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A Review of Sociological Theories of Suicide and Their Relevance in Sri Lankan Context

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Summary

Suicide is one of the leading causes of mortality in Sri Lanka (Ministry of Health Sri Lanka, 2001). It causes a major burden to the individual, family, the health care delivery system and the society at large. In addressing this important issue in an aetiological perspective, examining sociological theories is of special value, considering the high rate of suicide, which cannot be solely explained by mental ill health of the population.

The earliest sociological explanations for suicide were presented by Emile Durkheim, a French sociologist in 1897(Durkheim,1951). He described four sociological theories of suicide, namely anomic, egoistic, altruistic and fatalistic. The social elements described were subsequently expanded by several other sociologists. These include theories of social isolation, role conflict, imitation, reaction from the society, opportunity, social integration and rational suicide.

The understanding of the sociological theories would help researchers and service providers to focus on an important, yet neglected aspect of the role of the society in relation to the high rate of suicide in the country. In addition, it is of value in formulating preventive strategies in a broader perspective. This paper discusses the sociological theories with case examples from Sri Lanka.

Introduction

Suicidal behaviour leads to major social and health problems in many countries in the world. In year 2000, worldwide estimated suicide mortality rate was 16 per 100,000 population, with wide variations between countries. The World Health Organization reports an increase of over 60% during the past 45 years (World Health Organization, 2001). In Sri Lanka, according to the Annual Health Bulletin, in 1999, rate of suicide per 100,000 population was recorded as 30.1 with the rate for males being 44. Though the latest statistics suggests a decreasing trend, the rate is very high compared to10.5 per 100,000 in India. Sri Lanka currently falls into the first ten countries with high rates of suicide in the world (World Health Organization, 2001).

Patients presenting with suicidal behaviour could be broadly divided into two groups; those who are likely to complete the act and those who imitate the act to draw attention. The first category has certain characteristic behaviour pattern such as, taking all the precautions to avoid discovery of the act, leaving a suicidal note and making arrangements for the final act, whilst the second group has no real intention of dying. Inspite of differences, there is a big overlap between the two groups. In 1982, Abeysinghe reported that the majority of suicides in Sri Lanka are youth who attempt suicide on an impulse using lethal agents due to easy availability. This convenient use of lethal agents explains the high rate of suicide (Abeysinghe, 1987). Hence rate of suicide is high though the act is non-intentional. Various terms are being used to describe the second group; attempted suicide, parasuicide and deliberate self harm (DSH) . Deliberate Self-Harm is described as an act of non-fatal injury to self, by means of physical injury, drug overdose or poisoning, carried out with the knowledge that it is potentially harmful. In the case of drug overdose it is assumed that the patient knew the amount taken was excessive (Morgan., Cox , Pocock ,1975). This term DSH is currently used worldwide.

Among the patients admitted to hospital after suicidal behaviour, only a minority has psychiatric disorders, the rest facing difficult social problems (Gelder, Gath, Mayou, and Cowen, 1996). Many factors within the individual, family, community, peer group and society are said to have a correlation with the suicidal behaviour. In the absence of definite evidence for these associations, theories and explanations have been postulated to explain the link. These include the biological, psychological and sociological theories.

Biological theories suggest the possibility of genetic traits and frank mental illnesses playing some part in the suicidal behaviour. According to psychological theories, parental neglect or deprivation in childhood, aggression towards self, attention seeking behaviour are some of the explanations of suicidal behaviour. On the other hand sociological theories examine the social circumstances in which the members of the community live. The mental state of an individual is also influenced by the society in which he lives. Therefore, sociological theories are relevant in a psychological context, too.

Social variables that are described consistently in studies related to suicide include unemployment, social marginalisation and isolation, poverty and recession. Unemployment is a significant variable found to be related to suicide (Platt,1992).

Studies related to suicide at present have mainly focused on the presentations of suicide and management practices in the context of the individual. The sociological theories have not been fully explored as a link to the high rate of suicide in the country. Sociological theories may challenge the view that suicide is essentially an individual act. This may also result in taking into consideration social and cultural factors in the prevention strategy.

Therefore, this article attempts to examine the sociological theories of suicide in respect of the situation in Sri Lanka. Review of the literature with illustrative case examples from patients admitted to hospitals and other attempts in the community are discussed.

Sociological Theories: Emile Durkheim' s sociological theory

Emile Durkheim proposed four types of suicides: anomic, egoistic, altruistic and fatalistic. This was the first sociological theory on suicide.

1. Egoistic Suicide:

This suggests that when bonds between a person and society are few or weak suicide can occur.

According to this theory, vulnerable people have very weak links with the society, and therefore act independently of social norms; rules and obligations with resultant individualistic behaviour, thus making him vulnerable to self-regulated suicidal behaviour.

Further, egoistic suicide is said to be varying inversely with the degree of integration in religious society, domestic society and political society (Deflem,1999). Catholic countries generally tend to show a low rate of suicide than Protestant countries. Protestants show less religious integration and lack of traditional beliefs and practices permitting free inquiry (Durkheim, 1951).

Marriage, which leads to strong ties with the domestic society, correlates with lower rates of suicide. Rate of suicide was lower in married as compared to unmarried (Gelder, Gath, Mayou,Cowen, 1996). However, studies have revealed that among the married who commit suicide, variations exist according to gender from society to society (Deflem, 1999).

Political affiliations specially war situations, political revolutions and other forms of political crisis have lead to reduction in the number of suicide. The reason being such crisis or political activities increases the collective sentiments and encourages integration to challenge or to work against a common enemy. The situation at least temporarily creates strong social integration among people (Deflem, 1999). However, in the present Sri Lankan context, there is an ongoing war in parts of the country with repercussions on the rest of the country. Yet, the suicide rates are high. Possible explanation could be that though there is a "war" in the country, people may not perceive it as a "real war" with the collective efforts to "fight a common enemy". Rather they would feel the repercussions in the form of poverty and continued stress, which increases the vulnerability to suicide.

Based on Durkheim' theories, it is also suggested that suicide is a function of social isolation. Suicide occurs most commonly among people who lack stable relationships (Douglas, 1967). This further emphasizes the protective effects of social bonds on suicidal behaviour as described by the egoistic theory.

2. Altruistic suicide:

Altruistic suicide is supposed to occur when bonds between a person and society are overly strong, saicide occurring as a sacrifice with consequent praise from the society. In the primitive societies, subordinates were compelled to give the life to protect their superiors. In modern society altruistic suicide can be observed in the army and mostly in non-conventional fighting groups (Durkheim, 1951). The altruistic suicide is rarely reported in affluent societies. However, it is not so uncommon in South Asian

Countries.

Suicide bomber's behaviour as seen in Sri Lanka could be explained by altruistic theory of suicide, where they sacrifice life for the perceived cause of helping the group they belong to. Their behaviour is highly appreciated by the immediate sub culture. However the authors are not in a position to analytically describe the psycho-dynamics of the behaviour of suicide bombers, since first hand information is not available at this point.

3. Anomic Suicide:

This theory considers suicide to occur when the regulation exercised by the society over an individual's behaviour becomes too weak. The behaviour of individuals is disturbed by the collective order. Whenever serious readjustment takes place in the society, whether or not due to sudden growth or to an unexpected catastrophe, men are more inclined to self-destruction (Durkheim, 1999).

The difference between egoistic suicide and anomic suicide is that in the former, the person is not governed by societal norms and regulations when they are existent, and in the latter there are no norms and regulations in the subculture to govern individual's behaviour.

In Sri Lanka, suicide in agricultural resettlement areas could be explained by anomic suicide. In these areas, families from different parts of the country, with different values and norms are settled in agricultural areas to promote agricultural economy. However, serious problems occur as a result of different people coming together to make a living. There are no norms and regulations governing the behaviour of the new group. Due to lack of emotional and social support, people find it difficult to cope. As a result, some of them attempted suicide. In Mahaweli resettlement areas nearly 70% of reported deaths were suicidal (Silva, 1996). In support of this theory one could cite the high rates of suicides in Mahaweli resettlement areas compared to the traditional settlements.

4. Fatalistic Suicide

The theory explains suicide to be contemplated when the regulation exercised by the society over an individual's behaviour becomes too strong. Here the person suffers from strong oppressive social order and set of laws. A socially integrated individual may suddenly find himself in a social situation where the existing old rules may no longer be applicable to his life. This could pose a considerable stress to the individual promoting suicidal behaviour.

In Sri Lanka the children of families with high ambitions and high integration attempt suicide when they could not obtain desired results at competitive high academic examinations. In clinical practice, it is seen that students attempt suicide not because they fail, but because they are unable to obtain very high results in these examinations to fulfil the expectations of elders and their teachers. In these instances, the elders in the family and teachers pay much attention to academic learning, and child learns that the links with his immediate society is highly dependant on academic achievement. He attempts suicide when this link is no longer cherished by the immediate subculture, due to academic under achievement. He finds it devastating to his life as existing laws of sub culture are non existent now.

Apart from these theories, Durkheim identifies the following major social elements for suicide; the nature of the individuals composing the society, their associations that form the nature of the social organisation, the transitory occurrences which disturb the functioning of the collective life without changing its anatomical constitution such as national crisis and economic crisis (Durkheim,1951).

Role Conflict and Suicide

Jack Gibbs and Walter Martin have described suicide as a phenomenon related to role conflict. Rate of suicide has increased when people find it impossible to carry out the several roles they are presented with by the society (Gibbs, Martin, 1964).

In our clinical experience, role conflict has not been observed as a common cause of attempted suicide in Sri Lanka. Instead, many people who attempt suicide are seen to have problem of not having defined role or roles in the community they live. This common occurrence in Sri Lanka is related to egoistic suicide as described by Durkheim. When there is no defined role expected of the individual, by the society, it leads to weakening of the ties. Thus his behaviour is less governed by the norms of the society. This finding may be of interest to the researchers in Sri Lanka.

Suicide and Imitation

David Phillips and K. Bollen proposed imitation theory in their presentation named "Imitative Suicides".

In *the American Sociological Review* in 1982. This is the copycat effect involved with suicide. Glamorisation of suicide when reporting in media has an impact on the other members of the society. Deaths of celebrities, heroes and entertainers by suicide have been followed by an

increase in rate of suicide among the general public (Stack, 1987). Adolescents are seen to be more vulnerable to this kind of suicidal behaviour.

Case Example

A 28-year-old three-wheeler (a form of a taxi) driver was admitted to a hospital in Colombo suburb after consuming a pesticide following an argument with his wife. In the same year, two of his friends had committed suicide by the same method over problems with their girlfriends. It was seen that when such a suicide occurs the society often blames the spouse. During the interview, he revealed that when the crisis was not resolved with his wife, he looked for options. There was nobody to whom he could confide in. He could not see a solution to his problem and remembered the incidents associated with his friends suicide. He remembered the sympathy his friends received though they were dead. He impulsively consumed pesticide and told his wife which led to the admission. In this example, the individual has learnt the suicidal behaviour, as a way of coping with problems, which he perceived as insolvable.

Society's reaction to suicide

According to this explanation, in a society where suicide is condemned, the rate will be low and where it is accepted, the rate is high (Durkheim, 1951). When the society accepts suicidal behaviour, more and more members will be inclined to such behaviour in the face of adversity. Low rates of suicide in Islamic countries and among Roman Catholics as opposed to Protestants are cited as examples.

Sri Lanka, though predominantly of a Buddhist culture, which condemns the act of killing self, the attitude has not influenced the rate of suicide. At present, the reaction of the society at large to an act of suicide is sympathy with concurrent hostility towards others who are perceived as creators of problems to the deceased. Newspapers too evoke emotions enhancing this effect, and as a result, reaction of the society is not towards condemning the act but to encourage those who are inclined to carry it out. Hence, today Sri Lankan society indirectly encourages the suicidal behaviour. Our clinical experience too supports this theory.

Theory of Rational Suicide

Jacques Choron, in his controversial book "Suicide" proposed the phenomenon of rational suicide. This is described in normal people whose motives can be justified by the actions of contemporaries facing similar

circumstances (Choron, 1972). Severely ill patients wanting to die are also included in this category by Choron. Based on these authentic requests for suicides, a debate is underway to ascertain whether a person has the right to die. It was evident that both the proponents and opponents of this theory have strong support. It is interesting to note that some countries have liberalized laws to allow euthanasia.

Currently, in Sri Lanka, euthanasia is not allowed and is considered an offence. In our clinical practice, euthanasia is rarely heard of. Even otherwise, it is difficult to justify this suicidal behaviour on the norms prevailing in a country where rates of suicide are very high. A decision, which is rational to one, may not be rational to another person, in the presence of diverse aetiological factors. Hence, in the near future, in Sri Lanka euthanasia could not be justified.

Opportunity and Suicide

James Gundlach pointed out the importance of opportunity for suicide in a society (Gundlach, 1990). According to him, if the opportunities for suicides are great in the society, the rates of suicides and attempted suicides are bound to increase. Widespread gun ownership in the United States has shown to have a bearing on the mode and rate of suicide and an opposite trend in countries where firearms use is restricted.

In Sri Lanka, the main mode of suicide in the North Central part of the island is by ingestion of Kaneru (*Nerium odorum*) seeds owing to the widespread availability of these trees. Similarly in agricultural areas, suicide from pesticide poisoning is high. Lethality of these substances adds to the mortality by causing death, even with a very small dose, even though the intention was not there. This is supported by our clinical experience. Reduction of the availability of lethal poisons is one way of reducing deaths due to these agents. Presidential task force on prevention of suicide has already advocated a policy on cutting *Nerium odorum* trees in prevention of suicide. However, recent research shows that in urban culture, the mode of hospital admissions with self poisoning are more due to ingestion of substances which are commonly available in households like medicines and cleansing agents (Kathriarachchi, 1996). Hence restriction of availability may not be a feasible solution to reducing the rate of suicide.

Family, Religion and Suicide

Steven Stack claimed that the three measures of social integration that results in low rates of suicide: religion, children and work. These are often seen as giving life a meaning, reducing the acceptability of suicide (Stack, 1982).

Social disruption associated with the early stage of urbanization had been considered as a cause for high rates of suicide (Stack, 1982). According to Stack when the urbanization process began, people moved from rural to urban, which resulted in loss of family ties. Mostly it is individual members and not the family as a whole who migrate. However, in the later stages of urbanisation, people tend to move as a family due to availability of basic facilities.

Pescosolido in her paper "The Social Context of Religious Integration and Suicide" published in the Sociological Quarterly in 1990 (Pescolido, 1990) had put forward the theory of religious network having an impact on prevention of suicide. Long-standing religious infrastructure such as religious social clubs and schools, which promote networking and integration, will reduce the rate of suicide. Such structures promote friendship ties and social support. Especially a non-hierarchical religions culture, leads to a low svilidel rate in the society.

In our clinical experience we have found that people who are directly involved in religious activities of a non- hierarchical structure, rarely present to hospitals with attempted suicides. Similarly we have found that employed people attempt suicide less often than unemployed. In our chinical pracbice we see mothers of young children attempt suicide more often, contrary to this theory. In the case of the mothers, the problems they face are enormous and they attempt suicide as a way of coping. This observation needs to be examined thoroughly in a sociological and psychological perspective to understand the motive.

Applicability of the theories on suicide in Sri Lankan context

Suicidal behaviour is one of the leading causes for hospital admittance in Sri Lanka and is one of the leading causes of mortality (Ministry of Health, 2001). Medical officers in general medical wards as well as psychiatric units have to spend a considerable time caring for these patients.

Some of these people demonstrate suicidal behaviour in order to manipulate others, which is common among adolescents and young adults. Sometimes, inadvertently they may die as the person underestimates the lethality of the ingested poison. Though every individual showing suicidal behaviour needs to be taken seriously, a distinction has to be made between the types of impulsive and manipulative behaviour from the serious suicidal behaviour.

Some of the Sri Lankan examples of suicidal behaviour may be explained by the theories described by Durkheim and other sociologists.

The suicidal behaviour occurring in the middle aged and elderly population may be explained by theories of egoistic suicide and social isolation. In order to prevent suicidal behaviour in the elderly population, one has to facilitate a meaning-full life by providing links to the society.

On the other hand, in fatalistic suicide, where the problem is the control by the society being too strong, ways of reducing the stress on the individual, need to be focused on prevention. Many attempted suicides by the youngsters due to difficulty in fulfilling parental expectations can be reduced if the society at large understands the repercussions on the individual by the pressure the society imposes on him. When the youngsters fail to match the expectations of the society, there is a perceived loss of the status of the individual, leading to suicidal behaviour. Hence education on parental behaviour to reduce demands on children is important in reducing suicide among this group.

In agricultural resettlement areas, norms and regulations of the society are virtually non-existent, the suicides that take place are explained by the theory of anomiç suicide. Improving the quality of life by appointing village leaders, societies to regulate functions of sub groups such as children, women and farmers could be considered as suitable preventive measures.

Examining the theories of imitation and reaction of the society to suicide is very important, in the present context of the society. Media glamorisation of suicide of youngsters and the sympathetic attitude they learn from the society lead to imitation by other vulnerable youngsters. By minimising the glamorisation and by changing the attitudes of the society, imitation could be counteracted. These theories are of utmost importance and remedial measures could be tried by educating the media and the public.

In addressing the opportunity and suicide theory, restriction of available lethal poisonous agents is important in reducing the high rate of

suicidal behaviour. Presidential Task Force on suicide prevention has already advocated this policy. However, with the free availability of agricultural poisons, poisonous plants and over the counter purchase of medicines, restrictions cannot be fully enforced.

Position of the family, religion and work are important in examining the resilience to suicidal behaviour. These could be reinforced in a meaningful manner at the level of the society to eliminate the suicide menace from the country. Job satisfaction, children and non-hierarchical religious structures are useful tools in prevention. However, these cannot be easily achieved in the present crisis situation of the country when opportunities are limited. At the same time, a thorough examination is needed to understand the suicidal behaviour in mothers of young children, contrary to the theory of family, religion and suicide; where children are supposed to form a buffer.

Further, unemployment and poverty are some of the social factors associated with suicidal behaviour in studies carried out in other countries (Deflem, 1999).Sri Lanka, with a very low per capita income, having a high suicidal rate may warrant inquires in the future, regarding the relationship of the poverty to suicide in a sociological context.

Due to the multifactorial nature of suicide in Sri Lanka, preventive steps also need to address a wide range of issues, such as alleviating poverty, empowerment of vulnerable groups, reduction of the stress on the individual by changing attitudes of the society to suicide and providing links to the society. While the above steps form the primary prevention, developing guidelines on assessment of patients who attempt suicide would be of value in secondary prevention (Kathriarachchi, 2000).

In conclusion, examination of sociological theories of suicide in Sri Lankan context is of importance in understanding the suicidal behaviour and its prevention.

References

Abeysinghe, R. (1987), Suicide in Sri Lanka, *'Trends and prevention, in prevention of some common medical problems in Sri Lanka'*, Peradeniya Medical School.

Choron, J. (1972), *Suicide*. New York: Charles Scribner's Sons.

Deflem, M.(1999), *Classical Sociological Theory; A Review of Themes, Concepts and Perspectives*, Purdue University.

Douglas, J. D (1967), *Social Meaning of Suicide*. Pnnaton: Princeton University Press.

Durkheim, E. (1951), *Suicide,* Trans, Spaulding, J. A. and Simpson, G. Glencoe: The Free Press.

Gelder, M. Gath, D. Mayou, R. and Cowen, P.(1996), *Oxford Textbook of Psychiatry* Oxford: Oxford University Press, 414 - 437.

Gundlach, J. (1990), 'Absence of Family Support, Opportunity and Suicide', *Family Perspective*, 24: 7-14.

Jack, Gibbs, and P. Martin, W. (1964), Status, Integration,and Suicide, Eugene University of Oregon Press.

Kathriarachchi, S. T. (1996), 'An investigation into the psychosocial assessment of patients with deliberate self-poisoning admitted to the General Hospital Colombo', M D Dissertation, Post Graduate Institute of Medicine, University of Colombo.

Kathriarachchi, S.T. (2000), 'Audit of Deliberate Self-harm (DSH)', *Journal of the Ceylon College of Physicians*, 33: 135 - 137.

Morgan, H.G Cox. C.J., Pocock, H.P (1975), 'Deliberate self harm, Clinical and socioeconomic characteristics of DSH patients'. *British Journal of Psychiatry*, 127: 564-574.

Ministry of Health Sri Lanka. (2001). *Annual Health Bulletin*. Colombo.

Pescosolido, B. (1990), 'The Social Context of Religious Integration and Suicide: Pursuing the Network Explanation', *Sociological Quarterly,* 31: 337-357.

Platt, S. (1992), 'Suicide and Unemployment in Italy', *Social Science and Medicine*, 34: 1191-1201.

Stack, S. (1987), 'Celebrities and Suicide'. *American Sociological Review,* 52: 01-412.

Stack, S. (1982), Suicide: A Decade Review of the Sociological Literature, *Deviant Behaviour*, 4: 41-66.

World Health Organization (2001), *Global Suicide Rates,* Geneva.

World Health Organization (2001),SUPRE-WHO, *A Programme on Suicide Prevention,* www.whosa.org/it/text/14 suicide.html.