamental contradiction from the perspective of Levinas' ethics. This is because of the inescapable ethical dimension that persists even in self-destruction. This paradox emerges because, for Levinas, one's ethical responsibility to the Other precedes one's own existence as autonomous subjects. In suicide, one does not escape this responsibility but is rather intensified, the capacity to contemplate suicide already presupposes an ethical subject constituted through the relation with the Other. Hence, the self that contemplates its own death is already the self that is called into being through responsibility. Most importantly, suicide doesn't actually achieve the sovereignty it seeks. Death doesn't return the subject to themselves but rather delivers them to an absolute passivity; that lies beyond the subject's control (Levinas *God* 23). This tension places suicide beyond philosophical resolution because it reveals the limits of any philosophical system based on autonomous subjectivity. Considering the most extreme exercise of apparent autonomy (in this case suicide); it fails to escape ethical responsibility to Otherness. Hence, traditional philosophical frameworks that attempt to ground ethics in autonomy, rationality or meaning are fundamentally insufficient. In the context of the film *Taste of Cherry*, this Levinasian insight helps explain why Mr. Badii's quest for assistance with his suicide creates profound ethical discomfort in those he encounters. Each potential assistant is confronted not with an abstract philosophical problem but with an infinite responsibility they cannot escape; a responsibility and an understanding of death made visible in the face-to-face encounters that Kiarostami's camera focusses upon. The following section explains the same.

II
The Cinematic Face in Taste of Cherry

The visual language of the film *Taste of Cherry* privileges the human face in ways that illustrate Levinas' ethics as an alternative approach to understanding suicide. The film's extended close-ups during the conversations in Mr. Badii's car, creates a proximity to the face in way that the camera does not merely observe, rather it bears witness to the irreducible alterity of the Other. It institutes an ethical gaze, that is, the "...impossibility of killing the other..." (Cooper 67)

in the sense of the Levinasian injunction of "thou shall not commit murder" mentioned in the earlier section. Characters in the conversation rarely appear in the same frame which creates a visual grammar of separation paradoxically emphasizing connection. The camera seldom leaves Mr. Badii (who we know only later), capturing his profile at a medium close up, lingers along long, pensive and nervous silences that allows the faces (of characters in conversation) to speak. Hence, the face by it's mere presence places an ethical demand. This results in shifting of discourse on suicide as an abstract philosophical position to an embodied ethical encounter. Though we never know the reason behind his suicidal intent, the camera focussing on the face presents us with the redundancy of the psychological backstory or any philosophical justification. Instead, it exists as a concrete reality that confronts others through his (Badii's) face, his suffering visible but irreducible to conceptual understanding. This cinematically enacts Levinas's insight that ethical responsibility precedes comprehension or judgment.

The three encounters in the film further illustrate the same. They represent different philosophical approaches to suicide, each disrupted and complicated by the Levinasian encounter with the face. The first encounter with the young Kurdish soldier (12.43-31.09) represents societal prohibitions against suicide. Suicide is an unreflective taboo, the soldier's response is instinctive, unreflective and expresses collective cultural prohibitions that precede individual reasoning (Durkheim 75-76). The camera lingering on the soldier's troubled face reveals not abstract social principles but an ethical embodied discomfort. The soldier's face registers an uncomfortable recognition of Mr. Badii's suffering that disrupts the norm of suicide being a mere social taboo. He insists on being taken to the barracks, yet, Badii talks him into an isolated place where he shows him the pit where he is to be buried (the viewer has no access to the burial pit as yet, we only know it through the face). Eventually the soldier flees the sight, this represents not just rejection of the suicidal request but flight from the ethical demand presented by the face, what applying Levinas' ethics would be considered an attempt to escape infinite responsibility.

The second encounter (46.00-54.39) is with the Afghan seminary student who represents Islamic religious prohibition (applicable to most religions). Badii tries to engage the latter's services and offers him a ride. The seminarist is in Iran to

escape war, study and find work. He listens politely to Badii's request and seems to sympathize and understand (to which Babii objects). Badii explains that he decided to end his life but he doesn't divulge the reasons because they would be of no use to anyone. Badii explains that he believes that suicide has a practical application and surely the divine put it there so that people can free themselves from pain and sin. Further, he explains that an unhappy person hurts those around him so that is a sin too; besides he cannot understand his pain so Badii must end his life. The seminarist recites the religious injunctions that presents human life as divine possession and suicide as a violation of the divine sovereignty. They speak at the spot where the pit is but the seminarist does not change his mind and that ends their conversation. Kiarostami's visual attention to the seminarist's face reveals the tension between doctrine and ethical encounter. The camera captures his growing discomfort in the seminarist, as he recites the religious injuctions, the same way it captures Badii's suffering through his face that disrupts the validity of the doctrinal prohibition. It is interesting that when the seminarist speaks more generally about religious laws, the camera lingers around the surrounding landscape, but returns to the intimate close ups when the seminarist is confronted with Badii's gaze. Hence, illustrating that Levinas' ethics; that an ethical encounter precedes and exceeds religious systematization.

The final and longest encounter is the most complicated (55.50-1.26.19) Badii stops at a cement-producing site where he contemplates a burial under the falling rocks and debris where he would not need a helper. A worker asks him to move his vehicle and in resignation, Badii does so. Back in his car, he is addressed by a person the viewer does not see entering. But we know from the conversation that the purpose is revealed to him and the seated person has already accepted Badii's wish. He does continue to argue against his action and explains that problems can always be solved. The old wrinkled face is then made visible and is identified as a Turk who works at the natural science museum as a taxidermist. He defends life's precariousness and citing his own example he explains how he found himself in a mulberry orchard and the taste of the fruit saved him. Later, he refers to the taste of mulberry/cherry as a metaphor for life itself and its sensuous pleasures (1.03.52- 1.05.39) . His arguments have little effect on Badii and the Turk in need of money for his sick son, promises to bury him the next morning but refuses to take money in advance. Badii drops him at the museum (1.19.28-

1.23.44) and is soon seen driving back to the museum. He is seen excitedly (a little tense) looking for the taxidermist, Mr. Bagheri who he finds engaged in a lecture. He then tells him to make sure that he carries two stones which Mr. Bagheri can toss at him, but also shake him a little to make sure he is absolutely dead. Mr. Bagheri a little annoyed by the interruption nevertheless assures him that only a beheading would prevent him from carrying out what he has promised.

This encounter presents a phenomenological approach to suicide that most closely aligns with Levinas' ethics. The taxidermist neither prohibits nor judges Mr. Badii's intention, rather he responds from a perspective of shared vulnerability and embodied experience. He contemplates his own past meditation of suicide (1.03.52- 1.30.12) and subsequent return to life through sensory experience of the taste of mulberries. He does not offer abstract philosophy, rather embodied wisdom, thus taking the conversation from abstract philosophical arguments on meaning and permissibility of suicide to the concrete sensory experience that might reconnect Mr. Badii to his life. He brings forth arguments from the taste of cherries, moon, stars, children's sounds and sunrise suggesting that phenomenological experience may address suicide more adequately. He intends to bring Badii closer to the perceptual realm where meaning is directly experienced through bodily engagement (Ponty *Phenomenology* para 224) . The taxidermists approach to agreeing to do the burial if it is necessary while simultaneously dissuading Badii, creates an ambiguity and a tension that is unresolved; infact it resists all closure. This ambivalence enacts Levinas' insight that ethical responsibility may include both respecting the Other's freedom and maintaining infinite responsibility for their life.

The film's ending further amplifies the unresolvable nature of suicide as a discourse. Next morning Badii takes the sleeping pills (this the viewer assumes as what is visible is only Badii doing something through a window) and leaves for the burial place (1.26.20-1.34.39). He drives through a thunderstorm and frequent lightning and stops at his burial place. He then lies down and through flashes of lightning ones sees his face and eyes closing. The screen goes black and one hears only the sound of the rain. After a few minutes, one sees a landscape and shouts of a military squadron marching up the hills (1.34.40). Almost suddenly (1.35.15- 1.36.07) a cameraman and another man with a tripod appears, followed

by Kiarostami himself ordering through his walkie-talkie for the marching men to sit down under a tree. Homayoun Ershadi (Mr. Badii) walks up the hill, (just out of the pit) relieved from his role as an actor, offering Kiarostami a cigarette. Kiarostami takes it and the shoot is over. This meta-cinematic break can be read through Levinasian lens as reinforcing the unresolvable discourse of suicide. The cinematic formal rupture resists a narrative closure and returns to the face; not of the character, rather of the actor who is a real person exceeding the fictional restriction. This meta-cinematic turn embodies what Levinas describes as the "...rupture with the comprehension of being.", (Levinas *Totality*, 90) the breaking through of infinity into finite philosophical systems. By refusing to show whether Badii lives or dies and instead revealing the film's production, Kiarostami can be read as suggesting that suicide exceeds both narrative resolution and philosophical systematization. The face of Homayoun Ershadi smoking a cigarette with the crew returns us from abstraction to concrete ethical relation, a living face that preceded the film and continues beyond it. The face, thus does not offer a solution to suicide; rather a reorientation that acknowledges its fundamental unresolvability within systematic philosophy.

To conclude, Kiarostami creates a cinematic equivalent to Levinas's ethics and presents a visual language that places responsibility (towards the Other) before comprehension and relation (with the Other) before resolution. *Taste of Cherry*, read through Levinas' ethics suggests that discourses on suicide remain unresolvable not due to insufficient philosophical discourses but because suicide confronts us with the limits of philosophy itself. The film positions suicide not primarily as an abstract philosophical problem that can be systematically resolved, rather an ethical encounter with suffering that exceeds characterizing/ categorization. By privileging the face through extended close-ups and embodied encounters, the film reinforces the impossibility of resolving the question of suicide philosophically while insisting on the ethical responsibility one carries towards a face/ the Other who is contemplating it's own extinction.

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Precarious Minds: Understanding Suicidal Thoughts Through Vulnerability Studies

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Abstract

This paper employs the lens of Vulnerability Studies to examine the representation of suicide ideation in *If Tomorrow Doesn't Come* by Jen St. Jude and *Me (Moth)* by Amber McBride. Both novels portray protagonists grappling with profound psychological distress, exploring how vulnerability manifests through personal loss, mental illness, social isolation, and the navigation of identity. Drawing on Judith Butler's conceptualization of precarity and the relational ontology of vulnerability (Butler, 2009), the analysis foregrounds how the protagonists' suicidal thoughts are not merely individual pathologies but are entangled within broader social, cultural, and familial structures. The paper argues that these narratives reframe vulnerability not as a static weakness but as a dynamic, affective condition that offers the potential for resistance, relationality, and ethical engagement (Gilson, 2014). It also draws on Martha Fineman's concept of vulnerability being an inherently embodied concept that is universal, and responsive to external stimuli that arise due to human dependency on various factors. By doing so, the texts challenge stigmatizing discourses surrounding mental health and suicide in young adult literature, presenting vulnerability as a shared human condition that demands collective responsibility and care. The study concludes that both novels offer a powerful critique of the individualistic framing of mental health, urging a reconceptualization of suicide ideation through a lens that acknowledges systemic and affective interdependencies.

Keywords:

vulnerability, suicide ideation, young adult fiction, relational vulnerability, relational ethics

Introduction

The current discourse on young adult fiction that deals with suicide ideation navigates four interesting concepts namely vulnerability, normativity, performativity and precarity. The work done by Judith Butler, Bryan Turner, Erinn Gilson, Mackenzie, Rogers, and Dodds in this regard is quite significant. Jen St. Jude's debut YA novel *If Tomorrow Doesn't Come* (2023) is a sensitive, poignant exploration of mental health, queerness, and the enduring struggle with suicidal ideation in the face of personal and global catastrophe. Through its central character Avery Byrne, the novel does not sensationalize suicide but rather foregrounds the deeply personal and systemic dimensions of vulnerability. Amber McBride's debut novel that was a finalist for the National Book Award 2021 in the young people's literature category, *Me (Moth)*, very subtly depicts the theme of suicide by portraying the grief and loss experienced by the protagonist, Moth, who battles Survivor's Guilt after losing her entire family in a car accident. Employing the lens of vulnerability studies—particularly the works of Judith Butler (2004), Martha Fineman (2008), Bryan Turner (2006) and Erinn Gilson (2014) - this paper explores how St. Jude's and McBride's novels confronts suicide not as a singular event but as a complex manifestation of embodied precarity, self-deprecation, social marginalization, and existential despair.

Situating Suicide in Vulnerability Studies

Vulnerability studies, as articulated by Butler (2004), views vulnerability not merely as a deficit or weakness but as a constitutive part of human life. Butler writes that "vulnerability is not a subjective disposition but a relation to a field of objects, forces, and passions that impinge upon the living body" (Butler, 29). This relational understanding reframes suicide from an individual pathology to an expression of being overwhelmed by one's entanglement in unjust social, familial, and emotional conditions. Similarly, Mackenzie, Rogers, and Dodds (2014) argue that vulnerability is both universal and particular: while all humans are vulnerable, some are more exposed due to political, social, and economic conditions (Mackenzie, Rogers, and Dodds, 5). Martha Fineman, in her work, *The Vulnerable Subject: Anchoring Equality in the Human Condition* (2008), has explored several key concepts pertaining to the Theory of Vulnerability where

she as critiqued the traditional notions of equality and justice that often ignore the inherent and universal nature of vulnerability to human condition. She has emphasised that Vulnerability is fundamental and shared aspect of human condition; all humans are inherently vulnerable, and it is an integral part of what it means to be human. She has defined Vulnerability as a dynamic and relational condition that is responsive to various factors and stimuli; that is, it is relational to and is influenced by social, political, and economic contexts. Thus external stimuli play a huge role in exacerbating or mitigating one's Vulnerability, which is essentially relational to it (Fineman, 9).

Discussion and Analysis: Avery's Suicidal Ideation and Vulnerability

Precarity has also been linked to queerness by St. Jude thus compounding Avery Byrne's vulnerability. In *If Tomorrow Doesn't Come*, Avery's queer identity, depression, and sense of alienation form an intersectional triumvirate of vulnerability, which the novel carefully excavates. Her struggles are not only personal but also shaped by larger socio-cultural forces that dictate the terms of belonging and exclusion.

Avery's suicidal ideation is introduced early in the novel as a burden she carries silently. This articulation exemplifies what Gilson (2014) calls responsive vulnerability, the idea that vulnerability can become a site for ethical relations, transformation, and care (Gilson, 37). Rather than framing Avery as a tragic figure, St. Jude renders her vulnerable interiority with compassion, allowing readers to witness the oscillation between her desire for escape and her tentative will to live.

Avery's queerness is another axis of vulnerability. Her Catholic upbringing and the silence around her sexuality generate a sense of being out of place, especially within her family. Vulnerability here is not only emotional but also epistemological—a lack of validation and space for her identity to be known. Turner (2006) highlights that vulnerability can stem from one's position within normative social orders; Avery's queerness becomes a source of fragility because it collides with familial expectations and cultural norms (Turner, 51). St. Jude's narrative discusses precarity and queerness, emphasizing that queer individuals

often navigate systemic instability, social exclusion, and existential insecurity. Avery's internal struggle mirrors this broader condition of queer precarity, as she wrestles with the burden of invisibility and the fear of rejection.

A Literalization of the Suicidal Psyche

The apocalyptic backdrop of the novel—a comet hurtling toward Earth—functions as a literalization of the suicidal psyche. For Avery, the world's impending end externalizes the hopelessness she feels within. Yet, paradoxically, the shared vulnerability it induces creates possibilities for connection, care, and renewal. Avery's choice to finally share her secret with her loved ones, including Cass, is a moment of what Butler (2016) describes as grievability—the recognition of one's life as valuable and mournable (Butler, 14).

This gesture of sitting with someone in their vulnerability, of witnessing rather than fixing, aligns with the ethics proposed in vulnerability studies. Gilson (2014) warns against "resilience discourse," which tends to individualize and depoliticize suffering (Gilson, 94). Instead, *If Tomorrow Doesn't Come* centres care as a collective, relational act. The novel refuses quick resolutions or recovery narratives; Avery is not "cured," but she chooses to live in and through her vulnerability.

Responsible Representation of Suicide

One of the novel's most significant achievements is its responsible depiction of suicide. Rather than focusing on the act itself, St. Jude foregrounds the emotions, silences, and contexts surrounding it. Avery's eventual disclosure of her mental state becomes a moment of narrative rupture and ethical significance. As Whitehead (2004) suggests in trauma narratives, such moments open space for re-narration and transformation (Whitehead, 120). Avery begins to rewrite her story—not to erase her despair but to include her desire for life alongside it.

Furthermore, the novel models ethical storytelling by including resources for readers at risk and by avoiding graphic or romanticized depictions. It echoes the approach advocated by mental health scholars who emphasize the importance

of non-triggering yet honest narratives in YA fiction (Bridge, Goldstein, and Brent, 372).

> I wanted to hide my body somewhere no one would have to find it. Midway through my freshman year, I settled on the Saco River—a hungry stretch of icebergs and fog that slipped by the edge of campus. I liked the river because when I stood on its edge, it always felt like morning, even at sunset, even at midnight. I also liked it because it was practical and clean. It would take me away, wash every part of me. Bury me in its silt.

On a frigid February night, I cleaned my side of the room by moonlight as my roommate slept soundlessly. I deleted every photo of myself from social media and then sat on my bed writing goodbye notes on loose-leaf paper. I put the letters on my desk, tucked myself into my bed, and listened to an audiobook until our window glowed with the first sign of dawn (St. Jude, 13).

The above lines clearly illustrate how Jen St. Jude resists the resilience discourse—the cultural expectation that individuals must overcome suffering through sheer willpower—by using several symbols that complicate the idea of linear recovery. Instead of depicting resilience as a triumph over adversity, St. Jude illustrates how survival is a fragile, relational process rather than an individual achievement. The way she seeks refuge in the river also underscores the tactile relationality of the moment.

The Comet: A Symbol of Impending Doom and Collective Vulnerability

In the author's note to the reader with which the novel begins, St. Jude writes:

> Avery Byrne, the narrator of my YA debut, *If Tomorrow Doesn't Come*, doesn't know how to keep living. Her depression is a state, a feeling, a place: where things will never get better, not ever. Where she doesn't deserve anything better, anyway. Where the world keeps spinning in technicolor around her, but she's trapped in her own little gray apocalypse, alone. Then she learns

> an asteroid is hurtling toward Earth, and she has nine days left to live. Suddenly, her own private apocalypse is not so private. It's everywhere. It's everyone's. And they must all learn how to survive it, together (St. Jude, 10).

The approaching comet functions as a metaphor for Avery's suicidal psyche, externalizing her inner turmoil. Unlike typical narratives of resilience where protagonists "fight back" against despair, the comet suggests an inevitability that Avery must confront rather than conquer. Her thoughts parallel the world's existential dread:

> "It's going to be okay. You're going to get to Boston, you'll get on that plane, and you'll get out of here. You're going to get home."
> I had started to doubt that, but it was the only thing I could think to say.
> "Why are you helping me?"

It was a question I couldn't answer honestly. Aisha, you're an anchor. Aisha, I don't know how to be alive right now, but I have to get to Kilkenny to see Cass one last time, to be with my family. Drag me with you (St. Jude, 22).

This statement defies the resilience discourse by rejecting the pressure to "push through" pain. Instead, it aligns with what Gilson (2014) calls responsive vulnerability, where survival emerges through connection rather than self-sufficiency. When Cass comforts Avery, she does not try to force a narrative of recovery but instead sits with her in her pain:

> "So. You were suicidal."
> I couldn't say it, so I nodded.
> "And you were going to jump in the river that morning."
> "Right." I braced myself for her anger, her hatred, her hurt.
> "Come here," she said softly, and pulled me by the hand. She leaned up against a bale of hay, and I lay with my back to her chest. She held me to her, and I felt her tears, inally falling, in my

> hair. “I don’t even know what to say, Avery. I’m probably not going to say the right things.”
> “There’s no right thing,” I said. We sat there for a minute breathing while
> she collected her thoughts.
> “I’m sorry you felt so alone. I’m really, really happy you’re still here. I’m thanking every single God I got to love you like this. I’m angry it seems like I’m the last to know (St. Jude, 226).”

This moment challenges the individualized notion of resilience, which demands that people "save themselves." Instead, it affirms Judith Butler’s (2016) concept of grievability, emphasizing that survival is rooted in being seen and valued rather than merely enduring alone.

The River: An Alternative to the "Survivor" Narrative

The river is an important symbol in the narrative that connects Aunt Devin to Avery:

> And yet, when Peter and I discovered a tattered shoebox under my parents’ bed when he was eight and I was five, we pulled it out even though we both knew we shouldn’t. We found photographs, envelopes, ticket stubs, and clippings inside. In every photo, the same woman: red hair, blue eyes. Just like me.
> “That’s Aunt Devin,” Peter whispered, and my blood chilled. I knew she was Mom’s sister, and that she had passed away, but my parents only talked about “what Devin did” in hushed tones with each other, never us. Peter picked up a newspaper article and started reading it.
> “February second—Avery, that’s your birthday!—Police believe Devin Walsh entered the sea between Seapoint and the West Pier in south Dublin.”
> “What’s entered?” I asked, as quietly as possible.
> “I guess, like, walked into?” (St. Jude, 24).

In a key moment, Avery describes herself as a river, a striking contrast to the "warrior" or "fighter" imagery often associated with resilience. She reflects:

> "The river had seen the worst and the best of me, and all the while, I was enough (St. Jude, 260)."

Here, St. Jude subverts the resilience-as-strength framework by offering an alternative metaphor of survival. Instead of "overcoming" pain, the river suggests continuance without force or resistance. This aligns with what Turner (2006) calls ontological vulnerability, where fragility is not a weakness to be conquered but a fundamental condition of life.

Through symbols such as the comet and the river—St. Jude refuses to romanticize resilience as a solitary victory. Instead, she envisions survival as relational, collective, and non-linear. Rather than depicting Avery as someone who "overcomes" suicidality, St. Jude allows her to exist in her vulnerability, affirming that survival is not about heroic endurance but about finding spaces of care, connection, and acceptance.

Suicide: A Killing of One's Self or a Tragic Succumbence to Unfortunate External Stimuli?

Suicide, historically, has been conceptualized as the act of intentionally ending one's life, often seen as a personal and voluntary decision carried out by the individual who is typically burdened with the weight of this action. This traditional view, however, has been increasingly contested in recent decades as the mental health field has evolved toward a more nuanced and empathetic perspective. Modern psychological and sociological discourse advocates for a shift in the language used to describe such tragic occurrences. For instance, instead of the phrase "committed suicide," which carries heavy connotations of criminality or sin, scholars suggest the more compassionate "died by suicide." This re-framing diminishes the stigma associated with suicide, repositioning it as a consequence of psychological distress rather than a deliberate, conscious choice (Gould et al. 2003). Central to this transformation is the framework of Vulnerability Studies, which asserts that all human beings possess inherent vulnerabilities that are

often exacerbated by external factors. These studies emphasize that vulnerability is a dynamic, relational condition influenced by one's social environment, underscoring that the struggle to survive adverse life circumstances is often less about an individual's strength or will and more about the external forces at play (Butler 2004).

Amber McBride's *Me (Moth)* offers a poignant exploration of how grief and trauma influence an individual's susceptibility to suicidal ideation. While the novel does not directly address suicide, it implicitly touches upon the emotional and psychological processes that can lead to such thoughts. Through the character of Moth, McBride illustrates the devastating impact of losing a loved one, and how grief, isolation, and a loss of hope can alter one's perception of life. The novel begins with the tragic death of Moth's parents and brother in a car accident, leaving her with a profound Survivor's Guilt. This loss becomes an insurmountable barrier, preventing Moth from experiencing joy or optimism in life. As McBride poignantly writes:

> "I only ever felt at home when moving
> under the stage lights.
> When moving I could fly, but after the accident that split our car
> like a
> candy bar,
> I gave up movement,
> so sometimes I feel less alive" (McBride 15).

Moth's grief is compounded by her relocation to Virginia to live with her Aunt Jack, where she feels further isolated due to the lack of emotional support from her aunt and the apathy she encounters at school.

Intersectionality plays a significant role in amplifying Moth's vulnerability. Living in a predominantly White community, Moth is marginalized by her peers, who largely ignore her, and she attributes this exclusion to both her racial identity and the physical scar on her face from the accident. The alienation she experiences at both the personal and social levels exacerbates her sense of isolation, further deepening her grief. This marginalization contributes to a loss of hope, with Moth

purposefully distancing herself from things that once brought her joy—such as dance, her lifelong passion. Dance reminds her of the happy memories she shared with her family as well as a zealous drive towards life where she has always aimed to be the best

> "Instead of playing outside after school, Mom & I travelled to the best dance studios so I could flutter my wings & sprinkle dust on everything, so I could dance strong, like Misty Copeland—" (McBride 14).

The act of refraining from dance symbolizes her internalized belief that she is undeserving of happiness due to her survivor's guilt. As McBride writes, Moth creates a list of rules for herself:

> "1. Don't live too hard.
> 2. Fetal: huddle, knees tucked to chin
> 3. Be as silent as a seahorse.....
> ...13. Don't dance like Misty Copeland" (McBride 17).

These self-imposed limitations reflect Moth's emotional withdrawal from life, which, though not explicitly suicidal, mirrors the psychological toll that trauma can have on an individual's desire to engage with life.

Moth's vulnerability, deeply rooted in her grief, trauma, and the isolation she faces, reflects the broader conceptualization of vulnerability as an embodied condition that is shaped by both internal emotional states and external social factors. Her emotional turmoil underscores the theoretical arguments in Vulnerability Studies, which suggest that individuals who experience significant loss and trauma often become emotionally exposed, making them susceptible to feelings of despair and hopelessness. The lack of adequate emotional support compounds her vulnerability, illustrating the structural dimensions of grief. Butler's work on ethics of Vulnerability opines that vulnerability creates an ethical responsibility for others to care for those who are suffering (Butler 2012). Thus, there is a moral obligation or an ethical responsibility to Moth's aunt and her peers to help her navigate her vulnerable situation. However, she does not receive any recourse from them to

process her feelings and the rejection makes her feel more isolated. The novel thus subtly critiques the social systems that fail to provide necessary care and empathy for individuals experiencing trauma, leaving them more susceptible to further emotional damage. In this way, McBride's depiction of Moth's emotional and psychological state can be read through the lens of structural vulnerability, where her suffering is not solely a product of her internal weaknesses, but rather the compounded result of systemic neglect, societal isolation, and the profound emotional scars left by her traumatic experiences.

The Role of Relatability and Companionship in Healing

Relatability and companionship are often central to the healing process following trauma. A shared feeling to pain or emotional relatability can aid in healing from trauma that an individual faces. In *Me (Moth)*, this dynamic is beautifully explored through the relationship between Moth and Sani, a half-white, half-Navajo boy she meets at her new school in Virginia. Sani, who is grappling with his own mental health struggles stemming from a dysfunctional home life and an abusive stepfather, is the only person who truly sees Moth and acknowledges her pain. For Moth, Sani's attention becomes a vital lifeline that encourages her to open up about her tragic loss and re-engage with her passions, such as dancing—something she had abandoned after her family's death.

Sani, too, understands the weight of emotional distress, and this shared experience of trauma fosters a deep, empathetic bond between them. He takes medication to manage his mental health, and his openness about his own struggles helps Moth feel less alone. This mutual recognition of each other's vulnerability creates a foundation for their healing. Sani's companionship is instrumental in Moth's journey, offering her solace and a sense of comfort that she has not found elsewhere. Relatability and companionship can catalyst in a person's healing process, in this sense, Sani's support helps Moth regain a sense of purpose and direction as she starts to confront her grief.

Their shared connection extends to a literal and metaphorical journey of healing—a road trip to Sani's ancestral home in Navajo Nation, New Mexico. This trip serves as both a physical escape and a space for emotional exploration,

where the two of them talk openly about their dreams, trauma, and the future. Through this shared experience, they begin to heal together. Sani encourages Moth to return to dancing, reminding her that the death of her family was not her fault, and she in turn motivates him to pursue his passion for singing by applying to the Julliard Conservatory. Their connection helps restore a sense of optimism in Moth's life, allowing her to rediscover her dreams and aspirations.

A pivotal twist in the narrative, however, reveals that Moth has been a ghost all along, having died in the car accident with her parents. Sani, with the unique ability to see ghosts, is revealed to have been assigned to help her navigate her journey to the afterlife. This supernatural twist, while central to the novel's plot, can be interpreted as a metaphor for how companionship, empathy, and relational support can guide individuals through even the darkest moments. Moth's feelings of alienation are explained by her ghostly status—she is invisible to everyone except Sani. Yet, even without this supernatural element, the novel emphasizes how timely companionship can restore hope, even in the most dire circumstances. Sani's help allows Moth to process her trauma and guilt, and ultimately find peace in the afterlife, which can be seen as a metaphor for the emotional resolution that companionship provides in times of deep grief and loss.

Thus, while the novel's supernatural elements may frame Moth's journey in the afterlife, its core message about healing through connection and relational support is profoundly grounded in psychological and emotional realities. Moth's journey, both literal and figurative, highlights the transformative power of companionship—illustrating how being seen and heard by another person can catalyse healing and recovery, even when that healing is not from physical wounds but from deep emotional and existential suffering. The novel underscores a crucial insight from trauma theory: that connection with others, especially those who understand our pain, is essential for moving beyond trauma and finding hope (Brown 2010).

Me (Moth)

Poetic Language and use of metaphors in portraying vulnerability in *Me (Moth)*
In *Me (Moth)*, McBride blends prose with poetic elements, using vivid metaphors and figurative language to deepen the emotional resonance of Moth's experience with grief and trauma. The novel's structure, enriched with poetic devices, allows McBride to communicate Moth's internal struggles in a way that transcends the literal and brings readers into the realm of the emotional and the symbolic. One of the most striking examples of this is McBride's use of the simile comparing the car accident that claimed Moth's family to a candy bar:

"Two summers ago our car broke in half like a candy bar on the freeway & we all spilled onto the pavement as crumbled as sticky caramel-peanut filling." (McBride 11).

This simile serves a euphemistic function, softening the raw, violent reality of the crash while simultaneously allowing the reader to grasp the emotional devastation of the event through a familiar, almost mundane object. The candy bar's seemingly harmless exterior contrasts sharply with the horrific incident, echoing how trauma can initially seem alien and surreal to the person experiencing it. This choice reflects the function of metaphor in literature as a tool to render the invisible and intangible—like trauma—into something more perceptible and accessible (Lakoff & Johnson 1980). Through this juxtaposition, McBride masterfully transforms the abstract concept of vulnerability into something visceral, tangible, and profoundly felt.

McBride's language does more than just describe Moth's grief; it serves to externalize and personalize her trauma, enabling the reader to viscerally feel what Moth is experiencing. The use of metaphors in *Me (Moth)*, particularly in reference to the stages of the protagonist's emotional journey, draws on Judith Butler's (2004) concept of the vulnerable body. Butler contends that vulnerability is not merely a passive state but an active, relational condition of being "exposed" or "at risk." In the context of McBride's novel, the metaphor of the Moth—an insect that undergoes a transformative journey—echoes this vulnerability. Moth, the character, undergoes her own metamorphosis, not unlike the creature after which she is named. The stages of her life—from Larva to Butterfly—serve as metaphors

for her emotional and psychological progression as she navigates the trauma of loss and grief. McBride uses this symbolism to frame vulnerability as a fluid, evolving state, emphasizing that recovery is not a linear path, but one filled with setbacks, growth, and the continual reshaping of the self.

Furthermore, the novel's climactic revelation—that Moth is a ghost, and Sani is helping her navigate to the afterlife—serves as a poignant metaphor for relational support in the healing process. While the supernatural elements of this revelation may appear fantastical, they underscore a central theme of the narrative: that companionship, shared trauma, and mutual healing are fundamental to overcoming emotional despair. Sani's presence in Moth's life, despite her literal and figurative isolation, reflects the healing power of human connection and mutual understanding in the process of emotional recovery. McBride's use of these metaphors emphasizes vulnerability as not only an individual experience but also one that requires relational engagement to move forward. The novel culminates in a powerful metaphor about resilience and emotional survival, as expressed in Moth's final reflections:

> "It turns out
> when you step out of a cocoon,
> you can step out
> less alive
> but light enough to fly.
> It turns out
> there is enough
> magic & love
> in the universe
> to mold
> your own death mask
> but not fully die" (McBride 220).

These lines encapsulate the idea of metamorphosis, not as a return to the former self, but as an acceptance of the new, transformed self—one that, though marked by loss, remains capable of hope and flight. McBride's lyrical expression of this process offers readers a poignant commentary on the complexities of

trauma recovery, where healing involves not the eradication of pain but the transformation of that pain into something that can support new growth.

In conclusion, McBride's deft use of poetic language and metaphor allows her to vividly portray the vulnerability of her characters, drawing readers into the emotional intricacies of grief and healing. Her use of the Moth metaphor, in particular, illustrates the delicate balance between pain and transformation, a theme that resonates deeply with contemporary understandings of trauma and recovery. Through her lyricism, McBride not only conveys the struggle of the protagonist but invites readers to empathize with the universal human condition of vulnerability, in all its fragility and resilience.

Conclusion

In *If Tomorrow Doesn't Come*, Jen St. Jude offers a luminous narrative of vulnerability that does not flinch from pain but instead asks how we might live with, through, and alongside it. Suicide, in this novel, is neither condemned nor glorified; it is understood as part of a complex matrix of suffering, silence, and the desire for relief. Through Avery Byrne's journey, St. Jude enacts a politics of care, one that aligns with the core tenets of vulnerability studies: that our exposure to harm is also what makes us capable of relation, recognition, and love. The novel ultimately affirms that survival is not merely enduring but choosing, again and again, to be in the world—even when it hurts. McBride's novel *Me (Moth)*, although refraining from any explicit mention of suicide, depicts the loss of optimism and hope that can result from a traumatic incident or tragic personal loss. It highlights how external stimuli, such as the loss of a loved one, can amplify an individual's vulnerability, shifting the focus from personal fault to external stimuli causing trauma. The novel also aligns with Butler's ethics of vulnerability, which suggests that vulnerability is relational and shaped by external factors, rather than solely

an internal condition. It also reiterates that the role of those around the vulnerable person is crucial in navigating these challenges. McBride's portrayal of Moth's struggle thus removes the stigma and guilt from the ideation of suicide.

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SECTION II

CASE ANALYSIS

Case Analysis: Journey from Suicidal Thoughts to Rational Living Through REBT

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1. Context

Shaila, a 28-year-old marketing professional, had been in a committed relationship for five years. When her partner, Sanket, unexpectedly ended the relationship, she felt an overwhelming sense of loss and despair. She struggled with deep emotional pain, believing that her identity and worth were tied to the relationship. Her self-esteem plummeted, and she began isolating herself from friends, family, and work responsibilities. Feeling hopeless about the future, she attempted suicide by overdosing on sleeping pills. Fortunately, her roommate found her in time, and she was hospitalized. After receiving emergency medical care, she was treated by a psychiatrist and was referred to me for psychotherapy to address her underlying emotional distress and prevent future suicide attempts.

2. Presenting Issues

Shaila exhibited several psychological and behavioural symptoms that indicated severe emotional distress. She reported feeling persistent sadness, worthlessness, and hopelessness, often crying for hours at a time. She found it difficult to concentrate at work, leading to a decline in her professional performance. Socially, she withdrew from colleagues and friends, avoiding all interactions. She expressed a strong belief that without Sanket, her life had no meaning. Her most concerning symptom was recurrent suicidal ideation, accompanied by a sense of helplessness regarding her future.

3. Need Analysis

Given the severity of Shaila's distress, a structured therapeutic intervention was essential. Rational Emotive Behaviour Therapy (REBT) was selected as the most suitable intervention, as multiple studies (Prabu & Anbazhagan, 2021; Ojiem & Onah, 2021; Joseph & Mathew, 2024; Rani & Devi, 2022) have demonstrated its effectiveness in reducing depression levels among suicide attempters and managing suicidal ideation. REBT directly challenges irrational thought patterns and builds emotional resilience through rational thinking. Shaila required assistance in identifying and disputing her irrational beliefs about self-worth, relationships, and emotional distress. She also needed to learn healthier ways to cope with negative emotions and develop self-acceptance independent of external validation.

4. Psychometric Assessment

Psychometric assessments were used to gain additional insights into Shaila's progress in specific areas, such as the severity of depression and dysfunctional attitudes, to evaluate maladaptive beliefs associated with depression. The following two scales were used to measure these aspects:

1. Patient Health Questionnaire-9 (PHQ-9)- The PHQ-9 is a 9-item self-report scale developed by Kroenke, Spitzer, & Williams (2001), which assesses depression severity based on DSM-IV criteria. Each item is rated on a 4-point Likert scale, and the total score range is from 0–27. Studies (Yue et al., 2020) show that PHQ-9 has good reliability and validity. The Cronbach's coefficient of PHQ-9 was 0.892. Correlation coefficients between each item score and the total score ranged from 0.567–0.789 ($P < 0.01$); the correlation coefficient between various item scores ranged from 0.233–0.747. Good concurrent validity (Policastro et al., 2023) for PHQ-9 compared with SRQ-20 (71%, $p < 0.001$) was found.

2. Mathers Clinic Dysfunctional Attitude Scale- The Dysfunctional Attitude Scale (DAS) was originally developed by Weissman and Beck in 1978 (Weissman & Beck, 1978) to assess maladaptive beliefs associated with depression. The Mathers Clinic (Mathers Clinic. (n.d.)) has adapted this scale for clinical use.

This adaptation includes 35 items covering seven domains: Approval, Love, Achievement, Perfectionism, Entitlement, Omnipotence, and Autonomy. Each item is rated on a 5-point Likert scale. Positive scores indicate healthier attitudes, while negative scores suggest dysfunctional beliefs. DAS demonstrated good reliability and convergent construct validity in many studies. (Weissman, 1979; Graaf, Roelofs &Huibers, 2009)

5. REBT and the ABCDE Model

I introduced Shaila to the ABCDE model of REBT, explaining how emotions and behaviours stem not directly from events but from beliefs about those events. The ABC formulation process accurately describes the situation rather than uncovering and identifying the underlying cause of a clockwork problem. (O'Connor, 2018. p 39). The process was outlined as follows:

- **Activating Event (A):** The breakup of her long-term relationship.
- **Beliefs (B):** Shaila strongly believed that she was worthless because Sanket had left, that she could not survive without him, and that her happiness was entirely dependent on being in a relationship. Shaila's irrational beliefs can be categorized as follows:

  (I) Global Self-Depreciation:

  ✓ *I am worthless because my partner left me.*

  ✓ *If I were truly valuable, he wouldn't have left me.*

  ✓ *Being rejected means I have no worth as a person.*

  Irrationality: Shaila equated her self-worth with her relationship status, assuming that her value as a person is contingent upon being loved by Sanket.

  Rational belief- In reality, self-worth is independent of external validation and remains intrinsic regardless of external circumstances.

  (II) Catastrophizing:

  ✓ *I cannot survive without a partner.*

  ✓ *My life is ruined beyond repair.*

Irrationality: Shaila assumed that losing Sanket was an unbearable and irreversible disaster.

Rational belief: While breakups are painful, they do not make life unlovable. People go through breakups and still lead meaningful lives.

(III) Emotional Dependency:

✓ *My happiness is entirely dependent on being in a relationship.*

✓ *Without a partner, I will never be happy again.*

Irrationality: This belief falsely assumes that happiness can only come from external sources (in this case, a romantic partner).

Rational belief: In reality, happiness is influenced by multiple factors, including personal choices, coping mechanisms, and other fulfilling relationships or pursuits.

(IV) Self-Demands (Musturbatory Demands About Oneself)

✓ *I must get love and approval from others, and If I don't get that, I am worthless.*

✓ *I must always be loved and accepted by my partner; otherwise, I am unworthy.*

✓ *I must be in a relationship to be happy and fulfilled.*

✓ *I must handle this breakup perfectly; otherwise, I am weak and pathetic.*

Irrationality: These beliefs create unnecessary pressure on Shaila by making her happiness and self-worth conditional on external approval.

Rational belief: In reality, relationships are unpredictable, and self-worth is not determined by others' actions.

These beliefs contributed to her extreme emotional distress, reinforcing feelings of hvvopelessness and suicidal ideation.

• **Consequences (C)**: As a result of these irrational beliefs, Shaila experienced intense despair, feelings of hopelessness and meaninglessness, she engaged in social withdrawal and saw a decline in her career performance.

- **Disputation (D):** I guided her in disputing these beliefs and challenging their validity. I assisted her in examining whether her thoughts were logical, whether there was evidence to support them, and whether they were helpful. If they were not, I helped her in replacing them with alternative rational beliefs.

- **Effective Philosophy of Life (E):** Through rational thinking, Shaila began developing effective rational new beliefs. She started accepting that while breakups are painful, they do not determine a person's worth. She also began recognizing that happiness can be cultivated independently and that her identity was not solely defined by her relationship.

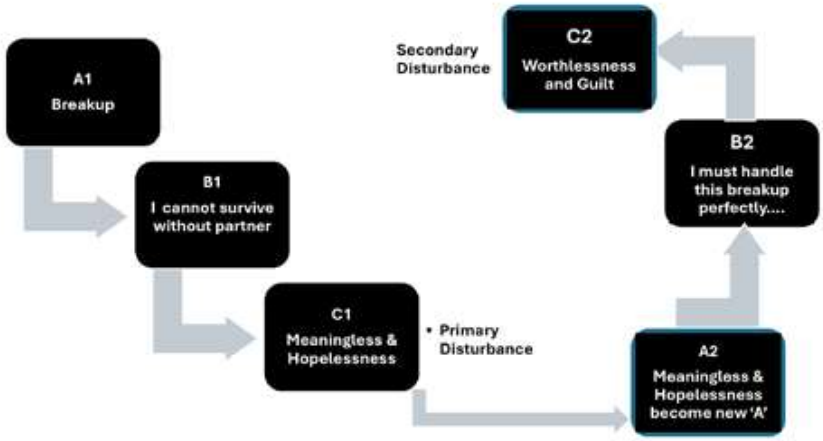
5. Disturbance about Disturbance

REBT (Ellis, 1979a, 1980a, 1994c, 1996a) suggests that people often need to address their disturbance about their disturbance before they can successfully resolve their original problems. In Shaila's case, it was also essential to address her secondary disturbance first before dealing with her primary one. Shaila's feelings of hopelessness and meaninglessness due to her breakup were her primary disturbances. However, she was not only experiencing a primary disturbance; on top of that, her primary disturbance also became a new Activating Event (A) in her life. She then evaluated her hopelessness and meaninglessness in light of her belief (B) that she must handle this breakup perfectly; otherwise, she would be weak and pathetic. She judged herself harshly for feeling this way, believing she was weak for not managing the situation better, and thought that crying made her even more pathetic. Because of this belief, she created the emotional consequences of worthlessness and guilt. This indicates that she developed a secondary emotional disturbance regarding her primary emotional disturbance, which compounded her suffering and led her toward suicidal ideation.

First, I worked with her to challenge the meta-beliefs that were fuelling her secondary disturbance. I knew that unless I addressed this layer first, I wouldn't be able to identify or work on her primary disturbance. Therefore, I focused on uncovering the beliefs underlying her secondary disturbance. Once I identified her meta-belief—' I *must handle this breakup perfectly; otherwise, I am weak and*

pathetic'—I traced it back to her deeper irrational belief: 'I cannot survive without a partner.' By addressing these layers step by step, she gained clarity, realizing that emotions like sadness and disappointment are natural responses to loss and that hope, and self-compassion are essential for healing.

Figure 1 – Shalia's Primary & Secondary Disturbance



6. Goals for REBT

REBT therapists (Ellis & Dryden, 1997. p104) individualize therapy to align with each client's goals and the objectives of the therapeutic process. Thus, in consultation with Shaila, it was decided that the therapy would focus on helping her reduce suicidal ideation and self-harm tendencies. It would focus on developing self-worth independent of external validation and teaching her rational coping strategies for dealing with emotional distress. Therapy would also aim to build emotional resilience and stability, equipping her with skills to handle future challenges more effectively.

7. REBT Intervention Steps

I developed a structured REBT intervention plan for Shaila, drawing upon the guidelines outlined in the REBT literature (Joshi & Phadke, 2025; Ellis & Dryden, 1997; David et al.,2010; Dryden, 2009; Ellis, 2001).

Step 1: Describing the Activating Event

Shaila recounted her emotional breakdown following the breakup. She detailed how she felt abandoned and believed she could not function without her partner.

Therapist: "Tell me, Shaila, what exactly happened when Sanket ended the relationship?"

Shaila: "He told me he no longer felt the same way about me. I felt my entire world shatter. I couldn't breathe. It felt like my life had lost all meaning."

Therapist: "That sounds incredibly painful. Can you share more about what was happening in your relationship leading up to this point?"

Shaila: All my relatives knew about our relationship, and we had even finalized the wedding date, which was just three months away. I was so excited, but lately, I started to feel that Sanket wasn't giving me enough time. Instead of spending time with me, he was busy with his own social circle."

Therapist: "That must have been frustrating for you. Did you discuss this with him?"

Shaila- "Yes, we had frequent arguments about it. I felt that since we were getting married, whatever time he had, he should spend it with me. But he didn't see it that way. He would get defensive, and we would argue. I thought it was just a normal part of relationships, and we would work through it."

Therapist: "It sounds like you were hoping things would improve over time. What happened next?"

Shaila: "One Friday evening, we had plans to meet up. I checked with him about where he was, and suddenly, he sent me a message saying he wasn't interested in continuing our relationship. Then he blocked me on all his social media accounts."

Therapist: "That must have been shocking and hurtful. Did you try to contact him after that?"

Shaila: "Yes, I tried calling him, but he was unreachable. I even tried to meet him in person, but he refused. I was desperate, so I asked our mutual friend, Neha, to talk to him. But Sanket told her that he didn't want to reconsider his decision. He was firm about ending our relationship with me."

Therapist: "I'm so sorry you had to go through that. How did this rejection affect you emotionally?"

Shaila: "The rejection took a huge toll on my mental health. I started feeling completely meaningless and hopeless. Suicidal thoughts began to swirl in my

mind. In the heat of the moment, I even tried to commit suicide. I just felt like I couldn't go on without him."

Therapist: "Shaila, that sounds indeed overwhelming. I'm really glad you're here with me now, and we're going to work through this together. You're not alone in this."

(I identified that Sanket's message of discontinuing the relationship was the Activating Event (A) in Shaila's emotional distress.)

Step 2: Identifying Unhealthy Emotions

Therapist: "Can you describe what you felt in that moment?"

Shaila: "I felt... empty. Like I was drowning in a dark void. I just kept thinking, 'I am nothing without him.'"

Shaila identified her emotions as extreme sadness, self-loathing, hopelessness, and meaninglessness. She described how these feelings made her want to give up on life.

Step 3: Identifying Irrational Self-Talk and Beliefs

Through guided discussion, Shaila recognized her irrational thoughts, such as believing that she was unlovable because her partner left, assuming that she was nothing without him, and thinking that she would never find happiness again. Here are some excerpts of the dialogues I had with Shalia.

Therapist: "Shaila, do you think these intense emotions you felt were solely because of the message Sanket sent you?"

Shaila: "Naturally!"

Therapist: "Naturally? Let's consider this: if 100 girls were in your situation, would all of them feel the same emotions and behave the same way you did? Take a moment to think before you answer."

Shaila: "No, not all 100 girls would feel and behave like me. Some might feel angry, some might seek revenge, and others might not feel as intensely as I did."

Therapist: "Exactly. So, you agree that Sanket's message or behaviour doesn't have the power to create emotions in you. It's your own interpretation and beliefs about the situation that influence your emotions."

(I unfolded the B-C connection and provided her with the insight that we are not mere puppets of the circumstances around us when it comes to our emotions and behaviour.)

Step 4: Disputation of Irrational Beliefs

Here are some excerpts from my conversations with Shalia.

Therapist: "Shaila, let's examine that thought— 'I am nothing without him.' What evidence do you have to support this belief?"

Shaila: "Well, I just feel empty. I don't know how to go on."

Therapist: "But does one failed relationship mean you are nothing? Before you met him, didn't you have hobbies, achievements, friendships?"

Through these disputational questions, Shaila began to introspect on the irrational beliefs in her mind. She had four major categories of irrational beliefs: Global Self-Depreciation, Catastrophizing, Emotional Dependency, and Self-Musturbatory Demands. Some of the key disputational questions that helped her challenge these beliefs are as follows:

(I) Global Self-Depreciation:

1. "I am worthless because my partner left me."

- What evidence do you have that your worth is solely determined by your partner's presence in your life?
- Can someone's worth be entirely defined by another person's actions or choices?
- Have there been moments in your life when you felt worthy, regardless of your relationship status?
- Could your partner's decision be based on their own issues rather than your worth?
- Even if this relationship ended, does that mean you have no skills, strengths, or qualities that contribute to your value?

2. "If I were truly valuable, he wouldn't have left me."

- Are all valuable people always in relationships?
- Can people end relationships for reasons that have nothing to do with the other person's worth?
- Does a breakup mean that every quality you possess suddenly disappears?
- Are there cases where wonderful, loving, and valuable people have also experienced breakups?
- If someone stays in a relationship, does that automatically mean they are valuable?

- Could someone leave a valuable person for reasons that have nothing to do with value, such as personal preferences or circumstances?

3. "Being rejected means I have no worth as a person."

- Does rejection define who you are, or is it just an event in your life?
- Is it reasonable to measure your entire self-worth based on one instance of rejection?
- Do all people who face rejection become worthless, or do they still have qualities and strengths?
- Is it possible that rejection is about compatibility rather than personal worth?
- If you reject someone for a job or a friendship, does that mean they are worthless?
- What are some ways you can still contribute, grow, and find fulfillment regardless of this rejection?
- How can you redefine my worth based on your values, actions, and contributions rather than others' perceptions?

These questions helped Shaila shift the focus from global self-depreciation to a more rational, self-accepting perspective, promoting self-worth independent of external validation.

(II) Catastrophizing:

1. "I cannot survive without my partner."

- Cannot? Will you not survive at all, or will it be difficult to survive without him?
- Instead of saying you "cannot survive," could it be more accurate to say, "It will be painful, but I can cope and rebuild"?
- Have you never been alone before and still managed to live and function?
- If your survival truly depended on your partner, wouldn't that mean no one could live after a breakup?
- Do other people who lose their partners not survive?

2. "My life is ruined beyond repair."

- Is this an exaggeration, or is there evidence that nothing good can ever happen again?
- Is there actual proof that your entire life is ruined?
- What is your definition of ruining someone's life?
- Have there been times in history where people thought their lives were ruined but later found happiness again?
- Are there still areas of your life that are intact and meaningful despite this setback?
- Can you think of people who have gone through heartbreak and still created fulfilling lives afterward?
- If life were truly beyond repair, would anyone ever recover from any hardship?
- Even if this is a painful experience, does it mean you are incapable of growth and happiness in the future?
- Could this experience, painful as it is, become an opportunity for personal growth or a new beginning?
- What small steps can you take to regain control and create new opportunities for yourself?

These questions helped Shaila disrupt catastrophic thinking and guide towards a more balanced, problem-solving mindset.

(III) Emotional Dependency:

1. "My happiness is entirely dependent on being in a relationship."

- Is it true that every happy person is in a relationship?
- If relationships were the sole source of happiness, why do some people in relationships still feel unhappy?
- Does this belief mean that single people are incapable of happiness?
- Can you think of times when you felt content or at peace without being in a relationship?
- Have you ever experienced happiness from sources other than a romantic relationship, such as friendships, hobbies, or achievements?

- Are you not overlooking other aspects of your life that bring you joy and fulfilment?
- What are some ways you can cultivate happiness independently without relying solely on a partner?

2. "Without a partner, I will never be happy again."

- Is "never" a realistic word to use? Can you predict the future with certainty? How do you know your future beforehand?
- Could it be possible that happiness comes from within and not just from external relationships?
- Aren't there things in your life that you enjoy, even without a partner? Doesn't this imply that your happiness isn't entirely dependent on him?
- If happiness were only possible through a relationship, wouldn't that mean that no single person could ever be happy?

These questions redirected Shaila's focus from external dependency to internal resilience, encouraging self-sufficiency and emotional well-being beyond relationships.

(IV) Self-Demands (Musturbatory Demands About Herself)

1. "I must get love and approval from others, and if I don't, I am worthless."

- Who decided that your worth is entirely dependent on others' approval?
- Is it possible for someone to be valuable even if not everyone loves or approves of them?
- Do you always approve of everyone you meet? If not, does that make them worthless?
- Wouldn't it be more realistic to say, "I prefer approval, but I don't need it to be worthy"?

2. "I must always be loved and accepted by my partner; otherwise, I am unworthy."

- Is it realistic to expect constant love and acceptance from one person?
- Does a breakup mean that everything about you is unworthy, or could it be due to other reasons?

- If your worth depends on a partner's love, does that mean you had no worth before the relationship?
- Do you believe your partner is perfect and never makes mistakes? If not, why base your self-worth on his judgment?

3. "I must be in a relationship to be happy and fulfilled."

- Are all happy and fulfilled people in relationships?
- Have you never ever felt joy, purpose, or fulfillment outside of a relationship?
- Do relationships guarantee happiness, or do some people in relationships still feel lonely and unfulfilled?
- If a relationship was the only key to happiness, wouldn't that mean single people could never be happy?

4. "I must handle this breakup perfectly; otherwise, I am weak and pathetic."

- Is there a perfect way to handle a breakup, or is it a learning process for everyone?
- Do all strong people handle breakups flawlessly, or do they struggle and grow from the experience?
- Who sets the standard for what "perfect" breakup recovery looks like?
- If you make mistakes while coping, does that erase all your strengths and abilities?
- Would you judge someone else as weak or pathetic for struggling after a breakup?
- Instead of demanding perfection, wouldn't it be rational to say, "I will do my best to heal at my own pace"?

These disputational questions challenged Shaila's rigid, unrealistic self-demands and encouraged her self-acceptance, flexibility, and emotional resilience.

Step 5: Identifying Rational Alternative Beliefs

Shaila worked on replacing irrational beliefs with rational ones. She acknowledged that while the breakup was painful, it did not determine her self-worth. A few examples of the alternative rational beliefs she acquired in each category are as follows:

(I) Global Self-Depreciation:

✗ I cannot survive without my partner.

✓ My worth is not defined by my relationship status. I am valuable as a person, regardless of who stays or leaves.

✗ If I were truly valuable, he wouldn't have left me.

✓ A relationship ending doesn't mean I lack value—it simply means it didn't work out. People leave for various reasons, many of which have nothing to do with my worth.

✗ Being rejected means I have no worth as a person.

✓ Rejection is a part of life and does not define my worth. Many experience rejection, and it does not make them unworthy.

(II) Catastrophizing:

✗ I cannot survive without my partner.

✓ While losing my partner is painful, I am capable of surviving and rebuilding my life. I have faced challenges before and emerged stronger.

✗ My life is ruined beyond repair.

✓ This is a difficult phase, but life is constantly changing. I can heal, grow, and create new opportunities for happiness.

(III) Emotional Dependency:

✗ My happiness is entirely dependent on being in a relationship.

✓ While relationships can bring happiness, they are not the only source of fulfillment. I can cultivate happiness through self-growth, friendships, and personal achievements.

✗ Without a partner, I will never be happy again.

✓ Happiness is not limited to one person or relationship. It may take time, but I can find joy in other meaningful aspects of life.

(IV) Self-Demands (Musturbatory Demands About Herself):

✗ I must get love and approval from others, and if I don't, I am worthless.

✓ While I prefer love and approval, I do not need them to be worthy.

✗ I must always be loved and accepted by my partner; otherwise, I am unworthy.

✓ No one is loved and accepted all the time. Love is important, but my worth does not depend on one person's acceptance.

✗ I must be in a relationship to be happy and fulfilled.

✓ A relationship can be enriching, but true fulfillment comes from a balanced life, personal growth, and self-acceptance.

✗ I must handle this breakup perfectly; otherwise, I am weak and pathetic.

✓ There is no perfect way to handle a breakup. It's okay to struggle and heal at my own pace. Strength comes from resilience, not from avoiding pain.

These rational beliefs promoted self-worth, resilience, and emotional independence in Shalia's mind and helped her to embrace a Rational philosophy of life.

Step 6: Identifying Healthy Alternative Emotions

Shaila aimed to replace despair with sadness, self-loathing with self-compassion and hopelessness and meaninglessness with hope and meaningfulness. By viewing her emotions in a more rational light, she found it easier to cope.

8. Session Details

The REBT sessions were structured following the guidelines outlined in the REBT practitioners' handbooks. (e.g., Ellis & Dryden, 1997., David et al.,2010., Dryden & Branch, 2008)

Session 1: Establishing Therapeutic Goals

During the first session, I introduced the principles of REBT to Shaila and set clear objectives for therapy. Shaila was encouraged to maintain a journal to track her emotional patterns.

Therapist: "Shaila, welcome to our first session. Let me explain what I do. There are times when we experience unhealthy emotions—feeling low, angry, depressed, or even a sense of meaninglessness. I help people understand that emotions are not automatic; we play a role in creating them. Our emotions stem from

our thoughts, and by working on these thoughts, we can bring about a positive change in how we feel. This process involves working on our cognitions. Do you think this approach will help with your concerns?"

Shaila: "Yes, it will be a great help to me."

Therapist: "Tell me, in which specific area do you need my help?"

Shaila: "I want to understand why I'm feeling so low and how to get out of it."

Therapist: "That's completely understandable. Our goal here is to set clear, achievable objectives for our sessions. One of the first things I'd like you to do is maintain a journal. By tracking your emotions and thoughts, we can better understand your thought patterns."

Shaila: "That sounds like a good start. I've never kept a journal before, but I'm willing to try."

Therapist: "Great! In your journal, try to note down any significant events, how they made you feel, and any thoughts you had at the time. This will help us pinpoint triggers and thought patterns that we can work on."

Shaila: "I'll do that. It might help to see my thoughts on paper."

In this session, Shaila and I discussed the activating event and her irrational beliefs that led to her emotional distress.

Session 2: Differentiating Between Healthy and Unhealthy Emotions

I helped Shaila understand the difference between her natural sadness (healthy emotion) over the breakup and the irrational despair (unhealthy emotion) caused by her self-defeating thoughts.

Therapist: "Shaila, let's explore your emotions in more detail. Healthy emotions are self-supportive—they help us move forward. In contrast, unhealthy emotions are self-defeating and can leave us feeling stuck. Take sadness after a breakup, for example. This emotion allows a person to acknowledge that something undesirable has occurred and objectively analyze the probable cause without resorting to self-blame. If the situation can be repaired, they may take constructive action to address it. If it is irreparable, they will mourn for a while, come to terms with the other person's decision, and eventually let go. However, if someone experiences despair or depression instead, they may become so overwhelmed that they struggle to take any constructive action. Instead of moving forward, they might blame themselves for what happened, further deepening their distress.''

Shaila: "So, my sadness over the breakup is a healthy emotion?"

Therapist: "Exactly. Sadness is a healthy emotion to a breakup. However, the depression and intense despair you're feeling are unhealthy emotions caused by your self-defeating thoughts. For instance, you might be telling yourself, 'I'll never find love again,' which amplifies your sadness into despair."

Shaila: "Oh! I didn't realize the difference until you explained it. It makes sense now. It's like I've been layering negativity on top of my initial feelings by talking to myself irrationally."

Therapist: "Exactly. By identifying these unhealthy emotions, we can begin to challenge the irrational thoughts that fuel them."

In this session, I used examples to differentiate between healthy and unhealthy emotions, highlighting their impact on mental well-being. Shaila learned to recognize healthy emotions, like sadness, and distinguish them from unhealthy ones, such as despair, which were amplified by her irrational beliefs. We discussed specific instances from Shaila's life to illustrate how these emotions played out.

Sessions 3 & 4: Understanding the ABC Model

Shaila explored how her beliefs shaped her emotional consequences and how irrational beliefs perpetuated her distress.

Therapist: "Let's delve into the ABC model—Activating Event, Belief, and Consequence. The activating event is the breakup. What belief do you have about this event?"

Shaila: "I believe that I'm unlovable, and that's why the relationship ended."

Therapist: "And what is the emotional consequence of that belief?"

Shaila: "I feel devastated and hopeless."

Therapist: "Exactly! Let's examine your belief that you are unlovable. Have you ever challenged this belief to test its validity? How do you support this thought? What concrete evidence do you have that you are truly unlovable? Apart from Sanket, has no one ever loved you?"

Shaila: (After thinking) "Well, I have friends and family who love me, and I've had relationships before. So, my belief that I am unlovable isn't entirely true."

Therapist: "That's right. If you shift your belief to something more rational, like 'This breakup doesn't define my worth,' don't you think the emotional impact would be less distressing?"
Shaila: "Yes."

During these sessions, Shaila was introduced to the ABC model, which helped her understand how her beliefs about the breakup were directly influencing her emotional well-being. We practiced identifying activating events, beliefs, and consequences in various situations. Shaila gained insight into how her beliefs shaped her emotions and began to recognize the irrational beliefs that contributed to her distress.

Session 5: Preparing for Disputation

In this session, the focus was on practical strategies for challenging irrational beliefs. I used the Socratic questioning method, a core technique in REBT (Ellis & Grieger, 1977; Gladding, 2009), to help Shaila challenge her irrational thoughts. This approach involves guiding individuals through a series of reflective questions to encourage the critical examination of their beliefs and the development of more rational alternatives. Through Socratic questioning, Shaila learned to analyze and dispute her maladaptive thoughts

Therapist: "Now that we've identified your irrational beliefs, let's challenge them using Socratic questioning. We'll start with the belief, 'I'm unlovable.' How can we dispute that?"
Shaila: "I could ask myself, 'What evidence do I have that I'm unlovable?'"
Therapist: "Great. And what evidence do you find?"
Shaila: "When I think about it, I realize I have many people in my life who care about me. So, the belief that I'm unlovable doesn't really hold up."
Therapist: "Exactly. Another helpful question could be, 'What would I say to a friend who had this belief?'"
Shaila: "I'd tell them that a breakup doesn't define their worth and that they are lovable and valuable."
Therapist: "Perfect. By asking yourself these questions, you can challenge and replace irrational beliefs with more balanced, rational thoughts."

During this session, I introduced Shaila to the technique of Socratic questioning to help her dispute irrational beliefs. Through guided practice, I encouraged her to ask herself key questions, evaluate evidence, and reframe her thoughts. As a result, Shaila recognized that many of her negative beliefs were unfounded and began developing more rational, self-affirming perspectives.

Session 6: Emotive and Behavioural Techniques

REBT offers (DiGiuseppe et al. 2013., Dryden & Neenan, 2003) a broad framework that accommodates various techniques. For Shaila, I selected Rational Emotive Imagery (REI) and role-playing to facilitate her progress. I introduced Shaila to a REI, which involves visualizing challenging situations and mentally rehearsing rational responses. To reinforce this, I engaged her in role-play exercises to help her prepare for difficult situations.

Therapist: "Let's practice REI. I want you to visualize a challenging situation you might face in the future and observe the thoughts that arise."
Shaila: "I see myself running into my ex at a social event. I might think, 'Oh! I've managed well so far, but what if seeing him reopens old wounds? What if I spiral back into depression? What if all my self-management efforts crumble?' I would feel anxious and either avoid him or leave the event."
Therapist: "Alright! You visualized that situation well. Now, can you imagine responding to it with a rational thought?"
Shaila: "I'll tell myself, 'It's okay to feel anxious, but I can handle this with grace and composure.'"
Therapist: "Great. Let's take this a step further with role-playing. I'll play your ex, and instead of avoiding me or leaving, you respond rationally."
Shaila: "Okay. 'Hi, it's good to see you. I hope you're doing well.'"
Therapist: "Excellent. You're taking control of your emotions and practicing a rational response."

In this session, Shaila engaged in REI and role-play exercises to practice responding to challenging situations with rational thoughts and behaviours. Through guided visualization and structured practice, she built confidence and emotional resilience, equipping herself with healthier ways to navigate difficult encounters.

Sessions 7 & 8: Unconditional Self-Acceptance (USA)

In these sessions, I introduced Shaila to the concept of Unconditional Self-Acceptance (USA) and assisted her in understanding that self-worth extends beyond external validation. Together, we explored the depth of the concept: Can we truly define our self-worth? Can we identify specific traits that make someone inherently worthy, or does lacking them render a person worthless? She struggled to pinpoint a single defining aspect essential for worthiness and gradually realized that human worth is immeasurable.

We also examined how others attempt to define our worth. Shaila reflected on how people's perceptions are shaped by their biases, experiences, and societal standards—factors that often have little to do with a person's intrinsic value. We discussed whether someone's opinion, no matter how strong or widespread, could ever alter the fundamental worth of another human being. She recognized that external judgments are subjective and fleeting, influenced by changing circumstances and personal viewpoints.

Therapist: "Today, we'll focus on Unconditional Self-Acceptance (USA). Your self-worth shouldn't depend on others' opinions or external validation."
Shaila: "That's tough. I've always relied on external validation to feel good about myself."
Therapist: "It's a gradual process. Start by affirming your worth daily. For example, say to yourself, 'I am valuable just as I am, regardless of others' opinions.'"
Shaila: "I'll start doing that. It feels liberating to think that my worth isn't dependent on others."
Therapist: "Exactly. By practicing these affirmations and embracing USA, you can build a stronger sense of self-worth."
Shaila: "But what if I make mistakes or struggle with self-doubt?"
Therapist: "Mistakes and doubts are part of being human. USA means accepting yourself despite them. Let's reinforce your self-acceptance with the USA Credo. Repeat after me: 'I accept myself unconditionally, regardless of my flaws.'"
Shaila- "I accept myself unconditionally, regardless of my flaws."
Therapist: "Well done. Keep practicing this affirmation daily."
Shaila- "I will. It feels empowering to accept myself as I am."

Shaila realized that neither we nor others can define self-worth because it transcends measurement. It is not something that can be assigned, measured, or diminished by external validation. She understood the importance of daily affirmations and gradually began to internalize the belief that her worth was not dependent on external validation. I reinforced the concept of the USA through the USA Credo. Dryden (2009) has formulated several 'credos' related to REBT concepts, including one on realistic unconditional self-acceptance. Given the length of Dryden's Credo, I adapted it for Shaila. This session focused on systematically analyzing the credo to ensure Shaila fully understood the principles of unconditional self-acceptance and their practical applications. She practiced repeating the credo and integrating it into her daily routine.

Session 9: Teaching an Effective Philosophy of Life

Shaila was encouraged to adopt long-term rational perspectives to navigate challenges more effectively.

Therapist: "Can you tell me how the rational philosophy you've adopted will help you in the long run?"

Shaila: "It will help me navigate challenges more effectively."

Therapist: "How?"

Shaila: "Earlier, I used to believe that if I couldn't handle challenges properly, it meant I was a failure. Now, I see these challenges as setbacks, not failures."

Therapist: "What's the difference between seeing them as failures and as setbacks?"

Shaila: "Failure is an exaggeration, while a setback is a reality. If I label myself a failure, I condemn my entire totality, which demotivates me and makes me feel like giving up. I start feeling low and inadequate. But if I see a challenge as a setback, I focus only on the current difficulty without labelling myself as a failure in every situation. I can rationally say, 'This situation is a setback, but that doesn't mean I'm a failure in all aspects of life.'"

Therapist: "Excellent! Also, when you see it as a failure, you focus only on the negative aspects of the situation. Can you identify any positive aspects of setbacks?"

Shaila: "Yes! I can see them as opportunities for growth and learning."

Therapist: "Great! I'm happy with your progress. What will you say to yourself moving forward?"
Shaila: "Instead of saying, 'I failed,' I will say, 'This is a chance for me to learn and improve.'"
Therapist: "Yes! This mindset will help you stay resilient and focused on personal growth. You can also remember a few slogans to reinforce this self-talk, such as Ralph Waldo Emerson's 'Every wall is a door' or Bono's 'Whenever you see darkness, there is extraordinary opportunity for the light to burn brighter.'"
Shaila: "I like those. They make me feel more empowered and less afraid of failure."
Therapist: "Remember, it's a process. By consistently practicing these rational beliefs, you'll develop a philosophy of life that supports your mental well-being."

In this session, the goal was to instill a rational life philosophy centred on personal growth, resilience, and a constructive outlook. Shaila embraced a rational philosophy to challenges, allowing her to navigate them more effectively.

Session 10: Review and Reinforcement
The final session summarized her progress and emphasized maintaining a rational philosophy for future challenges.

Therapist: "Shaila, you've made significant progress over the course of our sessions. Let's take some time to review your journey and the skills you've developed."
Shaila: "I've learned to identify and challenge my irrational beliefs, accept myself unconditionally, and adopt a more rational perspective on life."
Therapist: "Absolutely. You've done an excellent job. What specific techniques have you found most helpful?"
Shaila: "The ABC model really helped me understand the link between my beliefs and emotions. Disputation techniques, REI, USA credo have also been very effective."
Therapist: "Those are powerful tools. As you move forward, remember to maintain these practices. Continue journaling, challenging irrational beliefs, and using affirmations. These techniques will help you navigate future challenges."
Shaila: "I feel more confident and prepared to handle whatever comes my way."

Therapist: "That's wonderful to hear. You've equipped yourself with a strong foundation of rational beliefs and emotional resilience. Keep practicing these skills, and don't hesitate to reach out if you need further support."
Shaila: "Thank you for all your guidance. I feel ready to face the future with a new rational perspective."

In the final session, I and Shaila reviewed her progress and highlighted the key concepts and techniques she had learned. We discussed the importance of maintaining rational beliefs and practices for future challenges. Shaila reflected on her journey and expressed her confidence in applying the skills she had acquired. I reinforced the importance of continued practice and self-care, ensuring Shaila felt supported and prepared for the future.

9. Outcome Analysis

(I) Qualitative Analysis

Qualitative analysis focused on the descriptive and experiential aspects of Shaila's progress throughout the therapy sessions. By examining her subjective experiences, feedback, and self-reported improvements, I have gained a deeper understanding of her emotional and cognitive changes.

1. Self-Awareness- Shaila reported a significant increase in self-awareness. By maintaining a journal and participating in sessions, she became more attuned to her emotional patterns and triggers.
Shaila- "I've noticed that I'm much more aware of my self-talks and emotions now. I can identify when I'm having irrational beliefs and take steps to challenge them."
2. Emotional Regulation- Shaila experienced improvements in emotional regulation. She learned to differentiate between healthy and unhealthy emotions and apply emotive and behavioural techniques to replace unhealthy emotions with healthy emotions.
Shaila- "I'm better at managing my emotions now. Instead of spiralling into despair, I can pause and challenge my irrational thoughts."

3. Self-Acceptance- Shaila developed a stronger sense of self-acceptance. Through USA Credo, affirmations and cognitive restructuring, she embraced her self-worth beyond external validation.

Shaila- "I've started to accept myself unconditionally. I no longer rely on others' opinions to feel good about myself."

4. Resilience- Shaila reported feeling more resilient and prepared to face future challenges. She adopted a more rational philosophy of life and reframed challenges as opportunities for growth.

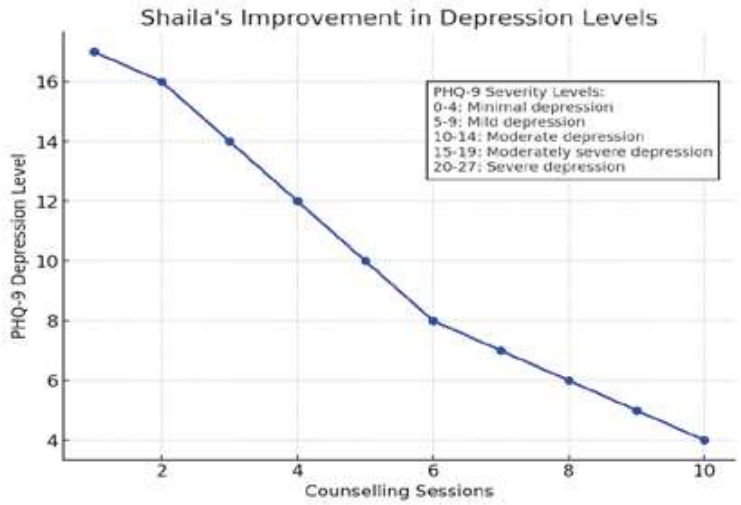
Shaila- "I feel more confident and resilient. I see challenges as opportunities to learn and grow."

(II) Quantitative Analysis

Quantitative analysis involved the use of measurable data to assess Shaila's progress. This included pre- and post-therapy assessments, self-report questionnaires, and ratings of her emotional and cognitive states.

1. Depression Levels (PHQ-9)

Shaila's depression levels were measured using the Patient Health Questionnaire-9 (PHQ-9) scale.

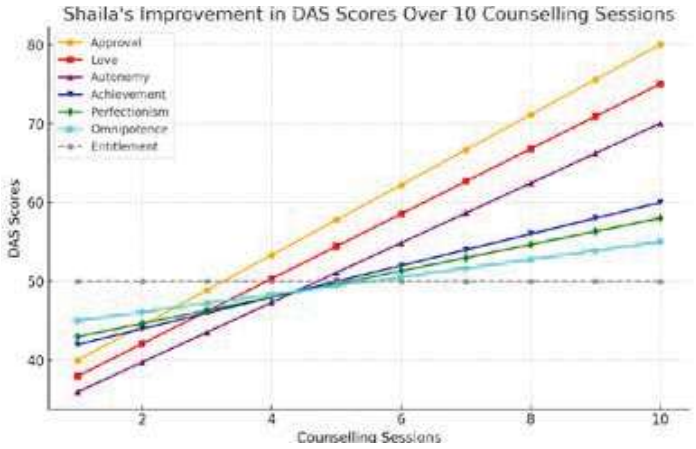


Graph 9.1 Shaila's Depression Levels over 10 counselling sessions

Graph 9.1 shows Shaila's improvement in depression levels over 10 counselling sessions. Her PHQ-9 score dropped from 17 (moderately severe depression) to 4 (minimal depression), indicating significant progress.

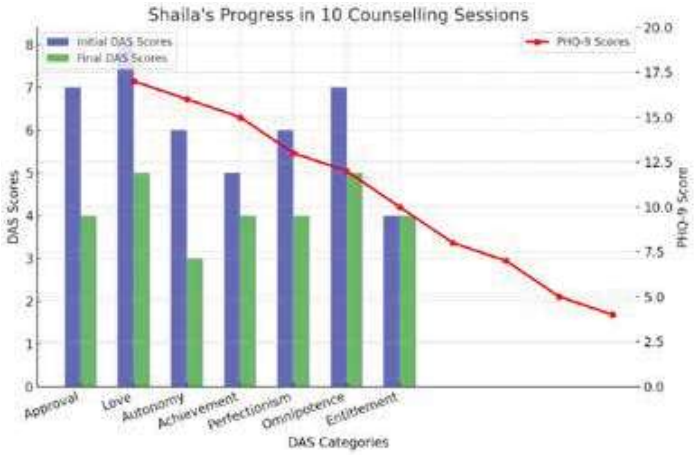
2. Mathers Clinic Dysfunctional Attitude Scale (DAS)

Shaila's Dysfunctional Attitudes were measured using the Mathers Clinic Dysfunctional Attitude Scale (DAS).



Graph 9.2 illustrates that over 10 counselling sessions, Shaila showed steady improvement in her Dysfunctional Attitude Scale (DAS) scores, reflecting a shift in her irrational beliefs. By the mid-sessions, her scores on approval, love, and autonomy had improved significantly, indicating greater self-acceptance and independence. Her scores on achievement, perfectionism, and omnipotence improved moderately, suggesting a gradual reduction in self-imposed high standards. Meanwhile, her entitlement score remained unchanged, as her initial positive score indicated she did not hold an unwarranted sense of entitlement. Overall, her progress highlighted a step-by-step cognitive shift toward healthier beliefs.

3. Overall Progress-



Graph 9.3 illustrates Shaila's progress in reducing her depression score over 10 counselling sessions. The red line represents the reduction in PHQ-9 scores (depression), while the blue and green bars indicate the initial and final DAS scores across different categories. Her PHQ-9 score dropped from 17 (moderately severe depression) to 4 (minimal depression), indicating a marked improvement in mood and overall mental health. Her DAS scores also show improvement in her dysfunctional attitude in approval, love, and autonomy, indicating significant progress, whereas the improvement in achievement, perfectionism, and omnipotence indicates moderate improvement. In summary, Graph 9.3 highlights the positive impact of therapy on Shaila's emotional and cognitive well-being.

10. Changes & Reflections

(I) Changes

The Changes highlights the specific transformations Shaila experienced throughout her therapy journey.

1. Behavioural Changes- Shaila adopted new behaviours, such as journaling, practicing REI, USA Credo, affirmations, and engaging in role-play exercises. These activities helped her build coping skills and emotional resilience.

2. Cognitive Changes- Shaila challenged and changed her irrational beliefs through Socratic questioning and cognitive restructuring. She developed more rational, self-affirming thoughts that improved her emotional well-being.

3. Emotional Changes- Shaila learned to differentiate between healthy and unhealthy emotions, which helped her manage her emotional responses more effectively. She reported feeling more balanced and in control of her emotions.

4. Philosophical Changes- Shaila adopted a long-term rational philosophy of life. She reframed challenges as opportunities for growth and focused on maintaining a positive, resilient outlook.

(II) Reflections

The Reflections capture Shaila's insights and takeaways from her therapy experience.

Shaila's Reflections

1. Self-Discovery- "Through therapy, I've discovered so much about myself. I've learned to identify and challenge my irrational beliefs, and it's been a transformative experience."

2. Emotional Growth- "I've grown emotionally and developed better coping skills. I no longer let my emotions control me. Instead, I take proactive steps to manage them."

3. Empowerment- "I feel empowered by the tools and techniques I've learned. They've given me the confidence to face future challenges with a rational perspective."

4. Long-Term Commitment- "I understand that personal growth is an ongoing journey. I'm committed to continuing these practices and maintaining my emotional well-being."

Therapist Reflections

1. Progress: Shaila has made remarkable progress throughout our sessions. Her dedication and willingness to engage in the therapeutic process have been key to her success.''

2. Strengths: "Shaila's resilience and openness to change have been her greatest strengths. She embraced the techniques and applied them effectively to her life."

3. Future Outlook: ''I'm confident that Shaila will continue to thrive. She has developed a strong foundation of rational beliefs and emotional resilience that will support her in the future."

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SECTION III

REVIEWS

A. MOVIE REVIEW

MOVIE REVIEW

‘Not Today’ (2021)
directed by Aditya Kripalani.

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Sociologist Emile Durkheim, wrote a now classic Sociology text, 'Suicide', in 1897 that was pathbreaking at the time as the book emphasised the role of social factors in suicide. WHO data from 2024 says each year 7,26,000 people take their own lives and is a global phenomenon; making it a severe public health problem that requires a public health response. Often, timely, low-cost intervention goes a long way in preventing it, and a life can be saved.[1]

Intervention plays out within a complex template- institutionalised intervention is important; of trained and professional people, able to deal with not just the severity and urgency that a situation can present, but also be able to intervene and save a life; while also be able to deal with the emotional and mental ramification of the kind of work, that it means for these specialised counsellors to do. Often intervention is by way of a phone call- being at one end of a suicide prevention helpline, and being tasked with changing someone's mind about taking their own lives, sometimes within minutes if not less time.

Preparedness required to deal with this level of crises and the stress that it presents, depends on the counsellor and the training they have had as well as experience. It could also be, that they fail, and that presents a different set of issues altogether. However, at the end of the day, just preparedness, experience and professionalism may still not be enough. Rather an ability to connect and

1 https://www.who.int/news-room/fact-sheets/detail/suicide Accessed on 25.03.2025

empathize with another human being in pain and suffering and a willingness to be vulnerable and reciprocate, could prove to be equally helpful.

The film, 'Not Today', in a sense brings all of the above to the fore and much more. One striking feature of the film and perhaps one of the its most endearing part is the equanimity of Aliah Rupawala, a twenty-four-year-old suicide prevention counsellor, who obviously is a novice and is still undergoing training. Nonetheless, she shows much fortitude and resilience as she deals with a deeply stressful crisis situation. The visual of her sitting on a divider on the road with her bright yellow clothes quietly talking to Ashwin contrasts sharply with the cars zooming around and past her, marking an amorphous, bleak, indifferent and almost dystopian presence. Similarly, her conversing with Ashwin atop a building under construction brings the contrast of cold and concrete with her deep empathy and warmth for Ashwin.

She moves through the city while in conversation with a deeply troubled man, who is dealing with the loss of a child from substance abuse and his own battle with alcohol dependence; that brings him to the brink both literally and figuratively, perched precariously at the edge of a railing on a high-rise building; constantly positioning and re-positioning himself on this side of the railing or the other, multiple times throughout the film, reflecting a despaired and troubled mind.

Ashwin Mathur, the man on the edge, is fifty-two-years old and used to be a very successful professional, winning awards and accolades in his field, but as it turns out, ended up becoming a suicide prevention counsellor with his own organisation! Aliah in comparison to him is a completely inexperienced novice, as apparent in the beginning of the film which opens with her training under a rather strict and stern supervisor, who interjects as they role play through a phone call. Aliah's first call in the centre turns out to be Ashwin. Soon after she answers the call, her supervisor asks her to hand over the phone to a senior; assuming Aliah does not have the experience or skill to deal with the crises that the call represents.

She does hand over the call but does not abandon the conversation; Aliah leaves the centre and continues with the 'intervention'/ conversation using her own

phone. The rest of the film focuses on this interaction as Aliah moves through different parts of the city, as directed by Ashwin, while talking to him all the while. This is also where the film perhaps, gets a bit tricky. Her engagement with Ashwin is deeply human and touching, and as we see, it saves his life and, in some ways, becomes a cathartic experience for her too as they exchange pieces of information about their respective lives- information deeply personal, about loss and trauma and their desperate attempts to heal.

However, can this really become a strategy in a suicide prevention helpline centre? Can a counsellor really do what Aliah did? Will a counsellor have the time, energy and inclination to invest as much. Also, as Aliah moves through the city on Ashwin's instructions, clearly in the evening and late night, and as she takes public transport to move from one place to another, one cannot help but also be afraid for her safety. At one point she goes to a bar on Ashwin's instructions and orders a cold drink and sits by herself and continues to talk on her phone, as Ashwin explains the significance of the place to her in his own journey of life. She looks clearly out of place as she sips on her cold drink.

The story is one of pathos and one of the strangeness of life and the fragility of it all- of vulnerabilities that constitutes of people. It is also about a commitment to save lives and take on extremely difficult and emotionally and mentally taxing work- of people who work in the area of suicide prevention. Of trying to formulate rules and regulations and a formula to saving lives - of people who may or may not want to be saved.

Aliah and Ashwin both with complex back stories don't meet but connect and end up sharing deeply personal aspects of their lives- set up as quid pro quo almost; eventually Ashwin decides not to make that jump – at least at that time and Aliah has a clear role to play in his decision.

The film is powerful in terms of its message; the actors clearly very skilled. It raises awareness about suicide and suicide prevention. About the state of a troubled mind that would consider such an extreme step. Feelings of despair, isolation, loneliness, feelings of hopelessness, worthlessness and emotional numbness all presented within a spectrum of symptoms that coalesce to drive a person to

the brink. Yet the film is also about hope and endurance, and resilience specially that Aliah personifies, as she continues to engage with Ashwin, again and again - distracting, deflecting, arguing, assuaging, sharing, moving through the city; doing whatever it takes.

B. BOOK REVIEW

BOOK REVIEW

Why Physicians Die by Suicide by Michael Myers

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Physician suicide is an enduring yet often overlooked crisis within the medical profession, a stark contradiction to the very ethos of healing that defines medicine. Michael F. Myers, MD, a psychiatrist specializing in physician health, delves into this issue in *Why Physicians Die by Suicide*, a 2017 publication priced at $14.99 in paperback and printed in the United States. With copyright to Myers, the book draws from his decades of clinical experience working with physicians struggling with mental health issues, situating itself at the intersection of medical culture, psychological distress, and systemic failings. Myers, also the author of *Doctors' Marriages: A Look at the Problems and Their Solutions and Tired of Being Tired: Overcoming Chronic Fatigue and Low Energy*, has spent his career dissecting the inner lives of physicians, making him uniquely positioned to engage with the sensitive and pressing nature of physician suicide.

Structured into four parts and twelve chapters, the book meticulously examines the phenomenon of physician suicide through a blend of empirical evidence, case studies, and theoretical insights. The first part introduces the physician's world, exploring personality traits and cultural expectations that predispose medical professionals to distress. The second part interrogates the reasons behind physician suicide, identifying structural, psychological, and sociological determinants. The third part shifts toward solutions, advocating for systemic reforms and cultural shifts within medicine. The final section synthesizes Myers' arguments, emphasizing the necessity for collective responsibility in mitigating this crisis.

A foundational argument of the book is that the very characteristics that make a physician competent—perfectionism, resilience, and self-sacrifice—can also make them vulnerable. Drawing from maladaptive perfectionism theories (Flett & Hewitt, 2002), Myers illustrates how high personal standards become a double-edged sword, pushing physicians toward excellence while simultaneously setting them up for chronic stress and burnout. Here, the book raises a crucial question: to what extent does the medical profession, as it is currently structured, demand a self-negation that is ultimately unsustainable? Becker et al.'s (1961) seminal work on professional identity formation offers a compelling sociological lens, arguing that medicine does not merely train individuals but reshapes them entirely. Physicians do not just acquire knowledge; they absorb an identity that often demands they suppress vulnerability. This expectation of invulnerability fosters emotional suppression, which, as Myers argues, may explain the reluctance to seek help even in moments of profound crisis.

The book further explores the culture of medicine as a space where suffering is normalized and emotional distress is pathologized only when it reaches catastrophic levels. Physicians, Myers contends, internalize the notion that seeking help equates to weakness—a belief that aligns with Erving Goffman's (1963) theory of stigma, which explains how individuals who deviate from occupational norms risk social and professional marginalization. The question then arises: does the medical community's emphasis on endurance paradoxically contribute to the erosion of physician well-being? The physician's resistance to becoming a patient, as discussed in the book, is rooted in a deep fear of professional repercussions, an argument supported by labelling theory (Scheff, 1966), which suggests that once a physician is marked as 'mentally ill,' their career trajectory can be irrevocably altered. This section invites reflection on how medical licensing boards and institutional policies may inadvertently reinforce a culture of silence rather than support.

The second part of the book, which examines why physicians take their own lives, is arguably its most unsettling yet illuminating section. Myers traces the historical patterns of physician suicide, engaging with Émile Durkheim's (1897) sociological classifications of suicide—egoistic, altruistic, and anomic—to contextualize this crisis. He compellingly argues that physician suicide is often anomic, stemming

from a fundamental breakdown between professional demands and personal well-being. The irony that individuals trained to save lives often succumb to preventable deaths themselves is an unsettling paradox that the book navigates with precision. This irony is compounded by physicians' access to lethal means and their intimate knowledge of pharmacology, which, as Myers demonstrates, increases the likelihood of successful suicide attempts. Cognitive dissonance theory (Festinger, 1957) offers an additional layer of analysis, suggesting that physicians must reconcile their awareness of mental health struggles with the professional expectation of competence and control, often resulting in psychological distress.

Burnout, psychiatric illness, and systemic neglect are central themes in this section, with Myers drawing from burnout theories (Maslach, 1982) to explain the cycle of emotional exhaustion, depersonalization, and reduced personal accomplishment that characterizes physician distress. Here, the book makes a vital intervention by highlighting that while individual resilience is often emphasized as the solution, structural conditions—long work hours, bureaucratic pressures, and punitive mental health policies—are the true culprits. A critical question then emerges: does the discourse on physician wellness need to shift from self-care narratives toward radical systemic reform? Myers advocates for institutional change, yet one could argue that his critique does not go far enough. Marxist critiques of labour exploitation (Braverman, 1974) could provide a sharper analysis of how the corporatization of medicine commodifies physicians, reducing them to dispensable labourers rather than human beings in need of care themselves.

The third section of the book presents a hopeful counterpoint, exploring how suicide prevention strategies can be embedded within medical institutions. Myers calls for a restructuring of medical education to integrate emotional intelligence and mental health training, a perspective supported by Goleman's (1995) research on emotional intelligence and resilience. He also discusses the potential for revitalizing the practice of medicine through autonomy and meaning-making, drawing indirectly from self-determination theory (Deci & Ryan, 2000), which posits that competence, autonomy, and relatedness are essential to well-being. However, while the book effectively argues for reform, it remains somewhat

limited in offering actionable strategies for systemic transformation. This raises a final, crucial question: can medicine, as an institution, truly be reformed from within, or does it require a fundamental paradigm shift?

In its concluding section, Why Physicians Die by Suicide, presents a deeply researched and compassionate examination of an often-overlooked crisis, yet the significance of his work extends far beyond the medical profession. At its core, the book interrogates a broader societal paradox—how institutions designed to heal can, paradoxically, become sites of suffering. Physicians, revered as the custodians of health, are caught in a relentless system that demands endurance while offering little reprieve. This contradiction raises pressing questions: If those trained to save lives are unable to safeguard their own, what does this reveal about the structures governing healthcare? More urgently, what does it signify about contemporary work cultures that valorize resilience but fail to provide the conditions necessary for it to thrive?

Myers' work is grounded in the psychological framework of burnout (Maslach, 1982), yet it also engages with sociological and philosophical critiques of labour. Contemporary discourse on burnout, particularly in high-stress professions, echoes themes articulated by scholars like Mark Fisher (2009), who argued that late capitalism's demand for perpetual productivity leaves individuals disillusioned and exhausted, unable to envision alternative ways of being. Within this context, physician suicide is not merely a personal tragedy but a symptom of a larger societal malaise—one that prioritizes efficiency over well-being and institutional preservation over individual lives. The book thus invites readers to reconsider the cultural narratives surrounding work and purpose: When did self-sacrifice become an unquestioned virtue, and at what cost?

Furthermore, Myers' exploration of stigma aligns with Erving Goffman's (1963) seminal work on the subject. The reluctance of physicians to seek help—fearing professional consequences or personal disgrace—mirrors broader societal patterns in which vulnerability is conflated with weakness. In this regard, the book serves as both a diagnosis and an indictment of a system that isolates those who struggle, rather than supporting them. It compels us to question:

Can a profession built on human care afford to dehumanize its practitioners? How might we construct a medical culture that recognizes vulnerability not as a liability, but as an essential aspect of humane and sustainable practice?

The relevance of these questions extends beyond medicine into contemporary debates on labour rights, institutional accountability, and the evolving discourse on mental health. The global workforce continues to grapple with the consequences of economic instability, geopolitical tensions, and the increasing integration of artificial intelligence into professional life. While automation promises efficiency, it also introduces new ethical dilemmas: Does the reduction of manual tasks lead to emotional relief, or does it further erode the autonomy and meaning that many professionals derive from their work? Myers' insights prompt reflection on whether technological progress is being harnessed to genuinely improve well-being, or whether it is simply restructuring old forms of distress into new ones.

Equally pertinent is the rise of performative wellness initiatives that claim to address burnout without tackling its structural causes. In corporate and medical settings alike, resilience training and mindfulness programs have proliferated, often shifting responsibility onto individuals rather than interrogating the institutional frameworks that create distress in the first place. Myers' work underscores the danger of reducing mental health discussions to personal responsibility rather than systemic intervention. Are we treating symptoms while allowing the disease to fester? What would genuine reform look like—one that prioritizes the well-being of those who are expected to care for others?

Ultimately, Why Physicians Die by Suicide is both a rigorous academic contribution and an urgent call for change. It forces us to confront the moral obligations of institutions that demand so much from their workers, and it challenges society at large to reconsider the ethics of endurance. If physicians, like many professionals in high-stakes roles, continue to be measured by their ability to persist rather than their capacity to thrive, then systemic failures—not individual shortcomings—must be held accountable. Myers does not offer simple solutions, but his work compels us to ask the necessary, difficult questions. And perhaps, in

grappling with these questions, we can begin to reimagine a future in which care is extended not only to patients, but to those entrusted with their healing.

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BOOK REVIEW

The Anxious Generation: How the Great Rewiring of Childhood is Causing an Epidemic of Mental Illness

by Jonathan Haidt (2024), Penguin Random House UK. Pp. 385.

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When you pick this book to read, it may take you through a self-reflective journey, at times scare you, while also making you feel helpless. Rather than just a discourse on certain changes in the conditions of human existence and the effects of it, it serves as a warning. However, in the last part of the book the author plays the role of rescuer, proposing possibilities and actionable steps that can be taken. The book begins with an analogy of Mars, metaphorically depicting how children are placed in a closed virtual world, blocked or distanced from the real world. Children throughout their adolescence are being over exposed to social media and other online activities, while they are not yet ready to manage its impact. With their underdeveloped frontal cortex their capacity for self-control and resisting temptation is not fully developed. Similarly they are vulnerable at this age due to their social insecurities and high need for social validation. The author metaphorically asserts "let the children grow up on Earth first, before sending them to Mars" (p.5), exclaiming that let the children live a normal, digitally unadulterated childhood. It highlights the dire need to restore a play-based childhood from a phone-based childhood. As the book is directed towards the Gen Z referring to them as the 'anxious generation' the author states that there is no real end date, as it would subsume the Gen Alpha or the generations to come.

In this review we are not going to engage in a part-wise or chapter-wise structure of understanding this literary work. We would rather try to connect with the deeper flow of deliberations in terms of what the author calls 'the great rewiring' of children and adolescents. The problem and its impact are located in the surge of metal health problems observed in adolescents, observed after 2010 and the sharp increase in young adults reporting anxiety related issues in the present time. Why do we need to take this seriously? Firstly, the author is not just drawing up on some of his well spelled out observations, but he also presents different sources of data and research evidence to back this 'state of alarm'. Secondly, he points out that there is a clear trend on how mental health impacts in adolescents is creating a supposedly 'psychologically weak' adult. Many of which are experiencing prolonged anxiety or a state of depression, propensity for self-harm or being suicidal. These mental health issues are also marked by other physical symptoms such as weight related issues, sleep problems and fatigue.

Hence the author tries to trace the cross-sectional data related to mental illness in adolescents and young adults which currently corresponds to the Gen Z population. But what changed with the Gen Z? The advent of and the 24x7 availability of smartphones and the continuous and unmonitored access to the virtual world was a distinct feature present in the lives of Gen Z through their adolescence. A virtual world, where girls realized their social lives through the social media ecosystems, enhancing their social validation through filters of Instagram, while boys sought thrill and immediate gratification in multiplayer video games and hardcore pornography. The author does give some convincing arguments why girls use social media more than boys, and what do boys do in this virtual world with two chapters dedicated specifically for it. However, in this review we abstain from engaging in questions related to gender differences to focus on the core issues described in the book.

The author presents three basic motivations, which are natural and important for the slow but healthy development of children. Free play, attunement (synchronizing their movements and emotions with others) and social learning. Today social media seems to have accelerated the social learning process, however the author warns that it is prone to conformity bias or prestige bias, as we like what others like or what makes us feel important or valued. However,

this discourse should also be absorbed with some caution. Firstly, is the author contrasting the old world and the new world? The former portrayed as more beneficial, while the new world inevitable. Every generation view their growth process in idealistic terms, while problematizing the newer one. Secondly is the surge in mental illness only due to the evolution of the virtual world or have there also been changes in the real or social world, which need to be accounted for?

A paradox which the author draws our attention to is that 'we overprotect our children from the real world, while under protecting them in the virtual world'. The author suggests promotion of unsupervised play, which prepares children to handle risks and challenges better. Hey lays importance on the discover mode as being necessary for learning and development to take place. Being over cautions or oversupevising the child would only activate the defend mode in children. By encouraging the discover mode through playgrounds, risky situations, thrills in rides, social learning through friendships the child gets the needed exposure, experience and gains a sense of mastery which can lessen anxiety overtime. A change in parenting seen through the 1990s and which grew in prominence even later was that of 'safetyism' a focus on psychological and physical safety of child, preventing the child to take physical, psychological and social risks in the real world. Hence 'safetyism' became the first experience blocker which millennials were succumbed to. With the coming of the Gen Z, smart phones became the second or additional experience blocker. Preventing children from exposure to different situations required to develop emotional strength and resilience. It's important to note here that the authors observations and assertions are mainly based in the American context, which may be true for the western developed world. Hence presenting autonomy as a virtue and safetyism as being relationally antagonistic can be situated in western cultures, while easter cultures may view it differently. However, the rise of fearful parenting and the decrease in play-based childhood, logically can account for catalyzing the transition from the real world to the virtual world.

The cost of the virtual world is multifold. Rise is the use of smartphones, made this form of reality inseparable, what the author refers to as 'phone-based childhood'. The phone ecosystem changed when phones stopped being just phones but a platform for multiple third-party apps, which were not only increasingly engaging,

but also striving to survive the competition by widening their userbase. Gaming consoles, internet-based games, social media, free streaming platforms all became a part of this virtual childhood. Social media became easy access and less risky mediums for self-presentation needs to be satisfied through 'profiles' and 'user generated content'. Similarly social relationship needs found a less intimidating medium through 'networking' and 'interactivity' goals obtained through social media. Messaging apps also further facilitated this process. The direct cost of this was not only seen in terms of 'waste of time' but also social deprivation (in terms of real relationships, friendships and experience of loneliness), sleep deprivation, attention fragmentation and behavioural addiction (sustained by long periods of elevated dopamine level). The effects of which leave a child be sleep-deprived, confused, impulsive, irritable and anxious.

The author through this book also raises some important questions, such as, is social media a cause or just a correlate? For e.g., girls who are depressed a more likely to use social media rather than the other way around. Hence the role social media plays in relation to mental illness may have multiple interpretation in correlational terms. Another important question which the author tries to address is that does a phone-based or screen-based life led to spiritual degradation. The great rewiring of childhood referred to in this book has distanced children from their families and communities, along with the spiritual practices, human connections and set of values inculcated through it. Similarly, the ability to be in silence, stillness and focus, the meditative type of experience (samadhi) also detoriated with the over stimulation and attentional fragmentation which came along with it. However, the author in this section of the book changes his mode to a more philosophical engagement with the question, from the data driven or evidence-based approach used throughout the book. The landscape of spirituality and religiosity is more complex and culture specific. Hence the author runs the risk of being reductionist or a generalist while the author tries to connect the phone to being a block to self-transcendence or when he looks at the process of connecting with God, or a higher consciousness/ sense of meaning, as the phone is just a medium to the trivial aspects of life.

In the last part of the book the author takes a sudden shift from a 'thinker' to a 'doer', from deliberating about a problem to a problems solver. Was it necessary? Is it too drastic a shift? Well, who are we to say? The author has every right to

define the scope and goals of his literary work. However, the transition from a reflective to a pragmatic stance is not as fluid as it may seem. The author calls for collective action, normalization and moralization (condemnation) of over use of phone. As individual action may make the person feel left out from this digital revolution, which ultimately will not work. The author also speaks of technological solutions, government regulation to control this. The author also has an entire chapter dedicated to what technological companies and governments can do. In which the author does give relevant examples of laws and regulations implemented by some governments to have some sought of control and monitoring for carving out the larger social good. However, would technological companies which created this menace, be truly willing to curb it at the cost of their benefits? With governments blatantly using social media as aggregators to shape public opinion and for fostering their political ambitions, can we rely on them? The author also deliberates upon the role of schools in restoring a healthy childhood through 'phone free' interventions to 'play full' schools. Parents role has also been emphasized, where in the real world the parent should continue to be the gardener nurturing the child's interests and natural tendencies. However, in the use of phones and avoiding screen time, the parent may have to take the role of a carpenter shaping exposure and ensuring some amount of control.

Conclusion:

The author throught the book poses well placed arguments to make ones point and draws on data and research evidence to support it. However, if we view this intricate work through a critical lens, one may also point that the author runs the risk of overdoing technological determinism, engaging in oversimplification and unidirectionality while explaining mental health issues. However, the author does emphasize that the focus is on the surge in mental health issues and the weakening of psychological resources important for transitioning to adulthood and facing the challenges of adult roles. The author does not seem to imply any type of causality, but focuses on shifts in the parenting approaches and technological ecosystems, which has led to increased vulnerability to mental illness.

BOOK REVIEW

Left Behind – Surviving Suicide Loss by Nandini Murali (2023)

published by Westland Books. Pp. 187, Rs 350/- ISBN 9789357769853.

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Suicide is one of the most stigmatized and least understood phenomena in human society. Nandini Murali's *Left Behind – Surviving Suicide Loss* (2021) is a seminal work that explores the harrowing yet transformative journey of a suicide loss survivor. This book is part memoir, part social critique, and part advocacy, shedding light on the often-muted voices of those left behind in the wake of suicide. Murali's work is not merely an account of personal grief but an interrogation of the systemic and cultural silence surrounding suicide in India. Through her deeply reflective and evocative narrative, she raises fundamental questions about loss, mental health, and societal responses to suicide, making this book an essential addition to the interdisciplinary discourse on suicidology, psychology, and sociology.

The book is structured into four parts, each unfolding a journey from devastation to transformation, making it both an intimate testimony and a guide for those navigating the uncharted waters of suicide bereavement. Murali's approach is marked by profound introspection, social critique, and an unwavering commitment to breaking the silence and stigma surrounding suicide. Each chapter begins with a carefully chosen quote, an artistic choice that lends intellectual and emotional depth to the narrative, situating personal grief within broader philosophical and psychological discourses.

The book forces the reader to confront uncomfortable truths: Why does suicide remain so deeply stigmatized despite its prevalence? How does language shape our collective understanding of loss? What does it mean to truly grieve in a society that urges us to "move on"? Murali's work is a masterclass in intellectual and emotional excavation, demanding that we rethink not only how we support survivors of suicide loss but also how we, as a society, construct narratives of death, loss, and healing.

R. Raguram's foreword sets the tone for the book, emphasizing self-discovery and transformation in the aftermath of profound loss. He introduces the idea that grief, while deeply painful, can also serve as a pathway to understanding oneself and one's relationship with the world. His reflections resonate with existentialist thought, particularly Viktor Frankl's (1963) *Man's Search for Meaning,* which asserts that suffering, when met with purpose, can lead to profound personal growth.

Murali begins with a harrowing account of her husband's suicide—a moment of complete rupture that leaves her in what she describes as a state of "collapse and chaos." The first part of the book opens with five chapters and is a visceral chronicle of grief's immediate aftermath, capturing the raw, disorienting nature of suicide bereavement. Drawing from thinkers like Elisabeth Kübler-Ross (*On Death and Dyin*g, 1969) and Joan Didion (*The Year of Magical Thinking,* 2005), one can see how Murali grapples with the tension between shock and the gradual realization of loss.

She captures the emotional collapse and overwhelming chaos (*Collapse and Chaos*), the deep despair of grief *(Drowned in Grief*), and the painful process of coming to terms with reality (*The Reality Check*). The chapter *Drowned in Grief* particularly evokes Judith Butler's (2004) notion of *precarious life*, where she argues that grief exposes our fundamental interconnectedness. Murali, much like Butler, emphasizes that grief is not just an individual experience but a relational one—a concept that resonates throughout the book. Her journey through early mourning aligns with psychological models of grief, particularly Elisabeth Kübler-Ross's (1969) five stages of grief, though Murali demonstrates how suicide bereavement often does not follow a linear path.

Through Potholes to Possibilities and *The Gift of Grief* shift the focus towards transformation. Here, Murali's reflections echo the concept of post-traumatic growth (Tedeschi & Calhoun, 1996), suggesting that through grief, individuals can develop new perspectives, deeper empathy, and greater resilience. However, she does not romanticize suffering; instead, she presents grief as an ongoing negotiation with pain.

The second part of the book is where Murali shifts from personal loss to broader systemic and social issues surrounding suicide loss. *Connecting with Carla* marks a turning point in her journey, where she finds solace and solidarity in fellow survivors. This is crucial, as research indicates that peer support plays a vital role in suicide bereavement (Feigelman et al., 2012). The chapter *The 4S's*: *Stigma, Shame, Secrecy, Silence* is particularly compelling, echoing Erving Goffman's (1963) work on stigma and Michel Foucault's (1978) discussion on how silence is weaponized in discourse. Suicide remains one of the most stigmatized forms of death, and Murali deftly unpacks the ways in which survivors are often rendered invisible, their grief deemed inconvenient or excessive. Here, the book also takes on a restorative tone. In *Owning Our Stories,* Murali invokes the philosophy of Brené Brown (2010), who argues that vulnerability and storytelling are essential for healing. Through her own journey, Murali models what it means to reclaim one's narrative in the face of societal erasure. This aligns with narrative therapy (White & Epston, 1990), which emphasizes rewriting personal narratives to process trauma. Her reflections also resonate with Paulo Freire's (1970) idea of *conscientization*—awareness that transforms personal suffering into social action. The final chapter in this section, *From Pain to Purpose*, encapsulates the transition from mourning to advocacy. Here, Murali's journey mirrors Judith Butler's (2004) argument that grief can be politically transformative, turning personal loss into a collective movement for change.

The third section includes seven deeply moving narratives that showcase how suicide loss affects different people. *A Mother's Search for Meaning* and *No Time to Say Goodbye* highlight the unique grief of parents and family members, while The Neglected Mourner brings attention to those whose grief is often unrecognized,

such as friends and colleagues. These narratives underscore Thomas Joiner's (2005) *Interpersonal Theory of Suicide,* which explains how perceptions of burdensomeness and thwarted belonging contribute to suicide risk.

A particularly striking chapter is *The Psychiatrist as a Survivor of Suicide Loss*, which examines the emotional toll of suicide on mental health professionals. This aligns with Michael F. Myers' (2017) work on physician suicide, illustrating the need for better mental health support within the profession. *Playing Hide and Seek with Sorrow, Redefining Resilience,* and *Grief Cast in Plaster of Paris* further explore how grief manifests in daily life, reinforcing Bonanno's (2004) research on resilience and adaptive coping. Murali's insights highlight that resilience is not about suppressing grief but learning to integrate it into one's life.

The final section of the book is both practical and philosophical. *The Right to Grieve* is a particularly compelling chapter, as Murali argues that all grief should be acknowledged, regardless of societal expectations. Her critique is reminiscent of Butler's (2004) argument that certain lives—and, by extension, certain deaths—are deemed more grievable than others.

What to Say and What Not to Say and Mind Your Language, Please serve as important guides for navigating conversations about suicide loss. Research suggests that the language used to discuss suicide significantly impacts stigma and help-seeking behavior (Wray et al., 2016). Murali's insistence on compassionate communication reinforces the idea that language shapes our realities.

The final chapters—*The Elusive New Normal, Transforming Through Trauma, Radical Self-Care for Survivors, The Oyster and the Pearl, and Churning the Ocean of Grief*—bring the book to a powerful close. Murali emphasizes that healing is a continuous process, advocating for self-care, community support, and policy change. Her reflections align with contemporary discourse on trauma recovery (Herman, 1992), which emphasizes the need for both individual and systemic healing.

The afterword includes contributions from leading experts such as Carla Fine, Michael F. Myers, Manoj Chandran, and Aravind Srinivasan. Their reflections contextualize Murali's experiences within the broader landscape of suicide prevention and mental health advocacy, reinforcing the book's interdisciplinary significance.

Left Behind is more than a memoir; it is a socially engaged text that challenges dominant narratives on suicide, mental health, and bereavement. By blending personal experience with systemic critique, Murali contributes to a growing body of literature that demands a more compassionate and evidence-based approach to suicide loss. The book is a testimony to the urgent need to reframe our understanding of grief—not as an individual pathology but as a relational, cultural, and political experience that requires collective acknowledgment and support.

Murali's writing is both poetic and unflinchingly honest, marked by a rare blend of intellectual rigor and deep emotional resonance. The decision to begin each chapter with a quote adds depth and intertextual richness, allowing readers to see her grief through multiple lenses—philosophical, psychological, and literary. This stylistic choice is reminiscent of Hélène Cixous' *The Newly Born Woman* (1975), where personal narrative becomes a means of critiquing broader socio-cultural norms. In *Left Behind,* Murali adopts a similar approach, refusing to let grief be reduced to a clinical checklist and instead portraying it as a deeply embodied, evolving process that cannot be rushed or neatly resolved.

Unlike conventional self-help books, *Left Behind* refuses easy resolutions. Instead, it invites the reader to sit with discomfort, to question dominant narratives around grief, and to consider how society can better support those left behind after suicide. This refusal to offer simple closure is perhaps the book's greatest strength—it respects the complexity of grief and honors its enduring presence in the lives of survivors.

While the book is deeply insightful, it could have further explored cross-cultural perspectives on suicide bereavement. Comparative insights from other

collectivist societies, such as Japan's deeply ingrained cultural attitudes toward suicide (*kamikaze, seppuku*), or indigenous healing practices, could have enriched the discussion. Additionally, a more detailed policy analysis would have strengthened the call for reform, particularly in the Indian context, where mental health infrastructure remains inadequate, and suicide prevention policies are often reactive rather than proactive.

Nevertheless, *Left Behind* is essential reading not just for survivors of suicide loss but for anyone seeking a deeper understanding of grief, resilience, and the social constructs that shape our mourning. At a time when mental health remains a global crisis, Murali's work is a clarion call for greater awareness, empathy, and systemic change. The book forces us to confront uncomfortable but necessary questions: How do we, as individuals and as a society, create spaces where grief is acknowledged rather than silenced? How can we change the language around suicide to foster compassion rather than stigma? What does it mean to truly bear witness to another's pain without seeking to 'fix' or erase it?

These are the questions that *Left Behind* compels us to ask—and they are questions that demand urgent answers. In a world that often demands resilience without offering care, Murali's work stands as a powerful testament to the necessity of radical empathy and collective healing. The challenge now is not just to read *Left Behind*, but to carry its lessons forward, ensuring that those who grieve do not do so in isolation, and that the silence surrounding suicide is broken, not through sensationalism, but through meaningful, systemic change.

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BOOK REVIEW

A Book of Light: When a Loved One Has a Different Mind by Jerry Pinto (2016) Speaking Tiger Books, New Delhi Pp. 176.

Genre: Non-fiction, Mental Health, Anthology

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A Book of Light: When a Loved One Has a Different Mind is a powerful and deeply personal anthology compiled by Jerry Pinto. Following the acclaim of his semi-autobiographical novel, Em and the Big Hoom, which explored his own experiences of growing up with a mother who had bipolar disorder, Pinto broadens the scope in this collection. This book brings together a diverse range of narratives from individuals who have lived alongside loved ones battling various mental health conditions.

Mental health remains a subject often clouded by stigma, particularly in cultures where psychological struggles are either dismissed or spoken about in whispers. Through this anthology, Pinto fosters an open and compassionate dialogue, shedding light on the realities faced by caregivers and family members. Rather than offering solutions or guidance on dealing with mental illness, the book provides an unfiltered and deeply human account of their experiences. It highlights the resilience, patience, and love required to support someone with conditions like schizophrenia, bipolar disorder, severe depression, and other psychiatric challenges.

Themes and Analysis

A central theme in A Book of Light is the far-reaching impact of mental illness—not only on those diagnosed but also on their families, friends, and caregivers.

The book shifts its focus beyond the individual's struggle, highlighting the experiences of parents, siblings, children, and partners who find themselves navigating an often overwhelming and emotionally exhausting reality. Through these narratives, the anthology explores the complexities of caregiving, shedding light on the love, helplessness, frustration, and even resentment that can emerge in such relationships.

One of the book's most compelling aspects is its refusal to romanticize suffering. Stories about mental illness often fall into extremes—either dramatising the condition or portraying it as a journey that ultimately results in personal growth or redemption. However, A Book of Light resists these simplifications. The contributors share their experiences with raw honesty, capturing moments of warmth and connection but also exposing the painful, unpredictable, and sometimes destructive nature of mental illness.

Another critical theme in the book is the stigma surrounding mental health. Many of the authors describe the reactions of their families, communities, and even medical professionals, revealing the widespread lack of understanding and the systemic shortcomings of mental healthcare. The anthology raises an important question: Why is mental illness treated so differently from physical health conditions? If a loved one were diagnosed with cancer or heart disease, they would likely receive empathy and support. Yet, when it comes to schizophrenia, bipolar disorder, or severe depression, families often find themselves isolated, forced to deal with the challenges in silence.

Identity, Agency, and Emotional Boundaries

The book explores complex questions about identity and agency, particularly in the context of severe mental illness. When someone undergoes drastic behavioural and personality changes due to their condition, their loved ones are often left grappling with difficult questions: How do we differentiate the person from their illness? At what point does caregiving turn into self-sacrifice? These dilemmas are at the heart of many narratives in A Book of Light, making it more than just a collection of personal experiences—it is a profound exploration of relationships, emotional boundaries, and resilience.

Writing Style

Jerry Pinto's role as the curator allows each contributor's voice to remain authentic and emotionally resonant. The book does not impose a singular writing style, yet the stories flow seamlessly, creating a sense of unity. The deeply personal and reflective tone, often resembling journal entries or heartfelt letters, makes the narratives feel intimate and engaging.

Despite tackling difficult themes, the book remains accessible. It steers clear of technical jargon and clinical descriptions, instead focusing on lived experiences that are easy to comprehend but emotionally profound. Some accounts are deeply painful, providing an unfiltered look at the realities of mental illness. However, there are also moments of tenderness and resilience, illustrating that love and hope persist even in the darkest times. The book's ability to balance sorrow with strength makes it a powerful and thought-provoking read.

These moments emphasise that even amid hardship, there is room for understanding and acceptance. However, the book also presents a sobering reality: love, no matter how deep, is not always enough to "heal" someone struggling with mental illness. This is a difficult truth that many caregivers must come to terms with. At times, the most compassionate choice is to prioritise their well-being while continuing to support their loved one in the ways they can.

Impact and Relevance

Beyond its literary value, A Book of Light holds significant social importance. In India, where discussions about mental health remain limited and often stigmatised, works like this help challenge taboos and encourage open dialogue. The country's inadequate mental health infrastructure, coupled with societal prejudices, frequently leaves individuals and families feeling isolated in their struggles. By sharing these deeply personal stories, Pinto and the contributors not only create awareness but also offer validation and solidarity to those facing similar challenges.

The book also reinforces the idea that mental illness does not define a person. Many of the narratives capture moments of joy, humour, and deep connection between caregivers and their loved ones, reminding readers that these relationships are not solely shaped by struggle. Additionally, A Book of Light underscores the importance of mental health advocacy. It sheds light on the shortcomings of India's mental healthcare system, highlighting the urgent need for policy reforms, improved psychiatric care facilities, and greater public awareness. While the book does not directly position itself as a call to activism, its emotional depth naturally encourages readers to reflect on these critical issues.

Final Verdict

A Book of Light: When a Loved One Has a Different Mind is a powerful, thought-provoking, and essential read for anyone interested in mental health, caregiving, or human relationships. It is not a book that offers easy answers or uplifting conclusions—it requires emotional engagement from the reader and presents the realities of mental illness with unfiltered honesty. However, it is precisely this rawness that makes it so impactful.

Jerry Pinto, through this book, proves his ability to bring attention to experiences that are often overlooked or misunderstood. This anthology is not only valuable for those who have personally dealt with mental illness in their families but also for anyone who seeks a deeper understanding of love, resilience, and the complexities of caregiving.

c. REVIEW

Saving Lives: A Review of the National Task Force on Mental Health and Well-being of Medical Students

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Introduction

A suicide is particularly tragic because it is an untimely death that is preventable. A death by suicide among those who are in training to save lives, as are medical students, is even more tragic. Ostensibly a death by one's own hands, in reality a suicide represents a systemic failure in access to and provision of meaningful, compassionate, and holistic support at multiple levels. The 153 page, 12 chapter *National Task Force on Mental Health and Well-being of Medical Students*, published in June 2024, is a much needed resource addressing the vital need to provide medical students in India with such support.

The author is the National Medical Commission (NMC), and the task force is chaired by Dr. Suresh Bada Math, Professor of (Forensic) Psychiatry at NIMHANS, Bangalore, who also heads both Telemedicine and the Digital Academy at NIMHANS. Professors from various medical colleges in India (Ahmedabad, Bangalore, Chandigarh, Jabalpur, Jamnagar, Lucknow, New Delhi, Rohtak, Sonipat) and an NMC member comprise the task force. The report starts with a reminder that the primary role of medical colleges is to provide quality education and training to medical students; in other words, to nurture the next generation of physicians, better called "compassionate healers" (p. iv).

Method

A three-pronged approach was used to collect most of the data that informs this report: Firstly, focused group discussions (FGDs) were conducted with many stakeholders in medical colleges, namely, students, department heads, and administrators, to uncover the challenges and best practices in provision of mental health support to medical students. Secondly, an online survey on student mental health and well-being was administered to both undergraduate (*n*=25,590) and postgraduate (*n*=5,337) medical students and faculty members (*n*=7,035). Thirdly, suggestions were obtained from members of important professional bodies including medical students' associations (i.e., Association of Doctors and Medical Students [ADAMS], Federation of Resident Doctors Association India [FORDA], Resident Doctors Association [RDA]). The members of the task force also interacted with parents of medical students. Another method employed was visits to medical colleges and inspections of key areas such as duty rooms, hostels, and cafeterias. Additionally, the task force incorporated insights from government policy and strategy documents such as the National Suicide Prevention Strategy (2022). Group and one-on-one interactions as well as email correspondence with medical students continued throughout the process, with students also given the opportunity to provide feedback whilst the recommendations were being drafted.

Context

As stated in the report, the aim in medical education is to empower medical students such that they have the requisite knowledge, skills, ethical stance, compassion, and resilience that are crucial for successfully meeting the challenging demands of the medical profession, and of life in general. In one of the messages prefacing the report, Dr. Vijay Oza, President of the Postgraduate Medical Education Board, highlights the vulnerability of medical students who are forced to fill "critical gaps in the public healthcare ecosystem", enduring "immense stress and workload", "in a challenging and often toxic environment", that too, "often without the necessary support and resources" (p. vii c). Intensity of training schedules, excellence expectations, sleep deprivation, continuous exposure to morbidity and mortality, coupled with inadequate availability and/

or access to (high quality) support in medical education may exacerbate susceptibility to mental health problems among medical students (Malhotra et al., 2021). Medical students have an elevated risk of mental health problems including suicidality, a conclusion well noted in both non-Indian (Dyrbye et al., 2006; Grant et al., 2013; Wilkinson, 2023) and Indian research literature (Malhotra et al., 2021).

Contributions

The results of the online survey (Chapter 10), predictably yet regrettably, are in line with the extant research literature. Thus, more than a quarter of the UG medical students (27.8%) and 15.3% of the PG medical students self-reported that they had a diagnosed mental health problem. Moreover, 16.2% of the UG medical students and as many as 31.2% of the PG medical students stated that they had engaged in suicidal ideation. Suicidality is higher among the medical students in this survey as compared to an oft-cited meta-analytic global rate of 11.1% for suicidal ideation among medical students (see Rotenstein et al., 2016). Rotenstein et al. (2016) have reported that prevalence estimates of suicidal ideation among medical students, extracted from 24 studies representing 15 countries (n=21,002), ranged from 7.4% to 24.2%, with a pooled rate of 11.1%. In comparison, Indian studies such as Goyal et al. (2012) have reported an egregiously high suicidal ideation rate of 53.6% among UG medical students, albeit with a far smaller sample size (n=265) drawn from a single medical college in Delhi, and with far lower rates of serious contemplation (4.9%) and attempted suicide (2.6%). In fact, the latter two rates are higher in the task force conducted online survey: One in 10 PG medical students had made suicidal plans (10.6%) and 4.4% had attempted suicide in the previous 12 months. Importantly, as per the task force online survey, only 5.1% of the UG medical students had sought professional help with regard to self-harm or suicidal ideation. In like vein, as many as 41.6% of the PG medical students were not comfortable seeking help within their medical college hospital for mental health-related problems, primarily because of confidentiality concerns (43.7%), followed by stigma (20.3%).

There is a wealth of information on prevention of suicides among medical students in the report. In this regard, Chapter 11 on Recommendations is especially

important. The task force has used the Universal, Selective, and Indicated (USI) prevention model in organising their recommendations, along with a student-centric approach in drafting and finalising the recommendations. The USI model was first proposed by Gordon (1983) and is widely accepted in the prevention literature as well as policy and action. Gordon (1983) defined universal measures as desirable and applicable for everybody, wherein the "benefits outweigh costs and risks for everyone" (p. 108). Selective measures, in comparison, are for the subgroup that is at risk; whereas, indicated measures are for the still smaller number of persons who are already displaying a risk factor or condition (Gordon, 1983). Accordingly, the task force has outlined universal strategies applicable for all (a) medical colleges (43 measures), (b) medical students (10 suggestions), (c) medical students' family members (6 suggestions), and (d) faculty members (7 suggestions). At the selective level, the task force has recommended identification of medical students who are high risk, referral, and accommodative measures. At the indicated level, the task force has advocated measures for medical students with mental health problems and those with a recent history of attempted suicide.

Many of the universal strategies for medical colleges are aimed at directly promoting student welfare and wellbeing. A table created for the purpose of this review illustrates these universal strategies (refer to Table 1).

Table 1. The task force recommended universal strategies for medical colleges aimed at directly promoting student welfare and wellbeing.

Level	Overall Aim	Examples of Recommended Measures
Universal: For all Medical Colleges	Educating medical students about mental health & promoting help-seeking	• A five-day orientation programme underscoring the importance of prioritising mental health and wellbeing, and information about campus resources such as counselling services. • A student-compiled Induction Manual. • Making Psychiatry a compulsory course in the UG curriculum. • Introducing a course entitled the Basics of Mental Health and Wellbeing. • Relevant training in MOOC format through the Swayam portal. • Observing World Mental Health Day (October 10), World Suicide Prevention Day (September 10), and Drug Prevention Day (June 26) among others.
	Providing mental health services to medical students	• 24/7 Tele Mental Health Assistance through the Tele-MANAS initiative of the Ministry of Health and Family Welfare. • Counsellor-student ratio of 2:500. • Separate ward/clinic/investigation facilities for students at no cost or subsidised cost.

Level	Overall Aim	Examples of Recommended Measures
	Safeguarding medical students from harm	• Anti-ragging measures. • CCTV monitoring and appropriate security measures. • Reducing access to means for suicide on college campus. • Gatekeeper training programme. • Regulation of duty hours per week: maximum of 74 hours, no more than 24 hours at a stretch, only one 24-hour duty, five 10-hour shifts, and one day off. • Regulation of type of duty: Ensuring that residents' worktime is spent in patient care and is protected from infringements such as clerical work and supportive tasks. • Reducing workplace stress by increasing the number of PG and super-speciality seats in India. • Ensuring adequate grievance redressal systems within the college. • An NMC operated e-complaint portal.
	Increasing professional support for medical students	• Mentor-mentee programme. • Hiring more senior residents. • Ensuring that there are no "ghost faculty". • Clinical linguistic proficiency classes for effective clinical practice in the local language. • Trial observership for UG students and trial residency for PG students. • Digitising the library and creating an online library system. • Guest faculty to augment student learning. • Liaison with local chapters of professional bodies such as the Indian Medical Association (IMA). • Career guidance and campus recruitment. • Establishment of Centres for Innovation, Incubation, Collaboration, Accelerator, Research, Entrepreneurship, and Medical Device Development (ICARED).
	Ensuring basic services and quality facilities	• Comfortable rest areas for students on duty (which one must add, need to be safe [note the tragic instance of the Kolkata doctor rape and murder]). • A 24/7 cafeteria for all on-duty doctors and hostel residents, with monitoring of food safety and quality. • Clean washrooms. • Safe drinking water. • Adequate and well-maintained hostel facility, preferably with single occupancy rooms. • Mess Committee for hostel mess, with student members. • Inclusive menus in the hostel mess that cater to different dietary preferences and meet nutritional needs.
	Reducing exam-related stress among medical students	• Reintroducing supplementary exams. • Displaying exam results without using student names. • Exploring the use of unbiased, mixed systems of grading, both traditional marking/grading and the Pass/Fail system.

Level	Overall Aim	Examples of Recommended Measures
	Reducing financial stress among medical students	• Reasonable fees for student hostels. • Making joining the hostel mess optional. • Removing fees for semester repetitions. • Policy changes with regard to bonds. • A uniform stipend policy, adjusted periodically for dearness allowance, with timely and regular disbursement.
	Taking care of the needs of students' parents, families and childcare	• Including family members of UG and PG medical students during the one-day induction programme within respective departments. • Parent-faculty meetings at least once a year. • Family accommodation for married students. • Onsite childcare facilities. • Compliance with the Maternity Benefit (Amendment) Act, 2017.
	Catering to the holistic wellbeing of medical students	• Access to value-added optional courses through offline, online or hybrid means. • Integrating Yoga in the curriculum. • Access to varied sports activities. • Instituting a Samajika *Sanskriti Campus* Council for participating in arts and cultural activities. • Liaison with community groups such as Rotary Clubs, Lions Clubs, and NGOs. • A 10-day vacation at least once a year for both UG and PG medical students on a rotational basis.

Similarly, the universal strategies for medical colleges include measures that are aimed at promoting the welfare and wellbeing of faculty members. Medical colleges are systems: any system is characterised by strong interdependencies. Undoubtedly, the wellbeing of each group of stakeholders is interdependent with the wellbeing of other groups of stakeholders in the college. Examples of measures specifically promoting faculty welfare and wellbeing include the following: addressing teachers' apprehensions about adverse outcomes arising from student grievances, instead promoting a culture of empathic respect where teachers feel validated and appreciated; a uniform pay scale aligned with the current Pay Commission; prohibition of private practice and institution of a non-practicing allowance; adoption of AIMS, New Delhi, faculty policies; a uniform retirement policy; a uniform pension scheme; rotational headship; and establishing a national Centre for Training of Medical Teachers (CTMT).

Selective measures, at the next level, first and foremost are focused on early identification of at-risk medical students. The task force has recommended

that teachers use the 5As to monitor early signs of distress among students: academic decline or difficulty, addiction (substance & non-substance), actions (behavioural changes), absenteeism, and asocialisation. Referral protocol must ensure privacy and confidentiality of students identified as high risk. Examples of accommodative measures are flexible academic schedules and provision of additional academic resources and support. Accessible deaddiction services and a peer support model are other measures recommended at the selective level. At the indicated level, the task force has recommended a supportive and inclusive environment which permits recovery and wellbeing among students with mental health problems in alignment with the Mental Healthcare Act 2017. Each medical college must have accessible, confidential, free-of-cost mental health services for medical students with mental health problems through a well-functioning Department of Psychiatry that offers not just crisis intervention services but also proactive preventive services. Each medical college must also have a Mental Health and Wellbeing Committee. The task force has also detailed a Fitness to Practice Protocol at the indicated level, and NMC regulations for mandatory reporting of suicidal attempts and death by suicide.

Overall, the report is replete with insightful suggestions and tips. For example, noting in Chapter 2 that suicide is not aggravated by talking to a person about it. Or for example, clarifying the use of nonstigmatising language to describe terms related to mental health problems and suicide: "It is essential to avoid using terminology that can stigmatize, incentivize, or glorify suicide" (p. 3). Chapter 9 on evidence-based interventions is also very useful with an excellent summary of mindfulness-based, stress management, resilience training, online, and yoga interventions. However, the task force has incisively pointed out that these interventions target the person whilst omitting to take into account the systemic issues in medical education that play a key role in the wellbeing of medical students. Therefore, they justifiably advocate a combined approach which embraces both individual and systemic features.

The seven annexures also deserve mention. The orientation programme schedule of sessions and activities, Indian and global resources for suicide prevention, Yoga modules for mental health and wellbeing, resilience after tragedy, legal considerations relevant to suicide attempts, myths related to suicides, and NMC

anti-ragging regulations are the annexures in the report. The annexures add to the comprehensiveness and exhaustiveness of the report.

Concerns

Of concern in the report are the conflicting findings obtained across the FGDs with different stakeholder groups (Chapter 10). Undergraduate students shared their concerns about the quality of teaching, the lack of classroom discussion, and that many teachers did not make eye contact with students whilst teaching. They also stated that teachers and administrators were insensitive towards students' mental health needs. The postgraduate medical students also emphasised the insensitivity of teachers towards students' needs, excessive students' workload, and that leave requests were frequently denied. Faculty were unavailable due to private practice or were ghost faculty. In sharp contrast, faculty members and administrators insisted that students faked or exaggerated mental health problems and suicidal ideation to get out of clinical and academic responsibilities. Faculty members also reported high stress from a variety of factors including student and parent complaints. They stated that they had gradually lost interest in teaching. Clearly, these findings indicate that each party is feeling misunderstood, invalidated and (to some extent) mistreated by the other. This is a fertile ground for escalation in stress and reduction in wellbeing and needs urgent redressal. Suicide prevention requires that members of each stakeholder group experience valued connections with other stakeholders. Another suggestion is that alongside Yoga, Vedanta could be used to integrate Indian Knowledge Systems into suicide prevention (see Parthasarathy, 2018), with both students and teachers as beneficiaries.

Many of the recommendations are optimal and not currently feasible such as single occupancy hostel rooms or sleeping for 7-to-8 hours a day when the recommended duty hours in the report itself are gruellingly excessive, well beyond what is articulated in the Residency Scheme 1992. Recommendations for policy changes represent a noteworthy start but remain on paper until the policy changes are effected and may perhaps not benefit current medical students or their immediate juniors. Though there is clarity and accuracy in the statistical analyses used for the online survey, it is at a very basic descriptive level and

no standardised psychological tests were embedded in the survey. Lastly, the creditability of the task force team notwithstanding, the task force could perhaps have benefited from a multidisciplinary team and approach.

Conclusion

Striving for living is fundamental to all living beings, including human beings; yet globally suicide is one of the top 10 causes of death, and the second most frequent cause of non-illness death (Nordentoft, 2011). According to WHO's fact sheet on suicide (29 August 2024), suicide is the third leading cause of death among youth (15-to-29 yr). A suicide indicates a ruptured connection with one's own deeper self and the helplessness and hopelessness experienced in connecting meaningfully with the external world. It is imperative that those who have committed to saving lives, as have medical students, are supported in high quality ways to build resilience and capacity such that their connections with their internal and external worlds contribute to their sustained wellbeing. It is vital that we safeguard the lives of our medical students, who are working so hard to safeguard the lives of those in their current and future care. This report is a clear step in that direction.

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TRIBUTE

In Memory of Dr. Anita Ghai: A Pioneering Voice for Disability Rights in India

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Professor (Dr.) Anita Ghai's legacy stands as a testament to the power of intersectional advocacy and scholarly activism. As a distinguished academic, disability rights advocate, and feminist scholar, she was among the few who framed the very landscape of disability studies in India while challenging deeply entrenched societal prejudices. As a professor at the School of Human Studies at Ambedkar University Delhi, she mentored countless students and scholars, inspiring a new generation to approach disability studies with radical empathy. Through her academic scholarship, activism and lived experience as a woman with polio, she was among the few scholars who have established a rigorous perspective on discussions of disability rights, gender, sexuality and social justice in India.

Her groundbreaking works include *(Dis)embodied Form: Issues of Disabled Women* (2007), *Rethinking Disability in India* (2015) and *Disability in South Asia* (2018). These books, along with numerous publications in prestigious journals and presentations at forums, have played a key role in shaping understandings of disability in the local, national and global south context. She compellingly argued that disability cannot be separated from other social categories like gender, class, and caste; such insights have profound implications for both theory and practice. What made Dr. Ghai's work particularly

powerful was her ability to weave together academic insight with personal narrative. In her writings and lectures, she shared her experiences navigating physical barriers and social prejudices with unflinching honesty, using her story to illuminate broader structural issues. They bring to the forefront the embodied nature of knowledge; how knowledge is often tied to our physical bodies, sensory capacities, and embodied experiences – an aspect much ignored by traditional epistemologies that frame our social and political systems today. Such theories not only challenge traditional normative knowledge theories, they push the boundaries of reconceptualising notions of normalcy, rationality and the epistemic subject, exposing the exclusionary nature of the politics of knowledge towards alternate ways and an inclusive life world.

As an activist, Dr. Ghai boldly spoke about challenges concerning accessibility in India. In her lectures and discussions, she highlighted the daily challenges in the lives of people with disabilities due to the inaccessible public and private infrastructure. She also brought to light how accessibility was crucially linked with citizenship rights and had on several occasions spoken against token efforts by governments and institutions that do little to improve accessibility to education, employment, public infrastructure (to name a few) for people with disabilities. Very vocal in her criticism of the charity and medical model of disability, she was among the few feminist voices who set the ground for the care-based social model has shaped and reshaped much theoretical and policy discussions in India. While her work is focused on South Asia, particularly India, it is also relevant to other countries in South and Southeast Asia, where disability issues overlap with similar socio-economic and cultural challenges. In bringing out the specific concerns and experiences of disabled women, her contribution to discussions on disability, gender and sexuality through workshops and courses makes a strong case for a sexuality education beyond sex and marriage.

As we honor Dr. Ghai's contributions, we carry forward a hope and a vision of a more inclusive world. She reminds us that disability rights are human rights, that accessibility is a matter of justice rather than charity, and that the voices of disabled people must be centered in conversations

about disability. Her life illustrates both personal courage and collective solidarity towards social change. Her contribution to disability studies, feminist scholarship, and human rights advocacy continues to challenge us to question our assumptions, confront our prejudices, and work toward a world where every person's dignity and potential is recognized and celebrated. In remembering Dr. Anita Ghai, we honor not just an individual but a movement; a movement toward justice, inclusion, and human dignity that must continue with renewed vigor. May her wisdom, courage, and commitment to justice inspire future generations of scholars and activists to carry forward the work of creating a more equitable and accessible world for all.

Rest in Power, Anita maám !

SUICIDE PREVENTION MENTAL HEALTH HELPLINE NUMBERS

State Wise List of Mental Health and Suicide Prevention Helpline Numbers:

Compiled by Arpita Naik.

Andaman & Nicobar

1. Maitreyi: 0413-2339999
2. TeleMANAS: 1-800-891-4416/14416 (24x7)

Andhra Pradesh

1. Health Helpline: 104
2. TeleMANAS: 1-800-891-4416/14416 (24x7)

Arunachal Pradesh

1. TeleMANAS: 1-800-891-4416/14416

Assam

1. TeleMANAS: 1-800-891-4416/14416

Bihar

1. Arogya Seva: 104
2. TeleMANAS: 1-800-891-4416/14416 (24x7)

Chandigarh

1. Asha Helpline: +91-172-2735436, +91-172-2735446
Timing: Mon-Sat (8 AM-7 PM)
2. Suicide Helpline: 0172-2660078, 0172-2661078

Chhattisgarh

1. Chikitsa Salah: 104
2. TeleMANAS: 1-800-891-4416/14416 (24x7)
3. Jeevan Suicide Prevention: 0657-6453841, 0657-6555555, 9297777499, 9297777500
Timing: Daily (10 AM-6 PM)

Delhi

1. Sumaitri: 011-23389090, 011-46018404, 9315767849
Timing: Mon-Fri (2 PM-10 PM), Sat-Sun (10 AM-10 PM)
2. Sanjeevani: 011-26862222, 011-26864488, 011-40769002
Timing: Mon-Sat (10 AM-5:30 PM)
3. Snehi: 011-65978181
Timing: Daily (2 PM-6 PM)
4. Fortis Stress Helpline: +91-8376804102 (24x7)

Goa

1. COOJ Mental Health Foundation: +91-832-2252525, +91-98225-62522
Timing: Mon-Fri (3 PM-7 PM)
2. TeleMANAS: 1-800-891-4416/14416

Gujarat

1. Jeevan Aastha Helpline: 1800-233-3330 (24x7)
2. TeleMANAS: 1-800-891-4416/14416

Haryana

1. TeleMANAS: 1-800-891-4416 / 14416

Himachal Pradesh

1. TeleMANAS: 1-800-891-4416 / 14416
2. 104: Timing: 8 AM-8 PM

Jammu & Kashmir

1. TeleMANAS: 1-800-891-4416 / 14416
2. 104: (24x7)

Jharkhand

1. TeleMANAS: 1-800-891-4416 / 14416

Karnataka

1. SAHAI: 080-25497777, +91-9886444075
Timing: Mon-Sat (10 AM-8 PM)
2. Mitram Foundation: 080-25722573, +91-9019708133
Timing: Daily (10 AM-4 PM)
3. NIMHANS Centre for Well-Being: 080-26685948, +91-9480829670
4. Arogya Sahayavani: 104 (24x7)

Kerala

1. Thanal Suicide Prevention Centre: 0495-2760000, +91-9495714262
Timing: Daily (10 AM-6 PM)
2. Maithri Kochi: 0484-2540530
Timing: Daily (10 AM-7 PM)
3. DISHA: 1056 / 104 (24x7)

Ladakh

1. TeleMANAS: 1-800-891-4416 / 14416

Madhya Pradesh

1. Sanjivani: 1253, 0761-2626622
2. TeleMANAS: 1-800-891-4416 / 14416

Maharashtra

1. The Samaritans Mumbai: +91-84229-84528, +91-84229-84529, +91-84229-84530
Timing: Daily (3 PM-9 PM)
2. Vandrevala Foundation: 1860-266-2345, 1800-233-3330 (24x7)
3. BMC Mental Health Helpline: 022-24131212 (24x7)
4. AASRA: 9820466726 (24 x 7)
5. Snehi: 9582208181 (10am – 10pm, all days)
6. Fortis Mental Health: 8376804102 (24 x 7)
7. iCALL TISS Helpline: 9152987821, 022-25521111 (Monday to Saturday, 8 AM to 10 PM)

Madurai

1. SPEAK2us: 9375493754

Manipur

1. TeleMANAS: 1-800-891-4416 / 14416

Meghalaya

1.TeleMANAS: 1-800-891-4416 / 14416

Mizoram

1. TeleMANAS: 1-800-891-4416 / 14416

Odisha

1. TeleMANAS: 1-800-891-4416 / 14416
2. Life: +91-78930-78930

Punjab

1. Medical Advice Helpline: 104 (24x7)
2. TeleMANAS: 1-800-891-4416 / 14416

Rajasthan

1. Hope Helpline for Students: 0744-2333666, 0744-2414141 (24x7)
2. TeleMANAS: 1-800-891-4416 / 14416

Sikkim

1. TeleMANAS: 1-800-891-4416 / 14416

Tamil Nadu

1. Sneha India Foundation: 044-24640050, 044-24640060

Timing: Mon-Sun (8 AM-10 PM)

Telangana

1. TeleMANAS: 1-800-891-4416 / 14416

Tripura

1. Suicide Prevention: +91-98631-00639
2. TeleMANAS: 1-800-891-4416/14416

Uttarakhand

1.Medical Consultation Helpline: 104 (24x7)

2.TeleMANAS: 1-800-891-4416 / 14416

Uttar Pradesh

1.TeleMANAS: 1-800-891-4416 / 14416

West Bengal

1.Lifeline Foundation: 033-24637401, 033-24637432

Timing: Mon-Sun (10 AM-6 PM)

CONTRIBUTORS' BIONOTES

Contributors

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Abhina Jose is a practicing counselling psychologist, having M.Phil in Geriatric counselling, and Ph.D. in REBT psychotherapy. Presently, she is Associate Dean and Professor of Human Resources, at Welingkar Institute of Management Development and Research, Mumbai. She has spent extensive tenure working in the field of education. She provides services as a 'Consulting Psychologist' and 'HR consultant' to many organizations. Having delivered several lectures and conducted workshops in organizations of repute, she also conducts personal and group counseling programs, employee training programs, corporate training programs and weekend workshops on effective self-management. She has handled many projects on competency management, Assessment & Development Centre, Student-Centric teaching method and Organizational development. She is a recipient

of several awards such as 'Young Doctoral Fellowship' by ICSSR, Linnaeus-Palme scholarship, Sweden, 'Best Academic Performance',' Best Mentor', 'Outstanding Achievement', 'Best Literature Award' by Maharashtra Foundation and Maharashtra Sahitya Parishad amongst them. She writes both, fiction and non-fiction and authored seven books till date. She has more than 100 articles and research papers to her credit published in magazines and national and international journals.

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Arpita Naik is a UGC Senior Research Fellow and PhD scholar in the Department of Applied Psychology and Counselling Centre at the University of Mumbai. She is also working as an Assistant Editor for the journal Sambhashan. Holding a Master's degree in Psychology.

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Aparna Satpute is an Assistant Professor at the Department of Psychology, Savitribai Phule Pune University, Pune, Maharashtra, India. Beyond teaching and research, Aparna has contributed to curriculum development for under- graduate as well as post-graduate psychology programs at various universities and has been a content developer for prominent online learning platforms. Her diverse experience also encompasses involvement in psychological testing, conducting workshops, delivering expert- talks and counseling.

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Ankita Singh is a third-year undergraduate student at FLAME University, Pune, where she is majoring in Psychology and minoring in Human Resource Management. She has a strong interest in understanding human behaviour and mental health, and she's passionate about finding ways to apply psychological principles to real-world challenges. Her work has been featured in Telangana Today and The Sentinel.

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Style Guide

Citation Style: Author-Date Referencing System of *The Chicago Manual of Style* (Chapter 15, 17th edition)

Authors should adopt the in-text parenthetical Author-Date citation system from Chapter 15 of the *Chicago Manual of Style* (17th edition).

Some examples are listed below

1) BOOKS

REFERENCE LIST ENTRY:

Book references should be listed at the end of the paper as "Works Cited" in alphabetical order.

Single Author

Carson, Rachel. 2002. *Silent Spring*. New York: HMH Books.

Dual Authors

Adorno, Theodor, and Max Horkheimer. 1997. *Dialectic of Enlightenment*. London: Verso.

Multiple Authors

Berkman, Alexander, Henry Bauer, and Carl Nold. 2011. *Prison Blossoms: Anarchist Voices from the American Past*. Cambridge: Harvard University Press.

Anthologies

Petra Ramet, Sabrina, ed. 1993. *Religious Policy in the Soviet Union*. New York: Cambridge University Press

IN-TEXT CITATION:

References to the specific pages of the books should be made in parenthesis within the text as follows:

(Carson 2002, 15)
(Adorno and Horkheimer 1997, 23)
(Berkman, Bauer, and Nold 2011, 100–102)
(Sabrina 1993, 122–135)

Please refer to 15.40–45 of *The Chicago Manual of Style* for further details.

2) CHAPTERS FROM ANTHOLOGIES

REFERENCE LIST ENTRY:

Chapters should be listed in "Works Cited" in alphabetical order as follows:

Single Author

Dunstan, John. 1993. "Soviet schools, atheism and religion." In *Religious Policy in the Soviet Union*, edited by Sabrina Petra Ramet, 158–86. New York: Cambridge University Press

Multiple Authors

Kinlger, Samual A., and Paul H. De Vries. 1993. "The Ten Commandments as values in Soviet people's consciousness." In *Religious Policy in the Soviet Union*, edited by Sabrina Petra Ramet, 187–205. New York: Cambridge University Press

IN-TEXT CITATION:

(Dunstan 1993, 158–86)

(Kingler and De Vries 1993, 190)

Please see 15.36 and 15.42 of *The Chicago Manual of Style* for further details.

3) E-BOOK

REFERENCE LIST ENTRY:

List should follow alphabetical order. The URL or the name of the database should be included in the reference list. Titles of chapters can be used instead of page numbers.

Borel, Brooke. 2016. *The Chicago Guide to Fact-Checking*. Chicago: University of Chicago Press. ProQuest Ebrary.
Hodgkin, Thomas. 1897. *Theodoric the Goth: The Barbarian Champion of Civilisation*. New York: Knickerbocker Press. Project Gutenberg. http://www.gutenberg.org/files/20063/20063-h/20063-h.htm
Maalouf, Amin. 1991. *The Gardens of Light*. Hachette Digital. Kindle.

IN-TEXT CITATION:

(Borel 2016, 92)
(Hodgkin 1897, chap. 7)
(Maalouf 1991, chap. 3)

4) JOURNAL ARTICLE

REFERENCE LIST ENTRY:

List should follow alphabetical order and mention the page range of the published article. The URL or name of the database should be included for online articles referenced.

Anheier, Helmut K., Jurgen Gerhards, and Frank P. Romo. 1995. "Forms of Capital and Social Structure in Cultural Fields: Examining Bourdieu's Social Topography." *American Journal of Sociology* 100, no. 4 (January): 859–903.

Ayers, Lewis. 2000. "John Caputo and the 'Faith' of Soft-Postmodernism." *Irish Theological Quarterly* 65, no. 1 (March): 13–31. https://doi.org/10.1177/002114000006500102

Dawson, Doyne. 2002. "The Marriage of Marx and Darwin?" *History and Theory* 41, no. 1 (February): 43–59.

IN-TEXT CITATION:

Specific page numbers must be included for the parenthetical references within texts
(Anheier, Gerhards, and Romo 1995, 864)
(Ayers 2000, 25-31)
(Dawson 2002, 47-57)

For further details please see 15.46–49 of *The Chicago Manual of Style*.

5) NEWS OR MAGAZINE ARTICLE

REFERENCE LIST ENTRY:

List should follow alphabetical order and need not mention the page numbers or range. The URL or name of the database should be included for online articles referenced.

Hitchens, Christopher. 1996. "Steal This Article." *Vanity Fair*, May 13, 1996 https://www.vanityfair.com/culture/1996/05/christopher-htichens-plagiarism-musings

Khan, Saeed. 2020. "1918 Spanish Flu cure ordered by doctors was contraindicated in Gandhiji's Principles". *Times of India*, April 14, 2020. http://timesofindia.indiatimes.com/articleshow/75130706.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

Klein, Ezra. 2020. "Elizabeth Warren has a plan for this too." *Vox*, April 6, 2020. https://www.vox.com/policy-and-politics/2020/4/6/21207338/elizabeth-warren-coronavirus-covid-19-recession-depression-presidency-trump.

IN-TEXT CITATION:

(Hitchens 1996)

(Khan 2020)
(Klein 2020)

See 15.49 (newspapers and magazines) and 15.51 (blogs) in *The Chicago Manual of Style* for further details

6) BOOK REVIEW

REFERENCE LIST ENTRY:

Methven, Steven. 2019. "Parricide: On Irad Kimhi's Thinking and Being." Review of *Thinking and Being*, by Irad Kimhi. *The Point Magazine*, October 8, 2019

IN-TEXT CITATION:

(Methven 2019)

7) INTERVIEW

REFERENCE LIST ENTRY:

West, Cornel. 2019. "Cornel West on Bernie, Trump, and Racism." Interview by Mehdi Hassan. *Deconstructed*, The Intercept, March 7, 2019. https://theintercept.com/2019/03/07/cornel-west-on-bernie-trump-and-racism/

IN-TEXT CITATION:

(West 2019)

8) THESIS AND DISSERTATION

REFERENCE LIST ENTRY:

Rustom, Mohammed. 2009. "Quranic Exegesis in Later Islamic Philosophy: Mulla Sadra's *Tafsir Surat al-Fatiha*." PhD diss., University of Toronto.

IN-TEXT CITATION:

(Rustom 2009, 68-85)

9) WEBSITE CONTENT

REFERENCE LIST ENTRY:

Website content can be restricted to in-text citation as follows: "As of May 1, 2017, Yale's home page listed . . .". But it can also be listed in the reference list alphabetically as follows. The date of access can be mentioned if the date of publication is not available.

Anthony Appiah, Kwame. 2014. "Is Religion Good or Bad?" Filmed May 2014 at TEDSalon, New York. https://www.ted.com/talks/kwame_anthony_appiah_is_religion_good_or_bad_this_is_a_trick_question

Yale University. n.d. "About Yale: Yale Facts." Accessed May 1, 2017. https://www.yale.edu/about-yale/yale-facts.

IN-TEXT CITATION:

(Anthony Appiah 2014)
(Yale University, n.d.)

For more examples, see 15.50–52 in *The Chicago Manual of Style*. For multimedia, including live performances, see 15.57.

9) SOCIAL MEDIA CONTENT

REFERENCE LIST ENTRY:

Social media content can be restricted to in-text citation without being mentioned in the reference list as follows:

Conan O'Brien's tweet was characteristically deadpan: "In honor of Earth Day, I'm recycling my tweets" (@ConanOBrien, April 22, 2015).

It could also be cited formally by being included in the reference list as follows:

Chicago Manual of Style. 2015. "Is the world ready for singular they? We thought so back in 1993." Facebook, April 17, 2015. https://www.facebook.com/ChicagoManual/posts/10152906193679151.

Souza, Pete (@petesouza). 2016. "President Obama bids farewell to President Xi of China at the conclusion of the Nuclear Security Summit." Instagram photo, April 1, 2016. https://www.instagram.com/p/BDrmfXTtNCt/.

IN-TEXT CITATION:

(Chicago Manual of Style 2015)
(Souza 2016)

9) PERSONAL COMMUNICATION

REFERENCE LIST ENTRY:

The expression "personal communication" covers email, phone text messages and social media (such as Facebook and WhatsApp) messages. These are typically cited in parenthetical in-text citation and are not mentioned in the reference list.

IN-TEXT CITATION:

(Sam Gomez, Facebook message to author, August 1, 2017)

Notes should preferably be listed as endnotes, followed by a works cited/references column.

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