Original Article

The Phenomenon of Family Suicides: An Explorative Study into Consecutive 32 Incidents in Kerala

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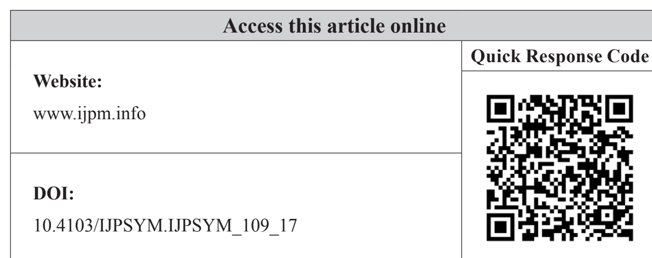
ABSTRACT

Background: Suicides rank high as the cause of human deaths. But research on whole family ending life is scanty. This study explored the family suicides in Kerala. **Methodology:** All the family suicides reported from four central districts of Kerala State during the year 2000 were included. Cases were prospectively located from different sources. A research associate systematically gathered information, from survivors, family and key persons in the locality. **Results:** 84 lives lost in 32 incidents involving 99 persons. No report from Muslim dominated district. Largest age group was 19 and below, others progressively decreased. Poisoning formed most frequent method; drowning, burns, hanging and wrist slashing followed. Suicide notes were left in half. Mental illness and physical illness were noted in five and eight incidents respectively. Financial crisis reported as the main reason. The SES of the deceased and their parents were same but half of the families were leading a life at a higher level than could be afforded. Warning signals noted in 12 incidents. Decision was taken by father and mother (17), mother (10) or father alone (5).The incidents came to the attention of others without long delay. **Discussion:** Firm stand of the religion against suicides on individual reasons could explain absence of family suicides from Muslim dominated district. Selection of sure method and flawless execution explains high lethality. Presence of victims explains more loss of young lives and profile difference from reported suicide attempts. Opening up of avenues for higher dreaming due to globalisation and wider visual media could be a reason for living unaffordable standard of life and resulting financial difficulty. The warning signals were recognised, but not responded by others. Social support was strong within the family but was non-existing with outside. Strong social support could be pathological if it is narrow.

Key words: *Dyadic death, family suicides, homicide-suicides, suicides*

INTRODUCTION

An 1840 publication by Forbes Winslow mentions about mutual suicides. Dyadic death comprises suicide pact and homicide-suicide. In the former, two or more persons commit suicide at same place and time due to the same reason. A person committing suicide after a murder is the latter. Many suicides happening in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DOI: 10.4103/IJPSYM.IJPSYM_109_17

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How to cite this article: Kuttichira P. The phenomenon of family suicides: An explorative study into consecutive 32 Incidents in Kerala. Indian J Psychol Med 2018;40:108-12.

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groups one after another motivated by the earlier in proximity is suicide cluster. In mass suicide, several people commit suicide together in response to lead by a charismatic leader with strong religious beliefs or loyalties.

While the interest in euthanasia increased in the recent past, the frequency of suicide pacts showed a decreasing trend.[1] Members of whole family committing suicide were observed in Kerala during the fag end of the past century. As per the data available with State Crime Records Bureau of Kerala, there were 25 incidents of family suicide in the year 1998, involving 68 persons - 30 males and 38 females. In 1999, it was twenty incidents involving 59 persons - 29 males and 30 females. Taking note of media reports about family suicide, National Crime Records Bureau started documenting such incidents from 2009 onward. There were 290 incidents in 2010 and 180 incidents in 2013 from the whole country. The national figures could be low due to no reporting of the specified category.[2] Due to the rarity of the condition, we decided to conduct an explorative study with the primary intention to develop an intervention program.

METHODOLOGY

"An act of ending life involving more than one person in a family, secondary to the suicide wish of at least one person among them" was the working definition used in this study.

The incidents of family suicides happening in four central districts of Kerala - Ernakulam, Thrissur, Palakkad, and Malappuram during January 1–December 31 of year 2000 was scanned through three sources, namely, media reports, police records, and an nongovernmental organization (Kerala Sasthra Sahithya Parishath [KSSP]) – a peoples' science movement with its grass root level workers spread throughout the state.

On receiving information, the field assistant (a worker of KSSP) visited the site at the earliest. He traced the route; established contacts with key persons in the locality and preliminary information gathered. Within the next 2 weeks, the site was visited by the research associate who was a postgraduate in psychology and experienced in doing field work, along with same research assistant. Survivors if any, relatives and key informants in the locality were approached for information. The event details, prior warning signals, possible causes, SES, personality disorder, and the the possibility of mental and physical disorders were collected using designed proforma.

OBSERVATIONS AND RESULTS

During the study, 32 incidents of family suicide happened in the studied districts. There was no incident reported from the district Malappuram, which was dominated by the Muslim population. Ninety-nine persons involved in the act among whom 84 persons (84.8%) died, pointing to the high lethality of the act.

Distribution of persons involved in family suicides according to gender and age are given in Table 1. Among 99 involved persons, 47 were males and 52 were females. Those 19 years and below formed the largest followed by age groups 20–39, 40–59 and those above 60 years in the progressively decreasing order. It was predominantly young persons' life which was lost in the family suicides.

Distribution of involved persons according to gender and mode of attempt is shown in Table 2. The highest frequency (68.1) was for poisoning. This was followed by drowning, burns, hanging, and wrist slashing. All the methods except hanging were used more by women and there were no men who did wrist slashing. In about half of the incidents (16) suicide notes were left. In five instances (15.6%), out of 32, there was information for the presence of previous mental illness. In eight instances (22.6%), at least one involved person had a major physical illness. Distribution of family suicides according to reported/perceived causes is given in Table 3. Financial crisis formed the main reason as it was the appreciated reason in 11 incidents (34.4%).

In thirty incidents (93.8%), the SES of the deceased was same as those of their parents. Only in two

Table 1: Distribution of persons involved in family suicides according to gender and age

Age group	Total	Male	Female	Male: Female Ratio
Up to 19	36	19	17	1117.6
20-39	35	11	24	458.3
40-59	22	13	9	1444.4
60 and above	6	4	2	2000.0
All ages	99	47	52	903.8

Table 2: Distribution of persons involved in family suicides according to gender and mode of attempt

Mode of attempt	Total, *n* (%)	Male	Female	Male: Female Ratio
Poisoning	69 (68.3)	32	35	914.3
Drowning	14 (14.14)	6	8	750.0
Burns	8 (8.1)	3	5	600.0
Hanging	6 (6.1)	4	2	2000.0
Wrist slashing	2 (2.1)	0	2	0.0
All methods	99 (100.0)	47	52	903.8

instances (6.2%), there was a decline in SES of those who died in comparison with the respective status of their prior generation. Distribution of family suicides according to their standard of living is given in Table 4. In 16 incidents (50%), family was leading a life at an optimum level. In 13 incidents (40.6%), they were living life at a higher level than could be afforded and in three instances (9.7%) the index family was leading a life which was lower in status than could be afforded.

In 12 incidents (37.5%), warning signals were given by at least one of those who involved in the act. It was in terms of direct communication of the suicide intent to someone near and dear. In one incident, neighbors were sure of family suicide when they noticed heavy smoke coming out of a particular house because they were suspecting it to happen at any time. In the rest twenty incidents (62.5%), there were no warning signals.

Distribution according to the family position of the person who took the decision to end life is given in Table 5. In 17 instances (53.1%), both father and mother took decision jointly. In ten instances (31.3%), mother took the decision and in four instances (15.6%) it was father. The deaths and survivals among instigators and victims are given in Table 6. Among the total of 49 instigators, 43 died (87.8%) and six survived (12.2%). Among the total of 50 victims,41 died(82%) and 9 (18%) survived.

There was a time gap between the incident of committing suicide and others recognizing it. In 18 (56.25%) incidents, it came to the attention of someone within 6 h. In eight incidents (25%), it took more than 6 h for identification of the incident. In six instances (18.75%), the time gap could not be clearly calculated, as the exact time of death was unknown. The postmortem reports were not accessed for that purpose.

Table 3: Distribution of persons involved in family suicides according to causes

Causes	*n* (%)
Financial crisis	11 (34.4)
Family problems	8 (25.0)
Mental illness	5 (15.6)
Physical illness	4 (12.5)
Objection to marriage	2 (6.3)
Wish to die together	1 (3.1)
Unwed pregnancy	1 (3.1)
All reasons	36 (100.0)

Table 4: Distribution of family suicides according to status of living

Status of living	*n* (%)
Optimum	16 (50)
Higher than could be afforded	13 (40.6)
Lower than could be afforded	3 (9.4)
Total	32 (100.0)

Table 5: Distribution according to the person who decided on the act

	n (%)
Both father and mother	17 (53.12)
Only mother	10 (31.25)
Only father	5 (15.6)
Total	32 (100.0)

Table 6: Distribution of family suicides according to death and survival of involved persons

Status	Total, *n* (%)	Died, *n* (%)	Survived, *n* (%)
Instigator	49 (100.0)	43 (87.8)	6 (12.2)
Victim	50 (100.0)	41 (82)	9 (18)
All involved	99 (100.0)	84 (84.8)	15 (15.2)

DISCUSSION

Lower rates of suicide among persons following Muslim religion gets mention in textbooks. The absence of any family suicide from Muslim-dominated district supports that view. However, we are aware of suicide bombers among terrorist outfits aligned to extremists of that religion. Perhaps, while individuals are discouraged from ending life on their personal interest, there is sanction for suicide for a common cause related to the faith.

Applying proposed classification for homicide-suicides all the cases in the present series will fall under category 4 - familicide-suicide.[3]

For every completed suicide, there will be at least 7–10 attempted suicides are the message in standard classroom teachings; meaning the actual lethality of any suicide attempt is 10%–14%. In the present family suicide series, the lethality is high. The figures are reversed with 15% as the survival rate. The instigator(s) are taking away the whole family with them through death. Probably, they believed without them, survivors will not have a satisfactory life. Hence, sure method was selected and perfect execution ensured. The same could explain more deaths among instigators themselves. However the information about the role as instigator or victim was based on overall impressions based on all sources of available information, it might not have any value more than a guess work. Loss of young lives including children was noteworthy, but the presence of victims could explain it.

Except in age group 20–39, the sex ratio was higher for males and the most preferred method was poisoning. These were in contrast to reported observation on attempted suicides from Kerala which

noted higher rates for females in both ends of age groups and preference for hanging as a method.[4] From meta-analysis of 27 studies, it was inferred that homicide-suicide is an independent entity separate from homicide and suicide.[5] It could explain the profile difference of family suicide from individual suicides. However, the inclusion of passive victims in the family suicides besides the "actual committers," could be an alternate explanation.

The Western literature asserts the presence of psychiatric syndromes in suicides, while it is a matter of debate in Indian literature. Adjustment disorder as the most common cause was one view,[6] whereas "secondary to mental illness and low rates" was the other. Psychosocial adversity causing mental distress and psychiatric disorders, social determinants of health significantly affecting mental health and difficulty in differentiating mental distress and disease were discussed extensively.[7] Misclassification of distress and disorder is likely where neighbors go with the former because of their awareness of the context and background of the victims, whereas psychiatrists go with the latter because of their learning.

Poverty negatively influences mental health because of accompanying insecurity, hopelessness, physical illness, and violence.[8] In the present series, actual decline in SES was not substantiated. Living a life higher in standard than could be afforded was a noticeable observation. There could be despair arising from the inability to live as aspired. Globalization and visual media coverage brought in avenues for higher aspirations, but reduced the opportunities and earnings of small scale workers and petty traders. Both contributed to their distress.

Expressed warning signals did not receive the attention it deserved. It could be because of the inability to perceive the seriousness, unawareness about how to respond or attitude to keep away from risk taking. The people around were available in the neighborhood and were watchful. Hence, there were no long delays in recognizing the deaths and initiate rescue. The persons involved in family suicides showed strong bonding among themselves, but not with anyone outside their close family. Social support system needs to be wide, not only strong. Intensely strong, but narrow social support could be pathological. It might explain the extremists' terrorism as well.

Nonuse of standardized tools, the absence of qualified mental health professional in the field for information gathering, etc., are limitations of the study. The research started in the background of decentralized planning in the state and the primary aim was to develop actions against the increasing suicides and family suicides in the state.[9] The team actively involved in the workshop of local level activists and subject experts held in January 2000 at Ponnani, one of the backward areas of the state which developed Ponnani Rekha (10 point program to counter suicides in the community)[10] and in the District Based Suicide Prevention Program[11] - a peoples' movement which came up following a family suicide losing seven lives in a single incident. The positive impact of those was appreciated and its influence on the then started fall on suicide rates in the state is underway.

CONCLUSIONS

The phenomenon of family suicide is reported from the state of Kerala with number of occurrence annually around 25. No incidents were reported during the study from Muslim-dominated district. The frequently used method was poisoning and more involvement of youngsters, possibly explainable due to the inclusion of both instigators and victims in the index incidents. The lethality was high. Financial reasons were reported as a cause in most of the cases. There was no actual decline in SES in comparison with the respective prior generations, but living an unaffordable standard of living was an observation. Neither mental illness nor physical illness made any noticeable contribution. There were warning signals, but no help reached them. Social support within the family was strong, but was weak with the society around. Methodological limitations in the study were appreciated. The research team gaining experience from the field contributed to the development of suicide prevention action plan and its district based implementation.

Financial support and sponsorship

This project was supported by Kerala Research Program on local level development with a fund of INR 3.25 lakhs and overall guidance and supervision.

Conflicts of interest

There are no conflicts of interest.

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