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Explaining suicide: Identifying common themes and diverse perspectives in an urban Mumbai slum

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ABSTRACT

Rates, demographics and diagnostics, which are the focus of many studies of suicide, may provide an insufficient account without adequate consideration of psychological, social and cultural contexts and motives. Furthermore, reported explanations of suicide are shaped not only by events but also the relationship of survivor respondents explaining the suicide. An explanatory model interview for socio-cultural autopsy has been used to assess underlying problems and perceived causes. This study in a low-income community of Mumbai in 2003–2004 compared accounts of the closest family survivors and more distant relationships. Our study design distinguished series-level agreement (i.e., consistency of accounts within a group) and case-level agreement for particular cases. Serious mental illness was the perceived cause reported by a respondent in either group for 22.0% of index suicides, but case-level agreement was only 6.0%. Regarding financial stressors, more closely related family respondents focused on acute stressors instead of enduring effects of poverty. Case-level agreement was high for marital problems, but low for other sources of family conflict. Tension was a feature of suicide reported in both groups, but case-level agreement on tension as a perceived cause was low (kappa = 0.14). The role of alcohol as a perceived cause of suicide had high series level agreement (46.0% in both groups) and case-level agreement (kappa = 0.60), suggesting comparable community and professional views of its significance. The study shows that it is relevant and feasible to consider general community patterns and particular survivor interests. Findings from this study recommend an approach to sociocultural autopsy to assess reasons for suicide in community studies. Findings clarify diverse views of underlying problems motivating suicide that should be considered to make mental health care more effective in assessing risk and preventing suicide.

Introduction

Suicide is recognized as a preventable cause of death that constitutes a major global public health problem, and it is particularly important in India (Patel et al., 2012; Phillips & Cheng, 2012). A profile of relatively higher risk for young adults, compared with the elderly, is a feature of suicide in India, where it is also the leading cause of death for women of childbearing age (Maselko & Patel, 2008; Shahmanesh et al., 2009). Active surveillance, compared with data from passive reporting in police and crime bureau records, has highlighted the extent of suicide for young adolescents in the 10–19 year-old age group, with rates from a community study by Christian Medical College, Vellore, south India, as high as 148 per 100,000 for young women and 58 per 100,000 for young men (Aaron et al., 2004).

Motivated by the priority indicated by the epidemiology, it is important to understand reasons for suicide, so that efforts to prevent it are well-grounded and guided by consideration of locally relevant motivations. An appreciation of community-reported reasons for suicide should also contribute to the broader interests of mental health in services and community action. Although rarely considered, it is also important to recognize that explanations of suicide are likely to be influenced by the perspective of whoever is explaining it, and preferred explanations may reflect professional values, personal relationships to the deceased, and the level of available details concerning a behaviour with complex determinants (Jacob, 2008; Phillips, 2004). Mental health professionals concerned with suicide prevention typically focus on the role of high-risk psychiatric disorders (Goldsmith, Pellmar, Kleinman, &

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Bunney, 2002; Harris & Barraclough, 1997), because their training and professional priorities suggest effectiveness relies on identification and treatment of mental illness that puts people at risk for suicide. This orientation guides strategies for universal and selective prevention targeting high-risk groups (Bertolote, Fleischmann, De Leo, & Wasserman, 2004).

Recent work suggests the relevance of considering the implications of other ways of explaining suicide, complementing the analysis of high-risk psychiatric disorders with consideration of local accounts of suicide from survivor informants (Parkar, Nagarsekar, & Weiss, 2009; Phillips et al., 2002) and patients' accounts of deliberate self-harm (Parkar, Dawani, & Weiss, 2006, 2008). Reasons for suicide reported by family, friends, and the popular press typically focus on the triggers and underlying problems, which may be regarded as perceived causes of suicidal behaviour. Newspaper accounts may refer to financial disaster, disturbed relationships, marital problems, and a variety of other issues and conflicts. Community studies of suicide in Kaniyambadi Block, Vellore District, in Tamil Nadu, highlight the underappreciated role of ongoing stress and chronic pain as reasons for suicide, in contrast with overestimation of the role of psychiatric disorders based on uncritical use of symptom check lists that are too easy to apply (Manoranjitham et al., 2010). Furthermore, attention to social determinants, such as economic problems leading to farmer suicides, suggests an alternative to the primary role of psychopathology (Sainath, 2010).

Traditional Hindu concepts of death in India typically regard suicide as a bad death. Although it does not necessarily stigmatize the family, cremation may be disallowed. The tradition is concerned with reasons for suicide, inasmuch as some reasons, such as inability to attend to required rituals at the end of life, may make suicide permissible (Parry, 1994). The community of recent Dalit Hindu converts to Buddhism has no indicated position acknowledging such Hindu values. The Islamic tradition, on the other hand, does not elaborate permissible circumstances, and cultural proscription of suicide is widely acknowledged as the reason for low rates of suicide in Muslim communities and countries.

Research in the rural Sundarban region of West Bengal considered community explanations of suicidal behaviour (Chowdhury, Shashmal, Dutta, & Weiss, 2004). Vijayakumar and colleagues emphasized the role not only of high-risk psychiatric disorders but also the importance of considering local contextual factors to guide prevention (Vijayakumar, John, Pirkis, & Whiteford, 2005). Research on urban mental health in a Mumbai slum highlights the impact of contextual features of harsh social settings contributing to mental health problems (Parkar, Fernandes, & Weiss, 2003).

Although mental health professionals are sensitive to the relatively more personal social contexts of a psychiatric history, broader social contexts are also relevant. These include gender, livelihood opportunities, environmental stressors (e.g., air, water and soil pollution), infrastructure and sanitation, and crowding in a slum community. The interrelationship of these various psychosocial and ecosocial factors is central to the agenda for needed developments in social epidemiology (Krieger, 2001). Our approach, based on an explanatory model framework, identifies local perceived causes, underlying problems and triggers for suicide, distinguishing relatively more enduring motivations and immediate precipitating factors. An emphasis on social and cultural determinants complements the conventional approach to psychological autopsy, which may be regarded as comparable to the aims of verbal autopsies. Although verbal autopsies and psychological autopsies acknowledge the importance of social contexts, their priority and validity is based on ascertaining a medical or psychiatric diagnosis. Verbal autopsies are typically used for assessing the medical cause of death in health demographic surveillance (Gajalakshmi & Peto, 2006), and psychological autopsies are typically used to identify psychiatric causes of suicide (Appleby, Dennehy, Thomas, Faragher, & Lewis, 1999; Beautrais, 2001; Cavanagh, Owens, & Johnstone, 1999). Our approach to sociocultural autopsy augments this approach with more attention to social and cultural determinants.

A previous report of experience using a sociocultural autopsy explained the need and value of enhancing psychological autopsies (Parkar et al., 2009). Its development is consistent with the interest of more recent reviews, which acknowledge the need for improving the next generation of psychological autopsies, both the content of interviews for which consideration of sociocultural content is relevant (Conner et al., 2011) and procedures for assessment (Conner et al., 2012), for which consideration of how accounts from multiple respondents relate to one another is relevant. These reviews of Conner and colleagues highlight the challenge of integrating reports of multiple respondents in the next generation of psychological autopsy studies.

In the course of our previous research on sociocultural autopsies, which was based on interviews with the closest surviving relative (Parkar et al., 2009), interactions with other family suggested that different relatives had different ideas about the suicide. It appeared that all survivor accounts of a single suicide were not the same. This led to development of a substudy, reported here, based on interviews with another relative in a second series of respondents to examine the common and distinctive features of survivor accounts of index cases of suicide.

This study aimed to address relevant but unexamined questions about the role of personal relationships and perspectives, and how they influence explanations of suicide among survivors. It examined patterns of distress, perceived causes of the suicide, and awareness of prior help seeking, as reported by different survivors in independent assessments. Using quantitative and qualitative methods to study the variety, distribution and priority issues from narrative accounts of survivors, we aimed to extend the scope of previous research on reasons for suicide by considering consistency and diversity in survivor accounts, and their implications.

Methods

Our approach is rooted in the framework of cultural epidemiology, which has been described by Trostle (2008) as "a set of methods and theoretical rationales for linking culture to human health at the population scale." We consider the theoretical basis of cultural patterning of distress and its meaning in a cultural epidemiology (Trostle, 2005), which complements the better known disciplinary framework of social epidemiology. Our approach emphasizes cultural concepts of meaning and motivation, in addition to the influence of social variables.

Setting

The study was initiated in February 2003 and completed in the first half of 2004 in Malavani, a slum community of Malad, which is a suburb 35 km north of central Mumbai. The total population of Malavani was approximately 150,000, with 60.1% Muslims, 38.2% Hindus and 1.7% Christians, according to the census of 2001. Residents included migrants seeking work in Mumbai from all parts of India, as well as refugees from Bangladesh. Socioeconomic features and environmental conditions of the community are compelling. Although the quality of housing and infrastructure may vary considerably, for the most part they are inadequate, unhygienic and a source of stress. While many ecosocial limitations in the community infrastructure are common for all slum dwellers, some living in unsanctioned slums are also subject to the threat of