CHAPTER - I

INTRODUCTION

Which is the suicide capital of India? WHO(World Health Organisation) has an answer; Kerala, known as `The God's Own Country' or in the words of Amartya Sen., the state which is a model for development'. In India, Kerala shines in various aspects like literacy, secularism, technological pursuits, life expectancy and political upsurge but bears impediments with respect to unemployment among educated youth, alcoholism, divorce and family break down. Despite these, one more factor needs to be added to the list i.e., increasing suicide rate. According to NCRB reports 2008, All India suicide rate is 10.5/lakh populations that is 324 suicides per day. Kerala shows suicide rate of 26.8/lakh which is more than two times higher than national average; which means one suicide per hour. In the last 11 years Kerala reports highest rate of suicide among other Indian states.

Incidence of suicide in India (1990-2006)

(Sl)	Year	Total No. of suicide In India	Estimated Mid Year Population (In lakhs)	Rate of suicide
1	1990	73911	8270	8.94
2	1991	78450	8496	9.23
3	1992	80149	8677	9.24
4	1993	84244	8838	9.53
5	1994	89195	9000	9.91
7	1995	89178	9160	9.7

8	1996	88241	9319	9.5
9	1997	95829	9552	10.0
10	1998	104713	9709	10.8
11	1999	110587	9866	11.2
12	2000	108593	10021	10.8
13	2001	108506	10270	10.6
14	2002	110417	10506	10.5
15	2003	110851	10682	10.4
16	2004	113697	10856	10.6
17	2005	113914	11028	10.3
18	2006	118112	11198	10.5

Source NCRB

While analyzing the suicide rate of India the period from 1997-2006 shown an increase in rate of suicide as compared to the previous years. In the year 1999 the table shows peak rate of suicide as compared to the preceding and succeeding years. But the year 2000 onwards the table indicates gradual decrease in rate as compared to previous years. It may be mainly due to the social change that had a profound influence on people in these years. The role played by NGO's and the increase in counseling services can minimize the suicide rate at extent.

Incidence & Rate of male female suicides in Kerala (1995-2007)

Year	Estimated Mid-year Population (in 100,000s)			Suicide Incidence			Suicide Rate (per 100,000 of population)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
1995	147.79	154.54	302.33	5615	2397	8012	37.99	15.51	26.50
1996	148.97	156.09	305.06	5414	2672	8086	36.34	17.12	26.51
1997	150.15	157.66	307.82	6215	2746	8961	41.39	17.42	29.11
1998	151.35	159.25	310.60	6503	2803	9306	42.97	17.60	29.96
1999	152.55	160.85	313.41	6853	2925	9778	44.92	18.18	31.20
2000	153.77	162.47	316.24	6609	2695	9304	42.98	16.59	29.42
2001	154.99	164.11	319.10	6787	2785	9572	43.79	16.97	30.00
2002	156.23	165.76	321.99	7165	2645	9810	45.86	15.96	30.47
2003	157.47	167.43	324.90	6935	2503	9438	44.04	14.95	29.05
2004	158.73	169.11	327.84	6598	2455	9053	41.57	14.52	27.61
2005	159.99	170.80	330.81	6830	2414	9244	42.69	14.13	27.94
2006	161.27	172.50	333.81	6583	2443	9026	40.82	14.16	27.04
2007	162.55	174.21	336.84	6588	2374	8962	40.53	13.63	26.61

Source SCRB

While analyzing Kerala scenario same trend can be seen in national level. The rate of suicide is consistently high and almost three times India's average. In a day, about

26 persons take their lives - of them 18 are men and 8 are women. From 1995 to 2003, suicide incidence rose by 17.8%; suicide rate rose by 9.6%, then shows a gradual decrease. The overall male-female ratio is 73:27. Male suicide rate has been rising since 1996. There is also unusual spurt in incidence and rates observed for the year 1999.

District wise Suicide rate

District / Year	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Idukki	48.6	41.1	43.3	43.0	43.0	41.5	49.2	49.7	51.0	42.4	40.3	38.6	39.5	34.6
Kollam	32.0	33.5	32.1	31.2	33.4	33.2	33.9	43.6	43.1	41.0	42.4	41.3	42.0	36.4
Wyanad	44.4	39.1	38.6	39.4	51.7	48.4	39.8	40.6	45.0	36.5	38.0	40.1	36.5	38.2
Thiruvananthapuram	17.2	33.2	40.6	41.3	39.8	41.4	41.4	38.5	32.7	35.5	37.0	37.8	37.0	34.6
Pathanamthitta	23.5	19.8	21.1	27.4	29.4	22.6	32.3	38.2	32.6	32.9	31.4	26.6	30.7	24.9
Thrissur	37.5	33.1	35.1	35.3	37.1	34.0	34.3	34.5	33.7	31.0	31.6	30.3	27.7	27.1
Palakkad	32.3	32.7	33.4	33.2	34.1	34.4	33.1	32.9	33.1	33.0	35.8	34.5	32.0	29.2
Kannur	27.7	29.3	29.2	30.1	27.5	26.7	32.3	32.2	29.5	27.1	25.2	23.4	23.0	23.8
Ernakulam	26.0	23.0	27.5	26.4	26.4	24.7	25.9	27.8	24.0	23.0	23.0	23.2	23.0	24.6
Ksaragode	24.8	22.0	24.1	22.5	24.0	19.0	22.1	26.1	23.5	22.8	21.0	18.7	20.5	18.9
Kottayam	23.5	20.8	23.1	25.1	24.4	21.8	24.6	25.4	26.0	22.5	23.0	22.2	21.3	22.5
Alappuzha	19.9	19.3	20.4	23.6	33.2	22.9	22.9	25.3	25.1	22.5	23.4	21.7	22.3	21.0
Kozhikode	22.0	21.4	24.5	24.6	24.8	23.7	25.5	24.3	22.7	21.4	22.3	22.0	22.0	19.7
Malappuram	12.0	10.1	14.6	14.2	13.5	14.7	11.7	11.8	12.9	12.8	12.0	11.3	10.6	10.6

Source SCRB

The table shows Suicide is maximum in Waynad, Kollam and Idukki districts. Suicide rate is high in Thiruvananthapuram, Palakkad & Trissur districts. Rate is more less steady in Kannur, Eranakulam, Kasaragode, Kottayam, Alleppy & Kozhikkod districts. Rate of increase in suicide is highest in Thiruvananthapuram district where it

has gone up from 17.2/l in 1995 to 34.6/l in 2008.Suicide rate is consistently low in Malappuram district.

The phenomenon of suicide represents the existence of social malaise. We come across a situation represented by the operation of a variety of social forces due to which the individual finds that he cannot cope with the tensions and strains, which threaten to engulf him. Under social such circumstances the behavior of a potential suicide may be reflective of this “Cry of help” which, when ignored, may result in a “shout of protest” in the form of indulging in self-immolation.

It may happen mainly due to some of the negative life experiences such as death of loved one, divorce, separation or breakup of a relationship, serious loss such as a loss of a job, house, or money, Chronic physical pain, intense emotional pain, loss of hope, (Being victimized such as domestic violence, rape, assault), A loved one being victimized such as child murder, child molestation, kidnapping, murder, rape, assault, Physical abuse, verbal abuse. Sexual abuse, serious legal problems, such as criminal prosecution or incarceration, inability to deal with a perceived "humiliating" situation, inability to deal with a perceived "failure, Alcohol abuse, drug abuse, feeling of not being accepted by family, friends, or society, horrible disappointment, feeling like one has not lived up to his or her high expectations or those of another and low self-esteem.

An act of suicide, says, Albert Camus, is prepared with in the silence of the heart, as is a great work of art. Suicide has been honored as well as condemned down through the ages. The philosophers approach to the topic of suicide hinges on the central query whether the human can decide to blow out the flame of his own life.

Suicidal death has been charged triple sinful because it is an act directed against God, state and man himself.

Suicide has been a part of civilization since time immemorial. The subject has remained the focus of attention with almost all religious. Depending on the time and culture, public attitudes towards suicidal behavior varied from one of acceptance to condemnation. Hinduism states that he who takes his own life will enter the sunless areas covered by impenetrable darkness after death. Islam considered suicide a very serious crime and Christianity prohibits suicide and considers it as a sin against God and his primary one of suffering and stress, and it is one of man's duties to withstand his suffering. Thus, suicide irrespective of any religion condemns and prohibits suicide.

Controversy clouds the point whether the tendency for self destruction is phenomenon of modern societies or whether it was an inherent quality of primitive mind. Certain anthropologists have claimed that suicide was unknown to certain tribes like Zoni of New Mexico, Andaman islanders and Australian aborigines, Nevereless others have found a higher occurrence of suicide among Navaho of North America and Fizi islanders when compared with the suicide rates in the advanced countries. Society however, is neither simple nor unitary it condemns suicide because it believes that the life is a condition of good fortune and because it does not want to put in the question the worth of values of which man find subscribes. Besides theologians and philosophers, sociologists, psychologists, criminologists and others ever interested in the study of suicide. The French sociologist, Emile Durkheim demonstrated that suicide was the result of disparity between the individual and the social structure. One

commits suicide only when one suffers from frustration, isolation, humiliation and dependency. Suicide implies that the person has reached a stage where he is longer able to function adequately in the many interpersonal relationships of a normal human being, and that the lies that bind the member of the organized group are broken. Investigations of suicide death reveal that in the great majority of cases, suicide did not occur suddenly, impulsively, impulsivity or inevitably, but was, on the contrary the final step or outcome of a progressive failure of adaptation. Several sociological, psychological, biological, medical factors and psychiatric illness have been identified as responsible for suicide in general populations.

When some people commit suicide means that society has failed to create conclusive circumstances to them to live happily. Moreover man has a tendency to imitate others. Therefore, those who commit suicide are setting a bad example to others, who are also tempered to commit suicide under unfavorable circumstances. Those who are doing research in sociology says that in a majority of cases, persons intended to commit suicide give a clue either by words or acts, to the effort that they are going to end their lives.

Disappointments, frustrations, failures, shock, greed and the like, how ever intense or unbearable can lead to suicide, although we may satisfy our material needs, this life of prosperity leaves us with a feeling of intense boredom. Unemployment, debt may be important economic reason leading to suicides. Poverty is still another cause for suicide. For example we read from newspapers now and then that a mother unable to bear the pangs of poverty till her children and then kill herself.

Suicidal behavior the public health problem

Suicide behavior is a very personal act with a wide social influence and implication and at the same time a major public health problem needing evaluation, help, treatment and correction.

It is estimated that about 87,00 people die by suicide each year world wide. (WHO, 2008). 6% of it is in the Asian countries. For each completed suicide there are 20 times more suicidal attempts. Each suicide, on an average leaves 20 times more people in severe distress.

Suicide is one among the ten leading causes of death world over. The risk of suicide after a non fatal suicide behavior is 100 times than that of general population. Most of the attempts are planned and precautions are often taken discovery. Often a suicidal patient gives warning, often to more than one person. It is interesting to note that third of patients with suicidal behavior might have consulted a doctor in the pervious month.

Medical profession has to be properly equipped to identify and manage suicidal behavior among medical service seekers as a large percentage of people who experience distress do in fact seek medical help. Unfortunately this message has not reached decision makers. Still psychiatry and behavior medicine is not taught as a main paper subject in the medical gradation curriculum.

Lot of factors is found to be associated with suicidal behavior. The completed suicides are found to be more in men, but the suicide attempt rates are about four times more in female. The suicide rates usually increases with age, but the adolescent peek is now becoming more and more significant. There are rate differences among

different religious groups. Marriage reinforced with children was thought to be protective, but some findings contradict it, especially in unhappy marriage.

A recent trend, especially in the state of Kerala, is the family suicides, where the whole family attempt suicide. In large number of such situations, murder-suicides is a possibility. Having a work outside home is found to be protective. With regard to economic and social status, the relative and sudden fall of status can act as a contributory factor for suicide. Terminal, severe and disabling physical illness has a significant relation to suicidal behavior.

In attempting to study the causes of suicide, there are some inherent difficulties. After a completed suicide we can only do a retrospective study, by getting as much information from individuals close to the dead, by the psychological autopsy method. On the other hand if we attempt to do a prospective study, we need to follow up a large population as the rate is about 30 suicides per one lakh population for a period of one year.

The difficulties can be possibility overcome by taking into consideration, the increased risk indicators of suicide behavior. Being a psychiatric patient carry increased risk. The feeling of hopelessness, alcoholic consumption and use of other psycho active substances are high risk indicators.

What ever may be the multiple interesting causes and contributory factors, at the time of the act, the behavior is totally destructive to the individual and hence it is a definite sign of psychological ill health.

Models of causation of suicidal behavior

Medical Model

The medical model accept that the causes for suicidal behavior are multiple and complex and interesting with each other. It includes mental disorders, physical illnesses, alcohol and substance related problems sociological factors, psychological factors and biological factors.

The common mental disorders associated with suicide are mood disorders (depressive disorders) alcohol or drug dependence and abuse, schizophrenic disorders, anxiety disorders, organic mental disorders, personality disorders and other mental disorders.

It is estimated that about 6% of people with mood disorders commit suicide. More rates are seen in depressed patients. If there is a past history of deliberate self harm, the chances for further attempts and suicide rates are more. When mood disorders are co morbid with other disorders like substance abuse the rates are high.

With alcohol or other psychoactive substance abuse or dependence there is a continuing and increasing risk of suicide. In such situation, the suicide rates are more in males, of older age with a long history of drinking. Past history of deliberates self harm or the presence of a co morbid depressive disorder in individuals with alcohol or a psychoactive substance use disorder the suicide rates are high. If such difficulties are associated with physical complications, marital problems, difficulties at work drunkenness offences, the rates of suicide are high.

Suicidal behavior as ill health

Another path breaking study was the one by Barraclough et al 1974, came out with the shocking disclosure that large of those who die from suicide have some form of mental disorder at the time of death. Subsequent studies have added further evidence in the same direction.

The classificatory system of psycharic was also undergoing revisions under WHO (WORLD HEALTH ORGANIZATION) and APA (American Psychiatric Association) the ICD (International Classification of Diseases) and the DSM (Diagnostic and Statistical Manual). The number and scope of diagnostic categories increased and disorders associated with stress like Adjustment disorders, acute stress disorders and post Traumatic stress disorders were defined as psychiatric disorders. Margin was drawn between senescent forgetfulness and dementias and between ADHD (Attention deficit disorders) and childhood mischief and between merry making and alcohol and substance use disorders.

The rapid development of IT, visual media and telecommunication and the changes in world order to a unipolar world and the globalization compelled the micro societies worlds over to get more organized in its functioning. More over, the matriarchic and matrifocal joint family systems have progressively giving way to nuclear or single parent families. As the culture barriers world over started to crumple, and as societies world over started to get more and more organized, and as family support of the disadvantaged in the joint family disappeared it become mandatory to view the suicide and suicidal behavior as pathological manifestation of human behavior needing correction.

In general, suicide and suicidal behavior are seen as manifestation of ill health, needing intervention, help and correction. To intervene, help and correct, proper scientific study of all the factors leading to suicidal behavior has to be carried out. The Medical model approach of suicide prevention strategies, talk into consideration all the physical, psychological, medical, social, economic, interpersonal and other stress related and belief system and cognition factors under one umbrella. This approach does not deny but accept and study the multifactor causation of suicidal behavior.

Biological factors in suicide

Genetic studies have found a strong association between suicidal behavior, impulsivity and aggression. Genetic factors may be responsible for the concordance of suicide in some families. Brain serotonergic system may be linked to suicidal behavior.

Psychological factors in suicide

Many psychological theorists have attempted to explain suicidal behavior. Sigmund Freud viewed suicide as aggression turned inwards. Karl Menninger called it an inverted suicide. He described the existence of a death instinct with three component of hostility in suicide-the wish to kill, the wish to be killed, and the wish to die.

More recent psychological theories of suicide explains the suicidal behavior as resulting from fantasies about what would happen if they commit suicide. It may include wishes for revenge, power, control, punishment or sacrifice. It may also be though of as an escape or sleep. Again imagination of rebirth or reunion with dead or a new life might lead people into such act.

The multifactor causation of suicide

A vulnerable individual with genetic loading other biological factors, developing over years through various stresses and strains of life, may develop many co morbid medical or psychiatric disorders. Alcohol or a drug related problem may be added on. The social and psychological factors may in turn contribute resulting in a suicidal behavior.

Causal factors and management of suicidal behavior

Since the causative factors are multiple, the management approach in suicidal behavior also should be multidisciplinary. A psychiatric team should be involved in the management. The team should consist of a psychiatric team should be involved in the management. The team should consist of a psychiatrist, psychologist, psychiatric social worker, and psychiatric nurse should work together. A well coordinated and functioning legal, psychiatric and social support system is most essential in the management of suicidal behavior.

"Suicide is a paradoxical phenomenon. On the hand it appears to be the most personal action an individual can take. On the other hand, it is ubiquitous, has occurred throughout human history in all corners of the world and often under circumstances that show such a striking similarity that one has but to conclude that social factors play an important, if not decisive role in its causation" RFW DIEKSTRA (1989).

Suicide – A Global Public Health Problem

Suicide accounts for nearly 3% of all world deaths. It has been estimated that about a million suicides occur annually with a global suicide rate of about 14.5 per 100,000 population with 1 suicidal death every 40 seconds is among the 10 leading causes of death for all ages in most of the countries.

Recently universal upward trend in suicide rates, particularly in young people have been noticed worldwide which is estimated to rise 1.53 million by 2020. In teenagers and young adolescents ages 15-24, suicide is a leading cause of death. Suicide attempts- 10 to 40 times more frequent than completed suicides.

Suicides and attempts at suicide have a profound impact- much distress and suffering, on family and friends, workmates, communities. Economic costs of suicide to society are substantial, estimated to be in billions of dollars.

Realizing these serious issues, WHO in 1989 recommended that members states should:

1. Recognize 'suicide' as a priority in public health
2. Develop national preventive programmes, interlinked with other public health polices and
3. Establish national coordinating committees

WHO has also come out with a landmark statement on 'self-directed Violence authorized by Diego De Leo, Jose Bertolote David Lester in World Report on Violence and Health in October 2002. It is disappointing to note that there is paucity information from developing countries from Asia Africa including India in this article. (Which cites 183 references, most of which are from the West).

Suicides in Kerala

District / Year	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Idukki	48.6	41.1	43.3	43.0	43.0	41.5	49.2	49.7	51.0	42.4	40.3	38.6	39.5	34.6
Kollam	32.0	33.5	32.1	31.2	33.4	33.2	33.9	43.6	43.1	41.0	42.4	41.3	42.0	36.4
Wyanad	44.4	39.1	38.6	39.4	51.7	48.4	39.8	40.6	45.0	36.5	38.0	40.1	36.5	38.2
Thiruvananthapuram	17.2	33.2	40.6	41.3	39.8	41.4	41.4	38.5	32.7	35.5	37.0	37.8	37.0	34.6
Pathanamthitta	23.5	19.8	21.1	27.4	29.4	22.6	32.3	38.2	32.6	32.9	31.4	26.6	30.7	24.9
Thrissur	37.5	33.1	35.1	35.3	37.1	34.0	34.3	34.5	33.7	31.0	31.6	30.3	27.7	27.1
Palakkad	32.3	32.7	33.4	33.2	34.1	34.4	33.1	32.9	33.1	33.0	35.8	34.5	32.0	29.2
Kannur	27.7	29.3	29.2	30.1	27.5	26.7	32.3	32.2	29.5	27.1	25.2	23.4	23.0	23.8
Ernakulam	26.0	23.0	27.5	26.4	26.4	24.7	25.9	27.8	24.0	23.0	23.0	23.2	23.0	24.6
Ksaragode	24.8	22.0	24.1	22.5	24.0	19.0	22.1	26.1	23.5	22.8	21.0	18.7	20.5	18.9
Kottayam	23.5	20.8	23.1	25.1	24.4	21.8	24.6	25.4	26.0	22.5	23.0	22.2	21.3	22.5
Alappuzha	19.9	19.3	20.4	23.6	33.2	22.9	22.9	25.3	25.1	22.5	23.4	21.7	22.3	21.0
Kozhikode	22.0	21.4	24.5	24.6	24.8	23.7	25.5	24.3	22.7	21.4	22.3	22.0	22.0	19.7
Malappuram	12.0	10.1	14.6	14.2	13.5	14.7	11.7	11.8	12.9	12.8	12.0	11.3	10.6	10.6

Source SCRB

Kerala is unique in many ways with its high population density (around 750/sq km). high rate of literacy, steadily increasing life expectancy, low rates of infant, under five and maternal mortality rates and total immunization coverage. Kerala model of health care has been acclaimed as nearing the levels of a developed society despite comparatively lower level of income, per capita. This sharply contrasts with increasing divorce rates, comparatively high rates of alcohol consumption and breakdown of traditional support systems. This is the social paradox of Kerala and may reflect the rapid social changes.

Are risk factors for suicides in India/Kerala different from elsewhere?

Age, Gender, Marital Status, choice of method and Association with mental disorders, and use of substances are the usual risk factors discussed. One of the classic principles in Suicidology is predominance of suicide among the elderly (men) and tendency for suicide rates to increase with age. In India shift in predominance of numbers from the elderly to young people is clear. 67% of suicides in India committed by persons below 35 years of age, 35% of victims are between the ages of 15-24 years. Only 7% of persons are aged 60 years and above.

Suicide rates in male are consistently higher than rates in females all over the world. Ratio of male: female suicide rates ranges from 3:1 to 10.4:1 reversal of the ratio is observed in females below 25 years ie 1:1.35. Verbal autopsy of 39,000 deaths from 1997-98 in rural Villupuram district of Tamil Nadu illustrate these differences. At ages 15-24 years the female suicide rate of 109/100000 exceeded the male rate of 78/100000. About 50% suicides were by self-poisoning (Gajalakshmi & Pto 1) Epidemiology 2007).

Social change in Kerala

In the areas of social change and suicide, Kerala occupies a special place. Not only in Kerala experiencing high degree of social change, has it also had high suicide rates

There are a large number of scholarly studies addressing both of these issues in Kerala. Notable are the large number of working paper of Centre for development studies and Samyukta provide insights into the changes occurring in the status of women, elderly, agriculture, education, migration and employment. In the following

section two view points are presented to illustrate the issue, a personal account of an immigrant Keralite to the change in the society and an academic analysis of the suicide paradox in Kerala.

The following is a summary of the observations of an immigrant Keralite on a recent visit to Kerala (personal communication).“Kerala has been steadily getting more and more materialistic. What started off a couple of decades ago as the “Gulf Flush” has come to stay, as Keralites have been spreading themselves across the globe and across the country as qualified employees. The relatively sudden rise in income levels has brought about a level of consumerism which is unparallel in the culture of the society. More money is spent for social recognition in the form of bigger houses, bigger cars and flashy clothes and jewellry, than in wisely thought-out long term investments. There is a love of money and materials, the kind of which was never seen before. Most people are fiercely self centered and form strange alliances to outmaneuver a rival, for achieving own goals…. Pollution of every sort is rampant. Noise disturbance from neighbours is meance. Daily wages for workers have increased disproportionately. As a result private agricultural cultivation is non-existant. Ecological balance has collapsed….. Local residents complain of sharp rise in robbery and break-ins, and very poor policing. Serious crimes like falsifying banknotes and production of explosives happen in backyards, in full public knowledge. Law enforcement agencies have become the butt of many cynical jokes because it is common knowledge that corrupt officials looks the other way until a catastrophy occurs…. Driving is crazy, no obeys any rules it is a free-for-all on the roads! Horrific accidents happen daily, some find their way into newspaper, others do

not. Accidents involving children and other pedestrians are far too many. There is no concerted effort to educate the public in roads rules. It is a stressful struggle to keep afloat. Without sinking! Neighbourly interference is a reality, which is extremely difficult to blance! There is more "behind-the-back" dealing than open, direct dealing. Telephone lines in Kerala are constantly engaged! There is no culture of physical activity for health and recreation. Alcoholism is rampant, and a well-accepted menace in the society. Festivals like Onam (which is based on a legend and comes at the peak harvest time in Kerala), or Christmas sees alcohol sales go up to unprecedented high levels. Many families have problems in connection with excessive alcoholism, although much is hidden for fear of social repercussions. Economic independence brings with it higher self-confidence and self-esteem. In the Kerala context, this new development is witnessing late-marriages and a disturbing increase in divorce. Materialism and consumerism is at its highest. Discontentment and greed spoils human relationships and drive people to irrational behaviour (January 2009).

Haliburton (1998) reviewed the 'Suicide: A Paradox of development in Kerala'. He summarises the as follows: "Rather than be confounded at how Kerala could have a high suicide rate despite high literacy and an impressive socio-economic development, there is need to understand why elements in social programmes may have a particular impact. Although much attention has rightly focused on issues of socio-economic development because of its impressive standards of living statistics (in life expectancy, literacy, health care and other areas), there is an equally starting trend in this state that goes largely unaddressed in social science research: Kerala has the highest suicide rate in India- and by a substantial margin of three times the

national average and 50 per cent more than the second highest state. Lay theories abound as to why this trend is occurring. Some point to a gap between the high level of education obtained by many Malyalis and the lack of commensurate jobs. Others allege that the problem stems from a loss of tradition and its accompanying moral and spiritual fortitude through media and modernizing influences (such as the proliferation of satellite)TV and the breakup of the extended family) or blame the effects of urbanization. The rate of psychopathology is also believed to have increased through similar influence according to mental health professionals in Kerala.

Relating with Mental Illness

Western reports indicate that over 90% of those who commit suicide suffer from a psychiatric disorder. Findings of an extensive systematic review (Bertolote and Fleischmann 2002). "98% of those who committed suicide had a diagnosable mental disorder". Over 80% of the cases (studies) came from 3 countries only, namely UK, USA, Denmark. In contrast to this, a specific mental disorder was documented in 8.2% of the subjects, in the Bangalore study. Regular and problematic alcohol usage was recorded in 14.3% of men and 0.6% of women. 1.2% of the subjects had attempted suicide on earlier occasions. Association with 'clinical depression' was substantially lower than Western reports. These differences need to be interpreted with caution. Were conditions/information for the establishment of psychiatric diagnosis inadequate? Which is more suitable in non-western settings psychological authority autopsy vs. "socio-cultural autopsy"? These questions need to be answered.

Sometimes, suicide is due to purely psychological failures. Suicide is an individual phenomenon in terms of processes occurring within the psyche of the

person. It indicates a series of progressive changes from deep love of life, to a desire to escape from life and all that it implies. The psychological factors behind suicides are very powerful and important and that which led to suicide are depression, loneliness, deprivation, anxiety, fear, guilt, inferiority, rejection and despair. They produce a negative or bad psychological reaction.

It is a faith that psychological factors do cause suicide, we cannot ignore the sociological factors and causes behind suicidal deaths. Some of the reasons enumerated by the National Crime Records Bureau, Ministry of Home Affairs, Government of India, as the causes of suicide are poverty, sudden fall in economic status, unemployment, marital conflicts, breakdown of the joint family system and urbanization are other reasons cited by the NCRB statistics. Rapid social change due to technology, urbanization and industrialization is bound to lead to the creation of social flotsam and jetsam people, who being unable to lead with the pressures of rapid social change, tend to drift every from the mainstream of society and come to be labeled as "misfits" and other similar terms. Such people may react by taking to drugs or to self-immolation. Whenever changes spread fast, they disturb the social equilibrium and place new demands on the members of the society. Mannheem (1940 – 56) opined that people are unable to establish and maintain a coherent life plan when there is sudden change. Cooley remarked that changes induced disruption can become like a disease to the people.

Other sociological causes for suicide an enumerated by various sociologists are insanity, dreaded diseases, disgust in life; quarrel with in laws, failure in love affairs failure in examination, undesirable conditions at home, use of intoxicants, lack

or parental love, poor parent – child relationship (too harsh treatment) authoritarian attitude, and personality clashes are make emotional imbalance adversely and may induce persons to resort to taking of extreme step.

In a way, people's inability to face responsibilities and challenges in life compel to commit suicide. A person develops pessimism when he feels that he has fallen very low in his own estimation and also in the estimation of people whom he values. Thus it is to say these are some of the factors for the cause of suicide. Finally, at the outset it may be clarified that behind every suicide there can be multiplicity of etiological factors.

It is only one side of the picture on the other side we see terrible impact of suicide caused to the family members. This thesis throws light on the causes of suicide and its impact on the family members in the capital city of Kerala.It shows the highest suicide rate during the last 20 years are in the districts of Kerala.