24

Dalit Suicides in India

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As the previous chapters have highlighted, Dalits in India have historically endured marginalization and been among the most disadvantaged populations in the country. Since suffering has been known as one of the major reasons for voluntarily ending one's life (Minois, 2001), suicide rates among Dalit populations are expected to be high, especially compared to 'general' populations.

Suicide is a serious, yet preventable public health issue. Initially recognized as an entirely psychological phenomenon, suicide is now ubiquitously accepted as a multifaceted issue with various social, cultural, psychological, and biological aspects usually underlying the causal pathway. One of the indicators of suicide being a multidimensional issue is the consistent variation observed within and between countries and regions by different socio-demographic variables, instead of simply fluctuating between areas with higher or lower prevalence of mental health issues. In 2016, there were an estimated 7,93,000 suicides worldwide, a rate of one suicide every 40 seconds (World Health Organization [WHO], 2016). The global suicide rate in 2016 was 10.6 per 1,00,000 population, with higher male suicide rates (13.5 per 1,00,000 population) than female (7.7 per 1,00,000 population) (WHO, 2016). Overall, approximately 79 per cent of all suicides occurred in low-and-middle-income countries (LMICs).

India has some of the highest suicide rates in the world. According to the Global Burden of Disease (GBD) study estimates, in 2016, there were more than 2,00,000 suicides in India accounting for 25 per cent of male and 37 per cent of female suicides globally (Dandona et al., 2018). Rates in India are higher among males (21 per 100,000) than females (15 per 100,000), and while rates have declined among females, male rates have remained stable for the last 30 years (Dandona et al., 2018). Nevertheless, in 2016, India had the third highest female suicide rate in the world (WHO, 2016). Suicide rates in India are known to differ by socio-demographic factors such as geography, age, sex, marital status, method, and

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markers of educational achievement (Mayer, 2010; Arya et al., 2018; Arya et al., 2019a). While studies in the past have hypothesized that suicide rates in India likely differ by religion and caste status, very few studies have reported suicide rates by religion, while almost none have reported them by caste status. Importantly, barring a solitary study (Arya et al., 2019b), none of the recent studies have reported national or state-wise suicide rates in India by religion or caste status.

Paucity of Data on Dalit Suicides

Why have studies largely ignored reporting suicide rates by religion and caste status at the national or state level? A key explanation relates to the lack of recording of suicide cases in India by religion and caste status. The National Crime Records Bureau (NCRB) is a government organization that records and reports crime data based on police reports collected from each state and union territory in India. The NCRB has been reporting on suicide cases in India since 1967 and is the only national-level, publicly available data source on suicide in the country. Suicide data in India are first recorded at the local level, then aggregated at the district level, then at the state level, and finally at the national level, which are then presented in NCRB reports (NCRB, 2018). While the NCRB provides suicide cases stratified by factors such as sex, age, and method, among others, they do not report suicides by religion or caste status. The reasons for this are not clear, but it might be because of the perceived sensitivities around religion and caste status and fears relating to the politicization of suicide in India (Mayer, 2010).

There is another data source for suicides in India which is based on the Sample Registration System (SRS). Despite the Registration of Births and Deaths Act of 1969, which makes it compulsory to report births and deaths, birth and death registrations are under-enumerated in most Indian states (SRS, 2020). To counter this problem, the SRS, which uses the verbal autopsy method to record all the births and deaths in a nationally representative sample of 1.1 million households, came to be used (SRS, 2020). The SRS recorded suicide deaths between the years 2004 and 2013. While SRS data better enumerates suicide deaths than NCRB data (Arya et al., 2020), verbal autopsy data are not publicly available. Furthermore, similar to NCRB reports, the SRS and GBD data do not report suicide cases by religion or caste status.

Dalit Suicides in 2014 and 2015

In 2014 and 2015, the NCRB recorded information on the caste and religion of suicides for the first time; however, they are yet to publish this information.

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Arya, one of the authors of this chapter, managed to obtain this information under the Right to Information (RTI) Act (Roberts, 2010).[1] The NCRB provided suicide cases by religion and caste status for 2014 and 2015, stratified by all states and union territories but not by any other demographic factors normally presented in the publicly available NCRB reports (for example, sex and age).

The NCRB data showed that there were a total of 38,106 Dalit suicides in India in 2014 and 2015 with a national rate of 9.4 per 1,00,000 population. In contrast to the hypothesis that Dalits might have the highest suicide rates, higher suicide rates were noted among members of the Scheduled Tribes (STs) (10.7 per 1,00,000) and 'general' populations (15.0 per 100,000) (Arya et al., 2019b). However, there was substantial geographic heterogeneity in Dalit suicide rates observed across different regions in India (Figure 24.1), with

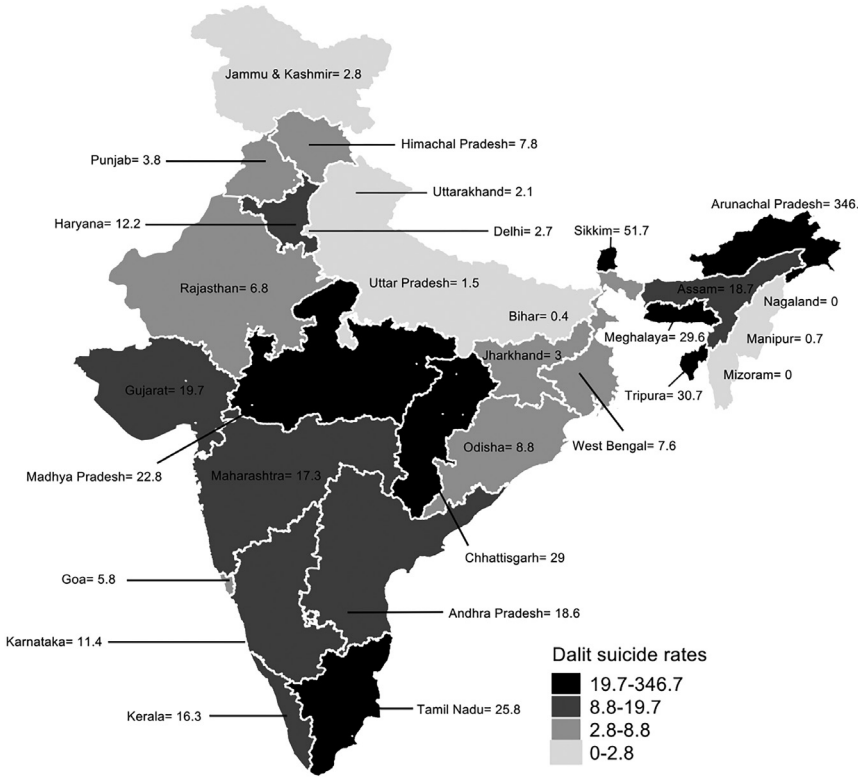

Figure 24.1 Dalit suicide rates in India, 2014–15

Source: Map compiled by the authors.

Note: Map not to scale and does not represent authentic international boundaries.

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some of the highest Dalit suicide rates observed in the states of Chhattisgarh, Madhya Pradesh, and Tamil Nadu. Some of the north-eastern states also noted high Dalit suicide rates, but that is due to the small Dalit population numbers in this region; also the number of Dalit suicides in this region were generally low (Table 24.1).

Table 24.1 State-wise Dalit suicide rates and Dalit population percentage, 2014–15

	Dalit suicide rate/1,00,000 (95 per cent CI)	**Dalit population by state (per cent)**
North India		
Jammu and Kashmir	2.8 (2.1–3.7)	7.4
Himachal Pradesh	7.8 (6.9–8.8)	25.2
Punjab	3.8 (3.5–4.1)	31.9
Chandigarh	13.3 (10.5–16.7)	18.9
Uttarakhand	2.1 (1.6–2.6)	18.8
Haryana	12.2 (11.5–12.9)	20.2
Delhi	2.7 (2.3–3.1)	16.8
Rajasthan	6.8 (6.5–7.1)	17.8
Uttar Pradesh	1.5 (1.4–1.5)	20.7
North–east India		
Sikkim	51.7 (35.1–73.3)	4.6
Arunachal Pradesh	346.7 (258.9–454.6)	0.6
Nagaland	–	–
Manipur	0.7 (0.0–4.0)	3.4
Mizoram	–	0.1
Tripura	30.7 (27.7–33.8)	17.8
Meghalaya	29.6 (12.8–58.4)	0.6
Assam	18.7 (17.5–20.0)	6.9

(*Contd*)

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Table 24.1 (*Contd*)

	Dalit suicide rate/1,00,000 (95 per cent CI)	Dalit population by state (per cent)
East India		
Bihar	0.4 (0.4–0.5)	15.7
West Bengal	7.6 (7.3–7.8)	23.5
Jharkhand	3.0 (2.6–3.4)	12.1
Odisha	8.8 (8.3–9.3)	17.1
Central India		
Chhattisgarh	29.0 (27.6–30.5)	12.8
Madhya Pradesh	22.8 (22.0–23.7)	15.6
West India		
Gujarat	19.7 (18.7–20.6)	6.7
Daman and Diu	5.4 (0.1–30.0)	2.5
Dadara and Nagar Haveli	26.3 (7.2–67.4)	1.8
Maharashtra	17.3 (16.8–17.8)	11.8
Goa	5.8 (1.6–15.0)	1.8
South India		
Andhra Pradesh	18.6 (18.1–19.1)	16.2
Karnataka	11.4 (10.9–11.9)	17.1
Lakshadweep	–	–
Kerala	16.3 (15.4–17.3)	9.1
Tamil Nadu	25.8 (25.1–26.4)	20
Pondicherry	54.0 (47.7–60.8)	15.7
Andaman and Nicobar Islands	–	–
Total	**9.4 (9.3–9.5)**	**16.6**

Source: Arya et al. (2019b).

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Table 24.2 Dalit suicides and social discrimination

Correlations	
Social discrimination variables (per cent)	**Scheduled Caste (SC) suicide rate, 2014–15**
Households practising untouchability	Pearson correlation = –0.029 Significance (2-tailed) = 0.908
Dalits who have experienced untouchability	Pearson correlation = –0.049 Significance (2-tailed) = 0.846
Dalit women with body mass index (BMI) < 18.5, 2005–06	Pearson correlation = –0.034 Significance (2-tailed) = 0.893
Dalit infant mortality rate, 2005–06	Pearson correlation = –0.237 Significance (2-tailed) = 0.345
Dalit with no latrine, 2008–09	Pearson correlation = –0.038 Significance (2-tailed) = 0.881
Rural poverty ratio, 2004–05	Pearson correlation = –0.180 Significance (2-tailed) = 0.474
Dalit population, 2011	Pearson correlation = –0.421 Significance (2-tailed) = 0.082

Source: Desai (2015); Mehrotra et al. (2011); EPW Research Foundation (2011); Census of India (2011).
Note: This and the following table do not include Goa, Jammu and Kashmir, Assam, Sikkim, the union territories, and the states of north-east India.

Given the disadvantaged position of Dalit populations in Indian society, it is surprising to find lower suicide rates among Dalit populations compared to 'general' populations. Furthermore, there was no correlation between Dalit suicide rates and the practice or experience of untouchability or with measures of economic deprivation (Table 24.2).

Minority Status and Dalit Suicides

Emile Durkheim's (1897) work on suicide, which is perhaps the most influential exploration of suicide in the field of science in general, and sociology in particular, argued that in certain circumstances minority status might have a protective

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effect on suicide (for example, the hostility faced by minority populations might 'toughen' them). By contrast, the minority stress theory posits that the discrimination and hostile social environment toward minority populations are associated with increased mental health problems and suicidal behaviour (Meyer, 2003). In the Indian context, it is conceivable that Dalits residing in regions with higher Dalit populations endure a less hostile and stressful environment compared to regions with a lower percentage of overall Dalit populations. Social deviancy theories also support this argument where social deviancy is not related to individual deviant behaviour but is based on interpersonal relationships constructed through the availability of peer groups (Wechsler and Pugh, 1967).

Despite these hypothesized relationships, we find that there was only a weak negative correlation between the state-wise Dalit population percentage and Dalit suicide rates (Table 24.2). This supports a general pattern of higher Dalit suicide rates among states with a lower percentage of Dalit populations compared to states with higher Dalit populations (this was the case for the ST and the Other Backward Classes (OBC) categories as well) (Arya et al., 2019b).

Dalit Suicide and Education

Dalit suicide rates were found to be positively corelated with some of the indicators of human development (for example, Dalit enrolment percentage in higher-secondary education) (Table 24.3). This is a curious finding given that increasing education is generally perceived as empowering. Furthermore, generally, suicide rates are higher among less educated groups compared to more educated groups, especially in high-income countries (Phillips and Hempstead, 2017). However, higher levels of education have been associated with higher suicide rates in India (Mayer, 2010; Patel et al., 2012; Arya et al., 2018). One reason for this disparity might be that literacy rates are an indicator of modernization and social change in India. Modernization and social change might result in an increasing gap between expectations and reality, especially among Indian youth, leading to higher suicide rates (Arya et al., 2018). For example, while female literacy rates have improved dramatically over the past decades, India continues to remain a largely patriarchal society, which might be resulting in increasing stress and suicidal behaviour among younger females in the country (Petroni, Patel, and Patton, 2015). It is conceivable that Dalit populations with higher levels of education are facing similar issues as the 'general' populations with higher education levels, resulting in increased risk of suicide.

It is also possible that as Dalit students attain higher levels of education, they constitute smaller percentages of the population at those levels, so their

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Table 24.3 Dalit suicides and human development

Correlations	
Education variables (per cent)	**Scheduled Caste (SC) suicide rate, 2014–15**
Dalit primary enrolment ratio, 2007–08	Pearson correlation = 0.570* Significance (2-tailed) = 0.013
Dalit upper-primary enrolment ratio, 2007–08	Pearson correlation = 0.591** Significance (2-tailed) = 0.010
Dalit secondary or higher secondary enrolment ratio, 2007–08	Pearson correlation = 0.662** Significance (2-tailed) = 0.003
Dalits in higher education, 2018–19	Pearson correlation = 0.329 Significance (2-tailed) = 0.182

Source: Mehrotra et al. (2011); Census of India (2011); Planning, Monitoring, and Statistics Bureau (2019).
Note: *Correlation is significant at the 0.05 level (2-tailed). **Correlation is significant at the 0.01 level (2-tailed).

supportive communities become smaller and their risk of suicide rises. Rakesh K. Maurya (2018: 24–25) reports:

> Participants [in a university in Uttar Pradesh] shared that they rarely face or feel caste prejudice and discrimination during elementary, middle, or high school from fellow UC [upper-caste] students. Caste-based social identities of students take shape gradually as they move towards higher education when UC students start harboring a feeling of caste-based superiority over Dalit students.

Indeed, discrimination against students belonging to Dalit or ST categories at universities has been documented previously. It has been argued that some suicide cases (for example, Rohith Vemula and Payal Tadvi) were a direct result of discrimination and abuse faced by the departed (Acharya, 2019). The coverage of such suicides by the media in India is of special concern. Indian media often reports suicides in lurid detail and ignores international best practice by presenting explicit details of suicide methods (Mayer, 2010). Research suggests that such sensationalized and simplistic media coverage of suicide may lead to 'copycat suicides' (Westerlund, Schaller, and Schmidtke, 2009). While some researchers argue that copycat suicides based on media reporting are mostly limited to celebrity suicides, most researchers agree that thoughtless media

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coverage of any suicide can potentially lead to 'copycat suicides' (Westerlund, Schaller, and Schmidtke, 2009). In the context of Dalit suicides, other Dalits in similar positions, as some of the departed mentioned previously (for example, facing harassment at university), might feel 'encouraged' to follow a similar route as a 'way out' of abusive or disadvantaged situations while also perceiving their act as a sacrifice for the greater cause. What are almost always lacking in the Indian media are links to suicide prevention organizations or helpline numbers for anyone who feels distress after reading an article.

Oppressed Minorities and Suicide

It is an obvious error to refer to 'Dalits' as though all are identical. The historical and regional experiences of India's many Dalit communities are diverse, and this observation is equally true of suicides. Dalit suicide rates are virtually identical to those of the general populations amongst whom they live ($r = 0.814$; sig @ 0.000).

Although there is overwhelming evidence that Dalits in all parts of India experience discrimination, there is an apparent paradox concerning suicide: where overt discrimination is highest, mainly in north India, Dalit suicide rates are very low (it must be noted here that suicide rates in general are low in north India compared to those in other parts of India). These are the same states where murder rates of Dalits are the highest (see Chapter 23). These relationships suggest some plausibility of Andrew F. Henry and James F. Short's 'frustration–aggression' hypothesis that where external constraints are greatest, aggression is directed outward, against others. Conversely, where external constraints are lower, these forces are directed inward (Henry and Short, 1954).

We know almost nothing about either the risk factors for suicides among Dalits or the protective factors. We find it instructive, therefore, to consider what is known of these factors, especially for adolescents and young adults, in the African-American community in the United States (Molock et al., 1994).

Historically, African Americans had low rates of suicide. According to Kevin E. Early and Ronald L. Akers (1993), suicide was actually thought to be a 'White thing' which did not happen in the African-American community. Since the 1960s, adolescent African-American suicide rates have been rising and are now virtually the same as those of European Americans (Droege, Robinson, and Jason, 2017; Oh et al., 2020). Rheeda Walker (2020) suggests that young African Americans may be 'hidden' suicide ideators, who find it difficult to share their thoughts with others or to seek counselling or other assistance.

Some of the risk factors for suicide among African Americans include the experience of racism, poverty, exposure to community violence – especially

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police violence – discrimination in access to education, and the strains of having to negotiate 'dual cultural contexts' (Oh et al., 2020; Walker et al., 2008). Conversely, factors of preservation include dense social networks and family support, high self-esteem, higher economic status, and religiosity (Droege, Robinson, and Jason, 2017).

If these factors of risk and preservation seem strongly parallel with those faced by Dalits in India, of equal relevance are some of the policy responses found in the United States. These include appropriate training for health and mental health professionals, access to such professionals – especially from one's own background – and appropriate online resources (Oh et al., 2020; Walker, 2020).

In India, suicide prevention remains largely at the zero-kilometre marker. Despite the urging of some of the nation's most distinguished psychiatrists, there is still no national suicide prevention strategy such as those developed elsewhere (Vijaykumar, 2007; Mayer, 2016). Given the paucity of mental health facilities or trained psychiatrists for most of India's population, especially its rural population, that there is no specific national strategy for the prevention of Dalit suicides requires no further comment.

This chapter highlights that there is an acute lack of data on Dalit suicides in India. The available government data from 2014–15 shows that in most states Dalit suicide rates are lower than suicide rates among 'general' populations. However, Dalit suicide rates are generally higher among regions with smaller Dalit populations (compared to regions with larger Dalit populations), perhaps reflecting greater hostility in these regions.

One of the most enduring observations in the study of suicide is that suicide rates are lowest in the most traditional societies and tend to rise with modernization and more individualistic outlooks (Durkheim, 1897). We can observe this in the geographic distribution of Dalit suicides in India which shows that suicide rates are lowest in the states of north India and higher in the south (Figure 24.1). The persistence of the multi-generational or 'joint' family serves as a proxy for the degree to which traditional social ideas remain dominant. Household size appears to be a 'lagging indicator': traditional attitudes seem to persist, even as household sizes shrink over time. Household sizes are largest in northern states such as Uttar Pradesh, Bihar, Haryana, and Rajasthan; they are smallest in Tamil Nadu, Andhra Pradesh, Kerala, and West Bengal. The correlation between the Dalit suicide rate in 2014–15 and the average household size in this period is moderately strong and in the predicted direction, but it is not statistically significant (r = –0.368; not sig @ 0.133). The correlation is stronger with family sizes in earlier years (2005: r = –0.702; sig @ 0.002; 1994: r = –0.720; sig@ 0.002). Madhya Pradesh and especially Chhattisgarh (which was separated

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from Madhya Pradesh in 2000), both of which have larger average family sizes and relatively high Dalit suicide rates, appear as significant exceptions to the general pattern of geographic distribution. Larger household size in 2015 is also positively correlated with the practice of untouchability (r = 0.539; sig @ 0.021) and the experience of untouchability (r = 0.573; sig @ 0.013).

Access to education is often associated with all aspects of human development. Generally, higher suicide rates in India are found to be associated with increases in education level. Dalit suicide rates, too, were found to be associated with measures of higher levels of education. It is possible that the reasons behind the association between higher suicide and higher education rates are impacting all population groups, including Dalits. However, it is also possible that this is because as Dalit students attain higher levels of education, their entry meets with hostility and their support systems become smaller (as they constitute smaller percentages of the population at higher education levels), increasing their suicide risk.

To that end, policymakers should turn their focus back to the recommendations from the Thorat report, which, despite its compelling findings, seems to have been relegated to the annals of the past. In 2007, the then prime minister of India, Manmohan Singh, commissioned the Thorat committee to investigate allegations of differential treatment based on the caste status of students in the All India Institute of Medical Sciences (AIIMS), Delhi (Thorat, Shyamprasad, and Srivastava, 2007). The committee found a myriad of problems related to caste-based discrimination and consequently made recommendations to tackle those issues, including remedial coaching in English; equal opportunity cells; sensitivity training for academics, administrative staff, and students; and objectivity in examinations for Dalit students. However, these recommendations are yet to be implemented in any of the Indian universities, including AIIMS. It is imperative that these recommendations are implemented in universities, not least because they might help curb suicides among Dalit or ST students. These recommendations can also be adopted in workplaces (for example, sensitivity training and objectivity for job appraisals), which might help Dalit and ST employees feel valued and secured in government or corporate environments.

Conclusion

The results of this chapter are based on preliminary data (two years of national-level data, not stratified by sex or age), and hence further research needs to be undertaken to better understand the epidemiology of Dalit suicides in India. First, the NCRB reports must include the caste status of suicides. For this to happen, all

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the suicides recorded at the local level (that is, police stations), which eventually inform the NCRB reports, must record and disseminate the caste status of suicides. The NCRB reports must, at a minimum, dissect this data by gender, age, method, and occupation at the state level. Second, suicide researchers in India should start focusing on the association between caste status and suicides. This includes such things as the incidence of depression and suicidal ideation among young Dalits, their relative confidence in seeking appropriate counselling, and the importance of potentially protective forces such as spirituality. Also, at the all-India level, we need to understand the reasons why in regions with relatively lower or smaller Dalit populations, their suicide rates are generally higher. Third, the phenomenon of 'copycat suicides' in India should be investigated to establish whether one suicide impacts or predicts rise in future suicide incidence, especially in the short term and among similar population groups (for example, among Dalit students after a Dalit student suicide). Finally, it can be predicted, with reasonable certainty, that as Dalits attain greater parity in education, especially at secondary and tertiary levels, their suicide rates will increase; this already appears to be the case in states like Madhya Pradesh and Andhra Pradesh where just over 50 per cent of Dalits are enrolled in secondary education and suicide rates are relatively high. In the absence of national suicide prevention strategies, non-governmental organizations (NGOs) working with Dalits should also work to develop community-specific strategies which can help prevent this predictable tragedy.

Note

1. The Right to Information Act, adopted by the Indian parliament in 2005, gives citizens of India a right to acquire information held by public authorities.

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