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Indian Psychiatric Society Publication

SUICIDE

Indian Perspectives

Sujit Sarkhel
Vinay Kumar
Lakshmi Vijayakumar
Shubhangi R Parkar



Foreword
Danuta Wasserman

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CHAPTER

4

Sociocultural Aspects of Suicide

Koushik Sinha Deb, Anuranjan Vishwakarma, Rakesh K Chadda

ABSTRACT

The recently published suicide statistics of India [National Crime Records Bureau (NCRB), 2021] reported 12 suicidal deaths per 100,000 population for the year 2021. The "Global Burden of Diseases Study" and the "Million Death Study", often considered as landmark research on suicide in India, report even higher rates and greater demographic clustering. Wide variations in suicides (sometimes over 10 times) across geographic locations, gender, marital state, and occupation have also been reported. An in-depth exploration of the sociocultural and geopolitical determinants, which shape the lives of Indian people, becomes necessary to understand these suicide research findings.

This chapter begins by exploring the complex past civilizations, rituals, and religious connotations of suicide. Acceptance of suicide by the elderly and death by immolation in females are India-specific patterns, starkly in contrast with the West, and comprehensible only by understanding our past. The changing Indian family systems, urbanization of the villages, and the inescapable loss of pride in farming represent some of the economic and commercial determinants driving suicide rates. Migration, exploitation, discrimination, social disconnect, apathy, and anomie of the city life are consequences of a rapidly changing social landscape. The rapid expansion of technology, internet, and social media has further disrupted customs, morals, and values of individuals, families, and communities, contributing to newer stressors and traumas.

India and many similar developing countries are in state of unstable cultural flux due to rapid changes in all spheres of life. Developing an understanding of these agents of change is necessary, not only to comprehend the patterns of suicide, but also for devising appropriate strategies of prevention.

Keywords: Suicide; Social theories; Cultural theories.

INTRODUCTION

Suicide or the act of voluntarily and actively ending one's life is counter-biological, counter-evolutionary, and counter-adaptive.[1] Yet, suicide forms one of the most common causes of death in the young adults, second only to accidents. The World Health Organization, which has been monitoring and advocating against suicide since 1950, suggests that 78% of the suicides occur in the low- and middle-income countries.[2] India and China together account for more than half of the suicides across the world, and India records the highest suicide rates among all other South-East-Asian countries.[3] Despite India's overall rate being similar to many other nations, the female suicide rate of the country is one of the highest globally.[4] India's (possibly under-reported)[5] suicide statistics of 2022, published by the National Crime Records Bureau (NCRB), reported a national rate of 12 suicidal death per 100,000 population,

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the highest rate ever reported by the Bureau since its inception in 1967.[6] Almost 50% of all these deaths occurred in just five of India's 28 states and 8 union territories and 64.2% of the victims earned <1 lakh rupees per year.[7] The marked variability of the rates, in terms of gender, geography, and wage, suggests factors beyond the individual at play, the evaluation of which forms the focus for this chapter. The role of mental and substance use disorders as a precipitator of suicide cannot be underestimated and this write up, by no means, intends to underplay the pivotal role of mental morbidity in suicide.[2] The chapter instead intends to look beyond the obvious and aims to sensitize the reader about the sociocultural fabric that operates behind the proximate cause of depression and self-harm.

CIVILIZATION, CULTURE, RELIGION, AND SOCIETY

India is the land of ancient civilizations. The Indus valley (proto-Dravidian) civilization of the North and the Dravidian civilization of the South flourished around two to three millennia before the birth of Christ (2500 BCE) and envisioned philosophical doctrines on life, death, rebirth, and morality which were followed by its people.[8] Subsequent waves of conquests, expansions, and influences over the next two millennia have brought in ideas from the Persian, Greek, Arabic, Mughal, and British (Christian) culture into the region, which shaped the traditional Indian society. Postmodern influences of globalization and westernization of values, urban migration and emigration, and a gradual shift from collectivism to individualism have created an immensely complex, rich, multi-layered, intertwined, and amalgamated culture of the subcontinent. These traditional and modern pressures on individuals constitute the unseen threads that knit the tapestry of life stories of people, and understanding them is vital to understanding the conclusion.

The Vedic Hindu philosophy believed in the doctrine of reincarnation and rebirth, with "Moksha" or "Mukti' providing liberation from this eternal circle. Unlike the strict proscription on suicide in the Islamic and Christian religion, the stance of the Vedas on suicide has been nuanced, resulting often in theological and religious debates.[9] The four Vedas, forming the oldest of Hindu scriptures of "Shruti" (what is heard), do not directly expound on suicide. The Vedas value life, with "ahimsa" being a virtue and "hatya" being a sin. Death, according to Vedas, comes naturally after living a full and pious life.[9] The Upanishads (written expositions of the Vedas), denounce suicides, stating that "he who takes his self, reaches after death the sunless region covered by impenetrable darkness".[10] Similar proscriptions are also found in the social-rules texts of Hinduism ("Shastras"). For example, "Arthashastra", written by Kautilya (advisor to Emperor Chandragupta Maurya), condemned men and women who committed suicide in the throes of sinful passions, and instituted a procedure for determination of death by commissioners.[11]

Acceptance and allowance of suicides are first noted in the text of "Dharma-shastra", the Hindu text on ethics. Death by starvation while on pilgrimage to Kailash (the place of Lord Shiva) at the end of fulfilling ones life's responsibilities forms the tradition of "Maha-Prasthana". Death by drowning in the Ganges at Kashi (Varanasi), jumping from a cliff at Amarkantak, and drowning at or jumping from a sacred tree at Prayag (confluence of the three holy rivers of Ganga, Yamuna, and Saraswathi) was suggested as a form of attaining Moksha. In the great Hindu epic, Ramayana, after the departure of Sita,

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Lakshman, unable to bear the sorrow, kills himself by drowning in the river. Ram, Bharat, and Shatrughan follow suit by drowning in the Sarayu river, along with thousand inhabitants of their city Ajodhya.[11] The other religious epic of Mahabharata provides numerous examples of accepting death for the righteous reason and for the greater good (e.g., Dadhichi offering his life for creation of weapons from his bones) but denounces taking one's own life for shame or before time.[12]

Over time, the Vedic philosophies mutated into societal rules and the British India saw a large number of religious suicides to end personal suffering. Hunter, in 1872,[13] recorded religious suicides in Puri, Orissa at the "Ratha-Yatra" festival of Lord Jagannath, where devotees took their lives by throwing themselves under the wheel of the chariot which was pulled by thousands of devotees.[14,15] The custom of "Sati"[16] and "Jauhar"[14] fascinated the British rulers and numerous recorded descriptions of these events were documented.[17] Raja Rammohan Roy, between 1818 and 1829, wrote several articles detailing the various Hindu religious doctrines and their interpretations, successfully arguing against the custom of "sati". The established dogma of "sati" as ordained by the ruling pandits did not bear any Vedic validation, according to Roy.[18] A crusade that started in 1814 after observing the burning of his brother's widow ultimately succeeded after 15 years, when Governor-General of India, Lord William Bentinck, declared sati illegal and made it punishable as a criminal offence through Regulation XVII of December 4th, 1829.

Other Indian religions have a far uniform proscription against taking one's own life. Jainism, founded by Mahavira (600 BC), is characterized by extreme respect for life.[10] The tradition of "sallekhana" or fasting unto death in Jainism represents a religious ritual intended to end the cycle of death and rebirth, and has the connotation of enlightenment, rather than suicide from suffering.[20] Buddhism similarly believes in the eternal cycle of life and suicide, therefore, does not alter or shorten any suffering. Islam, practiced by around 15% of the population of India, has the strongest moral and religious opposition to suicide, as life needs to follow the principles of "Allah".[21]

Indian family systems arising out of such cultures are also, therefore, understandably complex. The traditional Indian family would be classified as collectivistic, with group interests taking priority over individual aspirations.[22] The patrilineal and patriarchal structure of the traditional family provides security and safety of all, and shields members in times of hardships. Conversely, the subservient role of women in such families and the demands of the family on young adults to adhere to role

BOX 1: Excerpt of Roy's experience of "Satidahan".

"When Rammohan's brother—Jagmohan Roy—died, his wife Alakamanjari had to observe 'Sahagamana'. All arrangements were made for cremation. All the relatives gathered. Alakmanjari put on a laced-sari and there was 'Kumkum' on her forehead. Her hair was disheveled. Fear was written upon her face. The corpse was brought to the cremation ground. Rammohan begged his sister-in-law not to observe 'suttee'. Relatives objected to Rammohan's words. They bound her to the corpse and place her on the funeral pyre with the corpse. The pyre was set on fire.

Alakamanjari screamed and cried in fear, but she was not set free. Poor woman! She was burnt to ashes along with her husband. All the relatives praised her shouting 'Maha sati! Maha sati!' (a great wife) and went back."

Source: Adapted from Biography of Raja Rammohan Roy.[19]

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obligations form an environment of conflict and oppression, making such collectivism far from the ideal harmonious social unit.[11,23] The society of India, imbued in its tradition, has undergone rapid changes postindependence, due to forces of urbanization and economics. Work, opportunity, and education have taken families to far away cities, with alien language, food, culture, moral, and social values, making everyday life a struggle for adaptation. Modern nuclear families of the city face newer conflicts, as members differentially imbibe diverse aspects of the urban culture. Intergenerational gaps in moral and ethical values increase exponentially, creating culture clash and further fragmentation of the family.[24]

URBAN AND RURAL DIVIDE

Urbanization has been cited as a major driver of social change and disruptor of stability, and has long been the focus of sociological studies of suicide. The most influential work comes from the French sociologist Émile Durkheim, whose 1897 book Suicide: A Study in Sociology (French: Le Suicide: Étude de sociologie) formed the basis of our understanding of suicide over the next decades.[25] Durkheim posited that the society exerts coercive influence on individuals through its rules and obligations which he labeled as "social facts". These social facts are not merely in the mind of the individual but external and real, similar to the natural facts of the world we live in. Integration of the individual into the society follows a continuum, with too little integration causing "egoism" or the feeling of being untethered to the society one stays in, and too complete integration resulting in "altruism", where the self is completely subservient to the society. The rigidity of societal control creates the second continuum, at one end of which lies complete social abandon resulting in "anomie", while the other end being absolute control resulting in "fatalism". Sudden changes and upheavals in the social structure results in the social facts become skewed toward any extreme ends of these continuums, affecting the person living in the society. Durkheim rejected the psychological causation of suicide, and considered mental morbidity to be a result of the same societal forces, rather than in independent causative agent. Durkheim believed that social facts alone can predict the pattern of suicide and provided case studies and examples of the same **(Table 1)**.[26]

India with its 1.4 billion peoples ranks as the second most populous country in the world. Postindependence, India has seen a rapid growth in urbanization, with currently 35% of its population living in the cities.[28] Such accelerated urbanization exerts enormous pressure on city infrastructure, sanitation, transport, and public amenities, resulting in overcrowding and unsafe living. The migration to cities for better living standards transmutes into homelessness and slum dwelling. Indeed, 17.4% of Indians (one in every five family) currently live in slums, with the major metropolises of Mumbai (41.3%), Kolkata (29.6%), and Chennai (28.5%) far outpacing the national average.[29] The problems of urban India are further complicated by pressing public health issues. Urban India is home to 35 of the 50 most polluted cities of the world, with the national capital Delhi and the British capital Kolkata ranking as the top two most polluted cities world over. Delhi empties more than 3,500 million liters of municipal sewage in the Yamuna river, resulting in a 3,000-fold rise of fecal bacterial count and often covering the main water source of the city with toxic foam. Tuberculosis, pneumonia, and diarrheal diseases, as well as noncommunicable

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TABLE 1: Émile Durkheim's types of suicides.[27]

Type	*Durkheim's example*	*Indian example*
Egoistic suicide: Lasting feeling of not being integrated into the community with excessive individualization	Individuals not sufficiently bound to social groups, example unmarried man	Urban youths, students living away from family for studies or work
Altruistic suicide: Suicide occurs when the individual is too integrated into society	Individuals' belief for good of their society—suicide bombers, soldiers	Self-immolation as a form of protest against reservation. Freedom fighters and the custom of Jouhar
Anomic suicide: Occurs when the regulation of the society is disrupted	In contrast to egoistic suicides, where the individual feels untethered, here the society is untethered, and fails to provide guidance	Urbanization and globalization resulting in ambiguous ethical and moral rules of the metropolis
Fatalistic suicide: Occurs due to overly regulated regime, where the individuals choose suicide over the oppressive control of the society	Suicide upon enslavement or suicide in prison inmates. Durkheim considered them to be of theoretical value with very few real-world example	Suicide of women in abusive authoritarian families. Farmers suicide, when in debt trap and no means of support and recovery

disorders such as heart diseases, cancer, and chronic lung disease have been consistently shown to be two to three times more common in the cities as compared to the villages.[30] In addition to the sociological factors, industrialization has significantly increased the friction of city life, by increasing health demands, which the existing infrastructure is often woefully inadequate in coping with.

Search adversities of the city life have prompted many theoreticians, including Durkheim, and postulate the link between urbanization and suicide. Loss of traditional support mechanisms resulting in anomic and egoistic suicide has been demonstrated in the urban France by both Durkheim and others.[31] Indeed, early studies conducted in postindependent India reflects a similar trend, with significantly higher number of suicides reported in cities as compared to the rural areas. Studies by Banerjee and Nandi et al. in West Bengal,[32] Venkoba Rao in Madurai,[33] and Phal et al. in Panaji (Goa)[34] found urban suicide rates to be as much as 10 times than the national average. Studies from the northern states of India by Verma et al. (1972)[35] and Mishra et al.[36] show a similar trend, although the rates of suicides are overall lesser than the south. A change in pattern emerged around the late 1990s, when authors started reporting increasing rates of rural suicides, and in contradiction to existing sociological theories.[37] High rates and high lethality suicides by poisoning were reported by Gautami et al. in 2001 from the Telangana region of Andhra Pradesh.[38] Indeed, analysis of Indian literature by Mayer et al. in 2016 suggested a paradoxical increase in rural suicides in Indian states with higher urbanization and human development.[39] Suicide in the villages surpassed city rates in the urban states of the South and West India, while the agrarian North continued to report comparatively low rural suicide

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rates.[40] Similar shift in trends in suicide rates over time, from urban to semiurban and rural areas, has also been reported by the European countries of Sweden, Greece, UK, and Scotland and studies from the US show higher suicide rates in the more sparsely populated areas.[41] Chinese data show suicide rates to be not only higher in rural areas but also to be more in females than in males.[42] The rates are perhaps most disparate in Japan, where suicide rates in the elderly are reported to be as high as 240/10,000 in rural areas compared to 40/100,000 in the cities.[43]

Scholars have argued that the flux of change to be the primary driver of anomie than modernization per se. Urban cities in the early days of their formation are expected to have higher suicide rates, but with time and with stabilization, the city culture will see a decrease in the rates. As urban societies develop newer means of support and integration for their dwellers, through clubs, associations, and societies, the pressures of anomie and egoism will abate. Urbanization, in contrast, might exert a disrupting influence in the way of life in its surrounding villages. These villages then experience the disruption of their traditional ethical, societal, and economic values, resulting in strife and struggle. The dissonance between the traditional and the modern ways of living results in the same societal forces affecting life, which the cities of the old once faced.[34]

GENDER AND FAMILY

Globally and in India, the rates of completed suicide have always been higher in males as compared to females.[44] Despite most cultures around the world being patriarchal, increased suicide in males has been such a consistent finding that Durkheim considered suicides "to be an essentially male phenomena".[27] The traditional male role of being the breadwinner for the family exposes them to more societal demands and conflicts. Females, on the other hand, remain better integrated with family and society, decreasing anomic and egoistic forces. Even though suicide rates of countries have fluctuated over time, the proportion rated for each gender has remained remarkably stable. Only China, in recent times, has reported a higher suicide rate in rural females.[42] There have been some speculations on the possibility of increased suicide rates in females, with change in the traditional role and with the entry of women into the workforce. Modernization and gender equality may paradoxically increase the vulnerability of women to societal conflicts. However, globally this trend has not been observed, even in developed countries, where workforce parity has been achieved.[45]

Indian national data do suggest completed suicide rates to be higher in males. However, researchers have questioned on the veracity of the suicide data, as most attempted suicides are never reported, suicide being a criminal offence in the penal code.[46] Individual studies have reported that as many as 50% of "accidental" burn injuries in females may represent unreported self-harm attempt.[47] An analysis of the published data suggests female suicide rates in India to be significantly higher compared to global average even after correcting for national variances, making suicide rates almost equal between sexes. The Global Burden of Diseases study (GBD) of 2016 reported a male-to-female ratio of suicides at 1.34 in India, compared to the rates of 4.0 in Europe and 3.6 in the US.[48] A 2022 review by Ramesh et al.[46] suggests that the suicide rates in Indian females significantly outpace almost every other country in the world. India hosts 17.8% of the global population, yet accounts for 36.6% of the global suicide

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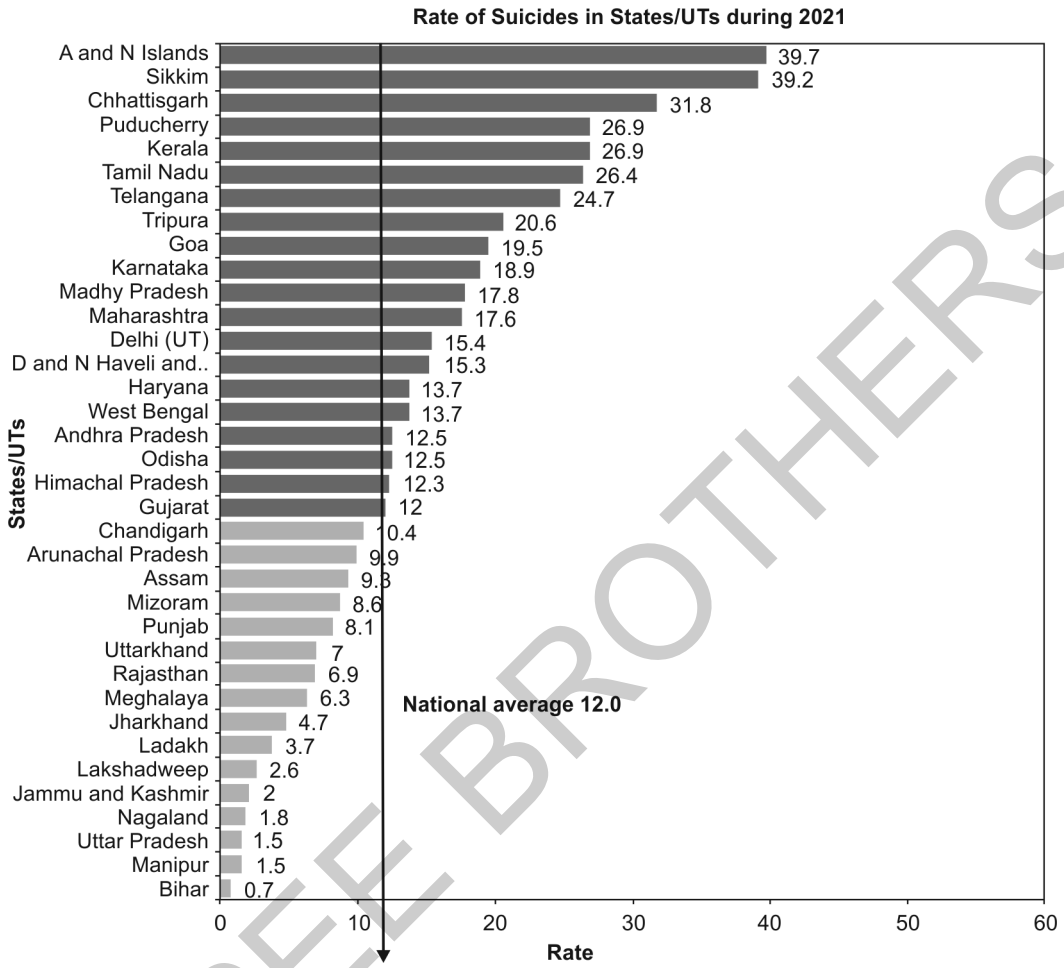

Fig. 1: Suicide rates across states of India. (UTs: union territories)

Courtesy: Data from National Crime Records Bureau, Ministry of Home Affairs. (2021). Accidental Deaths and Suicides in India-2021. [online] Available from: https://ncrb.gov.in/en/ADSI-2021. [Last accessed January, 2023]

deaths in women compared to 24.3% among men. Hanging remains the most common method of suicide in Indian females, in contrast to the global pattern of poisoning being the most common method in women. The western data and assumption, that men generally resort to more violent means of suicide, do not also apply to India, as hanging (followed by poisoning) remains the most common means used to end one's life. This change in pattern is partly explained by the stricter gun control laws in India and to the wider availability of pesticides for agriculture. Indeed, in the agricultural regions of India, pesticide consumption outpaces hanging as the method of suicide. Another distinctive pattern of Indian suicides in females involves the use of self-immolation as a means of suicide, a method that is rarely used by women in the west, due to possible concerns of disfigurement in death. Cultural memories of sati, Jauhar, and purification by fire of Sita

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have been proposed as possible reasons of acceptance of the method in India.[49]

Suicides in India are higher in married individuals (both male and female), in contrast to the western pattern of higher death rates in "loners" or individuals without families.[50] The Indian pattern contradicts sociological theories of connectedness as a protective factor against suicide, as married individuals are expected to be more integrated into the society and family. Indeed, according to the NCRB data, "family problems" remain the most cited cause of the attempt and account for as much as 32.4% of all deaths by suicide.[6] In Indian women, suicide rates are higher in housewives (compared to students or working women), suggesting family to be the primary source of stress. Domestic violence, dowry and demands by the husband's family, and substance use by husband, coupled with lack of economic independence and subservient family role, exert tremendous stress on women, resulting in increased suicide rates in the first 5 years of marriage. The most common government-reported cause "family problem" subsumes, oversimplifies, and dehumanizes a very complex and layered social inducer of death, unique to the Indian culture.[51]

SUICIDE ACROSS LIFESPAN

The effect of age, on the suicide rates of the population, is intricate, and is reflective of the role of an individual in the society at various life stages. Globally, suicide rates rise with increasing age and this pattern is observed

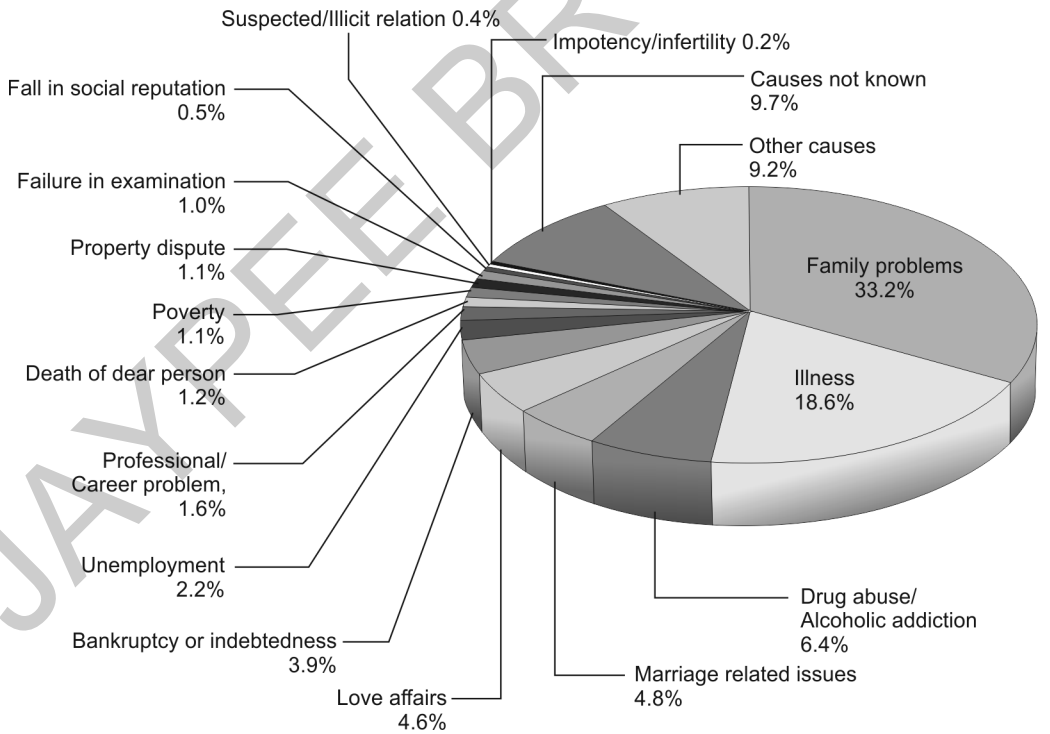

Fig. 2: Causes of suicide in India.

Courtesy: Data from National Crime Records Bureau, Ministry of Home Affairs. (2021). Accidental Deaths and Suicides in India-2021. [online] Available from: https://ncrb.gov.in/en/ADSI-2021. [Last accessed January, 2023]

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more clearly in the male suicides. Suicide rates in females show additional peaks in early adulthood, between the ages of 15 and 25 years and again in the later life after 60 years. To explain the variability in rates with age, Lester, back in 1982, proposed that for females, suicide age distribution was tied to the level of the economic development of the country.[52] For low-income nations, young adult women were at the greatest risk of suicide whereas in the wealthiest nations, female suicide rates peaked after the middle ages. Girard, in 1993, similarly suggested upward or downward sloping patterns of suicide (in both sexes), dependent on the human development state of the country.[53] In underdeveloped countries, where family and societal ties dictate the way of life, most suicides are expected to occur in the young adulthood, the phase of maximum struggle. Whereas in industrialized nations, an upward sloping pattern is observed, as most suicides shift to middle or old age. In addition, Girard postulated a bimodal pattern of suicides in nations going through the intermediate stages of industrialization, reflecting a transition from traditional to modern stresses of living. Other researches have also highlighted the vulnerability of young Indian for suicide in the current sociocultural milieu. Women below the age of 30 face the intense expectation of forming successful marriages, integrating with in-laws and bearing a male child. Despite modernization and rise in education, women still have a subservient role in India's patriarchal culture. The sense of powerlessness in young females, "trapped between the conservative past and the promise of a liberated future", acts as a significant precipitator for suicide in this age group.

State-wise gender-based suicide data have been published by the National Crime Records Bureau (NCRB) since 2001. Analysis of the last two decades of data indeed reflects an early peak in suicide rates in the economically weak states of Bihar and Uttar Pradesh, while in the economically prosperous Maharashtra Gujarat, as well as in Kerala with its high development index suicides in both male and females peak at a later age. Globally and in India, the rise of suicide in young adults has become a cause of concern. By proportion, young adults (15–29 years) account for 34.5% of all suicides in India. In the states of Kerala, West Bengal,

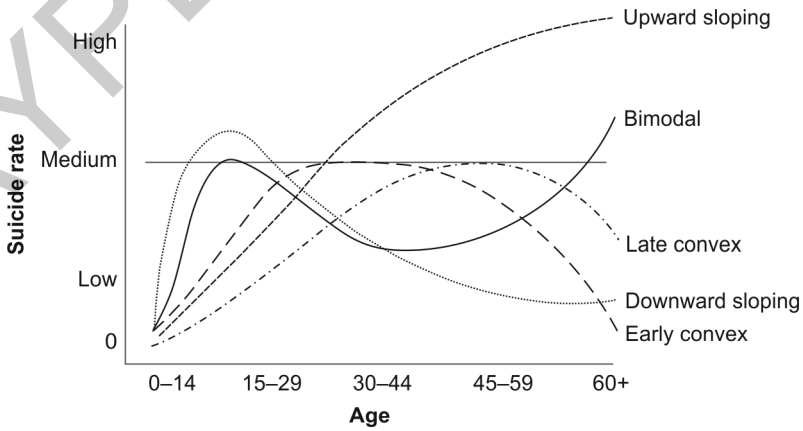

Fig. 3: Suicide patterns across age groups in various types of societies.

Source: Adapted from Mayer P.[34]

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SUICIDE
Indian Perspectives

The current book is a unique source of all aspects of suicide which are necessary for a complete understanding of this complex phenomenon. Each and every chapter has been carefully written mostly by experts working in the particular area. The language has been kept simple and information has been kept updated and authentic as far as possible. Although every chapter takes a general global viewpoint, Indian viewpoint, data and perspectives, wherever available and applicable, has been highlighted. Overall, this is meant to be an invaluable resource for any and everybody working or studying in the field of suicidology.



Sujit Sarkhel MD DPM works as a Professor of Psychiatry at the Institute of Psychiatry, Kolkata, West Bengal, India. Suicide Prevention is one of his prime areas of interest. He is working with the Suicide Prevention Specialty Section of the Indian Psychiatric Society (IPS) in various capacities for almost 10 years now. He has co-authored the IPS Clinical Practice Guidelines on the management of suicidal behavior. He is the Honorary Editor of Bengal Journal of Psychiatry, Associate Editor of Indian Journal of Psychiatry, Assistant Editor of Indian Journal of Psychological Medicine, and a member of the editorial board of several reputed journals. He has more than 60 publications in peer-reviewed journals and has won several awards for his research.



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