

2.1. REVIEW OF LITERATURE

Suicide has stolen lives around the globe and across the times. It is a behaviour that is very complex. Meanings ascribed to suicide and ideas of what to do about it have varied with time and space. It has been variously treated as an abomination, a sin, a crime, an act of supreme sacrifice, or a cultural requirement, but suicide continues to gather a persistent toll. Today suicide ranks among the top ten causes of death in the western society. According to World Health Organization (1992), at least 160000 people die by suicide each year.\(^1\)

The frequency of suicide brings up the question, again and again, of what causes it. The factors that force on an individual that lead to choosing suicide as an alternative are multi-dimensional. Sociologists contend the strong influence of social factors and relationships, as well as a complex, impersonal society, leads to self-destruction. Most psychologists, on the other hand, believe suicide results from internalized aggression and hopelessness. Many of these psychologists also have psychodynamic view, which rely greatly on the Freudian school of psychology. A more contemporary scientific area, biochemistry, places much importance on genetics, hormones, and especially amino acids and neurotransmitters.

Whatever the case may be, the increase in the number of suicide rates directly reflects the anomic condition of the societies. Prior to taking up the analysis of the available data pertaining to the main premise of this work, it is essential to scan the conceptual and theoretical structure as also to review the historical perspective briefly so that the background of the pandemic will be more clear. As such this chapter will make a modest attempt to review few of such efforts taken from time to time by various subject experts to make the problem more simplified and relate such ideas with the present study.

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Halbwachs\(^2\) (1930) regarded suicides ‘as a sort of thermo metrical index which informs us about the moral condition, the moral temperature of a group’. Halbwachs proposed that patterns of suicide distribution could be more simply explained by levels of urbanization. His analysis showed that suicide rates were lower in communities situated farther away from densely populated cities. He suggested that a lack of social integration in cities explained this phenomenon. He saw urban life as relatively transitory and impersonal, leading to a greater proportion of people becoming socially isolated and vulnerable to suicide.

He further added that if the individual becomes discouraged and neglects himself or if he becomes desperate and turns his anger against himself, it is because he has not wife and children to whom the double bond of affection and duty unite him; it is because he finds neither support nor guidance from the group of men who accept the same dogma and practice the same religion; or, finally, it is because he is not taken out of his selfish preoccupations and raised above himself by great political and national interests.

Sainsbury\(^3\) (1955) found that suicide rates varied according to the social character of a district. In particular, he found high rates of suicide in boroughs with high levels of social disorganization, isolation and mobility. The study revealed that ‘the nature of community life, its cohesion and stability, and the opportunities it provides for satisfactory relationships, alone afford a comprehensive explanation of the variations in suicide rate of communities and other social groups’.

The study further revealed that the impassive indifference of the metropolis and its capacity to engender feelings of insignificance and

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loneliness among its residents is a product of two major social processes: first, the differentiation of districts given over exclusively to lodging-houses, hotels and flatlets; and secondly, the isolation produced by a high mobility which debases human relationships to a formal level and compromises all values by offering so many alternatives.

The study also revealed that social isolation is a wider concept than living alone. It includes: the social and cultural isolation of the immigrant; the solitude of old age arising from lack of contemporaries to share values and outlook; the unemployed’s sense of social rejection; the ostracism resulting from infringement of a social taboo by divorce or a criminal act, or any similar activity that might diminish relatedness to the community. A high suicide rate is found in all these categories: only the concept of social isolation embraces and accounts for such a diversity of phenomena.

Powell4 (1958) opined that the risk of anomic suicide is directly related to the degree to which people achieve their social status aspirations or ideals. If these aspirations are frustrated, then a state of anomie arises. Powell described anomie as a ‘general loss of orientation accompanied by feelings of emptiness, apathy and meaninglessness’. Powell further distinguished two types of anomie: ‘anomie of dissociation’ and ‘anomie of envelopment’. Anomie of dissociation is characterized by a dissociation of self from the ‘conceptual system of the culture’, resulting in a reaction of flight and aggression in response to the fear of chaos. Powell considered this type of anomie to be mainly found among people in lower socio-economic groups. Anomie of envelopment is characterised by the envelopment of self by the culture, leading to a repressive lack of spontaneity through excessive commitment to the ‘prevailing conceptual framework’. Powell considered this

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(Cited by Lester 1989b)
type of anomie to be mainly found among people in the higher socio-economic groups.

_Stengel and Cook⁵_ (1958) examined the act of suicide as a social process. They contended that the suicidal person usually wishes to live and to die. Often suicidal people tell others or give clues about their intentions. The response of others and the setting chosen determine whether the person is rescued before they die. Suicidal behaviour is essentially risk-taking, and can be likened to the idea of a ‘trial’ or ‘ordeal’: it determines if they are ‘meant’ to live or die.

Stengel and Cook concluded that ludic motivation is very common in suicidal behaviour; that is, the person is gambling with life and death. The final outcome (living or dying) depends on factors beyond the person’s control, and usually involves the possibility of rescue by other people.

_Johnson⁶_ (1965) opined that the more integrated a society, the lower will be its rate of suicide. Johnson, however, suggests that ‘when the integration of society is very low or very high, then its suicide rate is high, whereas at moderate levels of integration, its suicide rate is low’.

_Narroll⁷_ (1965) suggested that if people are often ‘thwarted’ in their social interactions, then they become socially disorientated and frustrated and therefore more likely to commit suicide. He also examined that in non-literate societies suicides (in particular suicides characterised as being related to thwarting) are more common in societies in which thwarting disorientation interactions are more frequent. ‘Thwarting’ was measured empirically by recording data on domestic violence, alcohol-related violence, marriage restrictions, freedom of men to divorce, accusations of witchcraft, and war.

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⁵ Stengel E, Cook N. 1958. “Attempted Suicide” Maudsley Monograph (Cited by Taylor 1988, incomplete reference supplied.)
Palmer\textsuperscript{8} (1965) examined that societies where severe punishment for crimes is mandated will have high rates of homicide and low rates of suicide. However, he added, empirical studies in a number of non-literate societies have indicated that both homicide and suicide rates increase with the severity of punishment.

Ginsberg\textsuperscript{9} (1966) takes the position that anomie arises primarily out of the unhappiness and dissatisfaction resulting from discrepancies between people’s aspirations and their actual financial rewards. Levels of suicide therefore reflect the level of dissatisfaction in society.

Ginsberg suggested that, normally, if financial rewards increase (as in an economic boom), people’s financial aspirations also increase. Similarly if rewards decrease (in an economic depression), their aspirations decrease. Consequently, aspirations lead to appropriate behaviour to gain appropriate rewards. Usually, in an economic boom rewards increase faster than aspirations (this is a normal process). However, if aspirations increase faster than rewards, a state of anomie occurs, and this can lead to suicide.

Ginsberg predicted that suicides will normally increase just before the peak of business prosperity during slow rises. However, if the prosperous phase of the business cycle finishes earlier than expected, a large gap will arise between aspirations and rewards and there will be a larger-than-normal increase in suicides. In contrast, during sharp economic downswings suicide rates will fall, since at these times aspirations will almost catch up with rewards, so reducing dissatisfaction.

Maris\textsuperscript{10} (1969) pointed out that not all social relations protect against suicide. He further added if the individual is a member of a group where the group norms are pro-suicide, or where social relations or interactions are


\textsuperscript{10} Maris R. 1969 “Social Forces in Urban Suicide” Homewood: Dorsey.
painful, rejecting, deprecating, punitive or vengeful, then this will likely raise
the suicide rate, not lower it.

Giddens\textsuperscript{11} (1971) analyzed that ‘The self-accusations and feelings of
worthlessness which characterize depression are thus sentiments which really
refer to another person, and are stimulated by the real or imagined behaviour
of another or others’. He regards suicide as one extreme along a continuum of
possible forms of self-aggression, with those who suffer from extreme states
of depressive disorder as well as those experiencing an isolated case of
depressive mood both being vulnerable to suicide.

Giddens suggests that one factor important in determining why only a
certain proportion of people with depressive states make direct attempts at
self-destruction is the conscious and unconscious meaning that the individual
ascribes to death. He considers suicide may be more likely to accompany
depression when the individual regards death as having an instrumental or
functional significance: when death is perceived as something that can be
used to achieve solutions to problems, or a desired outcome.

Giddens observed that in modern societies males are more likely to
undertake anomic suicide, while females are more likely to engage in egoistic
suicide. He also observes that it is the task of the sociologist to study the
nature and character of the social institutions and processes that promote
egoism or anomie.

Phillips\textsuperscript{12} (1974) suggests that suicide rates will increase after suicide
stories are extensively publicized in the media. The study predicts that ‘copy-
cat’ effects can occur after the death of a famous person, after the publication
of books on how to commit suicide, or even following the publicizing of

\textsuperscript{12} Phillips DP. 1974 “The influence of suggestion on suicide” American Sociological Review 39:
340–54.
fictional accounts of suicide stories involving people that certain groups in the community strongly identify with.

Phillips proposed that once suicide rates reach a certain level, a high proportion of people in the population will know someone who has committed suicide. The effect of suggestion (or imitation) results in the suicidal behaviour becoming self-sustaining, and even perhaps accelerates the behaviour.

Smith et al.\textsuperscript{13} (1979) argues that the suicide rate for the adolescent population is not as high as that for middle-aged people (those who would be considered baby boomers); the adolescent suicide rate has nearly tripled since 1950. More specifically, approximately 4.5 out of every 100,000 adolescents committed suicide in 1950, whereas 13.2 out of every 100,000 adolescents committed suicide in 1990. The extreme increase in the adolescent suicide rate makes one wonder whether that rate will continue to rise. Will adolescents eventually be the highest risk group? Even if the adolescent suicide rate remains constant, the statistics just cited justify and encourage the development of school-based programmes to prevent adolescent suicide.

Neelemnan and Lewis\textsuperscript{14} (1990) depicted that the main causes of the suicide are social and economic– unemployment, divorce, dowry, poverty, serious medical illness and substance misuse – are commonly associated with suicide. In contrast, parenthood and being in a stable relationship appear to be protective.

The study reveals that one problem that besets observational research into the relative importance of socio-economic risk factors for suicide is our limited understanding of the nature of the underlying causal pathways for these associations. The study reveals that there is only a weak association

\textsuperscript{13} R. M. Smith, 1979. “Adolescent Suicide and Intervention in Perspective” Paper presented at the annual meeting of the National Council on Family Relations, Boston, MA, August

\textsuperscript{14} J. Neeleman, & G. Lewis, 1999 “Suicide, Religion, and Socio-Economic Conditions”, an ecological study in 26 countries (1990), Journal of Epidemiology and Community Health
between unemployment and suicide after controlling for an individual’s past experiences. However, analysis of temporal trends in unemployment and suicide shows that rises in unemployment are associated with increases in suicide. It seems improbable that the rise in unemployment causes depression. More plausibly, increase in unemployment result in greater levels of depression and distress and this in turn influences trends in suicide. Both pathways are likely to contribute to associations of suicide with unemployment.

The study also shows that Religious beliefs and other cultural factors may influence the likelihood of an individual acting upon suicidal thoughts. The reporting and portrayal of fictional or actual suicides in the media has also been found to influence patterns of suicidal behaviour. The media and religious beliefs may influence both the acceptability of suicide and an individual’s choice of method of suicide. More crudely, changing availability of particularly lethal methods of suicide may influence rates.

Gudrun15 (1992) in his study “Negative Life Events in Childhood, Psychological Problems and Suicide Attempts in Adulthood” investigates relations between childhood negative life events (parental loss, parental mental illness and parental abuse), adult psychological problems (depression, hopelessness, low self-esteem, low self-appraised problem-solving capacity, and alcohol problems) and suicidal behaviour. Risk of suicide attempt was found to be related to childhood negative life events as well as to psychological problems of adulthood. Moreover, the effects of childhood events were found to be partially mediated through the psychological problems, and gender-specific risk pathways were identified. For men, the central pathway involved parental mental illness during childhood and low self-esteem in adulthood. For women, childhood abuse, adulthood depression

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and alcohol problems appeared to constitute central factors. Additionally, effects were found for previous suicide attempts.

Hassan\(^{16}\) (1992) pointed out that in the cases where it is possible to obtain relevant data about half of the suicides were primarily “anomic”- caused by a social environment characterized by sudden or emphatic changes which impaired the individual’s capacity to regulate desires and aspirations. The other half was primarily “egoistic”- caused by social environments which impaired individuals’ bonds to socially given ideals and purposes, thus weakening the bonds with commonly shared meanings collective activity values and social purposes.

The evidence of the study shows that “relational” problems (unhappy love, family/marital problems, shame and guilt), (instrumental) problems (financial and unemployment problems, a sense of failure in life) and “health” problems are some of the principal circumstances preceding suicide. Among young women the principal cause appears to be related to “relational” problems; among middle-aged women the problems tend to be the instrumental type followed by health and among the aged the main causes are instrumental. Among young men the main “causes” tend to be instrumental factors, followed by “relational” problems among the middle-aged.

Hassan\(^{17}\) (1992) analyzed that suicide is ultimately a deadly violence directed against self. As a form of death it has evoked and evokes a multicity of reactions from the living ranging from sadness and fascination to repulsion and condemnation. The evidence in this study clearly suggests that suicide has become a major public health and social problem. Suicide now claims one life every four hours which results in the loss of one hundred thousand years life every year. Its increase has been especially dramatic among young people.

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\(^{17}\) Riaz Hassan, 1992. “Suicide in Australia”: A Sociological Study by, the flinders University of South Australia.
In 1960 only 2.3 percent of all deaths of males aged 15-24 years was due to suicide; the corresponding percentage in 1990 had increased by tenfold to 23 percent. He further added that among young females of the same age-group the percentage has increased from one percent in 1960 to 11 percent in 1990. To describe this change in another way, whereas in 1960 one in every 62 deaths of persons aged 15-25 years was caused by suicide; in 1990 one in every five deaths in this age-group was due to suicide.

Suicide is no longer regarded as an irredeemable moral crime but a fact of society, like the birth rate or the unemployment. It has social causes which are subject to discernible sociological laws which can be identified and analyzed scientifically and rationally. In social theory it is viewed fundamentally as a product of the nature of relationship between the individual and the society. The relative degree of regulation, control, isolation and oppression of individuals in society are the primary causes of varying degrees of suicide rates in different societies. These factors are often influenced by social and economic factors such as economic cycles, occupation, age gender, marital status, social cohesion, urbanization, modernization and public services.

Aleem\(^{18}\) (1994) analyzed that the reasons of committing suicide are many. But they are normally classified by the crime report in more than a dozen categories such as failure in examination; quarrel with spouse and in-laws, poverty, unemployment, dreadful diseases, dowry disputes etc. The author found that many a time there may be more than one reason for taking this drastic step. Many a time the real cause is not known. Generally, the act of suicide may be a chain reaction of a number of events, which can’t be separated easily from each other.

The study also revealed that the main causes of tension and frustration like poverty, unemployment, alcoholism are deep rooted in the social system. The social ills can’t be removed overnight nor can the social organizations like family, school, places of worship and voluntary organizations are more effective in creating congenial atmosphere for individuals, so that there urge for suicide may be reduced. She analyzed that generally it is observed that these social institutions don’t give attention or concentrate on this aspect of the problem. Many a time a vacuum is created in the life of an individual and when he does not find any one to console him, he prefers to put an end to his life. It is not the law but the will which can minimize the number of suicides in any society. She also analyzed that the increasing stress and strain is a worldwide phenomenon. The more the country is advanced, the more competition is there in every field leading to more stress and strain and even frustration. Many people unable to bear this put an end to their lives without realizing that it is not the end of their miseries.

Stack\(^{19}\) (1994) pointed out that for Durkheim the main ‘driving force’ behind the long-term increase in suicides was the impact of modernization, including the growth of urbanization, industrialization, secular education and laissez-faire capitalism. This increased the risk of anomic and egoistic suicide by decreasing the sub-ordination of the individual to group life, reducing the number of shared beliefs and practices, unleashing limitless appetites, weakening relationships based on the extended family and generating sudden changes in people’s lives, all of which contributed to the emergence of what Durkheim referred to as a kind of ‘collective sadness’. Stack further revealed that Durkheim’s theory can be regarded as a unifying theory in that it attempts to explain the observed relationships between suicide rates and a large number of different indicators (such as divorce rates, rapid social change, wars, etc.) using two key theoretical constructs – social integration

\(^{19}\) Stack S. 1994 “Reformulating Durkheim: 100 years later” In: D Lester (ed). Emile Durkheim: Le Suicide one hundred years later (pp. 237–63). Philadelphia: The Charles Press.
and social regulation. A large amount of empirical research has found, as Durkheim predicted, that indicators of social integration and regulation are correlated with low or high suicide rates.

Vernon\textsuperscript{20} (1996) revealed that the primary motivation for suicide is depression. Depression is a mood disturbance which is characterized by feelings of sadness, despair and discouragement resulting from and normally proportionate to some personal loss or tragedy. Depression can become an abnormal emotional state which exaggerates these feelings of sadness, despair and discouragement out of proportion to reality.

The study depicts that there are four major clusters of depressive symptoms; emotional, cognitive, motivational and somatic. Each of these clusters of depressive symptoms impact both dependently and independently upon the depressed individual. In fact, as one set of clusters begins to affect the individual another impacts and reinforces the depressive effect. Eventually, the emotional and cognitive clusters effect the motivational symptoms causing what clinicians refer to as a "paralysis of the will" and/or psychomotor retardation. (Psychomotor pertaining to or causing voluntary movements usually associated with neural activity) In severe depression the depressed person may actually experience a slowing down of his or her movements. They may even have trouble walking and talking. The depressed individual experiences physical changes which further exacerbate the depressive symptoms. The physical changes which occur are referred to as the somatic symptoms. This emotional symptom is felt worse in the morning usually as a result of not having been able to sleep. Feelings of anxiety are also present along with a loss of gratification and loss of interest.

The study revealed that an individual begins to feel sad and sustains a restless sleep. He begins to feel sad in the morning and experiences a lack of

\textsuperscript{20} J. Geberth Vernon, M.S., M.P.S. 1996 “The Psychology of Suicide” Former Commander, Bronx Homicide, NYPD.
interest in work (emotional symptoms). He then begins to question his ability to perform at work and starts to feel inadequate. This adds to the individual's anxiety and low self esteem (cognitive symptoms). He then discovers that he just can't get started in the morning and cannot bring himself to go to work and just loses interest in life (motivational symptoms). As the depression deepens, the individual loses his appetite, experiences weight loss which leads to weakness and fatigue. He then slips deeper and deeper into depression and becomes ill (somatic symptoms). The cycle of depressive symptoms will continue to evolve and the depression will worsen. At this point the individual loses his balance of mind and try to end his life.

Minois\textsuperscript{21} (1999) in his study “History of Suicide” opined that more than four times as many men as women die by suicide; but women attempt suicide more often during their lives than do men. Several explanations have been offered: a) Completed suicide is associated with aggressive behaviour that is more common in men, and which may in turn be related to some of the biological differences identified in suicidality. (b) Men and women use different suicide methods. Women in all countries are more likely to ingest poisons than men. In countries where the poisons are highly lethal and/or where treatment resources scarce, rescue is rare and hence female suicides outnumber males.

Brahe\textsuperscript{22} (2000) in his study “Sociology and Suicidal Behaviour” tried to examine why differences in suicide rates between countries remain relatively fixed or constant, and why, when suicide rates change within a country over time, they do so in a patterned way. He opined that the unique feature of Durkheim’s approach was his rejection of the importance of non-social factors

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\textsuperscript{21} Georges Minois, 1999 “History of Suicide”: Voluntary Death in Western Culture. Baltimore, MD: Johns Hopkins University Press.
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for determining variations in rates of suicide. His writings were the first to claim that variations in suicide rates in modern societies were very largely – if not entirely – determined by the social environment. He further added that societal conditions, the general moral and psychological climate of a society, could increase or decrease the propensity for individuals to react to problems and pain by committing suicide.

Davis, 23 (2000) in his study “Integration-Regulation and Lethal Violence” analyzed that as an epidemiological phenomenon, suicide ranks as one of the leading causes of mortality within the United States. In the late 1990’s the US National Centre for Health Statistics ranked suicide as the eighth leading cause of mortality. In the past several years suicide has declined slightly in ranking and as of 2002 was the eleventh leading cause of mortality overall. Despite this decline, suicide continues to take significantly more US lives annually than homicide which ranks fifteen.

He added that disaggregated by age, suicide is more prevalent among younger age groups (15-24), drops for middle or working-aged groups, and then rises into old-age. Due to these significant aged-based differences, researchers examining spatial patterns of suicide rates often utilize a standardized age-adjusted rate to control for skewed age-based population distributions. For multivariate regression analysis crude suicide rates and empirical controls for population age structure have been shown to produce better unbiased regression estimated.

The study revealed that historically, one of the most pronounced features of the suicide rate within the industrialized world is the overwhelming contribution from males. The study also revealed that throughout the first half of the 20th century suicide rates were consistently higher in urban locations. The 1950’s and 1960’s served as a period of rough convergence...

between rural and urban suicide rates. Since the late 1960’s rates of suicide mortality have been consistently higher in less urbanized and rural places. Across the US the relationship between suicide and rurality holds regionally, with the highest rates of suicides in the more rural and expansive regions of the West, as well as sub-regionally, with higher rates of rural compared with urban suicide within all regions of the country. Beginning as early as the late 1960’s, National Health Statistics publications demonstrate that the rural-urban suicide differential within the United States is primarily defined by the elevated rate of white male suicide in rural areas.

Tubergen24 (2001) opined that suicide rates drop in countries involved in national wars have provided a starting point for studies on the relationship between war and suicide. Durkheim found that during the war of 1866 between Austria and Italy, suicides decreased by about 14 percent in both countries. He found similar drops in suicide rates during the French-German war of 1870-1 and the 1864 war between Denmark and Saxony. Durkheim explained this wartime suicide pattern with his political integration resulted in a lower suicide rate. Political events, such as wars, but also elections and revolutions, were assumed to foster political cohesion, thereby lowering the suicide rate.

The study revealed that looking at aggregate suicide patterns during the First World War (1914-18) and Second World War (1939-45), cross-national time-series studies have found support for Durkheim’s theory. However, despite this evidence, Durkheim’s presumed wartime drop in suicides has been questioned. Three arguments stand out. First, it is acknowledged that in the First and Second World Wars, suicide rates were lower in belligerent countries, but at the same time, the suicide rates in surrounding – neutral – countries also decreased.

24 Frank Van Tubergen, 2001. “Political Integration, War and Suicide”, the Dutch Paradox University of Utrecht
The study revealed that Durkheim proposed his political integration theory for neighbouring countries that were at war. These were great national wars, which created the kind of nationalism and patriotism that brings society together. However, the First and Second World Wars were more diverse, including not only countries that were directly involved in fighting but also countries that were far from the field of battle.

*Sridhar* 25 (2002) in his study “Suicide, Gender and Age Variations in India” analyzed that across the country, the suicide rate for females is consistently lower than that for males, in keeping with the global sex ratios of suicides. But in the younger age-group, between 15 and 29 years, the female suicide rate is as high as that for males. Moreover, the rates for educated females - those who have gone beyond primary school - are higher than that for males. The greater vulnerability of women is also associated with the more unstable nature of their livelihoods. Sridhar's study reveals that the suicide rates for women are significantly higher than those for men among those engaged in non-agricultural activities - whether they are engaged in the activity on a regular basis or are self-employed. He points out that employment and incomes in such activities are unstable. The growing reach of the market into these sectors further destabilizes life in these sectors.

Sridhar's study provides shocking data of suicide rates among those who declare themselves totally unemployed. For males in the age-group of 30 to 44, the rate is a whopping 508 per 100,000 persons; for women it is more than 200. More important, as the duration of unemployment increases, suicide rates rise dramatically - the rates among men in the age-group of 45 to 59 is a shocking 1,812 per 100,000 persons and among women, nearly 550.

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Vijaykumar (2007) in his study “suicide and its prevention” pointed out that suicide is an important issue now-a-days in our country. More than one lakh (one hundred thousand) lives are lost every year to suicide in our country. In the last two decades, the suicide rate has increased from 7.9 to 10.3 per 100,000. There is a wide variation in the suicide rates within the country. Higher literacy, a better reporting system, lower external aggression, higher socio-economic status and higher expectations are the possible explanations for the higher suicide rates in society.

The study revealed that the majority of suicides (37.8%) in India are by those below the age of 30 years. The fact that 71% of suicides in India are by persons below the age of 44 years imposes a huge social, emotional and economic burden on our society. The near-equal suicide rates of young men and women and the consistently narrow male: female ratio of 1.4: 1 denotes that more Indian women die by suicide than their Western counterparts. Poisoning (36.6%), hanging (32.1%) and self-immolation (7.9%) were the common methods used to commit suicide.

The study suggests that suicide is a multifaceted problem and hence suicide prevention programs should be multidimensional. Collaboration, coordination, cooperation and commitment are needed to develop and implement a national plan, which is cost-effective, appropriate and relevant to the needs of the community. In India, suicide prevention is more of a social and public health objective than a traditional exercise in the mental health sector. The time is ripe for mental health professionals to adopt proactive and leadership roles in suicide prevention and save the lives of thousands of young Indians.

A deep study of the literature on Suicide reveals some common points. The conclusion drawn from these studies conveys that social set up that is

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responsible for the suicide. Suicide, like other social phenomenon, is also a social phenomenon. It can’t be studied separate from the society. Like marriage, divorce, and social interaction, suicide is also a social phenomenon and its cause has to be found out in social set up keeps the individuals in a balanced state and with social break up, there is chaos which might end up in increasing the rate of suicide.

Some studies also depicted that depression as the cause but a close scrutiny made it clear that the depression too has social causes. In simple words, we can say that suicide in its ultimate analysis is deep rooted in the society.