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An Exploratory Study On Suicide: A Comparative Analysis Of Gangtok And Darjeeling Sadar

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Abstract
This article examines suicide as a social fact (Durkheim) and a socially meaningful act (Douglas) in the context of two linguistically, culturally, geographically, and demographically similar collectives —Gangtok, Sikkim, and Darjeeling Sadar, West Bengal. While Gangtok, Sikkim, has a very high suicide rate, Darjeeling Sadar's suicide rate is underestimated, and suicidal deaths are underreported. This article argues that the underreporting from this society is due to the culturally interpreted meanings by the collective. Therefore, this article connects the suicide data with the social factors of suicide. This work utilizes a mixed method and a comparative design. It addresses the analysis of 447 suicide cases of Gangtok and 147 cases in Darjeeling Sadar, further addressing the problem of underreporting and underestimation of suicidal deaths in Darjeeling. Additionally, five case studies and conversational analysis will also be reflected. The major findings revealed that socio-economic differences also affect suicide rates of different collectives. Both Gangtok and Darjeeling Sadar comprise Nepali-speaking communities with similar ethnic distributions like the Rais, Bhutias, Sherpas, Magar, and other communities. Gangtok is the economic and administrative capital of a State, but Darjeeling Sadar is a subdivision of a District. Due to these contrasting political, administrative, and economic differences, there is also a difference in how suicidal deaths are treated in these collectives.

Keywords: *Suicide, Social fact, Social meanings of suicide, Gangtok, Darjeeling Sadar.*

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I. Introduction

Suicide is a decisive act by an individual who is anticipating death. It is an individual act of "ending one's life earlier than it would otherwise have ended" (Kagan, 2012, p. 318). Durkheim defines suicide as "all cases of death resulting directly or indirectly from a positive or negative act of the victim himself which he knows will produce the result" (Durkheim [1897], 2005, p. xlii). It is a global issue that accounted for 727,000 deaths in 2021 (World Health Organization, 2021), an increase from 703,000 in 2013. India accounted for 170,942 suicidal deaths in 2022, with a rise of 4.2% compared to 2021 (National Crime Records Bureau, 2022). The top five countries with the highest suicide rates, according to the World Health Organization (WHO) in 2021, are Lesotho (36.7), Eswatini (31.8), Guyana (26.3), Kiribati (17.5), and the Federated States of Micronesia (19.8). Globally, suicide is the second leading cause of death in the 10-24-year age group and the third leading cause of death among 15-29-year-olds, where more than half of global suicides (56%) happened before the age of 50 years. Suicide is the second leading cause of death in 15–19-year-old girls and the fourth leading cause of death among males of this age group (Suicide Worldwide in 2021). Adolescents, 10-19 years of age, who died by suicide belonged to a low-income or middle-income countries.

73% of global suicides occurred in low and middle-income countries in 2021, according to the World Health Organization (WHO). Rates of suicide in Eastern European countries like Belarus, Estonia, Lithuania, and the Russian Federation are the highest in suicide. Sri Lanka has also reported a high suicide rate, according to the WHO Regional Office for South-East Asia. Lower rates of suicide are found in Colombia, Paraguay, the Philippines, Thailand, and Haiti in 2003, with 86% percent of all suicides occurring in the low and middle-income countries (Radhakrishnan and Andrade, 2012, p. 305). Suicide rate among men has continued to be twice as high as that of women globally, with 12.3 per 100,000 vs 5.6 in 2021, and the gender gap in high-income countries is in a 3:2:1 ratio, according to the International Association for Prevention, 2025.

The data on suicide in India is retrieved from the National Crime Records Bureau report on Accidental Death and Suicide in India, 2022. Of the 170.942 deaths in India in 2022, Maharashtra (22,746), Tamil Nadu (19,834), Madhya Pradesh (15,386), Karnataka (13,606), and West Bengal (12,669) reported the highest suicides, accounting for 49.3% of the total suicides reported in the country. The highest suicide rate was reported in Sikkim

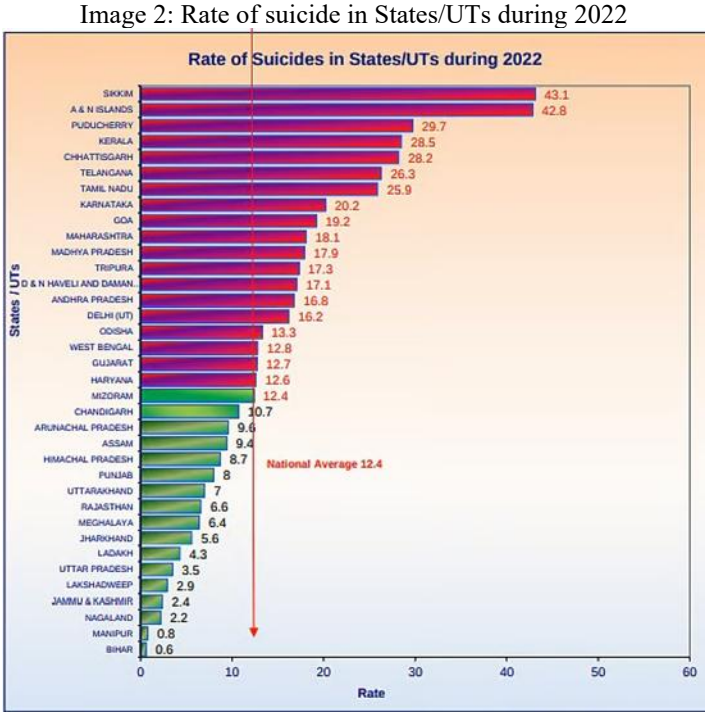
(43.1), followed by Andaman and Nicobar Islands (42.8), then Puducherry (29.7), Kerala (28.5), and Chhattisgarh (28.2).

Image 1: States with a higher percentage of suicide from 2020-2022

Sl. No.	Year					
	2020		2021		2022	
1	Maharashtra	(13.0%)	Maharashtra	(13.5%)	Maharashtra	(13.3%)
2	Tamil Nadu	(11.0%)	Tamil Nadu	(11.5%)	Tamil Nadu	(11.6%)
3	Madhya Pradesh	(9.5%)	Madhya Pradesh	(9.1%)	Madhya Pradesh	(9.0%)
4	West Bengal	(8.6%)	West Bengal	(8.2%)	Karnataka	(8.0%)
5	Karnataka	(8.0%)	Karnataka	(8.0%)	West Bengal	(7.4%)

source: NCRB report on Accidental Death and Suicide in India, 2022

Image 2: Rate of suicide in States/UTs during 2022



Source: NCRB, Reports on Accidental Death and Suicide in India 2022

Among all the Union Territories (UT), Delhi, the most populous, reported the highest number of suicides with 3,417, followed by Puducherry with 481 suicides. The States and UTs which shared a higher percentage increase in suicides in 2022 over 2021 were Lakshadweep (100.0%), Mizoram (54.5%), Uttar Pradesh (37.8%), Jammu and Kashmir UT (30.8%, Delhi Ut (20.3%), Jharkhand (19.5%), Ladakh (18.2%), and Nagaland (14.0%). The highest percent decrease was reported in Manipur (46.9%), Himachal Pradesh (27.6%), Bihar (15.1%, Tripura (7.5%), and Arunachal Pradesh (6.9%).

The male-to-female ratio of female deaths was 71.8, 28:2, with higher female victims for 'marriage-related issues. The most vulnerable group, 18-45 years of age, was the most vulnerable group. The leading causes reported were 'family problems' (2,556), 'love affairs' (1,578), and Illness (1,292) for children below 18 years of age. Among the male suicides, the highest suicides who died by suicides were by daily wage earners (41,433), followed by self-employed individuals (18,357), and professionals/salaried individuals (14,395). Among the females, the highest number of deaths by suicide was by housewives (25,309), the highest share reported in Tamil Nadu (3093 out of 25,309), followed by students (6,113) and daily wage earners (3,752). 67% deaths by suicide were among married individuals (1,14,485 out of 1,70,924), and 24.6% were unmarried (42,049). 64.3% were individuals who had an annual income of less than 1 lakh (1,09,875), and 30.7% were individuals with a yearly income who earned between 1 lakh and 5 lakh. 23.9% were educated up to the Matriculation/Secondary level, with higher numbers reported in Tamil Nadu and Maharashtra, and middle-level educated individuals accounted for 18%. Hanging (58.2%) is still the most common means of dying by suicide, followed by consuming poison (25.4%) and drowning (5.2%). Similar to the global data on suicidal deaths, India also faces underestimation.

WHO still correlates suicide and mental disorders, particularly depression and alcohol use disorders, which were observed in high-income countries. However, in recent years, impulsive suicides at the moment of crisis, the inability to deal with life stresses, like financial problems, relationship disputes, and chronic pain and physical illnesses, have also been noticed. Additionally, conflict, disaster, violence, abuse or loss, and isolation are associated with suicidal behavior. WHO has also traced higher suicide rates among vulnerable groups who are discriminated like refugees, migrants, indigenous people, and the lesbian, gay, bisexual, transgender, and intersex (LGBTQI+) individuals, also among prisoners. But WHO also states that there is an underestimation of suicide in low-income countries.

As the data shows, there is a difference in how the suicide rate varies in different countries and regions of India, and there is a predominant emphasis on the medical and mental health aspects of suicide. Additionally, the literature on suicide in India is largely dominated by the study on farmer suicide (Mohanty and Shroff, 2004,2005; Sarma, 2004; Vasani, 2009; Sadanandan, 2014; Stone, 2014; Kaushal, 2015; Münster, 2015; Dandekar, 2016; Mayer, 2016; Plewis, 2018).

Describing the occurrence of suicide and calculating the rates are only a small part of studying suicide. Which is why preventive measures are also focused on mental health and medical sciences, but in a socio-cultural setting where mental health itself is a stigma, how then can we understand suicide, both as a social fact and as a socially meaningful action? The work, therefore, emphasizes that even though statistical evidence is a required data for understanding suicidal deaths in certain collectives, there should also be a connection between this suicide data and the social factors.

II. Durkheim's Suicide

Durkheim argues that suicide is primarily a social fact, not just an individual psychological one. Its causes are rooted in the structure and state of society, particularly the levels of integration (the strength of social bonds) and regulation (the control society exerts over individual desires) that a person experiences.

Methodologically, he pioneered the use of official statistics to study social phenomena, arguing that stable suicide rates in different societies reflect distinct social currents. He moves from an aetiological (causal) investigation to a morphological (descriptive) one, classifying suicides by their social causes rather than their individual motives.

Durkheim identified four primary types of suicide, defined by the social conditions that cause them:

Egoistic suicide is caused by caused by low social integration, where the individual is isolated and not sufficiently bound to social groups (like family, religion, or community); altruistic suicide is caused by excessive social integration; anomic suicide is caused by a breakdown of social regulation. This occurs during periods of sudden social or economic upheaval (e.g., crises or booms) when the norms that guide desires and limit ambitions break down; and fatalistic suicide is caused by excessive regulation. This is the opposite of anomic suicide, where oppressive discipline and a completely blocked future (e.g., slavery) lead to suicide. Durkheim's fundamental conclusion is that suicide cannot be explained by individual psychology or cosmic factors alone. Instead, the varying rates of suicide across societies are a direct result of the health and structure of those societies—specifically, the balance between individual integration into social groups and the presence of clear, legitimate social norms that regulate behavior.

III. Douglas's Social Meaning Of Suicide

Douglas presents a fundamental critique of positivist approaches to studying suicide. He argues that suicide is a socially constructed meaning. A death only becomes a "suicide" when social actors (family, coroners, etc.) interpret and label it as such based on their cultural frameworks and biases.

Douglas proposed a "Bottom-Up" Approach**,** stating that sociology should use an inductive method, starting from detailed empirical observation of individual cases and then building towards theoretical patterns. Which Focuses on "Situated Meanings". Researchers must study the specific, real-world contexts in which suicidal actions occur. It involves studying Suicidal Communications, which are threats, warnings, and notes that should be taken seriously as strategic social actions, not dismissed as mere "cries for help." Therefore, Douglas proposes a radical shift in the sociology of suicide. The goal is not to explain statistical rates, but to understand the shared and individual meanings attached to suicidal actions and the social processes through which a death comes to be defined as a "suicide."

IV. Durkheim And Douglas

This work encapsulates a macro (Durkheim) and a micro (Douglas) approach. Durkheim's macro approach assists in treating suicide as a social fact with objectives, a collective trend that is driven by social forces like integration and regulation. It helps in answering questions like "What is the pattern of suicide in these societies?". While Douglas's micro approach provides a field-oriented meaning of suicide. It allows the research to capture the narratives of individuals and communities' subjective "imputation of meaning" to suicide, which

will be reflected in the data thus gathered. It helps in answering the question of "What does suicide mean to the people of these societies?". The combination of these approaches, therefore, requires combining both perspectives. While Durkheim helps identify suicide as a collective social pattern, Douglas's method is fundamental to interpreting that pattern by exploring the shared meanings and understandings that a specific community attaches to suicide. To simplify, the theoretical framework is based on Durkheim's structure to identify the "what" (suicide as a social fact) and Douglas's interpretation to explain the "why" (the meanings behind it).

V. Methodology

By employing mixed-methods and a comparative design, the goal is not just to apply old theories, but to discover a new, specific understanding of how social forces uniquely affect communities in Gangtok and Darjeeling Sadar, leading to a comprehensive explanation of suicide. Its fundamental purpose is exploratory: to generate new, context-specific sociological understanding by examining how social forces are uniquely experienced in Gangtok and Darjeeling Sadar, thereby providing a more complete and nuanced explanation of suicide.

It aims to bridge the gap between quantitative and qualitative methodologies.

Quantitative: The secondary quantitative data were retrieved from the National Crime Records Bureau, official records provided by the respective offices in Gangtok and Darjeeling Sadar. This work discusses 447 cases of suicide in Gangtok, and 147 cases in Darjeeling Sadar. Suicide rates are calculated according to the standard formula:

$$\text{Suicide Rate} = \frac{\text{Number of suicide deaths in a year}}{\text{population in a year}} \times 100{,}000$$

Qualitative: Five cases each from the collectives were retrieved through the process of in-depth interviews of families with suicidal deaths. These data were collected in sporadic intermissions between 2022 and 2025.

VI. Findings

Men account for 72.9% of completed suicides. The 20-29 age group has the highest rate of suicidal deaths (30.2%), followed by the 30-39 age group (20.58%). This aligns with previous state-wide research identifying young and middle-aged adults (16-45) as the most vulnerable demographic. While Émile Durkheim theorized that married individuals, especially those with children, have a greater immunity to suicide, the data from Gangtok shows the opposite. The suicide rate among married individuals (28.6%) was higher than that of unmarried individuals (24.3%). For married individuals, the most common trigger was identified as an 'argument with partner. The dominant community that showcases a high rate of suicide is the Rai community (13%), followed by Chettri (11.8%), and then Tamang (8.9%). Earlier studies on the whole of Sikkim also revealed that suicidal deaths among the Rai community are high (Chettri *et al*, 2016). This is the result of the Rai community being one of the largest communities residing in the state. The Subba community stands at 6.7% and the Lepcha at 5.1%. 5.8% of the total is contributed by the scheduled castes (Kami, Darjee, Ramudamu, Kalikotay, Biswakarma, Panchakothi, and Thattal) with other prominent communities like Pradhan (4%), Mangar (2.6%). Hanging is the most common method used with 96.8%, followed with a small percentage of 1.1% of jumping from height.

In Darjeeling Sadar, suicide among men is higher, accounting for 72% of the total suicides. The age group with the highest suicide rate is 20-29, and hanging is the most common method used. The percentage shares by communities are the highest by Rai (21%), Tamang (13%), Chettri (11%), Sherpa and Bhutia (10%), and Gurung (8%). Individuals who earn less than 1 lakh a year had higher suicide rates, and those who were educated till class 8 had the highest share. Apart from the 42 cases retrieved from the coroner's diary, 20 more cases were reported, and 85 suicidal deaths were not reported. The highest shares were from self-employed individuals (27%), followed by individuals who had private jobs (14%), students (10%) and housewives (8%).

VII. Underreporting And Underestimation Of Suicide In Darjeeling Sadar

A critical finding is the severe underreporting of suicide in Darjeeling Sadar, as there is no existing research on the subject in this region. The official data, which reported only six suicidal deaths in the Darjeeling Sadar area over five years, is unreliable and raises concerns of negligence. This discrepancy is confirmed by an unofficial data retrieval from the coroner's diary, which revealed 95 suicidal deaths for 2022 and 2023 alone for the entire Darjeeling district, with the coroner estimating 35-40 deaths per year, which should result to approximately 6.67 deaths per year. Darjeeling Sadar area, covering Darjeeling town, Singamari, Lebong, and Dali, and having a population of 118,805, is has a comparatively lower suicide rate than Gangtok, but the rate is calculated based only on the 'reported' cases of suicidal deaths.

This underreporting is driven by socio-cultural norms that regulate the practice and view suicide as a socially stigmatized act. Similar to East Asian societies, the culture in Darjeeling places a greater concern on "saving face," meaning shame plays a significant role in attitudes toward suicide (Cain, 2014; Leung and Cohen, 2011, as cited in Manning, 2020, p. 40). Consequently, the analysis in this chapter is based on a total of 147 identified cases from 2019-2024, a figure the researcher must admit is unfortunately less than the targeted number of 200, for the study

Another important finding indicate that the close-knit, traditional community (*Gemeinschaft*) quickly spreads news of suicides through word-of-mouth, yet there is a collective denial when officially confronted. This underreporting is a cultural practice—a product of shared values and a desire to protect the community's status. The role of local institutions like the *Samaj* is crucial in enforcing this silence. Consequently, there is a significant discrepancy between the increasing reality of suicide and the highly underestimated official data, as government officials also maintain confidentiality, further shaping a false narrative that suicides are rare in Darjeeling.

VIII. Case Studies

Case1:The35-Year-OldMaleandHisFather

This case involves a double death shrouded in violence and supernatural belief. A 35-year-old man, known for abusing his wife and having accidentally caused his mother's death, was found hanging. His paralyzed father was also found dead in another room with neck bruises, leading to speculations that the son had murdered his father before killing himself. The community rationalized the tragedy through a supernatural lens, blaming it on "bad karma" from the family's disrespect toward a temple built by his mother, who was a spiritual figure (*mata*). The man's own claims of being "called" by his deceased mother were cited as a driving force behind his suicidal act.

Case 2: The 83-Year-Old Man

An 83-year-old man, previously active, was left partially paralyzed after a stroke. He frequently expressed that he had become a burden to his family and that his life's work was complete, having seen his grandson grow up. His family had become accustomed to his despairing comments and did not recognize the immediate danger. One morning, he used a pretext to find a rope and was later discovered having died by suicide. The family believes he was depressed and rationally chose to end his life due to his physical limitations and feelings of being a financial and physical burden on his son.

Case 3: The 24-Year-Old Male Driver

A 24-year-old man struggled with unemployment and undiagnosed depression following the death of his mother, to whom he was extremely close. His situation deteriorated when his sister repossessed the car he used for his livelihood and his girlfriend ended their relationship. He began drinking heavily and spoke frequently of his deceased mother "calling" for him. On the night of his death, he posted ominous messages on social media and made farewell phone calls to friends while drunk. He was found dead the next morning. His friend rationalized the death through a cultural lens, wondering if it was his "destiny" and if his mother's spirit truly was calling him.

Case 4: The 34-Year-Old Husband

A 34-year-old man working at a casino had a troubled marriage due to his substance abuse, erratic behavior, and domestic violence. After a night of drinking, he accused his wife of having an affair. To avoid conflict, she left to stay with a friend. When she returned the next morning, she found he had died by suicide. His wife was left with profound confusion and mixed emotions—sadness, anger, and guilt—noting the tragic irony that she, the victim of abuse, was the one left behind while the perpetrator took his own life for reasons that remained unanswered.

Case 5: The 54-Year-Old Woman with MDR-TB

A 54-year-old woman with Multi-Drug Resistant Tuberculosis (MDR-TB) was also clinically depressed and had a history of suicide attempts. A known side effect of her medication was suicidal ideation. After a period of seeming improvement that made her family less vigilant, she was left alone for a short time. She then set herself on fire and succumbed to her injuries. Her husband was left with immense guilt and trauma, lamenting that despite their care, "when death calls, it will take you within seconds."

IX. Comparative Analysis

Gangtok demonstrates greater official transparency in reporting and addressing suicide, while Darjeeling Sadar exhibits collective concealment mediated through traditional institutions like the *Sama*j. Both approaches represent culturally embedded coping mechanisms, with different implications for prevention and support**.**

Both regions show significantly higher suicide rates among males (72.9% in Gangtok, 72% in Darjeeling Sadar), consistent with national trends but contrary to the global pattern, where women typically attempt suicide more frequently. This disparity appears linked to patriarchal norms that discourage men from expressing emotional vulnerability or seeking help. As one male informant expressed, "Kasari bhannu testo kura" ("How to share such things"). Women in both regions more readily admitted to suicidal thoughts but had lower completion rates, likely due to their choice of less lethal methods and greater willingness to seek support. Women were also more descriptive informants while talking about suicide.

Regarding age distribution, both regions show the highest suicide incidence among young adults (20-29 years). This pattern aligns with research identifying marital disharmony, unemployment, and life demands as risk factors in this age group. Gangtok and Darjeeling Sadar reported additional vulnerability among housewives, often related to domestic violence and limited emotional outlets.

Married individuals showed slightly higher suicide rates both in Gangtok and Darjeeling Sadar, and were often triggered by interpersonal conflicts within relationships, especially among married men. However, this research did not make a distinction between married individuals of certain ages.

In Gangtok, alcohol use disorder worsened these conflicts, with alcoholism being culturally tolerated yet stigmatized when chronic. But alcohol consumption is also a culturally accepted practice. The Rai community demonstrated particularly high rates in both, though this may reflect their population share rather than specific cultural vulnerability.

Hanging was the predominant method in both regions (96.8% in Gangtok, 91.2% in Darjeeling Sadar), consistent with findings from other Indian studies. This method's popularity relates to its lethality and accessibility—research indicates that while suicide attempters often choose less lethal methods like drug overdose, completers typically select highly lethal methods like hanging. As one informant noted, hanging "guarantees death," reflecting a pragmatic approach to method selection.

Official records in both regions cited "family problems" and "illness" as primary causes, but ethnographic research revealed more complex narratives. Financial stress emerged as a significant factor, particularly among male breadwinners experiencing unemployment or debt. Relationship conflicts were especially common for married women, with domestic violence serving as a frequent precursor. The COVID-19 pandemic exacerbated these issues, with lockdowns increasing economic uncertainty and social isolation—a finding consistent with research on pandemic-related suicidality. Patients of MDR-TB in Gangtok also shared a certain percentage in Gangtok's suicide rate, while physical illnesses, not particularly MDR-TB was part of an individual's personal motives.

X. Conclusion

The suicidal deaths in Gangtok and Darjeeling Sadar present a classic case of a society in a state of anomie. Gangtok, being the capital of a rapidly developing state, and Darjeeling Sadar, being the administrative and economic capital of the district, have experienced significant socio-economic transformation. However, this progress has not been accompanied by a stable, new moral framework to regulate individual aspirations and provide meaning. The limitless desires Durkheim described are evident in the financial pressures on young adults, the competitive job market, and the materialistic strains within families. The high suicide rate among men, in particular, points to a crisis of regulation where traditional masculine roles are challenged, but new, healthy expressions of masculinity and success are not clearly defined. The case studies—from the driver overwhelmed by debt and loss to the student shamed for theft—are narratives of individuals drifting in a society that has failed to provide clear limits and sustainable pathways to fulfillment. This anomie is further aggravated by substance abuse, which serves as both a symptom and an accelerant of this normative breakdown.

While mental health services are crucial, prevention must also target the social roots of anomie. This includes promoting economic resilience through diversified livelihood programs and financial counseling. Efforts should focus on fostering new forms of community integration and moral support, such as youth mentorship programs, community centers, and initiatives that strengthen social bonds beyond the family. Additionally, prevention cannot work against the *Samaj*; it must work *with* it. Public awareness campaigns should focus on normalizing conversations about emotional distress and framing suicide as a community health issue rather than a personal failing or a crime. Efforts are needed to build trust between communities and healthcare/legal systems, ensuring that seeking help is seen as safe and supportive rather than as a breach of community loyalty.

The act of suicide, therefore, cannot be understood without first understanding the specific social and cultural fabric in which it occurs.

References

[1]. Abrutyn, S., & Mueller, A. S. (2014). Are Suicidal Behaviors Contagious In Adolescence? Using Longitudinal Data To Examine Suicide Suggestion. American Sociological Review, 79(2), 211-227.

[2]. Broz, L., And Münster, D. (Eds.). (2015). Suicide And Agency: Anthropological Perspectives On Self-Destruction, Personhood, And Power. Ashgate Publishing, Ltd.

[3]. Chen, J. A., & Wu, K.K. (2020). The Role Of Stigma And Denormalization In Suicide-Prevention Laws In East Asia: A Sociocultural, Historical, And Ethical Perspective. Harvard Review Of Psychiatry, 28(6), 360–366.
[4]. Chettri, R., Gurung, J., & Singh, B. (2016). A 10-Year Retrospective Study Of Suicide In Sikkim, India: Sociodemographic Profile And Risk Assessment. Indian Journal Of Psychiatry, 58(4), 448.
[5]. Douglas, J. D. (1967). Social Meanings Of Suicide. New Jersey: Princeton University Press.
[6]. Durkheim, E. (2005). Suicide: A Study In Sociology (A. Sparding, Trans.). Routledge. (Original Work Published 1897).
[7]. Durkheim, E. (1982). Rules Of Sociological Method, (W. D. Halls Trans.). Routledge. (Original Work Published 1895).
[8]. Kagan, S. (1989). The Limits Of Morality. Oxford University Press.
[9]. Lama, M., & Rai, R. (2016). Chokho Pani: An Interface Between Religion And Environment In Darjeeling. Himalaya The Journal Of The Association For Nepal And Himalayan Studies, 36(2), 90-98.
[10]. Loomba, A. (1993). Dead Women Tell No Tales: Issues Of Female Subjectivity, Subaltern Agency And Tradition In Colonial And Post-Colonial Writings On Widow Immolation In India. History Workshop Journal, 36(1), 209-227.
[11]. Manning, J. (2020). Suicide: The Social Causes Of Self-Destruction. University Of Virginia Press.
[12]. Mene, T. (2013). Underestimation Of Suicide: A Study Of The Idu Mishmi Tribe Of Arunachal Pradesh. Economic And Political Weekly, 48(52), 129-199.
[13]. Mueller, A. S., & Abrutyn, S. (2016). Adolescents Under Pressure: A New Durkheimian Framework For Understanding Adolescent Suicide In A Cohesive Community. American Sociological Review, 81(5), 877-899.
[14]. Rasaily, S. (2019). Current Trend Of Suicide In Sikkim. The Journal Of Medical Research, 5(2), 98-101.
[15]. Sachdeva, S. A., Thapa, S. (2017). Suicide In Sikkim: A Socio-Psycho Assessment 2016-2017. Sikkim University
[16]. Zhang, J., Et Al. (2024). Phenomenology, Cultural Meaning, And The Curious Case Of Suicide: Localizing The Structure-Culture Dialectic. Philosophy Of The Social Sciences, 54(6), 516-540. DOI: 10.1177/00483931241246069.