Archives of Psychiatric Nursing xxx (xxxx) xxx–xxx

Contents lists available at ScienceDirect

Archives of Psychiatric Nursing

journal homepage: www.elsevier.com/locate/apnu

The Aftermath of Suicide: A Qualitative Study With Guyanese Families☆

Carla J. Groh*, Maureen Anthony, Jean Gash

University of Detroit Mercy, 4001 W. McNichols Road, Detroit, MI 48219, United States

ARTICLE INFO

Keywords:
Suicide
Guyana
Postvention

ABSTRACT

Introduction: The suicide rate in Guyana was five times higher than the world average in 2014 (WHO) which puts Guyana at the top of the list with 44.2 per 100,000 people, the highest suicide rate in the world. For every completed suicide, there are survivors who experience high levels of psychological, physical, and social distress, and report feelings of guilt, shame, social stigma, and search for meaning.

Aim: The aim of this qualitative study was to explore how family members coped and understand the suicide of their loved one, and to determine what resources were available to help them during this transition.

Method: Ten family members were recruited to participate in a focus group. The focus group lasted approximately 90 min and was recorded. The audio recordings were later transcribed.

Results: Four overarching themes emerged from the data: (1) perceived causes of suicide, (2) perceived solutions, (3) barriers to helping persons who are suicidal, and (4) personal and community reactions to suicide.

Implications for practice: Nurses in Guyana are uniquely positioned to take a leadership role in creating and implementing postvention programs for suicide survivors that are culturally and ethnically relevant. Opportunities to partner with schools of nursing in higher income countries are explored.

Guyana, a former colony of Great Britain, is the only English-speaking country in South America. Its diverse population of 809,000 reflects its history. The largest ethnic group, Indo-Guyanese, at 44% of the population, came as indentured servants from India with the British in the late 19th century. Afro-Guyanese (30%) were enslaved people brought from Africa on slave ships. Those of mixed heritage comprise 17% of the population and indigenous Amerindians are the smallest subgroup at 9% of the population. (World Population Review, 2016). Guyana, is considered a developing country, with 35% of its population living below the poverty line and unemployment rates that hover around 11% (Central Intelligence Agency, 2017). With a gross national income of only $4240 (USD) per capita, Guyana is the second poorest country in the Caribbean region, second only to Haiti (World Bank, 2016)

The World Health Organization (2014) reported Guyana to have the highest suicide rate in the world with 44.2 suicides per 100,000 people. This is compared to a global average of 11.4 suicides per 100,000. Possibly due to the stigma associated with suicide, the cause of many deaths in Guyana is officially designated as “undetermined”. This suggests the true suicide rate may be much higher (Pritchard & Hean, 2008).

Guyanese adolescents were found to have a high rate of suicidal ideation with 14.9% of males and 21.6% of females reporting serious suicidal ideation in the previous year (Rudatsikira, Muula, & Siziya, 2007). The Indo-Guyanese population is thought to be disproportionally affected by suicide (Graafsma, Kerkof, Gibson, Badloe, & van de Beek, 2006; Harry, Balseiro, Harry, Schultz, & McBean, 2016). In a study of suicide among young people aged 10–24 years in 19 countries in the Americas, Quinlan-Davidson, Sanhueza, Espinosa, Escamilla-Cejudo, and Maddaleno (2014) found Guyana to be the country with the highest relative risk of suicide mortality for this age group. The high suicide rate has been attributed to poverty, alcohol abuse, readily available poisonous pesticides, especially in rural areas, and mental health issues often misunderstood and attributed to witchcraft (Mohammed, 2015). Another contributing factor may be the suicide contagion or suicide cluster effect in Guyana. This explanation is based on the fact that the concentration of deaths by suicide is in limited geographical areas and among limited demographic clusters in Guyana's countryside. Fallahay (2012, unpublished manuscript) conducted a house-to-house community survey in Mibjicure and published a report titled “Suicide in Black Bush Polder” which he believed supported this explanation. He found that persons of East Indian descent in Guyana, especially in farming areas, were more likely to attempt suicide. The clustering effect on suicides in Guyana was also explored in an article by Scutti (2014).

☆ No conflicts of interest exist for any of the authors.

Funding for this research was made possible through a grant from the Women's and Gender Studies program at the University of Detroit Mercy.

* Corresponding author.
E-mail addresses: grohcj@udmercy.edu (C.J. Groh), anthonmy@udmercy.edu (M. Anthony), gashje@udmercy.edu (J. Gash).

https://doi.org/10.1016/j.apnu.2018.01.007
Received 6 December 2017; Received in revised form 8 January 2018; Accepted 19 January 2018

There is little empirical data on suicide in Guyana. Harry et al. (2016) examined a representative sample of 555 Guyanese who completed suicide between 2010 and 2012. Males completed suicide at a rate of 4:1 over females. Fifty percent were 20 to 49 years old, predominantly male, and 80% Guyanese of East Indian descent. Ingestion of pesticides was the most commonly used method in 65% of cases, with hanging the second most common at < 20%. The authors also found there were 20 to 25 suicide attempts for every completed suicide.

Hatim, Austin, Harikishun, Rampersaud, Callender, and Persaud (2016, unpublished manuscript) conducted a retrospective analysis of all available cases of suicide in 2015. There was a total of 145 cases (126 suicide attempts and 19 suicide mortalities). Risk factors among the suicide attempters were: age 12–25 years, being unemployment, and identifying as a Pentecostal Christian. East Indians and those with secondary level education were more likely to complete suicide. The most common reason for suicide attempt or completion was anger towards others, and the method used by most individuals was ingestion of poison.

Anthony, Groh, and Gash (2017) conducted a qualitative study to explore Guyanese nurses' and nurse aides' attitudes and experiences with suicide. The participants felt dysfunctional family issues related to unemployment, alcoholism, and harsh parenting styles contribute to the high suicide rate. They related many experiences when suicide attempters voiced regret, suggesting a cry for help or impulsivity, rather than a true desire to die. They also described a lack of community support for families of suicide victims and stigma related to suicide that hinders progress in dealing with this crisis.

Guyana has few mental health resources. National Psychiatric Hospital (NPH) is the only psychiatric hospital in the country, with 200 beds. There are also two outpatient mental health facilities, one administered by NPH and the other by Georgetown Public Hospital Corporation (GPHC) Psychiatry Department. In addition, NPH/GPHC provide monthly satellite clinics staffed by a mobile team (psychiatrist, nurse, social worker, and staff) to 10 different places in Guyana (per email communication August 11, 2017 with Dr. Bhiro Harry and Dr. Jorge Balseiro).

Family members of suicide victims or suicide attempters have unique insight into the contributing circumstances. The purpose of this qualitative study was to explore the attitudes and experiences of family members who have experienced the death of a loved one due to suicide.

METHODS

A qualitative descriptive study using semi-structured interviews was conducted to explore the attitudes, experiences and opinions of family members who had lost a loved one to suicide.

Criteria for inclusion in this study were English speaking participants who had lost a family member to suicide, and willingness to sign informed consent. Participants were recruited via a respected community leader and advocate who encouraged surviving family members to participate. We chose a focus group rather than individual interviews for two major reasons. First, the community and surviving family members were not known to the researchers and we felt the family members would be more comfortable in a focus group. Second, it was our hope that the focus group would provide support to the surviving family members and an avenue for continued support once the researchers completed the study.

Approval to conduct this study was obtained through the authors' university institutional review board. The study purpose was described, confidentiality was assured within the bounds of a focus group, and participants were informed they could withdraw at any time. Written consent for participation and audiotaping of the focus group was obtained and each participant received $20 USD at the end of the focus group in consideration of their time. One participant was unable to read so the consent form was read to her and she verbally indicated understanding and signed the consent. The focus group lasted 90 minutes and was conducted by two of the authors (CG and JG) in the local community center. After obtaining informed consent, the participants were asked open-ended questions regarding their experience of their family member's suicide, how they were doing now, and advice they could offer other relatives of family members who died by suicide in their community (Table 1). Prompts were used when necessary. The interviews were audio taped and transcribed. Qualitative content analysis was performed to provide a comprehensive account of the data since content analysis is the preferred analysis strategy for qualitative descriptive studies (Sandelowski, 2000). The interview transcripts were independently read multiple times, identifying recurrent patterns and themes within the text by two of the authors (CG & MA). The two authors compared their results and discussed any discrepancies. Individual participant characteristics are provided in Table 2.

RESULTS

Ten survivors of a family member suicide participated in the focus group in March 2016. The participants included nine women and one man ranging in age from 17 to 61 years. All ten self-identified as East Indian.

During the focus group, participants were asked open-ended questions that elicited descriptions of their experiences and feelings of being a survivor of a family member's suicide. Four overarching themes emerged from the data: (1) perceived causes of suicide, (2) perceived solutions, (3) barriers to helping persons who are suicidal, and (4) personal and community reactions to suicide.

Table 1
Interview questions.

General questions	Probing questions
1. Tell us about your experience when your family member died?	How did you find out? How did the suicide affect you emotionally? Did your family member's suicide take you by surprise? How did the community react to the suicide?
2. How are you doing now?	How long ago was the suicide? How did you cope when it first happened? Are there community resources for relatives of family members' who died by suicide? What has been the most helpful for you in dealing with the loss? How has the suicide affect your family? Was your church a source of support and comfort?
3. What advice or guidance do you offer other relatives of family members who have died by suicide in your community?	Are you in a place where you can support other relatives or is your distress and pain still to fresh? What advice or resources do you think is most helpful for other relatives? What other resources do you think need to be added for relatives in your community?