



## Review Article

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## Current trend of suicide in Sikkim

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### Abstract

The State of Sikkim has been witnessing increasing trend in suicide rate in last decade. Studies examining an extent, pattern and causes of suicide in Sikkim are limited and prevalent notion regarding causes of suicide are mostly based on descriptive narration of an individual suicide cases that usually promotes socio-economic factors and drug use disorders. An attempt has been made in this article to examine current trend of suicide in Sikkim, assessed risk factors by analysing published and unpublished available research studies, and highlight suicide prevention responses by East Sikkim.

**Keywords:** Suicide, Behaviour, Theory, Causes.

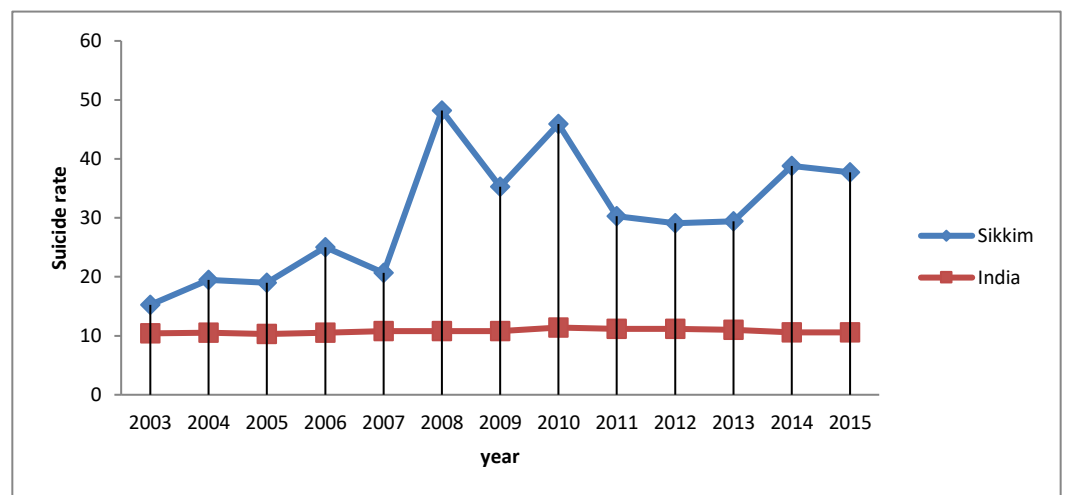
### INTRODUCTION

**Definition:** Suicide denotes “self-murder” that represents the person’s wished to die. [1] Suicide is an attempt to cope with an intense emotional pain. Suicide is viewed as a symptom of underlying disease or psychosocial problems rather than a disease per se which is effectively treatable by both pharmacological and psychological means.

### Prevalence:

Suicide is observed in all races, creeds, incomes, and educational levels. According to WHO report, approximately 8, 00,000 people die by suicide every year, roughly corresponding to one person every 40 seconds. Suicide accounted for 1.4 per cent of all deaths and second leading cause of death among 15-29-year age group globally. Suicide was the 18th leading cause of death in 2016; these figures do not include suicide attempts which can be 10-20 more frequent than completed suicide. [2] India recorded an increase of 17.3% in number of completed suicide (1, 33,623 in 2015 from 1, 13,914 in 2005). [3] There is also a growing concern regarding rising trend in suicide rate in Sikkim among Indian States. [4]

Fig 1: Trends in Suicide Rate (2003-15): Comparison between Sikkim & India (NCRB report). [5]



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Fig 1 clearly shows that the suicide rate in Sikkim is much higher than the national average of 10 per 1 lacs population. It is also evident that there is an increase in suicidal trends since 2004 in the state; however, the State could not develop any practical suicide prevention plan in the last decade. There has been a lot of debate on the top contributing factors for suicide ideation/attempted suicides in Sikkim.

**Theories of Suicide:** Suicide is a complex subject characterised by an intention to harm/kill oneself caused by multiple factors ranging from biological to socio-environmental determinants. There are 3 different theories or models developed by different specialists to understand occurrence of suicide in an individual and population viz sociological model, psychological and biological model.

(I). **Social Theory:** Emil Durkheim in his 1897 book *Le suicide* wrote, suicide may result from various events in life suggesting the inability to pin down the social causality of suicide. For one instance, "One man kills himself in the midst of affluence, another in the lap of poverty; one was unhappy in home, and another had just ended by divorce a marriage which was making him unhappy. In one case a soldier ends his life after having been punished for an offence he did not commit; in another, a criminal whose crime has remained kills himself". However, from the studies of more than 26000 suicide cases in Europe, he theorised the causal factor of suicide to be social in its nature. Sociological perspectives of suicide, particularly following Durkheimian approach, looks at the patterns of integration of individual with groups in society and structural constraints and regulatory mechanism the influence the suicide rate. According to Durkheim, suicide is caused by some power which is over and above the individual but neither an individual act nor a personal action. Many doctors and psychologists viewed majority of people who take their own life are in a pathological state and suffering from mental disorders, but Durkheim emphasises that social force plays instrumental role in causation of suicide, rather than psychological factors. He concludes that suicide is the result of social disorganisation or lack of social integration or social solidarity. [6]

**Critical evaluation of Durkheim's theory:** Despite the fact that Durkheim's hypothesis of suicide has contributed much about the comprehension of the phenomenon as a result of his weight on social instead of on organic or individual factors, the primary downside of the hypothesis is that he has laid an excess of stress just on one factor, in particular social factor undermining different variables.

(II). **Psychological Theory of Suicide:** Many psychodynamic theorists believe that suicide is caused by depression and unexpressed anger at others turns inwards towards oneself. Freud (1920) identified instinct, as drives that which are innate, universal and constantly felt and these instincts are two types; life instinct (eros) and death instinct (Thanatos). In the extreme emotional distress, the death instinct dominates and become powerful over life instinct and these extreme emotional distresses are known as depression. [7] Researchers have found close ties between childhood experiences and later suicidal behaviour. Boukoms and strainer studies of 200 family histories found that suicide attempters were more likely to occur to those individuals who have lost a parent during their childhood than the non-suicidal control subjects.[8] Schneidham proposes that the way to suicide is "Psy-ache"- a sentiment of mental torment, pressure, and enduring that makes life horrendous. Suicide endeavours may likewise be gone before by movements in examples of reasoning portrayed by distraction with issues, misfortune point of view, and suicide as the main answer for their adapt to difficulties.[9] They build up a critical conviction that their current conditions, issues or state of mind won't change. As indicated by hopelessness hypothesis (Abramson 1989) "a sort of misery gloom sets in when it is by all accounts no prospect to get either what one truly needs or to stay away from one truly doesn't need. As a component of this hypothesis, negative occasions can fill in as "event setters". What's more, mental model underscores more on

identity attributes and relational factors and built up a few treatment model or individual treatments to support a suicidal individual. [10]

(III). **Medical Model of Suicide** has been promoted by medical doctors and psychiatrists who viewed suicide as a symptom of another disease and disorders rather than personal weaknesses. Suicidal behaviour is characterised by suicidal ideation, urges, thoughts, plans and attempts that are caused by mental disorders, chronic medical diseases and substance disorders. As per WHO report, mental disorders attributes to more than 70-90% of completed suicide. Depression, bipolar disorder, psychosis, acute stress related disorders, somatoform disorders, chronic pain syndrome, anxiety disorders, dissociative disorders, chronic medical diseases such as cancer, tuberculosis, chronic pain, and other life threatening diseases, and substance use disorders are common diagnosis recorded in patients complaining of suicidal behaviour at psychiatry clinic. Individuals who attempt to end their own life are regularly endeavouring to make tracks in an opposite direction from a real existence circumstance that appears to be difficult to manage. Numerous who make a suicide endeavour are looking for help from: feeling embarrassed, liable, or like a weight to other people, Feeling like an injured individual, sentiments of dismissal, misfortune, or depression. One of every four families is probably going to have a family member with a conduct or mental disorder.[2] These families give physical and enthusiastic help, yet additionally bear the negative effect of shame and segregation. The majority of them (>90%) remain un-treated. Poor mindfulness about indications of psychological instability and absence of learning on the treatment accessibility are significant reasons for the high treatment gap. In this manner, connecting with somebody who is battling can make a difference. [11]

According to NCRB (National Crime Report Bureau), commonest causes of suicide in India is "Other Family problems .[5]

#### **Studies of Suicide in Sikkim:**

(A): Dr CL Pradhan conducted a psychological autopsy of 231 suicide cases in Sikkim between Mar 2014- Mar 2015 to study socioeconomic characteristics, psychosocial factors, psychiatric and physical co-morbidity associated with completed suicide, evaluate methods used in suicide completers and examine details of treatment sought prior to suicide. It was observed completed suicide was common amongst married Hindu male from rural background belonging to middle and lower socioeconomic status. Psychiatric disorders were noticeable in 68.35% of male and 71.23% females, the most prevalent psychiatric disorder being depression followed by schizophrenia. The present study negate popular held beliefs surrounding suicide in the context of Sikkim that promotes substance ( drug) abuse as primary cause of suicide as reported in news media/ newspapers regularly as study revealed drug addiction contributes to less than 5 cases out of 231 study sample . Further, diagnoses of the suicide victims were not known in 31.64% of male and 28.70% of female. [12]

(B): A 10-year retrospective study of suicide in Sikkim, India: Sociodemographic profile and risk assessment by Reshma Chettri, Jiwan Gurung & Bisu Singh (Published in Indian Journal of Psychiatry, Oct 2016). [13]

#### **Some salient findings of the study are as follows:**

1. A total number of 1604 suicidal cases were reported, of which 1051 (65.5%) were males and 553 (34.5%) were females.
2. Overall, there was an increase in suicidal incidence from 2006 to 2015.
3. Incidence of suicide was high among individuals in the age group of 21–30 years (24.4%)

4. Among all the ethnic communities who exhibited suicide, Rai (15.8%) was found to be the dominant community followed by Chettri (12.4%) and Subba (9.4%). The least number of suicides was observed among Jogi, Sarki, and Harijan (0.1%).
5. Hanging (94.8%) was found to be the significantly common method adopted for suicide by both males and females followed by jumping (2.1%), poisoning (1.4%), self-immolation (0.7%), drowning (0.3%), and overconsumption of alcohol (0.3%), stabbing (0.3%), and consumption of kerosene oil (0.1%)
6. The district-wise suicidal incidence shows the occurrence of most of the suicides in eastern districts (50.6%) followed by western (25.3%), southern (21.9%), and northern (2.2%)
7. In comparison, suicide was found to be fairly high among the rural people (82.6%) than the urban people (17.4%).

(C). In a study conducted by Dr Sachdeva & Thapa ( 2017) on “ Suicide in Sikkim: A socio-psycho assessment” in a sample of 242 suicide data shared by DESME & E, it was observed that suicide was high among sikkimese (65.56%) than non-sikkimese ( 34.44%), and among urban ( 79.32%) than rural population ( 20.68%) in the age group of 16-45 years ( 74.28%). It was also found that the incidence of suicide is highest among the lower income group (Less than Rs7500 (48.35%) followed by (15000-25000) income range. Married individuals constitute 58.51% with equal gender representation. Most of the suicide cases occurred among those who are illiterate, primary to higher secondary educated. The study has supported the hypothesis of positive relationship between rapid transformation from self sufficient rural economy to the dependent economy to urban centre with breakdown in family composition from joint to nuclear family system giving birth to individualism rather than collectivism & suicide in the rural areas of Sikkim. The investigators have concluded that most of the causative factors of suicide are rooted largely on social structure. [14]

Most of the studies of suicide in Sikkim are cross-sectional, retrospective in nature or hospital based that have primarily assessed socio-demographic variables without examining control population for comparison between high-risk and other groups. Retrospective studies can only give an idea regarding risk factors of suicide pertaining to sociodemographic factors for targeting vulnerable groups and population. However, such studies cannot establish the cause-effect relationships and therefore results cannot be generalised to the population. Valid conclusions from such studies cannot be drawn. Also, the relative risk and attributable risk percentage could not be calculated. To establish cause-effect relationship, a longitudinal or prospective study need to be designed, wherein a cohort of high-risk individuals are followed up for a period of several years.

Responses by Singtam District Hospital. Almost 1370 mental health programs has been conducted between Apr 2014 to Mar 2019 targeting schools, colleges, ICDS centres, PHSC, PHC, rehab centres & community. Several campaigns such as winning ways 2 wellbeing, college mental health, women's mental health, community mental health, outreach camps, East District suicide prevention awareness month, East District mental health awareness month, mobile mental health, psychological support to rehab centres, stress management campaign at winter coaching camps, observation of days, peer educators program at Singtam & Sirwani school, adolescent health, gatekeeper sensitization for suicide prevention, Sikkim pledge campaign, Solo bike ride for suicide prevention awareness in East Sikkim etc was launched under the banner of " Grameen Manasik Swastha Abhiyan. The Dept of Addiction Psychiatry, Singtam District Hospital, East Sikkim has been successful in developing linkages with stakeholders ( SIRD, RDD, Panchayati Raj Institution, GPU, legal cells,

police training centres, DIET, SCERT, Schools, colleges, Social welfare, Anganwadi workers, National Programs such as RNTCP, NHM, RKSK, NTCP, OST, SACS, School health), & SATTHI in capacity building training programs of respective stakeholders by providing experts/ resource persons in their training curriculum. Special emphasis has been laid on capacity/ skill development of Primary health care providers including ASHA & Anganwadi workers by regularly conducting training programs, and destigmatization of mental illness & drug addiction in community to enable individuals, family members & significant others to reach out for help without fear of stigma, and discrimination with an objective to take mental health & suicide prevention services to the doorsteps of rural population and every stakeholders. [15-18]

#### **Suggested strategies for suicide prevention:**

1. Formulation of State suicide prevention policy to formulate long term action plan to prevent and control suicide in the state of Sikkim.
2. Constitution of research and evaluation team to monitor trends in suicide rate, and conduct long term prospective research.
3. Investments in capacity building training of different stakeholders in prevention of suicide in their respective departments and institutions.
4. Inclusion of life-skills education program to develop adaptive skills in school & college curriculum and workplaces ( govt & private)
5. Appointment of Clinical Psychologists (MPhil) in senior secondary schools and colleges to provide counselling service at times of emotional crisis and other interpersonal issues.
6. Linkages with District Institute of Educational Training (DIET) to empower preservice teachers with information, materials and knowledge regarding emotional and behavioural problems to enable them to identify early threatening signs of suicide.
7. Prevention and control of child abuse, bullying in school and domestic violence.
8. Proactive involvement of panchayati raj institution in destigmatization of mental disorders and other causes of suicide. Further, PRI need to take ownership in preventive activities.
9. Linkages with Labour Department for prevention of workplace violence, stress and suicide at private company and factory.
10. Strengthening of substance abuse awareness programs.
11. Promotion of parental counselling program for building resiliency of a child to withstand minor setbacks and failures in life.
12. Provision of special care and support to geriatric population.
13. Establishment of 24X7 Helpline service in the entire 4 District for provision of emergency counselling service to suicidal clients.
14. Capacity and skill development of the existing human resources is required to fill in the gap in service delivery in mental health.

15. Stigma towards mental illness is still the biggest challenge to mental health service development. Stigma prevents people from accessing timely help at hospitals and other private set-up for the treatment of mental illness. The best methods to prevent suicide are early identification of suicidal patients, referral and treatment of diseases that leads to suicide.
16. Development of mental health infrastructure by establishing mental health facility.

## CONCLUSION

Suicide is a major preventable cause of premature death influenced by multiple factors ranging from psychosocial, cultural; to environmental risk factors that demands multipronged approach by policymakers and community stakeholders for encouraging public awareness and educational campaign to unite in commitment and action to promote understanding about suicide and removal of stigmatization.

## REFERENCES

1. Suicide. Available from URL: <https://www.thesaurus.com/browse/suicide> on 12 Apr 2019.
2. 8 lakh suicides every year: Suicide rates in various countries, reasons and preventive measures. Available from URL: <https://www.indiatoday.in/education-today/gk-current-affairs/story/suicide-rate-per-year-countries-who-1337780-2018-09-11>
3. Statistics of Suicide in India. Available from URL: [https://www.medindia.net/health\\_statistics/general/suicide-in-india-statistics.asp](https://www.medindia.net/health_statistics/general/suicide-in-india-statistics.asp).
4. Rasaily S. Integrating mental health services in primary health care system in Sikkim. *JMR* 2015; 1(5): 132-133.
5. Accidental deaths & suicides in India 2003-2015. Available from URL: <http://ncrb.gov.in/>
6. Durkheim E. Suicide: Available from URL: <http://durkheim.uchicago.edu/Summaries/suicide.html>.
7. The Psychodynamics of Suicide. Available from <https://www.counselling-directory.org.uk/counsellor-articles/the-psychodynamics-of-suicide>
8. Bouckoms A, Streiner D. Parental loss & Family Stability in Attempted Suicide. *Arch Gen Psychiatry*;39(9):1081-89.
9. Shneidman E. Suicide as Psychache: A clinical Approach to Self Destructive Behaviour. London. Jason Aranson Inc.
10. Abramson LY, Metalsky GJ, Alloy LB. Hopelessness Depression: A Theory Based Subtype of Depression. *Psychological Review*; 96(2): 358-72.
11. Rasaily S, Laden T, Pradhan M. Mental Health & Suicide Prevention Initiative (Reaching Out, Saving Lives), Singtam District Hospital, East Sikkim. *JMSCR* 2017 Dec; 05 (12): 32155-58.
12. Pradhan CL. Psychological Autopsy of 231 Suicide Cases in Sikkim 2015 (unpublished).
13. Chettri R, Gurung J, Singh B. A 10-year retrospective study of suicide in Sikkim, India: Sociodemographic profile and risk assessment. *Indian J Psychiatry*. 2016 Oct-Dec; 58(4): 448–453.
14. Sachdeva SA, Thapa S. Suicide in Sikkim: A psychosocial Assessment. Department of Sociology School of Social Sciences (SU); 2017.
15. Rasaily S, Sharma IL, Ongmoo K. Capacity building and community process in DMHP implementation in Gyalshing District, Sikkim: Two year report (13-14). *JMR* 2017; 3(3): 169-171.
16. Rasaily S. Initiative of Sikkim District Mental Health Program. *Eastern Journal of Psychiatry* 2015 Jul-Dec; 18(2): 41-42.
17. Rasaily S. Women's mental health campaign in East Sikkim. *JMR* 2015; 2(3): 53-54.
18. Rasaily S, Singh OP. Symposium on Integrating Mental Health Service in Primary Health Care System. 10th SAARC International Conferences Souvenir 2017.