

Suicidal Tendencies among Teenagers: A Sociological Review with Reference to Karnataka

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Abstract

Suicide among adolescents is a major public health concern and, at the same time, a deeply social phenomenon. This review examines suicidal tendencies among teenagers (13–19 years) from a sociological perspective, with specific reference to Karnataka, India. Drawing on classical sociological theory (Durkheim, Merton), the ecological model of human development, and empirical literature from India and abroad, the paper discusses the magnitude of the problem, its social determinants (family, school and examination pressure, peer relations, digital media, gender, caste, class and rural–urban differences), and the protective factors and policy responses available. The review finds that adolescent suicidal behaviour in Karnataka cannot be explained by individual psychopathology alone; it is shaped by weakening social integration, academic and aspirational pressure, family conflict, gender norms, economic distress and limited access to youth-friendly mental health services. The paper concludes with recommendations for schools, families, communities, and the state, and identifies gaps for future sociological research in the region.

Keywords: Adolescent Suicide, Suicidal Ideation, Anomie, Social integration.

Introduction:

Adolescence is a period of rapid biological, psychological and social transition. Young people must negotiate identity, peer acceptance, educational competition and changing family expectations at the same time. When these pressures are not matched by adequate support, some teenagers develop suicidal ideation, make attempts, or die by suicide. Globally, suicide is among the leading causes of death in young people (World Health Organization [WHO], 2021), and adolescent self-harm and suicide are recognised as outcomes of interacting individual, family and social factors rather than of a single cause (Hawton, Saunders & O'Connor, 2012).

India carries a large share of the global burden of suicide. A nationally representative survey found that suicide mortality in India is high among young adults, with a marked concentration in the younger age groups, and that official statistics undercount the true figure (Patel et al., 2012). State-level analyses indicate that southern states, including Karnataka, have recorded comparatively high suicide rates (Dandona et al., 2018). Because Karnataka combines a globally connected urban centre (Bengaluru), a large rural and semi-urban population, a competitive education system, and persistent agrarian and economic distress, it offers a valuable setting for a sociological reading of teenage suicidal behaviour.

The present paper therefore asks: (a) how does sociological theory explain suicidal tendencies among teenagers; (b) what social factors are associated with such tendencies in India and Karnataka; and (c) what social and policy responses are most appropriate?

Objectives of the Study:

To review sociological explanations of suicide as applied to adolescents.

1. To examine the magnitude and patterns of adolescent suicidal behaviour in India with reference to Karnataka.
2. To identify the social determinants and protective factors.
3. To suggest preventive and policy measures relevant to Karnataka.

Limitations of the Review:

This is a narrative review based on secondary sources and does not follow a systematic protocol. Official data are affected by under-reporting and misclassification due to stigma and legal concerns. Few Karnataka-specific adolescent studies exist, so evidence from other southern states has been used cautiously.

Methodology:

This is a narrative, secondary-data review. Peer-reviewed articles, national survey reports (NCRB, NIMHANS), international agency reports and classical sociological texts were consulted. Search terms included adolescent suicide, suicidal ideation, student suicide, India, Karnataka, anomie and social integration. Sources were selected for relevance to adolescents and to Indian or South Indian settings. No primary data were collected, and no individual cases are described.

Conceptual Framework

Key terms

Suicidal tendencies refer to a continuum that includes suicidal ideation (thinking about ending one's life), planning, attempted suicide and completed suicide. Self-harm without suicidal intent is related but distinct. For this review, "teenagers" are persons aged 13–19 years.

Durkheim's theory of social integration and regulation:

Émile Durkheim ([1897] 1951) argued that suicide rates are social facts that vary with the degree of social integration and moral regulation in a society. Four types follow from this argument: egoistic suicide (weak integration), altruistic suicide (excessive integration), anomic suicide (breakdown of regulation) and fatalistic suicide (excessive regulation). For teenagers, egoistic and anomic forms are most relevant: young people who feel detached from family, school or community, or who face sudden social change without clear norms, are more vulnerable. Fatalistic elements appear where rigid expectations about marks, careers or marriage leave little room for choice. A review of the later sociological literature confirms that integration, religion, family structure and economic conditions remain consistently linked to suicide rates (Stack, 2000).

Merton's strain theory

Merton (1938) proposed that deviance, including self-destructive behaviour, arises when society promotes cultural goals (success, status, wealth) but restricts legitimate means of reaching them. In the Indian context, the cultural goal of high academic achievement and a secure professional career is widely shared,

while access to quality education, coaching and opportunity is unequal. Strain is especially acute for students from poor, rural or first-generation learner families.

Interpersonal and ecological approaches

Joiner's (2005) interpersonal theory links suicidal desire to two perceptions: thwarted belongingness and perceived burdensomeness. These concepts translate easily into sociological language: exclusion from peer groups, family rejection, or the belief that one is a financial or emotional burden on a struggling household. Bronfenbrenner's (1979) ecological model helps organise determinants across levels: the individual, the microsystem (family, school, peers), the community, and the wider cultural and policy environment.

Magnitude of the Problem

Global and national picture

WHO (2021) estimates that suicide is one of the leading causes of death among those aged 15–29 years worldwide, with a large proportion occurring in low- and middle-income countries. In India, Patel et al. (2012) found that suicide mortality is substantial in young adults, and that women in the younger age groups are at notably high risk in comparison with many other countries. The National Crime Records Bureau (NCRB) publishes annual data on suicides by age, gender, cause and occupation (including student status) in *Accidental Deaths and Suicides in India*; these reports show students as a significant category, though NCRB figures rely on police records and are widely considered to understate the true burden (Vijayakumar, 2007; Radhakrishnan & Andrade, 2012).

More recent evidence confirms this pattern. India recorded 171,418 suicides in 2023, a marginal rise over 2022, and Karnataka is among the states with the highest share of suicides, along with Maharashtra, Tamil Nadu and Madhya Pradesh (NCRB, 2025). Students account for roughly 8 per cent of all suicides nationally, and the count of student suicides rose by about 65 per cent over the decade to 2023 (NCRB, 2025). A scoping review of 35 Indian studies published between 2000 and 2021 found mental health problems, family-related adversity and academic stress to be the most commonly reported risk factors, noted that suicides clustered between March and July (the period of examination results and admissions), and highlighted the lack of longitudinal and qualitative research on adolescents (Senapati et al., 2024). The same review cites NCRB data showing that 10,730 persons below 18 years died by suicide in India in 2021.

Karnataka:

State-level analysis of the Global Burden of Disease data shows wide variation across Indian states and higher suicide death rates in several southern states (Dandona et al., 2018). The National Mental Health Survey of 2015–16 included a Karnataka state report and documented a considerable treatment gap for mental disorders, a gap that is likely to be wider for adolescents, since specialised child and adolescent services are limited (Gururaj et al., 2016). Researchers should consult the latest NCRB tables for Karnataka (by age group 14–18 years and by cause such as examination failure, family problems and love affairs) to supply current figures; the numbers change annually and are best cited directly from the primary report.

A study of young people in rural southern India found that suicide in young persons was strongly associated with interpersonal conflict and that a high proportion of deaths happened in a context of familial

discord (Aaron et al., 2004). Although it was conducted in Tamil Nadu, its setting is socially comparable to rural and semi-urban Karnataka and offers useful insight.

Within Karnataka itself, the most direct epidemiological work comes from NIMHANS, Bengaluru. Gururaj and Isaac (2001) provide a city-level profile of suicides in Bengaluru, which remains a key Karnataka source for age- and gender-wise patterns and for the social circumstances surrounding suicide. Broader overviews by Math, Chandrashekar and Bhugra (2007) place suicide within India's wider burden of mental disorders and point to gaps in data and services that affect young people as well.

Recent official figures for Karnataka point in the same direction. NCRB data analysed in the Karnataka press showed a 21.79 per cent increase in student suicides in the state between 2017 and 2021 (Ramesh, 2023). For 2022, NCRB reported 162 suicides in Karnataka among persons below 18 years that were attributed to failure in examinations, one of the higher state figures in the country. Because NCRB assigns a single cause to each death and relies on police records, these numbers should be read as minimum estimates and as indicators of precipitating events rather than root causes.

The most directly relevant recent study from the state is a school-based survey in Udupi district. Praharaj et al. (2026) compared two cross-sectional surveys of students in grades 7 to 9 (ages 11–17) in nine schools, one conducted in 2016 ($n = 1,459$) and one in 2023 ($n = 1,153$). Reported suicide attempts rose from 2.1 to 6.6 per cent, suicidal ideation from 4.7 to 11.6 per cent, and self-harm from 8.5 to 15.2 per cent, with the sharpest increase in attempts seen among boys. Higher risk was associated with mental health difficulties, physical health problems, traditional and online bullying, urban living and non-nuclear family structures, while feeling safe at school and prosocial behaviour were protective. Because the two surveys covered different students, the findings show a change in prevalence between cohorts, not individual trajectories, and they come from one district.

Smaller Karnataka-based studies add context. Bhola et al. (2014) studied self-reported suicidality and its predictors among adolescents in a pre-university college in Bangalore, Beattie et al. (2019) examined the prevalence and correlates of psychological distress among 13–14-year-old girls in North Karnataka, and Gouda and Rao (2008) reported factors related to attempted suicide in Davanagere. Together with the NIMHANS work cited above, these studies show that evidence is available for urban, rural, coastal and northern parts of the state, but it remains fragmented and mostly cross-sectional.

Government-reported figures from the state are scarce and mostly appear in answers to the legislature. According to data provided by the minister and reported in the press, 21 students died in residential schools, colleges and hostels run by the Karnataka Residential Educational Institutions Society (KREIS) between 2023 and 2025, of whom six died by suicide; the same reply noted that the state planned a Karnataka Suicide Prevention Policy and had set up helplines and complaint systems for hostel students (Hemanth Kumar O. & Thalagunda, 2025). These figures cover a single institutional network and carry no year-wise break-up, so they illustrate the risk in residential settings rather than the statewide burden.

Social Determinants of Teenage Suicidal Tendencies

Family environment

Family is the first and most important source of integration. Case-control evidence from India shows that suicide risk is associated with family-related stressors such as discord, loss of a parent, and conflict, as well as with prior psychiatric morbidity (Vijayakumar & Rajkumar, 1999; Manoranjitham et al., 2010). In Karnataka, as elsewhere, the transition from joint to nuclear families, parental migration for work, and parental alcohol use can reduce emotional support for adolescents. Strict control, comparison with siblings

and cousins, and restrictions on friendships or choice of partner can create the kind of excessive regulation Durkheim described.

The Mysore-born sociologist M. N. Srinivas (1966) analysed how processes such as Westernisation and Sanskritisation reshaped family norms, status aspirations and social mobility in modern India. Read alongside the suicide literature, his work helps explain why rapid social change in Karnataka's families can raise expectations of children faster than the support available to meet them.

Education system and examination pressure

Educational competition is perhaps the most visible social pressure on Indian teenagers. Board examinations, entrance tests for engineering and medicine, and the growth of private coaching have turned school life into a high-stakes contest. Examination failure and fear of failure are frequently recorded as reasons in official suicide data and in Indian reviews (Radhakrishnan & Andrade, 2012). In Karnataka, the PUC stage and competitive coaching culture in cities such as Bengaluru, Mangaluru, Hubballi–Dharwad and Mysuru intensify this pressure. Students from Kannada-medium or rural backgrounds who move to English-medium, urban colleges may also experience language barriers, isolation and a sense of inferiority.

relations, bullying and romantic relationships

Peer rejection, bullying and the breakdown of romantic relationships are consistently reported precipitating stressors in adolescent suicide (Hawton et al., 2012). Because adolescents depend heavily on peers for identity and acceptance, exclusion can produce the thwarted belongingness described by Joiner (2005). Fear of social disapproval and honour-related norms around relationships, especially across caste or religious lines, add to the stress in many Indian settings.

Digital media and social comparison

Widespread smartphone and internet access has created new arenas for comparison, cyberbullying, and exposure to distressing content. Sociologically, social media can both weaken face-to-face integration and amplify anomie by presenting unattainable standards of success and appearance. Hawton et al. (2012) note the influence of media and internet exposure on adolescent self-harm. Research specific to Karnataka teenagers on this topic is still scarce and represents a clear gap.

Gender

Gender shapes both risk and the form of distress. Patel et al. (2012) and Dandona et al. (2018) document that young Indian women have relatively high suicide mortality compared with global patterns, which suggests that early marriage, restrictions on mobility and education, domestic conflict and limited autonomy are important social contributors. Teenage boys may face pressure linked to academic performance, employment prospects and norms that discourage help-seeking. Adolescents with minority gender or sexual identities may face stigma and rejection, although Indian data on this group remain limited.

Caste, Class and Economic distress

Poverty, debt and insecurity of livelihood affect the entire household. Karnataka has experienced agrarian distress, particularly in dry regions, and economic hardship can lead to reduced educational opportunities,

school dropout, early work and a sense of being a burden on the family. Students from socially disadvantaged communities may also encounter discrimination in educational institutions, which compounds strain. These links are best studied through disaggregated data, which are not yet routinely published at adolescent level.

Karnataka-based sociological work on agrarian suicides is useful for understanding the household context in which many adolescents grow up. Vasavi (1999) examined suicides in Bidar district as an outcome of changing market, state and agrarian relations, and her later book (Vasavi, 2012) treats suicide as a sign of a wider crisis in rural India rather than as a purely individual act. Assadi (1998) similarly read farmer suicides in Karnataka as signs of distress in the rural economy. Although these studies concern farmers, they suggest, by extension, how debt, market uncertainty and weakening social support can shape the lives and prospects of children in rural households.

Recent national data underline the agrarian dimension. Analyses of NCRB's 2023 report show that Maharashtra and Karnataka together accounted for more than 60 per cent of suicides in the farming sector, with Karnataka reporting 2,423 such deaths (NCRB, 2025); readers should confirm the exact figures in the NCRB tables.

Rural–urban differences:

Urban adolescents face crowding, competition and anonymity, whereas rural adolescents may face isolation, scarcity of services, and strong community scrutiny. Evidence from rural southern India shows that interpersonal and family problems are central in young people's suicides (Aaron et al., 2004). Easy access to lethal means in agricultural settings, including pesticides, is an environmental risk factor recognised in Indian and international literature (Patel et al., 2012; Hawton et al., 2012).

Mental health, stigma and help-seeking

Mental disorders, especially depression, are important risk factors for adolescent suicidal behaviour, but sociological analysis stresses that stigma, lack of awareness, cost and shortage of trained professionals prevent timely care (Gururaj et al., 2016; Vijayakumar, 2007). Suicidal behaviour is often viewed through moral or religious lenses, which discourages open talk. Substance use, including alcohol, is another recognised correlate (Hawton et al., 2012).

Protective Factors:

Protective factors mirror the risk factors. They include a warm and communicative family, a sense of belonging in school, supportive teachers and mentors, positive peer groups, participation in sports, arts and community activities, religious or cultural connectedness, life-skills and coping abilities, and accessible counselling (Hawton et al., 2012; Stack, 2000). In Durkheimian terms, strong but not oppressive integration, and regulation that allows reasonable autonomy, lowers vulnerability.

Policy and Programme Context

Several national measures are directly relevant to Karnataka. The Mental Healthcare Act, 2017 recognises the right to access mental healthcare and, through Section 115, presumes severe stress in a person who attempts suicide, which limits punishment. The Government of India's National Suicide Prevention Strategy (Ministry of Health and Family Welfare, 2022) sets a target for reducing suicide mortality and promotes means restriction, responsible media reporting, school-based mental health and strengthened

services. The national tele-mental-health programme, Tele-MANAS, provides free remote counselling. At the state level, Karnataka's institutions, notably NIMHANS in Bengaluru, are central to training, research and service development. Implementation at district and school level, however, remains uneven, and research that assesses reach among rural and marginalised adolescents is needed.

The most significant recent state-level measure is the Mental Health Policy for Educational Institutes issued by the Department of Health and Family Welfare, Government of Karnataka, dated 4 December 2025, and prepared with NIMHANS (Government of Karnataka, 2025). It follows the Supreme Court's judgment of 25 July 2025 in *Sukdeb Saha v. State of Andhra Pradesh*, which treated the right to mental health as part of the right to life under Article 21 and issued fifteen binding guidelines for educational institutions and coaching centres, and it was issued alongside Government Order ED 69 of 27 November 2025 directing implementation across the state's educational institutions. The policy draws on the National Suicide Prevention Strategy (2022), the UMMEED guidelines and MANODARPAN, and on an ICMR-supported multistate implementation project on suicide risk reduction led by NIMHANS for the Karnataka site.

Its main provisions are: annual orientation on student mental health for administrators, teachers and students; gatekeeper training for at least one faculty member per class or batch, with the aim of training one-third of teaching staff over three academic cycles; trained student Wellbeing Champions; a Student Wellbeing Team in every institution; confidential in-campus counselling with referral pathways; a written crisis response protocol that includes restricting access to high-risk areas such as rooftops; display of Tele-MANAS (14416) and other helplines; measures against bullying, harassment and discrimination; and annual reporting of any suicides and counselling uptake to the regulatory authority and the district monitoring committee (Government of Karnataka, 2025). The reporting requirement could, over time, produce the institution-level data on adolescent suicide that Karnataka currently lacks. Because the policy is very recent, its effect on adolescent outcomes has not yet been evaluated, and independent assessment of implementation in rural and government schools would be a valuable research task.

The reviewed literature shows that teenage suicidal tendencies in Karnataka and India are best understood as a product of social conditions interacting with individual vulnerability. First, Durkheimian ideas about integration remain relevant: nuclear families under stress, migration and digital life can reduce meaningful belonging. Second, Merton's strain concept explains why an unequal education system with a single narrow definition of success is so damaging, especially to disadvantaged students. Third, gender norms and family control cause distinct burdens for girls and boys. Fourth, the shortage of adolescent-friendly services and persistent stigma mean that distress is often unseen until a crisis.

A sociological lens also cautions against reducing suicide to "examination failure" or "love failure", the labels used in official records. These are precipitating events; underlying causes lie in prolonged distress, family climate and social structure (Vijayakumar, 2007; Radhakrishnan & Andrade, 2012).

Recommendations:

1. **Schools and colleges:** appoint trained counsellors, integrate life-skills and emotional well-being into the curriculum, reduce emphasis on rank-based comparison, train teachers to recognise warning signs, and enforce anti-bullying policies.
2. **Families:** promote open communication, reduce comparison and excessive pressure, and encourage parents to seek help early.

3. **Community and local government:** use panchayats, anganwadi and ASHA workers, youth clubs and self-help groups for awareness and referral; run stigma-reduction campaigns in Kannada and local dialects.
4. **Health system:** expand child and adolescent mental health services at district level, strengthen Tele-MANAS awareness among teenagers, and ensure follow-up care after any self-harm.
5. **Means restriction and media:** limit access to pesticides and other lethal means, and encourage responsible, non-sensational media reporting.
6. **Examination reform:** reduce high-stakes reliance on single examinations, provide supplementary exam opportunities and career guidance, and make support available during results periods.
7. **Research:** conduct primary, mixed-method studies in Karnataka covering rural, urban, gender and caste differences, and the role of digital media.

Conclusion:

Suicidal tendencies among teenagers are a social problem as much as a medical one. In Karnataka, the combination of educational competition, changing family structures, gender and economic inequalities, and limited youth services creates conditions in which some adolescents lose hope. Preventing such outcomes requires a coordinated response that strengthens belonging, relaxes excessive pressure, improves access to care and builds reliable local data. A sociological approach directs attention from blaming individuals to repairing the social environments in which young people grow up.

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