SUICIDE IN SIKKIM: A SOCIOLOGICAL STUDY

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Declaration

I declare that the dissertation entitled "***Suicide in Sikkim: A Sociological Study***" submitted by me in partial fulfilment for the degree of **MASTER of PHILOSOPHY of JAWAHARLAL NEHRU UNIVERSITY** is my own work. The dissertation has not been submitted for any other degree of this University or any other University

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Certificate

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

Suicidal behaviour has become a major public health problem across the world today. Data from the World Health Organization (WHO) indicates that approximately one million people worldwide die by suicide every year. This roughly corresponds to one death by suicide every forty seconds. The International Association for Suicide Prevention (IASP) describes suicide as *"a complex phenomenon that usually occurs along a continuum, progressing from suicidal thoughts, to planning, to attempting suicide, and finally dying by suicide, which represents the final tragic outcome of a morbid process"*. In India, suicides have been on the rise. As many as 1,34,599 persons committed suicide in 2010, thereby recording an increase of 23.9% since 2000 (NCRB, 2010). Sikkim has a serious problem staring it in the face with the number of lives it is losing to suicides. Over the past decade, the suicide rate has been consistently higher than the national average. The overall suicide rate for 2010 stood at 45.9% making it the suicide capital of the country, ahead of Puducherry and Andaman and Nicobar islands (NCRB, 2010). Although it is now widely accepted that too many suicides are taking place, individual realisation of how people around them could also take that route has not yet dawned. Suicides are still looked at from a sanitised distance of "*it couldn't possibly happen to us*". Any attempt at generating wider awareness and involvement on curtailing suicides has to begin by sharing case studies of how apparently normal children from normal families have also ended their lives. Currently, the problem of suicide has been studied from medical and psychological perspectives.

The National Institute of Health (NIH), US define suicide as *"the act of taking one's own life on purpose"*. Any action that could cause a person to die, like taking a drug overdose or crashing a car on purpose, is deemed to be suicidal behaviour. Medically, suicidal behaviour occurs in people with-

- Bipolar Disorder: A condition in which people go back and forth between periods of a very good or irritable mood or depression. It affects both men and women equally, usually starts between ages 15-25 years and occurs more often in relatives of people with bipolar disorder. There can be three types of bipolar disorder depending on the mood swings. Type I patients have had at least one major manic episode. Type II patients experience periods of high energy levels and impulsiveness which alternate with episodes of depression. The risk of suicide among bipolar persons is very high.

Apart from mood stabilizer drugs, medical treatments like Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS) may be used to treat the disorder (NIH, 2010).

- Borderline Personality Disorder (BPD): A condition in which people have long-term patterns of unstable or turbulent emotions, leading their inner experiences to take impulsive actions and have chaotic relationships. Possible complications among BPD patience include depression, drug abuse, suicide attempts and actually suicide. This disorder is more frequent among women and hospitalized psychiatric patients. It is diagnosed based on a psychological evaluation and the history and severity of the symptoms. Treatment includes individual talk therapy, such as Dialectical Behavioural Therapy (DBT), and group therapy (NIH, 2010).

- Depression: While it is common for a person to feel sad, down in the dumps, unhappy or miserable at some point or another for short periods, true clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or longer. Depressed people view everything negatively, unable to imagine that any problem or situation can be solved in a positive way.

- Drug or alcohol abuse

- Schizophrenia: It is a complex mental disorder that makes it difficult for the person to think logically, differentiate between real and unreal experiences, have normal emotional responses and behave normally in social situations. Schizophrenics suffer from anxiety, depression and suicidal thoughts. Antipsychotic medications are the most effective treatment for schizophrenia (NIH, 2010).

Psychologists viewed suicide as an intensely personal act of self-destruction and highlighted the role of psychopathic states like depression, feelings of hopelessness in explaining suicides. They emphasize on unendurable pain as a cause of suicide but they fail to explain the reason behind the same. The psychological perspective was put forth by Dr. Verma and Dr. Sachdeva in *'Suicide in Sikkim: A Psycho-Social study'* (2008). Accordingly, the major findings of the study included-

- ✓ Higher education provides a blanket against suicides. 90 percent of the victims had studied up to matriculation or below.

- ✓ 25 percent of the victims are farmers. While, the agricultural sector may be the largest employer in the State, its contribution to the State GDP is gradually declining since 1999-2000. The occupational structure must improve in order to generate more employment opportunities and provide satisfaction to individuals.
- ✓ Adequate steps have to be taken to control substance abuse.
- ✓ Education, both at home and in school, needs a re-check so that ethnic cultural practices and norms address the changing needs of a globalized era.

As understood from above, while the general overview of suicide majorly rests on the importance of psychogenic factors, my study focuses on a number of key social issues to highlight its sociological aspects. It is an attempt to provide a third perspective to understanding the problem of suicide in Sikkim. The core argument being that suicidal behaviour is shaped by the same social forces which influence and regulate other general patterns of social life in society. We need to understand that all the reasons that are good enough to live for are also good enough to die for. The main research questions for this study are, to find out:

- The link between suicide rates and external factors like religion, socio-economic status, marriage, education and modernisation.
- How people perceive their roles vis a vis the society?
- The level of integration of people in the family as well as the society.
- If cultural lag is a factor in people committing suicide.
- Are there any noticeable trends in the suicide pattern?

On the basis of the above questions the objective of this study is to arrive at a deeper understanding of the problem like what are the factors that lead a human being to commit the ultimate act of self destruction, what role does the society at large have in people's decision to commit suicide and also what mechanism it has adapted to control this. The first chapter lays out an introduction to the sociology of suicide. Taking Durkheim's *"Le Suicide"* (first published in 1897) as the core text, one arrives at a sociological understanding of suicide and why it is as much a social problem as it is a personal one. The second chapter discusses

suicide trends around the world- what are the different patterns that have emerged as well as select country studies. The third chapter narrows down the research to suicide trends in India with focus on Sikkim. In the fourth chapter, one can explore the framework for explaining suicidal behaviour in Sikkim i.e. the link between suicide rates and external factors like religion, socio-economic status, marriage, education etc. Also, if there are any noticeable trends in the suicide patterns. In the final chapter, I conclude with the findings and suggestions for tackling the problem of suicide in the state.

Data has been collected from official sources provided by the National Crime Record Bureau (NCRB) and State Police Records. A major limitation of this study involves the discrepancy in the total number of suicides as recorded by the NCRB and the State Police. While the former put the combined total at 1,075 suicides in a five year period, from 2006-2010, the latter recorded 1,679 suicides in the same time period. However, data with the State Police seemed inadequate in terms of details of the victims, except details of community which were taken from the records, therefore NCRB statistics were referred to in most of the analyses.

The present work is the first systematic sociological study of suicide in Sikkim and the findings should be of interest to university students, teachers, government policy makers, police, legal professionals and members of welfare associations.

SIKKIM: A BRIEF BACKGROUND

Sikkim is a landlocked state bounded on the north and north-east by Tibet, on the east by Bhutan, on the west by Nepal and on the south by the Darjeeling district of West Bengal. With a population of 6.07 Lakhs, Sikkim is the least populated state in India.[1] The Lepchas, original inhabitants of the land called it *Nye-mae-el* or paradise. The Limbus named it *Su Khim* or new house while to the Bhutias it was simply *Bayul Demazong* or the hidden valley of rice.

Sikkim embraces a synthesis of various communities along with their practiced religions. The original inhabitants of Sikkim are the Lepchas who are believed to have migrated from the Far East and inhabit central and northern areas of the state today. Along with the former, the native Sikkimese also includes the Bhutias, who migrated from the Kham district of Tibet in the 14th century. However, today the Nepalis comprise over 70 percent of the total population. Other migrant communities include Biharis, Bengalis and Marwaris, who are prominent in commerce in South Sikkim and Gangtok.

The Sikkimese are highly devout people and religions play a major role in Sikkim. Buddhism and Hinduism are the two major religions of Sikkim. The latter has been the state's major religion since the arrival of the Nepalis. Nepali is the lingua franca of Sikkim, while Bhutia and Lepcha are spoken in certain areas. An estimated 60.9 percent of the total population are now religion adherents of the, followed by Buddhism which accounts for 28.1 percent.[2] Despite this, Sikkim is mostly recognized as a Buddhist state and has some seventy five Buddhist monasteries, the oldest dating back to the 1700s. Christians in Sikkim are mostly descendants of the Lepcha people who were converted by British missionaries in the late nineteenth century, and constitute around 6.6 percent of the population. Other religious minorities include Muslims of Bihari ethnicity and Jains, who account for roughly 1 percent each.

In 1975, Sikkim became the twenty second state of India, resulting in the end of monarchy and an onset of democracy. In the post-merger Sikkim, this Himalayan state has

[1] Census of India, 2011

[2] Bareh, Hamlet, 'Introduction', *Encyclopaedia of North-East India: Sikkim*, Mittal Publications, 2001

made steady progress in both social and economic fields. The state has witnessed developmental initiatives in socio-economic sectors, including education. Sikkim's economy is largely dependent on agriculture and tourism, and as of 2011 the state has the fourth-smallest GDP among Indian states although it is also among the fastest-growing.[3] *"From a traditional economy with feudal slant, Sikkim has emerged as a modern and robust State of today"*.[4] However, at the same time, there is a possibility that the development initiatives might have brought new mechanisms of deprivations and problems and the development initiatives and achievements may not have find equal reflections in all walks of life. In spite of economic growth and all round development in all sectors, the challenges like drug addiction, alcoholism, suicide and domestic violence cannot be overlooked in Sikkim. These emerging issues are a matter of grave concern for the Sikkimese society which if not taken care of, can lead to pathological social conditions of great magnitude in the near future.

[3] www.unidow.com, 'List of Indian states by GDP', Retrieved on 24th September, 2011

[4] Sikkim Human Development Report, 2001 (Foreword)

CHAPTER 1

THE SOCIOLOGY OF SUICIDE

"Suicide: The act of deliberately killing oneself"- World Health Organization

When a life is lost, the trauma travels through family members, friends, colleagues, neighbours etc. A death affects everyone. Among the different kinds of death, some have the special quality of being the deed of the victim him/herself. This characteristic is fundamental to the common idea of suicide. *"Suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result"*.[5] When a person commits suicide, it becomes especially hard for those close to the victim to come to terms with the complexity of the situation. Questions and concerns about whether the suicide could have been prevented invade one's thoughts. The 2010 National Crime Record Bureau (NCRB) data shows that the overall suicide rate in India is up by 5.9% from the previous year.[6] The increase in suicides has been gradual from 10.5% in 2006, to 10.8% in 2008 and 11.4% in 2010.[7] While Tamil Nadu replaced West Bengal as the state with the highest number of suicides in the country in 2010, Sikkim has a serious problem staring it in the face with the number of lives it is losing to suicides. If one were to go by the rate of suicides, which is the number of suicides per one lakh population, this tiny Himalayan state tops the same at 45.9.[8] It is no wonder that Sikkim is now being called the "Suicide capital of the North East" after recording suicide rates more than three times of the national average during 2008-10 (See Table 5).

Much has been written about suicide over the years by theologians and philosophers alike. In the eighteenth century, it was seen as a moral problem and understood in terms of religion. But since the early nineteenth century it has come to be seen as a social problem

[5] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966.

[6] NCRB report, *Accidental Deaths and Suicides in India*, 2010

[7] Ibid.

[8] Ibid.

requiring scientific explanation. Many psychodynamic theorists believe that suicide results from depression and from anger at others that is redirected towards oneself. So far as social scientists are concerned, suicide has fascinated them for two chief reasons:[9]

1. Universality: Suicide is common to all societies, across culture and regions.

2. Suicide, by its very nature and definition, constitutes a form of deviant behaviour, therefore it demands close scrutiny.

The famous French social scientist, Emile Durkheim, can be credited with being the first thinker to conduct a systematic and scientific study on the subject. His book *"Le Suicide"* (1897, op.cit.) demonstrated how abstract sociological theories can be applied to a very real social problem. His study showed that suicide, believed to be a private and personal act, can best be explained from a sociological viewpoint. Such an insight in his work is the recognition that *"underlying the categorical groups that vary in their relative contribution to the suicide rate are structures of social relations, and that variation in the structure of social relations yields variation in the suicide rate"*.[10]

Close to Durkheim came Sigmund Freud who identified two types of instincts: life instinct (*Eros*) and death instinct (*Thanatos*). When the latter dominates the former, it gives rise to depression, feelings of self-accusation, worthlessness and mood disorder.[11] Such behaviour is not inbuilt but emerges as a result of negative changes in structural conditions wherein the individual lives. According to Freud, both depression and suicidal acts result from a withdrawal from society representing a hostile impulse which is directed towards others. He later introduced the psychoanalysis technique to the study of suicide. Both Freud and Durkheim have contributed immensely to the meaning and sociological dynamics of suicide, therefore any discussion on the same must begin with a review of the two thinkers.

In the late 1950s, a psychologist, Edwin S. Shneidman, coined the term *'suicidology'*. He attributed suicide to psychological pain, which he referred to as *psychache*, arising from

[9] Hassan, Riaz, *Suicide in Australia: A Sociological Study*, 1992

[10] Bearman, Peter S, 'The Social Structure of Suicide', *Sociological Forum*, Vol. 6, No. 3, Sep., 1991: 501-524.

[11] Freud, S (1936). *The basic writings of Sigmund Freud* (A. A. Brill, Ed. And Trans). New York. (Original work published in 1940).

frustrated or thwarted psychological needs.[12] Shneidman dedicated his life to researching suicide. He founded the American Association of Suicidology and his journal called *'Suicide and Life Threatening Behaviour'* is one of the major journals on the topic apart from *'Crisis'* today. Suicidology has its roots in sociology, psychology and psychiatry. Shneidman lays down the three perspectives to emphasize on different causes of suicide and to show how the three are inter-linked:[13]

Table 1

A Comparison of Psychological, Psychiatric and Sociological Perspective

Psychological perspective	Psychiatric perspective	Sociological perspective
Low self-esteem	Depression	Unemployment rates
Coping with stress and crisis	Schizophrenia	Disturbed marital status
Disturbed family background	Substance abuse	Economic crisis
Disturbed relationships	Alcoholism, drug abuse	Migration and ethnicity
Loss and grief	Borderline, anti-social	Influence of religion
Feelings of worthlessness	Neurobiological factors	Societal expectations
Depression		Societal values

These factors not only overlap but are also interdependent on each other. Thus one's relation with different groups may have a psychological effect on an individual, resulting in psychiatric disorders which may ultimately lead to suicide.

Suicide as a Social Fact

For Durkheim, the subject matter of sociology is the study of social facts. A social fact is a thing which is general, external and exercises constraint on the individual or group. In his *"Rules of Sociological Method"*, he cites currency used to undertake transactions,

[12] Shneidman, E. S. (1993). '*Suicide As Psychache: A Clinical Approach To Self-Destructive Behaviour',* Northvale, NJ/London: Jason Aronson, Inc., p.258

[13] Verma, Sunil K. & Swati A. Sachdeva, 'Suicide in Sikkim- A Psycho-Social Study', *Sikkim University*, 2008

religious beliefs etc. as examples of social facts.[14] Before getting into the question of whether suicide is a social fact, one needs to understand what is a social fact? A social fact is external to the actor, created as a result of collective forces. It exists in society as a whole and sometimes across societies. He further states that, *"These types of conduct or thought are not only external to the individual but are, moreover, endowed with coercive power, by virtue of which they impose themselves upon him, independent of his individual will".*[15] Such facts are different from psychological, biological or economic ones in the sense that they are social and rooted in group sentiments and values. While they seemingly appear as things, social facts are *"to be studied empirically, not philosophically".*[16] These facts regulate human social action and are enforceable by law. Those who violated such collective sentiments and values were punished by way of penalties or sanctions.

Durkheim distinguished between two types of social facts- material and non-material. The former were features of society such as social institutions in place like law, schools, the economy etc. while the latter was considered to be the main subject of study for sociologists. None-material facts, as the name itself suggests, have no material existence. Few examples of such social facts include norms, values, systems of morality etc. Since one cannot understand individual behaviour without understanding the social forces acting upon that individual, suicide too must be studied accordingly.

In his book on suicide, Durkheim proposes to uncover social facts that affect rates of suicides in different countries during different times. In his words,

"The relative intensity of this aptitude is measured by taking the proportion between the total number of voluntary deaths and the population of every age and sex. We will call this numerical datum the rate of mortality through suicide, characteristic of the society under consideration. It is generally calculated in proportion to a million or a hundred thousand inhabitants".[17]

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[14] Durkheim, Emile, *The Rules of Sociological Method*, New York, The Free Press, 1938

[15] Ibid., p.2

[16] Ritzer, George, *Sociological Theory*, Third edition, New York, McGraw-Hill, 1992, p.78

[17] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966, p.48

The suicide rate was therefore permanent and valid, making it *"a factual order, unified and definite"*.[18] He sought to verify his theory *"by establishing that suicide rates vary as a function of several social environments, such as religion, family, political society, professional group etc"*.[19]

By looking at suicide rates instead of individual suicides, he linked suicide to social integration- the extent to which individuals feel they are a meaningful part of society. Those with the strongest social bonds are less likely to commit suicide than those who are less meaningfully integrated and have weaker social bonds. *"Social suicide-rate can be explained only sociologically"* since each person has a collective force or energy driving him towards self destruction.[20] For example, his data demonstrated that married people had lower suicide rates than those who were single or divorced; people in the workforce had lower rates than those who were unemployed; and church members had lower rates than non-members.[21] Moreover, those religions that promote the strongest social bonds among their members, like Catholicism, had much lower suicide rates than less structured religions, like Protestantism.

Durkheim's Study on Suicide

The defining feature of suicide was the conscious renunciation of existence. Durkheim starts his study by challenging the dominant views held by the psychologists of his time for whom suicide needed to be approached from an individual psychological angle. In the first part of the book, he explores the various kinds of insanity and their connection to suicide based on the classification put forth by Jousset and Moreau de Tours.[22] Accordingly, we have:

1. Maniacal suicide: Due to hallucinations or delirious conceptions.

2. Melancholy suicide: Related to extreme depression and exaggerated sadness.

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[18] Ibid., p.51

[19] Hassan, Riaz, *Suicide in Australia: A Sociological Study*. 1992. p.4

[20] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966, p.299

[21] Ibid.

[22] Ibid., pp. 63-65.

3. Obsessive suicide: A fixed idea of death.

4. Impulsive or automatic suicide: Resulting from an abrupt impulse.

While psychological causes at the individual level were important, Durkheim admits that under similar circumstances a degenerate is more prone to committing suicide than a normal person but such an act cannot be accredited to his condition alone. Other factors too must be considered. In his words, *"Suicide is always the act of a man who prefers life to death".*[23] However, the causes determining him are not common in all cases; at times they even seem mutually opposed. He dismisses arguments put forth by psychologists that psychopathology, heredity or race are related to changing rates of suicide states and goes on to say that *"since suicides of insane persons do not constitute the entire genus but only a variety of it, the psychopathic states constituting mental alienation can give no clue to the collective tendency to suicide in its generality".*[24] While at first it may appear that a victim's acts were a result of his personal temperament, a closer look reveals that such an action is actually a prolongation and supplement of a social condition which is then expressed externally.

In the absence of very precise or complete data, Durkheim nevertheless took the analysis of suicide in a quantitative manner. For the same, he uses statistical methods to compare data cross-sectionally, over time, and among nations. As an example of this method, one can consider his analysis of seasons and its relation to suicide. If asked to logically foretell what season should be the most favorable to suicide, the answer would probably be when the weather is dreary; temperatures are low or humidity is at its peak.[25] Thus, Montesquieu considered colder countries to have higher rates of suicides. However, data revealed that the six warmest months (March to August) reported more suicide cases. *"Neither in winter nor in autumn does suicide reach its maximum, but during the fine season when nature is most smiling and the temperature mildest. Man prefers to abandon life when it is least difficult".*[26] This pattern was almost exactly the same everywhere.

[23] Ibid., p.277

[24] Ibid., p.67

[25] Ibid., pp. 106-107

[26] Ibid., p.107

Durkheim was basically drawing conclusions that associated the higher numbers of suicides with *"the time when social life is at its height"*.[27] For him, collective consciousness played an extremely important role in exerting external constraint on individual members of society. It was this same collective force which determined the rate of voluntary death. These natural factors must work socially, and affect some social aspects which are related to suicide. To demonstrate this he refers to the summer months when day time is longer, offering *"wider latitude to collective life"*.[28] While being uncertain about how it really affects the suicide rate, he stated that public activity is greater in the summer thus giving rise to accompanying effects, including suicide. This argument doesn't hold true when applied in the case of Sikkim. Between 2006 and 2010, higher numbers of suicides have taken place in a somewhat scattered manner, including both summer and winter months. As mentioned earlier, those religions that promote the strongest social bonds among their members, like Catholicism, had much lower suicide rates as compared to their Protestant counterparts. Rather than the religion itself, it is the social organization which is the cause of such difference. He takes the institution of family as the causing factor. Those in large families are less likely to commit suicide and vice versa.[29]

Types of Suicide

Cause determines effect and, dwelling on the same law, Durkheim argues that there must be several kinds of suicide which are *"distinct in quality from one another"*.[30] Accordingly, suicides need to be observed, studied in detail and grouped in distinct classes corresponding to the types just distinguished.[31] This means following the various currents that link an individual's social origins to personal manifestations which in turn generate suicide tendencies. *"Each victim gives his act a personal stamp… but these causes in turn must stamp the suicides they determine with a shade all their own, a special mark expressive*

[27] Ibid., p.119

[28] Ibid., p.118

[29] Giddens, Anthony, *Capitalism and Modern Social Theory: An Analysis of the Writings of Marx, Durkheim and Max Weber*, Cambridge, Cambridge University Press, 1971, p.83

[30] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966, p.277

[31] Ibid.

of them. This collective mark we must find".[32] The most important aspects of social organization and collective life for explaining differences in suicide rates are the social currents of integration and regulation. Based on the two typologies, four types of suicides have been outlined depending on high or low degrees of both integration and regulation.

1. Egoistic suicide- This occurs when the degree of social integration is extremely low, resulting in excessive individualism and meaninglessness in the social context. Here we can refer to Durkheim's classification of mechanical and organic solidarity. Societies that are based on the former do not report such cases since the community is very close knit and there is a strong collective consciousness. In modern societies, this bond has been weakened which may lead to dissatisfaction and, as a result, cause individuals to take their own lives. Durkheim concentrates on the differing rates of suicide by religion, family etc. to analyze the influence of integration. Although religion was not directly responsible for suicide it is the *"degree of integration which religion produces… through shared beliefs and a sense of belonging".*[33] To give an example, he compares suicide rates among Protestants (Denmark, Prussia) and Catholic countries (Spain, Portugal) in Western Europe. Data shows that one found higher suicide rates among the former.[34] This can be linked to the Protestant emphasis on 'free inquiry'; whereas Catholicism was strict so far as adherence to norms was concerned. In Durkheim's words,

"Inversely, the greater concessions a confessional group makes to individual judgment, the less it dominates lives, the less its cohesion and vitality. We thus reach the conclusion that the superiority of Protestantism with respect to suicide results from its being a less strongly integrated church than the Catholic Church".[35]

Similarly, one can also take traditional joint families and married persons as an example. Those living under a single roof enjoyed far greater social integration than their nuclear counterparts. Also, a great sense of collectiveness was felt in a married and family

[32] Ibid., pp. 277-278

[33] Hassan, Riaz, *Suicide in Australia: A Sociological Study*. 1992. p.7

[34] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966, p.152

[35] Ibid., p.159

life thus resulting in fewer suicides.[36] In short, egoistic suicide occurs when individuals have social ties that keep them bound to the society of which they are a part.

2. Altruistic suicide- The Oxford dictionary defines altruism as *"disinterested and selfless concern for the well being of others"*. Going by the same definition, altruistic suicide occurs when there is immense social integration. An individual completely identifies with the group, so much so that he doesn't have an identity outside it. Such kinds of suicides were frequent in *"relatively small, tribal and primitive societies"*.[37] Durkheim believed that such suicides were apparent in societies based on mechanical solidarity, like tribal groups, wherein each member is willing to sacrifice his life for the benefit of the whole. While it displays peculiar characteristics, altruistic suicide, according to him, falls into one of the following three categories:[38]

- Suicides of men on the threshold of old age or stricken with sickness.
- Suicides of women on their husbands' death.
- Suicides of followers or servants on the death of their chiefs.

Durkheim cited examples from among the age old custom of sacrifice among the sages of India, the practice of Sati which is ingrained in Hindu customs and large scale weapons, horses and personal followers who were burnt along with the body of the chief. The difference between egoistic and altruistic suicide stems from the fact that while in the case of the former society forbids the choice of death, in the latter it speaks of the sentence of death.[39]

In modern societies, one can find a special environment where altruistic suicide is chronic i.e. the army. Durkheim compares data of military versus civilian suicides in chief European countries like the United States, Austria, England, Italy etc. to show that the suicidal aptitude of soldiers is at a higher level than that of the civilian population.[40]

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[36] Ibid., pp. 171-175

[37] Hassan, Riaz, *Suicide in Australia: A Sociological Study*. 1992. p.5

[38] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966, p.219

[39] Ibid., p.220

[40] Ibid., p.228

Bachelorhood, alcoholism and disgust with the service were taken as possible reasons for the high suicide rate, which were dismissed later through his research. Also, while it was easy to tag as altruistic those deaths that were a result of a soldier sacrificing his life for his comrade, a more detailed study reveals that there is a strong tendency to accept suicide to escape unbearable situations pertaining to the rigid discipline, laws and procedures of the army.[41] Thus altruistic suicide *"springs from hope; for it depends on the belief in beautiful perspectives beyond this life. It even implies enthusiasm and the spur of a moment faith eagerly seeking satisfaction, affirming itself by acts of extreme energy".*[42]

3. Anomic suicide- This type of suicide is a result of sudden change in a person's social position creating an unfamiliar situation with which he is unable to cope. It is likely to occur when *"the regulative powers of society are disrupted".*[43] In the beginning of the chapter itself, Durkheim speaks of the economy as an influencing factor for suicidal tendencies. Thus, whether the nature of disruption is an economic boon or an economic crisis, the rates of anomic suicides are bound to rise in both situations. Other examples include during business failures, big lottery win etc. Times like these the society is *"incapable of exercising control over individual passions".*[44]

"Both this and egoistic suicide spring from society's insufficient presence in individuals", however the key difference between the two is that, in the former, society's influence is lacking in terms of individual passions, while in the latter it is *deficient in truly collective activity.*[45]

4. Fatalistic suicide- Durkheim spent very little time discussing fatalistic suicide. He described it as taking place when there was excessive regulation, for example suicide of married women who are childless. *"Persons with futures pitilessly blocked and passions violently choked by oppressive discipline"* may see no possible manner in which their lives

[41] Hassan, Riaz, *Suicide in Australia: A Sociological Study*. 1992. p.5

[42] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966, pp. 225-226

[43] Ritzer, George, *Classical Sociological Theory*, Third edition, New York, McGraw-Hill, 2000, p.196

[44] Hassan, Riaz, *Suicide in Australia: A Sociological Study*. 1992. p.8

[45] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966, p.258

can be improved, and when in a state of melancholy, may be subject to social currents of fatalistic suicide.[46]

Durkheim's study provided a new perspective to look at and understand suicide. The core logic of his argument was that *"differences or changes in the collective conscience lead to difference or changes in social currents, and these, in turn, lead to differences or changes in suicide rates"*.[47] Following him was Maurice Halbwachs, another French sociologist, who wrote *"Les Causes de Suicide"* (The causes of suicide) in 1930. In his book he expanded and elaborated on the former's theories on suicide. He substituted social isolation for Durkheim's concepts of anomie and egoism and found that suicide rates varied directly with the degree of social isolation. Thus, large cities reported more suicides. One of the core criticisms of his theory was that *"whilst suicide rates vary from city to city, they do not necessarily vary by size nor do they remain constant over time"*.[48]

Gold's paper on *"Suicide, homicide and the socialization of aggression"* (1958) derives hypothesis very similar to those of Henry and Short, employing an index of preference for suicide or homicide, the Suicide-Murder Ratio (SMR).[49] Henry and Short argue that the degree of external restraint determines how individuals choose to commit either of the two. The more an individual is externally restrained, the more likely it is that he will regard others as legitimate targets for aggression. Thus, chances of homicide are higher when the degree of external restraint on an individual is greater. Further, they state along Durkhemian lines that individuals involved in intimate social relations are more externally restrained. Thus married people and rural dwellers are more likely to prefer homicide to suicide.[50] Also, they suggest that the choice of suicide or homicide, prompted by a state of anomie, is not purely a psychological matter, that external restraint which grows directly out of position in the social setting leads to such an expression of aggression. Gold positions himself somewhere in the middle by stating that if such is the case then one needs to search

[46] Ibid., p.276

[47] Ritzer, George, *Classical Sociological Theory*, Third edition, New York, McGraw-Hill, 2000, p.194

[48] Hassan, Riaz, *Suicide in Australia: A Sociological Study*. 1992. pp. 10-11

[49] Gold, Martin, 'Suicide, homicide and the socialization of aggression', *American Journal of Sociology*, 63, May. 1958. pp. 651-61

[50] Ibid., p.661

for the manner in which these sociological variables get transferred into those psychological determinants which in turn lie closer to the actual individual choice.[51]

Social life assumes that an individual has certain personality traits which he is willing to surrender for the sake of the collective, but at the same time he is sensitive to ideas of progress to a certain degree. Accordingly, the stronger this is the more it influences individuals to commit suicide. This strength can depend on three sorts of causes:[52]

1. The nature of individuals composing the society
2. The nature of their social organization
3. The transitory occurrences which disturb the functioning of the collective life without changing its anatomical constitution, such as national crisis, economic crisis etc.

For Durkheim, individual qualities play a role only if they exist in all persons as minor qualities drown in the mass of others. Douglas, on the other hand, stressed the importance of an analysis of the individual meaning of suicidal acts in order to arrive at a social understanding of suicide. In *"The Social Meaning of Suicide"* (1967), Douglas emphasized on the need to understand the social and cultural patterns of suicide and to start with individual cases in an intense, descriptive and analytical manner. He was in favour of a case study approach to *"unravel the personal meaning of the suicidal action to the particular individual"*.[53] The actions and reactions of other stakeholders like family, friends, relatives etc. were equally important.

Both Pescosolido and Mendelsohn have explored another dimension of suicide studies. They state that while empirical analysis of the various social causes forms an important part of sociological inquiry, a more recent concern tailors to the construction of these suicide rates since there is *"pressure from local government officials, attempts at concealment by the family and the lack of evidence confounding the re-cording of cause in*

[51] Ibid.

[52] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966, p.321

[53] Hassan, Riaz, *Suicide in Australia: A Sociological Study*. 1992. p.14

suspicious deaths",[54] thus concealing the true social correlates of suicide. In their paper they distinguish among three types of errors: random error, uniform under-reporting and systematic misreporting. The systematic test, based on suicide data collected from 404 counties with population over 250,000, reveals that the errors found in the official suicide data in the United States are *"generally not large enough to preclude meaningful sociological analysis"*.[55]

Baller and Richardson revisit the classic debate of whether suicide indeed clusters in geographic space. They use techniques of spatial analysis and data in two different settings- late nineteenth century French departments and late twentieth century United States counties.[56] Results indicate that Durkheim's dismissal of imitation was premature. The former including non-western US contradicts his claims that imitation has no role in shaping the geographic pattern of suicide, western US however supports his view. The overall conclusion was that clustering of social integration cannot fully account for the clustering of suicide. Thus, the geographic pattern of suicide is indeed shaped by both social integration and imitation.

Criticisms

Durkheim began his career in the late 1800s when sociology was still not widely accepted in Europe or elsewhere as an independent scientific discipline, however his study on suicide has endured the test of time. Over the years, the sociological approach to suicide has been criticised on many levels. Inkeles (1959) has pointed out that Durkheim's analysis rested on psychological assumptions about the limitless nature of human desires. For Durkheim, human nature is substantially *"the same among all men, in its essential qualities"*.[57] If suicide could be explained by individual psychological problems, suicide rates would be static, but they vary across societies and over time. He treats psycho-biological

[54] Pescosolido, Bernice A. and R. Mendelsohn, 'Social Causation or Social Construction of Suicide? An investigation into the Social Organization of Official Rates', *American Sociological Review*, Vol. 51, No. 1, Feb., 1986, p.80

[55] Hassan, Riaz, *Suicide in Australia: A Sociological Study*. 1992. p.15

[56] Baller, Robert D. and Kelly K. Richardson, 'Social integration. Imitation and the Geographic Patterning of Suicide', *American Sociological Review*, Vol. 67, No. 6, Dec., 2002: 873-888

[57] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966, p.247

qualities as *constants* rather than as *variables* in his analytical scheme. The complete reliance on statistical data has also been criticized since such data was not collected with such a purpose in mind and was often inaccurate. Schneidman rejects Durkhemian typology of the three suicides in a setting wherein a clinician is face to face with a suicidal person. Douglas, on the other hand, questions those theorists who have uncritically accepted Durkheim's theory of collective consciousness, that each member is "*automatically enmeshed to the same degree in a homogeneous culture and holds identical normative values*".[58]

Hassan is correct in stating that no single theory of suicide can explain and embrace all facets of the problem in terms of accurate predictions which differentiate the potential victims from the unintended casualties or the social conditions that help explain the varying suicide rates.[59] Whether biological, psychological or sociological, the study of suicide must be judged categorically and viewed according to their empirical and theoretical contribution to the ongoing scientific investigation.

[58] Hassan, Riaz, *Suicide in Australia: A Sociological Study*. 1992. p.22

[59] Ibid., pp. 22-23

CHAPTER 2

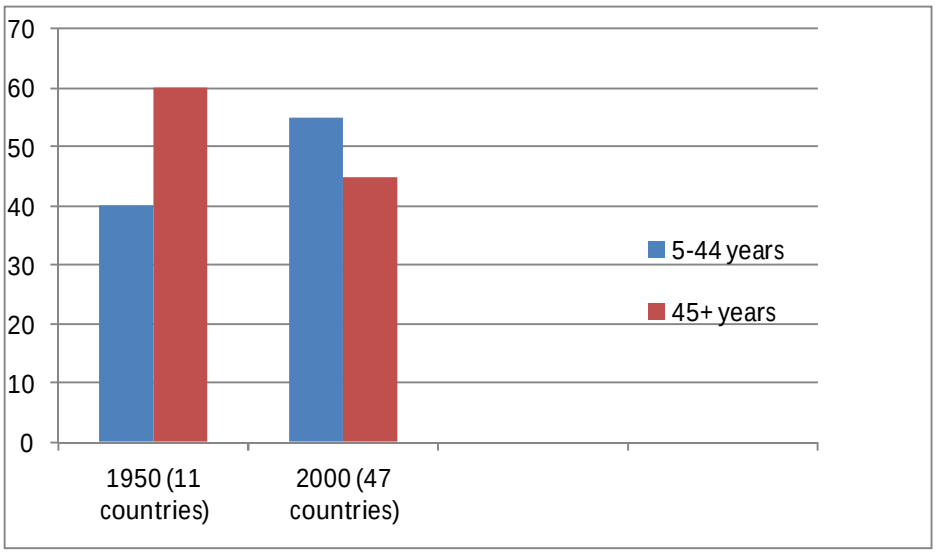
SUICIDE TRENDS AROUND THE WORLD

"September 10th, 2012 marks the 10th anniversary of the World Suicide Prevention Day: ten years of research, ten years of prevention, ten years of education and dissemination of information"- International Association for Suicide Prevention (IASP)

According to the World Health Organization, in the last 45 years suicide rates have increased by sixty percent worldwide, so much so that one person commits suicide every forty seconds. However, this data does not include suicide attempts which are up to twenty times more frequent than successful suicide. Also, changes in the age distribution of suicide between 1950 and 2000 show that in present times, people between the age group of 5-44 years are more at risk to suicide than those 45 years and older (see Figure 1 below). Suicide is now *"among the three leading causes of death among those aged 15-44 years in some countries, and the second leading cause of death in the 10-24 years age group"*.[60]

Figure 1

Changes in the Age distribution of Cases of suicide, 1950-2000



Source: World Health Organization, 2002

[60] http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/index.html

The prevalence of rates of both attempted and completed suicides are significantly different across the world. A report commissioned by the National Council on Suicide Prevention, Australia gives a detailed gender-wise distribution of suicide. It states that while there is a decline among the older females, the suicide rates have not increased for younger females. Among males, there has not been any substantial change in the global rate of suicide between the early 1960s and late 1990s. However, *"an examination of age-specific rates shows that suicide rates among young males (under 45 years) have risen while suicide rates among the older males (55 and over) have declined"*.[61] Hence, prior to 2003, when this report was first published, the relatively stable male suicide rate is the result of a shift in the balance of suicide risk between young and old males over the last four decades. Meanwhile, the reduction observed in female suicide rates in the same time period can be attributed to decrease in suicide among older females.

There are many explanations for the rise in suicides among the younger male population. This increase, especially in Australia, United States, Canada and New Zealand, may be a reflection of the combination of societal changes that have occurred in most developed countries since the end of World War II. In Australia, after controlling for age and period together, cohort effect was an important factor in male suicides in cohorts born after 1935-39.[62] Gunnell et al. argued that the unfavourable trend in the younger male group was related to social disintegration, such as unemployment, divorce, alcohol and drug abuse, decline in marriage, and income inequality. Whereas, *"a decrease in suicide rates of older people in England and Wales was attributed to a social safety network, namely the extended National Health Service health provision and wide-spread use of antidepressant agents as a result of an increased gross domestic product"*.[63] Unemployment is an important risk factor for suicide. Back in 1999, half of the record 33,000 people who committed suicide in Japan were unemployed. Suicide risk in relation to unemployment is far greater in men than women. *"In males, unemployment is associated with a two to threefold increased risk of*

[61] Leo, Diego D. & Russell Evans, 'International Suicide rates: Recent trends and implications for Australia', *Australian Institute for Suicide Research and Prevention*, Commonwealth of Australia, 2003, p.13

[62] Ibid., p.135

[63] Kwon Jin Won, Heeran Chun & Sung-il Cho, 'A closer look at the increase in Suicide rates in South Korea from 1986-2005', *BMC Public Health*, 2009; 9:72, 27th February, p.2

suicide, whereas risks amongst females are around 50 percent higher than those in employment".[64]

Further, the said report also explains suicide trends based on cohort size, as mentioned below:

- **Childhood (0-14 years):** The suicide rate among children has been on the increase in the last four decades in most countries in all regions, particularly in the New World (646% in New Zealand, 240% in Canada), Old World (420% in Scotland, 3900% in Ireland), and Scandinavian countries.[65]

- **Adolescence (15-24 years):** Since the last decade of the twentieth century, many countries have recorded declining suicide rates among male adolescents. "*The variable nature of suicide rates among adolescent females in most regions precludes any firm conclusions on trends".*[66]

- **Early Adulthood (25-44 years):** The report shows that there has been widespread decline in suicide rates in this age group since the late 1990s. In the New World and Eastern and Southern Europe, the recent decline represents an opposite trend in suicide rates. Large increases have been witnessed in only a small number of countries including Northern Ireland (58.2%), Japan (51.8%), and Bulgaria (27.3%).[67] Among females, suicide mortality declines have generally continued in the late 1990s.

- **Middle Adulthood (45-64 years):** The suicide rates among middle-aged men have been relatively stable in the 1980s and 1990s. Based on recent data, declines have been noticed in the Old World, Western Europe and Southern Europe, whereas an opposite trend is visible in Asia (South Korea and Japan). For middle-aged females, "*Recent data show that rates in some countries continue to decrease [e.g. Australia (-*

[64] Leo, Diego D. & Russell Evans, 'International Suicide rates: Recent trends and implications for Australia', *Australian Institute for Suicide Research and Prevention*, Commonwealth of Australia, 2003, p.126

[65] Ibid., p.75

[66] Ibid.

[67] Ibid.

54.4% since 1997), Scotland (-19.7%), and Hungary (-13.4%)] but most have been stable for the past several years (e.g. Switzerland, Canada, England)".[68]

- **Late Adulthood (above 65 years):** Data show that suicide mortality among older males and females has been continuously on the decline since the late eighties.

Why Suicide?

There can be a number of reasons as to why people commit suicide, followed by a variety of ways in which such an act is interpreted depending on one's location, more specifically one's culture and religion. Some are led out of sheer desperation or in a state of depravity while a few may end up taking their lives in an act of self sacrifice. Harris takes the example of the movie Armageddon wherein Willis chooses *"to take his life in an explosion on a meteorite in order to knock the meteor off its earth bound path"* thereby preserving life on earth.[69] While this act is one of suicide, majority of the people refrain from calling it so and settle for more respectful terms like 'self killing' or 'self sacrifice'. This is so because the word 'suicide' has always had a negative connotation in the West. The Roman culture viewed suicide as both heroic and immoral. It was a means of avoiding disgrace for the Romans, embracing death instead of surrendering or being punished. It was the same in Japan where ritual suicide, known as *hara kiri,* was respected and deemed to be an altruistic act. The Jews considered suicide to be an insane act and excluded it from religious and secular penal sanctions. In America, suicide is considered a negative action. Americans believe that those *"found in contemplation of or in the act of committing suicide are in need of help and not in their right mind"*.[70] In India, the practice of sati in which a recently widowed woman would have immolated herself in her husband's funeral pyre is not only traditionally accepted but also glorified. Islam condemns suicide severely. Similarly, Sikhs reject suicide as interference in god's plans. *"Suffering, they said, was part of the operation of karma, and human beings*

[68] Ibid., p.76

[69] Harris, Edward S., 'The Moral Dimensions of Properly Evaluating and Defining Suicide', *The Institute for Applied and Professional Ethics*, Chowan College, Ohio University, July 27, 2009

[70] Ibid.

should not only accept it without complaint but also to make the best of the situation that karma has given them".[71]

Based on most recent documented rates, Eastern European countries like Lithuania, Russia, Belarus, Latvia and Estonia figure among the top five countries with highest suicide rates, meanwhile Kazakhstan with an annual suicide rate of 28.7 and Finland with an annual suicide rate of 24.3 per 100,000 people are the lone Asian and Scandinavian representatives in the top ten.[72] The region with the lowest suicide rates is Latin America, while Western Europe, United States and Asia fall somewhere in the middle range. Unfortunately, the suicide statistics for many countries in the African region and South-East Asia are still unavailable. Depending on their high, medium or low suicide rates, the present chapter examines recent trends in suicide in select countries around the world.

Japan

As already stated above, suicide in the West has, more or less, been held negatively; most believe that it is a cowardly act, committed by someone who is mentally unstable and is not the solution to any problem. The Japanese view life, death and suicide in terms of absolute phenomenalism. Suicide is not a sin, rather the inherited romanticised notion of noble suicide still lingers. Since suicide is accepted, there is a strong understanding of it. Suicide can be of two types: honourable and dishonourable. A good example of the former would be kamikaze pilots during World War II. Dishonourable suicide, on the other hand, is *"a means of protecting the reputation of one's family after a member has been found guilty of a dishonourable deed such as embezzlement or flunking out of college".*[73] This is a cowardly act and a coward can only bring dishonour to his family. However, in the current context, a quarter of suicides have financial reasons as motives behind the act. Such *inseki-jisatsu* or responsibility driven suicides occur when people hope to clear outstanding debts through a life insurance payout. Thus, in Japanese culture, even though it is difficult to objectively judge the intent or motive for suicide when the actor him/herself is no more, the definition of suicide carries a positive connotation to it.

[71] Verma, Sunil K. & Swati A. Sachdeva, 'Suicide in Sikkim- A Psycho-Social Study', *Sikkim University*, 2008

[72] International Association for Suicide Preventin, http://iasp.info/wspd/pdf/2012_wspd_brochure.pdf

[73] Harris, Edward S., 'The Moral Dimensions of Properly Evaluating and Defining Suicide', *The Institute for Applied and Professional Ethics*, Chowan College, Ohio University, July 27, 2009

Japan has for years had one of the world's highest suicide rates. Based on the WHO data, the country ranked second in 2009 among the Group of Eight leading industrialized nations with a suicide rate of 24.4 suicides per 100,000 people after Russia's 30.1. *"Suicide is now the leading cause of death among men aged 20-44 and women ages 15-34"*.[74] The Annual report of the National Police Agency of Japan (2010) cited depression, economic hardships and job-related concerns as the reasons for committing suicide. Age and gender-wise break-up as shown in the data below give us a more detailed picture:

Table 2

Number of Suicides by Age-group and Gender, Japan

Age (years)	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75+	All
Males	34	1326	2657	3668	4131	4988	2993	2216	22189
Females	21	605	1085	1224	1102	1387	1431	1648	8518
Total	**55**	**1931**	**3742**	**4892**	**5233**	**6375**	**4424**	**3864**	**30707**

Traphagan explores the notion of suicide as expressed by older, rural Japanese among their age peers. Statistics from the Ministry of Health, Labour and Welfare (2000) showed that the national suicide rate was higher for people over 80 years compared to those in their twenties and thirties which stood at approximately 20 per 100,000 for the same year.[75] From a sociological perspective, the Japanese society shows a somewhat reverse trend so far as studies of suicide among the elderly are concerned. Urban, industrialized areas where some degree of breakdown in social integration has taken place normally report higher elder suicide rates than rural ones, however in Japan (other than Greece and California) suicide rates tend to be lower in urban than in rural areas.[76] Trapaghan's paper highlights why this

[74] Chambers, Andrew (3 August 2010). "Japan: Ending the culture of the 'honourable' suicide". London: *The Guardian*

[75] Traphagan, John W., 'Interpretations of elder suicide, Stress and Dependency among rural Japanese', *Ethnology*, Vol. 43, No. 4 (Autumn, 2004), p.317

[76] Ibid.

happens. While a multi-generation household with both the young and old residing under a single roof is seen as an ideal living situation for the latter, the issue of co-residence in the Japanese society is seen as *"a significant source of stress due to conflicting values held between generations"*.[77] Most times this stress can also lead to the ultimate act of suicide.

Although traditionally suicide rates have been highest among the male elderly, rates among young people have been increasing to such an extent that they are now the group at highest risk in about a third of countries, in both the developed and developing world. Impulsiveness is a major risk factor in Asia, as compared to mental disorders like depression or alcohol abuse in the West. Suicide is complex with psychological, social, biological, cultural and environmental factors involved. Common methods of suicide in Japan include drowning, poison consumption, drug ingestion, gas asphyxiation and leaping from a height, but the most common method by far is hanging. *"In 1996, for example, slightly under 60 per cent of all suicides were hangings, followed by jumping from a building (10.5 per cent)"*.[78]

South Korea

In 2004, among the thirty member countries of the Organization for Economic Cooperation and Development (OECD), South Korea ranked second after Japan with a suicide rate of 23.8 per 100,000.[79] Today South Korea leads the pack with 28 deaths per 100,000 people or about 40 people on an average daily.[80] According to a report brought out by the Ministry of Health and Welfare, the top three reasons for death between the age group of 10-40 years are suicide, traffic accidents and cancer.[81] Koreans are now taking their own lives at a rate which is three times higher than two decades ago which has piqued the concern of federal lawmakers. In 2011, a bill was passed promising to make funding available for suicide prevention centers nationwide. This included installation of surveillance cameras and

[77] Traphagan, John W., 'Interpretations of elder suicide, Stress and Dependency among rural Japanese', *Ethnology*, Vol. 43, No. 4 (Autumn, 2004), p.315

[78] Takahashi, Y., 'Culture and Suicide: From a Japanese Psychiatrist's Perspective'. *Suicide and Life- Threatening Behaviour*, 1997, 27(1), p.275

[79] Kwon Jin Won, Heeran Chun & Sung-il Cho, 'A closer look at the increase in suicide rates in South Korea from 1986-2005', *BMC Public Health 2009*, 9:72, 27th February, p.2

[80] Statistics Korea, http://kostat.go.kr/portal/english/index.action

[81] Ministry of Health and Welfare, http://english.mohw.go.kr/front_eng/index.jsp

emergency phones at the bridges, plus a law which calls for officials to revisit the issue within five years.

According to Hwang Sang-min, Professor of Psychology at Yonsei University, ""*When a situation is bad and they can't show their cool selves, Koreans tend to get frustrated, give up and take drastic choices*".[82] Suicide is normally linked to mental health, '*han*', celebrity suicides affecting common people, a highly competitive atmosphere, recession, crumbling traditional social networks etc. Han is a concept in Korean culture, which is linked to a collective feeling of oppression and isolation when faced with a seemingly insurmountable situation. Han does not have an English equivalent but can be loosely translated as sorrow, spite, pain etc. It has a deep history in Korean society and is passive i.e. it yearns for revenge but does not seek it. Someone who dies of han is said to have died of an anger-illness or fire-illness.

Based on the findings of their research on increase in suicide rates in the country from 1986-2005, Won et al. report a remarkable difference in the patterns between the age groups. Proportional suicide rate showed a steeper increase among the younger lot (45 years and under) and "*younger women showed the steepest increase in the later period*".[83] Meanwhile the absolute suicide rate increased significantly among the elderly. Despite the same, the proportional increase in suicide rates was higher among the younger group for both genders. Finally, "*the younger birth cohort (those born later) showed a higher proportional suicide rate compared to older cohorts*".[84] Post 1997 economic crisis, labour market reconstruction affected the increase in unemployment rates and part time workers, with further effects on younger people. These changes and job insecurity most likely contributed to the rise in suicide rates among younger people in Korea. Thirdly, social integration in Korean society also seems to have become weaker in the recent decade. This can be noted from the increase in divorce cases, decline in the number of marriages as well as increased late marriage etc. Widespread use of the Internet can also serve as a means to exchange tips and thoughts about

[82] http://digitaljournal.com/article/311163#ixzz1nHHph3mP

[83] Kwon Jin Won, Heeran Chun & Sung-il Cho, 'A closer look at the increase in suicide rates in South Korea from 1986-2005', *BMC Public Health 2009*, 9:72, 27th February, p.3

[84] Ibid.

suicide. Also, intense pressure to succeed at school and work may drive young Koreans to end their lives.[85]

Canada and United States

In Canada, as measured by the WHO, the suicide rate is low at 15 per 100,000. Despite the fact that women tend to make four to five times more suicide attempts than men, suicide is predominantly a male activity with the rate being four times higher than that of females. Also, suicide is the second leading cause of death among Canadians in the age group of 10-24 years.[86] According to University of Ottawa Psychologist Darcy Santor, the majority of suicide victims suffer from some form of mental illness at the time of their deaths, though it may not have been diagnosed.[87] Risk factors include anxiety, alcohol abuse, depression, bullying, learning disabilities, social isolation and often, at the root, shame.

Richard D. Christy's article explores the definitions and reality of men and masculinity which, according to him, are open to social change in every era. Common assumptions for the high suicide rates among men have been attributed to the fact that males are less likely to seek help for their problems and also tend to use more lethal means to end their lives. He tries to answer questions of how social changes may have altered the social position of men in Canadian society and whether these changes *"created a cultural climate in which the social roles of men have become confused and devalued?"*[88] While he agrees that the 1970 Royal Commission on the Status of Women identified inequalities in business, taxation, and social participation that needed to be changed, it also created a social setting in which boys and men are increasingly devalued and disregarded. According to him, the increase in the male suicide rate can be attributed to a crisis in masculinity. He argues that *"while the 1970 Royal Commission rightly addressed social inequalities for women, it also created a climate in which men and masculinity are devalued and often openly belittled"*.[89]

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[85] Ibid.

[86] Canadian Psychiatric Association, Mental Illness Awareness Week Fact Sheet, 2002

[87] http://www.theglobeandmail.com/life/health-and-fitness/health/conditions/teen-suicide-were-not-going-to-sit-in-silence/article4181694/?page=all

[88] Christy, Richard D., 'Societal changes and Suicide: The Crisis in Masculinity', *The Second Annual Conference on Male Studies: Looking Forward to Solutions*, New York Academy of Medicine, New York City, April 6, 2011, p.3

[89] Ibid., p.13

The traditional roles of men as providers and protectors had been eliminated or reduced which led to an increase in the rate of male suicides.

According to the National Adolescent Health Information Center Factsheet (2006), in 2003, suicide rate in the United States was 6.8 per 100,000 for adolescents and young adults aged 10-24 years. *"Suicide accounted for 11.2% of all deaths for adolescents and young adults, making it the third leading cause of death for this age group after motor vehicle accidents and homicide"*.[90] The rate of suicide continues to increase up to age 49, decreases between 50-74 years and increases again at 75 years.

Valois et al. research whether a crucial aspect of Quality of life (QOL) is associated with suicide ideation and behaviour among adolescents (13-18 year olds) in the US. Their focus is on life satisfaction, to analyze whether individual response to declines in life satisfaction and associated behaviour trigger risk taking behaviour which are health related, for example suicide attempts. Life satisfaction has been defined as *"a person's subjective evaluation of the degree to which his or her most important needs, goals and wishes have been fulfilled"*.[91] QOL has been conceptualized from two perspectives: objective and subjective. The former perspective focuses on external factors that contribute to quality of life, such as income levels, housing quality, friendship networks, and access to health services, while the latter refers to *"individuals' internal judgments of their quality of life"*.[92] Both objective and subjective life circumstances are equally important in an individuals' determination of the quality of their lives. The study revealed a robust relation between perceived life dissatisfaction and self-reported poor mental health, suicide ideation and behaviour. It suggested effective suicide prevention programs to be structured with proper guidelines for school officials when dealing with this issue, at the same time these guidelines need to be flexible enough to allow for proper handling of unique situations.[93]

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[90] National Adolescent Health Information Center (NAHIC), 2006 Factsheet on Suicide: Adolescents and Young Adults

[91] Valois, Robert F., Keith J. Zullig, E. Scott Huebner, J. Wanzer Drane, 'Life satisfaction and Suicide among High school Adolescents', *Social Indicators Research*, Vol. 66, No. 1/2, Quality of Life Research on Children and Adolescents (Apr., 2004), pp. 82-83

[92] Ibid., p.82

[93] Ibid., p.99

Russia

Russia annually features among the top three countries with the highest suicide rates in the world. According to the most recent WHO data, the gender wise break up of suicide rates per 100,000 showed males at 53.9 and females at 9.5 in the Russian Federation. A UNICEF report reveals that suicide is one of the three leading causes of death among young people aged 15-34 years. For Russia, this problem is particularly urgent because even though the overall suicide rate has dropped from an all time high of 42 per 100,000 in 1995, just after the break-up of the Soviet Union, to 23.5 per 100,000 in 2010, the suicide rate among 15-19 year olds is still alarming at 19 to 20 per 100,000 against a global average of 7.3.[94]

Table 3

Number of Suicides by Age-group and Gender, Russia Federation

Age (years)	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75+	All
Males	201	5319	7584	6486	7534	3458	3104	1701	35608
Females	75	869	974	834	1255	671	1048	1401	7247
Total	**276**	**6188**	**8558**	**7420**	**8789**	**4129**	**4152**	**3102**	**42855**

© WHO, 2006

Overall suicide rates for young people have changed little over time. *"On average, for each young woman who commits suicide, there are about three young men who take their own life"*.[95] The common methods of suicide among young men are *"by hanging, jumping from heights or through self-inflicted gunshot wounds and self-inflicted injuries with a sharp object as well as medication poisoning, whereas young females much more often choose to commit suicide by different types of poisoning"*.[96] The reasons behind the high suicide rates, including among adolescents, have been attributed to a number of reasons from

[94] World Health Organization, http://www.who.int/mental_health/prevention/suicide_rates/en/

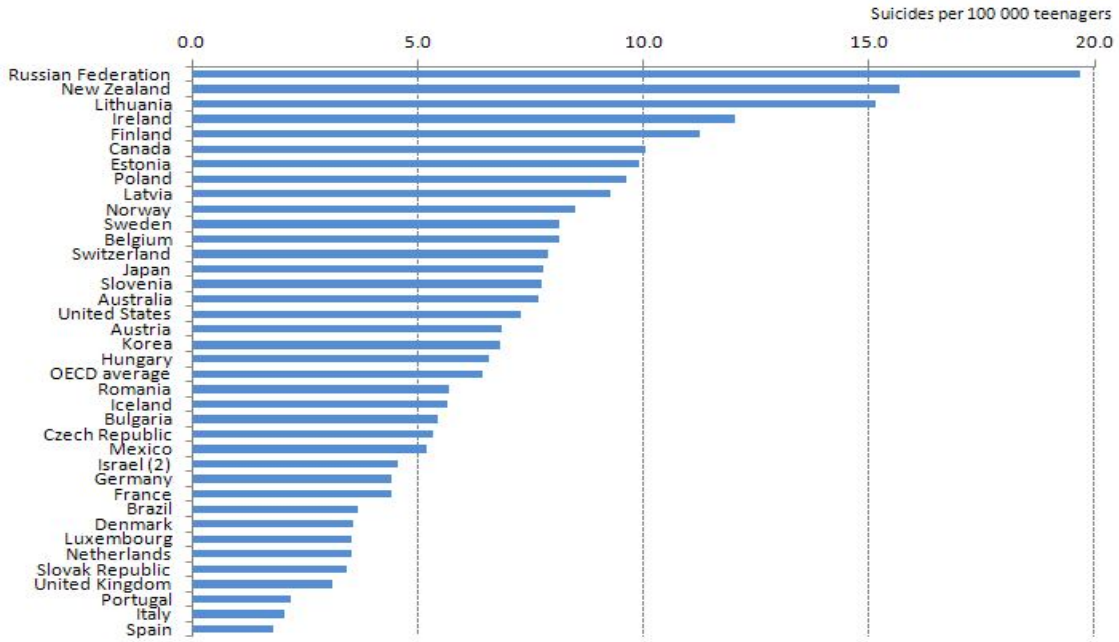
[95] UNICEF report, 'Adolescent deaths from suicide in Russia', 2011

[96] Ibid.

marginalization, unequal levels of socio-economic development, unemployment to drugs and alcohol abuse.

Figure 2

Suicides among 15-19 year olds per 100,000, 2009



© WHO Mortality Database, July 2011

Along with suicide rates, the rate of alcohol consumption in Russia is also among the highest in the world. The increased demands for alcohol was attributed to the social and individual stress resulting from the nineties reforms, Gorbachev's anti-alcohol campaign which created a market for illegally produced alcohol and a fraction rise in alcohol prices as compared to food and other staples. Pridemore's study shows a positive cross-sectional association between heavy drinking and regional suicide rates after controlling for social structural factors and this association held for both males and females.[97]

Australia

Hassan has taken a detailed study of suicide in Australia. He states that unlike Japan and some major European countries, the suicide rate in Australia has remained "*in the middle*

[97] Pridemore, William Alex, 'Heavy drinking and Suicide in Russia', *Social Forces*, Vol. 85, No. 1 (Sep., 2006): 413-430

ranges in the last one hundred years".[98] This stability has been attributed to the fact that the society has remained relatively cohesive despite enormous socio-economic and demographic changes. Social institutions continue to play an integrative role through a smooth functioning social security system and cultural patterns *"which emphasize mate-ship, equality and an easy going life style"*.[99] Male and female suicide rates follow different trends. The male suicide rates show a dramatic increase during the two World Wars and the Great Depression of the 1930s, while female suicide rates were not affected to the same degree. This, he explains, in terms of the differential impact that unemployment has on male and female family roles as the economic provider and nurturer respectively.[100]

Suicide Prevention Measures

"In 1996, the United Nations published guidelines to assist and stimulate countries to develop national strategies aimed at reducing morbidity, mortality, and other consequences of suicidal behaviour".[101]

The UN outlined several elements which would help increase the effectiveness of suicide prevention strategies. These included support from government policy, a conceptual framework, well established aims and goals, measurable objectives, identification of organisations capable of implementing objectives and ongoing monitoring and evaluation.[102] This further involved a number of activities like: increased access to information about all aspects of preventing suicidal behaviour, early identification, assessment and treatment of those at risk, promoting public awareness on issues of mental well-being, consequences of stress, suicidal behaviour and effective crisis management, establishment of institutions or agencies to promote and coordinate research, training and service delivery with respect to suicidal behaviour etc.

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[98] Hassan, Riaz, *Suicide in Australia: A Sociological Study*, 1992, p.43

[99] Ibid., p.44

[100] Ibid., p.46

[101] Leo, Diego D. & Russell Evans, 'International Suicide rates: Recent trends and implications for Australia', *Australian Institute for Suicide Research and Prevention*, Commonwealth of Australia, 2003, p.79

[102] Ibid.

Many countries have initiated various approaches aimed at reducing suicide mortality, some as early as the mid-eighties and others from the nineties onwards. Finland was the first county to develop a comprehensive strategy for suicide prevention. The Finnish strategy was basically implemented in four stages:[103]

1. A comprehensive analysis of some 1,397 suicides to identify target groups and issues (1986-1991),
2. Creation of an action programme (1992),
3. Implementation (1992-1996), and
4. Evaluation (1997-1998)

Since then, Finland's initiatives have been followed by several other countries such as Australia, Norway, United Kingdom, Estonia etc. In Australia, the National Youth Suicide Prevention Strategy (NYSPS) started in 1995. The National Suicide Prevention Strategy (NSPS) was introduced in 1999 to build on the former. *"Sweden established the National Council for Suicide Prevention in 1993, followed by the founding of the Swedish National Centre for Suicide Research and Prevention of Mental Ill-Health in 1994"*.[104] These suicide prevention programmes differ in the target groups that are emphasised. While countries like Norway and England focus strongly on the needs of high-risk individuals, Australia and New Zealand have a broader target. In addition, many countries have also implemented programmes to address broader public health problems of mental illness and substance abuse; two of the major risk factors for suicide that have a potential impact on suicide mortality.

It is difficult to narrow down to a specific pattern or study of suicide which can be applied uniformly. *"The lack of evidence supporting any particular approaches to suicide prevention is a particular concern"*.[105] Suicide trends around the world differ as the reasons for taking one's life are varied. Also, the way in which such an act is interpreted depends heavily on one's location, culture and religion. While in some cases, like Korea post the 1997 economic crisis and Russia, the increase in unemployment rates and unequal socio-economic

[103] Ibid., p.79

[104] Ibid.

[105] Ibid., p.141

development contributed to the rise in suicide rates among younger people. In Japan, we find *inseki-jisatsu* or responsibility driven suicides in a desperate bid to clear outstanding debts through a life insurance payout. Today, people in the age group of 5-44 years are more at risk to suicide than those 45 years and older (see Figure 1).[106] Social integration seems to have become weaker in present times. The increase in divorce cases, portrayal of idealistic lifestyles through media sources that may invoke unrealistic expectations of life and a distorted perception of reality, widespread use of the Internet as a means to exchange tips and thoughts about suicide increase suicide risk among the youth. In Canada, bullying, social isolation, alcohol abuse, depression etc. are the important risk factors for suicide among the 10-24 year olds. Meanwhile, in Japan, the issue of co-residence and a multi-generation household with both the young and old residing under a single roof caused a significant amount of stress due to conflicting values held between generations. Most times this stress also led to the ultimate act of suicide among the elderly.

In India, statistics, categorized by sex and age-group, reveal that persons between 15-44 years are at the highest risk (NCRB, 2010). Therefore, at a time when we are speaking of reaping demographic dividends in the near future, it is important that adequate policies and measures are adopted to address issues driving the young to take their own lives.

[106] World Health Organization, 2002

CHAPTER 3

SUICIDE IN INDIA: FOCUS ON SIKKIM

"It is estimated that over 100,000 people die of suicide in India every year. India alone contributes to more than 10% suicides in the world". – Maithri, Kochi[107]

Suicide is an important issue in the Indian context. In order to study the problem at the state level, one must first understand suicide at the national level. The National Crime Record Bureau (NCRB) annual publication, titled *"Accidental Deaths and Suicides in India"*, is the most comprehensive databank available with the Government of India on the subject. While previously the reports provided basic data on number of suicides in different states in the country, it has become more precise with information like gender and age-wise distribution of suicide, marital status, profession and education of victims of suicide, the means adopted etc. According to the NCRB, in the decade covering 1998-2008, the number of suicides recorded an increase of 19.4 percent. This was followed by 1,27,151 and 1,34,599 persons committing suicide in 2009 and 2010 respectively, thus recording an increase of 23.9 percent since 2000.[108]

Table 4

Incidence of Suicides, Growth of Population and Rate of Suicides (All-India), 2006-10

Sl. No.	Year	Total no. of suicides	Estimated mid-year population (in Lakhs)	Rate of suicide
1	2010	134599	11857.6	**11.4**
2	2009	127151	11694.4	**10.9**
3	2008	125017	11531.3	**10.8**
4	2007	122637	11365.5	**10.8**
5	2006	118112	1197.75	**10.5**

Source: The Registrar General of India, 2006-10

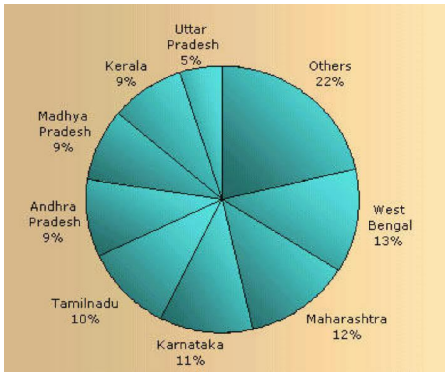
[107] http://www.maithrikochi.org

[108] NCRB, '*Accidental Deaths and Suicides in India*', Annual publication, 2010

Globalisation and industrialization seem to have a negative effect on suicide. Today, the stakes are higher and the struggle harder. The rewards are great if one succeeds, however the other end of this scale may lead to depression, suicidal tendencies, drug addiction, alcoholism etc. The society is becoming increasingly more individualistic. In India, although it is natural for youngsters in their twenties to depend on their parents, the trend is slowly changing. Maithri, a registered non-governmental organisation in Kochi (Cochin) working for suicide prevention in Kerala, shows that in 2006 there were pockets with high suicide rates than the rest of the country.

Figure 3

States which reported the Highest Suicide cases in 2006



© *Maithri, Kochi*[109]

The picture hasn't changed much since then. Although suicide trends vary within the country, southern states seem to have a higher suicide rate than parts of northern India. Vijaykumar quotes *"higher literacy, a better reporting system, lower external aggression, higher socio-economic status and higher expectations"* as possible explanations for the high suicide rates in south India.[110] A distressing feature is the frequent occurrence of suicide pacts and family suicides. Family suicides have been a cause of concern for the states of Kerala, Andhra Pradesh and Madhya Pradesh for some time now. In Kerala, it has *"claimed 56 lives in 2010 against 38 in 2009"*.[111] Like Sikkim, Kerala has a suicide rate which is consistently

[109] http://www.maithrikochi.org

[110] Vijaykumar, Lakshmi, 'Suicide and its prevention: The urgent need in India', Guest editorial, *Indian J Psychiatry*, 49(2), April-Jun, 2007, p.1

[111] Kerala State Mental Health Authority, '*Suicide in Kerala*', 2010

high i.e. almost three times the national average and 80 percent of the victims belong to the productive age of 15-59 years.[112] Although the reasons for the abnormally high suicide-proneness in Kerala is yet to be conclusively established, the major risk factors include weakening of the family system, increase in divorce rates, unemployment, consumerism and indulgence in a lifestyle which is beyond one's means, mental disorders, negative attitude towards suicidal individuals etc.

According to the NCRB report of 2010, Tamil Nadu was the state with the highest number of suicides (12.3 percent). This was followed by West Bengal with 11.9 percent, Andhra Pradesh and Maharashtra tied at 11.8 percent and Karnataka with 9.4 percent.[113] Although the overall numbers may be low, Sikkim has consistently been reporting a high suicide rate which is way above the national average. In 2010, Sikkim reported a 45.9 percent suicide rate putting the Himalayan state at the top of the chart, followed by Puducherry with 45.5 percent, Andaman & Nicobar Islands with 36.1 percent, Chhattisgarh with 26.6 percent and Kerala with 24.6 percent. Sikkim also recorded a 16.2 percent significant increase in suicides between 2009 and 2010.[114]

Table 5

A Comparison of the Rate of Suicides: All-India and Sikkim (per lakh population)

Sl. No.	Year	India	Sikkim	Difference
1	2010	11.4	45.9	34.5
2	2009	10.9	39.9	29.0
3	2008	10.8	48.2	37.4
4	2007	10.8	20.7	9.9
5	2006	10.5	25.0	14.5

Source: NCRB, 2006-10

[112] http://www.maithrikochi.org/suicides_in_kerala.htm#Impact

[113] NCRB, '*Accidental Deaths and Suicides in India'*, Annual publication, 2010

[114] Ibid.

As is apparent from the table above, Sikkim has consistently recorded a suicide rate which is double and more of the national average. From eighth position in 2007, it catapulted to the number one slot as the state with the highest rate of suicides in 2008 (48.2 percent), before coming in second to Puducherry in 2009 (39.9 percent), and then back again to retain the dubious distinction of being the suicide capital of the country in 2010 (45.9 percent).[115] While much research needs to be done on this topic, one such study by Verma shows that low education, weakening family structures, unemployment and substance abuse are the causes responsible for the high incidence of suicide in Sikkim.[116]

Table 6

Gender and Age-wise Break up of Victims of Suicide (All-India), 2010

Sl. No.	Age-group (in yrs)	Males (%)	Females (%)	Total	% to total
1	Upto 14	52.4	47.6	3130	**2.3**
2	15-29	55.4	44.6	47625	**35.4**
3	30-44	67.9	32.1	44846	**33.3**
4	45-59	74.5	25.5	27889	**20.7**
5	60 and above	71.5	28.5	11109	**8.3**

Source: NCRB, 2010

Statistics for the all-India distribution of suicides categorized by sex and age-group in 2010 reveals that young persons between 15-44 years are at the highest risk. According to the NCRB report, the percentage share of 15-29 and 30-44 years, at the national level, together, stood at 68.7 percent (see Table 6 above).[117] This stands true for Sikkim as well where the overall suicide among age groups of 15-29 years and 30-44 years was 36.1 percent and 28.6 percent

[115] NCRB, '*Accidental Deaths and Suicides in India'*, Annual publication, 2007-10

[116] Verma, Sunil K. & Swati A. Sachdeva, 'Suicide in Sikkim- A Psycho-Social Study', *Sikkim University*, 2008, p.55

[117] NCRB, '*Accidental Deaths and Suicides in India'*, Annual publication, 2010

respectively.[118] So far as gender is concerned, WHO statistics for India in 2009 reveal a male suicide rate of 13 percent and a female suicide rate of 7.8 percent. The near equal suicide rates of young men and women denote that more women die of suicide in India than their western counterparts. Dr. Jose Bertolote of WHO once commented in 2004, *"the more we look into those (Asian) cultures we see that the difference between men and women is not as big as it happens to be in Europe, so there is a major cultural element here"*. Women in western countries resorted to means such as slashing their wrists or swallowing pills, both methods being treatable. On the other hand, Indian women, particularly from rural areas, attempted suicide through methods such as hanging, consuming poison and setting oneself on fire. All three are difficult to survive. In the case of Sikkim, NCRB data suggests that Sikkimese men are more prone to commit suicide than Sikkimese women; the ratio being 70:30.[119] Apart from hanging, men were also keener to die from over alcoholism, self-infliction or injury, consuming poison, jumping from buildings or other sites, self immolation and drowning. Women, on the other hand, settled for means such as consuming poison, sleeping pills, touching electric wires, self immolation (two cases) and drowning (three cases in five years).[120]

Table 7

Profile of Victims Classified According to Profession (All-India), 2010

Sl. No.	Profession	Males (%)	Females (%)	Total	% to Total
1	Housewife	0	12.2	25058	12.2
2	Service				
	(i) Government	78.0	22.0	1842	0.9
	(ii) Private	85.7	14.3	10502	5.1
	(iii)Public sector	84.7	15.3	2900	1.4
3	Student	54.7	45.3	7379	3.6

[118] Verma, Sunil K. & Swati A. Sachdeva, 'Suicide in Sikkim- A Psycho-Social Study', *Sikkim University*, 2008

[119] NCRB, '*Accidental Deaths and Suicides in India'*, Annual publication, 2006-10

[120] Verma, Sunil K. & Swati A. Sachdeva, 'Suicide in Sikkim- A Psycho-Social Study', *Sikkim University*, 2008

4	Unemployed	82.2	17.8	10033	4.9
5	Self-employed				
	(i) Business	92.3	7.7	7154	3.5
	(ii) Professional activity	91.3	8.7	4059	2.0
	(iii)Farming/Agriculture	85.1	14.9	15964	7.8
	(iv)Others	77.8	22.2	28152	13.7
6	Retired person	83.7	16.3	898	0.4
7	Others	74.8	25.2	20658	10.1

Source: NCRB, 2010

From Table 7 above, we find a high number of suicides taking place among certain categories- particularly housewives, those who are self-employed like farmers or into private business, or unemployed. Common assumptions are that housewives lack love and respect at home, face mental/physical torture at the hands of the in-laws etc. On the other hand, men are driven to extreme ends mostly because of health or financial reasons.

NCRB data reports that some 12,134 women were driven to commit suicide due to dowry. So far as Sikkim is concerned, dowry system is not prevalent among the three predominant communities and dowry related deaths are virtually absent. The presence of social custom like bride price among certain communities also adds significance to the girl child. As such the share of housewives is negligible (see Table 7). At the national level, between 1997 and 2001, 1,10,424 housewives committed suicide which accounted for 52 percent of the total female suicide victims.[121] The 2009 report states that 223 men killed themselves daily across the country and the corresponding figure for women was 125; out of which 69 were housewives.[122] Divorce, dowry, extra-marital affairs, illegitimate pregnancy or issues pertaining to marriage play a crucial role in the suicide of women.

At the same time, news of farmer suicides in various parts of the country is perhaps the most distressing phenomenon observed over the last decade. India might be experiencing

[121] NCRB, '*Accidental Deaths and Suicides in India'*, Annual publication, 2001

[122] Ibid., 2009

economic boom but rise in the number of suicides of farmers, mostly by consuming the very pesticides that no longer work on their crops, is most disturbing. It is a given that debt and the resulting harassment to defaulters is a major cause of suicide in this group. In India, farmers fall into debt due to five chief reasons[123]:

- ✓ To cover high farming costs i.e. purchase of high yielding seeds, fertilizers and pesticides,
- ✓ Absence of a proper market in order to get good price for their produce,
- ✓ Competition from cheap imports,
- ✓ Droughts add to their escalating woes,
- ✓ Minimal financial support from the government and failure of the banking system which forces farmers to borrow money from private money-lenders who are notorious for charging high interest rates.

According to a UN Commission on Sustainable Development (CSD) study, more than 1,00,000 farmers have taken their lives since 1997 and 86.5 percent of these farmers were financially indebted.[124] The states of Punjab, Haryana, Maharashtra, Rajasthan, Karnataka, Kerala, Madhya Pradesh are the most affected. K. Nagaraj's paper on farmer suicides studies the magnitude, trends and regional trends, if any, in the incidence of these suicides. He states that *"in the ten year period between 1997-2006, as many as 1,66,304 farmers committed suicide in India"*.[125] This implies that on average some 16,000 farmers committed suicide every year in the same decade. Also, close to 85 percent of all farmer suicides are by male farmers. He divides states into groups depending on their rate of farmer suicides. Accordingly, Group I states of Maharashtra, Karnataka, Andhra Pradesh, Chhattisgarh and Madhya Pradesh have the highest farmer suicides. The Group II states consist of Kerala, Tamil Nadu, Goa, Puducherry West Bengal and Tripura. Group III includes Assam, Haryana,

[123] Pujari, Y. D., "Rural indebtedness: Causes and consequences", *Indian Streams Research Journal,* Vol. 1, Issue 1, February 2011: 124-127

[124] International farmer suicides crisis, http://www.un.org/esa/sustdev/csd/csd16/PF/presentations/farmers_relief.pdf

[125] Nagaraj, K., 'Farmers' suicides in India: Magnitude, trends and spatial patterns", *Madras Institute of Development Studies*, March, 2008

Orissa and Gujarat. Finally, Group IV constitutes a region consisting of 8 states in North India, largely concentrated in the Gangetic Plain.

Studying the cause of suicide implies focus on the interface between the individual and society. Mishra and Dandekar et al. locate the individual farmer in the wider concept of an ailing agrarian economy. They state that suicides were *"a direct result of the stress caused to the farmer by the pressure to pay back various money debts"*.[126] Mishra looked into what he called socio-economic stressors and their occurrence among the 111 families that he surveyed. Accordingly, indebtedness, deterioration in economic status, conflict with family members, crop failure, decline in social position, burden of daughter's/sister's marriage, suicide occurrence in nearby villages, alcohol addiction, disputes with neighbours and health problems were identified.[127]

Table 8

Profile of Victims Classified According to Profession (Sikkim), 2010

Sl. No.	Profession	Males	Females	Total	% to Total
1	Housewife	0	5	5	1.8
2	Service				
	(iv) Government	29	6	35	12.5
	(v) Private	52	3	55	19.6
	(vi) Public sector	21	10	31	11.1
3	Student	2	1	3	1.1
4	Unemployed	45	7	52	18.6
5	Self-employed				
	(v) Business	23	1	24	8.6
	(vi) Professional activity	21	1	22	7.9
	(vii) Farming/Agriculture	19	0	19	6.8

[126] Meeta and Rajivlochan, 'Farmers suicide: Facts and possible policy interventions', *YASHADA*, 2006

[127] Ibid.

	(viii) Others	7	1	8	2.9
6	Retired person	3	2	5	1.8
7	Others	13	8	21	7.5

Source: NCRB, 2010

In the case of Sikkim, Verma's study in 2008 showed that most of the suicide victims were farmers (25.63 percent), followed by the self employed (13.7 percent), housewives (12.99 percent), unemployed (12.6 percent) and students (9.5 percent).[128] NCRB report, 2010 shows a slightly different scenario, as shown in Table 8 above. Accordingly, the three groups at the highest risk include the self employed (26.2 percent), those working in the private sector (19.6 percent) and the unemployed (18.6 percent). Structural, social, cultural and personal factors are stated to facilitate suicide behaviour. Structural and social factors include employment status, modernisation, generational conflict, disturbed relationships etc. while personal factors like high aspirations, substance abuse, freedom etc. trigger the desire to take one's own life. In terms of the subjective experience, loneliness, depression, isolation and dependency for survival influence the individual. These experiences can easily lead to negative consequences once he/she feels meaningless, worthless, has low self-esteem, guilt, shame and low future orientation.

NCRB statistics show that unemployment is not among the major causes of suicide in Sikkim. The overall percentage of victims driven to such an extreme due to unemployment was very negligible, standing at 2.1 percent for 2010, 2.9 percent for 2009 and 0.8 percent for 2007.[129] The workplace is a vital locus of social ties and shared goals. To become unemployed means that these integrating forces cease to operate; which should increase the risk of suicide. A large number of aggregate-level studies of suicide have examined the role of unemployment and have generally found it to be significantly related to the suicide rate.

Preti and Miotto set forth to investigate whether, either the condition of being unemployed or, changes in unemployment rates are associated with suicide risks in Italy. They study Italy because it provides an ideal location for studying the relation between the

[128] Verma, Sunil K. & Swati A. Sachdeva, 'Suicide in Sikkim- A Psycho-Social Study', *Sikkim University*, 2008

[129] NCRB, '*Accidental Deaths and Suicides in India'*, Annual publication, 2007-10

two in the background of a difficult economic period with a progressive rise in unemployment rates. In suicide studies, unemployment is mostly viewed as a precipitating, rather than a causative, factor. Preti and Miotto state that this works in two ways- firstly by reducing financial availability and by provoking loss of social role and self esteem that a job confers.[130] The three pathways from unemployment to suicide, as suggested, are-

1. The Vulnerability Model: Limited access to supportive resources may increase stress, thus leading to suicide.

2. The Indirect Causative Model: Unemployment may provoke relationship difficulties or financial problems and favour the occurrence of events like suicide.

3. The third model proposes a non causal link between both unemployment and suicide which could result from a third factor, such as belonging to a socially disadvantaged section, which would increase the risk for either of the two.[131]

The social causation here pre-supposes that unemployment is damaging to well being and health. This damage has a different influence on the two sexes. Men associate their social identity with a specific working role. When unemployed, not only access to resources but, their position in society is undermined as well. Women, on the other hand, are able to assume a well defined social position even in the absence of a specific working role. As a 'housewife', she has precise commitments which imply responsibility and personal engagement. Thus, it is less common for a woman to feel deprived of her social identity so long as her role is maintained in the family structure. In terms of rising female unemployed suicide rates, Preti & Miotto explain it as "*maybe a reflection of the destructive effect exerted by economic crisis on the degree of family cohesion*".[132] Unemployment can have a domino effect on familial ties since increased social stress can cause problems at the relationship front, culminating to a divorce. In general, it may indirectly affect the mental health of other close members and not just the person experiencing it.

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[130] Preti, Antonio & Paola Miotto, 'Suicide and Unemployment in Italy, 1982-1994', *Journal of Epidemiology and Community Health* (1979-), Vol. 53, No. 11 (Nov., 1999), p.694

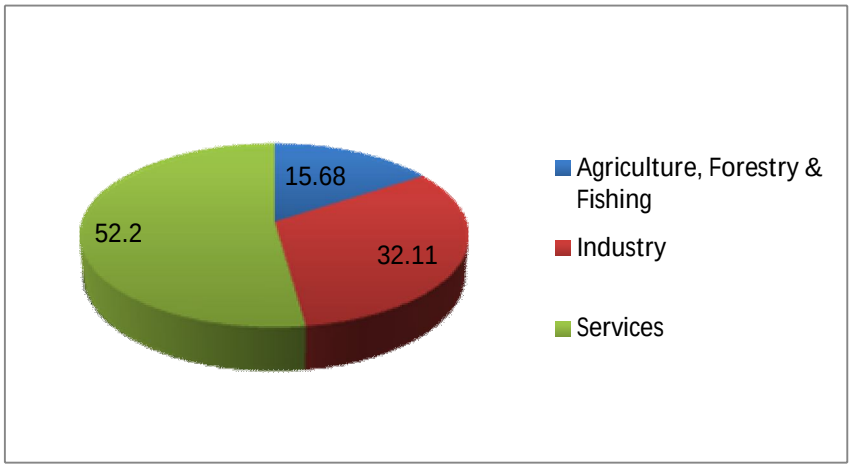
[131] Ibid.

[132] Ibid., p.699

Since its merger with the Union of India in 1975, Sikkim has been undergoing rapid modernisation. The multiple hydro-projects, a booming tourism industry (which has recently suffered a setback in the wake of the 18th September, 2011 earthquake) and buzzing information technology etc. all point towards the fact that Sikkim has slowly been making its way up the development ladder. Figure 4 and Table 9 show the Gross Domestic Product (GDP) by its component and overall GDP of the state and the rising per capita income from 2005-10, respectively. In terms of GDP, Sikkim may be ranked as the smallest economy among all Indian states but due to its small population, the per capita income is very high.

Figure 4

Sikkim GDP by its Component



Source: VMW Analytic Services, 2011

Table 9

Calculating the GDP at Constant Price (Base year being 2004-05), Sikkim

Sl. No.	Year	GDP (in Lakhs)	Per Capita Income (Rs.)
1	2009-10	2,58,614	42,888
2	2008-09	2,35,212	39,531
3	2007-08	2,17,841	37,111
4	2006-07	2,02,404	34,836
5	2005-06	1,90,962	33,327

Source, DESM&E, Govt. of Sikkim, 2005-10

Despite the above figures, indications suggest that unemployment situation in the state has been worsening. The national educated unemployment rate (usual status adjusted) for 15 years and above has shown a decline for both males and females in both the areas, as a result the overall (persons) rate has declined from 7.5 to 6.5 percent in rural areas and from 7.8 to 7.1 in urban areas from 1993-94 to 2004-05.[133] We find an opposite trend in Sikkim where the overall educated unemployment rate has considerably increased from 3.2 to 6.8 percent in rural areas in particular and from 4.9 to 6.4 percent in urban areas during the same period.[134] Males have been hit harder so far as the educated unemployment problem is concerned. *"It has increased by more than three folds from 1.8 to 6.1 percent and by almost two folds from 3.3 to 6.4 percent in rural and urban areas, respectively"*.[135] Perhaps this is one of the reasons why the latest census 2011 data has reported an increase in rural-urban migration. An overall rural decline of 13.9 percent has been covered by an increase in urban settlement. While there is an increase in rural-urban migration, the switch does not guarantee a better lifestyle or more opportunities for employment, and this may, in turn, result in social isolation and frustration, pushing the person towards the brink of committing suicide.

Causes

As far as the causes are concerned, in Sikkim we find that young people commit suicide as a result of failed relationships, break-up, pressure to perform in school or unemployment whereas older men and women commit suicide due to sickness/medical complications (of not being able to pay for medicines/upkeep), divorce/widowhood, breakdown of marriage etc. Verma's study (2008) revealed that the main reasons driving people to commit suicide included insanity (25.5 percent), family problems (17.9 percent) and prolonged illness (6.3 percent)**.** In a few cases, these factors not only worked independently, but were collective and complimentarily to each other. The top reasons that drove individuals to take their own lives varied from family problems (9.6 percent), insanity (8.9 percent), prolonged illness (8.2 percent), cancellation or unsettlement of marriage (6.1

[133] Reimeingam, Marchang, 'What went wrong with the Educated Unemployed of Sikkim', *Sikkim Express*, 30th March, 2010

[134] Ibid.

[135] Ibid.

percent) and unknown causes (42.4 percent).[136] A deeper analysis of the top three reasons behind suicides in the past five years reveals:

Table 10

Top Three Causes of Suicide in Sikkim, 2006-10

Sl. No.	Year	Cause #1	Cause #2	Cause #3
1	2010	Family problems	Prolonged illness	Insanity
2	2009	Unknown	Family problem	Career/professional problem
3	2008	Family problem	Unknown	Cancellation/Non-settlement of marriage
4	2007	Unknown	Family problems	Insanity
5	2006	Insanity	Unknown	Drugs

Source: NCRB, 2006-10

One of the biggest drawbacks of research on suicide involves no first person account. While some victims do leave behind a suicide note, Fleer & Pasewark (1982) state that roughly only a quarter of all suicide victims have been in therapy. In India, this might not even be the case. Added to this, there is the problem of classifying death as intentional or unintentional when it happens as a result of drug overdose, falling from a cliff, drowning in the river etc. These problems seem to apply in the case of Sikkim as well. The increase in numbers of suicides taking place in the state have been attributed to a variety of causes, ranging from high levels of unemployment, to a growing cultural gap between traditional norms and values and the influence of a globalised world order, rising aspirations and an inability to fulfil the same which ultimately leads to suicidal tendencies.[137]

[136] NCRB, '*Accidental Deaths and Suicides in India'*, Annual publication, 2010

[137] Both *'Suicide in Sikkim: A Psycho-social study'* by Dr. Sunil K. Verma, 2008 and an article *'Suicide: A daunting challenge before the State of Sikkim'* by Binod Bhattarai published in *Sikkim Now!,* Feb 19, 2012 point out that unemployment levels have been escalating in the Himalayan state. Verma states that in the urban area, unemployment has increased from 2.90% to 8.40% whereas in rural areas it increased from 5.1% to 17.5%. Bhattarai observes that unemployment rate at the national average stood at a much lower level as compared to Sikkim.

District-wise Break-up

Sikkim is divided into four districts. The East district is the most developed, followed by South and West districts. North district covers the largest area but is the least developed. According to the latest census 2011 data, East Sikkim has the highest urban population at 1,20,750 persons. South Sikkim comes in second with 21,089 persons, West Sikkim third with 5,239 persons and North Sikkim with an urban population of 4,648 comes in fourth. Similarly, the rural population for all four districts rests at 1,60,543 for East Sikkim, 1,31,060 for West Sikkim, and 1,25,653 and 38,706 for South and North Sikkim respectively.

The Census 2011 figures also show an overall rural decline of 13.9 percent which has been covered by the increase in urban settlement. Experts state that modernisation or globalisation has led to sweeping changes in the traditional value system, resulting in a breakdown of the joint family system, rise in divorce rates, cultural gap between established norms and a more western backed ethos etc. High expectations of parents from their children, exposure to a consumerist world order, cultural lag lead to depression and low confidence among the youth adds stress in the minds of the young. As mentioned earlier, while there is an increase in rural-urban movement, there is no guarantee that people enjoy more job opportunities or better lifestyle in urban areas. Infact once the individual finds there is no upward mobility after the switch, it might result in alienation and frustration, leaving the person vulnerable to suicidal behaviour.

Table 11

District-wise Number of Suicides in Sikkim, 2006-10

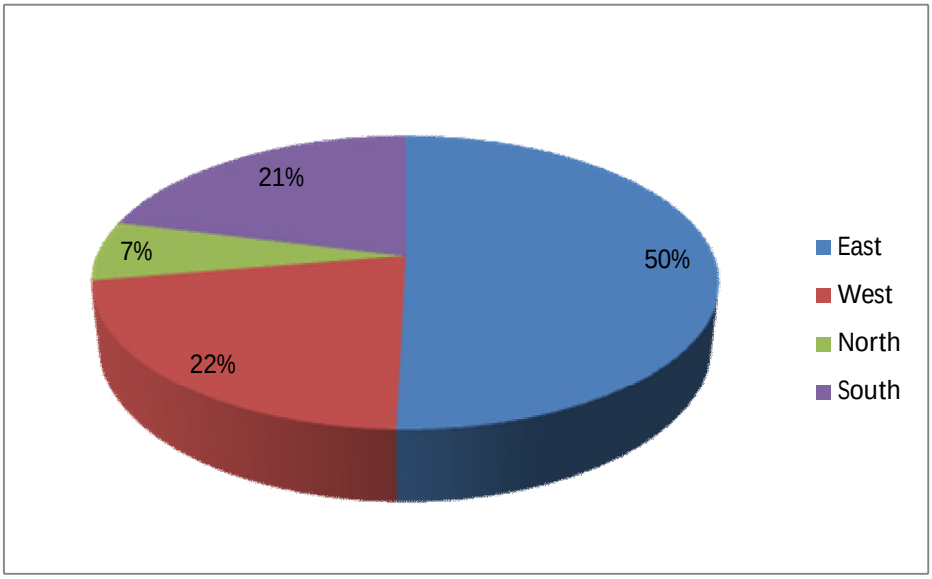
Sl. No.	Districts	2010	2009	2008	2007	2006	Total
1	East	202	167	163	143	146	821
2	West	80	81	77	64	55	357
3	North	27	29	20	19	13	108
4	South	79	78	53	61	72	343
	Total	**388**	**355**	**313**	**287**	**286**	**1629**

Source: State Police Department, Crime Branch, 2006-10

The district-wise break-up of suicides reveals East district as reporting the highest number of suicides. While South district recorded the second highest numbers in 2006, it has been superseded by the West district since then. However, the two are still closely tied. North district reported the least suicide casualties.

Figure 5

District-wise Share of Suicides (Sikkim), 2006-10



Source: State Police Department, Crime branch, 2006-10

A total of 1,629 cases of suicide have been recorded between 2006 and 2010. The causes for the increase in number of suicides in the state have been attributed to substance abuse, alcoholism, mental illness, anxiety and depression followed by family problems, drug addiction, prolonged illness, failure in examinations and love affairs etc. While these reasons may be true to an extent, one must also understand how the subjectivity of an individual manifests itself in suicidal behaviours. Sex, age, occupation, level of income, marital status, health care etc. have an important social role to play.

Means Adopted

Studies of methods used to commit suicide have generally revealed that men and women use different methods of suicide.[138] An explanation for the differential choice,

[138] Davis, E., 'The Relationship between Suicide and Attempted Suicide: A Review of Literature', *Psychiatric Quarterly*, Vol. 41, 1967: 752-765

especially between the two sexes, involves the 'lethality of intent'. Men are more intent on committing suicide than women. Taylor & Wicks cite a second hypothesis which focuses on differential socialization as the reason behind male and female differences in methods of suicide. Their final data provide little support for the former and only partial support for the differential socialization hypothesis.[139] Another perspective focuses on convenience and access. Hassan gives an example of people residing in urban areas who commit suicide by jumping from tall buildings; village dwellers committed suicide by hanging themselves from a tree or a high beam. In a similar fashion, even age can affect accessibility and, in the process, the choice of method.[140]

Table 12

Distribution of Suicides by Means Adopted (All-India), 2010

Sl. No.	Means adopted	Males (%)	Females (%)	Total	% to total
1	**Over alcoholism**	89.5	10.5	1490	1.1
2	**Drowning**	61.1	38.9	8409	6.2
3	**Self-immolation**	34.8	65.2	11885	8.8
4	**Fire-arms**	61.9	38.1	666	0.5
5	**Hanging**	68.6	31.4	42266	31.4
6	**Consuming poison (pesticide)**	66.5	33.5	25288	18.8
7	**Consuming other poison**	64.6	35.4	19247	14.3
8	**Self infliction of injury**	74.6	25.4	836	0.6
9	**Jumping (from building)**	74.7	25.6	795	0.6
10	**Jumping (from other sites)**	66.6	33.4	875	0.7
11	**Jumping off moving vehicles**	77.8	22.2	743	0.6
12	**Machine**	80.2	19.8	177	0.1

[139] Taylor, M.C. and J.W. Wicks, 'The Choice of Weapons: A Study of Methods of Suicide by Sex, Race and Region', *Suicide and Life Threatening Behaviour*, Vol. 10, 1980: 142-150

[140] Hassan, Riaz, *Suicide in Australia: A Sociological Study*, 1992, p.184

13	**Overdose of sleeping pills**	60.1	39.9	589	0.4
14	**Touching electric wires**	74.9	25.1	1150	0.9
15	**Coming under running vehicles/trains**	78.7	21.3	4204	3.1
16	**Other means**	68.0	32.0	15979	11.9

Source: NCRB, 2010

The all-India trend in terms of means adopted to commit suicide in 2010 reveals that hanging is the most preferred means, followed by consuming pesticide, consuming other poison and self immolation etc. There is very little evidence that persons committing suicide in Sikkim use a particular method because it holds a special fascination for them. What we do know, however, is that, in Sikkim, the most common means adopted to commit suicide (from 2006-10) shows death by hanging as the most preferred method with 77.2 percent in 2006, 76.2 percent in 2007, 44.9 percent in 2008, 61.4 percent in 2009 and 56.8 percent in 2010.[141] The NCRB data about suicide methods used in Sikkim offers a partial support for the 'socio-cultural', 'convenience' and 'accessibility' perspectives.[142] If we are to determine the reasons as to why certain means of committing suicide are selected, more systematic empirical work is needed to be done.

Apart from what has already been discussed, there are certain aspects of the Sikkimese society which needs mention. Firstly, with respect to death rituals, in Sikkim, the last rites performed for a person who committed suicide are no different from the rest i.e. the dead body is accorded the same rituals as any person who died under normal circumstances. With cases of suicide being reported in the local newspapers every alternate day, there seems to be a growing recognition of suicide as a reasonable solution to overcoming life problems. Such cultural acceptance has a negative impact upon the mind-sets of young people.[143] Secondly, the growing number of suicides among the youth is also seen as a result of the

[141] NCRB, '*Accidental Deaths and Suicides in India'*, Annual publication

[142] Hassan, Riaz, *Suicide in Australia: A Sociological Study*, 1992, p.193

[143] Gunnell, D., Lopatatzidis, A., Dorling, D., Wehner, H., Southall, H., and Frankel, S. (1999) 'Suicide and unemployment in young people: Analysis of trends in England and Wales', 1921-1995. *British Journal of Psychiatry* 175: 263-270.

imbalance between tradition and modernity. The escalating influence of Western values on the Sikkimese society which is traditionally a tribal one cannot be overlooked. One of the areas where this disparity is easily visible is in the region of language. While most youngsters speak fluently in English, one finds very few people who can converse in their local dialect with the same ease. As a result of instant access to the internet, social networking sites and mass media, people are exposed to idealistic lifestyles which may be well beyond their means. Once the individual finds a disparity between this perception and reality, it increases the likelihood for ending one's life in times of turmoil. Thirdly, like the general population, Sikkimese people, too, believe that suicide is a result of mental illness. This viewpoint however is changing in present times. Apart from this, there is a strong superstitious belief, especially in rural areas, that evil spirits force people to commit suicide. As such, once suicide has been committed the natural assumption is that others will follow soon enough. Sometimes, prayers are conducted in the village to ward off evil but this is a rarity, unless multiple suicides hamper the peace and quiet of the locality. However, once a history of suicide has been registered, some sort of biasness is shown towards the family of suicide victims. For example, people are reluctant about marrying into a family that has a history of suicide.

While the increasing rate of suicides all over the world today has drawn the attention of psychologists, economists, sociologists and researchers to address this problem, efforts are being made by the State Government to identify high risk people and refer them for treatment to the psychiatric health centres. The psychiatric department has also been conducting mental health programmes in schools and carrying out Information, Education and Communication (IEC) activities through local media as a part of the awareness campaign. However, apart from individual counselling, there is a need to understand suicide from a social angle. In the following chapter, a detailed sociological analysis of suicide in Sikkim has been undertaken in an attempt to try and comprehend how socio-economic factors influence or elicit suicidal behaviour.

CHAPTER 4

THE CASE OF SIKKIM: A SOCIOLOGICAL ANALYSIS

"Across the country and the world, the reasons prompting suicides are understood in reasonably clear detail and it naturally follows that efforts are mounted to suppress the triggers. No such enquiry has been invested to understand why so many in Sikkim end their lives. The times are now desperate for a detailed analysis to be undertaken".

– Sikkim Now! 13th March, 2012

A sociological review of the problem of suicide in Sikkim involves deeper analysis of socio-economic factors that influence or trigger suicidal behaviour. The following chapter focuses on the mediating role of family, work and occupation, education, gender, age and ethnicity in influencing suicidal behaviour in Sikkim. Data has been provided by NCRB and from the State Police records.

Family, Marital Status and Suicide

Charles H. Cooley defines a primary group as characterised by intimate face-to-face relations and it is this association that leads to a 'we' feeling. It means that one lives in the feeling of the group and *"finds the chief aim of his will in that feeling"*. The family is the most important primary group in every society. This nexus between the conjugal status and suicide has been a focus of sociological analysis for some time. Family integration has been given utmost attention in Durkheim's study of suicide. He suggests that higher suicides rates are associated with disrupted family structures and greater family strain. At the macro-level, this often involves *"examining suicide rates cross-sectionally and over time using rates of divorce and, sometimes, single parent-hood as measures of family disruption"*.[144] The micro-level work includes exploring the psychological dimensions of the lives of suicide victims and clinical analysis of those who have attempted suicide or have suicidal ideation. At this micro-level, *"measures of family structure as well as individual-level measures of family strain and conflict to measure social integration and regulation are applied"*.[145]

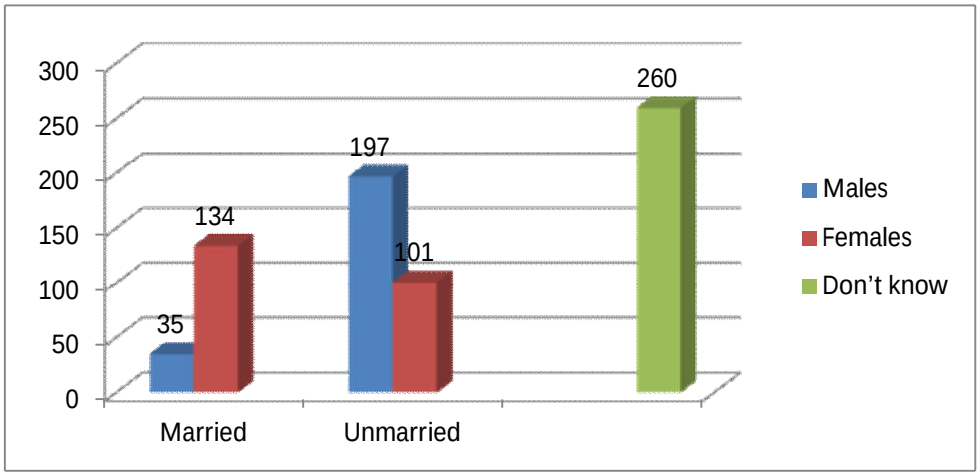
[144] Stockard, Jean & Robert M. O'Brien, 'Cohort Effects on Suicide Rates: International variations', *American Sociological Review*, Vol. 67, No. 6 (Dec., 2002), p.857

[145] Ibid.

Durkheim argues that *"from 20 years, married persons of both sexes enjoy a coefficient of preservation in comparison with unmarried persons"*.[146] Marriage provided a cohesiveness and support system which was unavailable to the unmarried, widowed or divorced persons. It acts as a social integrator and therefore as a factor that inhibits egoistic suicide; which is a result of 'excessive individualism' among people who have few social ties. The main thrust of egoism-anomie is that social control and suicide are inversely related.[147] He also puts forth that in a family of small numbers, common sentiments and memories cannot be very intense due to the lack of conscience which rests on collective representations and reinforcements. The state of integration of a social aggregate reflects *"the intensity of the collective life circulating it"*.[148] Thus, *"just as the family is a powerful safeguard against suicide, so the more strongly it is constituted the greater its protection"*.[149]

Figure 6

Marital Status of Victims of Suicide, Sikkim (2006-10)



Source: State Police Records, Crime Branch, 2006-10

In the case of Sikkim, official sources have details of age and marital status of suicide victims. What is missing though is information about family size, age of children and family

[146] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966, p.179

[147] Danigelis, N. L. and W. Pope. 1979. 'Durkheim's theory of suicide as applied to the family: A contemporary test', *Social Forces,* 57 (June): 1981-106.

[148] Ibid., p.202

[149] Ibid.

stress which could have provided meaningful insight into the study. A detailed analysis of the 727 suicide cases registered in the State Police records, between 2006 and 2010, show that Durkheim's logic of family and, subsequently, marriage as an integrating factor stands true as almost two-third victims were unmarried (see Figure 6). However, a deeper analysis reveals a greater disparity between being married and being single for men than for women. Unmarried women commit lesser suicides than their married counterparts. The hypothesis that suicide rates are substantially lower among the married population stood rejected in a study reported by Rico-Velasco and Mynko in 1973.[150] Their research, which was conducted in Ohio between 1960 and 1970, showed that married women appeared to commit suicide about twice as frequently as single women, irrespective of age. The mean annual suicide rates for married women are consistently higher than for single women. Marriage provides the best protection against suicide for men, while same is not the case for women. This may be due to the changing meanings of marital status in light of their economic and social independence. Hassan postulates that *"as women enter the labour market after finishing child bearing they may be placed under greater stress due to multiplicity of their roles they come to occupy"* increasing the possibility for role conflict or role tension.[151] Another hypothesis involves stress caused by a sick partner who needs constant caring. Gove's data supports the hypothesis that changes in the woman's role may have been detrimental to married women and that, *"as marital roles are presently constituted in our society, marriage is more advantageous to men than women"*.[152]

In Sikkim, 197 out of 232 (84.9 percent) male victims were unmarried as compared to only 101 out of 235 (43 percent) female casualties. A closer analysis needs to be undertaken in order to understand the link between changing status and changing meanings of marriage among both men and women in Sikkim since it tends to affect the nature of relationship between marital status, social integration and suicide rates.[153]

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[150] Rico-Velasco, J. & L. Mynko, 'Suicide and Marital Status: A Changing Relationship', *Journal of Marriage and Family*, Vol. 35, No. 2 (May, 1973): 239-244

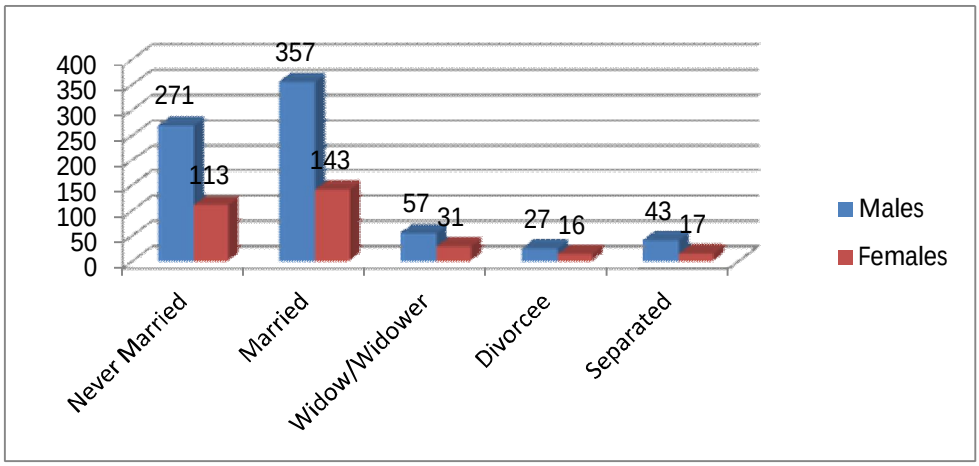
[151] Hassan, Riaz, *Suicide in Australia: A Sociological Study*, 1992, p.143

[152] Gove, Walter R., 'Sex, Marital Status and Suicide', *Journal of Health and Social Behaviour*, Vol. 13, No. 2 (Jun., 1972), p.211

[153] Hassan, Riaz, *Suicide in Australia: A Sociological Study*, 1992, p.146

Figure 7

Social Status of Victims of Suicide, Sikkim (2006-10)



Source: NCRB, 2006-10

However, Figure 7, which is based on NCRB statistics for the same period, shows that this disparity in suicide among married and unmarried males has been contradicted. Accordingly, 357 male victims (47.3 percent) were married as opposed to 271 (35.9 percent) unmarried ones. Overall, the Durkheimian logic still holds its ground as more victims were unmarried, widowed, separated or divorced (52.7 percent) than married, among both males and females, respectively.

Considering the fact that family is the most important primary group of our society, divorce is a central indicator of social disintegration. Familial responsibilities reduce suicide risk in several ways. For example, by immersing oneself in the troubles of others, egoism is significantly lowered in forgetting one's own suicidal thoughts. Divorce disrupted this state of cohesiveness and led to higher suicide rates. Given their loss of responsibilities to a spouse and children, divorcees are relatively high in egoism and anomie.[154] This assumption was, however, contradicted by Norstrom in his study of the impact of divorce on suicide.[155] In Sikkim, divorce cases have been on the rise in recent times and the link between divorce and suicide cannot be ignored in this case. Further scrutiny reveals that in the last five years, from

[154] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966, pp. 171-276

[155] Norstrom's study (1995) showed that the estimated effect of divorce on suicide was insignificant both in the ecological and time-series analysis. Only about 4 percent of the suicides could be attributable to divorce among Swedish men from 1963-65.

March 2007-12, a total of 493 cases have been registered in the Family Counseling Centre (FCC) run by ASHI (Association for Social Health in India), and FCC, located at the Police Headquarter. The registered cases range from maintenance issues, desertion, harassment & torture, alcoholism, bigamy and extra-marital affair, reconciliation etc. While 14.2 percent of the cases are related to bigamy and extramarital affair, 7 percent are linked to harassment due to divorce and desertion. The consistently rising numbers indicate the extent of deterioration which has taken place in the Sikkimese society. Within the family, too, parenting skills have changed in recent times. Parents tend to spend lesser time with their children nowadays. Stockard & O'Brien study the relation between cohort size and suicide rates. The relative lack of adults among large cohorts can lead to less attention and supervision, as adult resources are thinly spread among children. They comment that because adults are less involved in children's lives, peers have a stronger influence. While peers can provide social support, they cannot *"provide the same type of integrative or regulative forces, nor can peers provide the emotional support and guidance that can come from adults"*.[156] In Sikkim, the love and warmth one gets in a family has decreased as a result of changing parent-child relationship.

Unemployment and Suicide

Much of unemployment trends in Sikkim have already been discussed in the previous chapter. Durkheim observed that an organized work force provides strong protection against suicide since employment integrated the individual into the society. Unemployment, on the other hand, is a socio-economic problem that stalks the capitalist world everywhere. It is a social problem because unemployment leads to poverty as well as adversely affects social organisation. It *"weakens the individual's social integration, deprives him/her of social role and status and increases social isolation, all of which are positively associated with suicide"*.[157] A few studies highlight the link between unemployment and suicide trends.[158] In

[156] Stockard, Jean & Robert M. O'Brien, 'Cohort effects on suicide rates: International variations', *American Sociological Review*, Vol. 67, No. 6 (Dec., 2002), p.856

[157] Hassan, Riaz, *Suicide in Australia: A Sociological Study*, 1992, p.119

[158] Rushing, William A., 'Income, Unemployment and Suicide: An Occupational Study', *The Sociological Quarterly*, Vol. 9, No. 4 (Autumn, 1968): 493-503. Rushing's study confirms this link between unemployment and suicide among low income groups in the US. Results suggested a need to specify the employment-suicide relationship by income level. Unemployment appears to be closely associated with the suicide rate at low income levels, while employment is associated with it at high income levels.

Sikkim, since the merger, the state government has emerged as the major employer for carrying out development work. Public sector employment in Sikkim remains one of the highest in North-eastern states.[159]According to the Sikkim Development Report (2008), the current trend in employment shows a fall in the share of cultivators as well as agricultural labourers. This has been compensated by a rise in 'other' workers. This means that people are now opting for other employment avenues with opportunities diversifying in the process of development. The Vision Document of the state defines development in terms of ensuring livelihood for all.[160] *"This requires the government to facilitate job creation, empower people to become capable of fending not only for themselves but also creating job opportunities for others as well"*.[161]

It is important to understand that suicides cannot be attributed to a single cause. Most times various factors come into play, leaving the individual with few options other than suicide. Three such explanations, as discussed earlier, are: unemployment may induce *vulnerability* by increasing the impact of stressful life events; it can increase the *risk factors* that precipitate suicide; it could also end up being a *non-causal* association.[162] An interesting link transposes between education, unemployment and suicide, as we understand from Halliburton's study of Kerala. An aspect of Kerala's development success that may connect its suicide and psychopathology rates is education. In 1998, Kerala had the highest literacy rate in the country at around 90 per cent. Halliburton asserts that in the course of his research in Kerala, he encountered a great number of people who were unable to find jobs commensurate with their education and expectations. Therefore, while unemployment may

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Crombie, I.K., 'Trends in Suicide and Unemployment in Scotland, 1976-86', *British Medical Journal*, Vol. 298, No. 6676 (Mar. 25, 1989), pp. 782-784. The study found a positive correlation between the trends in unemployment and suicide rates in men. The data for women contrast with those for men. The relation between unemployment and suicide in women is unclear. Smith emphasised that the association between suicide and unemployment is, at best, weak among women. The importance of comparing trends among men and women lies in what it could show about possible causal mechanisms. For example, if loss of social contact or poorer financial circumstances were the important factors then effects of unemployment on both men and women might be expected. If loss of self esteem was the important factor then men, with their traditional role of breadwinner, might be affected to a greater extent.

[159] Sikkim Development Report, 2008

[160] Sikkim: The People's Vision, 2001

[161] Sikkim Development Report, 2008, p.56

[162] Blakely, T.A., S.C.D. Collings, J. Atkinson, 'Unemployment and Suicide: Evidence for a Causal Association', *Journal of Epidemiology and Community Health* (1979-), Vo. 57, No. 8 (Aug., 2003), p.594

not be cited as a common cause for suicides by official government sources, he fears underemployment may be a factor influencing the suicide and psychopathology rate in Kerala.[163] This view was supported by E. T. Mathew as well in his study on unemployment in Kerala (1997). While school and university enrolments had increased, job growth in the state had been weak. This gap between education/expectations and job availability triggered the high rates of suicide.

This explanation can be applied in the case of Sikkim as well. Census 2011 shows literacy rate has gone up from 68.81 percent in 2001 to 82.2 percent in 2011. At the same time, unemployment rates have also registered an increase. In a July '11 Sikkim Express article, Reimeingam traces the usual status adjusted unemployment rate as being considerably higher for youths when compared to the general (i.e. all ages) unemployment rate throughout the periods (NSS data). *"In rural Sikkim, the unemployment problem was increasingly more severe for the youth with 1.9, 6.4 and 10.3 percent in 1993-94, 2004-05 and 2007-08 when compared to the general with 0.7, 2.4 and 3.6 percent in the respective periods. While majority of the urban unemployed youth seems to be the new entrants into the labour force or those seeking work for the first time. These youths formed a large proportion of the new entrant unemployed. In urban areas, the problem was increasingly more acute for the youth with 7.2, 7.9 and 23.5 percent in the respective periods as compared to the general with 3.1, 3.7 and 10.2 percent in the respective periods"*[164]. Accordingly, the national educated unemployment rate (usual status adjusted) for 15 years and above has shown a decline for both males and females in both the areas as a result the overall (persons) rate has declined from 7.5 to 6.5 percent in rural areas and from 7.8 to 7.1 in urban areas from 1993-94 to 2004-05. We find an opposite trend in Sikkim where the overall educated unemployment rate has considerably increased from 3.2 to 6.8 percent in rural areas in particular and from 4.9 to 6.4 percent in urban areas during the same period. Males have been hit harder so far as the educated unemployment problem is concerned. *"It has increased by more than three folds from 1.8 to 6.1 percent and by almost two folds from 3.3 to 6.4 percent in rural and urban*

[163] Halliburton, Murphy, 'Suicide: A Paradox of Development in Kerala', *Economic and Political Weekly*, Vol. 33, No. 36/37 (Sep. 5-18, 1998): 2341-2345

[164] Reimeingam, Marchang, 'Escalating problems of Youth Unemployment in Sikkim', *Sikkim Express*, 10th July, 2011

areas, respectively".[165] Perhaps this is one of the reasons why the latest census has reported an increase in rural-urban migration. An overall rural decline of 13.9 percent has been covered by an increase in urban settlement. While there is an increase in rural-urban migration, there is no guarantee that people enjoy more job opportunities or better lifestyle in urban areas. Infact once the individual finds there is no upward mobility after the switch, it might result in alienation and frustration, leaving the person vulnerable to suicidal behaviour.

There has to be some consistency in educational and employment generational planning. The education system in Sikkim needs to be more vocational training oriented, or changes in the job pattern be made to fit a highly qualified work force. Halliburton states that maybe the macro-level inequalities in the global economy have affected Kerala, such that it is unable to provide jobs that are commensurate with education. This seems to be the problem in Sikkim as well. We need to understand that globalisation and other aspects of social change are not necessarily negative influences. Indeed it is possible to make these changes meaningful and useful.

Education and Suicide

In his 1897 study of Suicide, Durkheim shows that there seemed to be an exceptionally high number of suicides in the highest classes of society.[166] He also stated the secularization of education and increasing levels of educational attainment as contributing factors to individualism. Once education transformed from moral to scientific forms, the obedience to cultural tradition weakened. This scientific culture or the concept of 'free inquiry' contributed to suicide risk.[167] Gibbs and Martin predicted that those persons in lower status occupations were less likely to commit suicide.[168] Meanwhile, Li states that other studies, such as done by Breed and Maris, concluded quite the opposite, that *"the social*

[165] Reimeingam, Marchang, 'What went wrong with the Educated Unemployed of Sikkim', *Sikkim Express*, 30th March, 2010

[166] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966. p.165

[167] Stack, Steven, 'The Effect of Modernization on Suicide in Finland: 1800-1984', *Sociological Perspectives,* Vol. 36, No. 2 (Summer, 1993), p.138

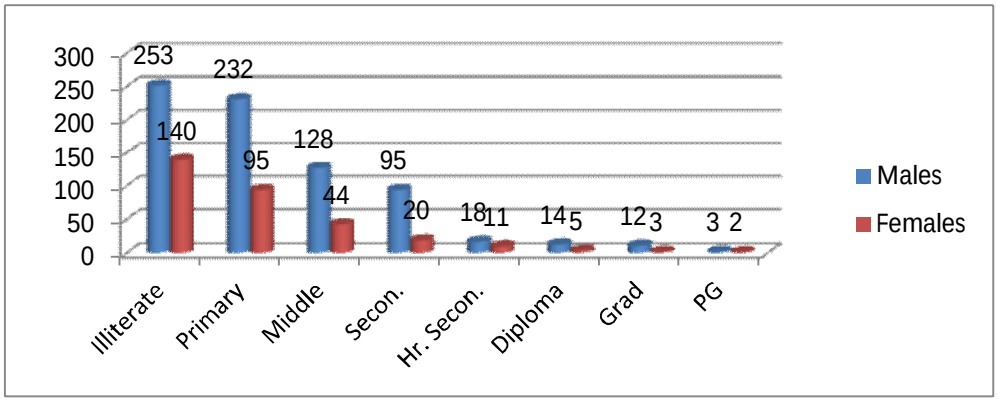
[168] Gibbs, Jack P. and Walter I. Martin, 'Status Integration and Suicide', Eugene, Ore.: University of Oregon Press, 1964, p.62

status hierarchy is inversely related to the suicide rate".[169] A third conclusion was brought forward by Dublin who studied British and American data to conclude that suicide is more frequent at the two extremes of the economic scale. Those in the higher social status rung were stressed about work and high aspirations, whereas those in the lower rung were driven to take their own lives due to hopelessness or poverty, unemployment and insecurity.[170]

In light of the above mentioned studies with regard to the relation between suicide and social status, Li studies a transitional society like Taiwan and uses educational attainment as an indicator of social status. Education is considered as the means through which knowledge and skills can be developed. It is a socialising agency, an integrating force, a social control mechanism, a key factor in social development and an escalator to social mobility. It equips a person for a job and also to perform the same with a fair degree of competence. It has been regarded as the key factor which determines the level of prosperity and welfare of the people. The Taiwanese society has been undergoing secularization since the end of the Second World War. It has shown a decline in fertility figures (which is another indicator of societal transition) and lesser importance is attached to extended families. Li's research findings reveal a negative correlation between suicide and educational status.[171]

Figure 8

Educational Status of Victims of Suicide, Sikkim (2006-10)



Source: NCRB, 2006-10

[169] Li, Wen L., 'Suicide and Educational Attainment in a Transitional society', *The Sociological Quarterly*, Vol. 13, No. 2 (Spring, 1972), p.253

[170] Ibid.

[171] Ibid, p.257

Like Taiwan, the Sikkimese society too is a transitional society. Verma's psycho-social study (2008) revealed that 93 percent of the suicide victims had below matriculate level education. Thus he attributed low education to be a possible cause of suicide. The 2010 figures reaffirm this link as 86 percent of the suicide victims have below matric level education. Figure 8 shows that suicide is more frequent among the illiterate (36.6 percent), followed by those who've studied up to primary (30.4 percent), middle school (16 percent) and so on and so forth. Thus, in Sikkim too, we find a negative correlation between suicide and educational status. Alternatively, the latest census data reveals that Sikkim has one of the highest literacy rates at 82.2 percent. Male literacy stood at 87.3 and female literacy at 76.4 percent, respectively. Judging by the issues with regard to unemployment, especially educated unemployment, on one scale and loss of lives, particularly among the uneducated or less educated, on the other, it seems to be a tricky situation for the state. While education might be a key tool in addressing the problem of high suicide rates in the state, the nature of education needs a re-look. It is seemingly too literary, theoretical, lacking aptitude and techniques and largely not job oriented or employable in the present labour market structure which is mostly specialised resulting in the increase of educated unemployed. Of course, in the recent decade or two various job oriented vocational courses have been dramatically introduced across the country including the state of Sikkim but more steps need to be taken towards this end.[172]

A much appreciated step in this direction was the *'Science, Spirituality and Education Conference'* organised in Gangtok, the state capital, from 20-23 December, 2010 by the Namgyal Institute of Tibetology. The effort was aimed at harmonising science with spirituality for adoption as a curriculum for school education in Sikkim. This initiative has its roots in His Holiness the Dalai Lama's efforts to encourage dialogue between science and religious philosophy to fashion a life science in which the two do not conflict, rather collaborate to deliver intelligence with compassion. The idea is to introduce spirituality into school curriculum by combining the ethics and morals which religious philosophies carry along with the scientific world's understanding of the brain and mind. Such a combination would formally introduce moral and ethical subjects in the school curriculum and help deliver

[172] Reimeingam, Marchang, 'What went wrong with the Educated Unemployed in Sikkim', *Sikkim Express*, 30th March, 2010

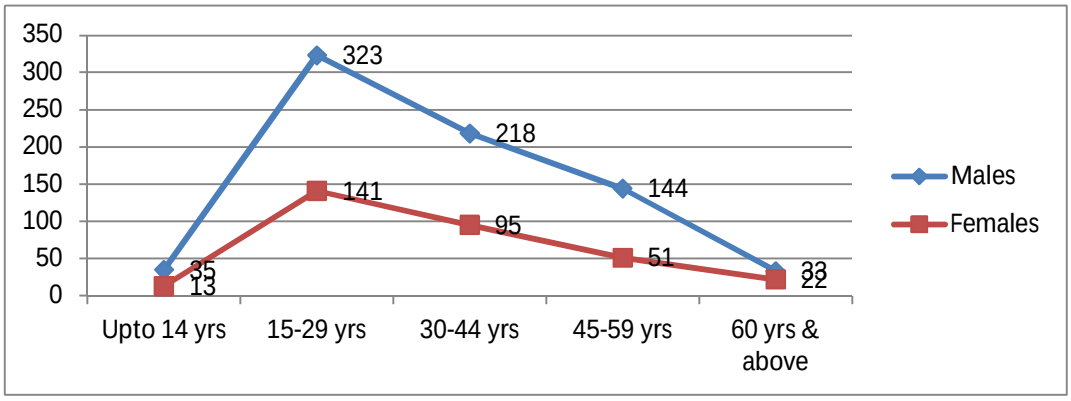
an education which is more complete and prepares the new generation with less disturbed minds and more positive outlooks.

Age and Suicide

A consistent cross-cultural pattern observed by Durkheim at the time of his research was the strong positive association of suicide with age. As he put it, *"not only is suicide very rare during childhood but it reaches its height only in old age, and during the interval grows steadily from age to age".*[173] In recent years this trend has shifted to include young people, especially young men. This is true not just in the case of India. Globally, people between the age group of 5-44 years are more at risk to commit suicide than those 45 years and older. WHO statistics show that suicide is now among the top three causes of death among those aged 15-44 years.[174] In Sikkim too, the Durkheimian hypothesis has proved wrong. NCRB data suggests that the youth are killing themselves at a rate higher than any other age group.

Figure 9

Age-wise Distribution of Victims of Suicide, Sikkim (2006-10)



Source: NCRB, 2006-10

Out of a total of 1075 victims, a staggering 464 casualties were from the 15-29 years category (43.2 percent). This was followed by 313 victims (29.1 percent) from the 30-44 years age group. Together, this means that Sikkim lost 777 lives to suicide wherein the victims were from the 15-44 years age bracket i.e. 72.3 percent in all. This figure includes the

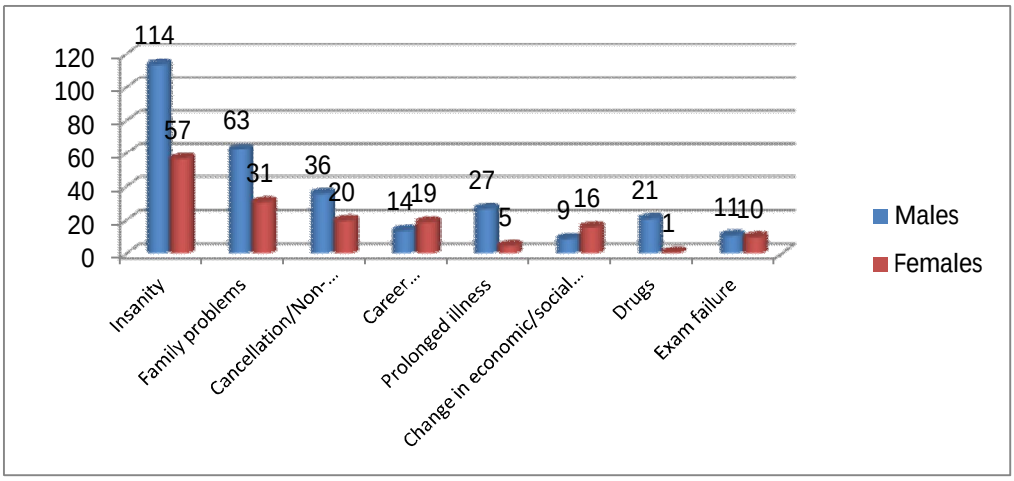
[173] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966, p.101

[174] http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/index.html

sex-wise break up which follows the same trend. The share of females and males was 21.95 and 50.32 percent respectively.[175]

Figure 10

The Causes of Suicide, Sikkim (2006-10)



Source: NCRB, 2006-10

If we go back to the previous chapter, the top three annual causes for committing suicide, in a five year period included family problems, prolonged illness, insanity, career/professional problems, cancellation or non-settlement of marriage, drugs and unknown reasons. A detailed analysis of the causes of suicide, from 2006-10, reveals an inclusive understanding of the changing scenario (see Figure 10 above). The NCRB has been updating its data base on a yearly basis; as such new causes of suicide are added annually, like suicide due to property dispute, divorce, a fall in social reputation etc. So far as the youth are concerned, the problems plaguing them range from insanity, family issues, cancellation/non-settlement of marriage, love affair/illicit relations, change in economic/social status, unemployment/career problems, drugs and failure in examinations etc. In two categories, career problems and changes or fall in economic/social status, women seem to be more affected than men. In terms of the former, it could be due to the added pressure of handling duties both at the home and career front. Family problem, break down of a marriage and drugs seem to be the important causes behind youth suicide rates. Drugs, particularly, has been a major problem among the youth in the North East, Sikkim being no exception. Statistics show that 95.4 percent of the victims who committed suicide by consuming drugs

[175] NCRB, '*Accidental Deaths and Suicides in India*', Annual publication, 2006-10

are males.[176] While raids of suspected drug peddlers have become a regular affair, it is not solely up to the government to take up the issue of drug abuse. Society needs to remove the moral sanctions against drug addicts and celebrate those who've recovered from their addiction. This can only help the future generation from falling into an easy trap.

Gender and Suicide

The theme of gender is an often repeated one throughout this study. Sikkimese women, as is the normal trend, tend to suicide less frequently than men. Hassan puts forth that the gender differences and changing patterns have been explained on two different accounts. Proponents of the first theses argue that increasing opportunities, stresses, challenges and strain in a modern era have caused women to act/react in a manner previously considered to be in the domain of men. Thus, if this trend were to continue then the gender differences in suicide rates will get narrow in the future. The second thesis focuses on power control theory. Mothers in patriarchal families are assigned roles to control their daughters relatively more than sons. This makes daughters less prone to risk taking behaviour. Therefore, gender differences in suicide and other forms of deviant behaviour are a direct result of "*sexual stratification in the social control of adolescents that is related to patriarchal family structures*".[177] Yet another study by Lester et al. interpreted the higher rates of suicide among Indian men (10.6) than women (7.6), between 1975 and 1994 in terms of the reasoning that men chose to solve their own problems. Meanwhile women were open to help and support from others. Although the latter were more prone to suffer from depression, men are more likely to commit suicide as they refrain of taking outside help to solve their problems.[178] Since the Sikkimese society is a patriarchal one, the second and third theses seem to apply to the question of gender difference among victims of suicide.

Alcohol, Drugs and Suicide

The alcohol factor is generally not considered in sociological studies on suicide. A possible explanation, as put forth by Norstrom, is that Durkheim explicitly dismissed alcohol

[176] NCRB, '*Accidental Deaths and Suicides in India'*, Annual publication, 2006-10

[177] Hassan, Riaz, *Suicide in Australia: A Sociological Study*, 1992, pp. 54-55

[178] Lester, D., Agarwal, K., Natarajan, M. 'Suicide in India', *Archives of Suicide Research*, 5, 1999: 91-96

as a causal factor of suicide.[179] In his influential theory of suicide, Durkheim quotes, *"A society does not depend for its number of suicides on having more or fewer neuropaths or alcoholics… Admittedly, under similar circumstances, the degenerate is more apt to commit suicide than the well man; but he does not necessarily do so because of his condition"*.[180] Hence, a large number of psychiatric and epidemiological studies single out alcohol abuse as an important risk factor in suicide but sociology has by and large ignored the same. For a sociological perspective, Skog takes up the network approach. He states that an individual's drinking habits are the product of interplay between three types of factors:

1. Individual characteristics (including biological constitution, psychological factors);

2. His/her social network, i.e. individual drinkers may influence each other's drinking habits, affected by individuals in their social networks who, in turn, are affected by other individuals;

3. General and specific material (including availability) and socio-cultural (including differential norms) conditions in his environment.[181] Further, he asserts that alcohol induced behaviours tend to dilute social relations.

Based on this premise, Norstrom's research reveals that a good third of the male suicides in Sweden appear to be attributable to the alcohol factor.[182] A study conducted by the Social Development Foundation of the Associated Chambers of Commerce and Industry in India (ASSOCHAM) pointed out that 45 percent of intermediate students in metropolitan cities consume alcohol excessively, at least five to six times a month.[183] This is dangerous because it runs a risk of alcohol dependency, moving on to more dangerous drugs and causing significant harm to themselves and others.

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[179] Norstrom, Thor, 'The Impact of Alcohol, Divorce and Unemployment on Suicide: A multilevel Analysis', *Social Forces*, Vol. 74., No. 1 (Sep., 1995), p.293

[180] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966, p.81

[181] Skog, Ole Jorgen, 'Alcohol and Suicide: Durkheim Revisited', *Acta Sociologica*, Vol. 34, No. 3 (1991), p.197

[182] Norstrom, Thor, 'The Impact of Alcohol, Divorce and Unemployment of Suicide: A multilevel Analysis', *Social Forces*, Vol. 74., No. 1 (Sep., 1995), p.310

[183] 'Alcohol intake among Indian teens on the rise', http://skmstudent.blogspot.in/2010/10/alcoholic-intake-among-indian-teens-in.html, Tuesday, 19th Oct., 2010

Alcohol use is traditionally prevalent in Sikkim. The National Family Health Surveys (NFHS) programme has emerged as an important and reliable source of data on population, health and nutrition for India and its states. According to NFHS-3, one-third of all Indian men drink alcohol and its consumption is negatively related to level of education and socio-economic conditions. Men from scheduled tribes are prone to drink alcohol in a higher proportion than men from other castes and tribes, and the same is true in case of scheduled tribe women. Also, the level of alcohol consumption among both urban and rural men is more or less equal. Overall, the survey shows that generally alcohol consumption among women is insignificant as compared to that of men. However, the proportion of women consuming alcohol exceeds 5 percent in eight states, with Arunachal Pradesh (33.6 percent) and Sikkim (19.1 percent) attaining the highest levels. Table 13 below shows the trends in alcohol use in the north-eastern states and in India.

Table 13

Percentage of women and men age 15-49 who drink alcohol in the north-eastern region (by state), India, 2005-06

Trends	Women	Men
India	2.2	31.9
Arunachal Pradesh	33.6	61.1
Assam	7.5	37.8
Manipur	1.8	47.4
Meghalaya	3.8	49.2
Mizoram	0.7	42.0
Nagaland	3.5	38.5
Sikkim	**19.1**	**45.4**
Tripura	9.6	40.9

Source: NFHS-3, 2005-06

The use of alcohol, as stated earlier, is traditionally accepted in the Sikkimese society. Liquor is also easily available in the state. It is normal for parents to send their children to buy locally made alcohol in the village. This means that children learn about alcohol from a

very young age. Especially in villages since '*Chang*' or '*Jaar*' (millet beer) is most popular, children tend to taste it out of curiosity in the absence of their parents. Also, it is a common practice among elders to drink openly in front of young children. Gambling also encourages use of alcohol. Infact, both gambling and alcohol mutually reinforce each other and there is a high possibility of suicide in most cases.

One of the biggest threats facing the Sikkimese society today happens to be in the form of drug abuse which has been on a rise. Details of drug peddlers arrested under the earlier Narcotics Drugs and Psychotropic Substances (NDPS) Act, 1985 and the more recent Sikkim Anti Drugs Act (SADA), 2006 also show the slow but steady rise in the market for drugs, especially in the last five years (see Table 14). The table below gives an indication of the extent of the rise:

Table 14

Drug peddlers arrested under NDPS, 1985 and SADA, 2006

Districts	2001	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11
East	4	4	2	-	3	4	4	6	16	35	55
South	-	-	-	-	-	4	6	26	39	87	59
West	-	-	-	-	-	1	-	3	2	1	-
North	-	-	-	-	-	1	-	1	-	2	1
Total	**4**	**4**	**2**	**-**	**3**	**10**	**10**	**36**	**57**	**125**	**115**

Source: Record Section, Crime, District Police Stations, 2001-11

Because of its proximity to West Bengal from where drugs are smuggled into the state, South district reported the highest number of drug peddlers. Despite strict vigilance at the border check posts, it seems the drug peddlers often use the river route especially during the dry seasons. It is a general notion that drug abuse is not class specific. Also, there is a strong consensus that drug addiction starts during adolescence since these are the most vulnerable years for any person. The profile of substance abusers in Sikkim was studied in the emergency services wing of a tertiary hospital in Sikkim (Bhalla et. al., 2006). The paper reports that out of the 54 patients seeking emergency services, the age range of substance

abusing (all drugs) population is 19 to 68 years with a median of 36 years. However, the age range of Intravenous Drug Use (IDU) population is 20 to 43 years with a median of 25 years. This means that IDU practice is common among the youth while the older population relies on other drugs, mostly alcohol. It was seen that the predominant substance abuse related emergency attendance is with alcohol (77.2 percent). At the same time, alcohol withdrawal (57.4 percent) has been the most common cause of attending the emergency ward. This they explain in terms of the high prevalence of alcohol abuse in this part of India. Thus, the study reveals that alcohol abuse and drugs are an important public health issue in the state.

Although readily comprehended, the close relationship between alcoholism/drugs and suicide has rarely been investigated. A few possibilities include the fact that substance abuse can lead to, and also sometimes be a result of, social decline, break up of marriage, loss of job and family ties etc. This may result in social isolation which is a potent cause of suicide. Intoxication also increases impulsiveness and a weakening of normal restraints against dangerous behaviour. Further, dependence on drugs and alcohol can lead to loss of self esteem, resulting in depression and ultimately suicide.

Religion, Ethnicity and Suicide

According to Durkheim, religious belief protects individuals against suicide by means of its integrative effects in the form of shared beliefs and social ties. Marx once wrote that religion is opium of the masses, meaning that it can provide comfort to the oppressed in society. Stack adds that religion can reduce suicide through means such as *"building up self-esteem by providing an alternative stratification system… promoting a belief in prayer as an answer to adversity; and glorifying poverty, a condition potentially conducive to suicide"*.[184] Thus religion has a calming effect on human disappointments, such as death, unemployment, poor health, divorce etc. Another important aspect of religion is its provision of an alternative stratification system which is generally built around moral principles. If one follows these principles in everyday life, he/she can have a relatively high rank. Thus this can become an esteem builder. Stack gives certain examples to justify his argument. For example, if a relatively low position in society leads to an individual having low self-esteem, one can turn to religion as an alternative source of the same. Failure in society, which could potentially

[184] Stack, Steven, 'The Effect of Religious Commitment on Suicide: A Cross-National Analysis', *Journal of Health and Social Behaviour*, Vol. 24, No. 4 (Dec., 1983), p.364

lead to suicidal behaviour, can be averted to pursue spiritual or moral success in religion's stratification system.[185] After a cross-national study of the relation between religious commitment and suicide rates in twenty five countries, Stack's findings indicate support for a theory based on the concept of religiosity, but only for females. While he correctly anticipated that religiosity had a stronger effect on suicide rates for females than males, he did not anticipate that male suicide rates tend not to be sensitive to religiosity levels present in the late 20th century world. Stack's explanation was that males are more involved in worldly affairs, such as the labour market etc., which justifies the behavioural changes in males before females. Thus, religiosity was still relevant to female suicide rates in the late 20th century, while the suicide rates of the more secularized males are not.

Unlike Durkheim's study which found a relationship between religious affiliation and suicide rates among the Catholics and Protestants in nineteenth century Europe, no such parallels can be drawn in the case of Sikkim. *"The demise of religion as an influence is viewed as inevitable by Weber (1922) due to industrialization and economic growth; by Glock (1973) and Black (1966) due to the rise of rationality in science and education, which undermines religious epistemology; by Cox (1965) due to urbanization; and by Swanson (1968) due to the competing secular religion of professionalism"*.[186] Even though it is mostly recognised as a Buddhist state, Hinduism is the dominant religion of the state, with 60.9 percent of the population adhering to it. 28.1 percent of the population are Buddhists, followed by Christians who form 6.7 percent of the population.[187] The main ethnic groups of Sikkim comprises of the Nepalis, Bhutias and Lepchas. It is the only state in the country with a Nepali majority of 70 percent.[188] Keeping this in mind, it is no wonder that a major chunk of the victims of suicide belong to this community. The Nepalis are Hindus, the Bhutias are Buddhists and the Lepchas are nature worshippers. The latter also form a major percentage of the Christian population in the state after having converted to the faith after British missionaries came in the nineteenth century.

[185] Ibid., p.365

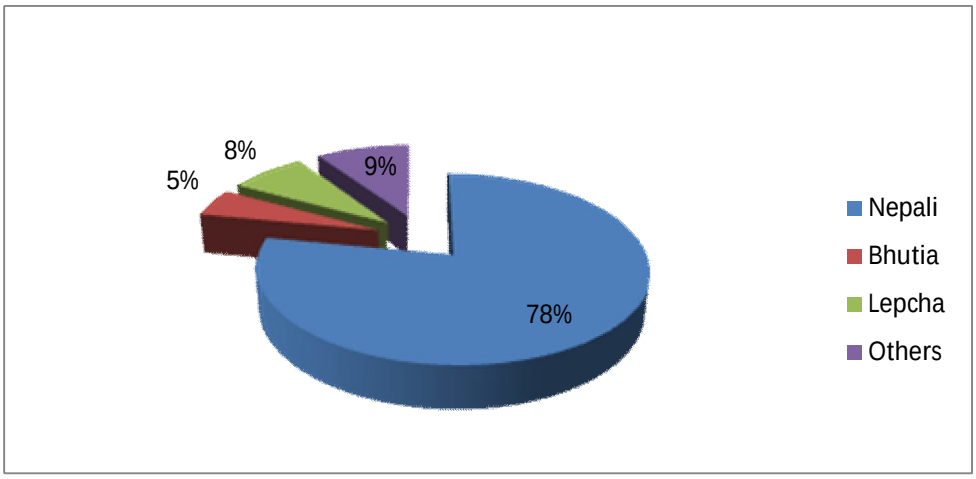
[186] Ibid., p.371

[187] Census of India, 2001

[188] Information & Public Relations Dept., Govt. of Sikkim, http://www.sikkimipr.org/sikkim_people.htm

Figure 11

Community-wise Break up of Victims of Suicide, Sikkim (2006-10)



Source: NCRB, 2006-10

Between 2006 and 2010, out of a total of 719 recorded cases, 561 victims (78 percent) were Nepalis, followed by 55 (7.7 percent) Lepchas, 35 (4.9) Bhutias and 68 9.5 percent) other victims. The Bhutia community are the least susceptible to commit suicide. 18 cases of suicide were registered wherein the victims were domestic helpers. Also, another 16 cases pointed out a case of inter-community/inter-religious marriage. Whether this is a result of non-settlement or breakdown of marriage has not been researched but the chances of the same cannot be overlooked.

Modernisation/Cultural Diffusion

In the previous chapter it has already been mentioned that a decline in the rural population has been balanced by an increase in the urban population. Migration in search of education, employment and a better lifestyle has seen an increase in the state. Durkheim viewed urbanization, industrialization and secularization as breaking ties between the individual and group life.[189] With the decline in group participation, egoism increased suicide potential. On the other hand, access to profits in industrial capitalism was, in turn, at the roots of anomic suicide. With the challenges presented at the academic, home and professional front, people are finding it difficult to handle all the stress and pressure. The Sikkimese

[189] Stack, Steven, 'The Effect of Modernization on Suicide in Finland: 1800-1984', *Sociological Perspectives,* Vol. 36, No. 2 (Summer, 1993), p.138

society has been undergoing transition in the 21st century. In the past decade, cultural diffusion from the West has accelerated through penetration of both print and mass media and the internet. A good example of this would be rise in the demand for Korean movies. As in the other North-eastern states, the influence of Korean movies and its subsequent effect in the fashion scene is widely apparent in Sikkim too. *"It has made the present generation more outgoing and more confident and not at all apologetic about what they want in life"*.[190] Historically, traditional norms and values were the order of the day but the previous sentence sums up a drastic change seen amongst the current generation.

Based on Durkheim's hypothesis, society does not have a strong foothold like it used to. This leaves space for individuals to become more egoistic or anomic. While modernisation seemingly opens up more avenues for growth, it also disconnects the individual from the integrating clutches of society at large. An important trend, in Sikkim, has been the growing acceptance of material culture. While it is okay to indulge in the same, it becomes harmful when one has not imbibed the non-material culture overriding it in the first place. A perfect example would be the infiltration of an MTV lifestyle among the youth today. The influence of media in the portrayal of idealistic lifestyles may invoke unrealistic expectations of life and a distorted perception of reality. This may, in turn, increase suicide risk among the youth.[191] Pub culture has also become increasingly popular nowadays. Youngsters like to indulge in this particular aspect without understanding that such a lifestyle comes at a cost. The mantra in the West traces a hectic weekday schedule followed by fun weekends. In Sikkim, this mantra has not been acknowledged. Unlike the West, youngsters continue to live off their parents well beyond 25 years. So far as parents are concerned, parenting too seems to be undergoing some changes in the present times. Compared to the past, there is relatively less attention and supervision of children. According to Stockard & O'Brien, this means that peers have a stronger influence in the absence of adults who are less involved in children's lives. While the former can provide social support, they are unable to provide the same type of integrative or regulative forces as adults; neither can they provide the emotional support and guidance that can come from adults.[192] As mentioned over and

[190] 'Kore-yeah', *Eclectic Vibes: Northeast India at its best*, July, 2011

[191] Gunnell, D., Middleton, N., Whitley, E., Dorling, D., Frankel, S., 'Influence of cohort effects on patterns of suicide in England and Wales, 1950-1999', *British Journal of Psychiatry*, 2003, 182: 164-170

[192] Stockard, Jean & Robert M. O'Brien, 'Cohort effects on suicide rates: International variations', *American Sociological Review*, Vol. 67, No. 6 (Dec., 2002), p.856

again, no single factor can be solely attributed to suicide. While modernisation and cultural diffusion can drive individuals to have rising aspirations and pursue unconventional goals, unemployment or failure to achieve these goals can lead to frustration, depression and ultimately suicide.

The empirical evidence analyzed in this chapter points out that suicide has an important symbolic content. From family integration, education, age, gender, unemployment to modernisation etc, each factor guides an individual to act or react in a certain way. Thus, there is an urgent need to focus on suicide and suicidal behaviour from the standpoint of a sociological inquiry if we are to arrive at meaningful and effective intervention strategies and measures to address the problem of suicide.

CHAPTER 5

AN OVERVIEW/CONCLUSION

"In sunny Sikkim, where sudden rains cloud the skies, death is the new challenge"

– The Telegraph, 24th October, 2010

Suicide is not new in human history. Its sources reach far back into the beginning of culture. An animal may die of disease or be destroyed intentionally or accidentally by an outside agency but as far as we know only man can will his death and kill himself.[193] It is a most personal action an individual can take. Hassan points out that death in modern societies commonly occurs in specialized settings such as a hospital, highway, and battlefield or on television. Since its causes are socially institutionalized, death that takes place outside the 'conventional' setting carries a social stigma and strong disapproval. Suicide happens to fall in the latter category and it is this which stigmatises it.[194] Understanding risk factors can help dispel the myths that suicide is a random act or results from stress alone.

The present study on suicide illustrates that the individual cannot be understood in isolation from his social matrix. Suicide has become a major public health and social problem in Sikkim. In the preceding chapters, an attempt has been made to understand and analyze suicide in the Sikkimese society by focusing on key social factors. Suicide is a fact of society and *"it has social causes which are subject to discernible sociological laws which can be identified and analyzed scientifically and rationally"*.[195] In Sikkim, for some time now, cases of suicide are reported in the local papers every other day. In some of the recent cases, a teacher has been accused of abetment to suicide. Investigations revealed that the 17 year old girl was beaten by her class teacher, following which she committed suicide by hanging.[196] In another case, a 47 year old man allegedly killed his second wife after which he himself

[193] Rastogi, Pooja, S. R. Kochar, 'Suicide in Youth: Shifting paradigm', *Journal of Indian Academic Forensic Medical,* 32(1), p.45

[194] Hassan, Riaz, *Suicide in Australia: A Sociological Study*, 1992, p.194

[195] Ibid., p.195

[196] *Sikkim NOW*! 22nd June, 2012

committed suicide.[197] Police investigation revealed that the second wife used to torture the children of his first wife which forced the husband to kill her.

Dr. C. L. Pradhan, Neuro-Psychiatrist, Sir Thutob Namgyal Memorial (STNM) Hospital, states that most of the suicide cases in Sikkim are a result of mental illness, stressful lives, substance abuse, narcotics and alcohol use. Explaining the reasons for the rise in suicides among the youth, he added that high expectations of the parents from their children can also enable students to take such lethal steps. The need of the hour, according to Dr. Pradhan, was awareness at the ground level about health and various other mental issues that bother people. Data from the Psychiatric Department of the STNM Hospital supports his statement.[198] A study of twenty cases revealed that the personal issues faced by patients who have attempted suicide at some point in their lives range from unresponsive family, feelings of hopelessness/worthlessness, depression, poor achievement (either academically or professionally), social isolation, alcoholism, schizophrenia or economic frustrations. In India, the majority of cases committed suicide during their very first episode of depression and more than 60 percent of the depressive suicides had only mild to moderate depression.[199] In Sikkim, in the twenty cases examined:

- Fifteen patients had a history of schizophrenia or depression in the family;
- Six patients were alcoholics;
- Four patients had problems within the family. In one case, the family had not accepted an inter-community/inter-religious marriage. The other three cases reported were those in which the patients had bad relations with their father or husband.
- One of the patients was a divorcee who was also facing social isolation both at work and home.

Although social drinking is not a way of life in the country, NFHS-3 data show that alcoholism is significantly higher among the scheduled tribes than the general population.

[197] www.isikkim.com, 16th June, 2012

[198] Performa of patients with suicidal tendencies collected from the Psychiatric Department, STNM Hospital, Government of Sikkim

[199] Vijayakumar L, Rajkumar S. 'Are risk factors for suicide universal? A case control study in India', *Acta Psychiatr Scand*, 1999; 99: 407–11

Alcoholism is a major social problem plaguing the Sikkimese society. A brief study of recovering addicts in three rehabilitation centres in Sikkim reveal that only 17 percent of substance abusers seeking treatment were females, whereas a staggering 83 percent of the addicts were males.[200] While quite a few from the neighbouring regions are admitted into these rehab centres, the data analysis done is in respect of locals only. This study is based on those who seek treatment for addiction and pans across to draw a holistic picture of the drug and alcohol problems in the state, as it exists today. Analysis shows that the alcohol and drug problem is male centric. Recovering alcoholics form the largest group, followed by those who are addicted to drugs. 57 percent of the patients were alcoholics, 26 percent were drug addicts and 15 percent were poly addicts i.e. both alcohol and drugs. Drug addiction is especially common among the younger age-group. Among the males, out of a total of 815 recovering addicts, 51.4 percent were alcoholics (419 cases), 29 percent were drug addicts (237 cases) and 19.5 percent were poly addicts (159 cases). However, there is an almost singular pattern found among females- 84.5 percent of the female patients were recovering alcoholics, 10 percent were drug addicts, mostly in their teens or early twenties, and only two were poly addicts. The nature of addiction was not known in the case of 4.1 percent. Both males and females showed a tendency towards drug addiction in the below 30 years age-group. Meanwhile, those above 30 years were prone to be alcoholics. The problem years in terms of addiction were between 20-49 years for both men and women. In terms of occupation, most of the male recovering addicts were unemployed, followed by those working in the lower end of the bureaucracy or into some private business, drivers or, in a few cases, retired servicemen. Among females, around 66 percent of the patients were housewives, 14 percent were government servants, 12 percent were in private jobs and 6 percent were students. Although data on alcoholic suicides is absent from NCRB and State Police records in a majority of the cases, the influence of alcohol or drugs in triggering suicidal tendencies cannot be overlooked. Also, apart from the addicts, many wives have been driven to suicide by their alcoholic husbands. A highly significant relationship between domestic violence and suicidal ideation in women has been found in many developing

[200] In the absence of relevant data, this study was conducted in three rehabilitation centres- *Sikkim Detoxification & Rehabilitation Centre, Nimtar, East Sikkim, Singitham Rehabilitation Centre, Namchi & Sanjeevani Rehabilitation Society, Namchi, South Sikkim, covering the period 2006-11*

nations in population-based studies.[201] Based on the above study, the magnitude of alcohol and drug abuse in the state can be drawn.

"The effects of modernization, specifically in India, have led to sweeping changes in the socio-economic, socio-philosophical and cultural arenas of people's lives, which have greatly added to the stress in life, leading to substantially higher rates of suicide".[202] Vijaykumar states that the high rate of suicide among young Indians can be associated with greater socio-economic stressors that are a result of the liberalization of the economy and privatization leading to more competition, loss of job security, huge disparities in incomes and the inability to fulfil role obligations in the new social setting. Since its merger with the Union of India, the Sikkimese society has undergone rapid socio-economic and cultural changes. As a result, most of the youth are affected by anxiety and stress today. As Gunnell put it, *"the incongruence between expectation and reality among the youth may increase suicide risk".*[203]A key hypothesis proposed by Durkheim was that unemployment or work loss deprives an individual of his/her social role and status and increases social isolation by weakening the individual's social bond with society.[204] Empirical evidence in the case of Sikkim, as discussed in previous chapters, supports the Durkheimian hypothesis.

Another hypothesis put forward by Durkheim postulates that marriage provides a sense of cohesiveness and support which is unavailable to unmarried, widowed or divorced persons. The data examined in this study supports the general thrust of the theory. While Durkheim's logic of family and, subsequently, marriage as an integrating factor stands true (see Table 18), a deeper analysis reveals a greater disparity between being married and being single for Sikkimese men than for women. Unmarried women commit lesser suicides than their married counterparts. This may be due to the changing meanings of marital status in light of their economic and social independence. After finishing child bearing, women may be placed under greater stress due to multiplicity of their roles increasing the possibility for

[201] World Health Organization, 'The World Health Report', Geneva: *World Health Organization*; 2001

[202] Vijaykumar Lakshmi, 'Suicide and its prevention: The urgent need in India', *Indian J Psychiatry*, 2007 Apr-Jun; 49 (2): 81–84

[203] Gunnell, D., Middleton, N., Whitley, E., Dorling, D., Frankel, S., 'Influence of cohort effects on patterns of suicide in England and Wales, 1950-1999', *British Journal of Psychiatry,* 2003, 182: 164-170

[204] Durkheim, Emile, *Suicide: A Study in Sociology*, Spaulding, John A. (trans.) with an introduction by George Simpson, ed., The Free Press, New York, 1966, pp. 241-246

role conflict or role tension.[205] Another hypothesis involves stress caused by a sick partner who needs constant caring. Overall, NCRB statistics show that more victims were unmarried, widowed, separated or divorced (52.7 percent) than married, among both males and females, respectively (see Table 19).

Perhaps Sikkim should try to pick up a lesson or two from Kerala.[206] The latter has been able to successfully address the problem of suicide in the state. From a 30.8 percent suicide rate in 2003, it has now come down to 25.2 percent in 2010.[207] , The efforts initiated include numerous government run counselling centres as well as non-governmental ones (NGOs) to deal with suicide intervention. Between Sikkim and Kerala, there are a few common factors. Both report alcoholism and family conflicts as the prime reasons for suicides. High literacy rates, 93.9 percent in Kerala and 82.2 percent in Sikkim, have also led to higher expectations and unfulfilled aspirations.[208] Vijaykumar states, *"In these areas, people are less aggressive and often brood over their problems. This leads to emotional turmoil"*.[209] In Sikkim, serious steps are yet to be taken to combat the problem of suicide, and bring down the rate of suicide to the national average. *"We have to treat suicide as an epidemic,"* says Dr. Pradhan. According to him, so far, Sikkim does not have any NGOs or help lines working for suicide intervention and prevention. Kshetrimayum adds that rapid modernization taking place in the state today is one of the reasons for the alarming growth in the suicide rates. Also, the lack of emotional security among children, which was previously given by parents, is another major factor. Along the same lines as Dr. Pradhan, Kshetrimayum opines the need for counselling to bring about massive awareness among the general masses. Apart from the government, other stakeholders like educational institutions, NGOs and religious associations also need to play a pro active role in educating the people on the issue.[210]

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[205] Hassan, Riaz, *Suicide in Australia: A Sociological Study*, 1992, p.143

[206] 'State of Suicide', *The Telegraph*, 24th Oct, 2010

[207] NCRB, '*Accidental Deaths and Suicides in India'*, Annual publication, 2003 and 2010

[208] Census of India, 2011

[209] 'State of Suicide', *The Telegraph*, 24th Oct, 2010

[210] 'Alarming Suicide Rate in Sikkim', Politics & Social Issues, *PapaToto Express Yourself*!, 18th November, 2009 http://www.papatoto.com/article/225479574265/Alarming_Suicide_Rate_in_Sikkim

The State Government, on its part, has taken a few steps towards prevention of suicide. So far, lectures by spiritual leaders such as Baba Ramdev and Paul Dinakaran on life skill lessons have been organized. Even the Science and Spirituality Conference, as mentioned in the previous chapter, is a step in the right direction. Another positive and a more recent initiative undertaken by the Government is the Chief Minister's Comprehensive Annual and Total Check up for Healthy Sikkim (CATCH) programme which was launched on 26th August, 2010. This is a comprehensive health check-up programme, which also assesses suicidal ideation, suicide attempt and depression. The idea is to discuss with the community and take detailed history and information of the area, family and person in a prescribed format. In this manner, the main problems and issues of the locale can be identified. To start with, the Health & Family Welfare Department carried out this programme on a pilot basis by adopting 20 wards in East Sikkim for the year 2009-10.

Table 15

Suicidal Thought and Attempt Reported in 20 Wards in East Sikkim, 2009-10

Name of the Ward	Suicidal Thought (%)	Suicidal Attempt (%)
Parkha	23.67	5.92
Kambal	36.65	0
Upper Lamaten	10.10	0
Lower Lamaten	0	0
Middle Sumin	84.62	15.38
Beyang	46.78	23.39
Ray Mindu	24.56	3.50
Tumlabong	38.25	0
Assam Linzey	79.47	6.62
Bardang	57.14	4.76
Kopchey	53.57	0
Sawaney	37.97	8.44
DhanBari	36.46	5.21
Pachey	86.96	7.25
Tshalamthang	66	3.3
Duga	81.19	12.82
Mamring	21.86	0
Dochum	75.47	12.58
Reshi	73.68	0
Saku	40.63	21.88
Total Prevalence/1000	**50.77**	**7.36**

Source: National Rural Health Mission (NRHM), PIP, 2011-12

Table 15 shows that a significant percentage of the population have suicidal thoughts, whereas only a handful actually go ahead with the attempt to die. If such individuals are identified and given timely aid and counselling, it can help prevent suicides. Based on information collected from NCRB, State Police records and the CATCH programme, the NRHM programme implementation plans, 2011-12 have stated the following as possible risk factors in order of importance in Sikkim:[211]

1. Mental illness, including depression;
2. Various social changes which may be as follows:
    - Rapid development, economic changes and the old certainty with regard to jobs and relationships are being swept away faster than the young can cope.
    - Loosening of family bonds- Individualistic cultures are leaving people without ideals. There is a loss of a sense of the future coupled with hopelessness.
    - Breach in the social support system which was initially there in society.
    - A gap between high expectations and the inability to fulfil their dreams leaves the younger population vulnerable to drugs and alcohol abuse.
    - Impulsiveness and/or aggressiveness in Sikkimese society are, perhaps, another cause of worry.
3. A sense of isolation;
4. Literacy rate has gone up from 34.1 percent in 1981 to 82.2 percent in 2011, as such there is rat race for getting white collar jobs;
5. Also, the pressure to perform better in academics leads students to commit suicide, especially when faced with failure in examinations;
6. Loss of tradition and social cohesion;
7. Smaller family sizes and the lack of role models;

[211] National Rural Health Mission (NRHM), Programme Implementation Plans 2011-12, High focus: North East; Sikkim http://pipnrhm-mohfw.nic.in/index_files/high_focus_ne/sikkim/4d2.pdf

8. Alcohol and substance abuse;
9. Chronic illness;
10. Weakening of cultural, social support and protective factors;
11. Exposure to and influence of the media and internet;
12. Family history;
13. Previous suicide attempts;
14. Absence of properly planned strategies and little coverage of community based mental health services.

Since the risk factors have been identified, these are the initiatives and activities currently being undertaken or in the process of implementation by the Mental Health Cell, Non-Communicable Diseases Division and District and State Referral Hospital for suicide prevention:[212]

- ✓ Under Non communicable Diseases Programme:
    1. Massive awareness campaign on mental health issues and suicide prevention.
    2. Sensitization of all levels of health care providers to offer Mental Health Services (MHS) through Primary Health Centres (PHCs).
    3. Sensitization programs for important stakeholders like medical officers, students, teachers etc. regarding emotional/mental health issues and suicide prevention.
    4. Basic anti-depressant drugs are made available in STNM, district hospitals.
- ✓ Sensitization of policy makers, administrators, health personnel and civil society through other non-communicable programmes.
- ✓ Breaking of taboo with respect to suicide.

[212] Ibid.

- ✓ Appropriate registration of deaths by the Birth and Death Cell to trace accurate data on number of deaths by suicide which would in turn help in forming an accurate database.
- ✓ Reliability of suicide certification and reporting is being improved.
- ✓ 24X7 help lines in all health institutions to be started.
- ✓ Issue of guidelines for media reporting i.e. no sensationalization of suicide, preventing adoption of 'copycat' methods of suicide etc. Also, issue of guidelines for preventing suicide for teachers, school staffs, general physicians and medical officers, PHC workers.
- ✓ Under CATCH Sikkim Programme:
    1. Basic counselling for all health care providers.
    2. A Community Suicide Prevention Program is in the pipeline.
    3. Vision for positive mental health put forward to the community.
    4. Community mobilization wherein community participation and its involvement is significant.
    5. Involving Psychiatric/Psychological Specialists during the Specialists' Health Camp in PHCs.
- ✓ *"World Suicide Prevention Day- Many places, many faces"* was observed on 10th September, 2010 in STNM. Healthy discussion on all issues of suicide was held.
- ✓ Mental Health Care is incorporated into Primary Health Care so that promotion of positive mental health and early detection of mental health problems can be done at the PHC itself.
- ✓ Massive community mobilization will be generated to promote positive mental health and reduce the consumption of alcohol and drugs.
- ✓ Those with suicide ideation would be identified by general practitioners, and intervention or referral services be offered.

Some Suggestions

As a result of efforts initiated to address this social pathology, good news has been delivered in the form of the latest NCRB 2011 statistics. According to the annual publication, Sikkim's suicide rate has gone down by 15.6 percent from 2010. The suicide rate for 2011 is 30.3 percent, placing Sikkim in third position, behind Puducherry and Andaman and Nicobar islands. This is a marked improvement since 2008 as the gap between the national and state suicide rate has reduced to 19.1 percent from 34.5 in 2010.[213] However, Sikkim still holds the dubious distinction of being the *"Suicide capital of the North East"* as the other North-Eastern states rank much lower in the Table, except for Tripura which is in ninth position.[214] According to the NRHM programme implementation plans, the following measures still need to be implemented in order to address the problem of suicide in Sikkim:

- Media sensitization;
- Advocacy workshops
- A coming together of the State Government initiatives and NGOs, along with enthusiastic participation from civil society, religious organizations etc. to ensure a healthy society, free from social maladies;
- Organize awareness programmes cum workshops in school, involve important stakeholders like teachers, students, parents, school staff etc.;
- Introduce 24x7 help lines as well as online counselling;
- A suicide prevention website must be set up so that friends and family of individuals with suicidal ideation or such individuals themselves may refer to the site for timely help and support.
- Most importantly, there is an urgent need to organize massive awareness campaigns. Unless mass community mobilization does not take place, it will be very difficult to prevent suicides. Responsibility for prevention of any social malady rests not only on

[213] NCRB, '*Accidental Deaths and Suicides in India'*, Annual publication, 2010-11

[214] Ibid.

the law enforcing personnel but also on public health and other human service agencies and civil society at large.

Suicide is a multifaceted problem and hence suicide prevention programmes should also be multidimensional. José Bertolote emphasizes the need to integrate public health and clinical actions to prevent suicide.[215] Collaboration, coordination, cooperation and commitment are needed to develop and implement a plan, which is cost-effective, appropriate and relevant to the needs of the community. In the case of Sikkim, the priority include reducing alcohol availability and consumption, improving the capacity of primary care workers and specialist mental health services, providing support to those bereaved by suicide and training gatekeepers like teachers, police officers and practitioners of alternative system of medicine and faith healers. Promoting and supporting NGOs working in the field of suicide prevention is also important. Although Sikkim is yet to have NGOs working exclusively in this field, efforts are on by some local NGOs. Recently, Concern for Complete Life (CARE), a Gangtok-based self-supporting NGO, held an awareness session on AIDS and suicide prevention at the Carmel College, Pakyong, East Sikkim on 16 March, 2012. *"The NGO has been organizing various seminars and workshops and radio plays, skits, power-point presentations and discussions with experts on these issues in different parts of Sikkim"*.[216]

Long term strategies to condense many mental health problems must incorporate reducing domestic violence and substance abuse. Public education must address the issue of stigma attached to alcohol, drug abuse and mental health treatment in order to allow individuals facing these problems to seek treatment freely. Other steps involve promoting mental resilience through optimism and connectedness. Education about suicide, including risk factors, warning signs and the availability of help is yet another important approach. Media also has a crucial role to play in preventing suicide. By relating suicide with negative outcomes such as pain for the victim and his survivors, conveying that the majority of people choose something other than suicide in order to solve their problems, media can influence the thought process of those with suicidal ideation.

[215] World Health Organization, 'Atlas of Mental Health resources', Geneva: *World Health Organization*; 2001

[216] 'CARE reaches AIDS and suicide prevention awareness to Carmel College', *Sikkim Now!* 20th March, 2012

At the end of the day, it is the collective responsibility of the society to help those individuals among us who are a part of the suicide high risk groups. These individuals must be given a chance to believe that their lives are worth something after all.

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