ACADEMIA International Journal for Social Sciences
Volume 4, Issue 3, 2025 ISSN-L (Online): 3006-6638

Unveiling Suicidality among Adolescents in Chitral: Identifying the Most Affected Age Group

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Received: 09-04-2025 **Revised:** 10-05-2025 **Accepted:** 15-06-2025 **Published:** 09-07-2025

ABSTRACT

Adolescence is a period that is considered critical for the onset of suicidality. Yet, minimal empirical evidence is provided for how much suicidal risk exists and how much it varies within different age groups. The study aimed to examine the distribution of age-group-wise and age-based suicidality risk among adolescents in Chitral, KPK. A cross-sectional study was conducted in Lower Chitral among 2000 school/college-going adolescents aged 12-19 years. The participants were assessed for suicidality risk using the suicidal behavior questionnaire–revised (SBQ-R), and the sample was categorized into three group's early adolescence (12-14 years), middle adolescence (15-16 years), and late adolescence (17-19 years). The data was analyzed using cross-tabs to identify age-wise suicidality risk among adolescents in Lower Chitral. The findings revealed that suicidality risk increased with age. Among which the high risk was the middle adolescence, n = 327 (46.8%), then the late adolescence with a risk of 42.2% and the least risk was found in early adolescence. Cross-tabs using chi-square test showed statistically significant results (p< .001). Along with that, among the middle-aged adolescents, the most at-risk age was 16 years old, results showing that the adolescents were highest in number for low risk (33.8%) and high risk (26.0%), making 16 years old the most vulnerable age in Chitral. These findings show that there is a need for age-specific mental health interventions in Chitral, particularly targeting those who are more vulnerable to suicidality. This study provides a large-scale, stratified empirical evidence of suicidality existing among adolescents in Chitral, indicating early interventions for preventive strategies for mental health problems in educational settings or the community.

Key words: *Adolescents, suicidality, age-groups, and Chitral.*

INTRODUCTION

The act of killing oneself due to depression or any other mental disorder is known as suicide (APA, 2018). The term suicidality refers to all kinds of behaviors that are related to suicide or thoughts, which include completion or attempted suicide, suicidal ideation, or communicating to commit suicide. The spectrum of suicidality consists of suicidal ideation, suicidal behavior, and passive thoughts regarding death and completed suicide, which is also the end of this spectrum (Brent et al., 1988; Gould et al., 1998; Lewinsohn et al., 1996; Reinherz et al., 1995). The definitions of suicidal thoughts and behavior were developed by O'Carroll et al. (1996), which were further adopted by the Institute of Medicine (2002). Thoughts about harming or killing oneself are known as suicidal ideation, whereas a destructive act that is self-inflated and non-fatal to die is known as attempted suicide, and a self-inflicted, dangerous, and non-fatal act to die is suicide. There is a significant number, especially younger people, who commit suicide (Wasserman, 2016). Every year, more than 720,000 people die from suicide (WHO, 2024; Bertolote,

2001). In 2019, reported figures were 759,028 cases, which resulted in a rate of 9 cases per 100,000 people across both genders globally. Research specifically addressing suicide rates in youth under 18 is essential to further understanding the progression of suicidal behavior as children mature through adolescence (McLoughlin et al., 2015). Suicide and psychiatric morbidity are increasingly recognized as critical public health issues in Pakistan's remote northern regions, including Chitral, the Hindu Kush, Karakoram, and Gilgit-Baltistan. A cross-sectional study conducted in the Hindu Kush and Karakoram regions between 2015 and 2016 assessed psychiatric morbidity among 478 individuals attending general medical camps. The study found that nearly half of the participants exhibited psychiatric morbidity, with significant inter-valley differences. Women reported significantly higher psychiatric distress than men, and occupation, rather than age, was significantly associated with psychiatric morbidity. The findings highlight the widespread mental health issues in the region, which are often unrecognized or untreated due to limited medical resources. This underscores the urgent need for improved mental health services in geographically isolated regions like Chitral, contributing to a broader understanding of psychological distress and suicidality in these populations (Ahmad & Hussain, 2018).

RESEARCH GAP

A study was conducted in Chitral and Gilgit, which used a qualitative method of research mentioned in their limitations, that there is a need for the study to be conducted on a larger sample (Khudadad et al., 2021). It is stated in a study which was conducted in Chitral and Gilgit Baltistan region, highlighted the causes through a qualitative study talking about what can be the reasons of suicide in that specific culture representing the north of Pakistan (Ghazal et al., 2021) the study also states that how much there is need for a mental health professional to conduct assessment of individuals at risk and recognize what can be the possible early signs along with developing a preventive plan or measures. There is a need to be given to the youth or adolescents. Regardless of the advancement in the prevention of suicide worldwide, despite that there are countless hurdles. The accuracy and reliability of suicide statistics are an ongoing issue of concern in a considerable number of countries (Tollefsen et al., 2012). The same study also suggests that research to find out the rate and causes of suicidal risk behavior needs to be conducted on a larger sample, so the results can be generalized. Suicide is a psychological aspect, and studies are required to be done by psychologists so that psychological factors leading to suicide can be identified (Khan et al., 2008).

OBJEVTIVES

1. To identify suicidality risk age-group-wise among adolescents in Chitral.
2. To identify the highest risk age for suicidality risk among adolescents in Chitral.

HYPOTHESIS

1. There would be a significant suicidality risk age-group-wise among adolescents in Chitral.
2. There would be significant numbers of adolescents who are at risk of suicidality in Chitral.

LITERATURE REVIEW

Zygo et al. (2029) reported a study involving a large dataset of 5685 adolescents, which showed that there were 24.6% reported suicidal thoughts, 15.5% reported they had made plans, and 4.4% had attempted suicide. In 2019, reported figures were 759,028 cases, which resulted in a rate of 9 cases per 100,000 people across both genders globally. Suicides are twice more in men as in women, with 12.6 per 100,000 men compared to 5.4 per 100,000 women (Ilic & Ilic, 2022). In low-middle income countries have a high rate of 73% globally suicides showing factors as poor socio-economic conditions, cultural impacts, and limited resources available on suicide rates (WHO, 2024). Differences among genders are shown significantly, and age-related trends of suicide, revealing further contextual factors responsible for

differences in rates. A nationally representative study by Nock et al. (2013) highlighted that One-third of the young people who have suicidal ideation initially plan for committing suicide, and the other one-third directly make a suicide attempt. This also proved that an intervention given at the critical or initial stage can reduce the threat of suicide attempts. According to earlier research, 300 suicides were reported between 2007 and 2011 in Chitral, among which youths were the main victims (Ahmed et al., 2016). Only during the four initial months of 2018, 22 suicide cases were reported, which is unacceptably high in a district having a population of just 4.5 lac (Khan, 2018). Only from a small village, which consists of not more than 50 households, seven youth suicide attempts are reported during the last few years (Ahmad, 2018). Due to the lack of separate systems for mental disorders and cultural sensitivity to suicide, only a few cases are reported to the local media and police department (Hussain et al., 2019). This study is guided by Durkheim's theory of suicide, which states that increased suicide in a society is the result of "anomie," which is a society's decreasing capacity for individual integration and regulation (Durkheim, 2005). The situation in Chitral is similar to that in Gilgit-Baltistan due to shared cultural heritage, and Durkheim's theory of anomie can help explain the phenomenon, where the failure of traditional cultures to integrate individual aspirations leads to increased suicides among youth (Sanauddin et al., 2022).

METHODOLOGY

Study Design

This study adopts a quantitative, cross-sectional survey research design aimed at examining suicidality risk age-wise among adolescents in lower Chitral.

Population and sample

The target population consists of schools and colleges from the public and private sectors, both in the lower Chitral, specifically the town area.

Sample size

A total of 2000 students were selected from educational institutes of the Chitral Town area in lower Chitral, KPK.

Sampling Technique

A simple random sampling technique was used to ensure representation from each educational institute.

Inclusion criteria:

1. Students without any physical disabilities were part of this study.
2. Students from Upper Chitral who are currently in educational institutes of Lower Chitral.

Exclusion criteria:

1. Students who were in Chitral's educational institutes as students but are not from Chitral.
2. Students who are in school or college but don't meet the age criteria for adolescent's i.e., have joined school late due to any illness or any other reason.

Research Instrument

A demographic sheet and Suicidal Behavior Questionnaire –Revised by Osman et al (1999), a revised suicidal behavior questionnaire aimed at measuring every aspect of suicidality, was used to gather data. It is a Likert scale which consists of 4 items, each with a different dimension measuring different aspects of suicide, such as suicidal ideation or attempt in lifetime, frequency of suicidal ideation in the past period of twelve months, intent of suicidal behavior, and self-reported suicidal behavior. The original version was

by Lihenhan(1981). The scale has a reliability of .97 and 89.5% of the total variance. It can be used on both adolescents as well as adults, in clinical and non-clinical settings.

Ethical Consideration

Initially, ethical approval for the topic was taken from the Institutional Review Board of National University of Medical Sciences (NUMS), then permission was obtained from the respective educational institutions from where the data was collected, and ethical and personal consent was taken from the participants. Before getting the data collected, the participants were debriefed regarding the research and made sure that their identity would be confidential throughout the procedure. A questionnaire was administered in person under the supervision of a teacher to ensure honest responses.

Data Collection Procedure

Initially, institutional approval had to be obtained from schools and colleges in Chitral town. After that, verbal consent was taken from the students, and those who gave their consent were selected for the study through simple random sampling. All the students were initially debriefed about the research. After that demographic sheet, along with the suicidal behavior questionnaire, was attached, with it was given to the students. Along with that, proper instructions were given in the local language (Khowar) with the assistance of a teacher from that specific educational institute.

DATA ANALYSIS

The data was analyzed using the statistical tool for social sciences (SPSS) version 26**.** The responses were compiled using descriptive statistics (Frequencies), and to test the hypothesis test was conducted using cross-tabs.

FINDINGS / RESULTS

Table 1

Frequency distribution of age groups of adolescents.

Age-group	Frequency	Percentage
Early Adolescence	380	19.0%
Middle Adolescence	894	36.3%
Late Adolescence	726	44.7%
Total	2000	100%

Note: f= frequency, %=Percentage

Table 1 illustrates the frequency and percentage of age groups of 2000 school/college students. The age group consisted of adolescents from 12 to 19 years old, who were divided into 3 groups: Early adolescence with a frequency of 380 (19.0%), middle adolescence with frequency of 894 (36.3%), and late adolescence with frequency of 726 (44.7%).

Table 2

Crosstabs Test showing differences across age-groups in Suicidality among adolescents in Chitral (N= 2000).

Age-group	High-Risk		Low-Risk		No-Risk			
	f	*%*	*f*	*%*	*f*	*%*	χ2 (df)	p
Early- Adolescents								
(12-14 years)	36	11.0%	126	20.9%	218	20.4%		
Middle – Adolescents								
(15-16 years)	153	42.2%	246	38.4%	495	33.3%	22.774(4)	<.001
Late- Adolescents								
(17-19 years)	138	46.8%	232	40.7%	356	46.3%		

Note: f= frequency, %=Percentage, p =significance, χ2=chi-square, df= degree of freedom. P<0.05 significant, P<0.001 highly significant, P>0.05 non-significant.

Figure 1

Risk of suicidality based on age groups.

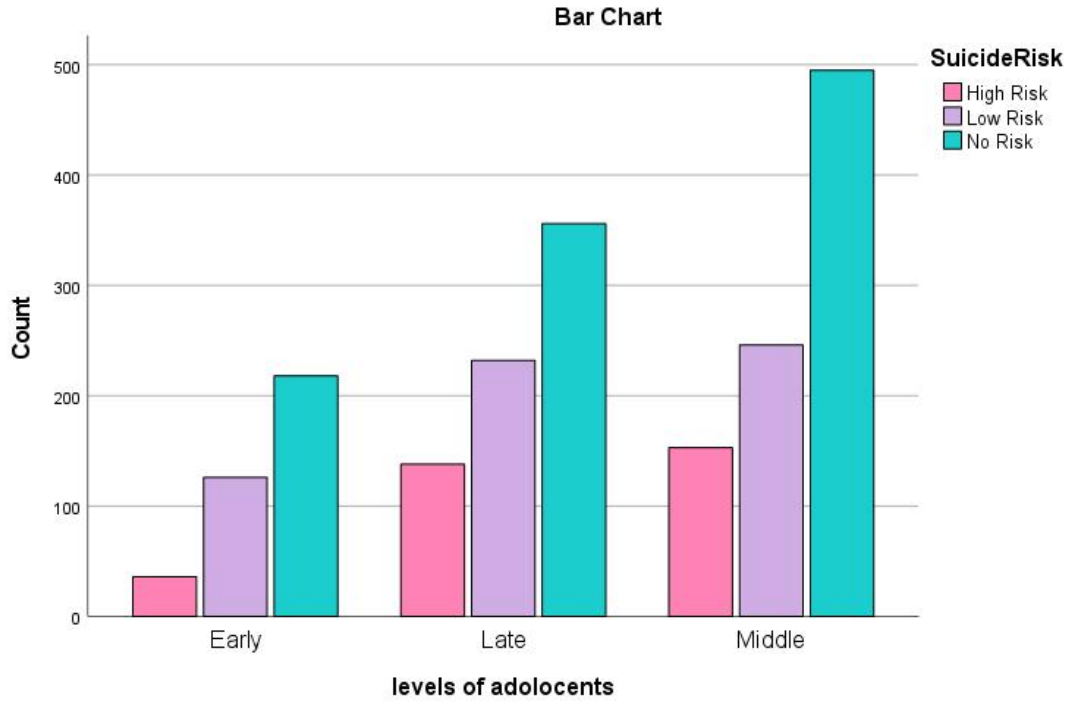

Table 2 and Figure 1 illustrate the frequency and percentage of suicidality risk level with age groups, showing that there is significant suicidality risk age group-wise among adolescents in Chitral. Results indicated that among early adolescents, 11.0% were at high risk, 20.9% were at low risk; among middle adolescents, 46.8% were at high risk and 40.7% were at low risk, and among the late adolescents, 42.2% were at high risk and 38.4% at low risk. The results significantly indicated that middle adolescence is the age group that is at risk of suicidality at both low and high risk.

Table 3

Crosstabs Test showing differences across ages in Suicidality (N= 2000).

	High-Risk		Low-Risk		No-Risk			
Age	***f***	***%***	***f***	***%***	***f***	***%***	**χ2 (df)**	**p**
12	1	0.3%	5	0.8%	3	0.3%		
13	2	0.6%	13	2.2%	17	1.6%		
14	33	10.1%	108	17.9%	198	18.5%		
15	45	13.8%	89	14.7%	231	21.6%	61.226(14)	<.001
16	108	33.0%	157	26.0%	264	24.7%		
17	68	20.8%	159	26.3%	213	19.9%		
18	56	17.1%	122	10.4%	122	11.4%		
19	14	4.3%	21	1.7%	21	2.0%		

Note: f= frequency, %=Percentage, p =significance, χ2=chi-square, df= degree of freedom. P<0.05 significant, P<0.001 highly significant, P>0.05 non-significant.

Figure 2

Risk of Suicidality based on age.

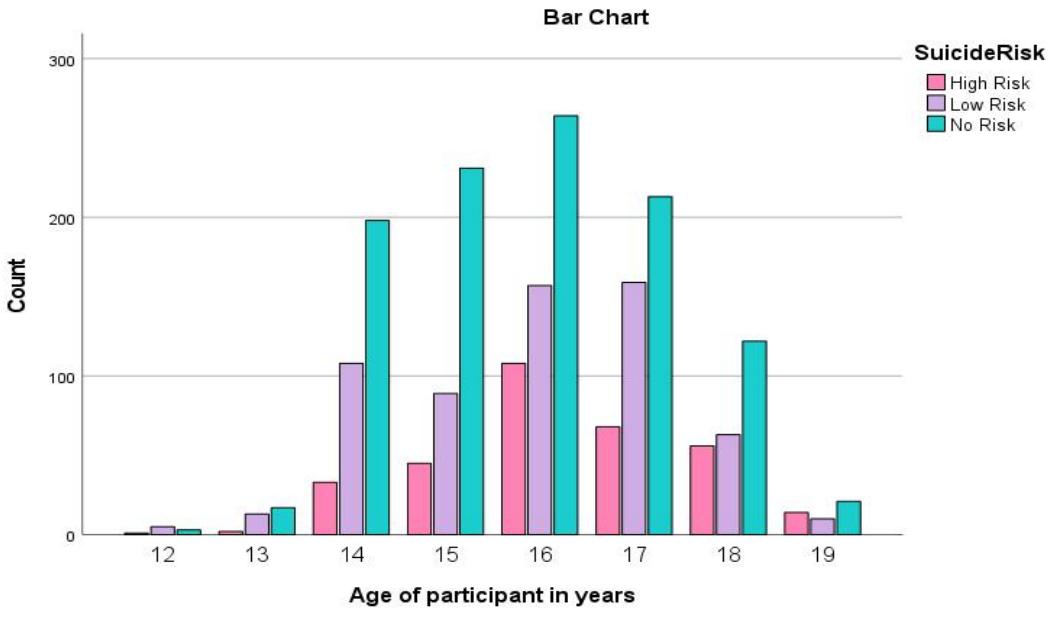

Table 3 and Figure 2 illustrate the frequency and percentage of suicidality risk level across different ages of adolescents, showing that there is significant suicidality risk age-wise among adolescents in Chitral. Results indicated that among 12 year old adolescent 0.3% were at high risk and 0.8% were at low risk, among 13 years old 0.6% were at high risk and 2.2% were at low risk, among 14 years old 10.1% were at high risk and 17.9% were at low risk, among 15 years old 13.8% were at high risk and 14.7% were at low risk, among 16 years old 33.3% were at high risk and 26.0% were at low risk, among 17 years old 20.8% are at high risk and 26.3% at low risk, among 18 years old 17.1% are at high risk and 10.4% at low risk and among 19 years old 4.3$ at high risk and 20.0% are at low risk. These results significantly indicated that the adolescents aged 16 are at the most risk of being suicidal, as they showed the highest percentages for high and low risk.

CONCLUSION

This study aimed to investigate age-group and age-based risk for suicidality among adolescents in Chitral from different educational institutions. By conducting quantitative analysis using frequencies and cross-tabs, our findings revealed significant insights on which age group and age is the most vulnerable and showed how suicidality risk varies across different age groups and how much differently it exists in a specific age group. Overall, the study shows that age is an important factor regarding suicidality. These findings show the importance of providing age-specific psychological interventions or awareness programs in educational institutions. The study also revealed that throughout adolescence, suicidality is experienced and it gets to its peak in middle adolescence, showing how much in schools there is in schools on the mental health of adolescents and identifying the causes, predictors, determinants, age, and culture-specific factors in Chitral.

DISCUSSION

This study assessed age-group and age based suicidality risk among adolescents in lower chitral, the findings revealed that that middle adolescents are the most at risk individuals among other age groups, whereas the other groups also had suicidality at different levels showing that adolescence is a period that is crucial overall and middle adolescence is the most vulnerable indicating 16 years of age as the individuals most at risk for suicidality, adolescents showing suicidality or being suicidal is a serious concern, 39% report suicidal thoughts and 9% attempts reported in Germany (Becker & Correll, 2020). It is rare to find suicidal ideation before the age of 10; it arises between the ages of 12 to 17 (Nock et al., 2012; Nock et al., 2013). Chitrali et al. (2011) in KPK identified that adolescents and young adults, specifically aged 18 -20 years, are the most vulnerable. This study also showed that every age-group had some level of suicidality either low or high, the study highlights the importance of also showing how many adolescents are in danger and how many are to be in danger, The ones having frequent and chronic suicidal ideation are at a greater risk of committing suicide (Czyz & King, 2015; Wolff et al., 2017). The susceptible periods for beginning suicidal behavior are adolescents and the initial years of adulthood, studies indicating that age groups like these are at risk for developing such shifts (Kessler et al., 1999). Adolescents are the age which is considered a fundamental goal for preventing the risk of suicide. According to the statistics regarding suicide rates showed that deaths are occurring more among young people aged 15 to 29 years, showing it to be a critical problem. A study in the United States showed that the third most common cause of death among young people ages 10-14 is suicide, the third most common cause, and among young adults who are up to 34 years in the second most common cause (Kabeya Diyoka et al., 2025; Nock et al., 2013). Despite the existing severe presence of suicidal thoughts and behaviors among adolescents, they still go unnoticed by guardians such as teachers, parents, and even healthcare professionals, which is a significant challenge in early prevention strategy (Cervantes et al., 2025).

RECOMMENDATIONS

1. Introduce prevention programs regarding suicide in educational settings at the start of the new batch.
2. Training programs for parents and especially for teachers should be provided for awareness to raise awareness of early signs of suicidal behavior.
3. Develop support groups or recommend these in schools at least once a month to create a non-judgmental environment for discussing problems and sharing them.
4. Strict mental health policies that have anonymous reporting systems were suicide threats can be reported by students themselves, as well as their peers.
5. Prevention programs should be inclusive of both genders.
6. School-based campaigns for teacher training to identify early signs of suicidality.
7. Schools and community organizations should implement early intervention programs to identify adolescents at risk for suicidal behavior.
8. Public campaigns and school programs that address mental health stigma and promote positive attitudes towards seeking help are crucial for reducing the risk of suicidal behavior in adolescents.

LIMITATIONS

1. Most of the sample is from the Chitral town of lower Chitral, consisting of only nearly 200 students from upper Chitral. This limits the generalizability of the findings to upper Chitral.
2. The findings may not fully represent Lower Chitral because it had very little data from the surrounding areas of Lower Chitral, such as Drosh, Ayun, and Garam Chahsma, as the data was restricted to Lower Chitral's town area only.
3. The study might have reporting bias because suicide is a sensitive topic adolescents might have a fear of stigma while reporting it.

SUGGESTIONS

1. To determine suicidality, a regional-focused study, covering the entire region of lower Chitral or upper Chitral, is required.
2. Focusing more on the cultural context that causes suicidality.
3. A good qualitative research using in-depth interviews in the local language to explore suicidality and its causes (contributing factors) and the personal experiences and perceptions.
4. Identify the protective factors to reduce suicidality.

ACKNOWLEDGEMENT

I would like to express my gratitude to the faculty and administration of all the educational institutions (Schools and colleges) in Chitral who permitted me to conduct my research and also facilitated me throughout the research. I'm deeply thankful to them as they placed their trust in me as a clinical psychologist and as a researcher, enabling me to conduct my work without any institutional barriers. Their openness reflects a true commitment to academic growth and knowledge advancement. This study would not have been possible without their cooperation.

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