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Suicide Rates Among Young, Married Women in Nepal

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Suicide Rates Among Young Married Nepali Women

I. Introduction

In 2009, a Maternal Mortality and Morbidity (MMM) report carried out in Nepal by the Family Health Division of the Department of Health Services accidentally stumbled upon a surprising leading cause of death in Nepali women of reproductive age (15 - 49). The result: suicide. And the numbers are still on the rise. There have since been no comprehensive follow-up studies and none, to my knowledge, that are currently ongoing. This leaves an urgent need for research to be done on the causes of these suicides (Benson and Shakya, 2011; Bertolote et al, 2005; Pradhan et al, 2009).

Globally, there is one death by suicide every 40 seconds (IASP, 2012). The number of lives lost around the world to suicide annually exceeds the number of deaths due to homicide and war combined (IASP, 2012). It is agreed in international literature that female suicides are higher than male suicides within Nepal due to social and cultural factors, whereas, globally, male suicide rates are higher. It's estimated that 15-20 women commit suicide every month in Nepal (Sarkar, 2010). Attempt rates can be 10-20 times higher.

Legally, in Nepal, suicide is a crime and socially it is stigmatized. Many suicides are reported as accidents due to the family's fear of stigma- if they are reported at all (Mental Health Foundation, 2012; Himalayan News Service, 2011). One study estimates that only 10% of all suicide cases are reported to the police due to legal difficulties and stigma (Rauniyar, 2010).

In Nepal's neighboring countries, there are reports and studies on female suicide as well. Parallels can be drawn between the countries, especially India, because the existing social structures and stress faced by women are very similar. Indian studies point to factors involving problems with in laws and inter-personal relationships as causes of female suicide (Bhugra and

Desai, 2002; Parkar et al, 2008; Vijaykumar, 2007). Married women had a higher rate of suicide (Patel et al, 2012). In one comparative study, Asian women reported more marital problems than their United Kingdom counterparts (Bhugra and Desai, 2002). A Pakistani study shows the same results: 75% of the women were under 30 and the majority were married (Khan and Reza, 1998). Women cited problems with their spouses or in laws as reasons for their suicidal behavior. In China, suicide is the leading cause of death among girls and boys aged 15-34 (Zhang, 2010). One Chinese study found marriage in China to be a risk factor for suicide. In fact, most risk factors for female suicide were family related, especially involving tensions with the mother in law (Zhang, 2010). Research in Nepal shows similar findings. Khan and Reza found the systemic social, economic, and legal discrimination against women in Pakistan predisposes them to psychological distress and suicidal behavior (1998). The same is argued for Nepal. A report from Bir Hospital in Kathmandu - where more than 80% of suicide patients go- found adjustment after marriage, domestic violence, and bad inter-personal relationship with family members to be key causes of suicide (Bhattarai, 2010; Sharma, ND). The question I pose for my research is as follows: *What are the causes of suicidal behavior among young, married women in Nepal?*

For the purpose of this study, 'young' is defined as between the ages of 15- 35. I have chosen to focus on married women because of the complex family dynamics that arise in Nepali marriages, especially arranged marriages. One study on suicide attemptees found that married women within the age of 15 to 30 were a major group to attempt suicide (Sharma, no date). Women of reproductive age carry the triple burden of productive, reproductive, and caring work (Astbury, 2001). Unlike most Western countries where marriage is a protective factor against suicide, in many Asian countries it increases suicidal vulnerability because the risk factors are family related (Parkar et al, 2008). For most young, married women in Asia today married life

means depression, mental torture, self-immolation, bride burning for dowry, etc (Joshi and Kharel, 2008).

I hope that my research findings will yield some clarification into the causality of such a high suicide rate in these women. I did not intend this study to be entirely comprehensive, merely to open avenues for further, larger studies.

II. Literature Review

I conducted a comprehensive literature review on suicide and psychiatric morbidity (occurrence of mental illnesses) relating to Nepal, women, Asia, and global trends. The findings include journal articles and grey material obtained from internet searches that were not published in academic databases. There is a lack of a standardized information management system and information sharing protocol relating to suicide data, violence against women, and many other relevant topics in Nepal. Most research done on the subject of suicide in Nepal has been conducted recently, in the last 5-10 years.

The MMM study researched a population of 86,000 women of reproductive age in 8 districts across Nepal. The study found that “the leading cause of death ... was ‘External causes of morbidity and mortality’ (25%).” It further states “This change was largely due to the increase in suicides” (Pradhan A, Suvedi B K, Barnett S et al, 2009). External causes include “intentional self-harm (suicide) and motor accidents, falls, injury by projectile or explosion” (Pradhan A, Suvedi B K, Barnett S et al, 2009). Suicide accounted for 16% of deaths. In South East Asia, suicide rates are more than double homicide rates (NHRC, 2009). The MMM study (2009) states that in 1998 and 2009, suicide was the single leading cause of death. Many studies agree in their conclusions that these findings “highlight the urgent need to address this issue, which has received little attention since its significance was first noted in 1998” (Pradhan et al, 2009) and

“calls for immediate action to better understand the causes and contributory factors” (Pradhan et al, 2009). Through analysis of verbal autopsy data, Pradhan et al (2011) suggest that mental health problems, relationships, marriage, and family issues including domestic abuse may be key risk factors.

The World Health Organization (WHO) cautions that global rates of suicide are increasing (Pradhan A, Poudel P, Thomas D, Barnett S, 2011; NMHF, 2012; NHRC, 2009). Suicides have increased in 48 of the 75 districts in Nepal (Bhattarai, 2010) with the highest rates for women in the Far-Western and Central regions (NHRC, 2009). It is estimated that 11 people commit suicide every day in Nepal (Rauniyar, 2010).

Data on suicide in Nepal is sparse, oppositional, and contradicting. Police data, individual nongovernmental studies, and governmental studies show different figures and factors for suicide. Numbers of female suicide range from 348 to over 2000 according to individual organization data, police data, or individual study estimates. Presently, police data is the only national suicide data. India, Sri Lanka, and the Maldives are the only South East Asian countries to report suicide data to WHO so cross country comparisons are difficult. Suicide Prevention International’s STOPS (Strategies to Prevent Suicides) programming campaign is not active in Nepal. Deaths and hospital entries are not systematically categorized. In Nepal, hospitals record the final cause of death under International Categorization of Disease ICD-X code. Like in the MMM study, suicides are classified under “External Causes of Morbidity and Mortality.” However, due to a number of factors, correct recording does not always happen.

The most common means of suicide among these Nepali women was poisoning by ingesting pesticides (Pradhan et al, 2011). Organophosphate was particularly common. Researchers hypothesize this is due to the accessibility of such substances.

III. Research

1. Research Methodology

The study gathered information on suicidal behavior, actions, and underlying reasons for suicidal behavior of young (15-35), married Nepali women. The study methodology covered both qualitative and quantitative aspects. Between October 2012 and February 2013, fourteen participants' data was collected via interview or questionnaire. Nine in depth interviews were conducted in person from October to December 2012 in Kathmandu with: (1) formal health care providers, (2) psychiatrists and mental health professionals, (3) mental health activists, (4) key informants working in the fields of gender based violence, human rights, (5) academics, (6) NGO workers. The interviews were used to gather information on care seeking behavior for individuals at risk of suicide, socio-cultural practices, quality and type of care provided, challenges in providing care, types of suicides, and possible reasons given for attempting/committing suicide. Five questionnaires were given to the same categories of individuals as mentioned for the interviews. The number of respondents was approximately 34%. A thematic analysis was carried out on their responses.

Participants were selected via nonrandom methods: hand selection and snowball methodologies. Participants were purposely selected because of their expertise, position, and knowledge of suicides, mental health, and/or women's situation on the ground in Nepal.

2. Limitations

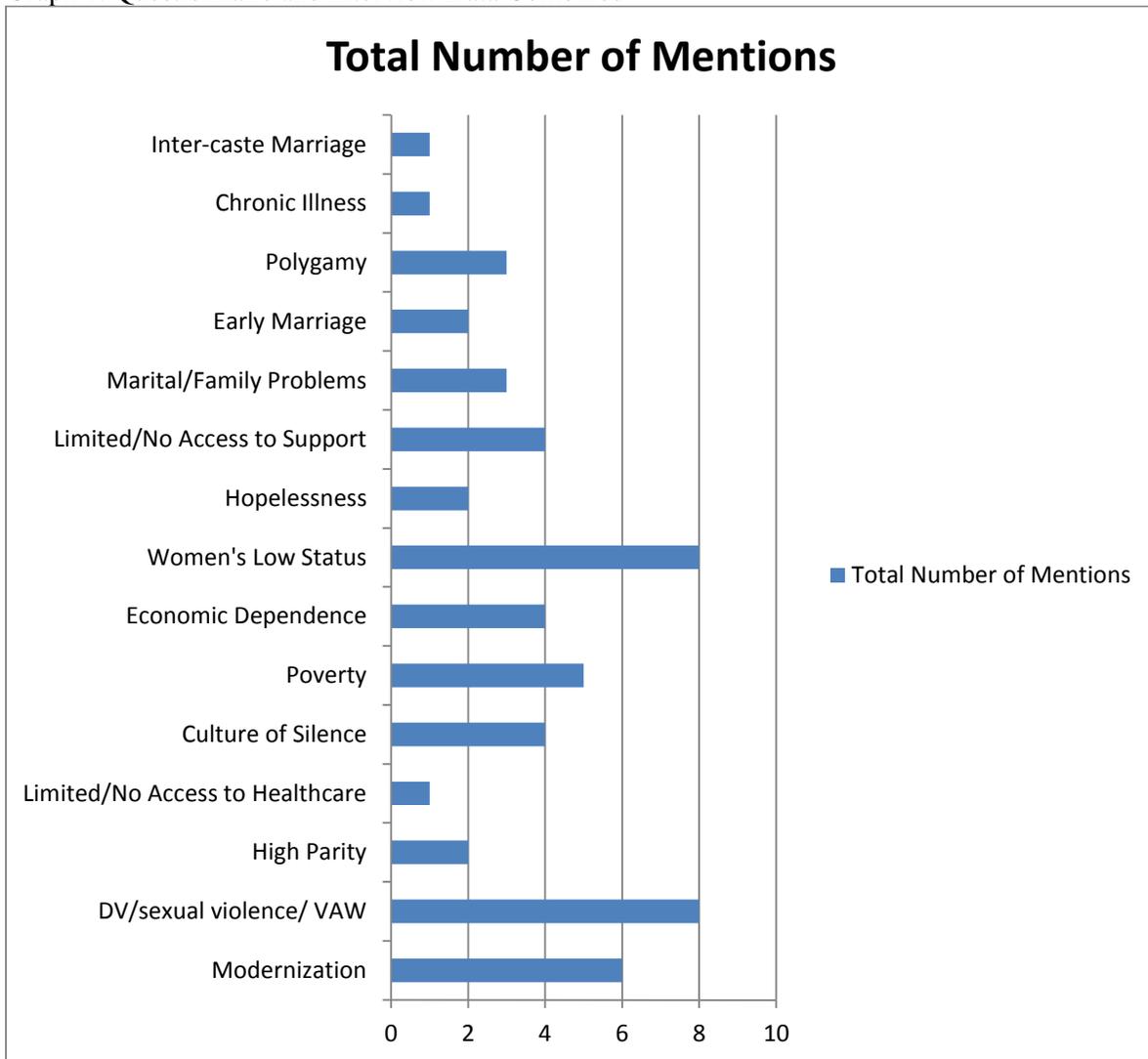
This study had several limitations. One limitation was that, due to ethical boundaries and language restrictions, information was only gathered from secondary sources. No family members or persons at risk of suicide or that have attempted suicide were contacted during this study. Another limitation was due to travel restrictions. Interviews only took place in Nepal's

Central district, around Kathmandu. Questionnaire participants are also located around Kathmandu or Pokhara, another large city. For this reason, though information may be gathered about rural settings, the conclusions drawn from this study may not be generalized to other districts. Another limitation was the scale of the study. With only one researcher, myself, only 9 interviews were conducted and 5 questionnaires returned. This limited the scope of the research. There was also a degree of researcher bias as I am a woman studying a women's issue. Limitations also arose with respect to the deeper context of the topic of women's suicide that as a foreigner, not native to the culture, I am not able to fully understand.

IV. Presentation and Analysis of Data

Forms of Violence, Women's Low Status, and Modernization were the top three factors when all data was combined. Forms of Violence and Women's Low Status each received the highest number of mentions indicating that participants believed suicidal behavior among young, married Nepali women was due, in a large part, to these two factors. These findings were supported by Astbury's WHO report on gender disparities in mental health. The report found gender based violence to be a major factor in female suicides and women's low rank to be a significant predictor of depression which leads to suicide (Astbury, 2001). It was interesting to note that Forms of Violence were a direct cause whereas Women's Low Status had a more indirect causal relationship to the women's suicidal behavior. Each factor leads to the feeling of hopelessness and desire to commit suicide, but there are many influences that combine to create the system where women have such low status. Modernization was third with six mentions. Poverty was fourth with five. Both of these factors are indirect and encompass a variety of contextual and psychological influences as well.

Graph 1: Questionnaire and Interview Data Combined



V. Discussion

1. Conclusions

Suicidal behavior always involves a multitude of predisposing (internal determinants) and precipitating factors (external/environmental influences). A woman's emotions, psychology, coping strengths, and desire to live are individualized and unique. I have identified four broad categories of risk factors: Modernization, Poverty, Patriarchy, and Traditional/Cultural Practices. The other factors such as Domestic Violence, Economic Dependence, Depression, and Husband's Alcoholism stem from these four.

Modernization: All districts of Nepal, especially the central districts of Kathmandu, are undergoing extremely rapid modernization. This manifests with large numbers of young men going abroad for work, increased exposure to alcohol, urbanization, shifting cultural priorities, increased competition for jobs and status, and the breakdown of the joint family structure toward nuclear families. Participants remarked that modernization played a key role in the increase of suicides in recent years. 22% of Nepal's GDP is remittance based, making it the 6th highest receiver in the world (Himalayan News Service 2012).

Poverty: Poverty is a deep cutting issue in Nepal and an indirect cause of suicide among women. It is indirect because it sets the stage for a number of other factors to play a role as well: stress, illness, hunger, hopelessness, and so on. 24.8% of Nepali families live on less than \$1.25 a day (World Bank, 2010). Nepal is ranked #157 out of 187 for UNDP's Human Development Index (UNDP, 2011). Poverty appears in many different aspects of society and women's lives. According to Nepali police, suicides cases triggered by poverty are increasing (Bhattarai, 2010).

Poverty affects what resources are available as well. Several participants mentioned that rural Nepali women often have no idea what services and rights are afforded to them. In the analysis of the health care literature within Nepal, mental health was often not mentioned. Less than 1% of Nepal's budget goes to mental health services (Luitel et al, 2012; Pradhan et al, 2009).

Patriarchy: Patriarchy in Nepal is all pervasive. It is within the caste system, it is within the school system, within government, within men and women's daily lives. Gender begins to define perceptions of abilities and, in Nepal, women are seen as less able and less productive. Nepal is ranked #113 out of 146 in UNDP's Gender Equality Index (UNDP, 2011).

One participant explained that women in Nepal have no self-confidence, self-trust, or self-respect. This is due to discrimination and treatment of women from birth and reinforced by social hierarchy. Girls are fed after their brothers, young wives care for their husbands, elderly women look after their sons and so on and so forth- the cycle of women's low status continues (Subedi, 2010). Women's low rank and gender based violence are significant predictors for suicidality (Astbury, 2001). In developing countries, married women face the greatest risk for suicidal behavior (Vijaykumar, 2004). Marital status itself is not the factor; "family and social integration" is the real determinant (Vijaykumar, 2004).

In Nepal, violence against women usually takes the form verbal harassment and emotional abuse in addition to physical violence (Joshi and Kharel, 2008). Several participants explained the commonality of what one called "mental torture" by the husband and mother in law. Other studies agree that the perpetrator is usually a family member (Sapkota, 2011). 2011 was the first year that the Nepal Demographic Health Survey collected data on domestic violence. The change occurred due to the findings on violence and suicide in the Maternal Mortality Report in 2010. Violence is estimated to occur in the majority of households in Nepal (Martin, 2008).

The patriarchal mindset also creates customs and cultural practices that serve to sustain and feed women's low status and disempowerment.

Traditional/Cultural Practices: Cultural traditions that are harmful to women and the pervasive existence of patriarchy in Nepal create a reality in which women must face and tolerate numerous hardships and tragedies in their lives. Prejudices are born from these cultural norms and values. Social norms restrict women's power by restricting their earning possibilities, limiting the tasks they can perform, restricting their presence in public and creates the cultural

construction of appropriate female behavior (Agarwal, 2007). According to interviews, gender relations in Nepal are based on assumptions and expectations of women's low status and wife's obedience and service. "From the early ages, boys are prepared towards 'outside world' to involve in 'productive' and decision making function, whereas girls are detained to the 'inside world' to learn the household chores to be a perfect 'home maker', 'dutiful and loyal wife,' 'loving mother,' 'subservient' and 'service provider'" (Basnet, 2011). This sentiment was echoed by all participants. A 'culture of silence' exists in Nepal and with it the suppression of female voices. Nearly all participants brought up having to keep silent and the influence that has on the woman's mental state. Women's self-silencing is how women internalize subordination and social inequality becomes part of one's felt worth and standing (Jack and Ommeren, no date). Women avoid expressing suffering or seeking help and eventually reach a stage when they see suicide as the only option.

In South Asia especially with one of the highest incidence rates of gender based violence in the world, idioms such as "the wife is the dust of the husband's foot" perpetuate harmful cultural practices that disempower women. Born from the patriarchal mindset that gives husbands full control over their wives, they fuel cultural and traditional norms of women's subservience. This leads to domestic violence and practices such as chhaupadi, dowry, incest, rape, and polygamy.

The confluence of these four major areas creates an environment in which young, married women are vulnerable to becoming at high risk of suicide. A woman's identity is dependent on that of a man's, whether it is brother, father, or husband. Very few Nepali women are raised to cultivate their own sense of worth or value, their own self-respect or self-confidence. Most women's lives are shaped, either subtly or unsubtly, by their low status in society and their

perceived limited value outside of being a wife and mother. They face high rates of violence, years of service to their husband and his family, and restrictions on what they are permitted to do and where they are permitted to go. They face obstacles in seeking and accessing support services- legal, financial, shelters, and otherwise. They face years of pregnancies and births. Some face poverty. Some face polygamy. One participant described a women lives being like slaves with no freedom (personal communication, 2012). The life expectancy of a woman in Nepal is a mere 69 years old. Numbers of suicides are higher than ever before in Nepal and have increased 60% in the last 45 years (Mental Health Foundation, 2012).

2. Recommendations for Further Research

I believe more research can be done to develop a profile for these young, married women and develop a model of the factors they face and the processes they undergo in creating suicidal ideations.

By analyzing current suicidal theory, I believe that these Nepali women most closely fit into Thomas Joiner's and David Malan's theories on suicide. Thomas Joiner (2005) postulated the interpersonal-psychological theory in 2005. It states that the person developing suicidal behavior must develop high levels of: a sense of thwarted belongingness, a perception of burdensomeness, and the acquired capability for suicide. The first two variables create the desire to kill oneself. However, Joiner also notes that the individual must cultivate a capability to suicide, aka the strong desire to go against our innate will to live and fear of death. He argues that this requires habituation through repeated exposure to physical pain and fear and be able to tolerate extremely high levels. Malan's (1997) theory is simple extremely simplistic. It states that suicide is the effect of accumulated trauma. From these two theories, possible prevention strategies could be drawn forth and developed.

Perhaps the most overlooked aspect of the suicides of these young, married women is what happens to their children after the mother's death. It could be expanded to study how the dynamics of the entire family shift after the woman's suicide. Participants explained that the husband usually remarries quickly. If the new wife does not like the children of the deceased woman, they could be exposed to beatings and violence or they are expelled from the house. For the children, this means they attempt to live with their mother's family or they are relegated to the streets.

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