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Gender differences in medically serious suicide attempts: A study from South India

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Abstract

Studying gender differences in suicidal behaviour is important in developing specific need-based service provisions. We aimed to identify gender-specific characteristics associated with attempted suicide in a general hospital sample in south India. Two hundred and three patients admitted to medical wards following suicide attempts were assessed using a detailed clinical interview, measures of suicide intent (Suicide Intent Scale), lethality (Risk Rescue Rating), depression (Montgomery-Åsberg Depression Rating Scale) and recent stress (Presumptive Stressful Life Events Scale). The majority of men attempting suicide were single. Men were more likely to use organophosphate poisons in their attempt to kill themselves and had higher rates of mental illness than women. As compared with men, women were more likely to come from rural areas, had a lower educational status, and had lower rates of employment outside the home. In women, the most common method of suicide attempt was by using plant poisons. Suicide attempt by self-immolation was significantly higher among women. Men had higher suicidal intent than women, although lethality, depression and stress were comparable between the genders. Rural women were more disadvantaged in education; however, in urban areas, men had higher psychiatric morbidity. Our results emphasise the need for a gender-specific approach among people who have attempted suicide.

Keywords: Suicide intent; Lethality; Stress; Depression; Rural; Urban

1. Introduction

Gender has been well documented as a socio-demographic correlate that is significantly associated with suicidal behaviour and is one of the most replicated predictors of suicide (Zhang et al., 2005). In most countries, suicide rates are higher among men, whilst rates of suicide attempts are usually higher among females (Voros et al., 2004). Differential rates of self-harming behaviour in specific gender and cultural groups have been described internationally (Canetto and Lester, 1995; Brown, 1997). Although none of the explanations for this difference have been widely accepted, it is generally agreed that the gender paradox is a real phenomenon, not an artefact of data collection (Canetto and Sakinofsky, 1998). However, the question of whether gender differences for suicidal behaviour are due to differential exposure to the known risk factors,

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or due to other factors inseparable from gender remains a puzzle (Hawton, 2000).

It has been suggested that acts of deliberate self-harm in women are more often based on non-suicidal motivation and are used to communicate distress or to modify the behaviour and reactions of other people (Hawton, 2000). Female attempters are mainly repeaters and are more likely to use self-poisoning. In men, deliberate self-harm is more often associated with greater suicidal intent and is often a reflection of underlying mental disorder. Women are believed to report suicidal ideas more frequently than men and attempt suicide more often, but men exceed women in the rate of suicidal deaths. Identifying the risk factors separately for both genders may help us understand why these differences occur (Fennig et al., 2005).

Subsequent mortality by suicide has been found to be high in those with medically serious suicide attempts (Beautrais, 2003). Studying the characteristics of those who have had serious suicide attempts will help to identify those at risk of future suicidal behaviour. The WHO/EURO multicentre study on suicidal behaviour (Voros et al., 2004) described a typical male suicide attempter as being unemployed, never married, tending to use violent methods and having alcohol problems or dependence. Men have higher suicide intent and their attempts tend to be more lethal than those of women (Haw et al., 2003). The mean number of life events is higher among men who attempt suicide (Heikkinen and Aro, 1994). To reduce suicide mortality, culture-specific information that can guide clinical practice and be effective in preventing suicidal behaviour in both genders is essential (Hawton, 2000). Management and prevention of attempted suicide, being a multi-causal phenomenon, is complex, and gender differences should be taken into account in designing intervention strategies (Voros et al., 2004). Literature from non-Western settings confirms the differences in attempted suicides in men and women, but studies mostly had a retrospective design (Khan and Reza, 1998; Aghanwa, 2004). Gender differences in medically serious suicidal behaviour clearly merit more research.

This study aimed to compare the differences between men and women with medically serious suicide attempts in terms of socio-demographic characteristics, clinical diagnosis, methods of attempt, measures of suicidal intent, lethality of attempt and recent stress. Our hypothesis was that, men who attempt suicide would more likely than women attempters to be single, unemployed and alcohol dependent. In addition, men would be more likely to use violent methods and have higher suicidal intent, lethality of attempt and more recent stressful life events.

2. Methods

This study was conducted in a large general teaching hospital in Pondicherry, South India, which functions as a tertiary referral centre and also offers acute and emergency care for the local population. The psychiatry department in the hospital offers liaison services to all the inpatient units.

2.1. Subjects

Patients between the ages of 16 and 65 who were admitted for treatment following a suicide attempt from September 1995 to July 1997 constituted the study sample. A medical serious suicide attempt was defined as an act of self-harm or self-poisoning that is considered by the treating doctors in the accident and emergency department to be medically serious and requiring hospital admission for inpatient treatment. All patients had been assessed in the accident and emergency department, and then admitted to the medical wards for treatment. Once their medical condition was stable, they were referred for psychiatric evaluation. The patients were recruited from consecutive referrals to the psychiatric department. All patients had a family member who was able to provide collateral information for corroboration. Two hundred and nine patients were referred during the study period, of which six refused to complete the assessment and were excluded from the study. The final sample comprised 203 patients who gave informed consent to be interviewed by a psychiatrist.

2.2. Assessments

2.2.1. Socio-demographic and clinical data

A semi-structured data sheet was used to collect the socio-demographic information. This included the patients' age, gender, marital status, number of years of education and place of residence (whether rural or urban). The unit of classification in this regard is 'town' for urban areas and 'village' for rural areas (Census of India, 2001). The clinical diagnoses according to the ICD-10 Clinical Description and Diagnostic guidelines (World Health Organization, 1992) were assigned after a comprehensive clinical interview covering all diagnostic categories. Additional information about the circumstances of the suicide