

# Student Suicides in the Context of Online Education During COVID-19 Pandemic in India: Analysis of Media Reports

To the Editor,

In India, online education emerged as an effective stopgap for continuing education during COVID-19-induced school closures. However, the transition to online learning might have been challenging for some students for varying reasons. Besides a few scientific publications, such challenges were spotlighted by multiple media reports of student suicides in the context of online education.<sup>1,2</sup> The current study aimed to understand the association between student suicides and online education through a thematic analysis of the media reports.

## Methods

A Google search was performed separately for each month from June 2020 to January 2021, by customizing the search period using the “tools” option.

The search command used was: online classes, suicides, India. For each search, we used an inbuilt filter within the Google search that shows the results after omitting the entries that were similar to those already displayed. By combining the search results from all eight months, we identified 899 nonrepetitive news items. These news items were subjected to the screening of title and content. Our inclusion criteria were as follows: (a) news items reporting incidents of student suicide in the context of online education and (b) news items providing adequate demographic details to establish the uniqueness of the incident, such as details of the victims (name, age, gender, class, etc.) and details of the incidents (date, time, place, area of the police station, etc.), to avoid inclusion of the same incident more than once. For the incidents reported by more than one newspaper, we chose those with more detailed descriptions of the incident.

## Results

Forty-two unique news reports were included for the analysis. After a detailed reading of the content, four

nonoverlapping themes were identified. These were: (a) being unable to access online education, (b) being unable to cope with online education, (c) being scolded by the parents, and (d) unknown (reason not reported). We organized the demographic details and thematic categories in a Microsoft Excel Sheet and performed a descriptive analysis. **Figure S1** explains the search strategy in detail. **Table S1** provides the online links to the included news reports. **Table 1** shows the information extracted from the news reports that were used in the analysis.

Among the victims, 79% ( $n = 33$ ) were between 14 years and 18 years of age, 14% ( $n = 6$ ) between 11 years and 13 years, and 7% ( $n = 3$ ) between 19 years and 20 years. Overall, 57% ( $n = 24$ ) of victims were females and 43% ( $n = 18$ ) were males. The victims were from both urban (52%,  $n = 22$ ) and rural (48%,  $n = 20$ ) areas. These cases were reported across 14 states, with the maximum number being from Tamil Nadu (31%,  $n = 13$ ). The most frequently reported theme (45%,  $n = 19$ ) was the inability to access online education because of the unavailability of smartphones or internet facilities. The second most frequently reported

TABLE 1.

**Student Suicides in India in Context of Online Education in India During COVID-19**

Date	State	Region	Age	Gender	Class	Method	Reported Reason
June-02-20	Kerala	Rural	14	Female	10	Burning	Unable to access
June-08-20	Punjab	Rural	17	Female	11	Hanging	Unable to access
June-18-20	Kerala	Urban	15	Female	10	Hanging	Unable to cope
June-20-20	West Bengal	Rural	16	Female	10	Hanging	Unable to access
June-24-20	Gujrat	Urban	12	Female	8	Hanging	Unable to cope
June-24-20	Assam	Rural	15	Male	10	Hanging	Unable to access
July-10-20	Tripura	Urban	14	Female	8	Hanging	Unable to access
July-27-20	Tripura	Rural	15	Male	10*	Hanging	Unable to access
July-31-20	Tamil Nadu	Rural	14	Male	10	Hanging	Unable to access
August-02-20	Madhya Pradesh	Rural	17*	Female	12	Poisoning	Unable to access
August-02-20	Maharashtra	Rural	17	Male	12	Hanging	Unable to access
August-03-20	Telangana	Urban	18	Male	12	Hanging	Unable to cope
August-06-20	Gujrat	Urban	18	Female	11	Hanging	Scolded by parents
August-19-20	Karnataka	Rural	15	Female	10	Poisoning	Unable to access
August-19-20	Tamil Nadu	Urban	15*	Male	10	Poisoning	Unable to cope
August-22-20	Haryana	Urban	11*	Male	6	Hanging	Unknown
August-26-20	Tamil Nadu	Urban	17*	Female	12	Hanging	Unable to access

(Table 1 continued)

Date	State	Region	Age	Gender	Class	Method	Reported Reason
September-03-20	Tamil Nadu	Urban	17	Male	11	Hanging	Unable to cope
September-03-20	Tamil Nadu	Rural	18*	Female	BSc	Poisoning	Unable to access
September-03-20	West Bengal	Urban	13	Male	8	Hanging	Unknown
September-07-20	Tamil Nadu	Urban	19	Female	BA	Not reported	Unable to cope
September-09-20	West Bengal	Rural	20	Female	BA	Hanging	Unable to access
September-16-20	Tamil Nadu	Rural	16	Female	10	Hanging	Unable to cope
September-16-20	Tamil Nadu	Urban	15	Female	10	Stabbing	Unable to cope
September-17-20	Tamil Nadu	Urban	14	Male	9	Hanging	Unable to cope
September-21-20	Tamil Nadu	Rural	13	Female	8	Burning	Scolded by parents
September-22-20	Tamil Nadu	Rural	18	Female	BSc	Hanging	Unable to cope
September-27-20	Telangana	Rural	18	Female	12	Poisoning	Unable to cope
September-30-20	Maharashtra	Rural	15	Female	9	Hanging	Unable to access
October-02-20	Karnataka	Rural	12	Male	7	Hanging	Scolded by parents
October-03-20	Odisha	Rural	14	Male	8	Hanging	Scolded by parents
October-15-20	Goa	Rural	16	Male	10	Hanging	Unable to access
October-16-20	Uttarakhand	Urban	14	Male	9	Hanging	Scolded by parents
October-20-20	Punjab	Urban	16*	Female	11	Hanging	Unable to cope
October-26-20	Gujrat	Urban	14	Female	10	Hanging	Unable to access
November-02-20	Telangana	Urban	19	Female	BSc	Hanging	Unable to access
November-05-20	Madhya Pradesh	Urban	11	Male	5	Hanging	Not reported
November-24-20	Andhra Pradesh	Urban	17	Male	12	Poisoning	Unable to cope
December-22-20	Telangana	Urban	18	Female	Polytechnic	Hanging	Unable to access
January-18-21	Telangana	Rural	14*	Female	9	Hanging	Unable to access
January-20-21	Tamil Nadu	Urban	17*	Male	12	Not reported	Unable to cope
January-26-21	Tamil Nadu	Urban	18*	Male	College	Not reported	Unable to cope

\*As age was not reported, the approximate age was calculated based on the student's class.

theme (36%,  $n = 15$ ) was the inability of the students to cope with online education, wherein they had expressed their difficulty in learning through the online classroom and the stress associated with it. The third most common theme (12%,  $n = 5$ ) was being scolded by parents for not paying enough attention in the online classroom and getting distracted by online games, videos, or social media sites. In the remaining 7% cases ( $n = 3$ ), victims were between 11 years and 13 years of age who died by suicide soon after attending the online class, for unknown reasons. The most commonly reported theme in the urban group was the inability to cope with online education (54.5%,  $n = 12$ ), whereas in the rural group, it was the inability to

access online education (70%,  $n = 14$ ). With regard to gender differences, the most common theme among male students (38.9%,  $n = 7$ ) was the inability to cope with online education, whereas for female students (58.3%,  $n = 14$ ), it was the inability to access online education. A large majority (71.4%,  $n = 30$ ) had used hanging as the method of suicide.

## Discussion

Although online education has helped millions of children continue learning during the COVID-19 pandemic, the current study underscores the important challenges experienced in the Indian context. The most frequently reported theme associated with student sui-

cides was the inability to access online education, which indicated unequal learning opportunities created by various socioeconomic disparities. A recent survey by the National Council of Educational Research and Training (NCERT) reported that nearly 27% of the students lack smartphones and laptops to study online.<sup>3</sup> Similarly, the United Nations International Children's Emergency Fund (UNICEF) reported that only 24% of households in India have internet access.<sup>4</sup> Further, our urban-rural and gender-based comparative analyses showed that higher proportions of rural students and female students had died by suicide because of their inability to access online education than the corresponding comparator groups. More

children from rural areas might be at risk of lagging in online education because of the poorer reach of technological advances in villages compared to towns or cities. According to the survey on "Household Social Consumption on Education in India," less than 15% of households in rural India have internet access, compared to 42% urban households.<sup>5</sup> Additionally, female children belonging to socioeconomically weaker sections of the society, especially in rural areas, have lesser utilization of digital technology that might also be reflected in the access to online education.<sup>6</sup> In our study, the second most frequent theme underlying student suicide was inability to cope with online education. Online learning could be challenging for some students because of the lack of necessary technical knowledge and difficulty in clarifying doubts. Exclusive online education often fails to generate the opportunities and experiences obtained from attending the school, such as peer interactions, academic discussions, extracurricular activities, and finding support. Some of these challenges, including the negative mental health impact of a transition to online education among students, have been highlighted by a few recently published surveys from India and elsewhere.<sup>7-9</sup> Additionally, some groups of children could be substantially more vulnerable to the stress related to the studies than others. In our study, more than half of the victims belonged to Class 10 and Class 12, which represents the board examinations in the Indian education system.

Our findings emphasize the need for diverse measures to improve access to online education for children, particularly those belonging to socioeconomically weaker sections and rural regions. Several creative ways might have to be used to enhance the coverage of online education to prevent the widening of the education gap in the country during the COVID-19 pandemic. More proactive initiatives are required to address the gender-based digital divide that creates barriers for girls to access online education. Promoting mental wellbeing among students is necessary to reduce psychological distress associated with difficulty coping with online education.

Teachers should be trained to identify psychological difficulties experienced by vulnerable students, such as those appearing for board examinations, and address their specific needs. Schools should take a flexible stance on the matters of attendance, syllabus completion, and conducting examinations to reduce stress among students.

## Limitations and Future Directions

While these media reports provide a glimpse into the ground realities of online education in India, their credibility as scientific evidence may be poor because of several reasons. Further, as psychological autopsies were not performed in the reported incidents, the role that online education plays in student suicides cannot be conclusively established beyond being one of the potential risk factors. So far, only a few sporadic research reports have been published on this topic.<sup>1,10</sup> More research is required to systematically explore the factors contributing to suicidal behavior among youth in the context of online education.

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## Addressing Confidentiality and Privacy Barrier to Mental Health Help-Seeking amongst University Students: An Experience

Dear sir,

A recent article by Arun et al. reported that amongst medical students, preference for informal consultations and concerns about confidentiality were amongst the most common barriers to help-seeking for mental health issues. These findings corroborate with previous Indian research amongst medical students.<sup>1,2</sup> In their concluding remarks, Arun et al. suggested that mental health services should be established taking into account the perceived barriers to help-seeking.<sup>3</sup>

To elaborate on the suggestion made by Arun et al., we share our experience in addressing confidentiality and privacy barriers while developing a “Distress and Suicide Prevention Help” (DASH) program for students from medicine and allied faculties. The university caters to about 1,300 students from 57 different courses. The Department of Psychiatry at our university has been steadfast in helping students in distress. In our practice with students, it was observed that the act of consulting a mental health professional was often associated with apprehension of loss of confidentiality and preference about the location of consultation. We faced two major challenges. Students were apprehensive to come to the psychiatry clinic as they feared that the interns or residents posted in the department would judge them or tell others about their consultation. The university uses an electronic medical record (EMR); many students taking consultation felt that their record

could be seen by residents or interns posted in the department. In a qualitative study done amongst medical students, aptly titled “I wouldn’t want it on my CV or their records,” Chew-Graham et al. found that students felt inhibited about sharing their experience with anyone associated with the university.<sup>4</sup> Similarly, another qualitative study by Winter et al. reported fear of stigmatization from the medical school amongst the barriers to help-seeking among medical students.<sup>5</sup>

To overcome the first issue of the location of consultation, students were provided consultations at a place convenient to them—either psychiatry clinic, academic block, student support block, or alumni office in the college building or elsewhere when required, with the kind support of the Dean, student support group, and Alumni Association. In our view, doing so blends “informal” with “formal” consultation and makes the student feel at ease while seeking help. The department is equipped with three senior and two junior consultants and one clinical psychologist. Junior consul-

tants look after the other clinical work when a call is received, allowing the senior consultants flexibility in the location of the consultation. A small number of flexible consultations are arranged after office hours, in a gender-matched manner, or if required, in the presence of a chaperone.

To overcome the second issue, our management team generously supported us in creating a separate module for DASH in the Shree Krishna Hospital Online Application for Clinical Excellence (SOLACE EMR). The record generated in this module is accessible to the four consultants from the Department of Psychiatry only. This was done to create a sense of trust in our students who approach us in distress. However, any medications prescribed could still be reconciled by a clinician from another department simultaneously providing medical care to the student.

All students are given a health card at the time of enrolment. It usually happens in our setting that students come to us in distress. We hear them out and convince them to enlist with the DASH clinic. A mental health practitioner from the department would place a phone call to the reception to register the student under the DASH clinic using his health card number. The service is provided to students free of cost. On request, the students are also provided mobile numbers by their clinicians for emergency contact.

The DASH module was activated in May 2019. Till December 2019, we provided 93 in-person consultations for both undergraduate and postgraduate students. Key program indicators are listed in **Table 1**. Subsequently, the lockdown was enforced; hence, the number of consultations between January 2020 and July 2020 reduced to 36. During the lockdown, we trained assigned faculty mentors to provide “Psychological First Aid” to all the students.<sup>6</sup> Students who

