

Short Report

Perceptions about suicide: A qualitative study from southern India

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ABSTRACT

Background. Studies from India have reported high rates of suicide. We aimed to understand the social and cultural factors that modulate the risks related to suicide.

Methods. Focus group discussions were conducted with community health workers (1 group) and members of the public (6 groups). In-depth interviews were also conducted with 5 people who had attempted suicide and survived. The interviews were tape-recorded and transcribed verbatim. The results were summarized and analysed using standard procedures.

Results. The most common causes for suicide were interpersonal and family problems, and financial difficulties. Mental illness was also reported as causal. All 5 subjects who had attempted suicide mentioned marital and family discord as the cause. The majority of the general population and all the subjects who had attempted suicide were not aware of any community and support services for the prevention of suicide.

Conclusion. Our study reveals that people perceived suicide as an option to overcome interpersonal, family and financial stress among normal individuals as well as those with mental illness. Healthcare providers should place greater emphasis on educating the general public regarding the policies and services available for suicide prevention.

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INTRODUCTION

Worldwide, deaths due to suicide are a cause for concern.^{1–3} Several investigators have studied suicide in different parts of India.^{4–11} However, recent reports from Vellore in southern India have revealed that suicide rates in India are grossly underreported.^{12–15} The annual suicide rate in Kaniyambadi block, Vellore district was 95.2 per 100 000 during 1994–99. This is 8–10 times higher than the reported national rate.

People attempt and commit suicide for a variety of reasons, and in diverse social and personal circumstances.¹⁴ Case histories of people who take their own lives suggest that suicide is a complex process. Reports from India have suggested that the presence of

chronic stressors and precipitating life events rather than mental disorders are major risk factors for suicide. Qualitative research can provide data that is 'emic' in perspective because it allows individuals to respond in their categorizations and perceived associations. It can be used to explore in detail people's attitudes, perceptions and experiences, examining 'not only what people think but how they think and why they think that way'.¹⁶

We did a qualitative study to obtain an insight into people's thoughts on suicide including perceptions, causes, methods of committing suicide, impact of suicide, and availability of support services and policies regarding suicide prevention.

METHODS

Setting

Tamil Nadu is among the more industrialized states in India with better educational, health and development indices than most other Indian states.¹⁷ The Department of Community Health, Christian Medical College, Vellore, has been working in Kaniyambadi block, Vellore district, for the past 50 years.^{18,19} This region is a geographically defined area of 127.4 km² with a population of about 1 10 000. A major proportion of the population is from the lower socioeconomic strata, and agriculture and animal husbandry are the major occupations.

Discussion guide

The focus group guide was developed based on the findings of previous studies.^{12–15} The key themes of the focus group discussions (FGDs) were: Have you heard about people committing suicide in the area? What are the methods employed to commit suicide? What are the likely situations and reasons for suicide? What is the impact of suicide on the family? And what sort of support can the community provide? The items also dealt with awareness and stigma related to suicide and mental illness.

Data collection

To gain insight into the complex sociocontextual model of suicide, FGDs were employed. This study is the pilot of a larger project combining quantitative and qualitative methods to design population-based preventive interventions to reduce the rate of suicide in developing countries. The institutional research and ethics committee approved the study.

Over a 3-month period we recruited participants from the area by a combination of tentative lists and the snowballing technique. Participants were selected on the basis of their roles as gatekeepers (health workers) and members of the public. These members were selected according to gender, age and place of residence in the catchment area. We conducted 7 FGDs: 1 with community healthcare workers and 6 with members of the general public. These were held at the base hospital and in the community. These sites were chosen according to ease of access for the participants.

Each FGD was moderated by the same two researchers (SM and BS), who ensured that each item on the agenda was fully discussed and that all the respondents had sufficient opportunity to express their views. The aim of the study and implications of participation were explained to the group at the start. The discussions lasted for 45–60 minutes, with an additional 15 minutes for informal conversation. At the end of the session,

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the participants were provided with information regarding support services available for suicide prevention. The FGDs were conducted in Tamil; one researcher facilitated the group while the other recorded the proceedings, noting key themes and monitoring verbal and non-verbal interactions. With the consent of each participant every session was audio-taped and transcribed verbatim. (These were in Tamil and translated into English by the researchers prior to coding.) Demographic characteristics such as age, sex and marital status were collected from the participants.

We also conducted in-depth interviews with 5 individuals from the area who had attempted suicide and survived.

Analysis

We used a framework approach to data collection and analysis.^{20,21} The analysis was designed so that it could be viewed and assessed by people other than the primary analyst. Notes and open codes were generated and organized manually, and similar codes were grouped into categories by 2 researchers independently. A multidisciplinary team (1 trained psychiatrist, 2 nurses, 1 social worker and the researchers) discussed these 'higher codes' that emerged from the data, including perceptions, causes, impact, support and the role of the government in preventing suicide. The team read the transcripts and notes several times and reached a consensus regarding the categories and 'higher codes'. Any disagreements were discussed regularly within the team to reach a consensus regarding coding. Finally, sections with similar coding were grouped according to the predetermined themes and pasted on sheets. Though rigour was not enhanced by multiple coding, the analysis was improved by constant comparison with the transcripts as advocated by Glaser and Strauss.²² The team identified and discussed a hierarchical scheme of specific themes, issues and problems that emerged from the data.

RESULTS

Forty-five people attended the FGD sessions. There were 8 community health workers (1 FGD) and 37 people from the general population (6 FGDs). All health workers were women who had studied till the 10th–12th standard with a mean (SD) age of 43.9 (3.3) years while the majority of the general population were women (54.1%), literate (51.2%) with a mean (SD) age of 46.1 (13.3) years. The participants from the general population were divided into homogeneous groups to facilitate communication: educated housewives, illiterate housewives, teachers, farmers, manual labourers and students.

Perceptions and causes of suicide

All the groups recognized a variety of causes for suicides (Table I). Many participants particularly emphasized marital discord, family problems and interpersonal conflict, while only a minority mentioned mental disorders as the main causes (*see* Box 1). Conflicts regarding fidelity and the husband's alcohol problem were common causes of marital discord. Among mental illness the majority discussed depression as a cause of suicide. Participants commonly reported that social and financial difficulties had an adverse impact on an individual's coping, significantly straining relationships and forcing them to commit suicide. A few participants (8/45) in both the groups said that breaking up of a love affair and academic failure were the main causes for suicide among young people.

Methods of committing suicide

Participants from both the groups said that poisoning (16/45) and

TABLE I. Common perceived causes for suicide as mentioned during focus group discussions

Perceived causes	Health workers (n)	General population (n)	Total (n)
Marital discord	8	6	14
Problems related to dowry	5	5	10
Problem with in-laws in joint families	5	4	9
Mental depression	5	3	8
Chronic physical illness	3	3	6
Inability to cope with stress	2	4	6
Problems related to alcohol abuse in family	3	2	5
Unemployment and poverty	2	3	5
Breaking up of love affair	2	2	4
Failure in examinations	1	3	4
Ill-treatment by teachers	0	3	3
Others	1	4	5

Box 1

Verbatim accounts from focus group discussions about the perception and causes of suicide

Adolescent participant

- 'Psychiatric patients are very sensitive and will not be able to cope up if problems arise.'

Community health worker

- 'A 24-year-old boy had a love affair with a married woman. The woman's mother-in-law came to know about it and scolded the boy and told him not to come near their house. The boy consumed alcohol and while other family members were busy with household work, he hung himself.'
- 'A woman near my house burnt herself. On enquiry the neighbours mentioned that she was suffering from some mental illness. I felt it may have been depression.'
- 'Because of social problems people become depressed and commit suicide.'
- 'Family problems are responsible for suicide.'
- 'If parents are not able to give proper food/education to their children, they commit suicide.'
- 'If they have problems in their married life, they end their lives.'
- 'One woman, after delivery, hanged herself in her mother's house because her mother-in-law asked her to get more gold for the baby.'
- 'People who are in debt manage to tell others that they do not have money to pay them back, but if anyone scolds them, they attempt suicide.'

Elderly man

- 'Aged people give away all their property to their children, thinking that their children will look after them when they become old. But they do not do so. This causes old couples to become depressed and commit suicide.'
- 'Most people commit suicide because of poverty.'

Middle-aged woman

- 'If a teacher harasses students, they commit suicide.' 'If students ask doubts to teachers, they do not clear their doubts; instead make fun of them, humiliate them. Some children become upset and there is a risk of their committing suicide.'
- 'If there is a major fight between husband and wife, one of them commits suicide.'

Teacher

- 'People who quarrel at home often commit suicide easily.'
- 'Some commit suicide after disputes in the family, often related to property.'

hanging (7/45) were the common methods employed by all age groups (see Box 2). A few participants in the community health workers' group (3/8) said that easy availability of insecticides and potentially dangerous drugs in pharmacies led to high suicide rates. Others mentioned that locally available poisonous plants such as *odduvanthalai* (*Cleistanthus collinus*) are ingested. Participants in both the groups (2/8 and 4/37) said that most educated people chose sleeping tablets to commit suicide. Both groups mentioned that burning was a common method among married women. Two participants reported that easy availability of kerosene at home was the main cause for choosing death by burning. Drowning was also mentioned as a method.

Impact of suicide

In general, participants felt that the psychological impact of suicide on family members was great (see Box 1). Community health workers (5/8) reported that family members became depressed. Most participants (20/45) reported that the social impact of suicide was more in the rural community. A few participants (10/37) from the general public group said that most families would have financial problems if the earning member committed suicide. They also highlighted the psychological impact of suicide on families.

Support services and policies regarding prevention

Most participants knew little about the support services available for suicide prevention (see Box 2). Suggestions from the general public included financial help from the government and help for women from the police. Participants also wanted the government to raise awareness about issues related to suicide and the help available.

Suggestions from health workers included reduced access to over-the-counter drugs, regulation of the media to stop them from broadcasting programmes provoking suicide and restricting them from reporting on suicide, treatment of mental illness and counselling for stress, and efforts to increase public awareness.

In-depth interviews with survivors

In-depth interviews were conducted with 5 people from the area who had attempted suicide and survived; 3 women and 2 men with a mean age of 28 (11) years (range 15–45 years) and a mean of 7.8

(1.6) years of education (range 5–9 years) were interviewed. Two of them chose poisoning, 2 burning with kerosene and 1 attempted hanging as the method of suicide. Three of them reported marital discord while 2 mentioned discord with other family members. All reported that the suicide attempt had had a major impact on the family. Stigma related to the incident was also reported and 2 did not mention the incident to friends and neighbours. They were not aware of any community resources and support to prevent suicide.

DISCUSSION

Our study is a broad-based qualitative investigation of perceptions regarding suicide in India. Focus group research has its disadvantages. First, it is likely that the views of those individuals who were more vocal were the most prominent although we made every effort to ensure that all individuals participated actively. Another issue is the limited generalizability due to the recruitment of small, convenience samples.

Causes of suicide

Based on the major themes that emerged from the findings, family problems were the most commonly mentioned cause of suicide. These included marital discord, interpersonal problems with in-laws, major differences of opinion between parents and children, dowry problems and property disputes. This finding has been reported in other studies where domestic strife was the most common cause of suicide.⁴⁻⁶

Participants from both groups reported that mental illness, mainly depression, was the most important cause for a person to commit suicide. This finding has also been reported in many studies. It shows that the general population is aware of psychiatric illness and its relationship to suicide. However, participants also said that people who attempt and commit suicide lack effective strategies to cope with life stressors.

However, none of the participants perceived this as a failure of the sociopolitical system in India. Though participants expressed their frustration generally, they were unaware of the larger public role and the inefficient system that contributes to such a state.

Methods of suicide

The participants were well aware of the various methods reported in other studies.¹²⁻¹⁵ Access to the method of suicide is an important risk factor for and determinant of suicide. The method used depends on the availability of the means and the individual motivation to kill oneself. Participants in both groups reported that poisoning and hanging were the most common methods of committing suicide by people of all age groups. Since pesticides are the most common method, attention should be focused on reducing the access to pesticides.

Impact of suicide on the family

Suicide has a devastating psychological impact on surviving family members and friends.²³⁻²⁵ Hence, healthcare professionals have a vital role to play. Survivors of a suicide experience severe bereavement and the family physician is identified as the key individual to initiate and ensure follow up care for the bereaved. In our study, the participants reported that the social impact was greater in rural communities. This may be because of the joint family system and close social bonding common in many places in India. Participants also identified sadness, depression, guilt and suicidal ideation as the major psychological reactions in families of victims. The financial impact of suicide was also recognized and was said to be profound in poor families, especially where the

Box 2

Verbatim accounts from focus group discussions about impact and community resources

Teacher: 'Some family members are not able to cope and they become depressed.'

Community health worker: 'I know a lady who was treated for depression because of her son's death.'

Teacher: 'If the head of the family commits suicide, the society will not give respect to other members in the family.'

Community health worker: 'The entire family will be excluded from village functions.'

Adolescent male: 'Some parents will not allow their children to go near the house.'

Middle-aged man: 'No, I do not know about sources of help in the community to prevent suicide.'

victim was the breadwinner of the family. Participants also identified social costs including loss of respect in society, exclusion from village functions and spread of rumours about the cause and issues. These findings suggest that the community health team has a major role to play in providing support and counselling to the bereaved family.

Perceptions related to suicide, support services and policies

Based on the major themes that emerged, we suggest that many people going through difficult personal and financial circumstances view suicide as an option. Suicide is not actively supported by society as suicide in a family is stigmatizing. The many suicides by farmers in different parts of India support this contention. People perceive poverty, lack of empowerment, a materialistic society, and the inefficient social and economic support system as major factors that push individuals towards taking their own lives. Understanding the complex sociocultural and economic issues that modulate and increase the incidence of suicide deserves serious consideration.

Suicide as an option among people with mental illness was also mentioned. Marital and family discord, and psychosocial stress were considered major contributors. The prevention, early detection, treatment and rehabilitation of people with mental illness and emotional distress should be a priority. However, depression is also closely linked to psychosocial issues such as gender, poverty and unemployment, tying it to the socioeconomic environment. Although suicide is considered secondary to mental illness in the West the results of our study and other studies from the region suggest that interpersonal, familial and social factors rather than biological disease are the major contributors to suicide. There is a need to conduct similar studies in different populations and settings, and develop appropriate programmes to prevent suicide.

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