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Suicide in rural Haiti: Clinical and community perceptions of prevalence, etiology, and prevention

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ABSTRACT

Suicide is a complex global public health problem, yet few studies have examined local socio-cultural explanatory models and other contextual factors surrounding suicide in low-and-middle-income countries. Such research is critical, as suicide frequency and etiology, as well as care-seeking in the case of distress, differ contextually and by sub-groups within a population. This is the first study of its kind to explore the dual perspectives of both healthcare workers and community members regarding suicide in Haiti. We conducted semi-structured, in-depth interviews between May and June 2011 with eight biomedical healthcare workers and 16 lay community members. Qualitative data analysis, drawing on interpretive phenomenological analysis, addressed themes including perceived suicide frequency, veracity of suicidal ideation claims, perceived causal factors, religious constructs related to suicide, and support resources for suicidality. Compared to community members, healthcare workers underestimated the frequency of suicide and were less likely to interpret suicide-related claims as representing true intent. Religious perspectives influenced attitudes toward suicide, albeit in different ways: Christian concern with the afterlife resulted in suicide being unacceptable and sinful, while Vodou explanatory frameworks displaced blame and stigma away from suicidal individuals. Healthcare workers' failure to recognize suicide as a serious problem suggests that the formal health system is currently ill-equipped to respond to suicide-related needs. Religious practice and community supports in rural Haiti may serve as essential resources for prevention programs.

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Introduction

Over one million people die from self-inflicted injuries annually, with over 85% of these deaths occurring within low-and-middle-income countries (LMIC) (WHO, 2011b). Globally, self-inflicted injuries are projected to rise from the 14th to 12th leading cause of death by 2030 (Mathers & Loncar, 2006). In some countries, suicide rates have increased by approximately 60% over the past 45 years (Bertolote et al., 2005). Completed suicides are only a fraction of the problem: 10–20 million individuals attempt suicide each year (Hendin et al., 2008). Despite its substantial burden, suicide remains under-prioritized among researchers and stakeholders compared to other mental health problems in LMIC (Sharan et al., 2009).

Lay and clinical interpretations of suicidal ideation and intent determine the availability and type of support for persons reporting suicidal thoughts (Osafo, Hjelmeland, Akotia, & Knizek, 2011; Osafo, Knizek, Akotia, & Hjelmeland, 2011, 2012; Owen et al., 2012). Misunderstanding of suicide communication events, including questioning veracity of reported suicidal ideation, is a barrier to support and referral (Owen et al., 2012). Physicians and nurses in the US often question the veracity of patients' suicidal statements and stigmatize them as malingerers (Rissmiller, Steer, Friedman, & DeMercurio, 1999; Ross & Goldner, 2009). A study found that US emergency department nurses often held negative attitudes toward persons who had attempted suicide (Pallikkathayil & Morgan, 1988). Stigma and communication between laypersons and providers may be worse in LMIC (Keusch, Wilentz & Kleinman, 2006).

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Only 14% of persons exhibiting suicidal behavior in LMIC pursue medical treatment, compared to 52% in high-income countries, and low-income country informants are less likely to disclose need for treatment (Bruffaerts et al., 2011).

Qualitative studies are crucial for documenting variation in communication and interpretation related to suicide. Qualitative studies examining interpretations of suicide among laypersons and clinicians reveal socio-cultural factors impacting patterns of suicidal behavior and communication, and have called for more effective prevention measures (Hjelmeland et al., 2008; Mugisha, Hjelmeland, Kinyanda, & Knizek, 2011; Osafo, Knizek, et al., 2011; Osafo et al., 2012). Negative attitudes toward suicide have been documented among psychology students in Ghana and Uganda and among medical students in India, with suicide perceived as cowardly or immoral (Etzersdorfer, Vijayakumar, Schony, Grausgruber, & Sonneck, 1998; Hjelmeland et al., 2008; Osafo, Hjelmeland, et al., 2011). In Ghana, psychology students, nurses, and lay individuals framed suicide as a moral issue and suicidal individuals as blameworthy (Osafo, Hjelmeland, et al., 2011; Osafo, Knizek, et al., 2011; Osafo et al., 2012). In contrast, Ghanaian psychologists regarded suicide as a mental health issue that deserves empathy and improved community psycho-education. Positive attitudes were attributed to the psychologists' level of education and clinical experience with suicide.

Lay and clinical interpretations of suicidal behavior and communication vary within and between cultures. In Uganda, suicide is perceived as dangerous to the family and entire community, and relatives of those deceased by suicide are not permitted to openly communicate their grief (Mugisha et al., 2011). Furthermore, social stigma of suicide impacts communication and willingness to seek care among Swedish and Turkish adolescents (Eskin, 2003). In Ghana, suicidal behavior has been condemned as a criminal act and as unethical (Osafo, Knizek, et al., 2011). In this context, suicide was understood through a cultural lens that values interdependence, upholding social obligation, and avoiding social shame. Thus, suicide goes against the ethics of divinity and community, simultaneously violating the sacred order and social harmony (Osafo, Knizek, et al., 2011).

Religious context may influence interpretations and disclosure of suicidal thoughts, but studies have reported contradictory findings regarding the role of religion in suicide, even in the same setting (Colucci & Martin, 2008). For example, in Ghana, Eshun (2003) found that religion was not significantly associated with suicide, whereas Osafo et al. (2012) found religion to be protective. Religion has been linked to perspectives that suicidal behavior is unacceptable (Colucci & Martin, 2008; Osafo, Hjelmeland, et al., 2011). In particular, Osafo, Hjelmeland, et al. (2011) and Osafo et al. (2012) found that Christian informants framed suicide as offensive to God and a failure of individuals to rely on their religion and other coping norms. Concluding a literature review of religion and suicide, Colucci and Martin (2008) call for more qualitative research into these complex issues, a greater focus on how the content of religious beliefs impacts suicidal perspectives and behavior, and greater attention to ethnographic context, of which religion and spirituality are core components.

As suicide is deeply embedded in local cultural settings, understanding individuals' worldviews of suicide is essential for informing the development of culturally-relevant and effective prevention programs (Atkinson, 1971; Bertolote et al., 2005; Wexler, 2006). Because physician education is one of the few evidence-supported interventions for suicide risk reduction (Mann et al., 2005), it is essential to understand healthcare workers' perspectives toward suicide, with a focus on the potential barriers and facilitators of successful interventions (Osafo, Hjelmeland, et al., 2011; Osafo et al., 2012). Reasons for negative perspectives among healthcare workers include anger or frustration when time is spent treating self-destructive individuals instead of the "seriously ill," as well as seeing repeat attempters as manipulative or attention-seeking (Pallikkathayil & Morgan, 1988). Such perspectives are problematic, as they can result in lack of empathy from the provider and thus poorer quality care (Osafo et al., 2012).

Studies that examine how different cultures conceive of and discuss suicide will improve our knowledge of the various contextual meanings of suicide cross-culturally, enabling the design of culturally-relevant prevention, screening, and intervention programs (Mugisha et al., 2011). Qualitative research allows for such nuanced, contextualized perspectives of suicide, which illuminate comparative worldviews and potential interventions. The present study, conducted among both community members and healthcare providers, is the first account of local interpretations of suicide in rural Haiti. Given the dearth of qualitative suicide literature in LMIC settings, our findings will contribute to future research and prioritization of mental health infrastructure, both in Haiti and LMIC settings worldwide.

Methods

Study setting: rural Haiti

Haiti is home to almost ten million people, of whom 80% live in rural areas (PRB, 2010). The family in Haiti is elastic and extended, usually including a large network of relatives, neighbors, and friends (Dauphin, 2002). Although there is overlap in tasks, women tend to care for children and the home and engage in market commerce (*fê komes*), while men work the land (*travay la tè*) and secure the home (Miller, 2000). Social groups in Haiti are affected by a profound class hierarchy based on educational attainment, language, and familial background (Desrosiers & St Fleurose, 2002). Nearly every Haitian speaks Kreyòl as their first language, and a minority of well-educated individuals speak French. Literacy is low; less than one-third of the population has education beyond primary school. Income inequality in Haiti is ranked among the worst in the world. Most of the country lives below the poverty line, and almost half live in extreme poverty (World Bank, 2001). Rural residents often lack indoor plumbing, have little access to social services, and depend on agricultural production for survival (Verner & Edset, 2007). Neocolonialism and legacies of slavery restrict access to political, economic, and social power and perpetuate severe inequality (Trouillot, 1990). Haiti has endured remarkable oppression and structural violence, contributing to its high burden of disease and premature mortality (Farmer, 2003).

Religion is a critical component of political, moral, physical, and social life in Haiti (Hurbon, 2004). There is dense religious diversity in Haitian communities, including Roman Catholicism, Vodou, and various Protestant traditions. The majority of Haitians, particularly poorer individuals, practice Vodou, and many individuals dually identify as Christian and Vodouisant (Métraux, 1958). Despite widespread practice, it is considered taboo to openly discuss Vodou (Ramsey, 2011), with followers disavowing such behavior, particularly to foreigners and in communities with powerful churches (Brodwin, 1996). The Vodou perspective relieves self-blame and rather attributes poor health and mental illness to something beyond the individual's immediate control (Desrosiers & St Fleurose, 2002; Pierre et al., 2010). However, despite mechanisms for blame displacement, shame associated with severe mental illness is nevertheless inflicted on the family and may cause debilitating stigma (Gopaul-McNicol, Benjamin-Dartigue, & Francois, 1998). The WHO does not report any suicide statistics for Haiti, and currently there are no published studies of suicide prevalence or interventions to address the issue in Haiti (Bertolote et al., 2005).

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