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**A qualitative study of the cultural implications of  
attempted suicide and its prevention in South  
India**

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**Reena A Lasrado**

**School of Nursing, Midwifery and Social Work**

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## **Abbreviations**

CBSE: Central Board of Secondary Education

CBT: Cognitive Behaviour Therapy

F: Female

M: Male

MH: Mental Health Professional (participant)

NCRB: National Crime Records Bureau

OP: Organophosphate

REBT: Rational Emotive Behaviour therapy

S: Survivor (participant)

SC: Scheduled Caste

ST: Scheduled Tribe

TH: Traditional Healer (participant)



## **Abstract**

*A thesis submitted by Reena A Lasrado to The University of Manchester for the Degree of Doctor of Philosophy in the Faculty of Medical and Human Sciences 2014.*

### **A qualitative study of the cultural implications of attempted suicide and its prevention in South India**

Suicide in India is a complex social issue and a neglected area by the state. Research has focussed on risk factors and the epidemiology of suicide; studies concerning the intersection of culture with attempted suicide are limited. The aim of this study is to explore cultural implications of attempted suicide and its prevention in Southern India by means of comparing and contrasting the accounts of survivors of attempted suicide, mental health professionals and traditional healers engaged in treating people with suicidal behaviour.

#### **Methodology**

A qualitative design is used drawing on constant comparison method and thematic analysis. The analysis of the data is underpinned by the theoretical concepts of Bourdieu's work. In-depth interviews were conducted with fifteen survivors of attempted suicide, eight mental health professionals and eight healers from Southern India.

#### **Results**

Application of Bourdieu's theory of symbolic power and violence, cultural capital and habitus to the analysis of data revealed the process of constant interaction among visible and invisible fields such as faith, power, control, family, religion and social systems which impact survivors' disposition to situations. Disparities in gender and role structures within families, financial challenges, health concerns, abuse, and violence were commonly cited factors by all three groups of participants. A few survivors and healers attributed misfortunes and distress to magic, spells and 'bad times'. Healers and professionals were particularly of the opinion that cultural transition has added to stress among people. Survivors considered religious and traditional methods of support as socially accepted norms. Medical assistance was sought only during apparent ill health. Psychosocial support was very rarely accessed and availed. A lack of awareness among family members and friends to identify mental health concerns and a wide gap between identification of severe stressors and treatment increased the risk of suicide and limited timely intervention.

#### **Conclusion**

This study identified a set of cultural mechanisms that produced negative impact and led to attempted suicide. The role of culture in causing suicide and attempted suicide is explained by unravelling the dynamics of cultural mechanisms and support processes that survivors experienced and as reported by professionals and healers. This research evidence presents pathways into attempted suicide and a life away from suicide.

## Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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## Acknowledgments

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# 1 Introduction and Background

## 1.1 Introduction to the study

Suicide in India is a complex social issue and is conceptualised by the government as a medico-legal problem rather than as an issue of social concern (Colucci and Lester, 2012; Vijayakumar and Thilothammal, 1993). In order to understand the problem of suicide, it is vital to consider and explore the experiences and interactions that individuals have with their cultural and social environment.

The vast majority of existing literature concerning suicide in India (discussed in the following sections of this chapter and chapter 2) has tended to focus on the epidemiology and risk factors associated with suicide. Very limited attention has been given to understanding the influence culture plays in relation to suicide. Therefore, this study seeks to understand the socio-cultural aspects of what leads people to attempt suicide and to understand what their help seeking patterns are from the perspectives of survivors. This study also explores the views of both mental health professionals and traditional healers in relation to their experiences dealing with survivors and their views on the treatments that are available or prescribed in India. The need to study the role culture plays in relation to suicide is identifiable by investigating the gaps in biomedical and social models of suicide and these are discussed in section 2.2 of the chapter on conceptual background.

To study suicide in India and explore the role culture plays in cases of those who attempt suicide, it is important to consider some national statistics. This chapter aims to present factual data on the demography of India, epidemiology of suicides,

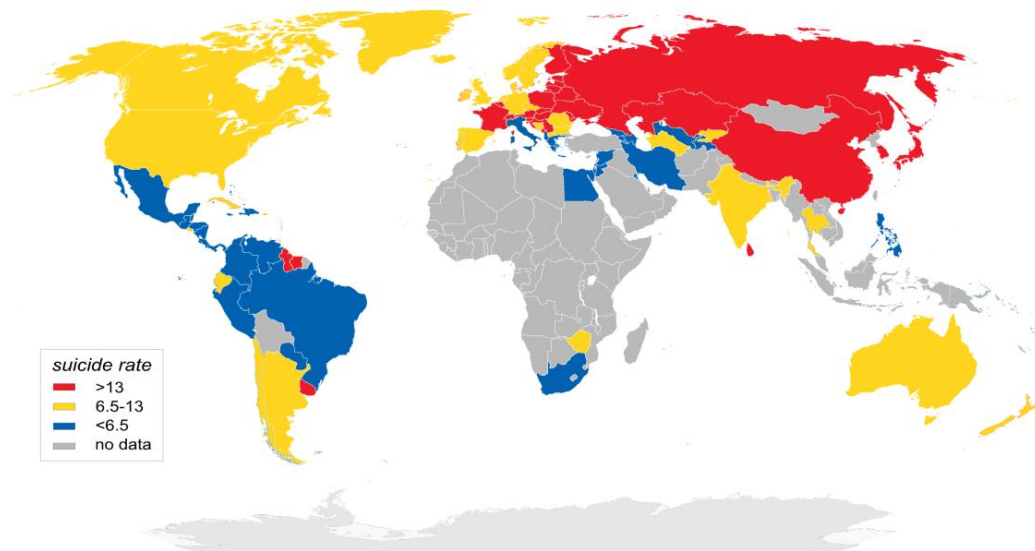
mental health provisions, systems for interventions and legislation related to suicide. By presenting epidemiological data on suicides, it demonstrates how national bodies conceptualise suicide in quantitative forms. It also highlights strengths and weaknesses in the data, such as the lack of data on attempted suicide and brings into focus the legislation surrounding suicide criminalisation and policy concerning mental health interventions. An understanding of these aspects is of great benefit when further exploring the social construction of culture and suicide in India. These topics will be explored further in later chapters.

## **1.2 Global rate of suicides**

The World Health Organisation (WHO) recognises suicide as one of 20 leading causes of death worldwide for all age groups (WHO, 2013b). WHO estimates the average annual global suicide death rate as 16 per 100,000. This estimate does not include the attempted suicide rate, which is 20 times higher than that of the completed suicides (WHO, 2011a). India ranks 44 on the list of countries by suicide rates (WHO, 2011b; WHO, 2012) with Lithuania being the highest and United Kingdom ranking 59 (see Appendix A : World Ranking by Suicide Rates on page 299). The validity of this ranking system is questionable as the data compiled for countries is not current, the year of last recorded data varies from country to country. For instance, Lithuania's reported suicide rate is for the year 2009, whereas Russian Federation which ranks third in the list is for 2006 and India for 2009 (WHO, 2011b). Secondly due to the socio-cultural and legal contexts, many countries including India acknowledge the danger of under-reported deaths by suicide (Hendin et al., 2008) which underestimates the problem of suicide and the

need to address it at a larger scale on a global and a national level. In line with this, Hendin et al's (2008, p. 9) discussion of WHO's rating of countries on the basis of quality of evidence, reported India to have been rated 3 'poor to fair'.

The following map provides an overview of rates of suicides on a global level.



**Figure 1 - Map of Global Suicide Rates 2011**

Data Source: (WHO, 2011a)

### **1.3 Demography and epidemiology of suicide in India**

India has a population of over 1.21 billion (The Registrar General and Census Commissioner, 2011) and is rated as the second most highly populated country after China (1.38 billion) (United Nations Department of Economic and Social Affairs and Population Division, 2013). India has more than 65% of its total population below the age of 35. There is a wide variation between urban (31.2%) and rural populations (68.8%) and nearly 55% of Indian population is engaged in agricultural activities. The literacy rate is circa 73%, with South Indian states having a better literacy rate (see Appendix D : Literacy Rate – India 2011 on page 304). The country

records 943 females for 1000 males as a sex ratio. India has more than two thousand ethnic groups and Hinduism is the major religion practiced by over 823 million people, followed by Muslims (138 million), Christians (24 million), Sikhs (19 million), Buddhists (7.9 million) and Jains (4.2 million) (The Registrar General and Census Commissioner, 2011). This discussion on demographic details will shed light on understanding the variation in practices, traditions and beliefs which interact with the lives of individuals, meanings of distress and the phenomenon of suicide.

### **Defining Suicide and attempted suicide**

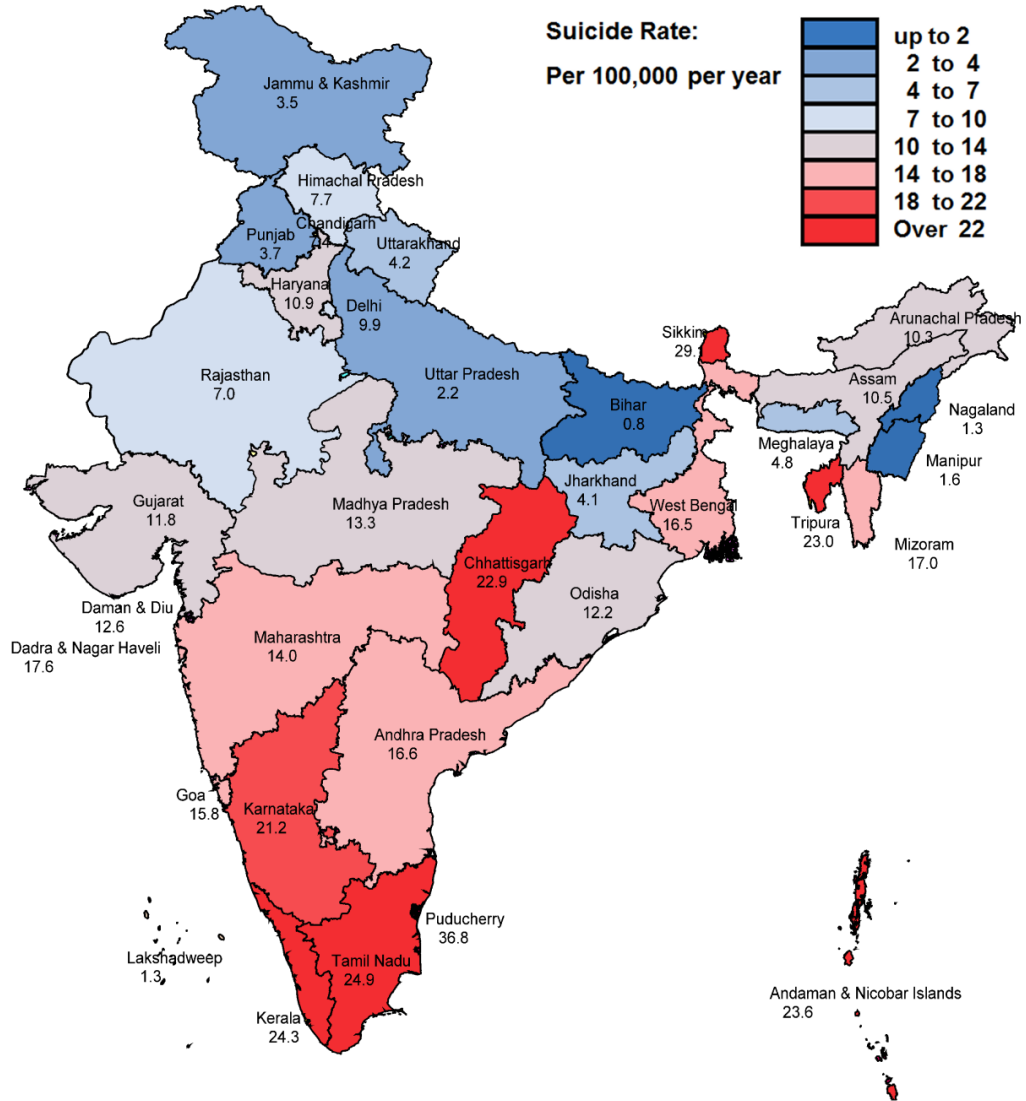
The World Health Organisation defined suicide as “the act of deliberately killing oneself” (WHO, 2013a). The data on completed suicide is collected and compiled by the Department of Police in India. These data are then collated by a national body viz. NCRB – National Crime Records Bureau. The NCRB outlines a few essential factors required for a death to be considered suicide, namely; ‘It should be an unnatural death, the desire to die should originate within him/her, and there should be a reason for ending life’ (National Crime Records Bureau, 2012, glossary v).

The term attempted suicide is used interchangeably with parasuicide and deliberate self harm in clinical practice (De Leo et al., 2006; Williams, 2001). De Leo and colleagues (2006, p. 14), following a WHO multicentre study on suicidal behaviour proposed to define attempted suicide as “A non habitual act with nonfatal outcome that the individual, expecting to, or taking the risk to die or to inflict bodily harm, initiated and carried out with the purpose of bringing about wanted changes”. The department of health in the UK does not provide for a classification of attempted suicide (Williams, 2001). The above definition presents attempted suicide as forms

of communication to express despair and distress where an intention to die is unclear and with a sole purpose to bring about changes. Distress is expressed and understood differently in various cultural contexts. In this study, attempted suicide is not understood purely as a behavioural communication to bring changes but as an act which may be fatal or non fatal inflicted upon oneself under conditions where one feels trapped.

The NCRB is the only national body that provides data on suicides while it fails to account for self-harm or attempted suicides category in the reporting of suicide in India. For the year 2012, it recorded 15 suicides per hour in India, reporting 135,445 (11.2/100,000 suicide rate) deaths due to suicide (National Crime Records Bureau, 2012). The number of suicides in the country increased in the decade 2002 (110,417) to 2012 (135,445) by 22.7%. Although there was no specific reason attributed to this rise, it may well be accounted for by the increasing population during the decade by 15.5%. There was a marginal variation in the rate of suicide from 10.5 for the year 2002 to 11.2 for the year 2012 (see Appendix B : Rates of Suicides against Midyear Population 2002 -2012 on page 302) (National Crime Records Bureau, 2012, Glossary xix). The map in Figure 2 presents recorded rates of suicide across the nation. It draws attention to South Indian states that record notably higher rates than the rest of the country.





**Figure 2 - Map of Indian Suicide Rates 2012**

Data Source: (National Crime Records Bureau, 2012)

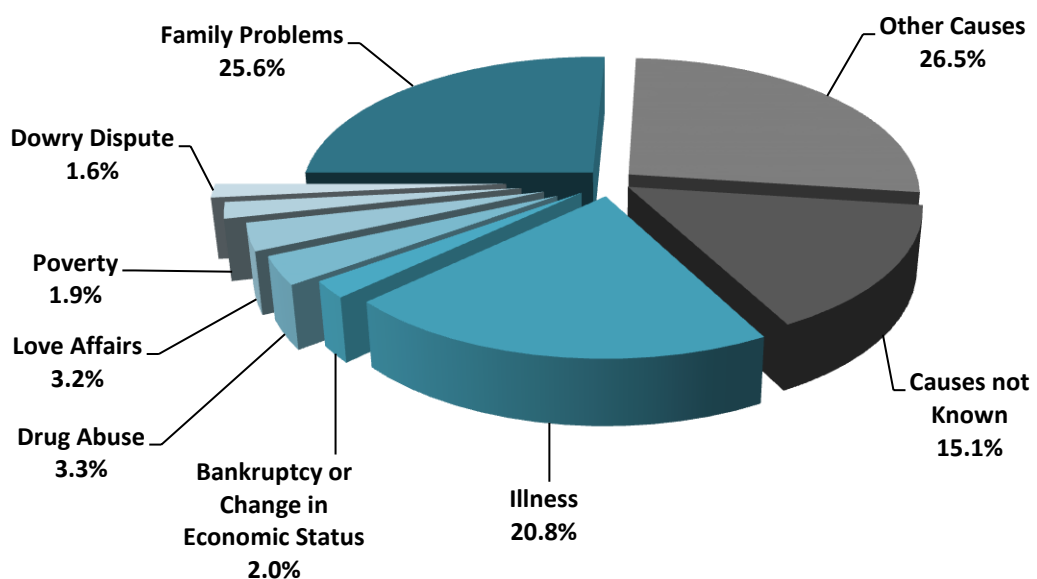
Five states in India (Tamil Nadu, Maharashtra, West Bengal, Andhra Pradesh and Karnataka) of which four are located in the south, together accounted for 55.3% of total suicides in the country (National Crime Records Bureau, 2012). The variation in suicide rates across India needs to be perceived along with other factors such as the inadequate reporting system (Vijayakumar et al., 2005), concentration of urban population, literacy and socio-economic contexts (Patel and Kleinman, 2003; Patel et al., 2012; Vijayakumar et al., 2005). The maps in Appendix C : Urban Population –

India 2011 on page 303 and Appendix D : Literacy Rate – India 2011 on page 304 reveal that South India accounts for a higher urban population and literacy rate compared to other parts of India (The Registrar General and Census Commissioner, 2011). The national report on suicide showed that the suicide rate for cities is higher (11.9 per 100,000) than the national rate (11.2 per 100,000) (National Crime Records Bureau, 2012, p. 189) and South India accounted for more than 50% of the country's total suicides (National Crime Records Bureau, 2012). A national survey on suicide rates conducted by Patel et al accounted for high rates of suicide in South India compared to other parts of India and they attributed this to 'acceptance of suicide as a coping strategy' with a combination of social, family, interpersonal and financial problems (Patel et al., 2012). Bose et.al (2009) and Hendin et.al (2008) recognised inefficient registration systems in rural areas as responsible for under-reporting of suicidal deaths. Similarly, gender difference, which is subject to domination and violence, also influenced the reporting of suicides (Aaron et al., 2004; Dreze and Khera, 2000; Mohanty et al., 2007). The verbal autopsy studies evidenced a higher rate of suicide in rural areas than those recorded by NCRB (Gajalakshmi and Peto, 2007; Joseph et al., 2003). Suicidal deaths in India go through a medico-legal autopsy and are thus registered by the local police, which may miss those presented as accidents to cover up suicides (Manoranjitham et al., 2007; Vijayakumar and Thilothammal, 1993).

The fear of complex legal proceedings which is followed by shame, social and family stigma often leads to under-reporting or misreporting of suicide and attempted suicides as accidents (Vijayakumar et al., 2005; Manoranjitham et al., 2007). Staples (2012a) pointed at the possibilities of under-reporting, over-reporting or

misreporting of suicides due to the nature of social capital attached to it. For example social stigma inhibits people from revealing suicide whereas in the case of suicides by farmers, the cases were reported more widely which might have had a political and economic bearing as the family of deceased farmers were given monetary compensation (for more information 2.5.5 on page 60). Staples also acknowledged that cases of attempted suicides are not recorded by the National Crime Records Bureau (NCRB). Furthermore, the NCRB suicidal death figures include homicide deaths which were covered up or misreported by attributing them as suicides.

The factors mentioned above not only lead to under-reporting of suicides, but also the causes associated with suicidal deaths. The following are the data on causes of suicides, in India, as recorded by the National Crime Records Bureau.



### Figure 3 - Percentage of Suicides by Causes during 2012

Data Source: (National Crime Records Bureau, 2012)

The recorded causes for suicide are interrelated and intertwined with each other. Most often, a stressful life event that precedes a suicide attempt is considered as the reason for suicide; however, the true cause may have been a series of different events, each one adding to the despair and distress on the individual, ultimately culminating in an attempt at suicide. What is striking about the data in the above graph is that we have very little information as almost 42% of suicides were categorised as either 'other' or 'unknown'. This data provides no insight as to what may actually have been the cause. Family problems account for just over 25% of causes, with illness a significant issue at 20.8% (National Crime Records Bureau, 2012). However there is little granularity in these figures. Family problems or illness covers a multitude, so it is clear that better quality information is needed. The low numbers associated with poverty and unemployment is questionable. Taking into consideration the age group it is noted that the highest number of suicides occurred among those aged between 15 – 44 years of age and the number of male suicides exceeded those of female suicides with a ratio of 66.2:33.8 (National Crime Records Bureau, 2012, p. 179). The rising rate of suicides in the economically productive age group raises an alarm for critical analysis of individuals' dispositions and responses to difficult situations, areas of stress, cultural and social capital that interact with individuals' lives within the social setting of a family and society. The difference in male – female suicide rate is not sufficiently investigated as verbal and psychological autopsy studies presented higher suicides among women than men which was contrary to the national report (Manoranjitham et al.,

2010; Mohanty et al., 2007). The classifications of causes discussed here do not explain in detail what leads men and women to attempt suicide; it highlights the need to explore how family problems or illness or love issues are perceived as distressing and ultimately result in suicide attempts.

The act of attempting suicide becomes clearer with an understanding of contexts and accessibility of methods used in attempted and completed suicides. The means used to attempt suicide is debated on several fronts. Poisoning, hanging, self-immolation and drowning were the common methods adopted in attempting suicide. There was a mixed trend in the use of hanging over the past three years (31.4% in 2010, 33.2% in 2011 and 37.0% in 2012) and the use of poisoning was on a declining trend (33.1% in 2010, 32.0% in 2011 and 29.1 in 2012) (National Crime Records Bureau, 2012). Methods used to commit or attempt suicide can be positively correlated with easily accessed means and substances (Lester et al., 1999). For example farmers in India use chemical pesticides and insecticides to end their lives as these are easily available to them (Gunnell et al., 2007). However there is a need to explore relationships between availability, thoughtful choice and socio-cultural meanings attached to the methods used to attempt suicide. The National Crime Records Bureau collated the following information on number of suicides by particular means.

**Table 1 - Incidence of Suicides Categorised According to Means Adopted – 2012**

Sl. No.	Means adopted for committing suicide	Number of suicides	% share of each means
1	Over alcoholism	1,521	1.1%
2	Drowning	7,882	5.8%
3	Fire/Self-immolation	11,438	8.4%
4	Fire-arms	450	0.3%
5	Hanging	50,062	37.0%
6	Poison:	39,374	28.1%
	<i>I. Consuming insecticides</i>	19,929	14.7%
	<i>II. Consuming other poison</i>	19,445	14.4%
7	Self-infliction of injury	596	0.4%
8	Jumping from:	1,318	1.0%
	<i>I. Building</i>	566	0.4%
	<i>II. Other sites</i>	752	0.6%
9	Jumping off moving vehicles/trains	620	0.5%
10	Machine	93	0.1%
11	Overdose of sleeping pills	660	0.5%
12	Electrocution	924	0.7%
13	Jumping under moving vehicles/trains	4,259	3.1%
14	Other means	16,248	12.0%
<b>Total</b>		<b>135,445</b>	<b>100.0%</b>

Data Source: (National Crime Records Bureau, 2012)

### 1.3.1 Summary

Among the recorded causes for death, India recorded 11.2 deaths by suicide per 100,000 population. There is a wider recognition of challenges associated in recording suicidal deaths. The NCRB data on incidences of suicides for male and female, rural and urban do not match with the data from research evidence. This calls for better recording systems in order to understand the propensity of deaths caused due to suicides. The national body also combines reasons for suicides under broad categories of family problems, illness, reasons not known and other reasons. The reasons for suicide are more complex than the way they are presented by

NCRB, therefore research is needed to explore what comprises ‘family problems, other reasons or reasons not known’. The limitations in understanding risk factors also limits plans for interventions (Chatterjee, 2012; Girdhar et al., 2004). The predominant use of quantitative approaches by the national body (NCRB) and means of accessing data through the Department of Police, points at the lack of exploratory data. To understand and deal with the problem of suicide, it is essential to explore the risk factors rather than being limited to classifying reasons under categories as described in the NCRB classification. The legislation surrounding suicide in India regards attempted suicide as a punishable offense, which makes suicide and reasons for attempted suicide difficult topics to explore. The following section will discuss the legislation on suicide and the current legal context.

## **1.4 Legal Aspects of Suicide**

Attempted suicide is a punishable offence under section 309 of the Indian Penal Code. Section 309 states “Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both”(Government of India, 2008, p. 10). Abetment of suicide is also punishable under section 306. Section 306 reads “If any person commits suicide, whoever abets the commission of such suicide, shall be punished with imprisonment of either description for a term not exceeding ten years, and shall also be liable to fine” (Government of India, 2008, p. 23). Section 309 was enacted in the year 1860 during the British rule in India. Suicide is perceived as a breach of a fundamental ‘right to life’ (Article 21) and section 309 is in pursuance of the article 14 ‘Equality

before law' (Government of India, 2008, p. 25). The first bill to repeal section 309 was introduced in the Council of States (Rajya Sabha – Upper House of the Parliament) in 1972 and provided for the omission in clause 126 as “harsh and unjustifiable; a person attempting suicide needs sympathy rather than punishment” (Government of India, 2008, p. 22). Clause 131 of the Indian Penal Code (Amendment) Bill, 1978, which recommended the omission of section 309, passed by the Council of States lapsed in the House of the People (Lok Sabha – Lower House of the Parliament) in 1979 since the House was dissolved. In 1995 the Law Commission of the Government of India undertook a revision of the Indian Penal Code with special reference to the Bill of 1978 from a socio-legal perspective, however, the 156<sup>th</sup> report in 1997 retained section 309 (Government of India, 2008, pp. 7,22-23).

With an attempt to sympathize with survivors and protect their rights, the Law Commission of India made a strong recommendation for the decriminalising of attempted suicide (IPC section 309) in its report (report no 210) stating that the “provision is inhuman” (Government of India, 2008, p. 39). Following which the Mental Health Care Bill (2013) included provisions to decriminalise IPC section 309 and anything that contains this law was introduced in the Council of States - Upper House of Indian Parliament (Rajya Sabha) in August 2013 (Bhaumik, 2013) and is currently pending in the House while being examined by the Committee on Health and Family Welfare. Another significant proposition that this bill makes in relation to suicide prevention is that it seeks appropriate state governments to plan and implement programmes to minimise the incidence of suicides, attempted suicides and to plan interventions to treat suicidal behaviour. Keeping in mind that this bill



is pending for a final verdict, the current provisions for treating suicidal behaviour and preventing suicide are discussed in the section below.

## **1.5 Prevention and Intervention**

A report produced by WHO on suicide and suicide prevention in Asia, identified that the problem of suicide is not being addressed adequately owing to the extent of the problem and that it lacks research and policy attention (Hendin et al., 2008). The organisation (i.e. WHO) believes that it is essential to have in-depth understanding of rates, demographics and geographical variation in order to plan interventions. Given the vast spread of population across India, an improved system of death registration is required in order to assess the impact of suicide prevention programs (Hendin et al., 2008).

In the past, the Government of India made partial contributions to those hospitals with a mental health speciality and those under central government to conduct training programs on suicide prevention. Much work was done by private and voluntary organizations such as Sneha, Aasra, Befrienders, Maithri, Sumaithri, Samaritans Sahara, Sangath etc. by means of counselling, providing telephone help lines, rehabilitation and other services (Vijayakumar et al., 2004). The government initiative did not address suicide on its own however and oriented its attention to a wider spectrum of mental health issues while considering suicide as a mental health concern (Murthy, 2011, p.232). This brings into question the current mental health services in India. The mental health care was integrated into the primary health care system in India under the provisions of the National Mental Health Programme of 1982, however most primary health care centres still lack mental health

professionals and thus fail to provide mental health care in the communities (Mayer, 2011; Gururaj and Isaac, 2003). With an aim to reduce the gap in mental health treatment, the government allocated more spending into training of 'non physician mental health professionals' and into community-based mental health programmes in the current 12<sup>th</sup> five year plan (2012-2017) (Planning Commission, 2011, p. 7). The spending was increased by threefold in comparison to the allocated budget in the 11<sup>th</sup> five year plan (2007-2012) but represented less than one percent of the total health budget on mental health (Staff Reporter, 2012; Mayer, 2011). Although suicide prevention was not on the national agenda in previous mental health policies, the proposed Mental Health Bill, 2013 decriminalises suicide, treats mentally ill people with dignity, gives people the power to make choice in their treatment and assigns central and state authorities to regulate mental health sector and register institutions.

An evaluation conducted by an independent body in the year 2008, presented to the government the need for suicide prevention not only from a mental health perspective but also acknowledged socio-cultural, economic and religious aspects (Government of India, 2011; Hendin et al., 2008). Despite this proposition very little has been done in addressing the gaps between mental health and social, cultural and economic challenges to prevent suicide. To plan effective intervention and prevention strategies, there is a greater need to explore and understand the factors that lead to suicidal behaviour while recognising individuals within their social setting, their interactions, the meanings they derive, their responses and the impact of such interactions.

## 1.6 Summary

This chapter introduced key aspects of data on suicides compiled by the National Crime Records Bureau and the controversies surrounding this data. Although the national agency recorded a suicide rate of 11.2 (per 100,000 population) as of 2012, there was a wider awareness that the rate is an under-presentation because of the legal contexts as discussed above and the socio-cultural factors that will be discussed in the following chapter. The current knowledge and understanding of reasons and variation in recording suicides are limited due to the use of quantitative approaches that concentrate upon quantifying reasons rather than conduct exploratory investigations to understand risk factors. The gaps in exploring and understanding the reasons for suicides have also limited the intervention methods. The chapter recognised efforts from national and international organisations that have contributed towards proposing decriminalisation of suicide in India through the Mental Health Bill, 2013 which is due to be approved by the Upper House of the Parliament. The government's initiative to making mental health care accessible to all is reflected in the current 12<sup>th</sup> five-year plan. The government has moved from perceiving suicide as purely a mental health problem to understanding that social, cultural and religious contexts are also influential. However, there is very little research evidence that elaborates how and in which way cultural factors in the contemporary society influence everyday living and may cause distress resulting in attempted suicides. The next chapter will discuss the social construction of meanings associated with culture and suicide from relevant sources of literature and highlights the gaps in current understanding and knowledge.

## **1.7 Organisation of the thesis**

This chapter has presented empirical data on the facts and figures surrounding suicide in India. The second chapter moves onto discussing the conceptual background of suicide and culture through the available and recent literature. Following this is a chapter on methodology and methods, examining the theoretical framework and the application of methods. Chapters 4, 5 and 6 present findings on 3 data sets obtained from survivors, healers and mental health professionals respectively. The interviews are presented along with the dialogues from participants in terms of distress and support factors around attempted suicide. In chapter 7, the findings are analysed with reference to Bourdieu's theoretical concepts of habitus, doxa, cultural capital, symbolic power and violence. It further presents a conceptual model explaining the relationship between culture and attempted suicide. The final chapter examines the contribution of current study into knowledge and makes recommendations for future practice, policy and research.

## **2 Conceptual Background**

### **2.1 Introduction**

This chapter contains a comprehensive review of literature and a conceptual framework related to suicide and attempted suicide in India. To begin with, a question is posed - 'why is the study of cultural implications necessary in understanding attempted suicide in India?' This question will be reviewed through the available literature and will also present a synthesis that describes a social construction of culture and suicide in India. The review will encompass a discussion of the meaning of culture and the relevance of the work of Bourdieu in understanding the interactions between culture and individuals with reference to suicide. The discussion of the ways in which the government conceptualises suicide in India will demonstrate that little attention has been paid to the socio-cultural factors, which are crucial to understanding distress in dealing with the problem of suicide. Thus, the second half of this chapter will engage in identifying the social structures, cultural norms, beliefs and religious practices that may have an impact in causing distress and suicidal behaviour. It will also review the work of other researchers who have explored suicide in India and will aim to analyse how they have conceptualised distress and risk factors while identifying the missing links between the cultural context and their analysis.

## 2.2 Why study the cultural implications of suicide?

### Defining Culture (what it means in this study)

The concept of culture encompasses a great diversity of meanings (Kroeber et al., 1952). Within the field of social sciences, Tylor (1871; 1871, p. 1) defined culture as "that complex whole which includes knowledge, beliefs, art, morals, law, customs and any other capabilities and habits acquired by man as a member of society". Tylor's (1871) perception of culture as a process of learning and transferring knowledge is complemented further by Kroeber's (1952) thoughtful consideration of history and experience which essentially differentiates one culture from the other. Within the limits of contemporary meaning associated with the concept, 'norms, values, beliefs, and expressive symbols' are described as four key elements of culture (Peterson, 1979). The meaning of culture in this research is not specified to norms, values, beliefs, practices and the process of learning alone but is conceptualised as capital both in its external and symbolic forms and relates to individuals' dispositions (responses, thoughts and actions) that are subject to change over time and space (Swartz, 1997). Inherent in this is also the notion of power relations, well identified and discussed by Bourdieu through his theoretical concepts of cultural capital, symbolic power, habitus and doxa (Grenfell, 2008). Bourdieu sees culture as a capital that is constantly in interaction with habitus and field. He goes on to explain human experiences cannot be specified to strict boundaries rather they are subject to interchange of "individual subjectivity and societal objectivity" (Swartz, 1997, p. 96), meaning the objective structures of society have a subjective effect on an individual's disposition.

## **Identifying the need to study cultural implications of attempted suicide**

The dualism of 'individual subjectivity and societal objectivity' (discussed above) is often neglected in studying suicide in India. Much research is carried out on exploring the risk factors and epidemiology of suicide (Vijayakumar, 2007), however the cultural connotations associated with risk factors are not explored in great detail (Colucci and Lester, 2012). Suicidal behaviour is comprehended at an individual level and receives biomedical attention rather than psychosocial interventions (Vishnuvardhan and Saddichha, 2012; Vijayakumar, 2007).

**The biomedical model** sees humans as biological entities and illness is due to pathological conditions (Engel, 1977). This perspective results in the 'medicalisation and abnormalisation of suicidal behaviour' and excludes psychosocial factors (O'Connor and Sheehy, 2001, p. 20). Laing (2010) comments that the abnormal and inappropriate behaviours of mentally ill people appear as normal to him yet these are classified as instances of disease. He further acknowledges the objective structures of society and power dynamics within the family influences individuals' perception, formation and assimilation of behaviour (Boyers and Orrill, 1972). Szaas also argues that it is inappropriate to address psychological disorders as illness, as they share little in common with physical illness (Szaas, 1974). The biomedical model does not adequately explain psychological and social notions related to suicidal behaviour.

**The social model** proposed by Durkheim identified social factors especially aspects of social integration in understanding suicide, however he did not consider culture in great detail (Durkheim, 1989; Univeristy of Regina, 1999). In an Indian setting

where culture, caste and religion are integral parts of life and identity, culture needs to be an essential component of the analysis rather than being seen purely in structural terms; that is something of society rather than something of the self. Therefore, this study aims to explore the interaction among the cultural capital, habitus and various fields of social structure (Grenfell, 2008) and their implications for attempted suicide.

The concept of '**Health and Wellbeing**' is used more recently to address a combination of physical, mental, social and emotional factors in addressing health inequalities from a non pathological perspective (Breslow, 1972). WHO set up a commission to examine how the social determinants operate and impact health outcomes (Marmot, 2005). Marmot's social determinants (Wilkinson and Marmot, 2003) explained social and economic conditions that impact lives of people, their health and even cause stress. The other factors presented by Marmot are social exclusion, early life conditions, work related issues, unemployment, social support, addiction, food, transport and social gradient. The social gradient encompasses both material and relative deprivation including spiritual resources and individual abilities. Although these aspects of social determinants are relevant in understanding individuals' life situations and measuring health outcomes however they are limited in exploring the inherent meanings of interactions amongst individuals and their community and society which are essential in understanding suicide. WHO highlighted the importance of addressing primary needs for survival for example having a healthy diet, well balanced work life and safeguarding human rights. Lack of resources to meet very basic needs may pose risk of harming life but this approach does not explain the process that caused distress in the first place, as



people draw meanings from their interactions and interpretations of their encounters with the cultural environment.

Before we plunge into critically analysing the social construction of culture and suicide in India, it is important to understand the interrelations between concepts of social structure and culture. The theoretical concepts of Bourdieu that are used in this study to make sense of human interactions and the dynamics of culture in relation to distress and suicide are discussed in section 2.4 below.

## **2.3 Social structure and Culture**

The concept of culture and social structure complement each other in the wider discourse of the concepts and assist the reader to understand what is happening within society (Peterson, 1979). Nadel explains social structure as an 'arrangement of parts in some total entity' and views 'culture and its provinces' as a distinct field from that of 'social' (Nadel, 1957, p. 4). For Radcliffe Brown humans become essential components of a social structure wherein relationships are defined and regulated by the institution (Huntingford, 1952). While Bourdieu finds a midway, addressing culture and social structure through symbolic power to understand the dynamics of social process (Bourdieu and Passeron, 1977). Swartz presents Bourdieu's claims "all cultural symbols and practices, from artistic tastes, styles in dress, and eating habits to religion, science and philosophy and language embody interests and function to enhance social distinctions.....the social distinction is embodied power relation in the social structure" (Swartz, 1997, p. 6). Bourdieu proposes a 'dialectical relation' between agency and structure. He argues human actions are a result of interactions between individual subjectivism and objective

structures. Following this structural theory of practice Bourdieu connects culture, structure and power under the concept of 'habitus' (Swartz, 1997). The following section will discuss in detail the relevance of Bourdieu's concepts to the study of culture and suicide.

## **2.4 Bourdieu's theoretical concepts**

The theoretical perspectives of Pierre Bourdieu, a French scholar provide a framework for examining conceptual categories and wider socio-cultural contexts within which they occur, to validate the findings of cultural implications in attempted suicide. Bourdieu's concepts such as field, capital, habitus, symbolic power and doxa though intense and complex to comprehend, demonstrate a form of detailing the real, actual and empirical aspects of cultural phenomenon in the study of attempted suicide. In considering Bourdieu's work, it must be made clear that Bourdieu did not intend to produce a theory rather he said " I never theorise, if by that we mean engage in the kind of conceptual gobbledygook... ....there is no doubt a theory in my work, or better, a set of thinking tools visible through the results they yield, but it is not built as such....It is a temporary construct which takes shape for and by empirical work" (Wacquant, 1989, p. 50). Bourdieu's concepts are not just 'temporary constructs' but appropriate tools in examining the findings of this study as they are developed on the basis of his own and others' empirical work (Jenkins, 2002).

### **Why Use Bourdieu**

Bourdieu's approach acknowledges the subtleties of cultural practices, influences and dynamics of power, which are instrumental in examining the association

between culture and suicidal behaviour. From the perspective of Levi Straus, cultural practices may be considered as structured forms of cultural capital (Nutini, 1971). For example, the structured traditions are demonstrated by gender roles within the boundaries of family, community and society. However, Durkheim's view illustrates the functionalist traditions of cultural norms that constantly restructure themselves to suit the functional needs of everyday life. The application of a structural and functionalist approach would enable us to understand the dynamic nature of various practices that work together to form specific roles and accomplish the functions of family (Urry, 2000). However, this framework disregards the unbalanced distribution of power between the structures (e.g. gender roles) and cultural practices.

Although Bourdieu criticised these traditions, he learnt from Durkheim's functionalism concept to understand human action. He developed mechanisms to decipher and understand symbolisms/meanings attached to cultural structures and practices that impact individual's dispositions from Levi Straus' 'structural rules of practice' (Jenkins, 1992; Grenfell, 2008). Bourdieu's approach identifies the power of cultural practices/capital that transform the functions and structures of gender roles in a social field of family and society. The negative impact of cultural power becomes apparent in the form of cultural pressure, which is significant in understanding distress and suicidal behaviour. Thus Bourdieu's approach acknowledges the dynamics of cultural power that is absent in structuralism and functionalist traditions. Bourdieu's theoretical concepts (see 2.4 on page 33 for information) are used to interpret and analyse the conceptual categories in the following sections.

This section will discuss the key concepts of Bourdieu that informed the discussion of current literature and analysis of findings.

### **2.4.1 Field**

Bourdieu's theoretical framework was used to examine the interrelatedness of cultural norms, practices and social structures within a social space which may be identified as 'field'. Bourdieu developed a concept of field through his work with Algerian tribes in response to the need to clarify relationships between socio-cultural structures and conditions acknowledging the role of agency (Robbins, 1991). Goffman (1986) framed the concept of field with a focus on individuals actions and responses, however Bourdieu not only focused on details of individuals' lives but also incorporated socio-economic and cultural structures that become the nucleus of his concept of field (Bourdieu, 1983). Field is defined as a domain or a social space within which struggles for 'stakes' take place (Jenkins, 2002, p. 84). The dynamics of field arise from the interactions between social structures and individuals, positions and dispositions of individuals and the role of capital (Warde, 2004).

In order to define 'field' in the current study the researcher had to consider: survivors within the settings of family, community and society; mental health professionals in interaction with survivors and healers contained by boundaries of social space and profession; healers situated in a wider socio-cultural arena with their healing practice that combines religious and cultural norms. As was demonstrated above by Bourdieu's work, field is seen to be influenced by structural factors, agency (education, location), beliefs and practices. The interacting

elements such as individuals' experiences, perceptions, dynamics of power, external context, networks, gender, religion, roles and economic aspects within the field bear the potential to alter the field boundaries.

### **2.4.2 Capital**

Bourdieu's use of the term capital was not limited to the economic field alone. He recognised the role of various forms of capital (economic, social, cultural and symbolic) in the 'structuring and functioning of the social world' (Bourdieu, 1986). The idea of capital is tied in with power 'conceptualising resources as capital' (Swartz, 1997, pp. 73-94). The economic capital that covers monetary, material and labour assets produce power relations and are preconditioned to transform into cultural, social or symbolic capital depending upon its functions within a field. Economic capital gained importance in the current study as the access and availability of financial and material resources tend to explain distress experienced by survivors and emerging interpretations through the accounts of healers and professionals. This study investigates how and under what conditions individuals' struggles for resources lead to stress and further to suicidal behaviour. Social capital is made up of social networks, connections and recognitions that can guide to potential resources which individuals possess as 'collectively owned capital' (Bourdieu, 1986). The social capital possessed by an individual depends on other forms of capital (economic and cultural) in a social space that increases the possibilities of multiple social hierarchies (Bourdieu, 1990). In Indian society economic resources earned by individuals within a family become the economic capital of the entire family while religious and caste groups relate to cultural and

social capital. In a review about suicides in Northern India, Sharma et al. (2007) discussed the availability of resources and family support as crucial in the process of seeking help. This points to the interacting nature of cultural capital and social capital that explains individuals' dependence on family and social network that provide access to resources.

Bourdieu describes cultural capital as the power relations that are inherent in a wide variety of resources such as 'verbal language, cultural awareness and educational credentials' (Swartz, 1997). He regards culture as a power resource that can be embodied in abilities, skills and internalised dispositions through a process of socialisation (Bourdieu, 1986). Legitimation of power happens only when symbolic forms (art, religion, language, science) take on an active role and in the process, structure and restructure the existing power structures (Swartz, 1997). For example, in India caste is a dominant factor that is manifested through religion, tradition, language and life style. Caste is in constant interaction with social and political capital, which together change the ways in which caste is practiced in contemporary society. These interactions may well be understood in terms of symbolic power, symbolic capital and symbolic violence as described by Bourdieu. An interesting feature of symbolic power that is relevant to this study is a lack of knowledge and understanding on the part of individuals that they are exercising or being subjected to symbolic power (Bourdieu and Coleman, 1991). The dynamics of power relations unveil the coercing nature that imposes meanings derived from political and economic power as legitimate within a social field and are taken for granted by both dominant and dominated and are expressed as symbolic violence (Bourdieu, 1990; Wacquant, 1989; Bourdieu and Wacquant, 1992). The distribution

of power and responsibilities within families in India is largely based on gender and roles. Violence inflicted on women within families is an example of legitimisation of power that forces women to accept violence and suffer. Symbolic capital is described as a social honour (Jenkins, 2002), a capital that recognises and legitimises the value of culture, power and position attached to symbolic forms with potential for symbolic power and violence (Bourdieu, 1986). The interactions amongst material and symbolic forms lie beyond social structures. These interactions perpetuate power and domination in a social field. It is in this field that individuals' dispositions are constructed and transformed through internalising and interacting with symbolic and material dominations. The various aspects (economic, social, and cultural) of life converge in a family field where specificity of power dynamics and its exchange vary in individual, family and social contexts. Thus, the study of individuals' lives as a field and family as a field is essential to explore not only the power dynamics but also the interactions among various forms of capital to understand what is leading to distress and suicidal behaviour.

### **2.4.3 Habitus**

Bourdieu defines Habitus as dispositions and responses of individuals, groups and institutions which are structured and are constantly being structured (Bourdieu, 1999). By 'structured structures' Bourdieu means the influences that individuals carry with them from their past experiences, family upbringing and internalised practices through the process of socialisation. 'Structuring structures' are a set of dispositions that are systematic and shape perceptions, habitus and practice.

Habitus may well be treated as a common ground where social structures and individual agency are reconciled (Grenfell, 2008, p. 50).

Habitus in this study focuses on the perceptions, behaviour, thoughts, actions and being of participants. It gives attention to the influences of environment and past experiences upon individuals' perceptions, interpretation of situations and choices to act in certain ways. Habitus is a process of carrying influences from the past into the present and transferring into the future under conditions that are not completely under individuals' control or making. The role of current context is central in exploring participants' choices and the choices that were available to them within a socio-cultural field. It is habitus that explains what leads individuals to certain choices for example the coping mechanisms adopted during stressful situations. In order to understand the cultural influences and suicidal behaviour one must recognise the evolving nature of social, cultural and economic fields where individuals' habitus is constantly evolving.

#### **2.4.4 Doxa**

Doxa refers to a 'deep system of beliefs that are naturalised through the process of unconscious mechanism where individuals accept and practice many things without even knowing them as though they were legitimate' (Bourdieu, 2000; Bourdieu and Eagleton, 1994). It refers to beliefs, opinions, traditions and practices that individuals accept and internalise in a social field. A relationship between doxa and power is intricate and intertwined. In this study, doxa is used to uncover the underlying beliefs among individuals that structure their perceptions and actions. For example, why are women within family settings in India more likely to



experience violence than male members? An ability to question the taken for granted practices and belief systems is absent in current thinking due to the symbolic power embodied in doxa carrying influences from socio- economic and cultural capital. Exploring such traditions and beliefs are essential to this study, because firstly, these may be transformed into forces that influence peoples' actions and secondly, because individuals under the influence of doxa do not always question the norms even though the norms and practices may have distressing effects.

## **2.5 Cultural and structural mechanisms of suicide in India**

To understand the interactions among the social structures of caste, religion, family, society and the cultural practices embedded in these structures, the 'theory of field' and 'cultural capital' become relevant paradigms for analysis. The cultural practices from the past interact with the present, which is a matter of investigation and analysis for a better interpretation of factors causing suicide. Culture, caste and religion are integral parts of everyday life which means that attention to such fields will establish understanding of perspectives and inherent tensions. This section will examine the impact of caste, religion and the practices derived from these structures in relation to understanding distress and suicide in contemporary society. The latter part of the section will deal with the dynamics and impact of gender and age variation, social and economic capital within the cultural context.

### 2.5.1 Caste and suicide

The caste system in India is a powerful form of social stratification. Caste divides people into specific groups according to race or job roles or varna which means colour in Sanskrit. The four main caste divisions are Brahmins (priestly class), Kshatriya (warrior), Vaishya (trading class) and Shudras (servile labourers) (Arunoday, 1993) which exist even today. The social production of caste is less defined through division of labour and more so by religious, ideological and political debate in contemporary society (Srinivas, 2003). Caste still defines power hierarchies in a social structure and assigns individuals with social positioning (Arunoday, 1993; Gupta, 1980). The practices within caste groups can be thought of as 'structural and functional homologues' (Swartz, 1997, p. 130) objectively established through interaction among various fields (religion, social, economic, culture). In modern day India, caste is active at political, social and cultural fronts. It is intertwined with the existing culture and society in a complex manner. It influences fields such as education, employment, political membership, marriage and others while affecting the social and cultural capital in a society that shares multiple cultures, religions, languages and practices. The meaning of caste and the ways in which it is exercised may vary from region to region, however little evidence may be found to prove the association between caste and suicide. It is useful to understand the oppressions and indifferences experienced by individuals from low caste groups in places of employment, education and communities. Kumar (2011) and Banerjee (2009) present cases of Dalit (low caste group) students, men and women who resorted to suicide following discrimination in colleges and in employment on the basis of caste.

Sharma (2012) recognised that the caste system was never a 'simple ritual hierarchy but a matrix of socio-economic and political relations' which describes social mobility, change and dominance. In contemporary society, caste is perceived differently at both individual and institutional levels. It may be perceived as a 'state of mind, non-existent and indefinable' for those distanced from cultural practices or living in cities. However caste becomes a part of everyday life for those in towns and villages (Moffatt, 1997; Sharma, 2012). While at an institutional level, caste is perpetuated through government policies. Osborne (2001) emphasised the role of government in continuation of caste system by segregating the low caste groups and tribes as marginalised groups and providing them with privileges. These privileges have enraged the public and institutions which in turn has a negative impact upon individuals from lower castes. It also creates an environment of apathy among groups of people and institutions. The government's policy on providing low caste groups with privileges may well be considered as a way of undoing centuries of oppression and ensuring social mobility. The execution of political power to influence cultural capital is evident in all its subtleties and made explicit through the process of eradicating and perpetuating the caste system. The interaction between political power and the threat of shifting cultural capital makes identification of suicides due to caste based oppression, influences or impact very limited.

A group of postgraduate students from an educational institute based in Southern India formed a committee (Senthilkumar Solidarity Committee) to investigate the death of a PhD scholar by suicide. The committee's (2008) report brought to light the indifference shown towards Dalit students within the institution. In addition,

the institute's efforts to cover up the death of a student with a medical reason were revealed. They associated his death with lack of performance whilst forgetting that the student was not assigned a supervisor. All of this points to the institution's subtle ways of expressing disagreement with the government's policy on reservation of seats for students from schedule castes in higher educational institutions. The political and social issues surrounding the ways in which caste is emphasised and practiced mean that the identification of violence or deaths by suicide among the oppressed caste groups become harder. The practices that are derived from caste structures need to be investigated to understand how they are manifested in causing distress and suicide or for that matter even how they merge into wider social and cultural contexts without being identified as a caste issue. In the context of this research, caste is considered as a part of the wider cultural context and not a separate subject of analysis in the study of attempted suicide.

### **2.5.2 Religious doctrines and perspectives on suicide**

This section reviews the relationship between religions and suicide. It aims to present an overview of cultural influences derived from religious beliefs and/or practices and examines their relevance to contemporary society in relation to suicidal behaviour. This understanding is essential to recognise interactions among religions, beliefs, practices, their meanings and individuals' habitus in this study.

The earliest attitudes towards suicide can be identified from Hindu scriptures. The forms of voluntary deaths that are discussed in religious books such as Vedas and Upanishads are self-sacrifice (human sacrifice) in worship of God, atoning for 'mahapatakas' grave sins, relief from incurable diseases or due to the lack of ability

to observe purification in old age (Mayer, 2011). The cases of human sacrifices are still evident in modern India however classifying them as suicide is a debatable issue as most of the cases that come to public attention are not voluntary; rather they are forced upon the victim but for the same reasons (religious beliefs, earthly gains, cure from infertility, illness etc.) as they were previously (McDougal, 2006). Suicides due to old age and incurable diseases are not generally condoned in the present times although it is still in practice among the Jain community in the form of Sallekhana (Jain, 2010). Sallekhana is a religious pathway of fasting unto death undertaken willingly (Jain, 2010; Braun, 2008).

Hindu philosophy of karma and reincarnation (Colucci and Martin, 2008) institutionalised suicide in forms of the suttee/sati system (Bhugra, 2005) and sallekhana/santhara (Jain, 2010; Laidlaw, 2005) in which religious beliefs and ideologies glorify sufferings in terms of the greater good. The religious context that idealises sufferings (Colucci and Lester, 2012) and presents relaxed notions towards voluntary forms of suicide (sallekhana) (VenkobaRao, 1975) may well be regarded as potential risk factors in the current society. The idea of self-sacrifice, which is rooted in religious beliefs, is manifested in different forms as voluntary or forced death. For example, mahaprasathana and sallekhana are voluntary forms of death, which even in today's society remain un-condemned. People believe it is a wilful choice made to renounce every other basic need of life including food, water, and starvation to death is required in order to redeem oneself from sin and pain (Colucci and Lester, 2012; Vijayakumar et al., 2004; Jain, 2010). This attitude derived from religious beliefs may pose a risk of worsening mental disposition to stress and affect ways of coping.

Another form of religious suicide is sati (widow burning), which may still be evident in the rural parts of the country despite the legislation on abolition of the sati system (Lester, 2012; Hawley, 1994). Women in Hindu society were powerless, considered to be lesser beings than men, and were to immolate themselves on their husband's funeral pyre through 'sati', because a widow was considered unholy in Hindu tradition (Lester, 2012). However, there are contradictions to the religious context of sati. Mani (1998) presented a debate concerning the economic motives of corrupt Brahmins and relatives who forced women into sati with a hidden intention of preventing widows from acquiring their husbands' property. The sati system of the past is transformed and is currently manifested in various forms of oppression, neglect, violence and abuse of women (for more information see 2.5.3 on page 46). Social sanctions may not be transfigured into sati during the 21st century however transgressing social and cultural 'fields' is likely to result in symbolic violence, social isolation, mockery, nagging, harassment and embarrassment.

Committing suicide for reasons other than those discussed above was condemned by Hindu scriptures. It was believed that an individual's soul will be lost in hell, their body defiled and if they survive, they should pay a fine (Thakur, 1963). Buddhism considers death as no end to life but leads to a perpetual cycle of birth and death. It was therefore believed suicide to be 'no escape from anything' (Becker, 1990, p. 547). Suicide or voluntary form of death that is undertaken in a serene and pure state of mind is recognised in Buddhism (Mayer, 2011).

Islam and Christianity oppose suicide as a mortal sin on religious grounds. Islam views suicide as a revolt against Allah, bringing upon himself the wrath of Allah (Hassan, 1983). While Christianity regards suicide as violation of one of the ten commandments 'Thou shall not kill' (Phipps, 1985). Mohanty and colleagues reported fewer cases of suicides among Christians and very rare cases among Muslims in India (Mohanty et al., 2007). There is very little research available on investigating the influences of Christian or Islamic religions and practices on attempted suicide in India. The scriptural views are still discernible in present day beliefs, however, there is insufficient evidence to recognise any practice or culture derived from Christian or Islamic religious faiths that causes distress or explains suicidal behaviour in an Indian context.

The underlying religious beliefs exercise cultural power upon individuals in the present society. It is manifested in forms of accepting violence, suffering, abstinence from one's desires and considering the collective good of the family as a form of attaining symbolic power and purification. There is a greater need to explore the relevance of religious beliefs in understanding how individuals perceive life situations and respond to stress. This may assist in unravelling the interrelations between religious influences and suicidal behaviour in contemporary society.

### **2.5.3 Understanding gender variation and gender based risks**

A study by McLeod in 1878, the first of its kind, on suicide in India presented the statistics for higher female suicides than male in British India for the year 1878. The same trend was demonstrated by Mayer in the year 1907 (Mayer, 2011). Likewise, Aaron et.al (2004) also found higher rates of female suicides in the city of Vellore in

South India. The study used a verbal autopsy<sup>1</sup> method and demonstrated the average suicide rate for young women to be 148 per 100,000, and for young men 58 per 100,000 in contrast to what the national agency had recorded. A nationally representative survey of suicide rates in India by Patel and colleagues (Patel et al., 2012) collected data from friends and family of deceased individuals. This survey presented high suicide rates among men (26.3 per 100,000) in comparison to women (17.5 per 100,000) which were in line with the reports provided by the national agency (NCRB). However, it revealed the possibility of underestimating suicide deaths especially among women due to the fear of criminal implications for the deceased's husband and family. The researchers also acknowledged misclassifications could have led to some amount of inaccuracy in the data. Patel et.al's findings suggested that NCRB underestimated suicide deaths among men by 25% and among women by 36% (Phillips and Cheng, 2012). This method may have the danger of reporting murders and criminal deaths as suicides or suicides as accidents. Variation in male and female suicides may be attributed to study methodology, death-registering system, culture of the state, legal implications, education and modern attitudes towards death. These issues are dealt with in detail below.

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<sup>1</sup> Verbal autopsy method estimates cause of death in population without vital registration or medical certification (see KING, G. & LU, Y. 2008. Verbal autopsy methods with multiple causes of death. *Statistical Science* 23 (1), 78-91.) It inquires deceased person's circumstances prior to death, mode of death from family and others to determine cause of death.



Indian culture treats men as providers for the family and women as responsible for household chores. Although the roles and responsibilities of men and women in contemporary urban India is in transition, cultural power still defines the nature of jobs they choose and the exercise of responsibilities. The interaction between the cultural capital and various fields such as family, employment, social and religion is influential in formulating individuals' habitus and in explanations of suicidal behaviour. One such example may be found in the study by Bastia and Nilambadhkar (2009). The study evidenced that higher education among men in Cuttack made them very choosy of employment and low economic status caused suffering and motivated men to attempt suicide. The cultural capital that these men derived from higher education meant that they now had reservations about certain types of jobs (i.e. those that were deemed to be 'below' them), which meant minimising opportunities for making their living, resulting in distress and suicidal behaviour. This identifies how cultural capital interacts with economic capital and leads to distress. It also draws attention to how researchers perceive low economic status as a cause for suicide while not paying much attention to the interaction that has led to distress in the first instance.

According to NCRB (National Crime Records Bureau, 2012) social and economic causes are associated with greater suicide rates for men whereas emotional and personal causes are cited for women. Sharma (2007) through a retrospective study of unnatural deaths in Chandigarh argued that the intergenerational and gender conflicts are intense in traditional agricultural society. As this study used verbal autopsy methods and obtained information from close associates of deceased individuals and reports, the base for this conclusion becomes questionable in

appropriating reasons for suicide. However, it is useful to understand the power relations among various fields that create a hierarchical structure (caste, class, economic) in an agricultural society in contemporary India. Industrialisation and modernisation motivate younger populations to move to urban locations thus disrupting functions of traditionally defined social structure (family, clan, community) and gender based roles. As a result, shifting values, changes in living situations and identity crisis may account for increasing differences among individuals within families. In a study of gay men in Mumbai, the use of quantitative mental health interviews reported crisis with sexual identity, lack of family support associated with cultural taboo, criminalisation of same sex behaviour and low self-esteem accounting for high stress, depression and suicidal ideation (Jayaprakash et al., 2013). These studies have identified the events that help in understanding the interactions among economic hardships, conflicts and sexual identity as reasons for distress and suicidal deaths. Nevertheless, they have failed to recognise the relevant factors surrounding events that created such an impact upon individuals' thoughts, behaviour, life style and interactions within the socio-cultural context. It is such an understanding that is essential to address the problem of suicide.

Gururaj et.al's (2004) case control study recorded emotional abuse, physical abuse, alcohol abuse, lack of social support and mental illness as the precipitating factors for suicide in Bangalore. Here, the authors tend to overlook gendered differences in the paper as they focused in quantifying risk factors for completed suicide. The question that arises here is, how is abuse constructed for individuals in the family and society that they live in? These types of classifications within the debate of suicide do help in directing attention to relevant areas but there is not sufficient

information to comprehend what is covered by abuse and support in a particular cultural context. This understanding could be enhanced through survivors' interpretations of abuse and support as their perception is central in comprehending distress.

The patriarchal society in India still structures the lives of women. Although education, employment, and economic capital empower and mediate women's lives, their disposition is influenced by structural and cultural norms and the patriarchal values embedded within it. Kermode et.al's (2007) qualitative interviews with women in Maharashtra revealed having an alcoholic husband often increased quarrels between husband and wife, discord among mother and daughter-in-law and infertility among men, while women were mostly blamed for these effects. Further Prasad et al (2006) reported marital discord, sexual conflicts, alcohol problems, lack of emotional and social support, financial problems and physical violence which accounted for acute stress preceding attempted suicide. Despite persistent violence and abuse faced by women, hardly any such cases are reported for medical help (Jain and Jadhav, 2008). Gangoli and Rew's (2011) study of the legal discourses on mother-in-law violence on daughter-in-law reminds us that women in certain roles become more vulnerable due to their position within the family. In the Indian family system the mother-in-law has power over the affairs of the house and over the daughter-in-law. The repeated instances of abusive behaviour and coercive control over prolonged periods of time may well explain suicide. However, it must be remembered, that the verbal autopsy interviews with relatives of the deceased may be subject to recall bias, while in certain cases individuals might be forced into suicides (Prasad et al., 2006). The researchers here

have identified several factors causing stress, depression and suicide among women but they tend to overlook the subtle differences in power relations, which may have influenced situations and stressors.

The social structure of the dowry system identified in the study by Bastia and Nilambadhkar (2009) recognised how women's suffering is constructed into both symbolic and physical violence. To add to this Lester and colleagues presented other stressors such as the illegitimate relationship of the spouse, infertility, failure to give birth to a boy child, illegitimate pregnancy, and no settlement of marriage (Lester et al., 1999). This has a stigmatising effect on women more than men and thus women are victimised into divorce, isolation, suffering, homelessness and poverty (Dhavar, 1999). Kumar (2003) cited growing demands for dowry, the joint family system and high expectations of a young wife especially with regard to cooking and household chores, as increasing the risk of death by burns. These deaths may be reported as suicide or accident while it might be a homicide. Sharma and colleagues (2005) identified several cases of death by burns among women through medico legal autopsy in Chandigarh. Dowry demands and expectations were reported causes of violence and suicide among women within four years of their marriage. Wyatt and Masood (2011) in a book on the 'dowry problem in India' recall how marital conflicts and violence frame a large part of the cultural discourse that uses legislation on dowry to convict a husband and his family. Thus dowry may be wrongly projected as a reason for suicide rather than interpersonal problems (Anupriya, 2012). Along similar lines Ghosh, reviewing the performance of legal measures to curb violence and exploitation of women argues that not all dowry deaths are related to dowry but other problems within marriage which lead

to suicides (Ghosh, 2013). The issue of dowry is argued on different levels by these authors, but they fail to recognise the oppression or suffering that a woman goes through under the pretext of being a happy and obedient wife and daughter. In today's society, dowry may be understood as an endless series of gift giving and receiving during marriage and continues after marriage. This entire process could be very pressurising for the newly wedded wife and her parents; it may be coercive and is closely attached to identifying oneself with the economic and social capital. These studies reveal that women are objectified through their roles in society and are victimised into experiencing stress in one way or the other both in physical and symbolic forms. Nevertheless, they engage little in discussing the impact of practices derived from traditional norms that form collective behaviours and leaving women to bear the consequences. There is minimum attention paid to the influences derived from religious or cultural norms and how they are reinterpreted in constructing a woman's identity and sufferings.

The women in Kerala from Southern India, share high aspirations in education and career despite gender-based discrimination throughout society. Mitra and Singh's (2007) analysis of secondary data acknowledged the role of cultural norms that mediate and dictate women to be subservient to men. This is helpful in comprehending the cultural domination that results in all forms of violence (physical, material and symbolic) upon women regardless of their education or employment status. Mohanty et.al (2007) undertook a four year retrospective study to identify the risk groups in Orissa (Northern India). The study results yielded a higher number of suicides in the age group (21-40). Most of the suicides were reported among Hindus, married and from less educated background. The study

method considered the trend over the years and found a strong relationship between social (marriage) and economic (financial burden) factors. This phenomenon is not transferable to other parts of India as being married and less educated may not always be the reason for distress and suicide. Kerala is an example of a state which has high literacy and yet the suicide rate among women remains equal to that of men and is comparatively higher than in other states (Mitra and Singh, 2007; Soman et al., 2009). A modern day woman whether in urban or in rural India shoulders double responsibilities be it household or employment. In a series of interviews with women in Punjab, Padhi investigated how women have been coping following the death of their husbands by suicide. The study identified the elements of patriarchal domination that undermine a woman's labour and devalues a woman by means of structured oppressions of caste and gender (Padhi, 2009). This study is particularly relevant in grasping how women's situations are made more difficult by ongoing oppression and lack of support despite their efforts to cope with grief and family responsibilities. Although this study does not speak specifically about suicides among women, it identifies how cultural norms and society rule the lives of women. Very few studies have identified these types of struggles and stressors in understanding distress and suicide.

Maselko and Patel (2008), in a community-based cohort study with a 12 month follow up, suggested that social and economic disadvantage and chronic physical illness are stronger predictors of suicide attempts than mental illness among women in Goa. Gajalakshmi and Petos's (2007) verbal autopsy study conducted in Vellore presented higher number of female suicides in the age group of 15-24. Both these studies accounted for suicide in terms of increasing risk of violence, inequality

and sufferings of women. Jayaprakash and colleagues in an investigation of suicides among women in Bangalore studied first information reports, statements made by relatives and post-mortem reports. They identified being married and living in nuclear families were adding to the risk of suicide while 'family problems and love failures' were regarded as immediate risks (Jayaprakash et al., 2013). The same trend has been recognised by several other studies (Abraham et al., 2005; Prasad et al., 2006; Sharma et al., 2007; Soman et al., 2009). These studies identified the risk factors for suicide among women, but did not analyse the interaction between culture and the individual, the influences of cultural dynamics and social capital upon the identified factors, and their impact on a person's thoughts and behaviour. Little is known about stressors among men although most of the studies have associated suicides among men with economic reasons (Sharma, 2007), depression, anxiety (Parkar et al., 2008), stress (Kanchan and Menezes, 2008) and relationship issues (Mukhopadhyay et al., 2012), while sexual identity (Sivasubramanian et al., 2011) is a recent issue in discussions of male suicides. Most of these studies have accessed data either from medico-legal reports or relatives of the deceased thus it is vital to hear from the survivors of attempted suicide about their experiences, perceptions, thoughts and those instances that influenced their decision to live or die. There is little information available to understand why economic stressors or relationship issues are particularly distressing for men in comparison to women and what are the interrelating factors that create varying impacts upon men and women. It is not only important to identify factors that cause distress but also to explore the process to comprehend gender specific impacts.

#### **2.5.4 Complex interplay of age in generating risks**

In recent years the national report and most empirical studies present high rates of suicide among adults aged 15 to 44 (National Crime Records Bureau, 2012; Patel et al., 2012). However, the survey and autopsy reports presented by Rao (1991) and Abraham et al (2005) state that suicides among the elderly (65+) population were high and under-represented in the reports. Rao recognised physical illness, depression, poverty and means of social integration as determining factors for suicides while Abraham acknowledged that reasons for suicides among the elderly population were less known. These research evidences do not explain well enough if it is the lack of health care in the case of chronic or physical illness or what sort of social support that has been missing that may have caused depression and suicide. Therefore, it is essential to consider not only the events but what led to such events and the impact caused, in the study of suicide.

Many studies that investigated risk factors among adults (15 – 29 years) relied upon psychological tools and quantitative methods to classify risks under particular mental health categories and such attempts can be seen in studies conducted in Southern India by Menon et.al (2013) and Srivastava (2013). The limitations of such approaches are that the study results replicate systematic criteria used by assessment tools rather than establishing an understanding of interacting factors that may be instrumental in explaining what leads individuals in particular age groups into experiencing repeated stress, anxiety or depression (Kumar and George, 2013). Parker et al (2012) recognise the need for socio-cultural autopsy to assess reasons for suicide however the socio-cultural autopsy approach needs to be



combined with qualitative approaches to be flexible and open to understanding risk factors rather than categorising events under the mental health classifications.

In a cross sectional study conducted among undergraduate students in Bangalore it was recognised that exposure to trauma during childhood, hopelessness and having affectionless parents correlated with suicides (Singh et al., 2012). A particular feature of Bholra and colleagues' cross sectional survey of adolescents in Bangalore recognised that the lack of timely help increased suicidal risks, abnormal behaviours and emotional problems (Bholra et al., 2013 (in press)). All of these studies acknowledged that stressful life events generate negative emotions, shame, humiliation, low confidence, and hopelessness. They also discussed events such as exposure to alcoholism, parental conflict, violence and poverty as contributory factors to suicide. The studies have identified events and elaborated an association between suicide and stressful life events. However, a closer examination of parent-child and peer relationships is more likely to identify information about how a young person constructs his/her perceptions of the social world and adopts particular habitus. This would be beneficial in exploring how adolescents and youth interpret certain situations as stressors that may be different from the ways in which adults would interpret similar situations.

Staple's ethnographic study of suicides in a leprosy colony in Bangalore does recognise how social situations and cultural beliefs shared within the region posed a risk of suicide for young healthy men who held high aspirations but lacked opportunity and resources. The influence of media and cases of suicide witnessed within one's surrounding were also identified as responsible factors. Whereas for

young women, challenges increased on marrying boys who were already facing difficulties in making their living (Staples, 2012b). The striking finding here is that circumstances are reinterpreted as distressing for healthy men and women living in a leprosy colony due to their interaction with a wider social structure that is outside their community. Staples described that suicide is not caused by structural situations or by an individual's choices only but by what he called a 'suicide niche' meaning 'several factors join together within the current circumstance and create a scenario prompting attempted suicide'. He further established an individual's personal agency and choices limited by habitus are factors that distinguish people who attempt suicide and those who do not despite experiencing similar situations. Although the concept of 'suicide niche' addresses structural, circumstantial and personal risk factors, the element of interactions among the three that derive specific meanings could differ in creating an attempted suicide scenario. Thus personal agency, choices and habitus are not the sole factors that deter an individual from attempting suicide. It is also possible to draw the conclusion that both agency and habitus are prone to change over time and space, and are key aspects in reviewing stressors and preventive methods.

In the city of Ahmadabad a survey of college students (18 – 24 years) indicated economic hardships, caste-based discrimination and communal unrest as high risks for suicidal behaviour (Nath et al., 2012). The state of Gujarat in which the city of Ahmadabad is located has experienced a history of violence and communal riots in the past. The findings from this study conducted in a city in the North West of India highlighted social, economic and culturally driven stressors which are different in nature to stressors experienced by people from other parts of the country. For

example, there have been no studies that identified communal violence as a reason for suicide in Southern India although a few instances of caste discrimination were reported. This variation calls for precautions to be taken while trying to generalise findings from one study conducted in a particular region to other regions due to cultural variations that influence social structures. Hence it is necessary to pay attention to the socio-cultural differences that are crucial in understanding stressors.

In a review of studies (including three studies from India) that investigated suicide in low and middle income countries, it was found that suicide among adolescents correlated with poor parental relationships, social isolation, poverty, lack of success and failure to achieve high grades in schools (Fisher, 2011). Khurana et.al (2004), through a cross sectional study conducted at an observation home for boys in Delhi, noted many children harboured feelings of hopelessness, depression, behaviour problems, and reported history of attempted suicide, sexual and physical abuse and substance misuse. The adolescents with traumatic experiences in childhood, witnessing and experiencing abuse in the family, being beaten, bullied and sexually abused were more likely to have mood disorders and depression than other children. The study used a combination of tools (questionnaire and psychological survey) to investigate the psychological status of the children. The results related very closely to the social and cultural environment that children grew up in. As this study was carried out in Delhi, a cosmopolitan city, the results are not truly representative of semi-urban and rural areas. For instance, family structures can vary hugely between cities and villages, which can make a difference to the stressors identified in this study. Also as the study was conducted in an observation

home which housed runaway children, the context and the setting of an observation home may have influenced the findings and thus they cannot necessarily be applied to the general population.

Siddhartha and Jena (2006) recalled that children who experienced parental neglect, presented runaway behaviours and witnessed suicide by a friend were at risk of attempting suicide in Delhi. This study limits itself to understanding suicidal ideation and attempted suicide as a form of abnormal behaviour. Intentionality, time, space, social and cultural issues were neglected. Children and youth are often forced into competition, to excel, succeed and prove their skills in order to gain power in the social structure. Lack of support while they face the stress to excel in everything can act as a precursor to attempting suicide. An increasing amount of pressure on students to perform well in education, to gain admission in esteemed schools and colleges are prominent issues and are guided by cultural capital. Failure to secure high grades and admission onto a desired course or college leave students embarrassed and humiliated hence they finally resort to suicide (Narayan, 2010; Lalwani et al., 2004). To add to this, Vijayakumar (2004) noted it is not always those who fail in exams that commit suicide but those with borderline and 80-90% marks. In response to the rising rate of suicides among students, the government altered the marking scheme from ranks to grades. Nonetheless suicides among students need to be analysed beyond mere features of 'high grades, expectations and success' because they result from individuals' interactions with social and cultural capital as presented to them by their parents or others which force them to redefine their identity.

Leach and Sitaram (2007) discussed a very alarming plight of school and college girls in Karnataka, vulnerable to sexual harassment at schools and colleges and whilst travelling on public transport. New beginners in schools and colleges also become victims of various forms of bullying. This study brought to light another instance of the disadvantaged position faced by young students and women, which pushes them beyond boundaries into suicide. However, the patriarchal society fails to put an end to women's exploitation despite several pieces of legislations in favour of women's rights and protection. In a few instances political parties have taken up issues, roles and staged protests against schools and colleges to which the student who committed suicide belonged (Staff Correspondence, 2009) without recognising the entire context in which a student attempted suicide. These protests could have negative or positive implications for the surviving members of the family or the student who survived the attempt. There is a need to explore the phenomenon of adolescent and youth suicide within the context of social, cultural and political settings. The causes of suicide evidenced in various studies need better interpretation and in-depth analysis of cultural transition and the interaction between social, religious, structural and functional fields within a society.

### **2.5.5 Is it modernisation or economic drift away from agriculture?**

Durkheim proposed a positive co-relation between suicide and modernisation based on the theory of social integration (Durkheim, 1989). A dominant view regarding the association between suicide and urbanisation is said to have been based on the notion of reinvented culture that overlooks traditional values and

disintegrates the family system (Mayer, 2011). In an attempt to test this view Sheen and Mayer set out on a time series analysis of male and female suicide in India from 1967 to 1997. Through the analysis of available data, they found that there was no significant relationship between modernisation and suicide (Steen and Mayer, 2004). They used urbanisation, female literacy and female work participation as components of a modernisation index, which suggests that their findings are strongly influenced by their assumptions about a connection between female emancipation and urbanisation in understanding suicide. To examine the impact of urbanisation in relation to suicide, we need exploratory methods that will account for even the subtle conflicts or influences or changes that may have larger effects.

The economic changes in India especially in southern states influenced the rate of development in the urban areas of the south compared to northern states. This widened the gap between the rural and urban, increased poverty in northern states while affecting the rural communities in the south as well (Kurian, 2007). Despite the shift to an industrialised society, India remains primarily agrarian with a large number of its population based in rural areas and dependent upon agricultural activities for their livelihood (Sriram, 2007; Mohanty et al., 2007). The introduction of new technology and methods to improve farming have in certain ways yielded negative results which have imposed huge debts on small farmers (Vedhanayagi, 2013). According to the national report for the year 2012, 36.7% of suicides were agriculture related (National Crime Records Bureau, 2012).

There has been a rise in the number of farmer suicides in a few states across India, due to reasons such as debt, crop failure and improper crop pricing (Das, 2011; Aggarwal, 2008b). Mathew (2010), in studying farmer suicides, interviewed farmers and families of the bereaved. He explained suicide among farmers as one of the ways adopted to cope with poverty. A massive loan waiver scheme (Government sector borrowing) had an adverse impact on Indian agriculture and compelled farmers excluded by the scheme's criteria to commit suicide (Paulose, 2010). The rising costs of production, falling prices of farm products, trade liberalisation and trade globalisation policies compel farmers to buy corporate seeds which need fertilisers and pesticides. These are believed to have contributed to despair and suicide among farming communities (Sainath, 2006; Sainath, 2009; Das, 2011; Mathew, 2010; Sundar, 1999; Venugopal and Jagadisha, 2000). It is evident that farmers have been unable to shoulder the economic burden of their families. The government policies that compel farmers to buy corporate seeds affected most of the cotton growing regions. The highest number of suicides is in Vidharba region of Maharashtra with 4000 suicides per year. It is said 'seed monopolies rob farmers of life' (Shiva, 2009). A more recent investigation of farmer suicides in Vidharba region by Dongre and Deshmukh (2012) used a mixed methods approach that exemplified other approaches as they recognised the interplay of social, economic and political challenges. They acknowledged the need for capacity building and improved mental health care in rural communities. The male heads of the family are generally responsible for providing for the family and when they fail to cater for family needs and pay debts they find themselves hopeless, helpless and forced to death (Das, 2011). Recently the Indian government launched schemes to

encourage women's entrepreneurship in farming. However, women from low-income families have always shouldered farming responsibility. None of the above studies classified suicides among women engaged in agricultural activities as farmer suicides. These studies present a specific feature in classifying reasons according to gender that are accepted widely and fall under socially stratified norms. There is insufficient research available that identifies women farmer suicides, which calls for a better analysis of the problem of suicide among both male and female farmers.

The green revolution in Punjab introduced genetic diversities and technology which increased crop vulnerability to external conditions. The communal violence in Punjab during the 1960's and 1980's was said to have been backed not by the economic backwardness but by the conditions created by the green revolution (Corsi, 2006). This is an example that illustrates how various forms of capital interact with each other and create undesirable situations for individuals. Sharma and colleagues argued that farming is dominated by the 'schedule castes, schedule tribes and other backward communities' (as addressed by the Indian legislation) (Sharma et al., 2007). While Sriram revealed that the micro credit system introduced by the government is not accessible to all farmers and not every farmer is aware of this (Sriram, 2007). Market economy and rapid industrialisation encourages individualisation. As a result, joint families split into nuclear and large land holdings into fragments. It adversely affects the agricultural output and encourages the young population to move to urban areas for better economic prosperity and lifestyle. On similar lines Sriram (2007) and Stone (2011) suggested that a lack of information about weather, crops, fertilisers and use of technology is responsible for farmer despair and distress. Muenster (2012) recalled the need for



ethnographic studies to understand the plight of farmers in their political struggle and explore challenges within agrarian practices that implicate suicidal behaviour. The political nature of farmer suicides means that it sustains its position within the economic domain. However there has been a recent trend in studies which associates suicide among farmers with the easy availability of pesticides (Banerjee et al., 2013). It is difficult to determine if suicides in rural areas are high due to the impact of industrialisation or lack of resources for better farming, low yields, or socially motivated causes or even easy availability of lethal means (such as pesticides and fertilizers). The ongoing changes in economic and social life introduce cultural transition. It is necessary to explore the impact of cultural transitions to understand if they are instrumental in generating distress or strategies to cope with distress. It is interesting to consider that very few studies analysed farmer suicides from a psychiatric point of view (Aggarwal, 2008a) while suicides in urban areas have largely been investigated with the help of psychological tools. The structural and political influences are very explicit in the choice of approaches taken to the study of suicide in different regions, among varying economic, gender and age specific groups. For example, most of the studies investigating the phenomenon among the 15-44 age group, associate suicide risks to anxiety, depression, alcoholism (Milner et al., 2013; Russell et al., 2013a; Russell et al., 2013b) besides widely known factors such as conflict and family problems (Banerjee et al., 2013) while not dwelling upon what causes conflict within families. Thus studies need to focus on how a single or a combination of factors such as economic hardships or transition in means of livelihood interact with other factors such as family and social networks and create an undesirable situation.

## **2.5.6 Medical and cultural orientation of intervention and Prevention**

Suicide was never acknowledged as a concern in need of prevention during ancient or medieval India. Rather those who attempted suicide had to face severe punishments. During the late ancient, medieval and pre independent eras in India, many people from a range of social strata fought against the Sati system (Bhugra, 2005; Bhugra, 2010; Fisch, 2007; Schneewind, 2007). This action against Sati can be considered as one of the earliest forms of suicide prevention in the history of India.

The plans for suicide prevention gained recent prominence within the health sector in India and allowed space for community based interventions. The biomedical model that relates suicidal behaviour to mental illness dominates intervention measures. However lately there has been awareness regarding the psychosocial, cultural and environmental risk factors but the lack of a national response to prevent suicide neglects treatment of suicidal behaviour at early stages (Bailey et al., 2011). The Mental Health Bill 2013 and the proposition to repeal legislation on suicide indicate the government's efforts to deal with the issue of suicide at a policy level (see 1.5 on page 24 for information on policy and mental health provisions). Vijayakumar et al (2011) and Patel (2010) made a strong case for a low cost intervention and prevention strategy to be embedded into the existing health care system by means of training counsellors at community levels to attend to the mental health needs of people in rural areas. This indicates that more and more studies are proposing biomedical methods and psychiatric models for treating suicidal behaviour. However in an Indian context where suicide and psychiatric

consultations are still an issue of stigma and legal concern, are the socio-cultural risks being ignored? Thus, the approaches to suicide prevention need to be inclusive of socio-cultural, religious and economic aspects (Wu et al., 2012) addressing regional variation within the country. There is a greater need to create awareness among people about the need to seek appropriate and timely support in problem situations. The rising dominance of psychiatric interventions is a by-product of cultural power shared by biomedicine which prevails through the current education system and the field of health care practice. Murthy and Jain question 'if this predominant biomedical approach was achieved at the cost of a loss of sensitivity to psychological and social issues relevant to the practice of psychiatry in India' (Murthy and Jain, 2009; p. 232). Mental health treatment in India is based largely on the administration of drugs and Electro Convulsive Therapy (ECT) (Jain and Jadhav, 2008) with traces of psycho-social therapies, counselling and the rehabilitation services in both government and private sectors (Joshi, 2009; Joshi, 2004). However, a considerable contribution is made by the non-governmental organisation (NGO) sector in rehabilitation of people with mental illness and terminal illness.

Patel et.al (2010) conducted a randomised control trial among patients with common mental disorders and attended public and private health care facilities in Goa to test the effectiveness of intervention led by lay health counsellors. The study aimed to integrate mental health treatment (antidepressants, psychological treatments and yoga) into primary health care settings. The group under intervention revealed changes in their symptoms during the follow up of six months compared to a control group which received no intervention. The study also

reported cases of suicide attempts in both the groups. The collaborative stepped-care intervention provided by lay health counsellors resulted in better recovery rates for people with common mental disorders in public health care settings compared to those treated in the private sector. This trial suggested pluralistic approaches in mental health and cost effective measures in reducing mental health gaps by training lay people within the community as counsellors. This approach may address early identification of mental health concerns but do these counsellors take on multiple roles of addressing stressors that may be linked to social, economic or cultural contexts? Unless the contexts in which stressful events occur are dealt with, they may still continue to impact individuals. As this trial concentrated on people with common mental disorders it is less considerate of issues other than mental health concerns, therefore the identification and care could vary vastly.

The TEACH-VIP (Training, Educating and Advancing Collaboration in Health on Violence and Injury Prevention) program by WHO introduced a model teaching resource in the absence of a structured curriculum for students, professionals, researchers and counsellors to reduce and deal with issues of violence, injuries and suicide (Malhotra, 2008). On the other hand policy impediments, insufficient budget for mental health, disregard for people with mental health problems, lack of mental health care services (Hendin et al., 2008) increased the risk of suicide and treatment barriers. Bailey and colleagues (Bailey et al., 2011) suggested that promoting understanding of suicide among the general public is instrumental in minimising the stigma attached to it which would encourage help seeking and reduce the alarming rates of suicide. WHO and other researchers have suggested measures to increase awareness about suicide but the implementation of

awareness programs is very limited. There is a need to establish regular workshops in schools, colleges, institutions, organisations and communities and also through the media to improve stress coping skills among people of all age groups. Another measure proposed by WHO and other researchers was to reduce access to lethal means of self-harm and suicide. The government of India took one such measure to control suicides by pesticides through ways of storing pesticides in locked boxes. These boxes are located on individual farms or at a central point in the local village, and the keys are held by a trusted family member or a respected community figure (Vijayakumar et al., 2005; Hendin et al., 2008). Reducing access to pesticides might have reduced incidence of suicides to some extent but more research is needed to investigate the effectiveness of the program.

Culture has vastly shaped perceptions towards mental health and mental illness and has even negatively influenced help seeking behaviour. People hesitate to approach counselling and psychological services for fear of stigma and being called 'mad' or classified as mentally ill (Patel, 2007; Patel et al., 2006; Patel et al., 2009). This classification adversely affects family life, career, education, marriage opportunities and other aspects of the social spectrum. Stigma associated with suicide, is common in almost all parts of the world and is reflected through the cultural forces of society (Mayer, 2011). In India, members of a victim's family are sometimes under the impression that a suicide attempt is a result of a black magic, evil eye and possession (Jayaram et al., 2011; Staples, 2012b). Whilst on the other hand the cost involved in accessing, consulting and obtaining medication could create a barrier in approaching medical and psychological support (Raguram et al., 2002). Due to these difficulties and the religious contexts, people share faith in

traditional healing methods. They tend to approach faith healers, herbalists and Ayurveda practitioners regardless of medical support (Parkar et al., 2009; Sebastia, 2009).

Raguram et al (2002) in a study of traditional community resources for mental health treatment conducted an ethnographic enquiry into the temple healing system in Tamil Nadu, a state in Southern India. The study identified improvement in the symptoms of psychotic illness without any psychopharmacological or other somatic interventions during their stay in the temple. The plurality and effectiveness of healing systems would be better acknowledged if the study had a control group to compare with. The influence of cultural capital on social structures and social interaction guide service users' response to stressful events and professionals' treatment plans; however these influences and interactions need to be explored with an in depth analysis. The other ethno medical study conducted in Gujarat evidenced people approaching multiple care providers within biomedical and indigenous/healing practices until their symptoms disappeared or they received the type of treatment (medication – antibiotics, injections) they requested (Karnyski, 2009). This elaborates the conflict that people undergo in the presence of multiple care facilities to approach the right service while they end up approaching several of them.

The national response to suicide prevention in India is limited. However, it has not failed to support the endeavours of non-governmental organisations (NGO) who are actively involved in suicide prevention and intervention programs (Vijayakumar et al., 2005). On the other side there is little evidence of specific suicide prevention

programs located in the government annals except for a brief mention of 'local governments to take on the responsibility to plan and implement intervention schemes' along with a proposition to decriminalise suicide (Bhaumik, 2013; Government of India, 2011). It is worth noting and keeping the debate open to explore the effectiveness and success of a new strategy that trains lay counsellors with an intention to bridge the gap between mental health services and the needy people. This is also used as a method to encourage early intervention in treating suicidal behaviour (Patel et al., 2009). Radhakrishnan and Andrade (2012) suggested preventive strategies planned and implemented at a community level may be more effective than those done at a national or global level. But the question here is are these strategies promoting a biomedical approach or are they considerate of local practices? Do they aim to deliver best care that is constructed within the social and cultural lives of people even if it means deconstructing those beliefs and practices that pose threat to human rights such as human sacrifice or physical violence during healing services?

## **2.6 Summary**

A discussion of risk factors in the literature interprets immediate events preceding suicide with very little attention to the intersecting nature of socio –economic and cultural aspects that explain distress and suicidal behaviour. The studies here have attempted to cite the link between suicide and mental illness and not many recognised the complex role of culture in shaping beliefs and opportunities which on the reverse make people vulnerable to suicide (Staples, 2012b; Colucci and Lester, 2012). Suicide is constructed within the biomedical (mental illness)

(Vijayakumar, 2007), social (family problems, conflicts) (Gururaj et al., 2004) and economic (farmer suicides) (George et al., 2009; Gruere and Sengupta, 2011) fields in the contemporary society of India at large. Although there is an awareness regarding the need to identify cultural factors, very few researchers have dealt with this issue. They have emphasised psychosocial stress and social isolation, perceived culture as a variable, identified the influences of urbanisation in reconstructing traditions in terms of changes to family structure, jobs and social positions (Manoranjitham et al., 2007; Manoranjitham et al., 2010). The patterns in help seeking are recognised with attention to stressful life events, lack of support and stigmatisation. There is also a belief in traditional healing methods that is approached alongside medical help (Colucci and Martin, 2008; Gururaj and Isaac, 2003).



## **3 Methodology and Methods**

### **3.1 Introduction**

This chapter examines the theoretical framework and methodological approaches that structured the study. The ontological and epistemological stance that positions the research within the qualitative paradigm and application of principles of grounded theory and Bourdieu's concepts (see 2.4 on page 33) are discussed in the first section. The chapter then considers the methods implemented in conducting the study. Finally, validity and limitations are considered.

The aim of this study is to explore cultural implications of attempted suicide and its prevention in South India. Specifically, the study seeks to:

- Explore whether cultural factors play a part in mental distress resulting in attempted suicide among South Indian adults .
- Understand cultural implications on modern methods (biomedical, psychotherapy, counselling) of interventions in treating survivors of suicide attempt in India.
- Explore alternate methods of healing mental distress and suicidal behaviour in India.

### **3.2 Ontological and Epistemological positioning**

The field and scope of the research topic 'cultural implications of attempted suicide' influenced the design of the study undertaken. The study of suicide in India is limited to systematic examination of suicide rates, correlation of risk factors with psychiatric illness and sociological studies (religion, 'sati', and farmer suicides)

(Mayer, 2011). Research studies are largely confined to quantitative approaches. There is very little evidence that addresses personal experiences and perspectives of survivors of attempted suicide in India. There has neither been any available study on perspectives of people (health professionals and healers) who treat survivors in India. Thus the approach to understanding cultural factors and attempted suicide included seeking to study how culture is produced, perpetuated and influenced through the interactions of those (survivors, professionals and healers) most concerned with the topic. Bourdieu's notion of cultural capital that embodies power and recognises the influences upon dispositions/habitus is particularly appropriate in understanding the interactions between socio-cultural process and the individual and further in constructing knowledge surrounding culture and suicide in India.

From an ontological perspective, this study assumes reality to be interpretive, socially constructed and a product of interaction (Crotty, 1998; Packer and Goicoechea, 2000). Given these threefold assumptions, the nature of reality surrounding attempted suicide considered in the study is that individuals interpret situations based on their personal experiences and perceptual understanding (Denzin and Lincoln, 1994) thus framing reality as highly variable and contextual. On a social front, the meanings that individuals attribute are socially constructed (Packer and Goicoechea, 2000) through a system of beliefs produced within organisational, cultural, political, faith and religious contexts. Individuals are in constant interaction with their socio-cultural environment which forms and transforms their beliefs, perceptions, meanings and interpretation of reality

(Stanley and Wise, 2002). Thus, meanings are not only influenced by interactions but are socially constructed as a product of interactions.

The basic assumptions about knowledge in this study are that knowledge is produced through privileging the experiences of participants (survivors, mental health professionals and traditional healers), acknowledging truth about knowledge is subjective, contextual and that everybody's knowledge is equally valid (Stanley and Wise, 1990). The knowledge produced here is generated through the experiences of participants, how they interpret their situations and the process of interactions amongst individuals, their surroundings and the researcher. 'Truth' is considered like knowledge to be plural and resulting mainly from what is being communicated by participants -survivors, professionals and healers. It is acknowledged that participants' ability to produce knowledge is influenced by their insight, context and subjective reality. On the other hand the ways in which their knowledge is communicated, understood by the researcher and is reproduced recognises the transition and adaptation which takes place during the process of knowing (Crotty, 1998; Henry and Pene, 2001). The approach of this study assumes that the accounts of every individual participant from all three groups are equally valid and no group's perspective seen collectively is likely to be more true than another. This concurs with the approach of exploring the issues rather than seeking to measure or define them as singular.

### 3.3 Research Design

In reviewing the ontological and epistemological assumptions, the researcher recognised the need to explore culture and suicide from within a qualitative paradigm that fits the interpretive and constructivist nature of the study.

The most important aspect of a qualitative approach is that it facilitates in depth exploration of social and cultural phenomena (Corbin and Strauss, 1992; Bryman, 2004) through the experiences and accounts of participants which could hardly be achieved otherwise through quantitative or statistical models (Lindlof, 1995). The current knowledge surrounding suicide in India is limited by quantitative approaches such as epidemiological studies and autopsies (Patel et al., 2012) which do not seek to address the perspectives and experiences of survivors or of those who treat survivors of suicide.

Multiple methodologies exist within the qualitative paradigm for example, ethnography, grounded theory, and phenomenology (Creswell, 1998). These three approaches share a common aspect in that they discuss culture as a social construct. Ethnography concerns itself primarily with cultural descriptions and the social world (Hammersley and Atkinson, 2007; Willis and Trondman, 2000), whereas phenomenology emphasises making sense of individuals' experiences (Moustakas, 1994). Grounded theory draws a mid-pathway between phenomenology – considering individual experiences; and ethnography- concentrating on the role of culture and its implication (Bryant and Charmaz, 2010). It is also inclusive of individual's beliefs and theories along with their stories within the social process. As such, grounded theory provides a combination of theoretical perspectives

(symbolic interaction, phenomenology, ethnography) to encourage a process of rich data collection. Holstein and Gubrium (2000) recognise the importance of context when researching a phenomenon which in this study would mean that the researcher not only studies the experiences of participants but also examines the contexts for both participants and the researcher. Grounded theory is very closely associated with symbolic interactionism (Strauss and Corbin, 1994) bringing together the study of individuals and social interactions in a social context in order to understand meaning production.

The ideas of symbolic interactionism provide a framework to examine the influence of culture in everyday events of life as experienced by survivors, perceived by mental health professionals and healers with regard to attempted suicide. In order to understand the cultural influences that cause mental distress, the data collection process aimed to explore the distinctive character of interactions that take place between survivors and socio-cultural practices, survivors within their families, communities, society and survivors in interaction with medical practitioners and healers. The interactionist perspective reminds that a response to situation is generated by meanings that individuals derive from situations or others' actions (Blumer, 1969). This applies to both participants within their own contexts and the researcher within the research process.

The purpose of grounded theory is that it explores interrelations and interactions among individuals and their social environment. It further seeks to understand how reality is constructed both at an individual and social level (Glaser and Strauss, 1967) with a primary focus on generating a theory to offer insight into the subject

under study. However, the process of generating theory proposed by a grounded theory approach did not meet the scope of the study as Bourdieu's theoretical concepts (see 2.4 on page 33) helped in shaping the understanding of how culture is constructed, perpetuated and the meanings generated for individuals within their social space in explaining suicidal behaviour. It must be remembered that the principles of grounded theory and symbolic interactionist perspectives on meaning generation heavily influenced this study in terms of data collection and initial stages of data analysis. The constant comparison method (Strauss and Corbin, 1998; Fram, 2013; Boeije, 2002) assisted in deriving themes for critical inquiry into culture by recognising the spoken and unspoken knowledge of participants, their meaning-making process and in generating conceptualised categories. It was difficult to determine when the categories were saturated as the themes were analysed from a critical perspective and underpinned by Bourdieu's theoretical concepts. Combinations of approaches led the researcher to rich description of data and gave voice to participants especially survivors, whilst conceptualising generative cultural mechanisms that explained suicidal behaviour by presenting a model. Therefore, in terms of approach, this study drew from the influences of grounded theory, symbolic interaction and phenomenology in its design and process whilst underpinned by the theoretical concepts of Bourdieu's work.

### **3.4 Research process**

This section will discuss procedures concerned with conducting the study, providing readers with a detailed description of the methods used and how the study advanced through the stages and proposed a conceptual model.

### 3.4.1 Setting

The study was situated within a combination of urban, semi urban and rural locations such as the Bangalore/Bengaluru, Mysore/Mysuru and Coorg/Kodagu districts in Karnataka, Southern India with the focus on being inclusive of both rural and urban locations (see Appendix E : Location of Field Study on page 305). The reasons for locating the study in South India were based on the high trend in suicides evidenced in South Indian states (Tamil Nadu, Kerala, Andhra Pradesh, Maharashtra and Karnataka) over the past decade which accounts for over 50% of the country's total suicides (National Crime Records Bureau, 2012). The same trend has also been confirmed through a nationally representative survey of suicide rates (Patel et al., 2012). Secondly, the national report presented higher rates of suicide in cities (11.9 per 100,000) compared to the all India incidence rate (11.2 per 100,000) (National Crime Records Bureau, 2012). It should also be noted that South India has more concentration of urban population than the rest of the country according to the most recent Indian census (see Appendix C : Urban Population – India 2011 on page 303) (The Registrar General and Census Commissioner, 2011). Bangalore recorded the highest rate of suicides (42.1 per 100,000) as per reports for the year 2008 (National Crime Records Bureau, 2008) and was called a metropolitan suicide capital for the year 2010 (National Crime Records Bureau, 2010). However the latest report (year 2012) recorded 23.4 (per 100,000) for Bangalore and 45.1 (per 100,000) for Jabalpur a city in Madhya Pradesh, central part of India as the current metropolitan suicide capital.

Considering the data on suicide rates during the design stage, Bangalore and surrounding towns and cities were regarded as appropriate sites for this study. It is hard to estimate if Bangalore is representative of completed suicides and the survivor population in India overall because of the limitations inherent in the reporting system (see 1.3 on page 13). However, Bangalore is a home for multi-ethnic, multi-religious, multi-class and caste groups which makes it an appropriate site for exploring social, cultural, economic and legal issues around attempted suicide.

### **3.4.2 Sampling and recruitment**

When designing this study, a thoughtful consideration of practical issues in sampling and recruiting participants was considered. The sampling strategies employed were purposive and snowball (Silverman, 2013; Bryman, 2004) with the aim of achieving the research objectives. As the focus was on exploring cultural influences in causing distress that lead to suicidal behaviour and impact help seeking, the survivors considered for the study were within a year since the last attempt. Professionals and healers had to have been in practice for more than a year and be experienced in treating survivors of attempted suicide in order to meet the study's inclusion criteria. Sampling size was influenced by data saturation (Strauss and Corbin, 1994) however there are limitations in arguing that the size was solely determined by theoretical saturation. The limited availability of time, access difficulties and diverse cultural and religious practices across wider geographical areas limited the sample size and challenged if data saturation was achieved (this is discussed further in the limitations section 8.3 on 271). The recruitment of participants coincided



with data collection and analysis over a six month period. It was important that participants understood and spoke either English or Kannada to facilitate the interviewing process and obtain rich data.

It should be noted that survivors, professionals and healers were all accessed from a wider geographical location not specifying to the city of Bangalore alone but from rural and urban Bangalore, surrounding regions of Mysore and Kodagu districts. Owing to the mixed range of urban and semi-urban locations, it was likely that the study could access participants from varying socio-economic, religious and cultural backgrounds which was important to achieving the intended diversity in the data generated. The following table presents the exclusion and inclusion criteria for participants.

**Table 2 - Inclusion and Exclusion Criteria**

<b>Inclusion criteria</b>	<b>Exclusion criteria</b>
Ability to speak and understand English/ Kannada	Do not understand and follow English/ Kannada
Willing to participate	Unwilling to participate
Possess clear verbal expression	Difficulty in speech and hearing
<b>Survivors</b>	
Survivors who approached hospitals / clinics in urban and rural Bangalore, Mysore and Kodagu districts	Survivors who did not approach hospitals/ clinics in urban and rural Bangalore, Mysore and Kodagu districts
Survivors aged between 18-44	Survivors aged >44 <18 age
Within 1 to 12 months of attempt	Less than a month or more than 12 months since their last attempt
In a state of stable medical recovery since last attempt	Lack of medical recovery/poor physical health condition
Those who do not have severe mental health concerns	Those who suffer from severe mental health issues and lack mental capacity
<b>Mental Health Professionals</b>	
Professionally qualified general practitioner, psychiatrist, social worker and psychologist.	Other medical and paramedical staff.
Professionals who have treated survivors of attempted suicide.	Professionals who did not treat survivors of attempted suicide
Practicing professionals in a hospital or clinics based in rural/urban Bangalore, Mysore and Kodagu districts.	Non-practicing professionals. Practicing professionals based outside rural/urban Bangalore, Mysore and Kodagu.
Professionals in service for a minimum of a year.	Professionals in service for less than a year.
<b>Traditional Healers</b>	
Practicing faith healers, exorcists, Ayurveda and Siddha practitioners.	Non practicing faith healers, exorcists, Ayurveda and siddha practitioners.
Healers who practice in Karnataka.	Healers who practice in regions outside the state of Karnataka.
Healers who belonged to Hindu/ Muslim/ Christian faith.	Healers who did not belong to Hindu/ Muslim/ Christian faith.

### **3.4.2.1 Accessing survivors**

It was decided that the general hospitals with well-established psychiatric inpatient services may be approached in consideration of the challenges in approaching survivor population. However due to the difficulties in obtaining approval from relevant hospitals, the researcher broadened the access points to general hospitals with a psychiatric unit not necessarily with psychiatric inpatient services, non-governmental organisations and private health clinics. Recruitment via hospitals and health clinics was deemed best as the survivors of attempted suicide were presented to the casualty section and later referred for psychiatric consultation.

Mental health professionals from these hospitals/clinics were accessed as gatekeepers to gain access to survivors. The professionals who were recruited into this study and those that were not recruited both acted as gatekeepers. However, this method could introduce recruitment bias which would be addressed by applying the inclusion and exclusion criteria mentioned here. The professionals did not discuss the case history of potential survivor participants before or after the participants were referred to the researcher. This further helped to minimise bias during recruitment and data collection. They referred those survivors who were directed to the psychiatric unit by the casualty section and those who approached for a follow up treatment. Thus, the referrals were more random than conscious choice. The referred survivors arranged to meet with the researcher in person, where the researcher explained the study, gave the welcome pack and arranged another meeting if they were interested. During the second meeting survivors had an opportunity to express their consent where the date and time of interview was fixed.

Purposive sampling was used to determine survivor participants as they were considered for their representative experience and not merely demographic criteria (Bryant and Charmaz, 2010; Corbin and Strauss, 1942). Purposeful selection criteria provided representative characteristics of the samples. This criteria otherwise would not be regarded under snowballing or convenience sampling. Survivors within the age group of 18 – 44 years were considered as this range falls under the high risk age group (National Crime Records Bureau, 2008; Patel et al., 2012). Including both female and male gender across any religion, caste and class, regardless of their ability to read and write, means of livelihood and professional background were expected to bring diversity in perceptions and understanding of distressing factors leading to suicide. A total of 25 potential participants were identified and approached to obtain consent however only 18 consented whereas others did not respond to the invitation. Out of 18 survivors, 15 survivors last attempted within a period of 1 month to 12 months were interviewed whilst another 3 survivors who consented to be interviewed did not appear on the scheduled date and time.

#### **3.4.2.2 Accessing mental health professionals**

Mental health professionals were accessed through general hospitals, teaching hospitals and clinics in rural and urban Bangalore, Mysore and Kodagu districts. This group of participants consisted of psychiatrists, general practitioners, psychologists and social workers. Each of these professionals plays a different role in the health care delivery system however, given a limited number of mental health professionals in India (Vijayakumar, 2007; Patel et al., 2010), the above

mentioned professionals often take on multiple roles which make these professionals' perspectives central to understand care of survivors of suicide in India. They were sampled using purposive methods, which guided the recruitment of those who have experience of treating survivors of attempted suicide for more than a year as their experiences have the potential to elicit rich data. A General Practitioner forms part of this group as most of the survivors do not seek mental health treatment (Saddichha et al., 2010). It was possible that professionals could be employed in general hospitals whilst they had their own private practice. The potential practitioners were contacted via phone, emails and in person to explain the study and information packs were sent out to them. Professionals' gender, age, religion, caste and class did not form a part of criteria for recruiting into the study. A sample of 16 mental health practitioners was approached through emails and by telephone. Overall 10 practitioners consented to be interviewed, of those 2 psychiatrists, 2 psychiatric social workers, 2 psychologists, 1 general practitioner and 1 medical social worker were interviewed, while the remaining 2 psychiatrists could not make it to interview appointments.

#### **3.4.2.3 Traditional Healers**

The healers were accessed with the help of previous users of healing services, believers of services and personal contacts. The recruitment of this sample group followed a snowball strategy as purposive sampling was difficult to achieve. Healers were difficult to reach due to the social and religious contexts and their reservations towards non-service users, non-believers and restricted access. Without the above-mentioned gatekeepers, it would be difficult to access, recruit and obtain healers'

consent to participate in the study. Healers were sampled from across Karnataka in South India, as more than 20,000 traditional healers are said to be based in Karnataka according to a newspaper report in South India (2010)<sup>2</sup>. They were handpicked from three religious groups (Christian, Hindu and Muslim) in order to be inclusive of varying healing practices across religions.

A total of 15 traditional healers were approached in person and were given a welcome pack with the details of the study and an invitation to participate. Ten of them consented to participate in the interview and the other five did not respond to the invitation. Among 10 participants, eight were religious ministers across Hindu (2), Muslim (4) and Christian (2) religions. The other two participants were lay people from Hindu and Christian religions practicing religious/ faith healing. One of the Muslim healers, a religious minister had to be excluded as he failed to provide an appointment for the interview during the following three months (March – June 2012) since the first meeting (mid-March). The data collection process was expected to be concluded by June 2012 which made it necessary to exclude this participant.

During the course of the interview, one participant (lay Christian healer) decided to withdraw as he seemed to be annoyed with the interview questions, dissatisfied by the researcher's answers about faith and further declined to continue and consent to use any of the interview material for research. The sample size was unequally distributed across gender, as there were very few female healers. Out of 15 approached healers, there was only one female healer. Limited availability of time,

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<sup>2</sup> India lacks a national database that provides information on healing practices and healers.

a wider time gap between the point of contact and obtaining consent challenged the recruitment strategy and the ability to recruit more participants which was essential to address emerging themes.

### **3.4.3 Data Collection**

The data were collected by means of in-depth interviews which were directed by topic guides (see Appendix F : Topic Guides on page 306). The conversational approach of the in-depth interview method (Patton, 1990) made exploring sensitive data possible which may have posed challenges if using structured methods. The intention of using topic guides was to anticipate gaps in data (Patton, 1990). The flexible nature of open-ended, in-depth interviews encouraged the participants to direct the conversation into aspects they deemed as important. All the interviews, where permission was given, were recorded and transcribed into the source language. In the absence of permission to record, detailed field notes were taken. The interviews provided opportunity to document voices so far unheard and unattended in the current literature. Interviews lasted between one and two hours, with intervals when needed. A written or verbal consent (in the case of those participants who were illiterate, which was audio recorded) was obtained expressing an agreement to participate in the study. The interviews (across all three groups) were in English or Kannada however a few of the participants used a combination of other (Hindi, Malayalam, Tamil, Konkani) languages. This was done to explain a particular situation or words that they could do best in the language with which they were most comfortable. As the interviewer spoke and understood these languages the data were preserved in the source language however at the

time of transcribing the words or expressions spoken in a language other than English or Kannada were translated into a principal (Kannada/English) language of the interview. The topic guides were continuously revised to be inclusive of a wide range of issues that came up during the interviews. Interviews became more focused as progress was made with the analysis (Corbin and Strauss, 1942).

The topic guides were developed with a purpose of exploring the life situations of survivors of attempted suicide, their interpretations and meaning making process while also attempting to comprehend the healers' and professionals' interactions with survivors, their interpretations of risk factors and approach to treatment and prevention. Kvale (2009, p. 124) suggested 12 key aspects that assist in understanding the interview interactions. They are: "life world, meaning, qualitative, descriptive, specificity, deliberate naïveté, focus, ambiguity, change, sensitivity, interpersonal situation, and a positive response". These 12 aspects were kept in mind while developing topic guides for this study and reviewing the interview schedules used by other researchers to obtain qualitative data in the field of suicide, attempted suicide and self harm (Hunter, 2011; Chantler et al., 2001) helped further in structuring topic guides. These interview guides assisted in considering what aspects to focus on to begin with, at the same time it provided the flexibility to adapt questions and move into further topic areas as the interviews progressed. It is also advised there should be no more than 15 questions to guide the interviews (Boyce and Neale, 2006) thus providing the opportunity to modify the guide based on responses and experiences.



The topic guides for survivors included broad and open ended questions starting with what led them to such a decision, factors causing mental distress leading to suicide, role of family and society, their influence and response to such behaviour, any support accessed and received. The process of consent and obtaining consent was challenging as this is a sensitive issue and survivors were hesitant to open up their experiences to a stranger (i.e. the researcher). Topic guides led the participants into topic areas that needed to be explored, letting them take control of their sharing without any interruption unless necessary. At times when interviews caused distress to survivors, the interview was paused and they were given the choice of returning to the gatekeepers for further support. A follow up appointment was made to continue the interview if the survivor was still willing. Fifteen survivors who matched the inclusion criteria were interviewed in depth, nine interviews were audio recorded, out of which three did not want to continue with the audio recording half way through the interview. Two survivors sounded very uncomfortable with the recording and so considering survivors' interests the audio recording was terminated. Detailed notes were obtained from the interviews that were not audio recorded.

Saddichha (2010) argued that not all cases of attempted suicide present to mental health services which highlighted the need to recruit and interview general practitioners. The topic guide for mental health professionals included broad areas such as common reasons presented for suicide, practitioner's perception, understanding and interpretation of these reasons, methods used in treatment, impact of their own culture in practice and the role of traditional healers. The researcher's position as a researcher and a qualified social worker influenced the

professionals' responses. For instance, they perceived the researcher as a professional who is aware of mental health issues and social concerns, thus a few of them were less elaborative of situations (risk factors). All of the eight interviews were audio recorded.

Eight healers from three major religions (Hindu, Christian and Muslim) were interviewed in healing centres/temples/churches. Three healers consented for the interview to be audio recorded, out of which one healer requested a copy of the recording. The other interviews followed a detailed note taking procedure. The topic guide explored reasons for suicide as posed by the service users and understood by healers themselves, methods of treatment, interrelation between suicide and methods of treatment, its philosophy, taking responsibility for the service users. The researcher found it challenging to approach and obtain rich data from the healers as some of the healers presented extreme reservation towards the gender, religion and culture (e.g. – dressing, accent of dialects/languages spoken) of the researcher. The researcher presented to the healers as a mental health social work researcher and when asked she revealed her religious, cultural and faith identity. The researcher's identity as a researcher created suspicion and cautiousness amongst the healers. The healers perceived and made judgments about the researcher's cultural and religious grounding through the types of questions posed by the researcher during the interview. A few of the healers expressed their disinterest, disappointment and annoyance when the researcher did not meet their expectations towards dressing (not wearing a bindi/red dot on the forehead, bangles, flowers) and being perceived as a non believer. The healers perception of the researcher's identity interacted with the way they chose to

respond to interview questions. For example, a few were reserved and brief in their responses while others emphasised that religious healing is a remedy to those illnesses and conditions to which medical science has no cure.

#### **3.4.4 Data Analysis**

Interview transcripts and summaries were written followed by the interviews in the language of the interview. The researcher maintained a detailed reflexive account of the interviews immediately following its completion in order to capture the contextual details. These reflexive notes were used in parallel with the interview recordings to make complete meaning of the participants' contexts and interview material. The researcher listened to the interview recordings and made a list of key points in the interviews prior to writing transcripts. This helped to keep track of evolving themes in the consecutive interviews. As the interviews with participants from three groups did not occur in any particular order, rather they occurred in a mixed manner. This approach helped in comparing and contrasting the themes across interviews and groups.

A summary of interviews were written in English for those that were conducted in Kannada in order to facilitate a better understanding and discussion of themes with the supervisory team. A computerised software programme QSR Nvivo 10 was used to organise data and to help with thematic presentation of the data. Transcripts that were in both Kannada and English languages, detailed notes, reflexive accounts and memos were uploaded to NVivo. These data were then coded line by line. The codes were organised under themes and a higher order of themes was then

created. Key themes were then brought under major categories. These themes and categories were compared and contrasted within groups and across groups.

The process of analysing complete account of themes involved several readings of interview transcripts, notes, memos, reflexive accounts and initial codes. This analysis was further aided by a constant comparative method where data were analysed in parallel with data collection as emerging issues guided data collection and led to developing codes, themes and categories (Corbin and Strauss, 1942). This study followed the first two steps of constant comparative method discussed by Glaser (1964). Firstly it guided the process of integrating codes, themes and categories, secondly compared themes under each categories and across groups. The application of other two steps “delimiting theory and writing theory” was not possible in this study as data were interpreted through Bourdieu’s theoretical framework. Following Strauss and Corbin’s (1998) idea that comparison is a creative process, analysis expanded beyond the contexts and conditions of the data. The process of questioning the contexts, conditions and interactions for both participants and the researcher helped in acknowledging the hidden interrelationships in the data and identify less obvious themes (Fram, 2013; Boeije, 2002).

The findings from survivors, professionals and healers were analysed and presented individually to capture their voices. Bourdieu’s theoretical concepts were then used to analyse and test the findings. On the other hand, findings brought into operation Bourdieu’s concepts through a critical discussion of data. An emerging conceptual

model was presented diagrammatically to explain cultural mechanisms in attempted suicide (see 7.4 on page 256).

### **3.4.5 Ethical issues**

This study was designed and conducted under careful consideration of principles for ethics, good practice, information, access, health and safety as laid by UK research governance framework for health and social research (Department of Health, 2005), ESRC framework for research ethics (2012) and Indian National Committee for Ethics in Social Science Research in Health (2000).

Ethical approval was obtained from the University Research Ethics Committee on the 10th of February 2012 (ref: ethics/11336) (see Appendix G : Letter of Ethics Approval on page 308). The University of Manchester provided the necessary insurance cover. The study adhered to the ethical guidelines as stated by the University of Manchester. The main ethical issues identified during this process were:

- Obtaining permissions from the relevant organisations and consent from each individual interviewee.
- Maintaining confidentiality and anonymity of the participants
- Safeguarding of the participants and researcher from physical and emotional threats or distress during the interviews

There were potential problems encountered in obtaining permission from organisations in India. The psychiatric hospital in Bangalore directed the researcher to the Ministry of Health, Government of India to obtain permission to access participants through the hospital. On approaching the Ministry of Health there was very little guidance provided as to the procedures involved in applying for consent.

On receiving no response from the ministry, the researcher approached private teaching hospitals in Bangalore. However, there were specific demands made by the hospital with regard to authorship and monetary fees, which the researcher and the University of Manchester reckoned as unreasonable. Therefore the researcher approached small scale hospitals, health clinics and counselling centres in and around Bangalore, Mysore and Kodagu regions that are managed by health care professionals (psychiatrists, general practitioners, counsellors). A few of these practitioners were also employed by the state run hospitals. As the researcher made sure that the professionals were approached and interviewed within their private practice, it became essential that they provided individual consent to access survivors and for themselves to be interviewed.

The researcher assured all the participants that their identity would be anonymised. Furthermore, the survivors wanted assurance that the contents of the interview would be kept confidential, meaning not to be discussed with their family or the hospital staff. A few of the healers were hesitant to provide their name and address, in such cases a pseudonym name was suggested and healers were then happy to consent to be interviewed.

These completed consent forms are now being kept in a secure cabinet at The University of Manchester. The transcripts of the interviews have been stored as encrypted files on a University laptop. All audio recordings of the interviews have also been saved in an encrypted format on the University laptop and securely deleted from the recording device.

The researcher paid special attention to the safety of participants. Healers and professionals were interviewed within their place of work. The researcher used discretion in deciding to whether to be accompanied by a friend while travelling to remote locations. The accompanying person did not enter the room of interview during the interview. Few of the healers expressed their disapproval of the ways in which the researcher was dressed (not wearing flowers, bangles, kumkum or bindi), this influenced the ways in which the healers treated the researcher and their participation in the research. Most of the survivors were interviewed in health clinics and hospitals. The health professionals allotted a separate room for the researcher to conduct interviews. Survivors felt more comfortable speaking to the researcher once the researcher had ensured that none of the family members or hospital staff were outside the room. The physical space was a means to ensure privacy and confidentiality to the survivors. If survivors felt distressed during the interview, then the interview was paused or terminated and the researcher endeavoured to stay with survivors until they felt better and they were then directed to counsellors or professionals if willing.

The researcher received constant support from the supervisory team during data collection and analysis. The supervisory team recognised the impact of the emotional nature of the study and supported the researcher. Supervision and reflexivity assisted the researcher with emotional support and analytical tools.

### **3.4.6 Rigour**

The rigour in qualitative study may not be attained by a single standard approach (Silverman, 2013). Many researchers use various terminologies in assessing the

quality of qualitative studies ranging from terms such as reliability, validity (widely regarded as quantitative terms) to trustworthiness and rigour (qualitative terms)(Morse et al., 2002). Although Lincoln and Guba's (1985) criteria (credibility, confirmability, dependability, transferability and authenticity) to assess trustworthiness of qualitative study recognised the difficulties associated in assessing the relativist nature of truth/reality, this framework is limited in its approach as it depends on 'contradictory philosophical position' and is firmly grounded within constructivist paradigm (Seale, 1999). While Hammersley's (2008) approach to quality criteria is positioned within the realist paradigm, that pays attention to subtle realism of language and reality outside the text. This helps researcher to draw a midway by being aware of constructivist nature, avoiding its general application to the research and assessing the reality of the process and the study.

Hammersley and Atkinson (2007) suggested that validity is attached to 'meanings attributed to data and inferences drawn from the data'. This idea of assessing trustworthiness by enquiring into the validity of the inferences made from the data (Hammersley, 2007) is applied in exploring the rigour in the current study. The key to managing the trustworthiness of this study required the researcher to be conscious of what is happening in the research process (Cohen et al., 2011), to account for her decisions, manage a reflexive practice throughout the research process and to be transparent.

The researcher's position is one of the key elements to be considered in assessing the trustworthiness of the ways in which research is conducted and the data are



interpreted. This concern was addressed by taking a reflexive stance, being transparent, separating the voices, discussing interpretations of the data with supervisors and finally comparing and contrasting interpretations as a means of triangulating the data at an interpretive level. It must be noted that the data triangulation method used in this study is within its conceptual meaning to establish validity of the study (see 3.4.6.3); it is not to verify the truth or accuracy of data generated by any of the participants (see section 3.2 on page 72 for a discussion of the plurality of 'truth' within the research). The trustworthiness of the current study is demonstrated through the following rigorous approaches employed during the research process.

#### **3.4.6.1 Reflexivity**

Reflexivity was an essential tool in identifying the researcher's position and maintaining transparency. The researcher's position as a woman, native of the country to which the phenomenon is under study, is aware of the cultural and religious background and values that can influence the type of data collected, interpreted and categorised. The researcher as an insider to the cultural and professional context, provided a better understanding and analysis of cultural phenomenon, expressions, language and meanings which would otherwise be lost. However, the disadvantage of this position was being embedded in the culture; the researcher could be blinded to the most common issues within the culture that might have been remarkable, valid and different if seen by an outsider. The risk of carrying subjective opinions and interpretations of culture, religion and value systems along with the tendency to miss the most obvious aspects of accounts and interpretations were checked through the process of discussion with supervisors.

The presentation of initial findings to a group of peer researchers and academics further helped in recognising bias and addressing relevant issues. The use of a reflexive diary helped in making conscious researcher subjectivity.

The key reflexive issues in my study are set out below. My professional background as a mental health social worker influenced the way in which I directed the interview questions (see Appendix M : Reflexive Notes – Extracts on page 324) with the survivors. I realised that my past knowledge and experience of conducting mental health assessments potentially would interfere with the way I conducted interviews, making them clinical/professional rather than exploratory. The use of a topic guide helped in redirecting the interviews to meet the objectives of the research. On the other hand, being a mental health professional helped in interpreting data which assisted in identifying issues that would not have been realised if I were not a mental health professional. For example, I could establish a link between socio-cultural factors and psychosomatic symptoms that was evidenced in survivors' accounts on presenting physical symptoms of pain as a reason for attempted suicide. The combination of cultural knowledge and a mental health background helped in understanding why survivors preferred to present physical illness as a reason for suicide rather than accounting the actual reasons. A systematic method of organising data through NVivo facilitated development of themes and categories aligned with data rather than solely influenced by my interpretations and experience of being a mental health social worker. Both the reflexive diary and NVivo became useful tools for evaluating and reflecting on my decisions during data collection and analysis process.

Transparency was set as a benchmark to maintain the credibility of the study. Transparency during data collection, coding, analysis and peer review process allows readers to understand methods and tools that the researcher used in collecting and analysing data, and these are identified as the key areas to apply transparency (Hiles and Cermak, 2007). As a researcher, it was essential for me to be transparent with participants, the supervisory team and myself. I was aware of my preconceptions and assumptions and recorded every reason for the decisions I took during research process. For instance, I recognised the influences from my environment, culture, education, training, experiences and personal history upon my thoughts and emotions as I interviewed participants, transcribed and analysed data. Constant awareness, reflection and discussion with supervisors helped me to realise my role in the process of data collection and analysis, for example during data collection, a few of the women survivors kept returning to me for support and counselling after the interviews were completed. I had to emphasise my role as a researcher while I helped the survivors to establish better interactions with the existing support or liaise with appropriate organisations and counsellors in view of long-term assistance (job placements, rehabilitation, family counselling, and childcare services). Discussing such experiences with the supervisory team helped me to realise my position as a researcher and become aware of my limitations within this position. Acknowledging my strengths and limitations as a researcher and a mental health social worker I was transparent with myself and participants especially with survivors in the above context which established credibility with participants and of what they chose to share with me. I recorded these reflections in the form of memos which was a way to assess and ensure transparency regarding

the decisions and interpretations made during the research process. My reflective notes recorded the challenges encountered during data collection, doubts and questions asked in order to make decisions about the ways to improve topic guides and to organise data; attempts to understand data, fears about casting opinions and tendency to question if the participants were telling me the truth (see Appendix M : Reflexive Notes – Extracts on page 324).

I made a conscious choice in emphasising particular aspects of my personality and identities while interviewing participants. For example, I interviewed professionals as a researcher and a fellow mental health professional, whereas with survivors I presented myself, first of all, as a woman with a similar socio-cultural background who understands their pain and to some extent therefore shares an insider status. At the same time my identity as a professional, my economic class, and lack of experience as a survivor positioned me as an outsider. With healers I was a woman and a researcher who was interested in understanding how well their methods work. By emphasising particular aspects of my identity in this way, I could establish better trust, rapport and credibility with all three groups of participants. It further benefited the research in obtaining rich data.

The use of reflexivity bridged data, participants and I as a researcher and challenged my judgments and interpretations. This is elaborated with an example where my plans of accessing and interviewing participants in a particular order such as decision to interview survivors first then professionals and healers was challenged due to practical reasons such as limited time, long duration in obtaining consent and participants spread across a vast geographical area which involved longer travel

hours. I had to reorganise my plans and be flexible in my approach to accessing participants and conducting interviews, which in a way proved beneficial in applying the constant comparison method. On another occasion following a supervision meeting during which I was questioned about how participants interpreted economic hardships and my reluctance to acknowledge poverty as an obvious reason for suicide helped me to acknowledge the variation that exists in the interpretation of poverty and its impact. Attention to these details has contributed to establishing credibility of the data and its analysis.

#### **3.4.6.2 Voices**

“Attention to voices – to who speaks, for whom, to whom, for what purposes – effectively creates praxis, even when no praxis was intended” (Lincoln, 1995). The researcher took on the serious role in listening to voices that were unheard and silent through observing expressions, behaviours and attempting to perceive the meanings attributed by the participants. It was a complex process of identifying what the survivors sought to represent through their accounts, how professionals and healers interpreted their clients’ experiences and represented their own perceptions, knowledge and experiences. The importance lies in addressing each of these voices independently to comprehend the meanings that the accounts produced and the influences of interactions among the participants and the researcher to whom these (participants’) voices had great significance.

The researcher took great care in segregating survivors’ voices, professionals’ and healers’ voices and identifying the voices that professionals and healers reproduced from their clients’ accounts. By ‘voice’ both the content of what is said and the

ways in which it is told are of significance. It was essential to separate the researcher's voice from participants' voices during analysis to avoid bias. The researcher sought to represent authentically what participants expressed in their accounts without making any judgments or privileging one voice over the other. The researcher's openness to multiple voices and interpretations of data can be judged and valued as a criteria to assess the inclusiveness and representative nature of data. The important aspect is to analyse multiple perspectives and voices in relation to participants' experiences. If readers feel that some data are stronger than the rest, it can be attributed to the knowledge of the participants deserving more weight during the analysis.

#### **3.4.6.3 Triangulation**

Triangulation is considered as an analytical tool to weigh the credibility of evidence, sources, analysis and results (Guion et al., 2011). Data triangulation in its true meaning refers to using multiple sources of data about the same person or event to explore the phenomenon under study (Guion et al., 2011). Application of triangulation in this research deviates from a standard method, meaning although the researcher used multiple sources (survivors, healers and professionals) of data, the healers and professionals were not discussing the same people who were the survivor participants in this study. The researcher did not interview the same professionals or healers whom the survivor participants approached because of the sensitivity of the subject, socio-legal context and issues surrounding data protection. Therefore, the data gathered from three (survivors, professionals and healers) sources do not triangulate in its original sense, but triangulate at a conceptual level as all three groups of participants produce data on the subject of

culture, attempted suicide and its prevention from their vivid experiences and perspectives.

The method of triangulation in this research analysed perspectives for consistencies and inconsistencies. This became evident during data collection and analysis. The use of in-depth interviews with three groups of participants (survivors, mental health professionals and traditional healers) gained insight into their perspectives, explored interactions and gave voices to each group. The topic of cultural influences in causing distress and seeking help was explored through survivors', professionals' and healers' accounts which were compared and contrasted during analysis. Triangulation at a conceptual level as applied in this study considered, with equal importance, the views of three groups of participants. As the research was conducted in a different cultural context (India), discussion of initial findings and analysis with researchers and academics who understand Indian culture and those who do not, helped in addressing the loopholes in interpretation of data. The researcher was guided to look at data both subjectively and objectively which recognised the applicability of the data to a wider population in India and among Indian communities living in different parts of the world.

## **4 Findings - Survivors**

### **4.1 Introduction**

The purpose of this chapter is to introduce the readers to the experiences and life events of the participants in the context of their life situation and socio-cultural background. The chapter details the information provided by the survivors of attempted suicide who consented to participate in the research study. The survivors who were interviewed dared to share some very sensitive details with the researcher. For those who have attempted to end their own lives, the topic of suicide is a sensitive one. It typically involves the person revealing very private feelings or personal circumstances and may even reawaken distressing thoughts within the individual. Furthermore, suicide is illegal in India, thus the information was provided with caution and in the strictest confidence.

This chapter provides an in-depth understanding of the interviews with survivors in terms of causes attributed to attempting suicide, the means used and the availability and the accessibility of support systems.

### **4.2 Recruitment**

The recruitment of survivors of attempted suicide took place over 6 months in and around the regions of Bangalore, Mysore and Kodagu. The following Figure 4 details the number of survivors who were accessed, those who responded and participated in the study. Table 3 highlights the participants' characteristics to facilitate a better understanding of the analysis and participants accounts presented



in this chapter (see 3.4.2.1 on page 82 for more information on sampling and recruitment).

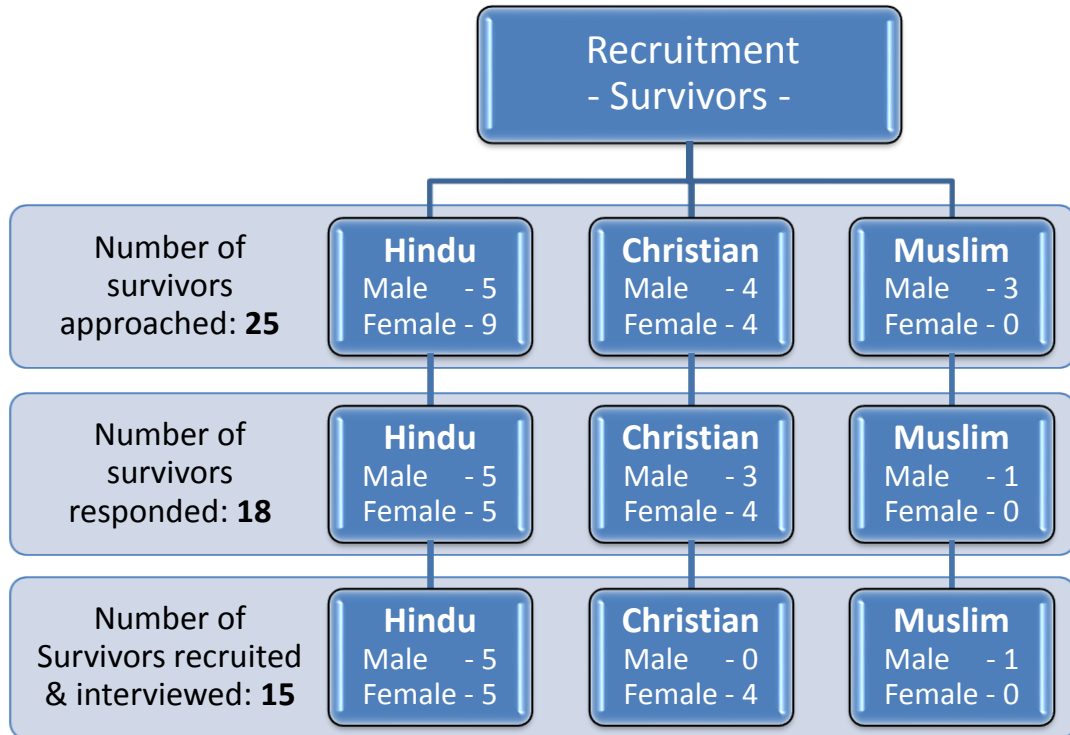


Figure 4 - Recruitment - Survivors

**Table 3 - Participant Characteristics - Survivors**

Code	Age	Sex	Education	Employment status	Religion	Marital Status
S1	19	M	Secondary Education, Diploma	Student	Hindu	Unmarried
S2	25	F	Secondary Education	Cook	Hindu	Unmarried, In relationship, 2 abortions
S3	23	F	Secondary Education	Home maker	Christian	Separated, 4 children
S4	22	M	Bachelors Degree -BA ongoing	Student	Hindu	Unmarried,
S5	21	F	Partial Secondary Education	Restaurant Worker	Christian	Unmarried, In relationship
S6	30	F	Partial Secondary Education	Home maker	Christian	Separated, 2 children
S7	27	M	Masters Degree -MBA	Unemployed	Hindu	Unmarried,
S8	27	F	Bachelors Degree -BCA	Employed	Hindu	Unmarried,
S9	22	F	Secondary Education	Unemployed	Christian – SC	Married, 1 child
S10	20	M	Pre University College	Banner Designer	Muslim	Unmarried,
S11	28	F	Bachelors Degree -BA	Employed	Hindu	Married, 1 child
S 12	18	M	Pre University College	Student	Hindu	Unmarried,
S13	36	M	Uneducated	Agriculturist	Hindu	Married, 2 children
S14	24	F	Secondary Education	Employed – Beautician	Hindu	Married, 2 children
S15	30	F	Masters Degree – M.Com	Home maker	Hindu	Married, 1 child

### 4.3 Understanding suicide in India

This section on survivor findings brings forth the meanings that the survivors relate to their life events. It took a lot of courage and thoughtful decision for the survivors to confide in the researcher and to share the most troublesome stories of their life. There was a mixed approach towards the researcher. A few survivors saw the researcher as a counsellor and others viewed the researcher as a police agent. The researcher followed a 'process consent', repeatedly assured participants of maintaining confidentiality and on producing documents such as information sheets and consent forms in English and Kannada together with ethics approval letters they were sufficiently confident to trust the researcher and become part of the research. The researcher simplified and explained the contents of the documents in a language that the participants spoke which were mostly Kannada and Hindi.

The presentation of findings in this chapter is divided into categories and themes with subsections. Minimal use of literature is attached to the background information provided to facilitate an understanding of survivor stories. The use of direct quotes is in the original language of the interview with interpretation in English. In the case of unrecorded interviews, the quotes from the detailed notes that were written during and after the interviews are incorporated.

The following list outlines how the data findings are categorised into themes and sub themes and these are then discussed in the remainder of this chapter.

- Contributory factors for attempted suicide:
  - Gender differences and association to sex, marriage and relationships

- Encountering abuse, violence and torture:
  - Silent forbearance of pain and torture
  - Role of family in inflicting torture
  - While faced with surveillance
  - Alcoholism in relation to abuse
  - Economic Factors
  - Is it suicide or homicide or a threat?
- Parental pressure - young adults victimised into depression
- Medical & psycho somatic presentation
- Sexual orientation and rejection by society
- Cultural stereotypes, opinions and expectations – distressing or impending?
  - Double standards of culturally specified gender roles
  - Social attitudes and responses on the face of attempt
- Means of attempted suicide
- Legal and ethical concerns
- Intervention and prevention methods:
  - Religion
  - Hospital intervention

## 4.4 Contributory factors

The survivor interviews reveal struggles and hardships, major life events and day-to-day living with set boundaries as contributory factors for attempting suicide. As humans, we are social beings subject to social structures and cultural norms (Giddens et al., 2011). The duality and polarisation of cultural practices subjecting individuals to internalize cultural norms come across very strongly through the survivor interviews. Participants' presentation of contributory factors for attempted suicide is organised into the following themes. The development of themes and sub themes under this section is a result of participants' direct

connection with the issues and the researcher's attempt to bring to the forefront the issues that were less evident and implied in the data.

#### **4.4.1 Gender differences and association to sex, marriage and relationship**

Indian culture lays strict boundaries on premarital sexual relationships and approves physical and sexual intimacy only within the bounds of marriage. A few studies claim that this conservative view is changing in contemporary society (Abraham, 2001) but the question is how has it impacted the lives of young men and women? This study identified two women participants (S 2 and S 3) who were under a lot of pressure to marry the person with whom they were in a sexual relationship to justify their act of sexual involvement that would be covered under the bond of marriage and therefore not be victimised or ill-treated within the community. Being surrounded with this pressure, participants insisted on marriage regardless of whether the aspect of love was present or not in the relationship. The following extract from the transcript is an example of cultural binding and an expression of different standards of sexual behaviour based on gender.

“ಅವನಿಂದ ನಾನು ಕೆಟ್ಟೋಗಿದ್ದೀನಿ. ಇದನ್ನು ಇಷ್ಟಕ್ಕೆ ಬಿಟ್ಟು ಬಿಡಕ್ಕೆ ಆಗಲ್ಲ, ನಾನು ಬದುಕಿದ್ದು ಇವನ ಜೊತೆನೇ ಸತ್ತುಕೂಡ ಇವನ ಜೊತೆನೆ. ನನಗೆ ಬೇರೆ ಯಾರನ್ನೂ ಮದುವೆ ಆಗಕ್ಕೆ ಇಷ್ಟ ಇಲ್ಲೆ.”

‘He has spoiled (sexually exploited) me. ‘I can't leave it at this; I shall live or die with him alone. I don't wish to marry anybody else.’ (S 2)

A possible explanation for this is that women feel culturally bound to marry the person with whom they are sexually involved, despite abuse, torture and misuse.

On the other hand, men may not be held responsible for their sexual involvement as much as women as indicated by the participants during the interviews. Women are taken into confidence with the promise of marriage, where women feel comfortable to progress in the relationship; however, when this promise is broken they find themselves in a devastating situation where they are not in a state to face either the family or community. This happened to participants S 2 and S 5. Men are aware of this cultural dynamic in a society that binds women and thus coaxes women in the name of marriage. The data identifies the different ways in which 'marriage' is being perceived by men and women. For instance women participants perceived marriage as a commitment and a pathway to secure their future while they discussed how men misused the concept of marriage to deceive women.

The women participants were not explicit in expressing their attitude towards approaching the police or legal aid, however, it was implied in the data that they did not feel comfortable to file a police complaint regarding abuse or misuse as their private life would be known to the police and the community. The participant S 2 took one such action against her boyfriend when he refused to marry her. He instead went about telling the community about their private life.

“ಅವನು ಅವನ ಫ್ರೆಂಡ್ ಜೊತೆ, ನೋಡೋ ಅವಳನ್ನು ಎಲ್ಲಾ ಮುಗಿಸಿಬಿಟ್ಟಿ. ಅವಳ ಹತ್ತಿರ ಏನು ಪ್ರೂಫ್ ಇಲ್ಲ. ಅವಳು ನನ್ನನ್ನು ಸ್ಟೇಷನ್ ಮೆಟ್ಟಿಲು ಹತ್ತಿಸಿದ್ದು. ಆದರೆ ಅವಳ ಕೈಯಲ್ಲಿ ಏನು ಸಾಧಿಸಕ್ಕೆ ಆಯ್ತು. ಏನು ಆಗಲಿಲ್ಲ ಅಂತ ಹೇಳಿ ಜೋರಾಗಿ ನಗಾಡ್ತಾನೆ.”

‘He mocks me telling his friends that he finished everything (sex) with me, she has no proof against me, she went to police but she could not do anything’. (S 2)

This indicates cultural polarity of the concept of shame that lies more with women than with men.

A large number of women participants expressed their desperation about the legal system that fails to act effectively and in time. For participants S 2 and S 11, being victims of abuse, they found themselves helpless and succumbed to suicide in order to punish their partner and family with the hope that the perpetrator (partner, family) of violence would be interrogated and jailed by the legal system. Many participants shared a similar opinion.

There is another side to the story of being in a relationship. If women want to be married to men for love and cultural reasons, there are men who also want to be married for love. In both cases, men and women have to wait upon their family to consent their relationship. Three male participants (S 1, S 4, and S 10) stated that they had to either keep their relationship a secret or split up with their girlfriends as neither of their parents would consent to their relationship despite the fact that both families belonged to similar caste and religion.

[I was in a relationship for three years, but the girl whom I was in love with got married to someone else, as her parents found her a husband from their own caste and status] (S 4)

[My parents didn't know about my relationship with the girl from our neighbourhood. She is a Muslim and from the same community as I am. I do not know whether my parents will consent to my relationship or beat me up. I am very much afraid of my father] (S 10)

This draws attention to the cultural perception of premarital relationships which restricts families' approval of love marriages. The culturally dominant practice of arranged marriages where the family has power and control in choosing a mate for the son or daughter is thus challenged. If a man or a woman's parents do not approve of their relationship, they are forced to marry someone else of whom the family approves. The reader needs to understand that not all arranged marriages are forced marriages. Parents consider a lot of factors in finding a suitable mate for their daughter/son with a view to protect the son/daughter's interests. It is considered as one of the biggest responsibilities on Indian parents. The cultural power plays a significant role in the formation of family.

Break up of relationships were devastating for the participants no matter what the reasons for the break up were. According to participants S 1 and S 7, their girlfriends cheated on them and were in love with someone else. These accounts reveal that women have the freedom to opt in or out of a relationship.

“I feel that's a waste. I was happy with myself; I had good times. But when she left me I was very sad.....She told me that she is in love with someone else but 15 days ago she rings me and says she is confused don't know what to do”. “I took on to drinking from the time I was working in the bar. I was put off; I was pissed off with life. When I was with her, I didn't know life is hard but when she left me I realised. I was expecting more of myself.” (S 7)

“ನನ್ನ ಲವರಾಗೋಸ್ಕರ” ಅವಳು ಶನಿವಾರ ನನಗೆ ಫೋನ್ ಮಾಡಿ ನಿನ್ನ ಹತ್ತಿರ ಏನೋ ಮಾತಾಡಬೇಕು ಅಂತ ಹೇಳಾಳೆ. ನಾನು ವಾಪಾಸು ಫೋನ್ ಮಾಡ್ತಾಗ ಅವಳು ನನಗೆ ಬೇರೆ ಬಾಯ್‌ಪ್ರೆಂಡ್ ಇದ್ದಾರೆ ಅಂತ ಹೇಳಾಳೆ.” (S 1)



'It (attempted suicide) is for my lover' 'She phoned me on Saturday and told me that she wanted to speak to me. When I returned her call, she told me that she has another boyfriend' (S 1)

#### **4.4.2 Encountering abuse, violence and torture**

The overarching theme of abuse is used to encompass threatening behaviours, violence, sexual abuse, physical abuse, sexual jealousy, neglect and encouraging another individual to inflict torture on the victim. Intimate partner and family member violence is the most common form of violence expressed by survivors that affected their physical, mental, emotional and psychological wellbeing. Six sub themes emerged from participants' accounts on abuse, pain and violence which is a result of both participant and researcher making connections with the issues presented as subthemes.

- Silent forbearance of pain and torture
- Role of family in inflicting torture
- While faced with surveillance
- Alcoholism in relation to abuse
- Economic Factors
- Suicide or homicide or a threat?

##### **4.4.2.1 Silent forbearance of pain and torture**

Culture defines roles for men and women to carry out their responsibilities within the institution of family and society. The cultural roles and expectations of men assign men with power to control and dominate the household (Wallace and Fogelson, 1961). This is a story of survivors who are in conflict with self and their surroundings and strive to reach the standards of perfect daughter, wife, daughter

in-law and mother. The vast majority of survivor interviews contained accounts of abuse, assault and torture within marriage and those involved in heterosexual relationships. The following section examines what drives women to silently bear pain and torture.

Marriage is a significant institution in Indian society (Milner Jr, 1994). Culturally, there is emphasis to be grounded in marriage and it is women's responsibility to make a successful marriage. The data point towards women who are under pressure from the family to continue in an abusive marriage as leaving it would affect the family reputation. Participant S 14 recounts the dominant stereotype that conflicts within marriage and how broken marriage attracts community's judgment of the woman and her parental family as it is often associated with the learning acquired from parents especially the mother of the bride. She further reports, being married very young, her age did not equip her to resist violence and rather she was guided to persevere in marriage to preserve the family's status.

“ನನ್ನ ತಾಯಿ ಮಾಡಿಸಿದ್ದು, ಅವರಿಗೆ ಕೆಟ್ಟ ಹೆಸರು ಬರಬಾರದು ಆಮೇಲೆ ನಾನು ಸಣ್ಣವಳು. ನನಗೆ ಏನು ಗೊತ್ತಾಗ್ತಿರಲಿಲ್ಲ”

‘My mother got me married, I didn't want her name to be spoilt. I was young, I didn't understand things’ (S 14)

ನನ್ನ ಮನಸ್ಸಿಗೆ ಅನಿಸಿದೆ ಇವನನ್ನು ಬಿಟ್ಟರೆ ಮಾತ್ರ ನಾನು ಸಮಾಧಾನದಿಂದ ಇರಬಹುದು. ಆದರೆ ನಮ್ಮ ಅಮ್ಮ ಅಕ್ಕಪಕ್ಕದವರೆಲ್ಲ ಗಂಡನ ಬಿಟ್ಟು ಇರೋದು ಕಷ್ಟ ಅಂತಾರೆ.

‘I feel I can live a peaceful life only if I leave him, but my mother and neighbours say that it is difficult to live without a husband.’ (S 11)

In the case of participants who were brought up by a single parent (mother), they had been persuaded not to split away from their husband because their mother did not want the daughter to face the life of a single woman and go through the difficulties as she did. The data recognised the ways in which community and society categorises women to be of loose character, shameless and disrespectful when they break away from marriage and live life as a single person. It is implicit in the data that a woman gains her identity and status through a man (father/husband/son) in Indian culture.

[My father abandoned us when I was 8yrs old. My mother took care of my brother and me. To make a livelihood, she started working as a house cleaner to several families in the town. Nevertheless, my husband's family say that my mother and I run a 'business' (prostitution) for our livelihood. When my father left my mother, she was still young and beautiful, if she wanted she could have remarried, rather she struggled alone and brought us up. If I leave my husband and go to my mother, then my mother will be sad that I have left my husband, she does not want me to go through what she has been through] (S 9).

There were many examples of the women describing situations in which they felt forced to compromise for the good of children and these compromises often included being abused. They did not question the thought processes that led them to carry on their lives in this way nor make connections with internalised cultural expectations. For participants S 6 and S 9 the thought of breaking away from marriage caused a lot of anxiety regarding the future of their daughters more than

anxieties about their own future. They indicated the importance of having the identity of the father for their daughter's secure future.

[I have only been putting up with them for my daughter's sake. My daughter needs a father] (S 6)

[I bear all the pain, shouting, screaming, abuse and beatings because my daughter needs a father and I need a husband. I am ready to obey all their conditions but I want a father for my daughter]. (S 9)

The participants' accounts pose a dichotomy related to a father figure that they perceive as essential to secure their child's future. The same participants reported abuse and expressed the fear of this abuse being inflicted on children. This dichotomy draws readers' attention to understand the parental responsibility in the context of Indian culture. In an Indian culture the father takes an active role, bears the responsibility of his daughter and is under pressure to get his daughter married by a particular age (Nanda, 1992). Participant S 9 recalls the struggles her mother went through as a single woman, bringing up both herself and her brother without the support of a husband. She reports that the family was treated as characterless.

[My father abandoned us when I was 8yrs old. My mother took care of my brother and me. To make a livelihood, she started working as a house cleaner to several families in the town. But my husband's family say that my mother and I run a 'business' (prostitution) for our livelihood] (S 9)

This attitude of society necessitates participants to seek a father's shelter especially for daughters, for greater protection and with the view to find the right mate in due

course. Double standards of culture forced women to bear the burden of pain and shame without men being held accountable.

#### 4.4.2.2 Role of family in inflicting torture

Family is an integral part of Indian society and the dynamics of family diverges across cultures. This theme deals with violence perpetrated by the family members. Participants S 11 and S 3 report instances of repeated violence perpetrated by husband, parents-in-law and other members of the extended family. Although they lived separately from their parents in-law, their interference and influence was persistent which impacted their relationship with their husband and resulted in more violence and abuse.

“ಅದು ಆಗಿ ನಮ್ಮ ಅತ್ತೆ ನನ್ನ ಗಂಡನ ಚೇಂಜ್ ಮಾಡಿದ್ರು. ಅವರ ಮಾತು ಕೇಳಿ ನನಗೆ ಹೊಡೆದ್ರು, ಕತ್ತು ಹಿಚುಕಿದ್ರು

‘My mother in law has had negative influence on my husband. Being persuaded by his mother, he beat me up and strangled me’ (S 11)

[One day they all came to my house and started accusing me of a relationship with another man from my neighbourhood. My sister in law beat me up and cursed me saying that it was better for me to die than live. In addition, her husband spread false rumours of a relationship that never existed in my neighbourhood and the community. I never shared this with my mother] (S 3)

The participants reiterated the influence of parents-in-law and extended family, which had adverse effects on their family life. The data depict the exercise of power by taking on particular roles within the family. There is a constant

interaction among the structural settings, which define individual's position and orient perceptions and behaviours. Their husband and in-laws who hold power by ways of control and domination manifest the interplay of power in this process through symbolic and physical violence where women (daughters-in-law) are subjected to violence.

For participants S 3 and S 9, female offspring were one of the reasons to be tortured by the husband's family. The participants made implicit reference to the general notion associated with bearing sons and continuity of heredity whereas daughters are considered as objects to be handed over to a man in marriage when they attain physical maturity. Participants S 3 and S 9 reported discriminations they faced in the family for giving birth to daughters. Although only a few survivor interviews discussed discrimination and violence faced for bearing female children the intent to protect the female offspring from abuse and the torture that they themselves have been through were explicit in most of the survivor accounts.

[They tortured me because I have all four daughters. I went and got operated (not waiting for a boy child) without notifying my husband or anybody in the family] (S 3)

[They don't like my daughter either] (S 9)

“ನನಗೆ ಹೆಣ್ಣು ಮಗು ಇದ್ದಿದ್ದರೆ ಅದಕ್ಕೂ ನನ್ನ ತರಹ ಕಷ್ಟ ಇರೋದು” (S 14)

'If I had a girl child, even she would have to bear the torture like me' (S 14)

These data bring across the anxiety of having female children because when these children grow to be women they would also be subjected to violence and thus

victimised. Women have expressed themselves as helpless without a voice to speak against violence. The internalization of cultural norms and expectations has burdened women, a burden which they reluctantly carry and hand over to their offspring. The participants draw a strong inference from this process to social positioning.

#### 4.4.2.3 While faced with surveillance

This theme emerged from seven of the participants' accounts, wherein participants were overwhelmed by distress, abuse and lack of freedom when the husband and his family kept a close surveillance. Surveillance in domestic abuse is a form of control and suspicion of infidelity by intimate partner/husband and family members. Participants expressed their devastating experience of being suspected and checked upon by partners. The sense of being surveilled for reasons such as sexual jealousy and control made it harder for participants to come to terms with the fact they were being treated as objects. The following extract manifests the power status of the dominant and the trajectory of harassment and torture inflicted upon the participants.

“ಅವರು ನಾನು ಫೋನ್‌ನಲ್ಲಿ ಇರಬೇಕೆಂದರೆ ನನ್ನ ಮಾತು ಕೇಳಿಕೊಳ್ಳೋದು ತುಂಬಾ ಹೊಡೆಯೋದು, ಯಾರ ಜೊತೆಗೂ ಮಾತಾಡಬಾರದು, ಎಲ್ಲಿ ಕೂಡ ಹೋಗಬಾರದು.” “ಅವನು ನನಗೆ ತುಂಬಾ ಟಾರ್ಜರ್ ಕೊಡ್ತಾನೆ. ನನ್ನನ್ನು ಫಾಲೋ ಮಾಡೋದು, ನನ್ನ ಮೊಬೈಲ್ ಚೆಕ್ ಮಾಡೋದು.”

‘He listens to my conversation while I am on phone and beats me up. I should not talk to anyone nor go anywhere.’ ‘He tortures me. He follows me and checks my phone’ (S 14)

[He doubted me that I was in another relationship. He would return from work heavily drunk and get close to me, smell me, check (sexual organs) me to make sure, if I had engaged in sexual relations when he was away. He would even beat me up naked, bite me and tear my clothes in front of my children] (S 3)

The behavioural patterns of and the relationship between the dominant (husband/boyfriend) and dominated (wife/girlfriend) are influenced and regulated by cultural roles. The interference of field, such as employment and family, had a mixed impact on an individual's disposition.

It was a painful experience for participant S 9 to know the person whom she loved spied on her. In order to prove her fidelity to her husband, she was forced to quit her job and give up her financial independence. The women participants in this study strongly indicated that they took up paid work not out of choice but to fulfil family needs and expenses. In return, husbands or family members tortured them to quit jobs and remain at home.

[They tortured me because I had a job. However, without a job I starved] (S 9)

For participant S 15, the process of adapting oneself to a new culture after her marriage was not easy. She was born and brought up in North India but after her marriage she had to migrate to South India to live with her husband. This came with many sacrifices. She was asked to quit her job, give up her financial independence and accept taking care of the household and children as the major priority of her life. She also had to accept her husband's idea of not letting her work



as that might affect their marriage. Although she desired to continue her career and extend financial support to her husband, she had to give up on her own desire for a career. She assumed responsibility of her children drawing consolation from it.

[He is possessive of me. He works for a group of hotels. So he sees how girls are. In addition, one of his friends was separated from his wife after 12 years of marriage. Therefore, he does not want to risk our family. Although I feel I want to work but my child is my priority. My child should not question me- 'what have you done for me'] (S 15)

Eight participants reported that the friends and family of their partner influenced thoughts and gossip about wife/girlfriend's character. This had negative implications and ended long-standing marriages or relationships.

[My husband's sister wants me to divorce my husband and she wants to get him married to another girl. My husband and his family accused me of loose character and harassed me] (S 9)

[My boyfriend's family consented to our wedding initially but someone among the relatives told my boyfriend something about me and this led him to cancel our wedding] (S 5)

The interaction among visible and invisible fields such as class, family status, caste and religion is intense. The process of constant interaction impacts individual disposition and response to situations and relationships. During the interview when women were posed with the question about their partner's fidelity, one of nine reported husband's infidelity whereas the rest believed that they were not being

cheated upon. The data show evidences that women become victims of false rumours and gossips more than men do. Men are more likely to believe rumours and end up torturing their wives, partners and even end relationships.

“ಜನ ಹೇಳ್ತಾರೆ ಅವರಿಗೆ ಬೇರೆ ಸಂಬಂಧ ಇದೆ ಅಂತ. ಆದರೆ ನೋಡದೆ ನಾನು ನಂಬಲ್ಲ.”

‘People say that he is into other relationship, but I wouldn’t believe unless I have seen it for myself’. (S 11)

#### 4.4.2.4 Alcoholism in relation to abuse

The experience of assault and abuse were everyday occurrences for a large number of women participants. Conditions of addiction, specifically alcoholism, worsened the situation for women participants wherein violence was perpetrated more so than in the absence of alcohol.

“ಕುಡಿದು ಬಂದು ಎಲ್ಲರ ಜೊತೆ ಜಗಳ ಹೊಡೆದಾಟ.”

‘He comes home drunk and fights with everyone’ (S 11)

[My husband beat me up every day. Most of the time he comes home drunk] (S 9)

Alcoholism is not a cover for abuse and violence perpetrated on women. The previous themes elaborated the incidents of abuse and violence in the absence of alcohol. Although the wider literature provides a link between alcoholism and abuse, providing evidence for increase in severity and incidence of violence under the influence of alcohol (Gururaj et al., 2004; Kermode et al., 2007), may not be accepted as an excuse to cover violence. The participants expressed feelings of powerlessness and the fear of being victimised due to the stigma and sensitivity

attached to abuse and violence. They were persuaded to suffer silently and cope with day-to-day living. Repeated violence and no realisation on the part of the husband brought the participants to a breaking point and an attempt at suicide.

Men expressed their dependence on alcohol in order to forget the pain and difficulties of life. Participant S 7 used alcohol to cope with the situation when his girlfriend left him and he became unemployed. Men blamed unemployment, financial hardships, conflicts with family members and breakdown of relationship as reasons for their drunkenness. For five male participants struggles of coping with problems were demonstrated through their dependence on alcohol, which gradually led to other problems such as isolation, sense of being unwanted, low self-esteem and a feeling of worthlessness among the participants.

“I drink to forget my problems. I have had no job for the last one year. My parents don’t want to leave me alone. They don’t want me to go back to Chennai. They are afraid I might do something similar (harm self, alcohol, drug) and get back to old life style” (S 7)

“ನನಗೆ ಅಭ್ಯಾಸ ಇರಲಿಲ್ಲ. ಆದರೆ ಇವೆಲ್ಲ ಟೆನ್ಷನ್ ಶುರು ಆಗಿ ನಾನು ಈಗ ಕುಡೀತೇನೆ”.

‘I was not in the habit (drinking alcohol), but ever since these tensions I took onto drinking’ (S 13)

All the male participants believed alcohol to have soothing effects on them. They explained the impact of alcohol on self-poisoning with two reasons: One is to increase lethality and second is to reduce the pain of dying and to die under the

influence of alcohol is not to know one is dying. It has also influenced one's judgment and ability to think and decide.

"I thought if I mix poison with alcohol, the severity would be more and I won't survive. I want to come out of these feelings. So I drink to forget my problems" (S 7).

#### **4.4.2.5 Economic factors**

Economic stability was a significant theme for all the participants. Poor living conditions and difficulty in making ends meet were some of the stressors expressed by nine participants, although all the participants mentioned poor economic conditions as the cause of repeated stress faced in their childhood and in the marital home.

[We were 12 children in the family and 3 of 12 died in childhood. Not every one of us went to school because we didn't have money]. [I owe money to a lot of people. Creditors come home every day asking for money. I have no job to pay off my credits. Most of the time my children and I have nothing to eat, If there is little food in the house then I would feed children otherwise getting them to sleep is the only way of dealing with hunger] (S 3)

Double standards of cultural roles have placed women in a difficult situation wherein they are expected to support the family financially and yet simultaneously as a wife and mother her major responsibility was to take care of children and manage household chores. The participants struggled between their roles, when the men of the family (husband) failed to fulfil their responsibility of earning a livelihood for the family, the burden shifted onto women. There was an additional

burden on women to be accountable to creditors for the money borrowed by their husbands which was a dominant factor in nearly half of the participant accounts. For participant S 14, she felt under pressure and unsupported when her husband's creditors were at her doorstep and her husband does not acknowledge her phone calls. She stated that her husband failed to take care of the family as he stayed out of work and he went about borrowing money from people, he stole her gold ornaments and vouched it for money, which was used to gamble and buy alcohol.

“ನನ್ನ ಗಂಡನಿಗೂ ಸಂಪಾದನೆ ಇಲ್ಲ,” “ನನ್ನ ಬಂಗಾರ ಎಲ್ಲ ತಗೊಂಡಿದ್ದಾರೆ. ತಾಳಿ ಕೂಡ ಇಲ್ಲ. ಅದನ್ನು ಅಡವು ಇಟ್ಟಿದ್ದಾರೆ” “ಆ ದಿನ ಅವರಿಗೆ ದುಡ್ಡು ಸಾಲ ಕೊಟ್ಟಿರುವವರು ಮನೆಗೆ ಬಂದು ಜೋರಾಗಿ ಮಾತಾಡಿದ್ದು ನನಗೆ ಲೋ ಬಿಪಿ ಅದು ಕೇಳಿಕೊಳ್ಳಲಿಕ್ಕೆ ಆಗಲಿಲ್ಲ. ನಾನು ಅವರಿಗೆ ಫೋನ್ ಮಾಡಿದಾಗ ನೀನು ಯಾರಂತ ಗೊತ್ತಿಲ್ಲ ಅಂತ ನನಗೆ ಮತ್ತು ಅವರಿಗೂ ತಿಳಿಸಿದ್ದು” (S 14).

‘My husband has no earnings’ ‘He has taken all my gold and even my ‘Tali’ (gold necklace-symbol of wedding) and pawned them for money’. ‘That day his creditors came home and were shouting, I suffer from hypertension, I could not bear that. I phoned my husband, he said that he doesn’t know me at all, I didn’t know what to do’ (S 14)

[We have a lot of financial problems. It has been worse in the recent days. My husband had invested in business and lost money. Although I want to support my husband, he does not want me to work] (S 15)

[We have been married for 4 yrs. Although we quarrelled, we patched up. The counsellor suggested that I give up my job. Even after I quit my job, my husband and his family did not stop harassing me. My child and I were left to starve. We currently live in a slum and no one supports me] (S 9)

The tradition of endowing a daughter with lots of gifts in kind, gold, cash and property at the time of marriage has been followed through the ages. Most married women participants felt the pressure to hand in these assets to their husband and his mother after marriage. Participant S 11 felt coerced and threatened by her husband's family when she clung on to the wealth she received from her parents in marriage. These gifts were given to her with the view to secure her future in her husband's house. A significant number of participants identified this practice to be life threatening and subjected them to torture as it encouraged greed in men and their family to obtain the wealth that the newly married woman brings into the house. For instance, S 11 reported that her husband's family conspired to kill her to attain her wealth.

“ಅವರೆಲ್ಲ ಸೇರಿ ನನ್ನನ್ನು ಸಾಯಿಸಬೇಕು ಅಂತ ಪ್ಲಾನ್ ಮಾಡಿದ್ದು ನಾನು ಸತ್ತರೆ ಎಲ್ಲ ಇವರಿಗೆ ಹೋಗುತ್ತೆ.”

‘They have joined together in planning to kill me, if I die they would get everything (money, gold)’ (S 11)

#### **4.4.2.6 Is it suicide or homicide or a threat?**

A small proportion of participants (S 3 and S 14) used suicide as a threatening measure to persuade husband and family to stop the torture inflicted on them. When S 14 felt frustrated due to continuous conflicts and abuse, she threatened her

husband that she would consume poison. Rather he forced her to drink poison. Likewise, participant S 3 was set on fire and yet she did not intend to die rather only threaten her husband.

“ನಾನು ಕುಡೀತೇನೆ ಅನ್ನುವಾಗ ಬಾಟಲ್ ಹಿಡಿದುಕೊಂಡು ನನ್ನ ಬಾಯಿಗೆ ಇಟ್ಟು ಫೋರ್ಸ್ ಮಾಡಿದ್ದ. ನನಗೆ ಹೊಡೆದು, ಗೋಡೆಗೆ ಹಿಡಿದು ಹೊಡೆದು, ಕತ್ತು ಹಿಚುಕಿದ್ದ”

‘When I told him that I would consume poison, he forced the bottle to my mouth. He beat me up, pushed me to the wall and strangled me’ (S 14).

[My husband was very abusive and would not stop beating me. I threatened him, if he did not stop torturing me, I would burn myself and I poured kerosene all over me. I did not intend to die] (S 3)

In the case of participant S 9, her husband threatened to commit suicide if she continued to stay in his house. Both male and female participants used suicide as a means to threaten.

[My husband does not want me anymore in his life. He threatened to hang himself if I did not leave the house. I was forced to leave him and go to my mother’s house] (S 9)

The data detail the challenging nature of proving the case for suicide or homicide and also detail the possibility for misrepresentation of the case. Although few participants used suicide as a means to threaten, the intense situations led their partner/husband to coerce the participants to consume poison and in the case of participant S 3, her husband set her on fire. The data did not plunge deeper into

the investigations of possibilities of homicide or attempt to murder as the research entailed interviewing only the survivors of attempted suicide.

#### **4.4.3 Parental pressure - victimising young adults into depression**

Parents feel the responsibility to safeguard and help their offspring regardless of age to make choices and decisions in life. Elders in Indian families have influence in shaping an individual's life, career and choosing a wife/husband (Isaac et al., 2014). The Indian culture is contrary to the Western culture as it encourages the offspring to live with parents even after attaining the age of consent and adulthood. Participants S 7 and S 10 experienced tremendous parental control and domination, which stopped them from living life according to their desires. They were forced to consider the career options that parents sorted for them. The sense of frustration, lack of independence and having to give up their choices over parents' choices pushed them across boundaries and into depression. Although this is not seen as a direct cause of attempted suicide it does draw attention to mounting pressure and stress in the participants.

[I was sent to my sister's house in Kerala. My parents thought if I stayed in Bangalore, I would be spoilt being in the company of my friends. My father is a banana merchant. I have been involved in banner designing for the last 8 months. My father and three brothers are all banana merchants so my father wanted me to do some other job] (S 10)

[I have been living with my parents for more than a year now. I want some peace and independence] (S 7)



It could be argued that both parents and their offspring share the burden of pressure and stress in their own different ways. The above context and extracts signify the dynamics of role and power in affecting individual's dispositions.

#### **4.4.4 Medical and Psycho somatic presentation**

The most common medical reasons for suicide presented by both male and female participants during the interviews were headache and stomach ache. For several participants the stress caused by work pressure, conflicts, money worries and family pressure was manifested through psychosomatic symptoms. According to participant S 15, she underwent a thorough medical investigation and was advised of no biological cause for her persistent headache.

[Whenever I get a terrible headache, I feel like hurting myself. I have felt like this ever since I have had my first baby. I have difficulties in sleeping as well. My family doctor sent me for a thorough medical examination but all the results were negative. I was told stress is causing these headaches and was advised to practice meditation] (S 15)

The onset of sad events and internalising the cause for such events affected the participant's mental health. Major life events such as loss, death, broken relationships and conflicts within the family left the participants shattered and with low confidence. For instance, participants S 4 and S 12 relied heavily upon the family for support and guidance. Within their family they felt that they were set with boundaries to behave in certain ways which restricted them from approaching family for help. The participants felt that they had no support and considered suicide as an escape from crisis.

[I have trouble in concentrating whenever I am sad. I lost one of my friends while I was in ninth class (13yrs). This affected me deeply and I attempted suicide then. I have thought of suicide several times. I feel embarrassed when my parents quarrel with each other and the entire community speak ill of them] (S 4)

The accounts of several participants illustrated the limited role of family in identifying mental health problems at an early stage. Families failed to understand the participant's presentation of low mood, lack of sleep and appetite, continuous sobbing etc. as the cause of mental health concerns. The lack of knowledge regarding mental health problems and stigma influenced the help-seeking behaviour among the participants and their families. The following extracts are examples of long-standing and untreated mental health problems that were identified only after the suicide attempt.

[When she left me, I was very sad. I feel that I am good for nothing, no one likes me, and everyone hates me] (S 7)

[Sometimes I feel sad and cry without any reason] (S 8)

“ತುಂಬಾ ಬ್ಯಾಡ್‌ವರ್ಡ್ಸ್ ಯೂಸ್ ಮಾಡ್ತಾರೆ. ನನಗೆ ಯಾವುದರ ಮೇಲೂ ಇಂಟರೆಸ್ಟ್ ಇಲ್ಲ. ಊಟ ಬೇಡ, ನಿದ್ರೆ ಬೇಡ.”

‘He uses many bad words. I have no interest in life. I have no hunger and neither do I want any food nor any sleep’ (S 14)

The awareness about mental health concerns among the general public may not always be associated with their educational, employment and social status. As it is evidenced in the case of participant S 13, he commented that the way he feels and

the suicide attempt may be due to his mental illness. This participant did not make explicit connections with religious or cultural discourses in relation to his attempt to suicide but rather thought of it in terms of his unstable feelings, moods and mental status.

“ನನಗೆ ಈ ರೀತೆ ಮನಸ್ಸಿಗೆ ಅನಿಸಿದ್ದು ನನ್ನ ಮನೋರೋಗ ಅನಿಸುತ್ತೆ.”

‘The way I feel is because of mental illness’ (S 13)

#### **4.4.4.1 Sexual orientation and rejection by the society**

One of the 15 participants expressed his distress caused by society’s response to him being a transgender and being sexually attracted to the same sex. His distress worsened when he became a laughing stock in the school and the community and even the family failed to understand him. Members of the family, his father and the community repeatedly threaten him to keep a watch on the way he walks and speaks. He was once seen by his father trying to dress into his mother’s clothes at the age of 16 and was beaten up for doing so. Although there was a history of transgender in previous generations of the family, it did not seem culturally appropriate to talk about this in the family or in public.

[I want to dress like a female but I am a male. I have tried to wear my mother’s saree without anybody’s knowledge. However, my father found that out and he shouted me and beat me as well. I attempted suicide when I was in 11<sup>th</sup> class (16yrs) because my classmates were teasing me that I am not a boy but a girl]. (S 12)

The participant S 12 expressed his desperation to undergo any form of treatment or surgery that would make him behave and act like a man. He feared otherwise he would be mocked all through his life. He foresaw a danger of being victimised into prostitution as he might be mistaken for a woman or a eunuch.

[I believe that only god and doctors can help me. I fear that I might be forced into prostitution if I am not a complete man] (S 12)

The following extract from S 12's interview is an example of the strong influence of culture, social norms and expectations laid upon the participant that altered his life decisions to qualify for social and cultural inclusion. Cultural power and cultural capital enforces cultural norms and traditional values through the formation of social structures.

[If I were given an opportunity to move to a new place where this is a common condition, I would not mind continuing the way I am. If no one talks about me and gives me the freedom to live the way I want then definitely I want to change into a female] (S 12)

#### **4.4.5 Summary**

Most participants identified series of events and experiences that led them to attempt suicide. The participants' perceptions and experiences of life events and situations were prominent in classifying a particular situation as a problem situation and a trigger for attempting suicide. The data reflects the complexity of participant responses to stressors that are social, cultural and psychological.

This category discussed various issues even the most sensitive details of their relationships and marriages leading to feelings of pain, abuse, torture and neglect. The participants demonstrated difficulties in dealing with situations of family pressure, deceit, surveillance and abuse. Although the data displays an interconnection between several problems, it is difficult to establish a hierarchy of problems. In few cases relationship issues led to other difficulties such as alcoholism and in others alcoholism to breakdown of marriage. The Discussion chapter will present the interaction among various problems with further insights into situations and participants' perceptions (see Chapter 7 on page 228).

#### **4.4.6 Cultural Stereotypes**

Two sub themes emerged from the analysis of stereotypes presented during the interviews. These were:

- Double standards of culturally specified gender roles
- Social attitudes and responses on surviving suicide

##### **4.4.6.1 Double standards of culturally specified gender roles**

Culture treats individuals according to gender, caste and class while mediating the construction of economy in India (Kapadia, 1997). The survivors' interviews depicted the power of cultural norms, beliefs and practices in choosing a job, finding means of livelihood, following a way of life and behaviour. Participants even expressed the internal conflict that they face constantly in making decisions and finding a balance between cultural norms and individual/family needs. For participant S 15 obeying her husband and staying behind at home by giving up her job was a way to integrate herself into a new family, culture and proving herself to

be a good wife/ daughter-in-law. The stereotype in this context is associated to role and power where a man exercises his power over a woman in a specific role (wife) within the family structure.

[Following our wedding, my husband asked me to spend more time with the family, to get to know the tradition, customs and family in the South as I am a North Indian] (S 15)

Although culture is said to lay strict boundaries, the fluidity of culture forced participant S 11 to support her husband by earning a livelihood in a bar. The participant indicated implicitly that a woman's dignity and safety is at risk when she works in a bar selling and serving alcohol to strangers. She (S 11) experienced humiliation and social awkwardness while supporting her husband at the bar earning a livelihood. In this case a double standard of culture forced participant S 11 to take on a job as a bar assistant contrary to the traditionally accepted role of a woman in the home due to a dual obligation to be supportive (in this case financially) to her husband. This participant makes a case that women are forced to be adaptable and compromise with situations due to the culturally attributed stereotypical behaviours and expectations of women and yet they do not receive recognition or respect in the family or society. She presents conflict between the agency and cultural expectations.

“ಆದರೆ ನನ್ನ ಕೈಯಿಂಥ ಈ ಬಾರ್‌ನಲ್ಲಿ ಸಾರಾಯಿ ಕೂಡ ಹುಯ್ಯಿಸಿಕೊಟ್ಟು.”

‘He made me serve drinks to customers in the bar’ (S 11)

In this part, cultural stereotypes will be discussed in terms of power and identity within the family structure. Cultural stereotype grants power in the hands of men subjecting women to obey the orders, a notion expressed by many participants. Participant S 11 expresses her grief and questions why women are treated as embodiments of culture and tradition therefore they are expected to obey their husbands.

“ಒಂದು ಗಂಡಸು ಹೇಳಿದ್ದೆಲ್ಲ ಹೆಂಗಸು ತಲೆ ಬಗ್ಗಿಸಿಕೊಂಡು ಕೇಳಿಕೊಂಡು ಹೋಗಬೇಕಾ?”

‘why should a woman keep her head low and obey her husband’ (S 11)

Likewise S 3 and S 14 also present a constant struggle to break through the culturally binding roles of an ‘obedient wife’ and be a reasonable human being to stand up for one’s rights and safety. However, no accounts provide evidence of expectations of men to be ‘obedient husbands’. The stereotypical expectation of a woman to be obedient and faithful to her husband further leads to a question about women’s identity in the case of divorce.

For participants S 3, S 14 and S 11, the thought of divorce or getting separated from their husband was very challenging. The participants’ families and their experiences forced them to assume that the life of a single woman/mother would be hard and terrifying. In addition, the data considered women burdened with the responsibility of nurturing children and elderly members of the family.

“ನಾನು ಡೈವೋರ್ಸ್ ಕೊಡಿಸಿದೆ ನನ್ನ ಮಕ್ಕಳನ್ನು ನೋಡಿಕೊಂಡು ಇತ್ತೀಚೆಗೆ ಅಂದರೆ ನನಗೆ ಯಾರೂ ಸಪೋರ್ಟ್ ಮಾಡಲ್ಲ. ಪ್ರಪಂಚದಲ್ಲಿ ಇರಕ್ಕೆ ಆಗಲ್ಲ ಅಂತಾಂ”

'If I get divorced, I will look after my children but I know no one will support me. I am told it is not possible to survive in this world (as a single mother)' (S 14)

“ನನ್ನ ಮನಸ್ಸಿಗೆ ಅನಿಸಿದೆ ಇವನನ್ನು ಬಿಟ್ಟರೆ ಮಾತ್ರ ನಾನು ಸಮಾಧಾನದಿಂದ ಇರಬಹುದು. ಆದರೆ ನಮ್ಮ ಅಮ್ಮ ಅಕ್ಕಪಕ್ಕದವರೆಲ್ಲ ಗಂಡನ ಬಿಟ್ಟು ಇರೋದು ಕಷ್ಟ ಅಚಿತಾರೆ”

'I think, I can live a peaceful life only if I leave him. But my mother and neighbours say it is difficult to live without a husband' (S 11)

Culture thus instils fear in the participants to hold them bound to the family despite the torture. On the other hand, no participants talked about such fears among men either towards divorce or towards shouldering the burden of the family (children). Participants indicated that men felt freer to end their marriage and remarry.

“ನನ್ನ ತಾಯಿನ ನನ್ನ ತಂದೆ ಬಿಟ್ಟು ಬೇರೆ ಮದುವೆ ಆದ್ದು”

'My father left my mother and married someone else' (S 14)

The participants also explained that they cannot return to their parents on breaking up a marriage as it would attract stereotypical opinions and behaviours of the society about women who live in their parents' home or those who live life as a single person after marriage. In the case of participant S 13, the data clarifies, men are not affected by this stereotype as the culture sanctions authority to men to live in their parents' home even after their marriage.

Cultural double standards become evident through the above-mentioned instances of a participant's life. The question of freedom, power and gender interact at various levels creating stereotypes within the cultural boundaries. It is difficult to



arrange these in a hierarchical order, as there is a constant interaction among these factors within the social process.

#### **4.4.6.2 Social attitudes and responses on surviving suicide**

This theme summarises the ways in which the participants' experiences of community influenced their life beyond the suicide attempt.

For participant S 3 life became tougher on surviving her suicide attempt. After her separation from her husband, she rented a house with her children. She was asked to vacate the house by the house owner on attempting suicide. She faced the harsh treatment of society, which failed to empathise with her. The pain and distress got worse on surviving a suicide attempt. There was not much support and help available to her in distress.

[The owner asked me to vacate the house because I had tried to attempt suicide (Participant felt overwhelmed with sadness and kept crying)] (S 3)

This account leads to an understanding of the hostile behaviour in society. It is not clear from the account if this hostility is motivated on cultural grounds or due to the fear of legal implications. The stereotypes about a single woman with children made it harder for participant S 3 to find a house to rent before the suicide attempt but this got worse after the attempt until the hospital social work team intervened in finding a house. What becomes apparent from the account is the symbolic power and conflict between the participant's struggle for survival and society's resistance to support the participant.

The ways in which survivors were treated in the community and the family after their suicide attempt varied. In the case of participant S 3 it was hostility from society but for participants S 7, S 10 and S 14 it was restrictions on social life, forbidden use of mobile phones, geographical relocation and being watched by the family constantly. Participants viewed these restrictions and lack of freedom as increasingly distressing and awful. On attempting suicide there is a shift of power and control from participants to their elders in the family who then make further decisions for them. The transition of power is associated to a stereotypical notion of participants' suicide attempts and their lack of ability to think well for themselves.

For participant S 6, the situation was even worse as she felt thrown open to the criticism of society when she left her husband and started living with her mother and brothers. Living with her mother triggered conflicts in her brother's family and his wife left him and went to her parents. On the occurrence of these events, she held herself responsible and attempted suicide. Although this attempt won her brother's sympathy it did not really change the community's attitude towards her and so she retreated into depression.

[The society speaks ill of me because I do not live with my husband and now my sister in law left my brother. Everybody says it is because of me. I thought if I die, things might be eased] (S 6)

The judgemental attitude of the community towards the participant subdued her reasoning and perception. This case illustrates the impact of internalising the social and cultural stereotypical attitudes on the mental status of individuals.

The fear of being judged, hampering future prospectus for a career and, finding a suitable groom stopped participant S 8 from revealing the suicide attempt to the extended family and community. The issue of shame and impact on future life forced the participant and the family to present physical illness as a reason for hospitalisation so that she is not taunted and ill-treated by the community.

[None of my neighbours know that I attempted suicide, they were told that I had an epileptic attack. If they know they will think that I might have been in love and somebody cheated on me so I attempted suicide] [We are 5 in the family, have 2 sisters, 2 brothers and parents. Brother studies for BCA (Bachelor's degree) final year. My sister is married. I am not married still. Because I am working my marriage is delayed] (S 8)

Many participants provide evidence for falling victim to the judgmental cultural norms and social attitudes that were distressing. In case of participant S 13, community viewed his attempt at suicide as unbecoming of a man of his age.

“ಅವರು ಇವನಿಗೆ ಈ ಕಾಲಕ್ಕೆ ಯಾಕೆ ಈ ಕೆಲಸ ಅಂತಾರ್ಲಿ”

‘They say, why did he have to do this at this age’ (S 13)

In the Indian family system, elders are much respected and their advice is sought on every decision in the family or community. It is culturally dishonouring for an older person to attempt suicide as it is perceived as a cowardly act that brings shame and stigma upon the surviving members of the family (Radhakrishnan and Andrade, 2012; Rao, 1991). There is an interaction among the culturally ascribed position and the participant's personal life situations.

#### 4.4.7 Summary

This theme discussed the cultural stereotypes through cultural double standards and social attitudes. The evidence from participants' accounts illustrates culture set double standards based on gender when it concerned power, identity, job role and caring responsibilities. Women bore heavy consequences of this cultural disparity however, men did not escape from the stereotypical attitudes of the society either.

#### 4.5 Means of attempted suicide

This theme outlines the various methods used by participants in attempting suicide. Participants offered insight into the use of particular methods. A range of precipitating factors and their relation to the very nature of the accessed method and its lethality was of practical importance to the meanings drawn from the insights presented by participants. This theme covers four types of methods as presented by the participants: poisoning, hanging, burning and drug overdose.

For several participants, their use of different types of poison such as rat poison, bed bug poison, toilet cleaners/bleach, insecticide and pesticide were a matter of easy access and avoiding suspicion. This method was used as a combination of both planned and unplanned means. For participant S 1, his pre-pondered intentions to die led him to get drunk with his friends as he envisaged it to be his last evening, he then went to buy a bottle of bed bug control. Likewise, for participant S 7 it was a well thought out means and he mixed the poison with alcohol with the intention to increase the lethality.

“ಅಪ್ಪನ ಕೈಯಿಂದ 100 ರೂಪಾಯಿ ತಗೊಂಡು ಹೋಗಿ ಬೆಡ್‌ಬಗ್ ಪಾಯಿಸನ್ ತಗೊಂಡುಬಂದೆ”.

'I borrowed Rs 100 from my father and bought bed bugs poison' (S 1)

[I thought if I mix the poison with alcohol, the severity would be more and I won't survive] (S 7)

The above extracts demonstrate participants' search for accessible and common means to avoid suspicion that would reveal their intent to attempt suicide. Participants S 1 and S 7 described their choice of particular methods as well planned, however they (choices) largely depended on accessible methods; whereas participants S 13, S 11 and S 8, provided no reasons for their choice but used whatever was available within the house premises at the time of crisis. For example, S 11 drank phenyl and S 13 consumed insecticide. In these instances (S 8, S 11, S13) participants did not rationalise the use of such methods rather it was the case of expediency and availability rather than pre pondered deliberate preference of means.

[In a rage of anger I consumed poison] (S 8)

“ಕೀಟನಾಶಕ -ಅಲಿಮೆಲ ಮದ್ದು ಕುಡ್ಡೆ. ರಾಗಿ ಬೆಳೆ - ಒಂದು ಎಕರೆ ಜಮೀನು ಇದೆ. ಅದರಲ್ಲಿ ಬೆಳೆತೇವೆ.”

'I drank insecticide (particular type) which is used in our farm. We grow ragi (millets)' (S 13)

“ಫಿನೈಲ್. ನನಗೆ ಏನಾಯ್ತು ಅಂತ ಗೊತ್ತಿಲ್ಲ”.

'I drank phenyl; I didn't know what happened to me' (S 11)

The occurrence of drug overdose was reported by participants who were prescribed medicines for insomnia, hypertension and mood regulation. Overdosing of prescription medication and other common drugs easily available over the counter were also used as means to attempt suicide by participants (S 3, S 9 and S 15).

[I consumed too many of those tablets for hypertension & sleeping pills as well] (S 15)

[I consumed tablets intending to die on the way to my mother's house from the counsellor's office] (S 9)

From participants' accounts, it became evident that only female participants used drug overdose as a method to attempt suicide. In the case of participant S 3, she tried multiple methods that involved hanging herself, drug overdose and setting herself on fire. Participant S 3 did not stop or repeat the same method but kept trying different methods.

[Not knowing what to do I poured kerosene over me, he started scolding me with vulgar words, beating me up, and doubting me, he would go to my parents' house and tell them that I have kept another man. Despite of telling them I have no other relation they would not trust me. So I tried to burn myself] (S 3)

The participants' choice of particular methods to attempt suicide did not provide any sort of religious or cultural association. The participants' occupation made a difference to the means they chose. The agriculturist (S 13) used pesticide, students and employed participants used poison (bed bug, rat) and drug overdose, housewives used drug overdose, poison, hanging and self-immolation methods.

The participants' discourse on methods closely related to their social roles and occupation. This provides a closer reflection of accessibility into particular means rather than dominated by choice.

## 4.6 Legal and Ethical concerns - Social System, Law and Police

This theme discusses the ways in which participants struggle with their life problems when they come in contact with police, legal action or in the web of complex social system.

Feelings of frustration and powerlessness were dominant in most of the participants' accounts. The participants felt that their efforts to help themselves and change situations were less successful or even a failure unless they had the patience and resources to battle with the system and undergo lengthy court procedures. Participant S 2 took an extreme step to end her life when all systems had failed to bring justice to her and punish the culprit. The participant directly expressed that this was her way of punishing the perpetrators by holding them responsible for her suicide.

“ಆದರೆ ಅವರು ಮಾತಾಡಿದ್ದೇ ಮಾತಾಡಿದ್ದು. ಅವರು ಬಗ್ಗೋಂಗಿಲ್ಲ ಅಂತ ಹೇಳಿ, ನಿಮ್ಮ ಮನೆ ಮಕ್ಕಳಿಗೆ ಮೋಸ ಮಾಡಿದ್ದೆ ಬಿಡ್ತೀರಾ? ಸರಿಬಿಡಿ ನನಗೇನು ಮಾಡಬೇಕು ಗೊತ್ತಿದೆ. ನಾನಂತೂ ಬದುಕುವಂಗಿಲ್ಲ. ಅಬಾರ್ಷನ್ ವಿಷಯ ಗೊತ್ತಾದ್ರೆ ಅಮ್ಮ ಬಿಡಲ್ಲ.”

‘They kept repeating the same thing, they stuck onto what they wanted. Would you spare if someone cheats on your daughter? Well I know what I

should do. I won't live. If my mother learns about my abortion, she would not spare me ' (S 2)

The Indian legal system has taken measures to safeguard women's rights and interests. However, it is sad to see how little justice is reached out to women in need. When the legal system has failed to bring justice to the victim and punish the culprit, an attempt at suicide is viewed as a way to punish the culprit by holding the husband/family responsible for the suicide.

Women do file complaints against domestic violence, dowry and harassment. However, they have to invest a lot of money in the police to serve the legal notice to the victim and execute an arrest or to fight their case in the court. The victim keeps waiting for justice for years and years having no outcome on her case. This is a period of frustration and exhaustion of her financial resources, time and energy.

For some other participants the legal system and the law have worked in their favour depending upon their situation. It leaves a question, is the law and the legal system adaptable according to situations or if the implementation fails or is neglected? Most of the participants reported that police got them to sign the statement but did not take action against them. Attempts at suicide have legal implications in India (see 1.4 on page 22).

**Researcher:** ಸಾಯಲಿಕೆ ಅಂತಾನೇ ಕುಡಿದದ್ದು ಅಂತ ಪೊಲೀಸ್ ಹತ್ತಿರ ಹೇಳಿದ್ರಾ?

Did you tell the police that it was an attempt at suicide?



**Participant:** ಹೌದು, ಅದರೆ ಅವರೇನು ಮಾಡ್ಲಿಲ್ಲ. ಏನಾಯ್ತು, ಸಮಯ, ಯಾಕೆ ಅಂತ ಸ್ಟೋರಿ ಬರೆಯ್ತು ನನ್ನ ಸಹಿ ತಗೊಂಡು ಹೋಗಿಬಿಟ್ಟು. ನಾವು ಒಂದು ನೂರು ರೂಪಾಯಿ ಕೊಟ್ಟೆವು. ಅವರೇನೂ ಮಾಡ್ಲಿಲ್ಲ.

‘Yes, but they didn’t do anything. They wrote about what happened, when and why story and got me to sign. We gave them Rs 100/- They didn’t do anything to us.’ (S 1)

All the participants referred to instances of giving money to the police. The police never refused to accept money while there were no financial charges involved. In their accounts, participants indicated implicitly that bribing a police officer was common practice. The police officers were often misguided by the survivors and their family members while taking down the statement. People do not wish to reveal the actual reasons for suicide and the incident is hardly recorded as an attempt at suicide.

Participant S 11 stands her grounds and refuses to sign the statement when the police officer did not write her statement down correctly detailing the facts that she had reported. Rather she found that the statement was written in favour of her husband while in reality she was holding her husband responsible for the abuse and distress she went through and the consumption of poison as well. She felt that she was at the mercy of the police to plead for justice. Many participants in different situations reported instances of misuse of power by police officers.

“ಇಲ್ಲಿ ಪೊಲೀಸ್ ಬಂದಿದ್ದು, ಆದರೆ ನಾನು ಹೇಳಿದ್ದು ಏನು ಅವರು ಬರೆದಿಲ್ಲ. ಅವರಿಗೆ ಬೇಕಾದ ಹಾಗೆ ನಾನೇ ಬೇಕಂತ ಮಾಡಿಕೊಂಡಿರುವ ರೀತಿಯಲ್ಲಿ ಸ್ಟೇಟ್‌ಮೆಂಟ್ ಬರೆದ್ದು, ಅದಕ್ಕೆ ನಾನು ಸೈನ್

ಮಾಡಲಿಲ್ಲ. ಪೊಲೀಸ್‌ಗೆ ಅವರು ದುಡ್ಡು ಕೊಟ್ಟಿದ್ದು, ಪೊಲೀಸ್ ನನಗೆ ಸ್ವೇಷ್‌ನಿಗೆ ಬಂದು ಕಂಪ್ಲೇಂಟ್ ಕೊಡಕ್ಕೆ ಹೇಳಿದ್ದಾರೆ.”

‘Police had come here. But they did not write anything that I told them. They wrote it as they wanted which seemed that I had done it deliberately. That’s why I didn’t sign it. He (husband) paid the police some money. Police asked me to go to the station to file a complaint’ (S 11)

Participant S 3 reports, when she and her then boyfriend ran away from home at the age of 13 and got married, the police decided to let her remain with her husband aged 15 then, just because she was pregnant. This decision of police did not prove to benefit or protect her interests or even safeguard her from abuse. She attempted suicide several times. She was then brave enough to file a case against her husband and family but it yielded no results. Although she was separated from her husband, the abuse continued.

[When I was young (13 years), I eloped with my husband and got married to him. I was pregnant then. My parents filed a police complaint because they could not find me. When the police found both of us, I chose to remain with my husband and the police agreed to it. Now my husband tortures me, beats me, he used blade to cut my face and arms. No one from his family helped me rather even they joined him in torturing me. I then filed a police complaint] (S 3)

## 4.7 Intervention and prevention methods

This theme summarises the participants' experiences of various support systems and interventions at the time of crisis and after an attempt at suicide. Participants followed a combination of treatment approaches such as religious practices, traditional healing methods, medical treatment and counselling. Participants explicitly linked medical intervention to extreme conditions of physical health. Therefore, in most cases, depression, anxiety or other forms of mental health problems were not diagnosed unless they were presented to the hospital on surviving attempted suicide.

### 4.7.1 Religion

Most participants and their family believed in religion and sought remedies for their problems through religious measures. Participants S 1 and S 4 did not believe in religion but it was central to their family. Both participants were male students. They were dependant on their family for their living. Participant S 1's mother had vowed to a god that she would offer his hair when he recovered. He was obliged to follow the religious practices to please his family members. Likewise, for participant S 4 god and worship did not make much sense.

“ನನ್ನನ್ನು ಕರೆದುಕೊಂಡು ಮೊಟ್ಟೆ ಹೊಡೆಸಬೇಕು ಅಂತ ಅಮ್ಮ ಅಂದುಕೊಂಡಿದ್ದು. ನಾನು ಹಾಗೆ ಹೇಳ್ಕೊ ಹೋಗಿ ಮೊಟ್ಟೆ ಹೊಡೆಸಿಕೊಂಡು ಬರುವ ಅಂತ. ಆದರೆ ನನಗೆ ಅದರಲ್ಲಿ ಏನೂ ನಂಬಿಕೆ ಇಲ್ಲ”

‘My mother had vowed to a god, that she would offer my hair. Even I thought I must go and do it (head shaven) but I don't believe in all this’ (S 1)

[I go to temple but ignore the worship as I don't believe in god] (S 4)

These participants expressed mixed association to religion and religious practices and its influence on their problem situations. They stood on a middle path between faith and denial of faith. They did not explicitly deny their faith but projected a confused opinion regarding the influence of religious practices on their wellbeing.

For participants S 3 and S 6, their husband and family forced upon them worship of Hindu gods. They were in an inter-caste marriage; to protect their marriage they had to give in to practicing a different religion against their will, which did not help them in getting out of distressing situations but rather increased their pain and distress.

[I am a Christian but my husband is a Hindu. My husband was not very happy that I didn't worship Hindu gods. He got a picture of the god and asked me to worship] (S 3)

[They forced me to worship their gods. I have done everything that they wanted me to do] (S 6)

For participants S 5, S 8, S 12 and S 13 religion and faith in god comforted them and helped them to regain hope in life. The events that made the participants feel hopeless with their situations and left them in despair were relieved through the support of religion, faith in god and support of religious groups. Participant S 12 (transgender) felt an outcast within the community and wider society. The only place that he felt welcomed and accepted was church. Therefore, he converted from Hinduism to Christianity without the knowledge of his family. He continues to keep the matter of conversion hidden from his family.

[I became a Christian without the knowledge of my parents. I go to church because I feel comfortable there but my father does not know about this] (S 12)

[Whenever I felt I should not live, I went to church and prayed. I go to church on Tuesday mornings and spend an hour there] (S 5)

[I have a lot of faith in god, I observe fast for 2 days a week] (S 8)

For a few participants the misfortunes of their life are linked to effects of evil spirits, bad omens, casting spells, magic and curses. Thus, participants engage themselves in religious and traditional healing methods to distance themselves and the family from the bad effects of magic, omens and curse. Participant S 11 believed that her troubles were due to the effects of magic cast upon her under the instructions of her mother-in-law. She perceived that the food and objects that her mother-in-law brought to her house had a magical impact as she was forced to eat them, she also noticed unusual things such as red thread, ash, lime (citrus), and a mud pot tied to the ceiling over the threshold. She believed that because of these, she faced repeated problems in the family, her husband was no longer being supportive and turned to being abusive. To undo these ill effects of magic she approached several healers and she reports that her situation forced her to believe these things.

“ಅವರು ಏನೆಲ್ಲ ಮಾಡಿಸಿಕೊಂಡು ಬಂದು ನನಗೆ ತಿನ್ನು ತಿನ್ನು ಅಂತಾರೆ. ಅವರಿಗೆ ಎರಡು ಸಲ ಅತ್ತೆ ಕಡೆಯವರು ಮದ್ದು ಇಕ್ಕಿದ್ದು. ಅದನ್ನು ನಾನು ಶಿವಾಜಿನಗರದಲ್ಲಿ ತೆಗೆಸಿದೆ. ಅವರ ಅಮ್ಮ ನಮ್ಮ ಮನೇಲಿ ಮಡಕೆ ಕಟ್ಟಾರೆ. ಕೆಂಪುದಾರ, ಭಸ್ಮ.. ನಿಂಬೆ ಏನೆಲ್ಲ ತಂಧು ಇಡ್ತಾರೆ. ಇದೆಲ್ಲ ನಾನು ನಂಬುತ್ತಿರಲಿಲ್ಲ. ಆದರೆ ಈಗ ನಂಬಬೇಕಾಗಿದೆ. ತಾಯಿ ಮನೇಲಿ ನಾನು ಪೂಜೆ ಮಾಡ್ತಿರಲಿಲ್ಲ.” (S 11)

'She gets something (magic, utterings) done to the food and forces me to eat. My husband had eaten such stuff twice and I got this undone in Shivajinagar. She (mother-in-law) comes home and ties a pot, leaves behind red thread, ash, lime etc. I did not believe in these things but I have to believe them now. I was not religious in my maternal home...' (S 11)

A significantly positive aspect of approaching religious or traditional healing methods is when healers form a frame of reference to time and positive reinforcement that creates an impression for hope and better times. In participant S 14's case this impression convinced her that she is strong enough to face the problems and look forward to better times.

“ಹೌದು, ನಾನು ಹೋಗಿದ್ದೆ ಆವಾಗ ಹೇಳಿದ್ದು ಸುಮಾರು ಟ್ರೈ ಮಾಡಿದ್ದಾರೆ. ಆದರೆ ನಾನು ತುಂಬಾ ಸ್ಟ್ರಾಂಗ್. ನನ್ನ ಟ್ರೈಮ್ ಮೇ 15 ರವರೆಗೆ ಸರಿ ಇಲ್ಲ ಅಂತ ಹೇಳಿದ್ದಾರೆ. ಅದಕ್ಕೆ ನಾನು ವೇಯಿಟ್ ಮಾಡಿದ್ದೀನಿ.”

'Yes I went to the healer, then he said that someone had tried several times (to harm by casting magic spells) but I am too strong. He told me that I have a bad time running until the 15<sup>th</sup> of May, so I am waiting.' (S14)

A vast majority of participants discussed the influences of religion and their faith in God during times of crisis, as a ritual, as a tradition and as a powerful symbol. A few participants (S 4, S 9, S 10 and S 13) did not express their dependence on the concept of God to find a reason for their difficulties nor to find support but were often persuaded by family into performing religious rituals. For participant S7 God and religion made no sense and thus he did not attribute any of his life situations and difficulties to God. A relevant finding in this section is participants who did not

commemorate God and religion yet they rediscovered meaning in 'fate'. For instance, participant S9 blamed her fate for her difficulties and troubles.

[If anything goes wrong at home they blame it on me. I don't think it is anything to do with magic but it is my fate] (S 9).

#### **4.7.2 Hospital intervention**

All participants had a good recollection of being referred to psychiatric assessment during the period of their hospital stay in order to qualify for a discharge from the hospital. Participants report counselling and alternative methods as one of the methods of intervention they were guided to.

[Doctor did not want to prescribe me any tablets although I wanted. My family doctor advised me to attend counselling. I do not feel that I need counselling. Because I was complaining of repeated headaches, they took the x-ray and there was no evidence of any biological concerns. So they advised me to practice meditation] (S 15)

[I received medical treatment and was counselled in the hospital] (S 3)

It seemed clear that participants shared a belief in both medical and alternative methods (meditation, counselling, Ayurveda etc.) in getting help during problem situations. The participants' accounts give evidence of lack of continuity in help-seeking behaviour. Participants' ideas of approaching counselling were specific to the problem situation. For most of the participants, counselling was a one off visit. Although they were advised to return for a follow up they could not be bothered.

[I have never approached any counselling services or mental health professionals after I was discharged from the hospital] (S 5)

[I attended counselling while I was in the rehabilitation centre for a few months] (S 7)

## **4.8 Conclusion**

This chapter explored the risk factors and intervention methods for attempted suicide from survivors' perspectives. Participants' accounts unravelled the stressful events and situations that they perceived to have influenced their decision to attempt suicide. Conflicts of interests/roles within families as well as high expectation of individual roles and responsibilities were commonly discussed factors among men and women survivor participants. The issues of abuse, violence, torture, surveillance and gender disparities were closely associated to women, as were their roles, status and power within families and society. The men participants expressed relationship breakdown as a prominent concern however they also presented issues of alcoholism, unemployment and failure to fulfil their duties, to be issues that were distressing and stressful. For both men and women participants the occurrence of a series of stressful life events added to their distress which they had not shared with anybody. Thus participants ultimately considered suicide as the only way out of the problems. Attempt at suicide was described in two ways. One was as an escape from difficulties and the other was as a threat to the perpetrators of violence and deceit. The most accessible methods were used to attempt suicide. As suicide is illegal in India, there is an understandable fear of legal implications and social stigma that limits willingness to approach help. Survivors



considered religious and traditional methods of support as socially accepted norms where they discussed life's problems. Medical assistance was sought only during apparent ill health. Psycho-social support was very rarely accessed and availed. A lack of awareness among members of family and friends to identify the need to seek mental health consultation and a wide gap between identification of severe stressors and treatment increased the risk for suicide and limited timely intervention.

## **5 Findings – Traditional Healers**

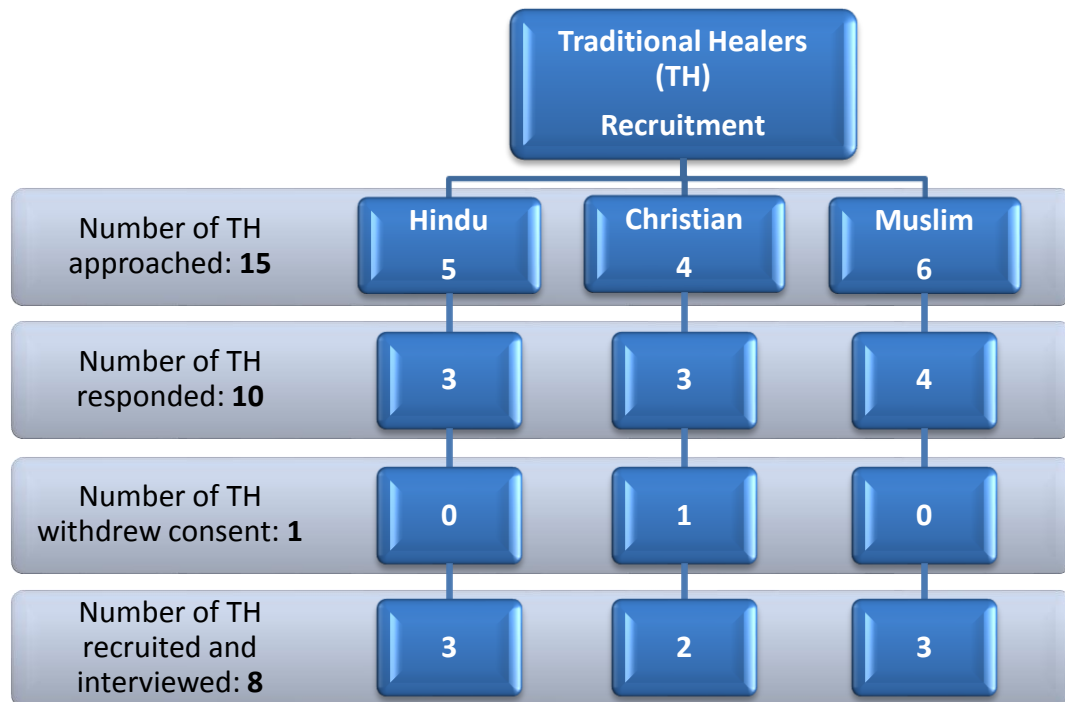
### **5.1 Introduction**

This chapter discusses and analyses the perceptions of traditional healers towards suicide. The focus of the analysis will be on how traditional healers understand the lives of their clients, their recognition and interpretation of the factors that lead to suicide and intervention methods they applied.

The first section in this chapter presents themes that have emerged from the participants' presentation of risk factors and situations that led their clients to attempt suicide. This is followed by a discussion of various means and methods of attempted suicide. The participants spoke very little about legal issues, alternatively they reviewed the various healing practices with specific cultural reasons attributed to their own practice.

### **5.2 Recruitment**

The recruitment of participants took place over 6 months. Figure 5 presents the number of participants approached, recruited and interviewed (see 3.4.2.3 on page 84 for more details on recruitment and sampling).



**Figure 5 - Recruitment - Traditional Healers**

### 5.3 Traditional Healer Perspectives

The participant interviews are analysed with an understanding of healers’ religious and cultural backgrounds. The healers’ perspectives are clearly distinguished from the researcher’s interpretation of data in order to provide a discourse on each participant’s views of attempted suicide and prevention.

The group of traditional healers included religious ministers and lay people from the three dominant religions in India, namely Hindu, Muslim and Christian. The other characteristics are detailed in Table 4. The Christian healers are accountable and regulated by a superior body within the Catholic Church, whereas Muslim and Hindu healers may practice independently to their role as religious ministers. Hindu healers were found to conduct their service mostly within the temple. On the other hand, Muslim healers were noted to use clinics and offices specifically for the

purpose of consultation and treatment. Muslim and Hindu healers practice alternative medicine such as Ayurveda, Reiki and Hamdard (naturopathy). The participants reported that these practices have been handed down to them from past generations within the family.

**Table 4 - Participant Characteristics - Traditional Healers**

Code	Age	Sex	Education	Practice	Religion	Language	Place of interview
TH 1	50	M	Bachelors degree in Ayurvedic Medicine	Hamdard, Ayurveda	Muslim	Kannada & Malayalam	Konangeri
TH 2	35	M	BA theology	Catholic Priest & charismatic preacher	Christian	English	Madikeri
TH 3	55	M	Secondary Education	Ancestral practice	Muslim	English & Urdu	Bangalore
TH 4	53	M	BA, course in Reiki & Magneto therapy	Reiki, Acupressure, numerology & Magneto therapy	Muslim	English & Hindi	Bangalore
TH 5	35	M	BA theology	Catholic Priest & charismatic preacher	Christian	English	Bangalore
TH 6	60	M	Secondary Education	Religious Hindu temple practice	Hindu	Kannada	Bangalore
TH 7	46	M	Secondary Education	Religious Hindu temple practice	Hindu	Kannada	Bangalore
TH 8	40	F	Illiterate	'Kani' fortune telling	Hindu	Kannada	Madikeri

Four categories emerged from the data with themes and sub themes under each of the categories. The emergence of themes is linked to the process of analysis and direct reference to the data (see 3.4.4 on page 90 for approach to data analysis). The following is an outline of the traditional healer data findings in categories and themes.

- Contributory factors for attempted suicide
  - Role identities and conflicts in marriage and relationship
  - Women and suicide
  - Children weighed down by pressure
  - Influence of the media
  - A measure to threaten and punish
  - Material wealth, money and economic power - a disguised source
  - On returning to milieu that lays boundaries
  - Influence of black magic, spells and bad omens
- Means and Methods of attempted suicide
- Legal and ethical concerns
- Intervention and prevention methods
  - A combination of counselling and religious methods
    - Use of objects and materials
  - Establishing Referrals

## 5.4 Contributory factors for suicide

The participants discussed in detail their perceptions of stressors, challenging life situations and reasons for attempted suicide. These discussions were derived from participants' experiences of working with survivors of attempted suicide and their family members. A narrative account of the precipitating events and experiences of the participants is presented through the following themes. The participants' socio-cultural and religious beliefs influenced their interpretation of risk factors for suicide. Thus, the development of the following themes is relative to the participants' perceptions and understanding of stressors expressed by their clients.

### 5.4.1 Role identities and conflicts in marriage and relationship

This theme encapsulates the challenges and conflicts that exist amidst the various individual members and their respective roles fulfilled within the family. It further discusses the participants' views on stressors for suicide such as abuse, torture, issues of surveillance, financial difficulties, change in life style and values. A large number of participants (7 out of 8) suggested that conflicts within the family were a significant cause of attempted suicide. These conflicts were associated with disparities created by the individual roles within the family structure. When the participants discussed the issue of conflicts and discord within families, it was addressed as if the conflicts were between the two individual's roles within the family rather than the individuals.

“ಗಂಡ/ಹೆಂಡತಿ ಕಡೆಯಿಂದ ಪ್ರಾಬಲ್ಯ ಇರುತ್ತೆ. ತಂದೆತಾಯಿ, ಇನ್ ಲಾ ಕಡೆಯಿಂದ ಪ್ರಾಬಲ್ಯ ಇರುತ್ತೆ. ಅದಕ್ಕೆ ಮೆಂಟಲ್ ಟೆನ್ಷನ್/ವರೀಸ್ ಜಾಸ್ತಿ ಆಗಿ ಅವರು ಬಂದು ಕೇಳಾರೆ. ಈ ತರ ಆಗ್ತಾ ಇದೆ. ನಾನು ತೀರ್ಮಾನ ಮಾಡಿಕೊಂಡಿದ್ದೇನೆ. ಸೂಯಿಸೈಡ್ ಮಾಡಬೇಕಂತ”. (TH 3)

‘There will be problems between husband and wife, father and mother, and ‘in-laws’. They experience increasing worries and tensions due to the problems and conflicts. They come to me for help and sometimes they tell that I have decided to commit suicide’. (TH 3)

The analysis of individual's roles in connection to conflicts drew attention to other factors such as social setting, expectations, responsibility, power and authority associated with roles within the family. Participant TH 3 addressed the issue of role-based power that affected relationships among the individuals within the family in the above extract.

It is hard to determine a hierarchy of events to understand stressors for suicide in marriage, relationship and within families. For participants TH 1, TH 3, TH 5 and TH 6 conflicts between husband and wife were due to unfaithfulness and a husband doubting his wife on account of misconduct and extra marital relationships. The presence of violence was one of the common factors evidenced in all the participant accounts. Most of the participants acknowledged that the decision to attempt suicide was not motivated by the occurrence of a single event or an experience of a sole problem (e.g. unfaithfulness, violence). Participants explained the interaction of challenging issues in a client's life over a period of time which influenced their response to stressful situations. Participant TH 1 demonstrated the interaction between doubt, surveillance, violence and breakdown in relationships and their mutual impact resulting in a decision to attempt suicide.

[Husband doubts his wife and tortures her because of which wife attempts suicide] (TH 1)

Participants differed in their perception of reasons for conflicts amongst couples and other members of the family. Participants TH 6 and TH 7 perceived economic independence between husband and wife to be responsible for raising concerns of unfaithfulness, alongside a lack of trust in marriage and relationships. Other participants considered an inclination towards the 'modern way of life' (TH 5). For example, the healers' reference to modern life referred to concepts such as possible changes in lifestyle from the traditional ways, disintegration of joint families into nuclear families, busy work schedules and less time available for family. Modern life from the perspective of the healers could also reflect a driving spirit to excel, be

successful in life that was seen as contributing to accumulating stress and the creation of differences among individuals within a family. These perceptions recounted by participants necessitate an in-depth analysis of the association between the challenges that individuals face in accepting or resisting social and cultural change. The participants' perception of transforming lifestyle, habits, social life, patterns of dress and families were influenced by their own acceptance and approval of the current social and cultural changes. For instance, participants TH 4, TH 6 and TH 8 condemned the notion of money and success being central to a happy life. For these participants changes in value systems affected the traditional values of sacrifice and asceticism, which were considered key to a happy family life.

Along similar lines, participants TH 2 and TH 6 presented increasing materialistic needs in a family as a reason for neglect and conflicts in marriage and further resulting in attempted suicide. The data show how the traditional healers perceived that the desire for materialistic gain among people has made a subtle entry into individuals' lives and thus affected long-held values such as respect, sacrifice and safeguarding family interests. Participants aligned such economic drivers to individual identity. For example, when participants discussed the values and traditional practices that were practiced within the families in the past, they indicated that an individual's beliefs and identity were closely related to the interests of the family unlike the present days, where an individual is defined and driven by professional, economic and social achievements.

[The desires of a man to want to be great and earn more money lead to suicide] (TH 4)



“Another reason in the family, one partner doesn’t get attention from the other partner as they are busy” (TH 2)

Participants’ accounts indicated two main reasons explaining breakdown of relationships leading to attempted suicide. All the participants recognised the issue of relationship breakdown as a common factor affecting young people. Participants felt strongly that young people faced difficulties in persuading parents to consent to their relationship. Failure to obtain parental consent resulted in stress and in certain cases to attempt suicide when they were forced to withdraw from a relationship completely. In view of the participants, the exercise of parental role, power and authority was evidenced to be distressing for young individuals. Participants TH 1 and TH 8 recorded a different perception where the individuals were obliged to obey their parents for economic reasons, fear and respect for parental authority, self-identity and family reputation.

[The family fails to consent to the relationship that their son or daughter is involved in which further leads to breakdown of love relationship] (TH 4)

Deception is the second reason evidenced in the accounts that was responsible for relationship breakdown. Participants shared different opinions with regard to the concept of deception, where few participants blamed women as deceiving and others blamed men. For participant TH 4 women cheated upon men whereas for participant TH 6 men cheated upon women. The Muslim male healers were not particularly sympathetic of women who were in pre-marital or extra marital relationships. Participants’ own religious and cultural backgrounds influenced the way they perceived and treated their clients.

[I have noticed 99.9% girls cheat on boys and break off the relationship. I console the boys saying that this person was not meant for you] (TH 4)

The Hindu and Christian counterparts expressed sympathy towards women but they attributed the breakdown of a relationship to the will of god and thus convinced their clients to keep hoping to meet a right partner. The participants encouraged their clients to surrender their troubles and worries to god/goddess. The participants from these two religious communities use the concept of god to console people in distress. However, this may well bring out the concealed motive to create fear and guilt in people and thus avoid getting involved in a relationship that lacks societal consent. In a sense, participants are presenting their clients to be in a struggle between different emotions, god, daily reality and behavioural expectations.

[Many girls come to the temple grieving, when their boyfriends deceive them and write letters to the goddess about their experiences and desire to kill themselves. They attempt to cut their veins. I tell the girls that if this particular boy is meant for you 'amma' (goddess) will unite you both. And if he is not meant for you then she (goddess) will allow this relationship to break up] (TH 6)

### **5.4.2 Women and suicide**

A large number of participants indicated the rate of suicide was higher among women than men. They attributed the reasons to the menstrual cycle and women being, in their view, emotionally weaker than men are in general. According to participants (TH1, TH3, TH4, TH6, TH7) from two religious backgrounds (Hindu and

Muslim), occurrence of suicide among women was perceived to be high during the clients' monthly menstrual cycle. They further perceived that women are more susceptible to the effects of bad omens during menstruation. This line of thought needs to be read within the context of the knowledge about status of women and their religious duties in the Hindu and Muslim communities. According to the Hindu code of religion, women are required to abstain from visiting places of worship and involve in any form of worship or even touch any objects of worship during their menstrual cycle (Hembroff, 2010). The Islamic religious code lays similar restrictions on women in performing religious duties and regulates their life (Moaddel, 1998). Participants (TH 1, TH 2, TH 5, TH 6, TH 8) described that their clients carried out religious duties according to the respective code of religion. However participant TH 6 provides an example where certain beliefs 'dosha' (blemish) derived from dominant culture (Hinduism) influence the beliefs of people across other religions. The participant described that people from all the religions believe in the concept of 'dosha' (blemish) but this concept is not discussed. According to participant TH 6 women are affected by 'dosha' during menstruation and therefore have thoughts of suicide.

[Women are prone to 'dosha' (impurities) when they attain physical maturity (menstruation) which is around the age of 13. During their periods, they are susceptible to attempt suicide because of the 'dosha'] (TH 6)

The participants from the Christian community did not draw any relation between the higher rates of suicide among women and the menstrual cycle. On a different note, in connection with relationships they rather questioned 'why are girls held

accountable for involving in a relationship or being seen with a boy?’ (TH 2). They questioned the social and cultural norms that discriminate men and women. Participant TH 2 expressed his discontent towards the unjustified ways of society that questions women rather than men for their involvement in a relationship. The participant further disagrees with the social norms that make recommendations for with whom a woman could be or not be seen in public. In addition, the participant goes on to explain that society stigmatises a woman in any circumstance whether she is in a relationship or when she breaks away from a relationship even if she does so because the partner is cheating upon her.

“As I observe male have the opportunity to betray the partner. Male will recover within 2- 3 days, if he is betrayed. For females it is difficult because- it becomes a social stigma” (TH 2)

Participant TH 7 discussed how unmarried women were particularly affected by stress and desperation when the family failed to find the right partner for her to marry as this was critical and could lead to suicidal behaviour.

[Most of those who come here are unmarried girls, who are frustrated about not finding the right alliance to be married to] (TH 7)

The participant made an implicit reference to failing to marry by a certain age could attract varying and ill opinions of a woman. However, this was contradicted in a later part of the data where the participant spoke of changes in society’s outlook of a woman.

According to Indian tradition a woman joins her husband and his family, leaving behind her own (Ward, 2000; Singer, 2007). Participant TH 4 draws attention to the distressing factors that affect women after their marriage. Participants (TH 4, TH 6, TH 8) consider factors such as: 'change of home, surroundings, living amongst unfamiliar people, being demanded and instructed by husband to take care of his parents, uncles, aunts and their children' to be very challenging for a woman, more so if she hails from a smaller or nuclear family. Participants also highlight that a woman's struggle to prove herself as a good wife, daughter in law and more so as a woman is associated with her ability to put on her best self and adjust to the new family, carry out the daily tasks such as cooking, washing, cleaning etc. Failing to carry out these tasks could result in the woman being tortured. Participant (TH 4) indicated a woman's problem-solving technique, response to stress and sufferings may be influenced by the emotional and economic support available to her by her parents and other immediate members of the family.

[When a woman joins her husband after her wedding, she is expected to serve her husband and every religion preaches the same. However, these days, a husband gets wife to serve his parents, grandparents, uncles and aunts. If a wife refuses to do so, she will be tortured. If the girls are from poor families, they withhold their sorrows from their parental family and ultimately attempt suicide. Most of the people from poor families gather money, prepare for their daughter's wedding over the years, and give the groom gifts disguised as dowry] (TH 4)

### 5.4.3 Children weighed down by pressure

Several participants commented on children in the age group of 5 – 18 years, who felt pressurised by parents and teachers to perform well at schools and colleges. The participants' impression of pressure to excel and achieve best results early on in life is closely associated with their perception of social and cultural change. For participant TH 5 'parents' busy work schedule, life style and social status' was perceived to be reasons for lack of emotional support in children's struggle to achieve best results. Rather participant (TH 5) expressed that children are weighed down with the expectation to maintain their parent's reputation in society, which might be affected if they do not achieve the desired results.

The precipitants and potential risk factors identified in all the participant accounts point to the overwhelming pressure to compete and attain the best results in exams, sports and other events. Participant TH 1 recalled a case where parents compared the child's performance with other children which became the source of humiliation for the child and thus in their view led the child to attempt suicide. For participant TH 6 excessive parental pressure had the potential to turn 'boys into hooligans' which worsened their situation in the family and gradually led to desperation.

[Parents compare their children's performance in exams and achievements with other children which humiliates those children who are not so clever]  
(TH 1)

Participants recollected that this form of pressure is often transferred from parents and teachers to children. They were of the view that continuous strain to excel in

performance leads many children into anxiety and later to internalise 'performance pressure'. It is evident from participants' accounts that they perceive there to be an unhealthy transfer of stress from one role (teacher, parents) to the other (student). On similar lines, establishing set patterns and high standards of expectation of self in young minds, without the appropriate support and guidance was subtly conveyed in the data.

"Teachers pester study study... with that trauma they do (attempt suicide)"  
(TH 2)

The participant TH 2 referred to parents who provided their children with independent rooms and access to media. Participants perceived this facility as creating distance between parents and children. In this account the participant linked children's failure to share their problems with parents to making them more vulnerable to depression, behavioural problems, self-harm and suicide. Recalling the joint family system, the participant explained that the larger family provided children with an opportunity to grow within the family, where there was always someone or other present to take care of them and even children had someone with whom they could share their feelings.

"But they think that they are not important in the family. Negligence is the main cause for these kinds of tendencies, negligence from teachers and parents. These days parents are very busy and have no time for children. In older days in joint families, grandparents used to spend time with children but now-a-day's families are becoming more nuclear and parents are busy in what they call social service neglecting their own families" (TH 2)

#### 5.4.4 Influence of the media

Participants TH2 and TH7 in particular identified the influence of media on suicidal thoughts. They suggested this was especially true at times of personal struggles for children and adults. The two sources of media mentioned were television and the internet. They made reference to certain TV programmes, namely 'hatyachar, warrant, murder, news channels' which telecast series on real life events of murder, suicide, rape and other crime scenes and which are watched by all age groups. These programmes are broadcasted during any part of the day and night. Exposure to such violent scenes was claimed to influence the mind and guide the individual to attempt suicide. Participant TH 1 suggested that the mechanism was that the individual thinks they have the same problems as that which is represented in the media and which led to suicide: "even I have the same problem so I must end." (TH 1)

For participants TH 2 and TH 7 watching these programmes broadcasted on TV could influence the choice of methods for suicide. They related that people tend to use the methods that are evidenced for completed suicide on broadcasted TV programmes.

[Media is loaded with suicide related issues from which people learn different methods of attempting suicide. Moreover, television programmes (hatyachar, news) present instances of attempted suicide] (TH 7)

The rest of the participants did not infer that media had an influence on their clients' thoughts of suicide, however they nevertheless believed that media was accountable for changing patterns of life, influencing value systems and



transforming family structures, which subsequently contributed to stress among individuals. In a particular reference participant TH 8 presented a critique of the dressing habits and fashion that women have adopted from the media. The participant being a woman herself, her critique was loaded with influences from religious and cultural beliefs. Likewise participants TH 6, TH 1 & TH 4 did not differ much on the point of influences of the media on encouraging consumerism among people. They were of the opinion that the materialistic culture motivated by the media leads to economic and social stressors.

[During this computer era, modern girls desire a lot of fancy things (refers to make up material such as lipstick). If a husband is an auto driver and earns only 300 – 400 Rs per day he cannot afford to buy his wife the fancy make up items that she desires. This leads to quarrels within the family and stress among men which might even result in suicide] (TH 4)

#### **5.4.5 A measure to threaten and punish**

Suicide as a means to threaten is analysed at two levels. At one level participants discuss suicide as a means to threaten different members of the family, partners and teachers. Participant TH 5 identified a few cases who revealed the lack of pure intention to commit suicide. The participant reported a case where the wife threatened her husband that 'she would jump into the open well if he did not stop torturing her'. Further analysis of the participant's comments provided an understanding of stressors such as violence, abuse, failure and negligence that had precipitated thoughts of suicide. According to the participant, suicide is used not

only as a means to threaten but as a sign of utter desperation and a symbol of courage to fight suppression.

At another level participant TH 2 discussed suicide as a means to punish those whom the individuals (clients) disliked. In the case of children, suicide was used to intimidate parents and teachers who exert power and control.

“They (children) say if I commit suicide you will face the problem” (TH 2)

The dominant discourse in this analysis is participants TH 5 and TH 2, presenting their view of suicide as a means to attack the coercing power, control and authority at various stages of life. Thus, only two participants referred to suicide as a means to threaten and punish; whereas the rest of the participants indicated that suicide was due to the way the individuals felt about particular situations; the occurrence of external events with internalised impact. When the participants were explicitly asked about suicide as a means of intimidation, they responded as ‘haven’t had such case’ (TH 1) or ‘only a few have said that to me’ (TH 5).

There was a clear ‘no’ from the participants when they were asked to comment on cases of homicide being presented as suicide or of attempted to murder presented as attempted to suicide. Due to the legal context of suicide, the participants may not have revealed the entire truth as they deliberately switched topic and refused to comment on the topic of homicide and murder.

#### **5.4.6 Material wealth, money and economic power - a disguised source**

For most of the participants, growing economic independence and increasing demands for a materialistic life were reasons for stress. They associated stress from these sources as a potential reason for attempting suicide. Participants had experience of the worst situation where an individual obtained credit beyond their capacity to pay off, resulting in suicide. Participants as sources of accumulating stress also identified conflicts within the family over limited financial resources to fulfil the needs of every individual, low-paid jobs and high costs of living.

[They commit beyond their capacity that increases the financial burden]

(TH 1)

[The desire to become great is the root cause of suicide. The rise in unrealistic needs and desires are leading to financial stress and other problems] (TH 4)

A few healers argued that parents unable to pay for their children's education and livelihood, are more likely to send their children to work. In a particular reference, participant TH 4 points at uneducated parents who send children to work and expect them to bring home their day's earnings. Failure to find a job could result in turning children to pick pocketing, robbery etc. Not being able to earn enough money and bring home the specified amount of money was presented as a reason for suicide.

[Children are pressurised by a few uneducated parents to work and earn money. Failure to bring money home could result in torturing the child.

Thus, children are easily led to robbery, pick pocketing and other crimes besides attempting suicide] (TH 4)

Participant TH 7 had a different view on the relationship between material wealth, stress and attempted suicide. The desire to live an independent life by the younger generation meant disregarding the system that was followed through generations in the family. While speaking of the traditions of the land, the participant indicated India as a 'land of toil, sacrifice and asceticism', where the produce is shared by all members of the family and the West as a 'land of pleasure'. He thus implied that the younger generation is inclined to follow the Western lifestyle and culture that increased their burden and stress as they could expect limited support from family. This participant discussed his perception of the past where individuals were taught to live a life of sacrifice, discipline and adopt an ascetic lifestyle in view of the future good of self and family. However, he claims that these values have been replaced by individualism, self-centeredness and a notion of instant gratification.

[Our land is called a land of toil (karma bhumi). There is a system in the society, especially the family system which we have received from our ancestors. However, the younger generation hardly follow these or consider the family traditions] (TH 7)

#### **5.4.7 On returning to milieu that lays boundaries**

This theme discusses the setting that clients return to after attempting suicide. A large number of participants' accounts present the challenges faced by individuals within the family. Family in this context is elucidated as a controlling unit, the powerful structure of social and cultural norms in society. Participant TH 2 gave an

example of a family's failure to understand a crisis situation. Instead they laid restrictions on individuals which created a stressful environment and led to a repetition of debilitating events/incidents.

“The situation arises within the family or within the society. The family members do not give enough attention instead when the similar situation arises they tend lay conditions you should not speak, not go outside etc.”

(TH 2)

A considerable link is established within the data between the living/family environment and suicidal behaviour. The environment in which talking about stressful situations is proved to be helpful can also be the harmful at the same time. Participant TH 2 explained that the family laid restrictions upon a client and curtailed their freedom with a view to preventing another suicide attempt. However, in the participant's view, this form of restriction became a reason for distress and depression. Participant TH 2 pointed to –‘having reminded or talked repeatedly of the attempt or the situations that lead to such decisions could instigate the trigger’.

Participants acknowledged that the risk of repeated attempts and relapse into depression was minimised when their clients willingly spoke of distressing situations and shared their problems. The participants stated that their clients did not mind the different ways of probing that healers used in an attempt to understand clients' life situations and stressors. For Participant TH 6, the act of kindness and offer of a listening ear helped in treating clients with problems of depression and hopelessness.

[I called her and asked her what happened. She was badly kept and starving. I offered her a cup of tea and asked her what happened, she sadly (crying) narrated that her husband beats her every day and so she decided to jump into the lake. There she said that she saw the picture of the Goddess in the water that brought her here to the temple before attempting to jump into the lake] (TH 6)

#### **5.4.8 Influence of black magic, spells and bad omens**

A large number of participants considered magic, spells, bad omens and curses at one point or another as a causative factor for the client's distress and suicidal behaviour. Participants had their own means of identifying the source of problems. The first method was to speak to clients and their families. Secondly, they depended on uttering verses from Holy Scriptures, numerology, astrology, or used water, beetle leaves and lemon in experiments to prove if the particular problem was due to magic or a bad omen. Participant TH 1 narrates a case wherein he asked the client to eat a beetle leaf and relate its taste to being tasteless, bitter, sweet or sour.

[Each of the four tastes mentioned by the participant referred to as sour – black magic, tasteless – possessed by the spirit of an unnatural death, Sweet – Gyn (creation before human beings/ gyn has no physical appearance/ Satan is superior to gyn), Bitter – Satan/ devil] (TH 1)

[I examine (prayoga) the clients to find out if the evil spirit has affected them. On identifying such cases, I refer them to the religious magical (tantric) healing practice] (TH 7)

Each of the participants explained their own ways of identifying the source of the problem. For participant TH 3, repeated thoughts of suicide were related to the effects of black magic where someone would have cast a magic spell on the client and the client would lose their ability to rationalise and thus be affected by thoughts of ending their life.

“ಮಂತ್ರ ಮಾಡಿ ಮೈಂಡ್ ಅಪ್‌ಸೆಟ್ ಆಗುತ್ತೆ. ಮನಸ್ಸಿನಲ್ಲಿ ಅದೇ ಯೋಚನೆ ಇರುತ್ತೆ. ವಿಷ ತಗೋಬೇಕು ಅಥವಾ ಬಾವಿಗೆ ಹಾರಬೇಕು. ಇದೆಲ್ಲ ಮನಸ್ಸಿನಲ್ಲಿ ಬರ್ರಾ ಇರುತ್ತೆ ಯಾವಾಗಲೂ.”

‘Through magic mind could be affected. They keep thinking of the same thing. Consume poison or jump into well, these thoughts keep recurring’  
(TH 3)

Participant TH 4 reports incidents of terrifying magic practiced in a neighbouring state of Andhra Pradesh which is called ‘Banamati’. To control the effects of this magic, the government of Andhra Pradesh intervened by creating a separate cell which consisted of healers and police officers. The following extract evidences the use of two sources (healers and police) to fight the effects of magic. These data point at traces of belief in powers to explain problems which do not have an immediate solution/outcome.

[Medical science does not accept many things, for e.g. black magic. If you go to Andhra Pradesh (place in South India) there is a separate cell that consists of police and mullas to deal with the effects and impact of Banumati magic. Banumati was the founder of this horrible black magic. Medical science does not accept spiritual healing] (TH 4)

Participant TH 2 illustrates that people tend to relate their misfortunes and troubles to magic and spells cast by their rivals. Participant TH 2 further expresses his challenges in an effort to bring people to realise 'no such thing (magic) exists' TH 2.

Participant TH 7 and TH 8 infer problems and suicidal behaviour to 'sarpa dosha'; that is the damage or effects of bad deeds committed by ancestors or other members of the family. The participants prescribe specific methods of worship and advise clients to follow set procedures. By doing this participants aim to reposition clients' attention and establish faith, confidence in supreme power and thus regaining self-esteem and encouraging clients to give themselves sufficient time to deal with the problem.

[In case of 'sarpa dosha'(blemishes and curses brought upon the family by ancestors) people face difficulties in getting married and even if married then might have difficulties in bearing children. This can be solved by offering worship (pooja) to a god (kukke subramani). There are cases which have been healed; specific gods are worshipped in relation to certain illness and problems] (TH 7)

Participant TH 2 differed in his opinion from that of others, with regard to magic and its influence on an individual's health and life. The participant here makes a sophisticated link between the manifested mental status of the client to violence/abuse experienced within the family that is projected as possession and the effects of magic by the other members of the family.

"More than their belief in word of God they believe in black magic, they say my daughter was very good, she has possessed, or someone has put some



medicine on her or tied something around her, even if we explain such things are not there they don't understand. Because of the torture the family members give, the mental status is bad, but they think it is black magic and so on" (TH 2)

On similar lines participants TH 7, TH 1 and TH 5 presented a relative perception wherein they considered that magical impact was relative to a client's mental status indicating that the 'individuals who are mentally weak were easily affected by evil eye and magic' (TH 5). The data reveal that the participants paid particular attention to their client's mental cues, assessed the entire situation and re-presented the problem to clients with appropriate solutions. This process enabled people to experience a better outcome. The interviews evidence the kind and approachable nature of participants with their clients. They listen to clients' problems patiently, gain people's trust and encourage clients to visit them again.

[I called her and asked her what happened. She was badly kept and starving. I offered her a cup of tea and asked her what happened, she sadly (crying) narrated that her husband beats her every day and so she decided to jump into the lake. There she said that she saw the picture of the Goddess in the water which brought her here to the temple before attempting to jump into the lake. I spoke to her, told her it is her husband's fault and now the goddess (Amma) has blessed her, everything is going to be fine. She had food and slept in the temple. Meanwhile her husband, in-laws came here looking for her so I spoke to them all and counselled. This way one life is saved] (TH 6)

From the participants' accounts suicidal attempts due to love issues were highly stigmatising. By presenting them as associated with magic or possession, individuals gained sympathy and support from the entire community instead.

## **5.5 Means and methods of attempted suicide**

Participants presented varying perceptions and reasons to interpret means of attempted suicide. They referred to self-poisoning, hanging and jumping into open well/river/lake as the common methods used by their clients, whilst a few participants (TH 3, TH 5, and TH 8) mentioned the use of drug overdose, cutting veins and self-burn. The participants' position as traditional healers belonging to a particular religious faith and their perception of the researcher influenced the way they presented their arguments. Participants did not clearly express the differences between the accessible means and the well-planned means.

There were two obvious reasons for the choice of methods used to attempt suicide evidenced during the course of the analysis. The first is considering time (inauspicious time), the second is media and cases of completed suicides to have influenced the choice of methods in attempted suicide. Participants TH 1 and TH 6 expressed that their clients were led to a particular source such as a river/ well or a bottle of poison due to the inauspicious time (in rahu kala).

[But what happens is when that time (rahu kala) comes, they are either led to a well or poison....] (TH 6)

[They either try to hang or jump into water at that stage in time] (TH 1)

On discussing in detail the concept of time and its relation to the use of methods in attempted suicide, there was no specific evidence to support the claim that their clients were led to a well/river than hang while they (clients) were in the house. The lack of sufficient evidence is an indication to consider other factors such as social setting, distressing situation, response patterns, client thought process and coping strategies. These might be relevant to help unravel the connection between time (in terms of best time of the day or night) and methods employed in attempting suicide. The participants hardly dealt in depth with the details of social settings while explaining the methods that were used. Participant TH 7 confirmed the connection between attempt, time and method through elaborating the cases where relatives of survivors or deceased through suicide approached the healer. The readings of the 'panchanga' horoscope of the survivor or the deceased person revealed that the attempt or death was during an inauspicious time named as 'rahu' or 'yamagantha kala'. Only three participants (TH 1, TH 6, and TH 7) addressed the issue of inauspicious time and its relevance to methods employed in attempted suicide. Other participants referred to 'inauspicious time' as a factor responsible for attempted suicide but a relevant finding here is that 'inauspicious time' as explained by participants always coincided with distressing situations.

The second reason for the choice of methods used to attempt suicide evidenced during the analysis was the influence of media and learning from completed suicides. Participants expressed that the TV programmes with scenes of attempted suicide or completed suicide provide people with a guide that informs them about the lethal methods.

[TV telecasts cases of suicide, so people learn from those] (TH 7)

Another incident reported by TH 2 informed the analysis that television is not the only source through which people learn about lethal methods. People also learn from their surroundings where they hear or witness cases of completed suicides. The participant made particular reference to children who learn from TV, internet and incidents of completed suicide within their communities. In the view of the participant children tend to use methods that they have witnessed either in TV, internet or in the surroundings, that have resulted in completed suicides.

“They think even I have same problem so I must end they don’t know if hanging is a good method or poisoning or jumping into water is good. They see the person who has done that is dead so they think that is good and they don’t have parents to talk to” (TH 2)

Other participants (TH 3, TH 5, and TH 4) made a vague reference to television from which people learn about methods however, they did not indicate that people watch specific programmes on television with a pure intention to learn about lethal methods of suicide. Thus, these evidences of influence of media may not be sufficient to establish that the methods used to attempt suicide were well-planned methods. There is a possibility of three factors (media/surrounding, planning and access) triangulating which makes it difficult to determine if the methods were well planned or accessible.

## 5.6 Legal and ethical concerns

All the participants were aware of the legal context of an 'attempt to suicide'. They explained that most of their clients did not present as being suicidal in the first instance rather approached them for help because of problems and a series of stressful life events. It required skill on the part of the participants to lead their clients to self-disclosure. The role of family in bringing survivors of attempted suicide to the healers (participant) was recounted and in a few cases clients (survivors) walked in voluntarily. In none of the cases had the participants reported clients to police for having attempted suicide or when domestic violence or abuse was identified. The data did not evidence instances of police approaching the participants in connection with investigating suicide related cases. It is implicit in the data that participants kept away from legal issues or reporting any incidents of abuse to the police due to the complicated and lengthy legal proceedings and system although this concerned their clients.

[As per our Indian legal code, suicide is a punishable offense. One who comes here does not say that I have attempted suicide. When the parents bring their son/daughter to me, they complain about other problems but not mention suicide] (TH 4)

“ಹೇಳ್ತಾರೆ ಆತ್ಮಹತ್ಯೆಗೆ ಪ್ರಯತ್ನಿಸಿದ್ದು ಎಂದು ಹೇಳ್ತಾರೆ. ಪೊಲೀಸ್ ವಿಚಾರಣೆಗೆ ಬರಲಿಲ್ಲ”.

'They admit their attempt to suicide but no police have ever come here to investigate (cases of suicide)' (TH 3)

In the above extract participant TH 3 acknowledges not reporting any cases of attempted suicide to the police and also states that neither do police conduct a thorough investigation in such cases. The participants (TH 1, TH 5) express it is unlikely that police would approach them seeking information about cases of attempted suicide.

Participants are not bound by any professional ethics organisation that regulates their practice and dictates treatment approaches. Participants use various methods to persuade their clients to share their life situations with the healers as they believe it is crucial to a healing process. For instance, participant TH 1 suggested his client to make a vow before God that she (client) would tell only the truth during the healing session. In view of the participant, this approach apparently created pressure in the client to tell the truth. Although this approach may appear coercive, participants still believed that this method is essential to help the clients to deal with the root cause of their problems. This is an example, which elaborates that participants are not restrained by any ethical considerations or regulations, as there is no prescribed ethical body for traditional healing practice in India.

## **5.7 Treating Stress and suicidal behaviour**

This theme summarises the various methods used by participants in treating stress, suicidal behaviour and other problems presented by clients. There are a few commonalities and differences in practice among participants from the three religions of Hindu, Muslim and Christian. The following themes and sub themes emerged from the analysis of the data on intervention methods used to treat stress and suicidal behaviour.

- A combination of counselling and religious methods
  - Use of objects and materials
- Establishing Referrals

### **5.7.1 A combination of counselling and religious methods**

All the participants laid an uncompromising emphasis on the need to establish rapport with their clients and understand their mental status despite their differing opinions and perceptions of situations and problems. A common feature of practice was that all the participants used a combination of counselling and religious methods. According to participants, counselling is understood as providing their clients with an opportunity to create an environment where clients feel comfortable to speak about their problems to the healers. On explaining the counselling process, participants TH 3 and TH 5 stressed the importance of being patient and listening to clients' problems, so to help them 'to release tension and think clearly' (TH 5). The participants across all religions predominantly used verses from Holy Scriptures, water and oil in the healing ceremony. It is evident from participants' discourse that there is a relevant association between client's thinking patterns and situations and the participant's (healer) choice of particular method of intervention. The participants' religious identity did not limit their service to people from particular religions alone rather they reported having clients from various religions.

[People of all religion come here] (TH 6)

A large number of participants believed in using various methods to motivate their clients to unwrap the secrets of their life and problems to the healers (participants). Participant TH1 suggests one of his clients makes a vow before gods thus,

instigating a fear of god and the ill effects of making a false pledge could result in bringing more problems upon self and immediate family. The dominant discourse in religious healing processes identified in the data is that of participants instilling various emotions in clients and attaching them to god and supreme power. For participant TH 7, ascertaining faith in god, presenting god as love, a symbol of hope and supreme power on whom they (clients) have to wait patiently for his mercy, resulted in boosting clients' self-image, building confidence and giving courage to live life.

[People can witness the impact of their worship only when they perform worship (poojas) with complete faith. The more faith they exercise and wait patiently the more benefits they will reap] (TH 7)

Participants TH 6, TH 7 and TH 8 used an analogy of 'time and constellation of stars' to interpret the problems and find solutions to the problems. This process meant convincing their clients that they are soon to approach a better time where good things will happen and meanwhile they have to perform some rituals to reduce the bad effects. Participants explicitly indicate that this method worked as it gave their clients hope and helped them to reorient their thoughts by engaging in different activities.

[It is not possible to reduce the problem and bad effects all of a sudden, asking them to visit a temple everyday creates a change in environment, which might be therapeutic. I also look into their horoscope (jataka) and advise them when they would be relieved of the problem] (TH 7)



Participants TH 1, TH 4, TH 5 and TH 6 explained that a few of their clients were under the effects of evil spirits which led them to self-harm and to attempt suicide. Thus, the participants administered the process of discharging the evil spirit and gyn through the utterance of verses from Holy Scriptures and giving their clients the holy (blessed) water to drink. However, the method of casting off spirits varied among participants from different religions. For participant TH 1 exorcising a spirit ceremony involved beating and whipping the possessed person. Another method was fumigating fragrant herbs to create smoke. These methods were used symbolically to drive the spirit away. Participant TH 7 points at another sphere of practice in Hindu religion known as 'Tantric practice' which deals with casting off spirits. The data implied the entire process to be very exhausting for the client but at the same time, the client is supported by the family and entire community thus obtaining attention and extra care.

[This person was possessed by a spirit of the girl who died through suicide. That spirit refused to leave that house so I placed a big picture of goddess (Ammma) in the house and every day we offered worship(pooja). I told that spirit you can stay in this house but do not trouble us and we will not trouble you; I will take care of you just like my daughter. In this way I exercised power and took control of the spirit] (TH 6)

Participants from a Christian background revealed that the 'sacrament of confession' helped their clients to trust the participants (healers-priests), share their problems and take the advice of the healers (participants). These accounts highlight the process of obtaining trust and rapport-building through confession as the

identity of the client and the participants both were concealed in confessionals. For participant TH 2, bringing clients out of the confessional for continued support and counselling was a perceived need to which many of his clients with suicidal behaviour and severe problems responded.

“Few voluntarily speak of the attempt in confession so I ask them if you need counselling they need to see me outside the confessional. So they come for counselling as they believe in me but I tell them believe in yourself” (TH 2)

#### **5.7.1.1 Use of objects and materials**

The common objects used by participants across all religion were water, oil and verses from Holy Scriptures. As these participants were religious ministers at churches, mosques and temples, their healing or intervention process included offering worship, prayers alongside counselling and use of various objects. Participants from Hindu and Muslim religions used pieces of metal and paper dipped in sandalwood to inscribe holy verses or ‘mantras’. These were then given to their clients to be tied either around the arms or around other parts of the body or to be kept in the house. Participant TH 6, further explaining the effects of using such objects, reveals that although the used objects may or may not have any medicinal impact they help people because clients believe in the power of god being transferred through these objects to them.

[I gave her a piece of metal (tayta) to tie around her neck or waist. I spoke to her and extended her my support. She felt a bit courageous. Then I advised her to go to a doctor. There is no magic but people believe in these

things. There are cases of stomach-aches, I advise them to mix saffron in water and drink. Women without children come here to be blessed with offspring, so I offer some poojas and cast away the bad eye. In other places what they do is they give some things to eat which is made of some butter and make the clients vomit so when they vomit it is said all the bad effect has been done away with but I don't do such things here. Other healers powder the tablets (commonly available - paracetamol) and give the powder to the clients] (TH 6)

Participant TH 4 accounts for the release of negative energy through 'reiki' and the crystal healing system. He located various energy points in the body, used crystals to release negative energy and to reinforce positive energy. The participant indicated this being a process of protecting a client from further evil impact. He described twofold approaches that follow release and revive techniques by using reiki or crystal healing.

[I drive away evil spirits with Quranic healing and give them the locket (piece of metal with inscriptions from scriptures) for protection. Besides spiritual healing, I practice reiki and counsel them] (TH 4)

A large number of participants, except for participants from the Christian community used Ayurvedic medicines. Although not all of them were qualified to practice Ayurvedic medicine. The cost of some of these medicines and oils were very expensive. Participant TH 3 claimed the limited supply, complicated extraction process and the remote location are the factors influencing the cost of such products. None of the participants charged for their service but their clients were

free to offer any donation if they wanted to. The significant difference among the participants from three religions were, Christian healers did not offer their clients any objects therefore did not charge, Muslim healers charged for the objects, medicines and oils that they offered clients, Hindu healers charged their clients for performing certain 'pooja' worship, sacrifices, objects, materials and Ayurvedic medicines.

[We don't charge here but accept gifts. However offering certain poojas have additional charges. The tantra pooja (form of worship) is done here on demand but few poojas are expensive. We give some yantra (object) written with beeja akshara (Single syllable) verses from githa (scripture) on a piece of metal. It is hard to say how effective or how soon it will be healed as it depends on the case] (TH 7)

[Services are not charged however, people are free to offer if they wish to. Nevertheless, they have to pay for the medicine] (TH 1)

"When they come to me they come voluntarily and I don't charge for the service" (TH 2)

### **5.7.2 Establishing Referrals**

This theme discusses the instances where participants refer their clients to other healers and hospitals for medical and psychiatric treatment. The latter part discusses the attitude of the healers towards their own practice and other practices around them.

The interviews recount two types of referrals. The first type of referral is internal where healers refer cases to other healers who specialise in specific areas within

their own religion. For example, participant TH 7 reported that he directed clients with evil effects to 'Tantric' (magic) healers for a deliverance 'pooja' ceremony/worship.

[I examine (prayoga) the clients to find out if an evil spirit has affected them.

On identifying such cases, I refer them to the religious magical (tantric) healing practice] (TH 7)

Participants described that every form of healing practice is a result of special graces and gifts of god. On the other hand, they also acknowledged training and hereditary practice. There is an absence of referrals to healing practices across religions. Participant TH 2 commented that the use of objects such as lemon, tayata (piece of metal) in healing practices does not work. This discourse locates a sense of doubt among participants about healing practices in other religions.

"I feel materials that Hindu healers give doesn't work. They come with a trauma and if we are giving some more problems, they can't take it. It is only negativity and they need positive strokes. They come out of their problems with these positive strokes" (TH 2)

The second type of referral is external where healers refer clients to health care professionals (psychiatrists, general practitioners). Several participants referred cases to hospitals for further investigation and medical treatment. Participants gave various reasons for referring clients to an external source (hospital). For participants TH 1, TH 2, TH 5, TH 7 and TH 8 clients with biological conditions and mental illness required medical attention. For participant TH 3 psychiatric support along with healing process for his clients was crucial. However, a few of his clients

disregarded the psychiatric treatment due to the extensive nature of enquiry during the process of history taking. Participants indicated implicitly in their accounts that people find it comfortable to approach healers for a number of reasons one being that people would be less judgmental of persons approaching healers.

“ಯಾಕೆಂದರೆ ಸೈಕಿಯಾಟ್ರಿಸ್ಟ್ ಸರ್ಪೋರ್ಟ್ ಬೇಕು. ಈ ನನ್ನ ಮಂತ್ರನೂ, ಮೆಡಿಕಲ್ ಟ್ರೀಟ್‌ಮೆಂಟ್‌ನು ಎರಡು ಸೇರಿ ಮಾಡ್ಲಾಗ ಒಳ್ಳೆದು”.

‘Need psychiatry support as well as these spiritual chantings. Then only they can benefit’ (TH 3)

Participant TH 4 saw spiritual healing as the answer to the problems to which medical science has no answer. Other participants related instances of people who have had no results from medical treatment and thus turned to religious/Ayurveda healing practices. Participants TH 3 and TH 4 describe them as cases of possession. Participants also relate instances wherein doctors from various hospitals have referred cases to healers (participants). Most of the participants, except for Christian healers, used Ayurveda/Hamdard (naturopathy) medicines in their healing process.

[From my experience, I can say spiritual healing begins when medical science stops. A patient suffering from high temperature underwent a thorough diagnosis in a well-known hospital here. All the test results were normal, they could not identify what was causing the problem. When I performed Quranic healing, the evil spirit that possessed the patient left him] (TH 4)

[The surgeons and doctors from well-known hospitals refer us cases who suffer from devilish effects] (TH 4)

All the participants thought along similar lines when it concerned the comparison between the medical system and their stream of practice. Each of the participants claimed that their practice has worked so far; therefore, it is the best method. However, participant TH 2 mentioned the need for upgrading knowledge and skills to meet future needs.

[Based on my experience I can say this is a best method] (TH 1)

“I know only this method, there are other methods but my method is working, in the future maybe I have to update but from past 9 years I am practicing the same” (TH 2)

Although the participants claim their practice to be the best, they do acknowledge the need to approach medical help. The interview data explicitly indicate that no participants held back from referring people to conventional medical practice when they identified the need. Neither did they disregard other traditional healing practices. In a way, participants knew their limitations and did not hesitate to admit them to the clients. Participants were transparent and felt a sense of responsibility towards their clients.

[I tell them along with our prayers, they also need to see the doctor](TH 5)

[We need to have both the approaches – God and medicine, the grace (krupe) of God and consultation by the doctors. So people do approach both the ways. ‘vaidyo narayana bhavo’ (doctor is equal to God) so traditional methods and medical approach both are needed] (TH 7)

For participant TH 2 the limitations of traditional healing systems were that the ‘results depended on the faith of people and their patient endurance’. On similar

lines participant TH 8 cites 'if people believe they will see the cure otherwise they won't'. Participant TH 4 refers to an example illustrating the merits of spiritual healing and medical practice. The data did not indicate the slightest feeling of threat among the participants regarding the co-existing healing practices or amongst conventional medical practice.

[Spiritual healing is good for spiritual diseases and current medicine can cure physical ailments. If anyone suffers from effects of magic, evil spirit and sudden loss in business this is undone through spiritual healing alone. I have found some lemon or tayta (piece of metal) in their residence or place of work that confirms that someone has casted spells or black magic upon the individual. Therefore spiritual healing is good in this way] (TH 4)

Most of the participants use a mechanism of 'invisible power' (TH 1) accompanied with the concept of god to gain people's trust in their healing practice. Participant TH 3 claims that this form of spiritual healing helps people to reorient their thoughts and have a better outlook on situations and life in general. On the other hand, the participant is of the opinion that traditional healing systems prepare individuals mentally for the medical treatment.

“ಮೆಡಿಕಲ್ ಟ್ರೀಟ್‌ಮೆಂಟ್ ಬೇಕು. ಆದರೆ ನಮ್ಮ ಟ್ರೀಟ್‌ಮೆಂಟ್ (ಸ್ಪಿರಿಟ್ವಲ್) ಒಳ್ಳೆಯದು. ಯಾಕೆಂದರೆ ಮಾನಸಿಕವಾಗಿ ಅವರನ್ನು ತಯಾರು ಮಾಡಬೇಕು. ಯಾಕೆಂದರೆ ಪೂರ್ತಿ ಅಪ್‌ಸೆಟ್ ಆಗಿ ಔಷಧಿ ತೆಗೆದುಕೊಳ್ಳುವುದಿಲ್ಲ. ಅದು ತೆಗೆದುಕೊಳ್ಳುವ ಹಾಗೆ ತಯಾರು ಮಾಡಬೇಕು. ಆದರೆ ಔಷಧಕ್ಕೆ ಅದು ಮಾಡಕ್ಕೆ ಆಗುವುದಿಲ್ಲ. ನನಗೆ ಔಷಧಿಯೇನೂ ಬೇಡ, ನನಗೆ ಬದುಕಕ್ಕೆ ಬೇಡ, ಸಾಯ್ತೀನಿ. ಇಲ್ಲಿ ಹಾಗೆ ಆಗಲ್ಲ ನಾನು ಅವರಿಗೆ ಒಳ್ಳೆ ರೀತಿಯಲ್ಲಿ ಹೇಳ್ತೀನಿ. ನಿಮಗೆ ಔಷಧಿನೂ



ಬೇಡ, ಅಪರೇಷನ್ ನೂ ಬೇಡ. ನಾನು ನಿಮಗೆ ನಿವಾರಣೆ ಮಾಡ್ತೀನಿ ಅಂದಾಗ ಅವರು ನಿಧಾನಕ್ಕೆ ಸರಿಹೋಗ್ತಾರೆ ಅನಂತರ ಅವರು ಔಷಧಿ ತಗೋತಾರೆ”.

‘They need medical treatment as well. But our treatment is good because when they are completely upset they can’t take medicines. They have to be prepared to take medicines. There is no medicine to prepare them to take medicine. They become stubborn towards taking medicine. Whereas here I tell them, you do not need any medicine or any operation. I will heal you. So gradually they become normal and start taking medicines as well’ (TH 3)

From the participants’ perspective, neither the traditional healing system nor the medical systems were effective on their own. In their view, clients received maximum benefit when they approached both systems. However they also acknowledge that ‘patient endurance and faith’ (TH 5) are instrumental in the healing process.

### **5.7.3 Conclusions**

The participants’ cultural and religious background dominated their perception of risk factors for suicide. Suicide was perceived as a fight against coercing and undesirable events in their clients’ lives. In some cases suicide was a progression from depression, negligence, suppression, lack of support and the impact of Western culture and lifestyles. Many participants expressed that the thoughts of suicide and misfortunes in the house were closely related to the client’s belief system, the ill effects of magic, spells and ‘bad times’. Participants considered suicide as an unjustified way to respond to problem situations in life. However, it does not mean that the participants did not empathise with their clients.

Participants believed that an honest confession by their clients remained essential in order to plan any interventions.

In the view of participants' experience with their clients, the identification of problems was essential before they planned treatment. For most of the participants, facilitating their clients to speak out about their problems was central to their intervention process. Religious methods of healing were perceived to recreate hope and faith in individuals and encourage them to have a positive outlook on life. Alternative medicines such as Ayurveda and natural medicines were practiced alongside religious methods. Participants acknowledged the limitations of their practice and referred cases to other healers and to conventional medicine.

## **6 Findings – Mental Health Professionals**

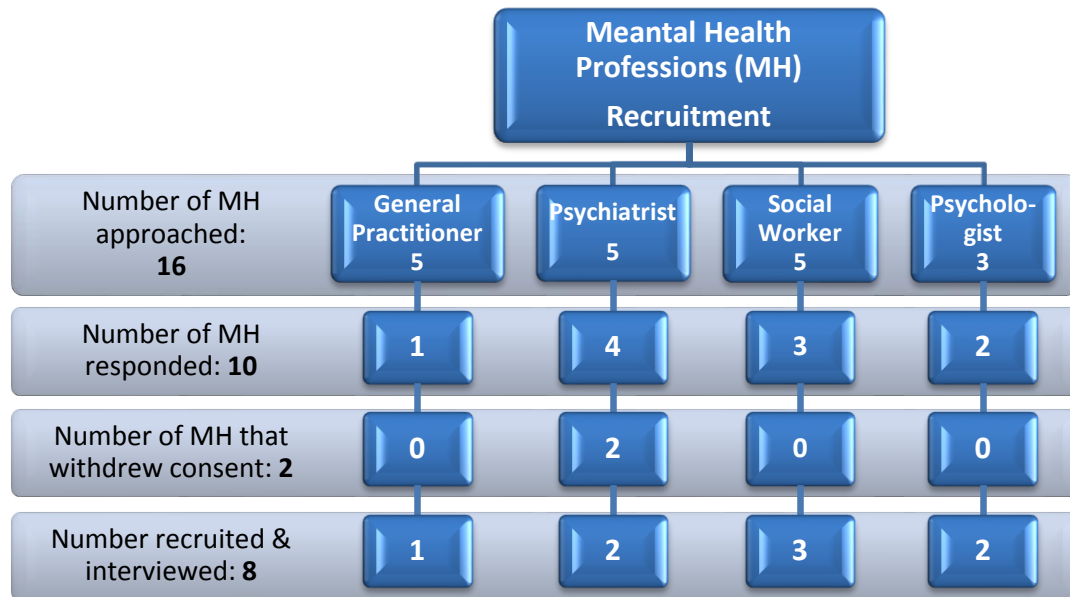
### **6.1 Introduction**

In this chapter, the focus is on the perceptions of mental health professionals and their understanding of reasons for suicide. The participants' accounts are discussed in terms of the identified stressors and challenging issues experienced by their clients and participants' interpretations of reasons for suicide in general. The latter part of the chapter analyses the treatment process followed by the participants in dealing with suicidal behaviour and preventive measures to minimise the rate and occurrence of suicide.

### **6.2 Recruitment**

A sample of 16 mental health practitioners were approached through emails and by telephone, of those 10 practitioners consented to be interviewed. Figure 6 details the recruitment process (see 3.4.2.2 on page 83 for more details on recruitment and sampling).

The participants' professional background was crucial to their interpretation of risk factors for suicide and rationale for intervention methods. Regardless of their professional differences, participants own social and cultural background became evident during the course of the interview. Table 5 shows information on participant characteristics.



**Figure 6 - Recruitment – Mental Health Professionals**

**Table 5 - Participant Characteristics – Mental Health professionals**

Code	Age	Sex	Education	Practice	Language	Place of interview
MH 1	30	M	MD Psychiatry	Psychiatrist	English	Bangalore
MH 2	31	F	MD psychiatry	Lecturer and general practitioner	English	Bangalore
MH 3	35	M	MD Psychiatry	Professor and consultant psychiatry	English	Bangalore
MH 4	43	F	PhD Psychiatry Social Work	Psychiatry Social Worker	English	Bangalore
MH 5	29	M	MSc in Clinical Psychology	Clinical psychologist	English	Madikeri
MH 6	55	M	PhD Psychology	Professor and consultant youth counsellor	English	Mysore
MH 7	35	M	MSW	Medical social worker	English	Bangalore
MH 8	54	M	PhD Psychiatric Social Work	Professor & community mental health social worker	English	Bangalore

## **6.3 Mental Health Professionals' perspectives**

The participants presented their perceptions and discussed the instances from their experiences of working with survivors of attempted suicide. Their accounts are discussed and compared across the group to unravel significant themes and evolving categories. The participants' perspectives of risk factors and intervention methods were not completely independent of their own social and cultural influences.

To facilitate analysis of the interviews, data was classified into four categories. The first category discusses four themes that emerged from cross-case analysis of the interviews. The following is a list of the categories and themes that were derived from the interview data.

- Contributory factors for attempted suicide
  - Gender and role structures within families
  - Locating values and traditions through cultural transition
  - Living with limited resources
  - Making sense of physical and mental health dynamics
- Means and Methods of attempted suicide
- Legal and ethical concerns
- Intervention and prevention methods

## **6.4 Contributory factors for attempted suicide**

The participants discussed several factors that they perceived to have affected their clients' mental wellbeing and decisions to attempt suicide. This section analyses their views on stress causing situations and dynamics of stressors presented to them by their clients. Participants' interactions with their own social and cultural

surroundings, their experiences and beliefs are recognised while analysing their interpretations of risk factors.

The Participants instantly responded with a list of reasons for suicide that replicate the data from the NCRB (National Crime Records Bureau) report (see 1.3 on page 13 for NCRB data). For instance, participant MH 4 identifies relationship issues and low scores in exams as common risk factors among student population and provides very little explanation on family problems. This example acknowledges the influences of widely known phenomenon on the way the participants perceive and interpret the contributory issues for suicide.

“Family problems, academic, students if they score less, love affairs among student population, among families interpersonal relation between husband and wife, mother in law, some of the cases might be financial problems, marital issues” (MH 4)

The following four central themes emerged through the process of comparing and contrasting participants’ accounts and analysing them.

#### **6.4.1 Gender and role structures within families**

All the participants identified that an individual’s gender and roles within a family bears influence on their behaviours and interactions with the roles that other members of the family take on. For participant MH 8 the behavioural patterns of every man and woman are instructed by culturally loaded expectations. This participant analyses this notion and expresses that it is unbecoming of a man to reveal his emotions and share his problems. This further leads to attempting

suicide, which is perceived as the only solution to the problem as described by the participant.

“being a man how can I talk about these and cry so best thing is take life, whereas for women if I do this thing cause a problem for the family or it is a shame for the family so attempt suicide” (MH 8)

The above extract is a clear example of where a man is expected never to portray a weaker image of self whilst a woman is held accountable for her every move and becomes very anxious about any shame caused to her family. Participants MH 6 and MH 8 acknowledged culturally prescribed behaviours and socially accepted norms that regulate people’s choices and outlook on life. However, participant MH 6 differed from this view and assigned this perception to the middle classes, for who, in his view, seeking better socioeconomic status has led to problems of mistrust and unfaithfulness in marriage and relationships. This perception and the following extract is a depiction of transition in cultural power where men and women of middle class are in conflict with their own cultural values as they strive to achieve a better socio-economic status in society.

“In Indian context those days wife was never a working woman but now wife is a working woman, the family status is very high, at the same time talking about social relations husband and wife how differently they interact, they have no time for each other. If they are working in same place it’s ok. Working in different areas all for better socio economic status that can cause other social problems, trust, mistrust all these lead to relationship

problems. But this is in middle class. Higher and lower economic status does not apply” (MH 6)

Understanding the context of cultural expectations based on gender forms a background to analysing the interactions of roles within families. Every participant reported issues of conflict, neglect and misunderstanding among couples, abuse, stress and lack of support as risk factors for suicide. Whilst analysing these factors in more depth, participants accounts revealed power, behavioural expectations and roles triangulated with each other giving rise to conflict and stress within families. For instance, the participant MH 2 related the differences among mother-in-law and daughter in-law relationship where the mother-in-law feels threatened by a daughter in-law that she would lose her power in the family and thus she exercises control and resists change.

“Mother in law has been ruling the family probably a decade, 2 decades and suddenly a new lady (daughter-in-law) enters and tries to impose, rules and lays her kind of restrictions or try to take away so there is some amount of friction and insecurity” (MH2)

Participant MH 5 reported instances from his experience where women are victimised into physical abuse, torture and assault by men or by the other older members of the family. This account brings to the forefront the power shared by men and other members in specific roles and positions within the families. Thus, these accounts are analysed in terms of dominant and submissive roles. According to MH 5, in a family structure male and female members occupying particular roles



share dominance and power, while women and younger members of the family generally accept submissive positions.

“I have seen physical abuse mostly male to female or family members - elders in the family” (MH 5)

The participant elaborated the idea of cultural dominance with an example where the family (mother and brother-in-law) forced the girl into marriage. Certain roles within the family structure (father, son-in-law, son, and mother-in-law) come with power through tradition and are often associated with responsibility. Most of the participants highlighted the cultural tradition of assumed roles and responsibilities that various members within a family share which is said to have assigned them with power. As in the case presented by MH 5 in the following extract, mother and brother-in-law felt responsible to get the girl married in order to secure her future.

“Her father passed away mother was managing the family and her brother-in-law was taking care of the family needs, her mother forced her to get married to another guy who was well off, they tortured her and got her married. Family abuse, in this case particularly mostly sister’s husband, uncles, mamas, they take right over the family, they have asked them to listen to them” (MH 5)

Participant MH 2 explained conflicts among couples from a perspective other than the concepts of role, power and control exercised by husband and wife. MH 2 referred to a transition in cultural values where people are becoming more individualistic and consider their happiness before the family’s interests. This

transition and growing individualism is considered to be a cause of conflict which participant (MH 2) named as 'ego clash' among couples.

“Most of them are individualistic, it's me my happiness. It is not much of sacrificing as you can see in the previous generation. This will definitely lead to ego clashes between the couple, stress levels increase, difficulty in coping” (MH 2)

Unlike MH 5 evidencing women's submissive roles, MH2 acknowledged influences of nuclear families and independence that empowers couples in their respective roles. Analysing the above extract from a different standpoint, participant MH 2 is a woman who interpreted conflicts among couples because of 'ego clashes'. This perception may be enabled by her status as a woman and a working professional, thus recognising equality of power shared by both husband and wife that might be perceived as a threat by a husband within the setting of a nuclear family.

For participant MH 4 'low tolerance' among women was the reason for conflicts among couples that leads to further distress. This is another example of a culturally dominant perception of women. The participant established links between conflicts, low frustration levels, and attempt at suicide. The analysis revealed the participant's affiliation towards culturally dominant norms disregarding the participant's own status as a woman and a psychiatric social worker. It is implicitly expressed in a few of the participants' accounts (MH 2, MH 3, MH 4, and MH 6) that their own cultural beliefs and experiences influenced their ability to empathise with their clients, which might have affected the intervention process.

“It is low frustration tolerance. The tolerance level is low. This is more among the females” (MH 4)

The interview data reveal that exercise of power and control was not limited to gender alone but also extended across generations where older adults in the family administer power and control over younger members of the family.

Participants (MH3, MH 5, and MH 8) provided evidences of such control while discussing relationship breakdown. Participants reported failure to express a love affair to parents and obtain parental consent forced individuals to break off relationships. This experience is acknowledged as a distressing factor resulting in suicide. Participants MH 5 and MH 8 elaborate that the breakdown of a love relationship may not always be linked to forced marriages. They implicitly refer to cultural pressure that a family endures while a younger member of a family is involved in a relationship without the family’s consent and approval.

A further analysis of power and control exercised by particular roles within a family structure identified relevant association to participants’ accounts of attempted suicide among children and youth. Participant MH 1 analyses distress experienced by children from a performance perspective and describes that children feel pressurised by parents, teachers and peers to achieve best results in exams, sports and other non-academic activities.

“Children don’t get a figure of parents but much more rigorous types of teachers at home. They have to see teachers in school and again at home. This happens more with the highly educated parents, less educated parents

think that we send child to tuition which might be good where child is able to recognise that their parents are real parents” (MH 1)

The above extract identifies interface among parents’ level of education, economic status and parental role that is instrumental in setting expectations for their offspring. For instance, MH 1 described the way that highly educated parents switch between their roles as parents to teachers which compelled children to be performance oriented at all times. On similar lines, MH 6 discussed how children fall victims to parents’ engagement in preserving their social status. The participant further explains that parents enrol their children to schools that run central syllabus that is comparatively tougher than the state government syllabus without recognising children’s ability to cope with the syllabus.

“When we talk about students, it is the academic reason. We have state school, central school CBSE. The suicide rate is more among the students for CBSE. As it is more tough, difficulty level is higher than the state school syllabus. If they can’t cope up with the difficulty level that is one reason (for suicide), further parents’ perception about the child, if the parents are given awareness of their child’s potentiality, if they accept it is fine, but most do not and put more pressure on children. They see from their status, family, I am an industrialist and my son must study in prestigious school, to cope with the difficulty level they are sent to tuitions so ultimately children have to take pressure from every side, pressure from parents, peer, teachers, administration, self, system, all these things for the students” (MH 6)

The participants' accounts (MH 1, MH 3, MH 4, and MH 6) reveal the standards set before children by parents compel children to take the pressure and expectation upon themselves and when they feel that they do not meet the expected standards they attempt suicide. Besides parental pressure, MH 6 reports the negative impact upon children of witnessing suicide in the family or in the neighbourhood and its influence on suicidal behaviour. As discussed earlier parents set standards for children, children also learn from their environment and adopt ways to deal with situations.

“A lady committed suicide a young boy witnessed this may be out of curiosity he also tried it now we can't stick onto the age it is how he/she perceived the situation” (MH 6)

#### **6.4.2 Locating values and traditions through cultural transition**

Participants tended to discuss cultural transition in terms of modernisation and analysed it from the point of view of Westernisation. For all the participants Western culture had a significant impact on lifestyle, modes of dress and family structures. In exploring participants' accounts of transition of extended families into nuclear families, a subtle and valid analysis of stress in the everyday life of individuals became clear. Participants perceived stress in this context to be associated with lack of support, materialistic culture and decline of traditional values.

“It is I and my family now but in earlier days we had brothers, sisters the family living together which would have given me a way out to share” (MH 6)

“The influence of the Western culture where the families are a lot of nuclear, I suppose the defragmentation of little extended or joint families. Coping with chores, taking care of family, now the urban couples, both of them are working, they have difficulties, wife needs to be at home looking after the children, chores, then as well as go to the office, the stress levels is quite high. Where as it were a little extended family, she would get some help from mother in law or sister in law anyone else to take of the child, the chores would have been distributed” (MH 2)

Participants’ reference to traditional values and changing trends in family life presented a convoluted association to Western culture. It is unclear whether this association was drawn from their perception of family structures and lifestyles in the West or if it was their reverence of the culture that they were brought up in and the values of respect, honour and selflessness learnt from the family which is perceived to be lacking among the younger generation. However, the influence of Western culture cannot be disregarded as MH 3 debated the institution of pubs, dance clubs and late night parties. The participant thus claims that it has affected society adversely.

“Unfortunately social scenario is undergoing reformation which is not a favourable one. It is becoming more Westernised” (MH 3)

Participant MH 3 further acknowledged the benefits of industrialisation and Westernisation that have reduced the impact of caste in urban areas and orientation towards economic empowerment. MH 7 and MH 3 reported issues of the suppression that people experience in rural areas due to their caste differences.

MH 7 elicits caste differences through an example; where people of lower castes are restricted to their own caste groups while celebrating festivals or offering worship to gods.

“Sometimes their caste (high or low) also plays role. In rural areas there is a division of caste. They feel they are suppressed” (MH 7)

Participant MH 8 discussed incidents of sexual harassment among ‘dalits’ low caste groups that lead to completed suicide. However, the limitations of the reporting system and the dangers of under-reporting completed suicide and attempted suicide is acknowledged to be a barrier in understanding the propensity of the problem of suicide among low caste groups.

“I don’t have much info to share. If it’s much among the dalits or persons of that nature because it is very underreported and have a larger picture. Probably it cuts across. In terms of completed suicide we have heard of sexual harassment or rape that has occurred which is predominantly among the lower caste group especially the dalit which they have never opened up and successful suicide kind of a thing” (MH 8)

The above extract implicitly refers to abuse, rape and sexual harassment experienced by members of lower caste groups being concealed for fear of stigma and negative identity, reputation and lack of support. Participant MH 6 argued that fear of stigma and status is no different to individuals from other caste and class groups.

Participants MH1 and MH 5 stated that faith in god and religious practices are declining due to what they perceive as cultural transitions i.e. to modernisation and Westernisation. Nevertheless, there are also cases where people believe that their troubles, difficulties and illness in life are a result of a curse or god's wrath.

“What we have felt is among Hindus there are so many sects and sub sects and now a day's faith in religion is coming down” (MH 1)

“Then they got married but what happened was she broke the marriage in the temple where she got married. They started telling her that her family might suffer because she has broken the marriage. It started disturbing her. That thought happened because this particular delusion she had about being cursed by god” (MH 5)

Participants perceived religious beliefs and practices to have a therapeutic impact on individuals and provide the members of the entire family with an opportunity to gather together in offering worship or celebrating festivals. Participant MH 1 makes particular reference to family gatherings during unfavourable or difficult times and organised ceremonies/worships as advised by astrologers or healers as an opportunity to support persons in distress.

“Most of them go to the astrologers whether male or female, they get together and establish some kind of harmony in the family so they say we must do it (ceremonies/worship) in this way so the entire family gets together. Among the Christian community attempts are low. Every week they all go to church for prayer, whether they are interested or not” (MH 1)



Alongside MH 1, MH 2 was of the view that a lack of community gatherings on a regular basis for worship among Hindus was regarded as one of the factors accounting for a higher suicide rate among the Hindu community in comparison with Muslim and Christian communities. Participants considered religious ethics and traditions to be instrumental in controlling incidents of suicide and attempted suicide. However, obligatory religious practices among Muslims and Christians were perceived as a form of finding comfort in distressing situations. The conduct of religious duties and worship among Hindus was presented as being more adaptable and varied across different sects and families.

“Muslims go to mosque, they have been asked to and I suppose it is the same in Christian community as well. Christians go to church where as Hindus are little more liberal. If you want, you can go to temple or else no. We don’t have anything you can attempt or don’t attempt suicide. Whereas Bible dictates, it is a sin to take away life. It is a little more I don’t say it is only factor”. (MH 2)

### **6.4.3 Living with limited financial resources**

All the participants discussed financial difficulties as one of the contributing factors for attempting suicide. Participants varied in their conceptual understanding of the ways in which financial stressors had an impact. For instance, in view of participant MH 8, economic development of a place instilled desires for more materialistic wealth among people. MH 8 further explained that materialistic culture leads people to extravagant spending habits and obtaining credits beyond their ability to pay off. This gradually amounts to unbearable pressure and then to suicide.

“As consumerism is higher these we are finding in these places Tiptur and other places specific epicentres there is specific cycle what we are looking now. The level of purchase of consumer goods is higher, level getting loan to pay another loan, not able to pay off the interest and loan, finally seizure of the material that is a shame for the family so If I die family can have a small amount and no shame” (MH 8)

In discussing the above extract participant MH8 highlighted a relation between consumerist and credit behaviours that accounted for stress. The other overlapping factors presented here are commitment towards family, safeguarding individual and family reputation. The Participant (MH 8) perceived suicide as a way of providing the family with some money (received from life insurance) which might take care of the family's needs and outstanding credits. No other participants made any association between suicide and life insurance claims.

Unlike MH 8 who rationalised that consumerist behaviour in developing towns and cities caused stress and gradually led to suicide; participant MH 6 established a connection between poverty and cultural values practiced in certain geographical locations. According to the participant, the honest and hard-working nature of people was not recognised and people were often disadvantaged due to unequal wages.

“It is not only about the family, it is the socio economic status. In South India people are poor but honest and hardworking, their work is not recognised, these (honest, hardworking) are all part of culture, if these are not recognised there is a threat” (MH 6)

Participant MH8 discussed the transition in individual lifestyle and choices alongside economic and technological growth of a town or city. On the other hand MH 6 considered a transition in cultural values alongside the struggles to overcome poverty in their (MH6, MH 8) discourse on antecedents to suicidal behaviour. Participant MH 4 provided an example where farmers obtained loans to buy better varieties of seeds and fertilisers with the hope for a better yield and income. On the contrary, when the yields failed the creditors surrounded them. Having no means to pay off their debts, farmers attempted suicide.

“Financial problems which are more among the farmers, they would have obtained the loan expecting some amount of profit which may not happen. It may not be for their day to day living but to buy seeds or fertilisers” (MH 4)

All the participants acknowledged changing lifestyle, increasing needs and insufficient income were stressful factors that contributed to suicide. Participant MH 1 recognised this pattern was common among both men and women.

“It’s not just male but also females have attempted just because they wanted to earn more money and well settle in the urban area like in Bangalore. Even the partner may not know why my wife has done this” (MH 1)

Many participants indicated that financial stress was a more dominant factor among men than women. All the participants acknowledged this disparity was because men were held responsible to provide for the entire family. In the view of the participants, although women extend help to male members of the family to earn

money, culturally it is males, who are responsible for the economic well-being of a family.

“Financial burden is mainly faced by the male who is supposed to be the heads of the family. They have a lot of burden including running the family, most are joint family, they have to contribute to that also” (MH 3)

All the participants shared a few common views on the causes of financial stressors that led to attempted suicide. The common factors mentioned are seeking a better way of life, need for financial independence, increasing materialistic culture and conflict between cultural values and desire for a better lifestyle. Participant MH 5 presented a distinguishing factor that no other participants acknowledged. The participant identified a lack of appropriate money management plans to have caused misery and financial struggles in most people’s lives. The participant elaborates it with an example of a temporary project run by an organisation that provided a financial advisory service to people in the community but the programme was gradually withdrawn due to lack of people’s cooperation.

#### **6.4.4 Making sense of physical and mental health dynamics**

Participants exhibited a range of mental health issues, coping with physical pain (head ache, stomach-ache), lack of awareness and ability to identify the early symptoms as contributing factors for suicide. Two participants (MH 1, MH 6) regarded the untreated conditions of abdomen pain, period pains and headaches to have motivated suicidal behaviour. However, for MH 6 it was not an agonizing physical condition but a perceptual and interpretive notion of pain among adolescents and women that was linked to attempting suicide.

“They refer to social and personal problems, medical issues rarely but it is mostly the pain perception, pain due to any problem, e.g. women during their monthly cycle get stomach pain. Pain may not be that severe but the perception of pain makes the adolescent age group to attempt. There are people suffering from chronic diseases, disability also attempt” (MH 6)

Participant MH 1 emphasised the lack of medical consultation and receiving no empathy from their surroundings to have affected children and adolescents specifically. The data from MH 1 and MH 6 recounts evidences that the physical presentation of pain is neglected and not dealt with immediately; absence of physical wellbeing implies that children, adolescents and women are perceived to have less power and reduced ability. These accounts highlighted the association between the experience of pain, decision to seek support and the response of the social surroundings. The analysis of these accounts indicates that suffering from physical illness on its own does not explain attempted suicide but it needs to be explored alongside the process of seeking support and social conditions.

“A case I saw child is suffering from repeated pain in the abdomen, for which they have not seen the consultant and he has attempted by consuming aluminium phosphate. Another case was an adolescent girl suffering from severe headache for which she consumed rat poison. And even peer pressure, most of the time, a child having squint child is teased, child needs correction or spectacles which child doesn't like due to this child goes into depression and this affects the performance” (MH 1)

Participants felt strongly that the survivors of suicide presented with symptoms of depression, stress, feelings of worthlessness and helplessness. The basic argument evidenced in all the accounts was a lack of awareness about mental health issues among the general public and medical practitioners. This opinion was elaborated further with presentation of psychosocial perceptions such as shifting blame to the external surroundings (MH 8) and coping mechanisms (MH 5, MH 6).

Participants MH 5 and MH 8 identified that people do not recognise the feelings of worthlessness, severe stress, feeling low - depressed and disinterested as mental health concerns that require intervention. Rather 'blame outer world' (MH 8) and continue to suffer for years which ultimately manifests as attempted suicide. For MH 1, it was lack of problem solving skills among people that compels one to think 'suicide as the only solution to all the problems'. While addressing coping mechanisms, MH 5 and MH 6 referred to dependence on alcohol as a strategy used by men to deal with problems. On the other hand, alcohol dependence is also presented as a reason for conflict, misunderstanding, financial hardships and violence in relationships and within family.

"When it is not accepted, the culture is stopping me from all this, but I take alcohol to feel free" (MH 6)

"It is under the influence of alcohol, or substance abuse, relationship problems in between- husband and wife, father and son, mother and family, constant nagging of parents or wife, may be beaten up the child" (MH 5)

MH 5 reports that people in urban areas have a better understanding of when to seek mental health assistance than people in towns or villages, where they understand mental health in terms of absence of mental retardation and madness.

“But most of them are not aware of the problems. People not aware of mental health related problems. In general, people end up going to physician that’s how few cases have been recognised. In cities people are aware when to approach help but not in B towns, taluks or villages people only know mental retardation and madness not beyond” (MH 5)

The issue of mental health awareness is presented as a concern both among the general public and medical staff. MH 2 detects this situation in general hospital settings where people do not recognise ‘lack of appetite, sleep, interest and disengagement in activities is due to depression’ (MH 2) and instead seek medical advice for ‘bodily symptoms’. The medical staff are less equipped with mental health training which limits their ability to identify mental health concerns.

“They are undiagnosed; they would have visiting a physician or surgeon for various other complaints, bodily symptoms. There is a lot of ignorance about mental health, not only among the lay people but also among the other medical field also has medical ignorance” (MH 2)

MH 1 argues ignorance among medical staff from a different perspective where he acknowledges the busy work schedule, limited time, lack of mental health professionals, and for student doctors, lack of appropriate training and practice hours in the psychiatric department during their training period. The participant further identified a link between lack of private consultation rooms in general

hospitals and patients' inability to confide in doctors which limits their diagnosis and plans for interventions.

“One thing I can say is they might either be very busy practitioners or may not have given a time period, or not interviewed in depth or maintained confidentiality they will not be able to recognise” (MH 1)

The above discussion and analysis draws attention towards participants' status as mental health professionals that enable them to perceive ignorance and lack of awareness of mental health (depression, anxiety, stress) crisis as contributory factors. The significant finding in this section is that participants recognise the psychosocial aspects from the survivors' point of view alongside their own perceptions as mental health professionals in analysing the risk factors for suicide.

## **6.5 Means and methods of attempted suicide**

All the participants recorded the use of Organophosphate poisoning, drug overdose, consumption of poison with alcohol, toilet cleaning liquids, hanging and burns as common methods of attempted suicide among survivors who were treated in hospitals. The form of poisoning reported by the participants coincided with accessibility. MH 1 made a clear statement to this effect. The participant further referred to the common notion among people that consumption of poison with alcohol increases how lethal it is.

“Most common is OP compound poisoning, insecticides, pesticides, which are easily available” “Patients usually mix alcohol and poison they feel severity will be more there will be high lethality” (MH 1)



While analysing the use of various methods such as drug over dose, cleaning liquids and acids, hanging and burns; MH 3 recognised a connection between specific methods and age and gender groups. Drug overdose described in all the participants' accounts involved consumption of tablets (psychotic drugs, sleeping pills) prescribed to self or other members of the family or those easily available (paracetamol) over the counter.

“Students drug overdose, agriculturist OP poisoning, house wives medication (drug) overdose, OP poisoning, whichever they get over the counter or any of their family member would be taking” (MH 3)

For MH 6, drug overdoses, drinking acids and cleaning liquids were methods employed in the urban areas and he referred to these as 'soft methods'. The participant recalled that incidents of self-inflicted burns and jumping into a well/lake/river are common to rural locations as kerosene is easily available for purposes of cooking in semi urban and rural areas. MH 6 referred to more incidents of burns using kerosene among women in South India, as women intend to threaten those who torture them and as an expression of revenge on those who perpetrate violence and abuse. Further elaborating on incidents of burns or hanging in urban areas, participants mention the possibility of homicide presented as suicide.

“In South Indian context it is kerosene that is used often or hanging. Women take up kerosene with the intention let the person whomever they want to take revenge on let him see me suffering and kill myself or taking revenge against him. If at all you have come across in urban areas it is actually homicide people convert it to suicide” (MH 6)

Participants MH 1 and MH 8 report low survival rates among people who hang themselves or burn or jump before trains. The participants' accounts do not elaborate the reasons for variations in chosen methods of suicide however, they acknowledge the relevance of accessibility, urban-rural locations, gender and age groups. The identified methods by participants appreciate the need for deeper analysis of intentions and the revelation of possible homicide. There was very limited evidence of homicide converted to completed suicide in participants' accounts.

## **6.6 Legal and ethical concerns**

Participants discussed law in terms of reporting and recording cases of attempted and completed suicide that were admitted to hospital. MH 1 and MH 6 explain that medical officers in a casualty department are under legal obligations to report cases of attempted and completed suicide to the police stationed on hospital duty.

“The cases first get recorded in the casualty records, police come and take the patient's statement which will be recorded and not be given to doctors or patient or family. The doctor's file will not be given to police or family unless and until it is must” (MH 1)

All the participants shared a common understanding of the procedure implemented by the hospital and police in the process of recording suicide. Police generally approach survivors and family members of persons with completed suicide to obtain a statement of an attempt or death. However, MH 7 revealed a novel way of dealing with the unsympathetic legal system, where medical officers consult survivors or the family of persons with completed suicide and then report to the

police. This process is acknowledged to have made people aware of the legal nature of suicide and how they might wish to alter their story when they provide the police with the statement of an attempt or death.

“The family is afraid of the social stigma. So family doesn’t want to reveal”

“If death is due to suicide we handover the body to the family so they do the rest of the procedures. In case of attempted suicide they don’t reveal neither do we. Only if someone has filed any case then the police come and so they have to face the consequences. I have not had any legal case here. Working in MIC (Medical Intensive Care) counselling, one case was brought burnt so the police were involved” (MH 7)

MH 8 recognised that people rush cases of attempted suicide into hospital with an intention to save life and thus not being aware of legal issues attached. The participant claimed that people become aware at the point of registering the details in the hospital records. The fear of social stigma and legal proceedings as expressed by all the participants, prompt misrepresentation of an event as an accident or a medical condition rather than an attempt to suicide.

“When they reach the hospital and it has to be registered predominantly there is a larger role, where they have been educated by the local people and say this was not deliberate of self poisoning but was more of accident. The end of the day it gets registered as an accident so that they are out of the clutches. If you go and approach the care taker of mortuary he will be able to give you better data but the medical certificate will say it is due to some medical phenomena.”

In connection with completed suicides, MH 6 presented a varying opinion where medical officers feel obliged to reconsider the cause of death, as it would have implications for the family in receiving financial benefits. The participant explained this with an example where one of his neighbours committed suicide with an intention that his family would be able to secure enough money for their survival and to marry their daughters from the indemnity funds.

The underlining theme marked successively in all the interviews is that the law fails to empathise with survivors and grieving families. Participants conveyed that police, medical officers, survivors and family members find their own way of dealing with the unsympathetic legal system. Participants acknowledged that the ethical obligations towards their patients are primarily to maintain confidentiality, to ensure safety and provide the best of care. In times where participants hear events of abuse, violence and harassment from their patients, they referred such cases to family counselling centres operated by nongovernmental organisations.

## **6.7 Intervention and prevention methods**

A large number of participants' accounts revealed a hierarchy of intervention methods employed in treating cases of attempted suicide in hospitals. This is discussed in the initial parts of this section. Four key aspects received emphasis during the analysis of participants' accounts on prevention of suicide. Participants viewed creating awareness, community based intervention, use of media and reducing the 'mental health gap' as crucial to preventing attempted suicide.

There was a genuine acceptance of the hierarchical system of practice by all the participants despite the differences in their profession as psychiatrists,

psychologists and social workers. The stages in treatment as detailed by the participants are, medical management and referral to a psychiatric unit prior to discharge from hospital. MH 2 reports that the lack of mental health professionals limits their ability to function effectively and psychiatrists rely on prescribing medicines as the quickest way to deal with cases. However making reference to a particular hospital in Bangalore, MH 2 explained that clients receive a one to one level of care by the mental health team. It was obvious from other participants' accounts (MH 1, MH 5, MH 6) that not all the hospitals were equipped with a mental health team that would consist psychologists, psychiatric social workers, psychiatric nurses and psychiatrist.

“Medical management, emergency management they handle the patient. Once the medical condition is stable, it is been referred to us. Later on we evaluate, if they require any medication especially anti-depressant for preventing impulsiveness also, if it is not depression empirically we start on SSRI (antidepressant) to prevent any further attempt. If I identify any particular issue, we do address those, try to solve the differences. We do give couple therapy. It is not done extensively as in other institutes. Because it is only psychiatrist and we don't have psychologist or psychiatric social worker here” (MH 2)

Alongside medical management, participants reported the use of therapies such as cognitive behaviour therapy (CBT), reality therapy, couple therapy and rational emotive behaviour therapy (REBT) as forms of addressing psychological concerns. For participant MH 5 the success of therapies depended on the client's belief

system and level of follow up. He stated people believe more in medication rather than therapies and thus this participant claimed even vitamin pills produce a therapeutic impact.

“Initially they come with a conviction they go back with the same conviction I am getting healed, over a point of time, the psychological healing takes time, this time factor may sometime let them loose hope. They say give some tablets” (MH 5)

Participant MH 7 added a sociological perspective to treating suicidal behaviour where he relates the importance of addressing emotional, financial and family issues to minimise the risk of suicide. He further argues that with the help of psychosocial interventions people are able to relocate themselves into mainstream society. In addition to psychosocial interventions, MH 8 stated the need for ‘community based interventions’ (MH 8) with the state assuming active responsibility.

“We deal with emotional and family issues, emotional support, financial support. We have a regular follow up maybe once a month or once in two months. If they don’t we send our field workers to visit or tell them to see us when they come for medical follow up. We see that they get rehabilitated into main stream of life. That is very important. When they say financial burden, we help them in finding jobs. So we mobilise jobs for the needy” (MH 7)

The most common treatment method evidenced in participants’ accounts is medical management. Not all the cases go through psychiatric consultations (MH 1) due to

lack of beds, time and mental health professionals. The discussion presented above is an analysis of participants' citations of their experience in different hospitals. This brings an understanding that not all the hospitals are well equipped with professionals and thus vary in level of care and intervention methods.

The analysis of participants' dialogue on the prevention of suicide identified a gap in mental health literacy among medical professionals and the general public. The ignorance identified among medical professionals is linked to their failure to identify the early symptoms of depression, anxiety or other mental health concerns. MH 1 stated explicitly this need in the following extract and is supported by participant MH 2 who reported that medical practitioners concentrate only on the bodily complaints (stomach-ache/ head-ache etc.) rather than enquire into the cause, triggers or mood/feeling. These are factors, which MH 2 analysed as essential to early detection of mental health concerns.

“Because we need to create awareness in our fraternity, then we can identify and treat at early stage. That is one service that is going on through tertiary centres” (MH 1)

In contrast to the above analysis, MH 5 discussed that people approach physicians in the first instance whether it is for physical ailments or mental health concerns. Physicians thus refer cases to psychiatrists. MH 5 acknowledged that referrals established in this way do not always comply with follow up as the clients do not feel comfortable to speak openly about their life events to a counsellor or a practitioner. The participant further justified that people believe in medication rather than therapy. In addition, MH 6 provided a valid reason for discontinuity in

treatment as people approaching psychiatric services or attending counselling sessions feel rejected by the family and society. Both the participants (MH 5, MH 6) differed in their accounts in describing the conditions in urban locations, for MH 5 people felt reasonable to approach mental health services and were aware of mental health needs.

“They are worried about the status, if I go to the psychiatrist or to counselling I am rejected from the society, not only my family but also people around me. With all these problems why I want to tell the society I have a problem. That is preventing definitely the problem increases” (MH 6)

All the participants extended respect towards the various methods people implement in dealing with the challenges of life whether in relationships, the family or concerning health and welfare. Participants indicated that people approach multiple services such as medical, religious and traditional healing systems. The participants’ accounts revealed that the belief system people share affected their decision-making and problem-solving ability.

“They go to a doctor, temple and perform some kind of rituals too so they get washed away from those kind of problems which they have. This is usually performed by a faith healer or a priest” (MH 2)

For participants MH 4 and MH 5, people shared a dynamic belief system and expressed a readiness to try any method that would prove beneficial. As perceived by the participants this meant people approached temples, prayed to gods, offered sacrifices and worship, followed rituals, carried out the instructions given by healers and simultaneously approached medical services as well.



“They would have gone to the healers sometimes what they do is they have been going there for years and that not found any improvement then come here. When they come for the first time but most of them go back to the healers. They have gone to the temples, been asked to do some poojas, the moment they would have felt the patient is better but later they feel they need medical support” (MH 4)

MH 1 recollected the various types of cases including those of attempted suicide and possession referred to hospital by the healers. MH 3 testifies that most of his clients/patients approached religious and healing methods as a first resort because their faith in religious methods is much stronger. This participant stated that “faith healing works for cases of possession” (MH 3). Participants MH 1 and MH 3 treated religious and traditional healing practices as therapeutic while, the analysis revealed that their own beliefs and religious backgrounds influenced this perception.

For MH 6 and MH 8 religious methods formed an essential part of holistic intervention processes in addressing mental health concerns. Participants’ attention was more towards supporting their clients to achieve a better health condition. However, both the participants expressed little agreement with certain rituals practiced by the healers. For example, MH 8 condemned rituals such as plucking blocks of hair, exorcism and any forms of physical assault or those procedures that violate human rights. According to MH 8, there is a need to guide people out of their current unhealthy belief system that impacts their safety and worsens the health conditions especially of those vulnerable in society. Thus for

this participant reducing a gap between the process of creating awareness of mental health problems and seeking medical help was a current identified need.

“We are flexible if these kind of things can solve the problem of the client why not accept it. But not in all circumstances” (MH 6)

“In this sort of practice, they are finding the soothing effect and other practices should not be coming on the way; except we should not allow practices such as exorcism and other things because that threatens the basic rights of a particular person who is having distress. Beating, whipping, cutting of the hair, pulling the block of hair and nailing it to a tree these are few practices that we need to be against. These are a sort of belief system we need to work a lot with it instead of asking them to be away from it” (MH 8)

## **6.8 Conclusion**

This chapter explored the perceptions of mental health professionals with regard to risk factors for attempted suicide, means of attempted suicide, legal aspects and intervention methods used in treating and preventing attempted suicide. The core themes discussed under risk factors communicate the stressors in terms of gender and role structures within families, cultural transition, financial challenges and health concerns. These themes are concerned with challenges and conflicts that people experienced while carrying out their roles and responsibilities within the family and in an effort to match expectations in society. The theme on means and methods of attempted suicide was highly representative of accessible means although there were differences in methods used by specific gender (housewives-

kerosene – burn) and age group (student - drug overdose). The data evidenced the use of accessible means rather than well planned means to attempt suicide. As members of health care units, professionals acknowledged their legal responsibility to report cases of attempted suicide. However, the professionals found their own ways of dealing with the legal issues, in certain cases professionals obtained consent from the survivors or survivors' family before reporting a case to the police.

All the participants indicated that medical intervention was a more prominent method of dealing with attempted suicide, followed by psychosocial intervention methods limited to urban and semi urban areas. Participants reported a greater recognition of faith in religious and traditional healing systems among the general public alongside their (people's) faith in medication. Participants argued that the awareness regarding mental health problems influenced help-seeking behaviours. Participants analysed the success of psychosocial intervention methods with people's perceptions; where people considered biomedical (receiving tablets/tonics) methods as more effective than psychosocial interventions. The analysis of participants' accounts revealed that their own cultural background influenced the way they understood the risk factors, empathised with their clients and treated them.

These themes are associated with other themes and categories discussed in the findings chapters of Survivors and Traditional Healer groups. The categories of risk factors, means and methods of attempted suicide, legal aspects and intervention and prevention of attempted suicide run through the previous chapters which will

be analysed more in depth with the help of Bourdieu's concepts and for the development of a conceptual model of culture and suicide in the next chapter.

## **7 Discussion**

### **7.1 Introduction**

This chapter brings together a substantive discussion of the themes that emerged from the data and analyses the data from the perspectives of Bourdieu's conceptual framework. This conceptual framework supports an emerging model for the role and operation that culture plays in influencing those who attempt suicide in the specific context of South India.

### **7.2 Understanding conceptual categories through Bourdieu**

Chapters 4, 5 and 6 have presented findings in relation to the categories and themes that emerged from the data analysis. The following will use the same conceptual categories as a framework, which is underpinned by the work of Bourdieu, for the development of a model. This addresses the key concern of this thesis: what are the implications of culture for attempted suicide in South India?

The six conceptual categories are:

- Structuring roles and gender identities within family
- Coming to terms with limited resources
- Interpreting physical and mental health concerns
- Accessibility of means in the context of a socio-cultural field
- The socio-cultural effects of the Indian Penal Code – Section 309
- A balanced choice of contemporary medicine and traditional practice

Each topic is examined in turn with respect to Bourdieu's concepts of habitus, doxa, symbolic power and violence (Bourdieu, 1999; Bourdieu and Coleman, 1991; Jenkins, 1992; Grenfell, 2008). These are also used as tools to comprehensively understand and examine the cultural dynamics that motivate suicidal behaviour.

### **7.2.1 Structuring roles and gender identities within family**

Roles and gender identities understood as power entities, served to explain conflicts, distress and suicidal behaviour as encountered by survivors and recounted by healers and mental health professionals. Gender roles were found to be recurring themes in the discussion of stressors by all three groups of participants. However participants failed to recognise gender roles as a powerful factor which actually determined behaviours, dispositions and habitus (Bourdieu, 1999). For instance, survivors talked about their roles as a wife, husband, son or daughter in a family but they did not explicitly suggest that the roles influenced suicidal behaviour. Nevertheless, the dominant discourse on gender roles reaffirmed participants' reluctance to recognise the governing power of cultural practices.

Traditional healers recognised pressures experienced by individuals, such as; being a wife, husband, son, daughter, or a parent in particular situations and they then explained suicidal behaviour in connection with these pressures. However, they overlooked the underlying cultural meanings that explained what it meant to be a wife or son or husband in those situations, which in turn created a link to suicidal behaviour. For instance, when healers discussed conflicts within families, they drew attention to factors such as social setting, expectations, responsibility, power and authority associated with roles within the family. On the other hand, they failed to

perceive the cultural pressure that individuals battled on a daily basis in order to preserve and re-emphasise positive identity and image (Bourdieu and Coleman, 1991). The participants (S, TH, MH) addressed the relevance of gender and role as issues in explaining suicidal behaviour but they failed to notice their significance. In establishing a relationship between gender roles and suicidal behaviour, they disregarded contextual and perceptual meanings of cultural capital that explained this relationship.

#### **7.2.1.1 Role expectations and interacting capital**

The practices, traditions and values within families, communities and societies are influenced by cultural capital, and as such bear the power to modify roles and family structure. Thus roles are not a fixed entity, they are in fact highly contextual. The findings revealed that cultural and social expectations are linked to specific roles in particular contexts, created pressures that led to suicidal behaviour. As a small proportion of mental health professionals recognised, it is the distressing nature of the cultural expectations of being a wife, husband, father, daughter or mother that creates pressure on an individual to demonstrate a particular behaviour within their role or roles. They further identified a link between achieving these expectations and obtaining better social recognition, respectability and inclusion into social groups. This example illustrates an interaction between cultural expectations of roles and those which cultural capital would enable an individual to achieve within society. The pressure to fulfil the cultural expectations of a role correlates with a pressure to achieve social capital (social recognition, networks) as it creates access or barriers to achieving perceived social positions (Bourdieu, 1999). This correlation became evident when participants (survivors, TH

and MH) discussed the cultural connotation of economic independence for a man as being associated with his manliness and a means to achieve social esteem and recognition. The pressure of cultural and social expectations experienced within specific roles is relevant and significant in understanding distress and suicidal behaviour which can be associated to gender roles.

Survivors' habitus within the field of family and society was noticed to be influenced by cultural practices bearing a heavy burden of expectations upon gender roles. Most of the survivors internalised cultural expectations of roles. Goffman thinks about human actions as fundamentally social in nature with a tendency to present objectified versions of meanings and offer idealised behaviours, actions and representation learnt through social interaction (Goffman, 2000; Alford, 1993). The process of internalisation and social interaction altered survivors' perceptions of cultural norms and capital alongside their experiences over a period of time. In the case of a woman survivor, she internalised the cultural expectations towards bearing a son as normal practice. Her perception of cultural norms and acceptability of wider gender role expectations changed over time with her continued experience of having daughters, physical-mental torture and the responsibility towards fulfilling the everyday needs of her family. The characteristics and behavioural patterns of survivors represented a habitus that was governed by practices, perceptions and experiences. The cultural capital of gender roles held power to influence individuals' habitus, as illustrated in the above example. For women survivors, it was the experiences and perceptions of suppressing power and violence that was responsible for them adopting a negative habitus and was a factor in pushing them towards suicidal behaviour.



### **7.2.1.2 Cultural capital and power associated to age and gender roles**

Paradoxically, participants' (Survivors, TH and MH) accounts of stressors directly addressed the issue of power assumed by gender roles, however they failed to acknowledge the structuring nature of cultural capital and power in causing conflict, stress and further leading to suicidal habitus. For example, most survivors experienced stress and internal conflicts because of cultural expectations towards their multiple roles as a husband, wife, parent and son or daughter. The interplay of power in exercising each role was dynamic and was influenced by cultural practices and social norms. Role boundaries (as a wife, husband, mother, daughter/son) and power that are based on practices, gender and what is happening in the field of family, co-existed; this was challenging for survivor participants. This illustrates the association of suicidal behaviour to 'field'. The interactions among roles and gender within the field of family revived practices and consequently created boundaries that were unmanageable.

The findings revealed that gender and age were instrumental in determining who held power in the family. However, cultural capital (practices, norms, traditions) opened up margins for manoeuvring field (family, community, society) and agency (status-educated, employed) that could be used to redistribute power according to assigned cultural roles. As Bourdieu (Bourdieu, 1999, pp. 123-129) explains "power over social or physical space/field comes from possessing various kinds of capital, takes the form in appropriated physical space." For instance, despite being educated and employed, female survivors translated their social position as a wife and daughter in-law into being subjects of social and cultural domination, which in turn left them with less power. However, there is a dichotomy where the position

of mother in-law is in spatial opposition and is substantiated with cultural domination and power. These oppositions are asserted in a social space of family with symbolic distinctions of cultural capital assigning power.

### **7.2.1.3 Resilient habitus**

The broken threshold of resilience to violence and torture within family and relationships is manifested in ways of attempted suicide. The complex interactions among the cultural capital of practices within fields of family and society forced women survivors to accept and live culturally portrayed characteristics as bearers of pain and shame in an attempt to preserve family reputation and keep the family united. For example, women survivors explained the cultural prescriptions for a perfect wife, mother, daughter and daughter in-law, which compelled them to suffer in silence and these prescriptions provided with limited access for support. Individuals in their respective roles within the structure of family shared doxa (cultural beliefs) which encouraged them to accept norms, behavioural patterns and socially set expectations (prescriptions, norms, practices) as they ought to be the way they are (Jenkins, 1992; Jenkins, 2002) even if it meant accepting symbolic and physical violence. This resulted in husbands and in-laws sharing habitus empowered by doxa to keep their wife/daughter in-law under close surveillance, restrict her movements and in a few cases even compelled to resign from jobs and become a homemaker. Women took on culturally prescribed responsibility to preserve family reputation resulting from internalised cultural pressure that coerced them to accept violence and to persevere in consideration of the greater good of the family. The gravity of situations that forced them to bear violence and suffer in silence is ideologically upheld as a reward.

Male and female participants (survivors) who accepted 'doxa' (dominant practices, traditions, beliefs) as a way of life or even questioned 'doxa' offered a certain degree of what might be termed as 'resilient habitus' (supple and strong disposition) to conflicts within the family. Resilient habitus is a term coined to explain resilience as a way of life and a way of death. Resilience is a way of life for individuals who have no other way of being able to behave, exist and live except within the mode of being resilient to familial and cultural practices, doxa or difficult situations. Having to be resilient becomes the only way of existence therefore it becomes habitus. Resilience as a way of death explains failure to accept and cope with practices, doxa and difficult situations, which in turn become deciding factors in attempting suicide. The modification in individuals' perceptions, dispositions, thoughts and decisions restructured the resilient habitus from being a way of life, to being a way of death. The cultural power of doxa guided women survivors to accept violence as a way of life and a means to safeguard family interests; thus developing resilience to the negative effects of doxaic beliefs, practices and cultural power. However, survivors' dispositions were constantly being reformed due to the interactions amongst various forms of capital, internalisation, cultural pressure, effects of doxa and transforming perceptions. Few survivors who experienced a transformation in perceptions and dispositions no longer accepted violence and abuse as a way of life. They presented another form of resilient habitus where they reported their case to the police, but experiencing no justice from this course of action nor any changes in their situation they resorted to suicide.

#### **7.2.1.4 Doxaic pressure and habitus**

The deep association between doxa, experiences of doxaic pressure and the impact upon individuals' habitus lies in understanding the conflict between the process of internalising the doxa and resilient habitus, which is instrumental in explaining suicidal behaviour. There is a double blind to this association as survivors discussed their habitus based on their experiences; healers and MH professionals discussed their perceptions from a position of doxa, i.e. they were themselves co-producers of the doxa to which the survivors were responding through their support of normative cultural and gender practices. Regardless of this variation, the influences of doxa and capital experienced by participants at all levels/roles revealed doxaic pressure to appreciate and adopt social practices, traditions and standards. The effects of such pressure operate within a social setting influencing perceptions and generating judgmental attitudes towards individuals who fail to abide by the social norms. Bourdieu overlooks the operational status of prejudice within society that influences perceptions and functions of individuals due to his engagement in explaining "practice as strategic action and everyone is capable of improvisation" (Fowler, 1997; Fowler, 1999, p 3). As in the case of women, children and young adults, their disposition towards time and space was shaped as a result of interactions between cultural beliefs, agency and without any exclusions of fear and anxiety towards prejudices within a society. No account of the dispositions and practices discussed by participants (survivors, TH and MH) are coherent unless it explains the affinity to cultural capital of roles, gender and prejudices practiced within a society.

The disappointment of failing to maintain social characteristics was exasperating for individuals in defending their position/role in social space. This leaves them with nowhere to go and they approach suicide as an escape. This is particularly true of men where their personal suffering was augmented by failing to fulfil role expectations (e.g. provide for the economic needs of the family), accepting transition of power, lacking in authority and coping with relationship breakdown. Under the influence of cultural capital, that which regulated behaviour and dispositions, forced them to hide despair and to present a strong, powerful image of oneself. They were forced into isolation, depression or resorted to alcohol which in turn heightened the likelihood of violence and conflicts. This interpretation of the significance of doxa was not one perceived by healers or mental health professionals whom were more likely to conceptualise distress as a consequence of the interaction between an individual and the modernised-Westernised cultural environment. The healers and professionals failed to appreciate the significance of distressed habitus leading to alcoholism, violence and attempted suicide as a system of transposable dispositions generated by Westernisation or modernisation (see 5.4.6 on page 170 and 6.4.2 on page 204 for information on healers and professionals perspectives of material wealth, westernisation and suicidal behaviour).

#### **7.2.1.5 Dialectical roles**

Cultural capital enforces beliefs regarding role functions and the ways in which culture prescribes them (Knorr-Cetina and Victor, 1981). Bourdieu attempted to specify order and social constraints as a production of indirect cultural mechanisms (Jenkins, 1992). The force of indirect cultural mechanisms that are perceived as

legitimate are instrumental in explaining conflict and contradiction of the dialectical roles held by women survivors. This pressurised them to prove themselves both as a perfect wife-homemaker and a working woman. Cultural capital imposed a force to legitimise power and systematise practices as evidenced in the participants' (survivors, TH and MH) accounts. The findings showed how women, forced beyond their capacity for resilience in the face of the conflicts and contradictions they experienced in their roles, resorted to suicide as a breakaway from the web of cultural burden, force and power. This is illustrated through the experiences of women survivors who were bound by their role as wife to be obedient and perfect homemakers; whilst at the same time they held an obligation to support their husband even if it meant financially they were forced to take up paid employment. These participants were pulled apart by two extremities of roles as homemakers and as working women whilst both were seen as fulfilling their duty as a good wife. Their struggle lies in experiencing constant pressure to prove themselves as perfect wives and yet be subjected to criticisms, physical-symbolic violence and classified as morally deviant and characterless amidst their attempt to make sense of role extremities.

The findings acknowledged multi-layered functions of responsibilities shouldered by adults in a parental role that explained a continuum of power, control, pressure, anxiety and difficulties while attempting to synchronise with social fields for success, excellence, career and family. This process was quite evident in participants' (survivors, TH and MH) accounts of younger generations. It was clear that children and young adults experienced disruption in the process of achieving socially and family projected characteristics for excellence, success in exams, career

and obtaining consent/obedience in choosing a life partner. The pressure to achieve any or all of these would lead them to suicidal habitus. The findings reveal the coexistence of cultural capital, field and habitus (“structuring and structured”) in the lives of parents who exhibit these influences and instil them in the younger generation (their offspring) by exercising cultural and symbolic power. This explains how children and young adults are forced to adopt and adapt to redefined forms of capital, field and habitus as a result of parents’ attempts to keep up with the changes in social structures. As aptly identified by participants (TH and MH) most parents in urban locations engage in paid employment with a desire to achieve better economic capital, fulfil materialistic needs and be able to identify themselves and the family in higher forms of social capital. Healers and professionals interpreted the consequences of parents’ limited availability of time and lack of emotional and psychological support to have resulted in children/young adults being more and more influenced by factors external to the family such as the media. This in turn has altered their dispositions/habitus towards accepting alcoholism, drugs and anti-social behaviours as a way of coping with their difficulties.

#### **7.2.1.6 Gender identity**

The gender identity of men being men, and women being women, within the boundaries of cultural prescriptions, laid a heavy burden of morality upon women survivors, whilst at the same time men were reported to have the cultural power to regulate or deregulate female behaviour. The social standards which attach morality to a woman’s conduct and behaviour are a result of cultural capital however they are questioned through the process of ongoing interactions among

the agency (education, financial independence, career- woman) and social setting/field. Skegg's concept of 'frameworks of representations and values' is appropriate in understanding women (survivors, TH & MH) participants in this study. These women materialised cultural capital, power and practices, which in turn produced structures (in combination with agency, social, cultural and economic capital) to recognise a woman as a mother, daughter, professional, wife and daughter in-law with her own identity and set of values. It is these frameworks that establish what it is to be a woman and not just a woman with "cultural baggage" as described by Skeggs (1997).

The evidence of social and cultural domination is exposed through the accounts of some of the healers who were under the influence of doxa. They for example, perceived women during menstruation as inauspicious, affected by a bad omen, emotional, weak and prone to suicidal thoughts (see 5.4.2 on page 161). In this way healers were involved in what Spivak (1988) calls ideological reproduction through the misreading of Holy (Hindu) Scriptures that legitimised their perception of women as sexually 'subaltern' subjects, inauspicious and prone to effects of bad omens. However, some healers also recognised physical and emotional frailty during menstruation and its relevance to suicidal behaviour. Although healers' perceptions were dominated by cultural and religious capital they recognised physical and mental health conditions from biomedical perspectives as well.

On the other side of the debate of women's identity are the women survivors' experiences of premarital relationships, physical and symbolic violence expressed in terms of fear, resentment, humiliation, perceived loss of power and being treated



as an object of pleasure. In this context women survivors attempted to persuade men to marry them with the aim of preserving honour, cultural capital and re-establishing themselves within a social field. However, failure to achieve the desired outcome resulted in adopting a suicidal habitus. Attempted suicide, in this case, is used not only as a means of persuasion but as a measure to safeguard and politicise a woman's identity and rights in order to influence their movement through social space. The act of attempting suicide to politicise woman's identity and rights is a way of demonstrating symbolic capital.

Framing gender identity for men is interpreted in terms of masculinity through the symbolisms of cultural institutions and practices that define power, authority, independence and sexuality. Cultural representation of masculinity was an important aspect in the lives of male survivors. They expressed distress on being unemployed, having to wait upon parents for consent, lack of power and not being able to control their environment as a sign of diminishing social positioning which led to them perceiving themselves as 'being a loser, failure, loner'. Skeggs points out that there is a 'reflexive relationship between identities and social positioning' (Skeggs, 1997). The above example supports this relationship between identity and social positioning nevertheless it elaborates gender identities as essential forms of capital in a social field. Butler recognises "being a man and being a woman are internally unstable affairs. They are set with ambivalence precisely because there is a cost in every identification, the loss of some other set of identifications, the forcible approximation of a norm one never chooses, a norm that chooses us but which we occupy, reverse, re-signify to the extent that the norm fails to determine us completely" (Butler, 1993, p 126). The enforcing nature of doxa, cultural

prescriptions for behaviours, appearance, dressing based on gender was particularly distressing for a survivor who was transgender. Society failed to empathise with the survivor and exercised symbolic violence by excluding him from respectable social positioning, limiting opportunities for career advances and making it impossible to engage in a relationship. This was distressing for the survivor who struggled to understand and accept the doxaic norms, symbolic power and the harassment sanctioned by cultural power.

#### **7.2.1.7 Summary**

This section has examined the power of cultural capital and doxa in redefining the cultural positioning and gender identities of individuals. It is crucial to recognise the symbolic power and violence as experienced by survivors in order to understand suicidal habitus. Constant restructuring of field had relative impacts upon social, economic and cultural capital modifying individuals' habitus. Individuals developed resilience to doxaic norms, practices and symbolic violence and accepted them as a way of life presenting with resilient habitus. However when they failed to accept and questioned doxa, they adopted suicidal habitus as a means to overcome difficulties. The data identified the negative impact of socio-cultural power that affected social, emotional, physical and mental wellbeing; manifested through habitus characterised by violent, depressed and even suicidal dispositions.

#### **7.2.2 Coming to terms with limited resources**

The focus on financial hardships is ambiguous and yet inseparable in explaining its boundaries attached to distress, negative dispositions and suicidal behaviour. The forms of economic capital are relative to social, cultural and political capital

(Grenfell, 2008). In the context of this study, survivors derived cultural and social power from financial stability. However when economic capital was threatened it reflected adversely upon their cultural and social capital and thus influenced them to adopt suicidal behaviour.

Healers and MH professionals identified the impact of modernity as significant and Western culture has constantly been restructuring contemporary Indian society. The findings from these two groups revealed that changes in the contemporary society redefined individuals' perceptions of social, cultural and economic capital. The perceptual changes attached new meanings and power to various forms of capital within the field of family, community and society that made them vulnerable to strive towards achieving newer forms of capital. As identified by healers and professionals, increased desire for materialistic needs have led to credit-seeking behaviours, stress, disharmony and violence in the family. The desire to accomplish improved standards of living explained violence among couples, parents in-law and daughters-in-law from the point of view of the Healers and MH professionals. The social and cultural pressures towards obtaining materialistic goals, (jewelry, latest consumer electronics), exchanging gifts of great value in marriage, academic achievements, securing a well-paid job and career progression goals have led individuals to internalise these pressures in order to achieve power. On the other hand, externalised redefined forms of social and cultural capital constantly restructure the boundaries of capital and create new dynamics of power within the field of family and society. The social and cultural capital in terms of social networks, influences knowledge and belief of cultural values and practices. The social and cultural capital are constantly restructured due to their interactions with

the dynamics of economic capital, power and identity, which are said to have contributed to increasing the stress among individuals within families, communities and societies.

The process of individual representation of social and economic capital operates both at an individual and institutional (family, society, community) level. The interaction among individuals and institutions created aspirations that led to the restructuring of economic capital to achieve newly identified socio-cultural capital and positioning. For healers, transitions in lifestyle adopted by young adults, are in imitation of Western culture and reflect the socio economic changes of society. The healers' perceptions revealed the intense interactions amongst individuals, family and society that lead to inward pressure associated with suicidal behaviour because of the limited resources available to fulfil the demands of the restructured capital.

The changing standards of economic and cultural capital (i.e. values and practices) may well be instrumental in explaining stress, conflicts and the role polarity experienced by women survivors. A key to understand the intangible complexity of these experiences is to use the structures and symbolisms of violence in a woman's struggle to minimise economic hardships of family life. Although culturally, men bear the burden of securing the economic interests of the family, in contemporary society a woman is required to step outside the traditional role of being a homemaker to become a working woman in order to secure her family's future and support her husband in fulfilling the economic needs of the family. Male survivors in this study felt humiliated, distressed and depressed when they lacked financial independence and failed to provide for the family. The economic capital as

experienced by male survivors had a negative impact causing symbolic violence in forms of shame and humiliation. Due to the pressures and behavioural norms of cultural capital, they could not express their grief and thus adopted a habitus that allowed them to resort to alcoholism as a coping strategy.

Healers and professionals perceived economic independence and increasing materialistic desires amongst the men and women as a cause for conflict and unfaithfulness within the family relationships. These participants presented a debate where doxa – the core values and discourses surrounding family life are in contradiction with the individual's desire to attain and prioritise a better economic and social life, rather than attending to the welfare of the entire family. This perception shared by participants is a result of the cultural capital and power that they experience in their environment. Each sub section of society holds sets of conflicting values and attempts to legitimise them through various forms of capital and power. The findings identified where financial factors were a dominant stressor, the aspirations for career enhancement and improved economic standards were in little agreement with the cultural values and duties towards their family as a wife, mother, daughter, husband and son. Although survivors felt compelled to accept doxa – traditional and cultural values, they overlooked the pathways to accepting doxa, which subjected them to symbolic violence and distress. The conflicting feature between the cultural prescriptions, doxa, and socio-economic capital, explained the suppression and internalisation of external norms, leading to violence, physical and mental distress.

### **7.2.3 Interpreting physical and mental health concerns**

The rationale that explains the relationship between ill health and suicidal behaviour is incoherent unless it is understood within the bounds of a socio-cultural context. The reporting of physical ailments in connection with attempted suicide by all three groups of participants were in some way interpreted through their own social and cultural capital. For survivors, presenting physical illness as a reason for attempting suicide was guided by a motivation to avoid social stigma. This motivation was derived from survivors' contextual understanding of social capital, the legal implications and the experience of symbolic power. The interrelatedness of socio-cultural capital, power and suicidal behaviour is to be understood beyond the emergence of mere ill health. The cultural capital of survivors led them to attribute conditions of ill health due to it being an inauspicious time or the negative manifestation of a curse or witchcraft. The findings interpreted survivors' judgments of situations, risk factors and stress as contextual and influenced by the cultural capital of practices within the setting of family, community and society. In order to understand why participants emphasised certain risk factors such as physical illness rather than mental illness, it is necessary to understand how individuals formed judgments regarding situations and how risks are constructed within the field of family and society that is loaded with doxaic norms and socio-cultural capital. The social and cultural practices structured participants' attitudes, judgments and habitus while explaining attempted suicide.

The participants' accounts revealed the impact of structural power conducted by social and cultural capital that affected perceptions, judgments and mental

wellbeing. Survivors perceived physical ailments as socially acceptable reasons for suicide rather than reporting relationship breakdown, violence, conflict or depression. The evidence of cultural power enforced through forms of social structures significantly influenced the internalising of distressing situations, forming perceptions and impacting mental health. In the case of a survivor who was transgender, his perceptions of gender, health, sexuality and behaviour were derived from his understanding and experiences of social structures and cultural sanctions. In the first instance, he attributed his distress to the genetic makeup of his physical being. However, the analysis revealed that social exclusion, ill-treatment and mockery constructed his perception and led him to detest himself and attempt suicide. In other words, it was cultural power, which had a negative impact upon the survivor's habitus.

The cultural and structural power, as experienced by survivors and healers minimised their recognition of stress, anxiety, depression and other forms of mental illness. Nonetheless, mental health professionals identified physical, mental and psychosomatic concerns in relation to suicidal behaviour. The appearance of risk factors and explanations for distressing events held cultural meanings alongside bio-medical reasons. The cultural beliefs provided limited causal explanations. Rayner (1992) explained in the essay on 'cultural theory and risk analysis' how culturally grounded belief systems bear the potential to emphasise practices and produce and reinforce social order within society. The perception and explanation of risk factors presented by a proportion of healers and survivors were distanced from the definition of mental illness as they appropriated reasons of misfortune, religious beliefs and cultural practices. The values and beliefs shared by doxa formed a

barrier against accepting bio-medical (mental health related) explanations and availing timely intervention to manage severe stress and mental health concerns.

The pain perception identified by mental health professionals is significant in explaining attempted suicide. The cultural value witnessed in survivors' accounts upheld sufferings on account of perceived benefits to self and family, religious significance and a way of repentance for one's sinful past. Individuals' habitus was coupled with influences from social and cultural practices that eventually led to neglecting one's own health or recognising early symptoms of stress and depression. The individuals assumed symbolic power by finding comfort in persevering with pain for religious and cultural reasons, while the institutions were equally responsible for the deteriorating conditions of individuals. The institutions reinstated cultural power in the forms of traditions, social structures and failed to empathise or support individuals in distress.

The disintegrative power of substance-dependence, predominantly alcohol related, was an overtly distressing factor affecting individuals' physical, mental and social wellbeing. The findings revealed various levels of interpretation for the use of alcohol. For male survivors alcoholism was a socially accepted coping strategy and a means to express power and distress without being humiliated. However, female survivors blamed a dependence on alcohol for increasing violence and disharmony in their family life. There were dichotomies in understanding the distressing nature of alcohol abuse. If the alcohol dependents referred to alcohol abuse as a coping strategy in hindsight, they derived power to abuse alcohol due to the context of social normality surrounding use of alcohol among men more than women. They



used alcohol to express grief, frustration and to cope with distress, whilst at the same time causing distress to people surrounding them, especially their family, by inflicting violence and torture. The cultural power that gave men the authority and control was often expressed in ways of violence and abuse especially under the influence of alcohol. The perpetrators of violence and victims both experienced severe stress, anguish and grief. They perceived troubles and misfortunes as being beyond their ability to recover from and thus resorted to suicide. The limited knowledge regarding mental health problems led to interpreting abuse of alcohol and alcoholism in socio-cultural terms rather than recognising the need for medical and psychosocial intervention.

#### **7.2.4 Accessibility of means in the context of a socio-cultural field**

The participants' (survivors, TH and MH) explanations of methods in attempted suicide did not provide accounts of strategic choices but rather opened up avenues to explore relationships amongst conditions of cultural, economic and social fields. The understanding of contexts and mechanism of fields facilitated interpreting individuals' experiences and the array of reasons guiding their choice of method. Each group of participants communicated from a position with their own doxaic values leading them to interpret the use of methods in different ways. Traditional healers carried influences from religious and cultural fields where the doxaic values and beliefs dominated their explanations and rationale. Healers conceptualised that individuals had fallen upon an inauspicious time or were under some curse,

and it was these factors that guided a person towards a particular means such as rivers, wells or poison to end their life.

The proposition and predisposition towards particular choice recalls the findings with the need to clarify the emergence of thought, construction of reasons and the context of the field in which it is produced. Bourdieu laid emphasis upon studying social and cultural fields to explore the mechanisms that influence habitus (Grenfell, 2008). Applying this line of thought to the analysis, the findings identified that accessibility of means was crucial to understanding the choice of a particular method, however, recognition of occupation and gender roles made a difference to interpreting accessibility and widened the context of analysis. Survivors presented a disposition which contemplated their chosen methods was based on what they found in their surroundings for example toilet cleaners, bleach, phenyl or self-immolation in case of women survivors. The distressing conditions in the field, modified the survivors' habitus leading them to consider any available means to hurt and kill themselves in an attempt to externalise their pain, hopelessness, and even to control the undesirable conditions of the field (family, relationships, community and society).

The interpretation of complex social contexts emphasised the differences in methods employed by men and women whilst similar sets of means were accessible to both gender. This difference may well be explained on the basis of cultural beliefs and the social positioning of survivors whose thoughts and actions carried influences from doxa. For female survivors, consuming toxic/corrosive cleaning solutions or using kerosene to self-immolate were not only contemplated methods

but were also instantly accessible means to threaten or escape distressing conditions. However, the methods mentioned above were absent amongst male survivors and was very rarely mentioned by healers or professionals in their accounts of the methods used by men. A combination of alcohol and poison, as methods of suicide, was predominant amongst men and absent among women. This finding revealed although survivors lived and shared similar socio-cultural contexts, their perception and interpretation of the dynamics of everyday situations and wider practices differed. However, their expressed affiliation to doxa and in certain cases constantly modifying perceptions led to restructuring doxa. Understanding survivors' positions within the purview of doxa will help to realise why men do not self-immolate and women rarely think of combining poison and alcohol.

The relationship between the choice of methods, intentions to end life and lethality of means employed is unclear from the data. Based on the current findings, questions are raised if the applied methods were expressions of reflexive symbolic power to politicise a cause or a demonstration of reformed habitus that found power in forms of symbolic capital to achieve its effects in fields of family or society (Grenfell, 2008). For instance, few of the survivors' attempts to self-immolate or consume poison were recorded as expressions of internalised power. These survivors exercised symbolic capital by means of attempting suicide and blaming it on persons responsible for causing undesirable conditions or suffering or perpetrating violence, in the hope that this act would inflict legal punishment upon them. While on the other hand, the participants' (survivors, TH and MH) accounts also unwrapped the possibility of projecting homicide into suicide mostly in forms

such as burning and poisoning. The relatedness of authority and power that is grounded in structurally and culturally ascribed gender roles and positions, is influential in understanding the methods used in suicide. However, this area requires more research attracting expertise from a social, cultural, psychological and forensic knowledge base.

### **7.2.5 The socio-cultural affects of Indian Penal Code – Section 309**

Socio-cultural sanctions are internal rules of practices whilst they are externally established in legislative forms (Lenoir, 2006). Section 309 and 306 of the Indian Penal Code criminalises attempted suicide and “abetment to suicide” with punishment and a monetary fine. Yet, the findings reported that none of the survivors were incriminated for having attempted suicide. Bourdieu recognised that the efficiency of any law or rule is relative to social acceptability; a rule is transformed into practice when it is associated with more gains through obedience than losses (Lenoir, 2006). Although the legislative field has the capital and power to enforce the law, the enforcing authorities expressed compassion and empathised with the survivors, thus expressing albeit tacitly, a social rejection of legislation on suicide.

Survivors and their family members’ dispositions and perceptions changed when they realised that attempting suicide is a punishable offense. However, this understanding did not deter several of the survivors from attempting suicide repeatedly. The lack of social acceptability and sanctioning of the law failed to create awareness among the public about the legal nature of attempted suicide.

The law infused fear of punishment and social stigma that deterred participants from reporting suicide; rather they reported an attempt at suicide as an accident. Medical professionals were faced with conflicting habitus while exercising ethical and legal responsibility of both social and professional fields. They were legally bound to report cases of attempted suicide to the police under the category of medico legal cases.

The legislation on suicide empowered several individuals to use suicide to politicise a cause or to inflict legal proceedings and punishment upon persons who were responsible for their miseries. Participants' (survivors) accounts represented attempted suicide as a distribution of misappropriated habitus, which could not be controlled within the scope of law. For survivors, internalisation of abuse and domination reproduced experiences of frustration, helplessness and powerlessness. However, the polarised and conflicting insights led them to realise their power and autonomy despite being frustrated and without hope. With this realisation, they used suicide as a means to combat oppression. The process of realising power and restructuring habitus to them meant, combat fears of being faced with social stigma on dissuading cultural norms, practices and reforming doxa. For many female survivors reporting abuse and violence was against the values they derived from their doxa. The awareness of women's rights and legal measures facilitated several women survivors to reflect upon the negative implications of prevailing doxa (practices, beliefs, values, norms). The legislative measures (capital) provided women survivors with power and the opportunity to re-establish themselves within the social field. However, participants' decisions to exercise power and approach legal proceedings vastly depended upon available social support. The majority of

the participants perceived legal engagements as exhaustion of capital (economic, emotional, social, cultural) and negatively impacting habitus creating disposition to attempt suicide due to the lengthy court proceedings, which often failed to obtain justice for the victims in their lifetime.

### **7.2.6 A balanced choice of contemporary medicine and traditional practice**

The findings interpreted contemporary medicine and traditional practices as exercises with specific boundaries that acknowledged the need for mutual collaboration in order to address the problem of attempted suicide and mental health concerns. The fields of contemporary medicine and traditional healing both advocated their own theory of practice. The primacy of each practice depended upon the perceived benefits and faith of individuals who approached these practices. Survivors hesitated to acknowledge their faith in traditional healing methods due to their perceptual understanding of the researcher's religious and knowledge capital and symbolic power. However, on identifying a similarity of doxaic beliefs between the researcher and the participants it proved possible to deconstruct the perceptual notions. This revealed their beliefs and approach to biomedicine, psychiatry, religious and traditional methods. The choice and preference of treatment in approaching either biomedical or healing methods varied depending upon the nature of illness. The social and cultural power experienced by survivors was crucial to considering these approaches beyond their interest for complete recovery. All the participants attributed a higher degree of social capital to biomedical practice. Nevertheless, opinion differed when referring

to psychiatric practice in the absence of drugs. As identified by mental health practitioners, people shared a better disposition towards consuming medicines rather than being responsive to therapies. This reveals a particular form of doxa as experienced by users of medical services in the field of medical practice.

Traditional healers' and survivors' religious and cultural capital led them to interpret health conditions, repeated suicidal behaviour and mental illness in terms of magic, possession, curse, inauspiciousness of time or the inappropriate positioning of celestial bodies. Most of the participants' accounts revealed the power of faith and belief that was instrumental in treating depression, resolving conflicts, developing self-confidence, provide assurance and courage to face difficult situations in life. This is an example of how the symbolic power of doxa (religious faith, belief in practices) in the lives of individuals interacted with their social and cultural capital by restructuring their disposition to situations and enforcing positive modification of habitus. Mental health professionals perceived this as a process of internalising the power of doxa (although they would not think or express themselves in these terms) and gaining complete control over undesirable conditions to invent modifications. However the findings revealed that the individuals' (survivors', service users of healing and medical practice) dependence on medical and healing practices was determined by their perception of benefits and experiences of recovery. For example, whenever survivors did not experience immediate effects or healing from medical services, they switched to traditional methods and in a few cases, survivors approached both practices simultaneously.

The field of medical practice takes pleasure in being identified with a higher-degree of social capital. The users of medical services do not always experience the same level of social capital. This is particularly true of those who approach psychiatric services as recognised by the participants (TH and MH) in this study. The stigmatising nature of cultural and social capital made psychiatric services impermeable and inappropriate to be acknowledged as a user in a community or social field. Healers and MH professionals appreciated the transforming social structures and technological advances in the field of society, which have opened up new avenues and phases of approaching psychiatric services in forms of therapeutic services (counselling, psychotherapies). They further acknowledged that the response rate to counselling is minimal in semi-urban locations, although it is increasing in urban locations. As evidenced from survivors' accounts, they derived benefits of therapeutic services from religious and traditional practices both in rural and urban locations. The cultural capital sanctions healers and service users' power and authority to use healing services as a means of support in times of distress. Thus, traditional healing services combined with medical practice performed positive effects in reconstructing individuals' habitus (thoughts, actions and behavioural responses).

### **7.3 Summary**

This chapter analysed the findings using Bourdieu's concepts to examine cultural influences on attempted suicide. It investigated cultural mechanisms by means of debating structuring roles and gender identities; interpreting cultural meanings associated with economic hardships, physical and mental ill health; recognising the



relevance of socio-cultural context with accessibility of means to attempt suicide; ambivalence of legislation on suicide and treatment of suicidal behaviour. This process of understanding, conceptualising, examining culture, norms, behaviours and interactions contributed to the development of a conceptual model on cultural implications of attempted suicide and its prevention.

## **7.4 Conceptual Model**

The following is proposed model for explaining the association between culture and attempted suicide. The previous chapters and earlier sections of this chapter identified the interactions amongst cultural norms, behaviours, roles, gender, power and all forms of capital (economic, social and cultural) that are instrumental in structuring the perceptions and responses people make to life situations. This analysis implores the need for a better understanding of suicidal behaviour and interventions. The model that is being proposed, presents the plurality of cultural interaction, culture as a process in conceptualising distress and suicidal behaviour, rather than simply classifying these factors based on a cause and effect relationship.

The cultural mechanisms shown in the model are derived from participants' perceptions and experiences of the culture they live in and what they recognised as stressful conditions. It also interprets the impact of culture as one that is perceived and internalised. Disparities between how this occurs for each individual is what differentiates the impact of culture on individuals who might either adopt or reject a suicidal habitus. Furthermore, it is the repeated, multiple and cumulative occurrences of challenging events that have an impact, thus creating stressful conditions. In other words there is nothing inherently stressful about the cultural

features identified, it is how they interact over time, whether they are single or multiple and the internalised perceptions of culture which collectively have an effect.

There are four pathways identified in this model that explain how culture implicates suicidal behaviour and also affects the preventive factors. The elements that are central to each individual pathway are:

**Pathway – A:** Cultural mechanisms evidenced in the data and their negative impact in the absence of support factors leading to attempted suicide.

**Pathway – B:** Complex positioning of support factors that mediate the effects of cultural mechanisms, prevent individuals from attempting suicide and change dispositions positively.

**Pathway – C:** The same support factors, which may have a contrary effect in ceasing to be preventive and becoming instead causal due to the influences drawn from cultural meanings and beliefs underpinning support and its delivery.

**Pathway – D:** The change in perception and environment, which is essential for individuals to escape from the perpetual cycle of distress and has the potential to lead individuals away from suicide.

In Figure 7, these pathways are mapped on a flow chart diagram. Sections 7.4.1, 7.4.2, 7.4.3 and 7.4.4 then go on to describe in Pathways A, B, C and D in greater detail.

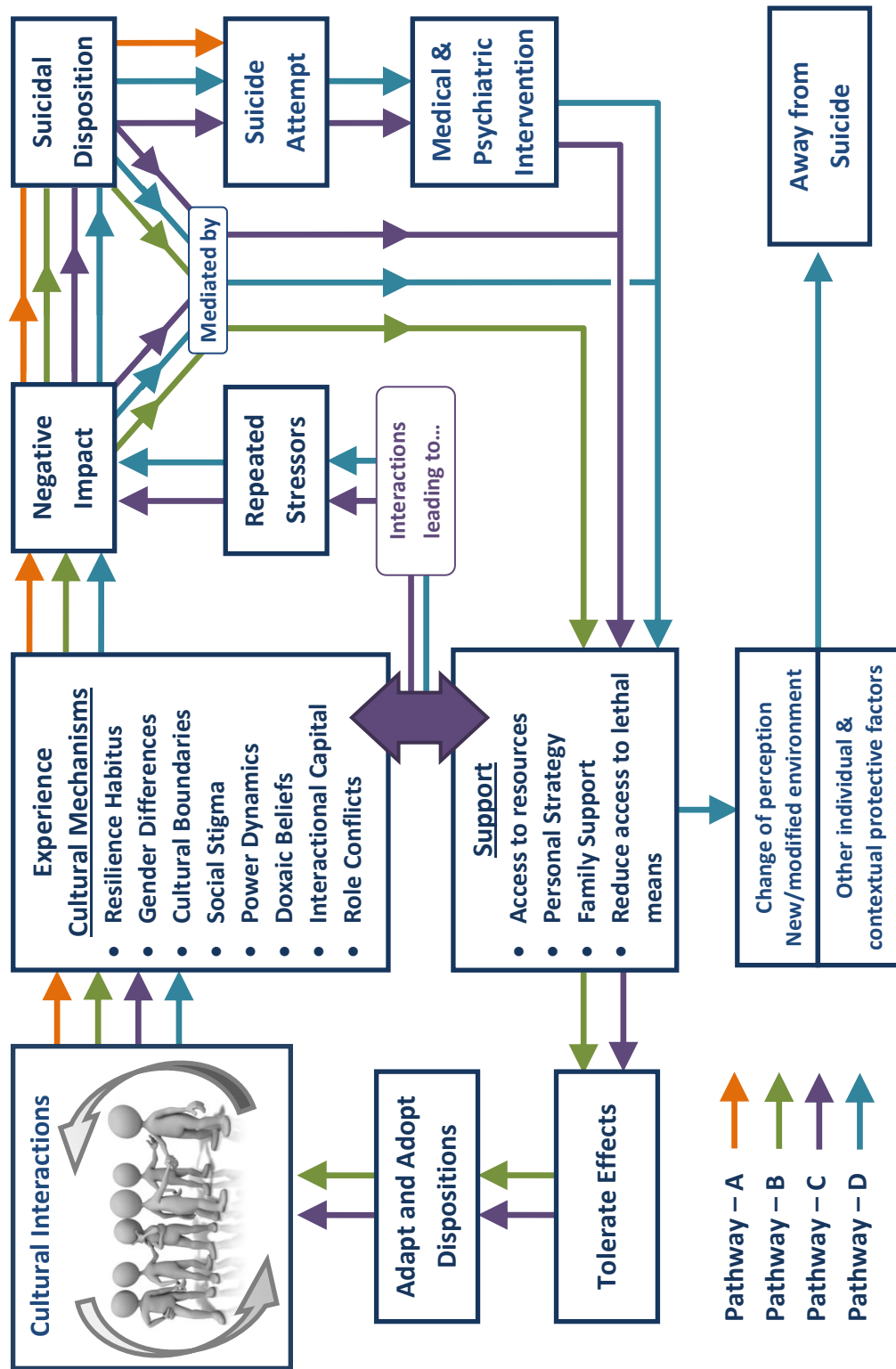


Figure 7 - Conceptual Model of Culture and Attempted Suicide in South India

### **7.4.1 Pathway – A: Negative encounters**

The Pathway – A recognises individuals' encounters with one or several of the cultural mechanisms presented in the model (Figure 8). The outcome of these encounters may be mediated by various support factors, however, in the absence of support it can produce negative impacts and lead to attempted suicide. The study found that individuals who faced stressors produced by a single or a combination of cultural mechanisms and lacked any form of support continued to experience negative impacts, which further led them to attempted suicide. It was not necessary that all of these mechanisms had to be present to create a negative impact and lead to suicide. For example, young men associated their independence and identity with financial stability. Having no job and being dependent meant they were less respected within the family and society while their power and identity was threatened. This example elaborates the distressing nature of economic, social and cultural capital for unemployed men within the family. They found it hard to express their struggles and grief to any members of the family and to seek external support. Having no support and continuing to experience repeated stress directed them to adopting thoughts of suicide and attempt suicide.

The experiences of cultural mechanisms although distressing did not lead everyone who experienced these mechanisms to attempt suicide. This process is explained further in pathway B.

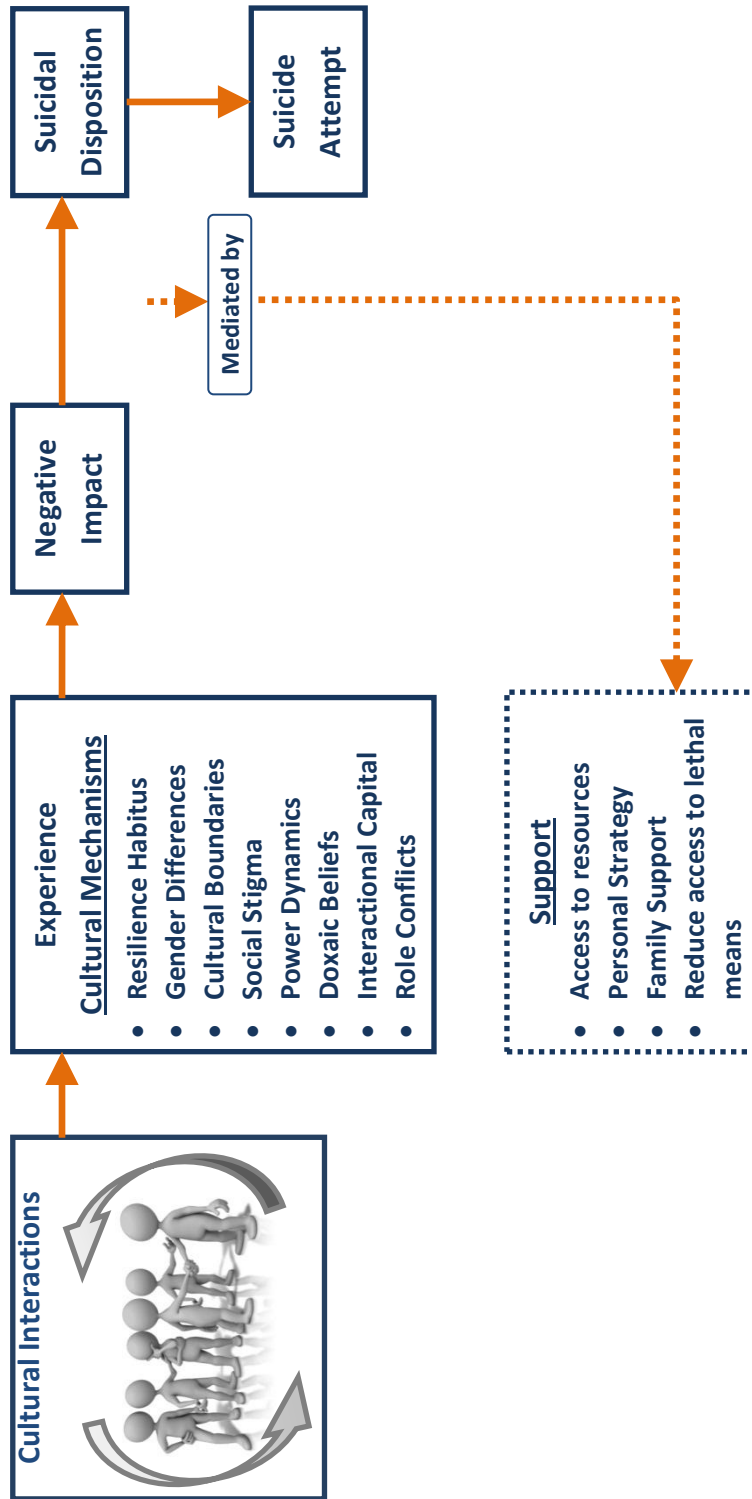


Figure 8 - Pathway - A : Negative Encounters

### **7.4.2 Pathway – B: Mediation**

Pathway – B establishes the proposition that if the impact generated by cultural mechanisms were mediated by support factors, individuals would be more likely to tolerate the effects and change their disposition towards life situations. The transition in perceptions and dispositions is largely influenced by support available within families and society. The factors identified in this research that are influential in preventing suicide are; accessibility to economic and physical resources, family as a supportive agent, personal strategy and limited access to lethal means. The support that individuals received from members of their family during crisis situations was also associated with economic, social and cultural resources. The availability of resources, such as financial, social networks and cultural capital, which could help individuals to re-establish themselves in the society, were crucial in lifting individuals out of a crisis situation. The external support made sense to individuals when they gathered courage and realised their abilities and skills to deal with problem situations and introduce a change into their lives. For example, a female survivor who gathered courage to fight violence in her marriage was protected and defended by her parental family during marital dispute and violence. However, her parents did not support the decision to divorce her husband, although she was confident that she could secure a job, live independently and maintain herself and her children. This offers a reason for how support made available to individuals at difficult times could deter them from attempting suicide but this support is expressed as a momentary remedy rather than a more permanent solution.

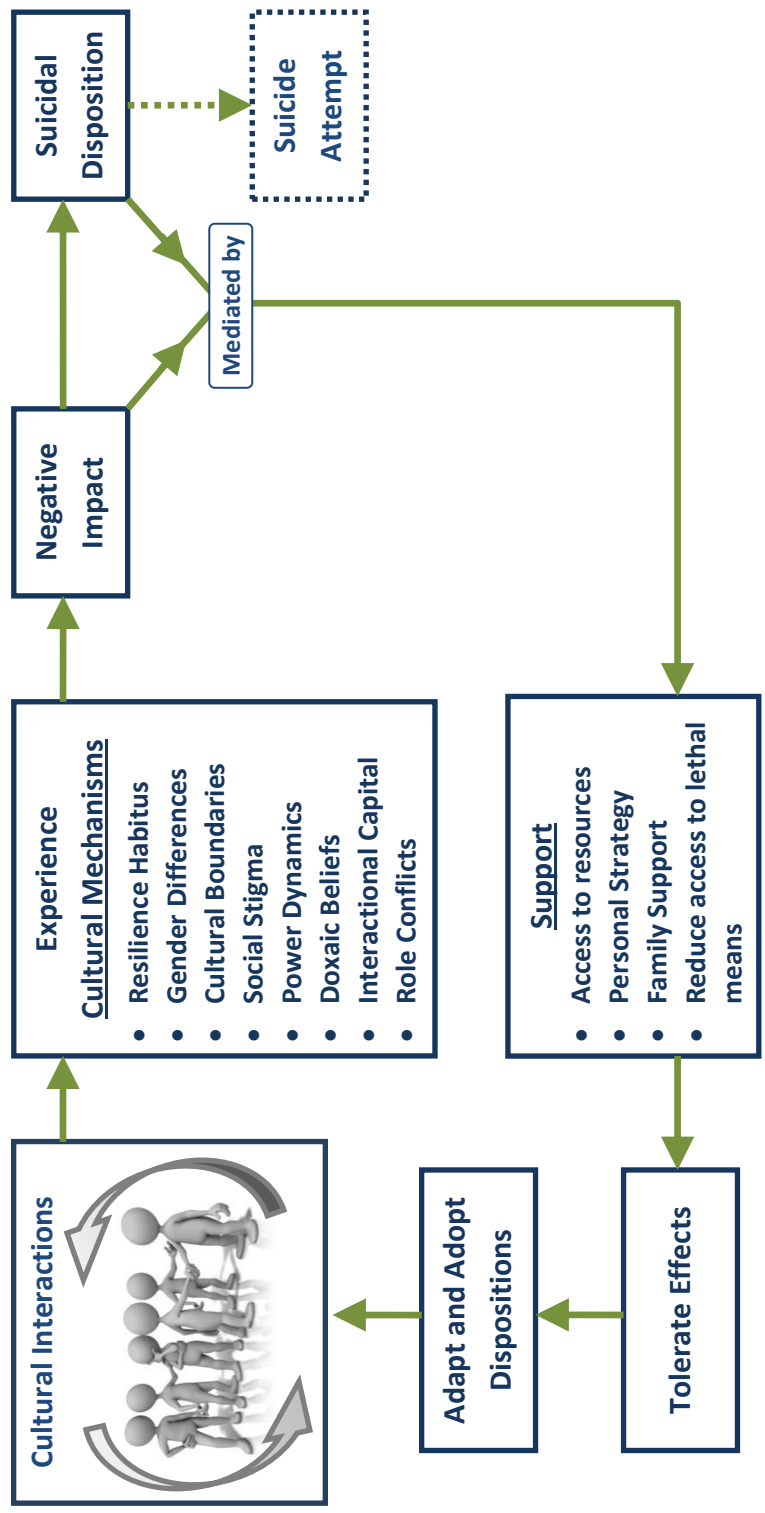


Figure 9 - Pathway - B: Mediation

### **7.4.3 Pathway – C: Course of transition**

Pathway – C reminds us of the intricate web of support systems that are constructed within the social and cultural milieu. It explains the influence of cultural meanings, a belief in the support that individuals receive and further identifies a constant interaction amongst cultural mechanisms and support factors. Combinations of interactions may lead to experiences of repeated stress and lead to the individual adopting a suicidal disposition. Thus, a response that is generated by psychological, cultural and societal mechanisms that gradually leads to attempted suicide. This observation takes into account the cultural process that translates support into a stress. In the case of a family, extending support meant the family takes responsibility to minimise any perceived risks. For example, a male survivor who attempted suicide on account of a relationship breakdown was persuaded by parents to quit his job, move city and relocate to the parental house. In this instance, parental support came with losing independence and being jobless, which was further distressing for the survivor. The role of family in helping individuals to cope with challenging situations emerged as a significant yet unstable element of family support. Support is structured within the cultural context and is dependent on other variables such as social responses, economic resources and cultural capital. For instance, female survivors who received no support from their parental family to end an abusive marriage, male survivors who felt isolated, neglected and powerless within the family because of unemployment and alcohol abuse adopted suicide as a means of escape. In such a case, support factors no longer had a deterring impact and thus led to suicidal disposition. This thought may help in understanding repeated suicide attempts despite the available support.



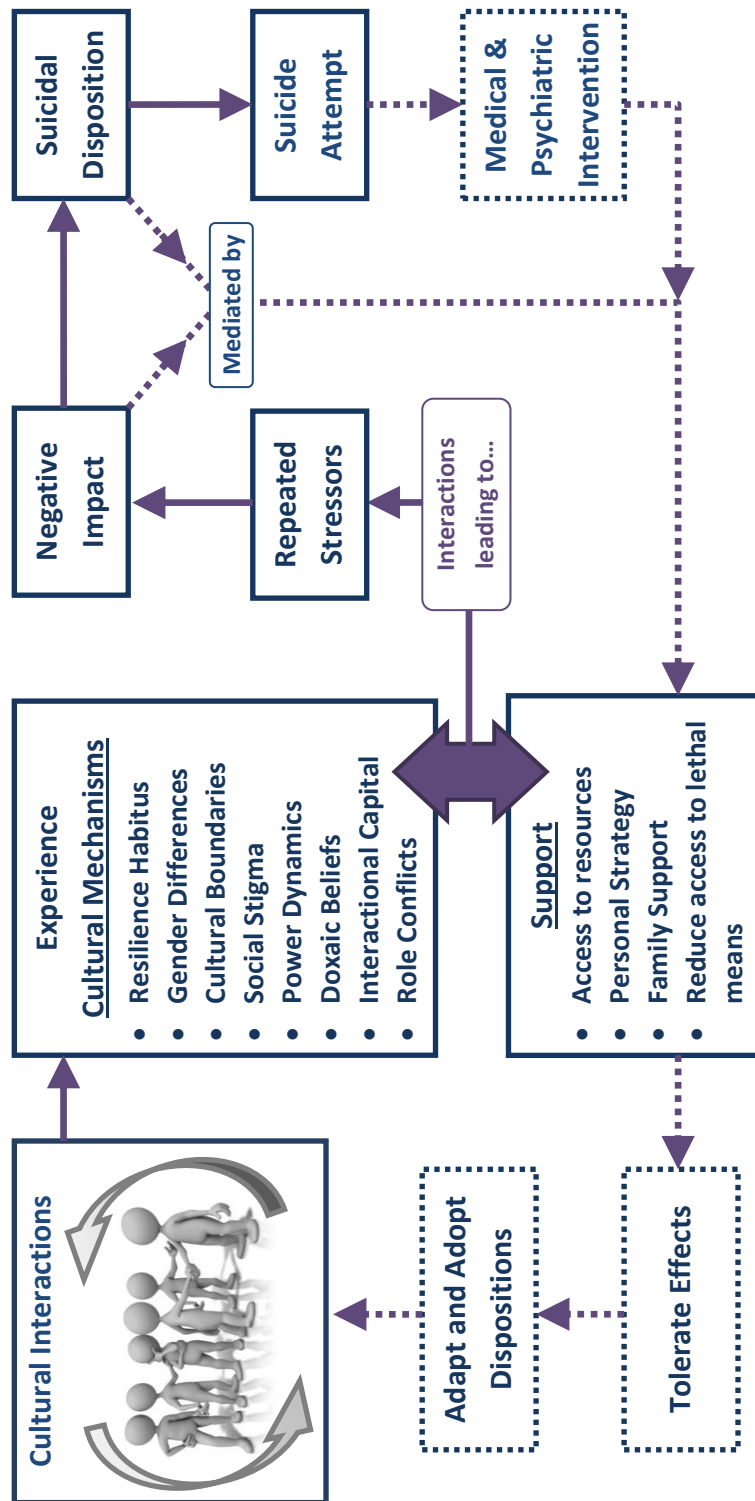


Figure 10 - Pathway – C: Course of Transition

#### **7.4.4 Pathway – D: Away from Suicide**

Pathway – D proposes a life away from suicide when support factors are enhanced with a new environment, changes in perceptions and attitudes towards life. No amount of personal resource (internal strength, courage, skills and abilities) is sufficient if the distressing situations persist. Therefore, a combination of personal resources and environment can help individuals to move away from suicidal dispositions and behaviours. The personal resources would further help individuals to seek and identify appropriate external resources. In order to foster a life away from suicidal thoughts and attempts, it is essential for individuals to make use of personal and external resources to remove themselves from distressing situations and contexts. Experiencing changes in the environment and perceptions are crucial in this process. For instance, a female survivor attempted suicide twice as she was exposed to the criticisms of the neighbourhood and community for separating from her husband and returning to the parental house. This example illustrates the need for perceptual and environmental change to address the problem of suicide and help individuals to remove themselves from the perpetual cycle of stress - attempted suicide - support.

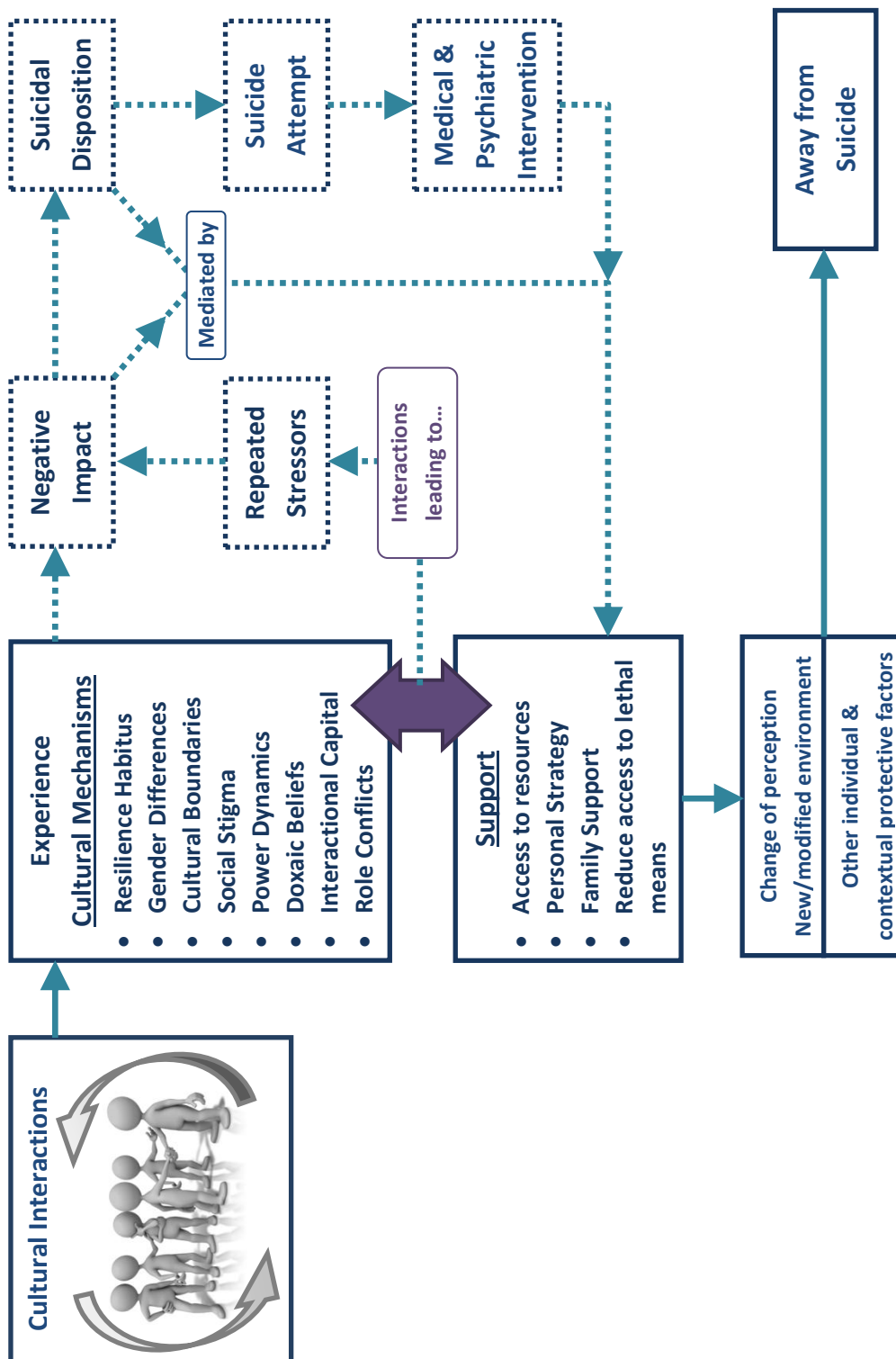


Figure 11 - Pathway - D: Away from Suicide

This model not only identifies the factors that cause attempted suicide and prevention but more importantly it recognises how these factors cause distress and how support may also be a risk which itself can lead to suicide attempts. The model is firmly embedded in an understanding of the cultural impact of context and not a simple biomedical or psychosocial explanation. There is a need for further research to test this proposition and to add to this model.

## **7.5 Examining the model through relevant concepts**

The cultural mechanisms discussed in this model are developed through the process of analysing the findings from Bourdieu's theoretical framework. This section attempts to produce a critical account of the cultural mechanisms and the model as a whole through relevant concepts and approaches such as capability approach, social resilience, coherence and salutogenic model.

The risk factors for attempted suicide identified in this study are perceived more so as cultural mechanisms due to their intrinsic ability to transform individuals' approach/ dispositions towards life situations. The cultural mechanisms presented in the model (see 7.4 on 256) are not only the analysis of human needs, living conditions, human capabilities and choices but a detailed account of the process of interactions. Sen (2008) recognised that individuals can function in different ways and have the freedom to choose a way of living, being or doing things. Sen's this idea is termed as capability approach and defined as "the alternative combination of functionings the person can achieve, from which he or she can choose one collection" (Sen, 1993, p 31). The applicability of this concept in the study of attempted suicide is limited as the findings demonstrated that although individuals

have choices but their choices are guided by dominant cultural practices, contexts, interactions, and meaning making process.

The concept of resilience is used widely in the literature based on its principles of 'persistability, adaptability and transformability' (Keck and Sakdapolrak, 2013). Several researchers from various fields (psychology, ecology, disaster, educational) of study have associated the concept of resilience to positive adaptation and recognised the concept as a process (Harrop et al., 2006). The analysis of findings in the current study identified resilience as an evolving process with a potential for positive and negative outcome/response. Although Rutter (1985, p 608) in a way perceived negative aspects of resilience (lack of resilience, avoidance of stress) but was limited by his affiliation to pathogenesis (aetiology of disease). He believed resilience as a way of encountering stress which on the other hand improved self confidence, social competence and responsibility. This idea closely resonates to Antonovsky's salutogenic way of living (Almedom, 2005) because of its ability to recognise individual's capacity to comprehend stressful situation (sense of coherence) and use available resources (material, social, non-material) (Antonovsky, 1987). The protective factors discussed in the model proposed in section 7.4 on page 256 may seem aligned with salutogenic model however, these factors are identified from the data and stand independently of salutogenesis for the following reasons. Firstly the nature of protective factors (see Figure 7 - Conceptual Model of Culture and Attempted Suicide in South India) are contextual therefore its efficacy is relative. Secondly, due to the process of interactions amongst individuals, their society and culture these factors have the potential to transform into risk factors (see section 7.4.3 on pg 263).

## **8 Conclusion**

The overall aim of this research project was to explore the influence and impact of culture on attempted suicide in South India (see Chapter 3 on page 72 for research aims). This chapter discusses the key findings, strengths and limitations of the study, and examines the contributions made by this study to current understanding of attempted suicide, particularly in the context of Southern India, and explores the implications for policy, practice and future research.

### **8.1 Summary of key findings**

This study explored the association between culture and attempted suicide within South Indian cultural context and conceptualised the impact of culture as cultural mechanisms. The cultural mechanisms discussed in the model (see chapter 7) presented an in-depth understanding of the process of interactions amongst norms, practices, behaviours, power, role and gender at an individual, community and societal level; that cause distress and influence suicidal behaviour. The model discussed how these mechanisms and the support factors (see section 7.4 on pg 256) bear the potential to create both positive and negative impact and lead an individual to adopt or reject suicidal disposition.

### **8.2 Strengths of the study**

One of the strengths of this study is the use of combinations of approaches in data collection and analysis (see 3.3 on pg 75). The principles of grounded theory (Glaser and Strauss, 1967) in specific an approach to understand individual behaviours in a social process, the symbolic interactionist (Blumer, 1969) perspective which

explored the meaning making process of participants and the phenomenological approach to understanding individual experiences provided a strong theoretical underpinning. The flexibility of constant comparison method (Strauss and Corbin, 1998; Glaser, 1964) and data collection tools allowed the data to emerge, enabled the researcher and participants to explore issues that evolved during the course of interviews and a sensitive approach in studying attempted suicide amongst complex and challenging situations. The use of Bourdieu's concepts to analyse data further elaborated the inherent meanings of cultural process in causing distress and attempted suicide.

The reflexivity implied in this study makes this study credible. The researcher's position as an insider to the cultural context and an outsider at the same time (lack personal experience of the phenomenon under study) and by being transparent (see 3.4.6 on pg 94) about the research process has increased the trustworthiness of the study. The data from three participant groups were presented individually in three different chapters in order to give voice to each participant groups with an intention to limit influences and convergence of subtle meanings although expressed through similar words by participants from different groups.

This study becomes a common reference point for researchers, policy makers, health professionals and general public to understand survivors' experiences, mental health professionals' and healers' understanding of risk factors and their approach to intervention and prevention. It is also useful in exploring gaps in professionals and healers understanding and their approaches.

One of the major strengths of this study is that it presents a conceptual model of cultural implications of attempted suicide in South India. This is helpful in understanding the ways in which cultural process can implicate suicidal behaviour and transform protective factors into risk factors for attempted suicide.

### **8.3 Limitations**

The findings from this study need to be considered in terms of limitations imposed by study design, sample size, ethical concerns and the sensitive nature of the subject under investigation. The use of multiple approaches draws readers to multiple perspectives of the data which might lead to misreading and failure to perceive the context of interpretation. The combination of approaches became a strength as much as a challenge as it assisted the researcher in regarding the robust methods for data collection, to maintain integrity of the data and provide a theoretical base to examine the findings. From another point of view, the principles of grounded theory and symbolic interactionist approaches led the researcher to miss identifying widely known issues such as poverty and illness that may have received better attention within critical theory. The use of Bourdieu's concepts, although assisted in recognising cultural dynamics and its impact in causing distress; It bound the researcher's interpretation of data to using complex terminology and adopt particular standpoints in the analysis of data.

The researcher's identity created both strengths and limitations in gaining access to participants, the type of samples obtained and interpretation of data in the study. The participants' responses to the researcher imposed a certain amount of limitations on the type and quality of data due to their perception of the



researcher's identity as a woman, a mental health professional and a young researcher.

The motivation to sample heterogeneous groups was to obtain diverse and rich data to explore the topic under study. In this study participants' religion, socio-cultural background, qualification and profession were demographic variables. For traditional healers, religion became one of the criteria for sampling. Sample was limited by age for survivors, by profession for mental health professionals and by religion for healers.

The presentation of data from three participant groups into three different chapters may seem a repetition of data as they were all interviewed on the same subject of study. However these chapters need to go in parallel with chapter 8, which analyses the findings by applying Bourdieu's theoretical concepts and highlights variations in understanding and interpretation of data by both participants (survivors, professionals, healers) and the researcher.

The vast spread of Indian geography, with specific reference to South Indian states and cultural variation across regions and states in the country made it difficult to access sample groups from across India. Due to the challenges in obtaining ethics approval from the Ministry of Health to access participants through hospitals with mental health speciality, the study was limited to private health clinics, hospitals and organisations in Karnataka, South India to gain access to participants. The application of the conceptual model developed in this study is limited unless it is tested, verified in different cultural contexts within India and abroad.

The proposed conceptual model of culture and suicide in chapter 7 section 7.4 explained cultural mechanisms and preventive factors that were derived from survivors', professionals' and healers' accounts. These accounts were subjected to influence by the interview method, physical environment at the time of interview and perception of researcher's socio-cultural background. However, these influences were minimised by implementing rigorous methods during the research process as elaborated in section 3.4.6 on 94.

Although the conceptual model ultimately derived from the interpretation of the data (see 7.4 on page 256) indicates, what might lead individuals within similar cultural contexts and experiencing the identified cultural mechanisms, away from attempting suicide, this proposition has not been tested and therefore is subject to further analysis and research. The results are not necessarily generalisable beyond the context of the study.

## **8.4 Contribution to knowledge**

The conceptual model presented in section 7.4 attempted to unravel the complex interactions among cultural mechanisms and explained how these transitioned into causing distress. Among the risk factors discussed in chapters 4, 5 and 6 role and gender identities, cultural pressure, role expectations, interactional capital (economic, social and cultural) and the subtleties of doxaic beliefs, are all captured within the dynamics of the socio-cultural process. This knowledge expands the current understanding beyond the widely classified risks in the literature, such as family problems (National Crime Records Bureau, 2012), issues of gender differences, parental control, performance pressure, relationship breakdown,

alcoholism and violence (Manoranjitham et al., 2010; Maselko and Patel, 2008; Milner et al., 2013; Nath et al., 2012; Radhakrishnan and Andrade, 2012). The model proposed in this research dwells upon the cultural process and looks in-depth at the impact intertwined cultural mechanisms have in order to gain a better understanding of what frames family problems, individuals' perceptions and construction of distressing situations. It builds a linking stream to the existing knowledge where cultural meanings of risk factors were rarely recognised and only the immediate precursors of suicides are considered (see 2.5.3 on page 46, 2.5.4 on page 55). By focusing on the implications of cultural mechanisms on attempted suicide, this study has identified the distressing and conflicting nature of structuring gender roles, symbolic power, cultural pressure, role expectations and the effects of doxa (cultural beliefs) that were scarcely recognised in existing studies on suicide. This study contributes to a better understanding of suicidal behaviour in India rather than classifying suicides under broad categories of family problems or mental illness as evidenced in the classification presented by the national agency (National Crime Records Bureau, 2012).

The conceptual model discussed in the previous chapter highlighted the plurality of cultural interactions; culture as an active process and not something that is inherent in an individual that forms one's identity. Culture is defined, constructed and reconstructed by multiple factors, contexts and situations, which have the potential to affect the lives of individuals both a positively and negatively manner. Hardly any research studies have identified culture as a process in studying mental distress and suicidal behaviour but rather viewed culture as a static variable. The way in which this research has come to use culture and its meanings, in relation to the study of

attempted suicide, stresses upon the contributions of Bourdieu and efforts to qualitatively understand the phenomenon of attempted suicide rather than quantitatively measure and define it as static risk factors for suicide.

In 'structuring roles and gender identities' (see 7.2.1 on page 229), the issue of violence, gender differences, family conflicts and relationship breakdown have been analysed to understand what led to these and how participants perceived such experiences as distressing. Although these issues have been discussed in relation to suicides by a few researchers (Manoranjitham et al., 2007; Bailey et al., 2011; Colucci and Lester, 2012; Fisher, 2011; Gururaj et al., 2004; Kumar, 2003; Lalwani et al., 2004; Mayer, 2011; Staples, 2012b), they paid little attention to considering how the socio-cultural environment constructs and reconstructs the events that produce varying impacts upon the positioning of gender and roles within families and society. This knowledge may be regarded as significant in understanding stressors and planning interventions as it is derived from the experiences and knowledge of survivors, who suffered these phenomena and professionals and healers who were instrumental in helping people cope with stressful situations and treat suicidal behaviour. The accounts of a number of professionals and healers also brought to light how they reinforced some of the negative cultural impacts on role and gender. This knowledge is particularly relevant in analysing the setbacks in suicide prevention, intervention and in a way reconstructing the issue of social stigma that prevents people from approaching help.

The concept of Resilient Habitus may be used as a tool to understand the contradictions that are inherent in the cultural prescriptions for behaviours, norms

and attitudes with the potential for shaping individuals' dispositions. In the previous chapter, this concept has been explained as a way of life and a way of death (see 7.2.1.3 on page 233). The complex interactions between individual and culture, in a given society, are captured within this concept. Although most studies acknowledged the relevance of culture in understanding distress, very few have dealt in depth with the issue of culture (Manoranjitham et al., 2007; Hendin et al., 2008; Patel et al., 2012; Bhugra, 2010; Vijayakumar et al., 2005). A study by Staples (2012b) did highlight a link between cultural influences and suicide, however this work concentrated on investigating a connection between habitus and the means which individuals chose to self-harm or attempt suicide.

This qualitative study applied principles from grounded theory, symbolic interaction and Bourdieu's theoretical framework. As such it is in contrast to the predominantly quantitative approaches as used by many other researchers in the study of suicide (Abraham et al., 2005; Gajalakshmi and Peto, 2007; Prasad et al., 2006; Curtis and Drennan, 2013; Das et al., 2012; Sivasubramanian et al., 2011; Patel et al., 2012; Banerjee et al., 2013). These existing studies aimed to quantify causes by means of psychological tools, surveys and verbal autopsy methods, rather than make use of exploratory designs to investigate risks and perception of risks by means of interviewing survivors, professionals and healers as undertaken in this research.

This study provides a common ground for readers to understand how survivors perceived challenges and responded to them. It also details how professionals and healers conceptualised events and stressors which were presented to them by their

clients. Understanding this conceptualisation allows insight into how they tailor their approach to treatments. For example, in the case of healers it becomes apparent how they bridged the gap between medical and psychosocial intervention.

The power and flexibility of the constant comparison method allowed the researcher to compare and contrast the accounts of survivors, professionals and healers. It assisted in developing conceptual categories and analysing using Bourdieu's theory of habitus, cultural capital, power, symbolic violence and doxa. The analysis of these categories, through Bourdieu's framework, directed the emergence of a proposed model of culture and suicide. The methodological and theoretical approach of the current study draws attention to a rare combination of approaches that investigate the issue of culture and attempted suicide. Such an approach is less common within psychological studies (Bastia and Nilambadhkar., 2009) or sociological theories(Durkheim, 1989) surrounding suicide.

## **8.5 Implications**

The following section outlines implications of this research study for policy, practice and future research.

### **8.5.1 Policy**

The legislation on attempted suicide has had little impact as a deterring factor. It further creates a fear of punishment among people, while also leads to misreporting and lack of follow up on treatment (Mayer, 2011; Vijayakumar et al., 2005). The criminalisation of suicide in India fails to address the issue of wellbeing. There have been several attempts in the past to repeal the legislation on suicide,

however this legislation was upheld in support of a fundamental right “right to life.”

The current Mental Health Bill 2013 decriminalises suicide based on the assumption that persons who attempt suicide are mentally ill. This study widens the scope of understanding the problem of suicide beyond mental illness. It considered the distressing nature of events within families and society as experienced by survivors and accounted by mental health professionals and healers. Thus the study identifies the need to establish a network of village counsellors, mental health professionals and support workers. The aim of this network would be to set up regular visits to the families of individuals who have attempted suicide to study the family situations in order to check for any instances of recurring violence, unemployment, conflicts in marriage or relationship issues and others. By doing so the networking team will establish appropriate support or link them to relevant resources such as employment, legal aid, counselling etc. While the team provides support to individuals in need, it also monitors the family situations and works towards a change of perception and environment within families and communities. This proposition attends to psychosocial needs and calls for policymakers’ attention to address the problem both at an individual and at a community level. A system of constant monitoring and extended support to individuals within families has the potential to prevent repeated attempts at suicide and deaths by suicide. This can only occur in practice if it becomes a policy.

In contemporary society where religious and traditional healings are in practice a system of registration for healers needs to be established. There is a need for constituting a national body that regulates healing practices across India and

establishes ethical responsibility among healers and their clients, while keeping a close check upon violation of human rights.

### **8.5.2 Practice**

The survivors who were admitted into hospital after attempting suicide were referred to a psychiatric unit for a mental health examination. As a policy, psychiatric consultation was made compulsory before they were discharged from the hospital. This indicates that the government has taken the initiative to improve public mental health and create mental health awareness. On the other hand, survivors failed to completely appreciate the benefits of therapeutic interventions (counselling, psychotherapies) in the absence of medication, this finding was consistent with mental health professionals' and healers' accounts (see 7.2.6 on page 253). There was also an issue of social stigma attached to psychiatric consultation that minimised the utilisation of follow up mental health treatment. There is a need to create awareness among the general public about the benefits of psychotherapeutic measures and recognise the need to approach help.

The significance of socio-cultural and religious beliefs identified in the research made traditional and religious healers more easily accessible than mental health professionals. As identified in the findings, a collaboration of a traditional healing system and mental health care enables individuals to deal with their problem situation most effectively and accept mental health care interventions. This collaboration needs to be established on a wider scale although it has been trialled by a few organisations in Karnataka and other states (Raguram et al., 2002). Bringing together bio-medical and healing practices within a common space is



challenging. The healers and professionals may envisage this sort of collaboration as a form of control or fear interference and lack of power or threats that may impact the way they practice.

The focus on how practitioners and healers understand and interpret the contributory factors in cases of attempted suicide is crucial for planning methods of intervention and is eminent in minimising repeated attempts. In this study, professionals and healers demonstrated their understanding from their position of doxa. With regard to mental health professionals, it was noted in this study that due to time pressures they concerned themselves principally with biomedical aspects of diagnosis and had little time to explore risk factors. This observation was also made by Vijayakumar (2007). Failure to explore the socio-cultural context may pose the threat of making a diagnosis that is heavily influenced by the biomedical approach and misjudging a behaviour that has resulted from a negative impact to cultural or social norms. However this aspect needs to be researched further. Therefore, there is a need for mental health professionals to work with healers, counsellors and social workers and take a wider approach in order to; identify risks and deliver effective care, create mental health awareness among the general public and health professionals. This would assist with the early identification of mental health concerns and facilitate means to better target intervention strategies.

Healers were noted to be in a good position to recognise the socio-cultural impact of situations that contributed to suicidal behaviour. Nonetheless, their interpretation at times was associated with religious, astrology, curse and magic

related reasons and therefore their methods of treatment involved religious and traditional means (see Chapter 5 on page 153). The methods used by healers to treat their clients were closely linked to clients' belief systems. The traditional healing system provides a non-medical method of counselling and family intervention and is one which can be instrumental in improving psychosocial situations within families. Healers also claimed that this approach worked best in preparing their clients for a medical or psychiatric treatment where necessary. The drawback in the traditional healing system is that it lacks accountability and ethical responsibility. Thus, there is a need to implement a registration body for practicing healers and conduct workshops on a regular basis to facilitate mutual exchange among healers and professionals, which would improve mental health care in India and create a sense of accountability among healers.

### **8.5.3 Future research**

This research has developed a conceptual model linking culture and attempted suicide. This needs to be compared and tested across different cultures nationally and internationally. As this study was a small-scale exploration of cultural implications of attempted suicide and intervention methods in South India, it would be useful to adopt similar methods in testing the transferability of these research findings and the model in an alternative cultural context such as in England (among survivors of attempted suicide, professionals and healers regardless of cultural heritage). By replicating the study design to explore cultural implications on attempted suicide in England it would be possible to test the validity of concepts

(healing, spirituality, stigma, wellbeing) in relation to suicide and its prevention; and cultural mechanisms presented in this study.

The study identified a need for better understanding of culturally relevant methods used in attempting suicide. It pointed to differences in methods used by men and women in the study. For example, women used self-immolation method and men used a combination of alcohol and poison to attempt suicide. Both these methods were very specific to gender however; however, methods of attempted suicide may vary in different cultures depending upon other factors such as accessibility. It is essential to understand the cultural relevance in the choice of methods in order to prevent suicides.

The complexity involved in classifying a mental health problem or a socio-cultural impact is recognised in the study. Only very limited research has been done on the misconceptions of cultural/social behaviours for mental health problems or vice versa. In order to understand the invisible margin between normal and abnormal behaviour, what is classified as culturally appropriate behaviour and what as a medical/mental health concern, an exploratory and observatory study in cross cultures is needed.

## **8.6 Plans for dissemination**

The research findings will be disseminated through various means to cover a wide range of population both nationally and internationally. The researcher presented initial findings at an International congress of IASP (International Association of Suicide Prevention) in September 2013 and further plans to present the overall findings and the model at forthcoming seminars and conferences. The other means

would be to submit papers for publication in journals that cover the subject area. In order to reach the general public, researcher also plans to submit articles for publication in local (India) news papers and liaise with relevant organisations to present talks on radio, schools and colleges.

## **8.7 Conclusion**

This study has made a significant contribution to understanding the role of culture in causing mental distress and suicidal behaviour within the context of South India. This understanding is essential in planning effective intervention methods to deal with suicidal behaviour and to prevent suicides by creating a policy for intervention. This would provide a comprehensive support system to address the problems individuals face within a family setting. The theoretical concepts discussed in chapter 7 identified the complexity of situations that amount to causing distress and disparity within an individual and amongst individuals. Identification of the constant interaction amongst visible and invisible fields of cultural norms and traditional practices in contemporary society has recognised the power of doxa. Equally there is the constantly structuring capital that impacts upon individuals' habitus. This research identified the need for building a platform upon which healers and mental health professionals could discuss together their approaches to treatment and develop a combination of approaches, inclusive of psychosocial, religious and biomedical methods, to deal with distressing conditions and address the problem of attempted suicide. It is hoped that this research will be a reference point for policy makers, health practitioners, healers and researchers.

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## Appendix A : World Ranking by Suicide Rates

Rank	Country	Year	Males	Females	National suicide rate
1	LITHUANIA	9	61.3	10.4	34.1
2	REPUBLIC OF KOREA	9	39.9	22.1	31
3	RUSSIAN FEDERATION	6	53.9	9.5	30.1
4	BELARUS	9	49.6	9.8	28.4
5	GUYANA	6	39	13.4	26.4
6	KAZAKHSTAN	8	43	9.4	25.6
7	HUNGARY	9	40	10.6	24.6
8	JAPAN	9	36.2	13.2	24.4
9	LATVIA	9	40	8.2	22.9
10	SLOVENIA	9	34.6	9.4	21.9
11	SRI LANKA	96			21.6
12	UKRAINE	9	37.8	7	21.2
13	BELGIUM	5	28.8	10.3	19.4
14	FINLAND	9	29	10	19.3
15	SERBIA	9	28.1	10	18.8
16	ESTONIA	8	30.6	7.3	18.1
17	SWITZERLAND	7	24.8	11.4	18
18	CROATIA	9	28.9	7.5	17.8
19	REPUBLIC OF MOLDOVA	8	30.1	5.6	17.4
20	FRANCE	7	24.7	8.5	16.3
21	URUGUAY	4	26	6.3	15.8
22	AUSTRIA	10	23.7	6.8	15
23	POLAND	8	26.4	4.1	14.9
24	CHINA (Hong Kong SAR)	9	19	10.7	14.6
25	SURINAME	5	23.9	4.8	14.4
26	CZECH REPUBLIC	9	23.9	4.4	14
27	CHINA (Selected rural & urban areas)	99	13	14.8	13.9
28	SLOVAKIA	5	22.3	3.4	12.6
29	BULGARIA	8	18.8	6.2	12.3
30	CUBA	8	19	5.5	12.3
31	GERMANY	10	18.6	6.1	12.3
32	SWEDEN	10	17.9	6.4	12.1
33	ROMANIA	9	21	3.5	12
34	DENMARK	6	17.5	6.4	11.9
35	ICELAND	8	16.5	7	11.9
36	NORWAY	9	17.3	6.5	11.9
37	BOSNIA AND HERZEGOVINA	91	20.3	3.3	11.8
38	IRELAND	9	19	4.7	11.8
39	NEW ZEALAND	7	18.1	5.5	11.7

<b>40</b>	CANADA	4	17.3	5.4	11.3
<b>41</b>	CHILE	7	18.2	4.2	11.1
<b>42</b>	UNITED STATES OF AMERICA	5	17.7	4.5	11
<b>43</b>	TRINIDAD AND TOBAGO	6	17.9	3.8	10.7
<b>44</b>	INDIA	9	13	7.8	10.5
<b>45</b>	SINGAPORE	6	12.9	7.7	10.3
<b>46</b>	LUXEMBOURG	8	16.1	3.2	9.6
<b>47</b>	PORTUGAL	9	15.6	4	9.6
<b>48</b>	NETHERLANDS	9	13.1	5.5	9.3
<b>49</b>	KYRGYZSTAN	9	14.1	3.6	8.8
<b>50</b>	TURKMENISTAN	98	13.8	3.5	8.6
<b>51</b>	AUSTRALIA	6	12.8	3.6	8.2
<b>52</b>	EL SALVADOR	8	12.9	3.6	8
<b>53</b>	ZIMBABWE	90	10.6	5.2	7.9
<b>54</b>	THAILAND	2	12	3.8	7.8
<b>55</b>	ARGENTINA	8	12.6	3	7.7
<b>56</b>	SPAIN	8	11.9	3.4	7.6
<b>57</b>	PUERTO RICO	5	13.2	2	7.4
<b>58</b>	ECUADOR	9	10.5	3.6	7.1
<b>59</b>	UNITED KINGDOM	9	10.9	3	6.9
<b>60</b>	MAURITIUS	8	11.8	1.9	6.8
<b>61</b>	TFYR MACEDONIA	3	9.5	4	6.8
<b>62</b>	ITALY	7	10	2.8	6.5
<b>63</b>	COSTA RICA	9	10.2	1.9	6.1
<b>64</b>	NICARAGUA	6	9	2.6	5.8
<b>65</b>	PANAMA	8	9	1.9	5.5
<b>66</b>	COLOMBIA	7	7.9	2	4.9
<b>67</b>	BRAZIL	8	7.7	2	4.8
<b>68</b>	UZBEKISTAN	5	7	2.3	4.7
<b>69</b>	SEYCHELLES	8	8.9	0	4.6
<b>70</b>	CYPRUS	8	7.4	1.7	4.5
<b>71</b>	GEORGIA	9	7.1	1.7	4.3
<b>72</b>	ISRAEL	7	7	1.5	4.3
<b>73</b>	MEXICO	8	7	1.5	4.2
<b>74</b>	ALBANIA	3	4.7	3.3	4
<b>75</b>	BAHRAIN	6	4	3.5	3.8
<b>76</b>	BELIZE	8	6.6	0.7	3.7
<b>77</b>	SAINT VINCENT AND THE GRENADINES	8	5.4	1.9	3.7
<b>78</b>	GUATEMALA	8	5.6	1.7	3.6
<b>79</b>	PARAGUAY	8	5.1	2	3.6
<b>80</b>	BARBADOS	6	7.3	0	3.5
<b>81</b>	GREECE	9	6	1	3.5
<b>82</b>	MALTA	8	5.9	1	3.4
<b>83</b>	VENEZUELA	7	5.3	1.2	3.2

<b>84</b>	TAJKISTAN	1	2.9	2.3	2.6
<b>85</b>	SAINT LUCIA	5	4.9	0	2.4
<b>86</b>	DOMINICAN REPUBLIC	5	3.9	0.7	2.3
<b>87</b>	PHILIPPINES	93	2.5	1.7	2.1
<b>88</b>	ARMENIA	8	2.8	1.1	1.9
<b>89</b>	KUWAIT	9	1.9	1.7	1.8
<b>90</b>	PERU	7	1.9	1	1.4
<b>91</b>	BAHAMAS	5	1.9	0.6	1.2
<b>92</b>	SAO TOME AND PRINCIPE	87	0	1.8	0.9
<b>93</b>	SOUTH AFRICA	7	1.4	0.4	0.9
<b>94</b>	AZERBAIJAN	7	1	0.3	0.6
<b>95</b>	MALDIVES	5	0.7	0	0.3
<b>96</b>	IRAN	91	0.3	0.1	0.2
<b>97</b>	EGYPT	9	0.1	0	0.1
<b>98</b>	JAMAICA	90	0.3	0	0.1
<b>99</b>	JORDAN	8	0.2	0	0.1
<b>100</b>	SYRIAN ARAB REPUBLIC	85	0.2	0	0.1
<b>101</b>	ANTIGUA AND BARBUDA	95	0	0	0
<b>102</b>	GRENADA	8	0	0	0
<b>103</b>	HAITI	3	0	0	0
<b>104</b>	HONDURAS	78	0	0	0
<b>105</b>	SAINT KITTS AND NEVIS	95	0	0	0

Suicide rate per 100,000

Data Source: (WHO, 2012)

## Appendix B : Rates of Suicides against Midyear Population 2002 -2012

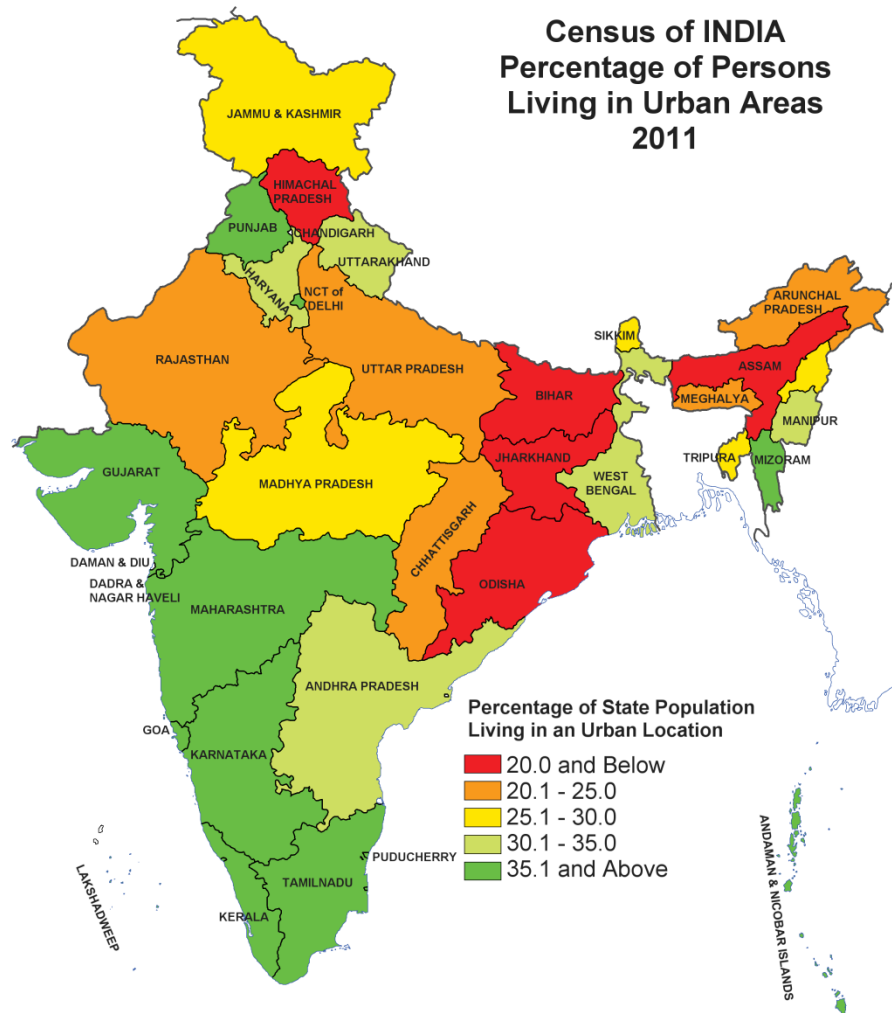
Sl. No.	Year	Total Number of Suicides	Estimated midyear population (in Lakh*)	Rate of suicides (per 100,000)
1	2002	110417	10506	10.5
2	2003	110851	110682	10.4
3	2004	113697	10856	10.5
4	2005	113914	11028	10.3
5	2006	118112	11197.8	10.5
6	2007	122637	11365.5	10.8
7	2008	125017	11531.3	10.8
8	2009	127151	11694.4	10.9
9	2010	134599	11857.6	11.4
10	2011#	135585	12101.9	11.2
11	2012	135445	12133.7	11.2
Percentage change in 2012 Over 2011		-0.1	0.3	-

# Actual Population as per census 2011 (provisional)

\*One Lakh = 0.1 Million = 100,000

Data Source: (National Crime Records Bureau, 2012, p. 190)

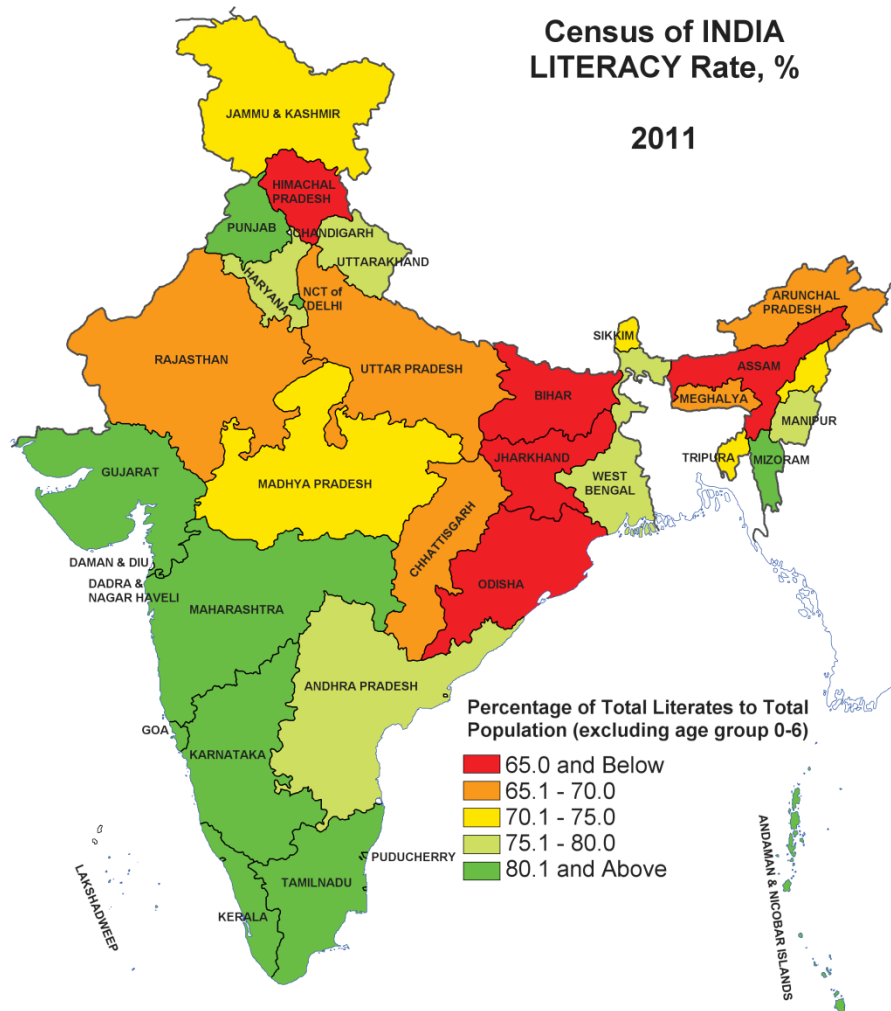
## Appendix C : Urban Population – India 2011



Data Source: (The Registrar General & Census Commissioner, 2011b)

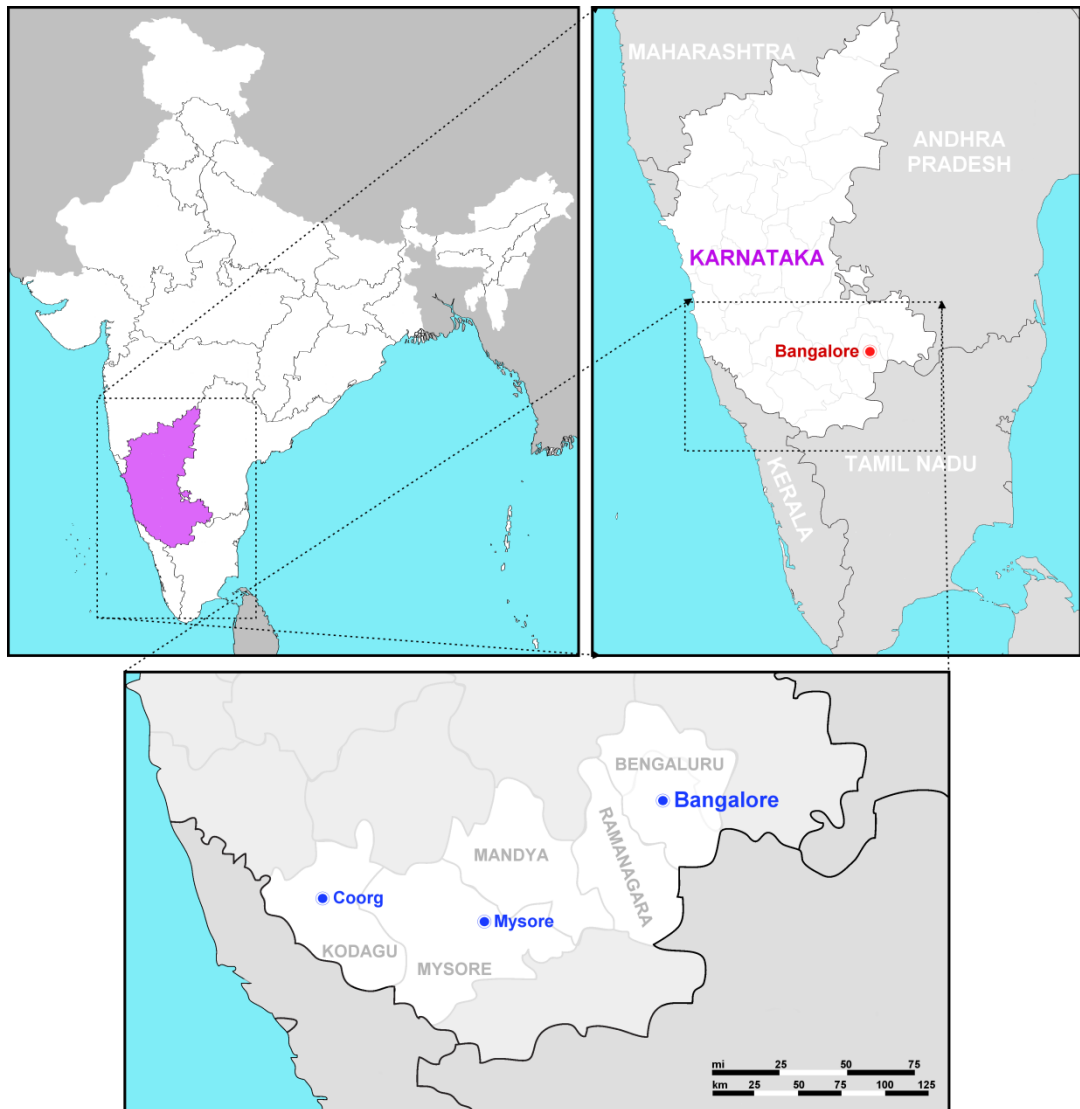


## Appendix D : Literacy Rate – India 2011



Data Source: (The Registrar General & Census Commissioner, 2011a)

## Appendix E : Location of Field Study



## Appendix F : Topic Guides

The topics below are themes, which are for the researcher only. The themed topics are helpful prompts in the interview, for the interviewer. If the interviewee selects a particular topic or topic not covered in the following list, they will be encouraged to concentrate on the same.

### Topic guide for Survivors

1. Demographic details – age, gender, religion, caste, economic status.
2. Family history – nuclear/ joint family, family dynamics
3. Health history – serious illness, chronic problems, medications
4. How did you come to realise that things were not quite right for you.
5. If it's Ok, please could you let me know what led you to attempt suicide?
6. How has your family and neighbours responded to you before and after the attempt.
7. History of attempts and means used
8. Where did you get treated and any psychological support received-
  - a. Intervention types,
  - b. Medical/psychotherapy/counselling/ self-help groups attended/ healing services
9. What was your expectation of the treatment and support you received or approached?
10. What benefits did you get out of these treatment measures?
11. What do you do to help you with distressing feelings/situations?

### Topics which are not covered and survivors wish to discuss

### Topic guide for Mental Health Professionals

1. From your professional experience, what are the key reasons for people attempting to take their lives?
2. What are the most common means used for -
  - a. Attempted suicide
  - b. Completed suicide.

3. What place if any do social, cultural and economic factors have in causing distress?
4. What place if any do social, cultural and economic factors have in treatment?
5. What are the intervention measures in place?
6. On average how many approach these services?
7. How inclusive these services are – in terms of culture etc.
8. What are the patient belief systems?
9. How does their belief system influence the treatment process?

**Topics that are not covered and professionals wish to discuss**

**Topic guide for Traditional Healers**

1. What is your perception of attempted suicide and how do you treat them
2. What are the distressing factors presented to you and what is your perception of these factors.
3. When do people come to for help – soon after the attempt/ when faced with difficulties/ when felt hopeless etc.
4. Who comes for help and is it voluntary – family members or survivors
5. Do they come for a follow up
6. What is the normal duration of your healing process?
7. What are the materials /herbs/medicines used in treatment and the philosophy behind use of these?
8. What is the cost of your service?
9. Why do you think your methods work? Can you give examples of:
  - a) Where a treatment you have offered worked
  - b) Where a treatment you offered did not work

**Topics which are not covered and traditional healers wish to discuss**

# Appendix G : Letter of Ethics Approval

The University  
of Manchester

MANCHESTER  
1824

Faculty of Medical and  
Human Sciences  
The University of Manchester  
Oxford Road  
Manchester M13 9PT

+44(0)161 306 0100  
www.manchester.ac.uk

**Secretary to Research Ethics Committee 1**

Email: [katy.boyle@manchester.ac.uk](mailto:katy.boyle@manchester.ac.uk)

Phone : 0161 375 1360

Miss Reena Lasrado  
Postgraduate Student  
School of Nursing, Midwifery and Social Work  
University of Manchester

[reena.lasrado@postgrad.manchester.ac.uk](mailto:reena.lasrado@postgrad.manchester.ac.uk)

ref: ethics/11336

10 February 2012

Dear Miss Lasrado

**Research Ethics Committee 1**

*Lasrado, Chantler, Young: A study on the cultural implication of attempted suicide and its prevention in India (ref 11336)*

I write to confirm that the amendments to the ethics application form, participant information sheet, consent forms and letter of invitation to participants satisfy the concerns of the Committee and that the above project therefore has ethical approval.

The general conditions remain as stated in my letter of 20<sup>th</sup> January 2012.

Finally, I would be grateful if you could complete and return the attached form at the end of the project or by February 2013, whichever is earlier. When completing this form, please reference your project as:

*Lasrado, Chantler, Young: A study on the cultural implication of attempted suicide and its prevention in India (ref 11336)*

We hope the research goes well.

Yours sincerely,

**Katy Boyle**

**Secretary to University Research Ethics Committee**

# Appendix H : Participant Information Sheet – Survivors

The University  
of Manchester

MANCHESTER  
1824

School of Nursing, Midwifery and Social Work  
The University of Manchester  
Jean McFarlane Building  
Oxford Road  
Manchester  
M13 9PL

+44(0)161 306 7767  
www.nursing.manchester.ac.uk

## Participant Information Sheet – Survivors ಭಾಗವಹಿಸುವ ಬಗ್ಗೆ ಮಾಹಿತಿ ಚೀಟಿ

**A study on the cultural implications of attempted suicide and its prevention in India**  
ಆತ್ಮಹತ್ಯೆಗೆ ಯತ್ನ ಮತ್ತು ಅದನ್ನು ತಡೆಯುವುದರಲ್ಲಿ ಭಾರತೀಯ ಸಂಸ್ಕೃತಿಯ ಪಾತ್ರದ ಬಗ್ಗೆ ಸಂಶೋಧನೆ

**Invitation to participate in research study:**  
ಸಂಶೋಧನೆಯಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಿಮಂತ್ರಣೆ:

You are being invited to take part in a research study. Before you decide it is important for you to understand, why the research is being done and what it will involve. Please take time to read this information carefully. Please ask if anything is not clear (contact details are given at the end of this form). Thank you for taking time to think about taking part in this research.  
ಈ ಸಂಶೋಧನೆಯಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಿರ್ಧಾರ ಮಾಡುವ ಮುನ್ನ ಇದರ ಉದ್ದೇಶ ಏನೆಂದು ತಿಳಿದುಕೊಳ್ಳುವುದು ಅಗತ್ಯ. ಈ ಮಾಹಿತಿ ಚೀಟಿಯನ್ನು ಚೆನ್ನಾಗಿ ಓದಿ, ಯಾವುದೇ ಸಂದೇಹ ಇದ್ದಲ್ಲಿ ನನ್ನನ್ನು ಕೆಳಕಂಡ ವಿಳಾಸ ಅಥವಾ ದೂರವಾಣಿಯ ಮೂಲಕ ಸಂಪರ್ಕಿಸಬಹುದು.

**What is the purpose of the research and interviews?**  
ಸಂಶೋಧನೆ ಮತ್ತು ಸಂದರ್ಶನದ ಉದ್ದೇಶ ಏನು?

The purpose of this research is to explore the *implication of culture* in attempted suicide and its prevention. This research is being completed as a part of my doctoral studies and has been reviewed by the University of Manchester Research Ethics Committee  
ಈ ಸಂಶೋಧನೆಯ ಮುಖ್ಯ ಉದ್ದೇಶ ಭಾರತೀಯ ಸಂಸ್ಕೃತಿಯ ಯಾವ ರೀತಿಯಲ್ಲಿ ಆತ್ಮಹತ್ಯೆಗೆ ಯತ್ನ ಮತ್ತು ಅದನ್ನು ತಡೆಯುವುದರಲ್ಲಿ ಪರಿಣಾಮ ಬೀರಿದೆ. ಸಂದರ್ಶನದಲ್ಲಿ ನಿಮ್ಮ ಮಾನಸಿಕ ಸ್ಥಿತಿ ಮತ್ತು ಮನೋವ್ಯಾಧಿಗಳ ಬಗ್ಗೆ ವಿಚಾರಿಸಲಾಗುತ್ತದೆ. ಆತ್ಮಹತ್ಯೆಗೆ ಕಾರಣ ಹಾಗೂ ಇಂತಹ ಮನೋಭಾವದಿಂದ ಹೊರಬರಲು ತೆಗೆದುಕೊಂಡಂತಹ ಕ್ರಮದ ಬಗ್ಗೆ ಕೂಡ ವಿಚಾರಿಸಲಾಗುತ್ತದೆ. ಈ ಸಂಶೋಧನೆಯು ಪಿಹೆಚ್‌ಡಿ ಪದವಿಯ ಅಂಗವಾಗಿದೆ ಮತ್ತು ಇದು ಉನಿವರ್ಸಿಟಿ ಆಫ್ ಮ್ಯಾನ್ಚೆಸ್ಟರ್‌ನ ಎತಿಕಸ್ ಸಂಗಡಿಂದ ಅನುಮತಿ ಪಡೆದಿದೆ.

**What will taking part involve?**  
ಇದರಲ್ಲಿ ಭಾಗವಹಿಸಲು ಏನು ಒಳಗೊಂಡಿದೆ?

The research involves one face-to-face in depth interview lasting a maximum of two hours exploring why you think people attempt to commit suicide, what aspects and situations in your life caused distress leading to suicide, as well as treatment/healing methods that are used when managing distress and/or attempted suicides. The interviews will be mainly directed towards these issues, but there may be other things, which you consider equally important and so there will be an opportunity to discuss these as the interview is designed to be flexible to allow issues that are important for you to be explored. As your participation is voluntary at no point will you be forced to share information which you do not wish to. Furthermore, you also have the choice to withdraw from the interview at any time and without giving any reason for wanting to stop or withdraw.

ಸಂಶೋಧನೆಯು ತಮ್ಮ ಜೀವನದ ಘಟನೆಗಳ ಬಗ್ಗೆ, ಅವು ತಮ್ಮ ಮಾನಸಿಕ ಸ್ಥಿತಿಯ ಮೇಲೆ ಯಾವ ಪರಿಣಾಮ ಬೀರಿದೆ, ತಮ್ಮ ಆರೋಗ್ಯವನ್ನು ಕಾಪಾಡಿಕೊಳ್ಳಲು ಆತ್ಮಹತ್ಯೆಯ ಯತ್ನದಿಂದ ಹೊರಬರಲು ತೆಗೆದುಕೊಂಡಂತಹ ಕ್ರಮಗಳ ಬಗ್ಗೆ ಸಂದರ್ಶನದಲ್ಲಿ ಕೇಳಲಾಗುತ್ತದೆ. ಇದರಲ್ಲಿ ಭಾಗವಹಿಸಲು ತಮ್ಮ ಮೇಲೆ ಯಾವುದೇ ರೀತಿಯ ಒತ್ತಡ ಅಥವಾ ಬಲವಂತ

ಇರುವುದಿಲ್ಲ. ಭೇಟಿಯಾಗಲು ದಿನ ಮತ್ತು ಸಮಯವನ್ನು ನಿರ್ಧರಿಸಲು ಸಂಪರ್ಕಿಸುತ್ತೇನೆ. ನೀವು ಭಾಗವಹಿಸುವುದಾದರೆ ಅನುಮತಿ ಪತ್ರದ ಮೇಲೆ ಸಹಿ ಮಾಡತಕ್ಕದ್ದು. ಈ ಮಾಹಿತಿಯನ್ನು ನಿಮ್ಮ ಎದುರು ಓದಲಾಗಿದ್ದರೆ ತಮ್ಮ ಅನುಮತಿಯನ್ನು ರೆಕಾರ್ಡ್ ಮಾಡಲಾಗುತ್ತದೆ.

The interview will take place either at your house or in a secure location. It will last up to two hours at the maximum and will be recorded with your permission. The reason why it is best to record the interviews is to facilitate accurate analysis and reporting of the findings. After the interview, the recording will be listened to carefully and every word that is said will be typed up. We do this to help us remember what you have said, to analyse the interview and to ensure there is a full and accurate account of your views. If you prefer not to be recorded, a detailed notes will be taken

ಸಂದರ್ಶನವನ್ನು ಕಛೇರಿಯಲ್ಲಿ ಅಥವಾ ತಮ್ಮ ಮನೆಯಲ್ಲಿ ಅಥವಾ ತಮಗೆ ಸರಿ ಅನ್ನಿಸುವ ಸ್ಥಳದಲ್ಲಿ ನಡೆಸಲಾಗುತ್ತದೆ. ಇದು ಒಂದರಿಂದ ಎರಡು ಗಂಟೆಗಳ ಕಾಲ ನಡೆಯಬಹುದು. ತಾವು ಒಪ್ಪಿಗೆ ಕೊಟ್ಟಲ್ಲಿ ಸಂದರ್ಶನವನ್ನು ರೆಕಾರ್ಡ್ ಮಾಡಲಾಗುತ್ತದೆ. ತಮ್ಮ ಹೇಳಿಕೆಯನ್ನು ರೆಕಾರ್ಡ್‌ನಿಂದ ಕೇಳಿ ಬರೆಯಲಾಗುತ್ತದೆ. ಆದರೆ ತಮ್ಮ ಹೆಸರು, ವಿಳಾಸ ಅಥವಾ ಯಾವುದೇ ರೀತಿಯ ಪರ್ಸನಲ್ ಮಾಹಿತಿಯನ್ನು ಬರೆಯುವುದಿಲ್ಲ. ನಿಮ್ಮ ಹೇಳಿಕೆಯನ್ನು ರೆಕಾರ್ಡ್ ಮಾಡಲು ಇಚ್ಛಿಸದಿದ್ದಲ್ಲಿ ಸಂದರ್ಶನದ ಸಮಯದಲ್ಲಿ ಪರಿಪೂರ್ಣ ನೋಟ್ಸ್ ತೆಗೆದುಕೊಳ್ಳಲಾಗುತ್ತದೆ.

**Why have you asked me to take part?  
ನನ್ನನ್ನು ಯಾಕೆ ಭಾಗವಹಿಸಲು ಕೇಳಲಾಗಿದೆ?**

Your participation is important because your experiences and life events will explain the various cultural, social and economic factors that cause distress. When you share this information and how you coped with difficult and distressing situations, it will help me to understand the stressors and these will be recorded without any personal details being mentioned.

ತಮ್ಮ ಜೀವನದ ಘಟನೆ ಮತ್ತು ಅನುಭವಗಳು ನಮ್ಮ ಸಾಮಾಜಿಕ, ಸಾಂಸ್ಕೃತಿಕ ಮತ್ತು ವ್ಯವಹಾರಿಕ ಸಂಬಂಧ ವಿಷಯಗಳು ಯಾವ ರೀತಿಯಲ್ಲಿ ಮನುಷ್ಯನ ಮನಃಸ್ಥಿತಿಯ ಮೇಲೆ ಪರಿಣಾಮ ಬೀರುತ್ತದೆ ಎಂದು ವಿವರಿಸುತ್ತದೆ. ತಮ್ಮ ಜೀವನದ ಅನುಭವವನ್ನು ಹಂಚುವುದರಿಂದ, ಸಾಮಾಜಿಕ ಸ್ಥಿತಿಯನ್ನು ಅರ್ಥಮಾಡಿಕೊಳ್ಳಲು ಸಹಾಯವಾಗುತ್ತದೆ.

**Do I have to take part in the study?  
ನಾನು ಇದರಲ್ಲಿ ಭಾಗವಹಿಸಲೇಬೇಕಾ?**

No taking part is voluntary. It is up to you to decide whether to take part. If you do not want to participate, you do not have to give a reason and it will not have any impact on you or your treatment. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part and later change your mind that is ok, also, as you can stop taking part in this study at any time and without having to give a reason.

ನಿಮ್ಮ ಮೇಲೆ ಯಾವುದೇ ರೀತಿಯ ಒತ್ತಡ ಅಥವಾ ಬಲವಂತ ಇರುವುದಿಲ್ಲ. ನೀವು ಇಚ್ಛಿಸಿದಲ್ಲಿ ಮಾತ್ರ ಇದರಲ್ಲಿ ಭಾಗಿಯಾಗಬಹುದು. ಸಂದರ್ಶನದ ಮಧ್ಯದಲ್ಲಿ ನೀವು ಮುಂದುವರಿಸಲು ಇಷ್ಟಪಡದಿದ್ದರೆ, ಸಂದರ್ಶನವನ್ನು ಅಲ್ಲಿಗೆ ರದ್ದುಗೊಳಿಸಲಾಗುತ್ತದೆ.

**How do I take part in the Study?  
ಇದರಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಾನು ಏನು ಮಾಡಬೇಕು?**

I will contact you by telephone, email or in person to fix a suitable date and time to obtain your consent once you have given permission for me to do so by informing me of your contact details by filling in the reply slip at the end of this information sheet. When I contact you I will arrange a time for us to meet so that I can interview you if decide you want to take part in this

study. If you decide you want to take part in the study you will also be asked to sign a consent form based on the information given in this information sheet to say that you agree to take part in the study and that you are willing to be interviewed.

ನಿಮ್ಮ ಉತ್ತರವನ್ನು ರಿಸೆಪ್ಷನ್ ಜಾಗದಲ್ಲಿ ಇಟ್ಟಂತಹ ಬಾಕ್ಸ್‌ನಲ್ಲಿ ಹಾಕಬಹುದು ಅಥವಾ ನನಗೆ ಅಂಚೆ ಮುಖಾಂತರ ಅಥವಾ ಫೋನ್ ಮುಖಾಂತರ ತಿಳಿಸಬಹುದು. ನಿಮ್ಮ ಉತ್ತರ ಸಿಕ್ಕಿದ ನಂತರ ನಾನು ನಿಮ್ಮನ್ನು ಸಂದರ್ಶನ ನಡೆಸಲು ವ್ಯವಸ್ಥೆ ಮಾಡುತ್ತೇನೆ. ನೀವು ಭಾಗವಹಿಸುವುದಾದರೆ ಅನುಮತಿ ಪತ್ರದ ಮೇಲೆ ಸಹಿ ಮಾಡತಕ್ಕದ್ದು. ಈ ಮಾಹಿತಿಯನ್ನು ನಿಮ್ಮ ಎದುರು ಓದಲಾಗಿದ್ದರೆ ತಮ್ಮ ಅನುಮತಿಯನ್ನು ರೆಕಾರ್ಡ್ ಮಾಡಲಾಗುತ್ತದೆ.

#### **Will my taking part in the study be kept confidential?**

ನನ್ನ ಭಾಗವಹಿಸುವುದರ ಬಗ್ಗೆ ಯಾರಿಗೂ ತಿಳಿಸಲಾಗುತ್ತದೆ?

Yes. Your personal data (name, address) will be anonymised. All papers, notes and interview records will be kept in a locked cabinet. Typed notes, electronic audio files will be stored on a password-protected, encrypted computer within a locked cabinet. Notes and computer files will not be played or shown to anyone other than me the researcher and my (two) faculty supervisors Professor Alys Young and Dr Khatidja Chantler. After the completion of this project, your personal data will be destroyed however; the notes and transcripts, which are digitised, will be stored for 10 years at the University of Manchester. When I type up the recordings made during the interviews and write about the results of the research, all personal details will be removed so that no one will know who you are. No real names will be used on any publications.

ಈ ಸಂದರ್ಶನದಲ್ಲಿ ನೀವು ಹೇಳಿದಂತಹ ಯಾವುದೇ ವಿಚಾರವನ್ನು ತಮ್ಮ ಹೆಸರಿನೊಡನೆ, ಯಾವುದೇ ಸಂದರ್ಭದಲ್ಲಿಯೂ ಹೊರತರಲಾಗುವುದಿಲ್ಲ. ನಿಮ್ಮ ಹೆಸರು, ವಿಳಾಸವನ್ನು ಯಾರಿಗೂ ಹೇಳಲಾಗುವುದಿಲ್ಲ. ಬರೆದಂತಹ ನೋಟ್ಸ್, ರೆಕಾರ್ಡ್ ಇವುಗಳನ್ನು ಪಾಸ್‌ವರ್ಡ್ ಹಾಕಿ ಸಂರಕ್ಷಿಸಲಾಗುತ್ತದೆ. ಈ ಮಾಹಿತಿಯನ್ನು ನಾನು ಮತ್ತು ನನ್ನ ಗುರುಗಳೊಡನೆ ವಿಚಾರಿಸಲು ಉಪಯೋಗಿಸಲಾಗುತ್ತದೆ. ಸಂಶೋಧನೆ ಪೂರ್ಣಗೊಂಡ ನಂತರ, ಈ ಎಲ್ಲಾ ಮೆಟೀರಿಯಲ್ 10 ವರ್ಷಗಳ ತನಕ ವಿಶ್ವವಿದ್ಯಾನಿಲಯದಲ್ಲಿ ಸಂಗ್ರಹಿಸಲಾಗುತ್ತದೆ. ನಿಮ್ಮ ಪರ್ಸನಲ್(ಹೆಸರು, ವಿಳಾಸ) ಡಿಜಿಟೈಲ್‌ನ್ನು ಯಾರಿಗೂ ಕೊಡಲಾಗುವುದಿಲ್ಲ.

#### **Are there any benefits in taking part?**

ಇದರಿಂದ ನನಗೇನು ಒಳಿತು?

Although there may be no direct benefits to you personally, the interviews will help me to understand if culture has an impact on suicide attempts. The researcher might be able to link you with various support agencies to help you deal with the problem situation.

ನಿಮ್ಮ ಹೇಳಿಕೆಯು ಈ ಸಮಾಜದ ಪರಿಸ್ಥಿತಿ ಮತ್ತು ನಿಮ್ಮ ಜೀವನದ ಆಗುಹೋಗುಗಳ ಮೇಲೆ ಸಂಸ್ಕೃತಿಯ ಪರಿಣಾಮವನ್ನು ಅರ್ಥೈಸಿಕೊಳ್ಳಲು ಸಹಾಯಕವಾಗುತ್ತದೆ. ನಿಮಗೆ ಅಗತ್ಯ ಇದಲಿ ಮತು ಕಷ್ಟ ನಿವಾರಣೆಗೆ ನೆರವು ನೀಡುವ ಸಂಘಗಳ ಬಗ್ಗೆ ಮಾಹಿತಿ ನೀಡಲಾಗುವುದು

#### **Are there any disadvantages or risks to helping with this research?**

ಇದರಿಂದ ನನಗಾಗುವ ದುಷ್ಪರಿಣಾಮ ಏನು?

The interviews are likely to last for up to two hours, which you might consider to be time consuming. However, the interviews can be split over two sessions if you prefer. Although the actual length of the discussion will depend on how much or how little you have to say, so they may last much less than the two hours stated here.

ಸಂದರ್ಶನವು ಒಂದರಿಂದ ಎರಡು ಘಂಟೆ ತೆಗೆದುಕೊಳ್ಳಬಹುದು. ನೀವು ಇಷ್ಟ ಪಟ್ಟಲ್ಲಿ ಈ ಸಂದರ್ಶನವನ್ನು ಎರಡು ಭಾಗವಾಗಿ ನಿರ್ವಹಿಸ ಬಹುದು. ನಿಮ್ಮ ಉತ್ತರದ ಮೇರೆಗೆ ಕಾಲವನು ನಿರ್ದರಿಸಲಾಗುತ್ತದೆ.



As this is a very sensitive subject and involves you to revisit those distressing moments and events of life, it may be that you undergo emotional distress during the interview or after the interview.

ಇಲ್ಲಿ ಕೇಳುವ ವಿಷಯಗಳಿಂದ, ನಿಮ್ಮ ಮನಸ್ಸಿನ ದುಃಖ ಸಂದರ್ಶನ ಸಮಯದಲ್ಲಿ ಅತವ ನಂತರ ಹೆಚ್ಚಿಬಹುದು.

**Will I be paid for participation?**

ಇದರಲ್ಲಿ ಭಾಗವಹಿಸಿದರೆ ನನಗೇನು ಸಿಗುತ್ತದೆ?

No, you will not be paid for taking part in the research study. However if you incur any additional expenses as a result of taking part in this study, travel expenses, up to a maximum of Rs100 will be paid.

ಸಂದರ್ಶನಕ್ಕಾಗಿ ನೀವು ಬಸ್ಸು ಅಥವಾ ರಿಕ್ಷಾದಲ್ಲಿ ಬಂದಿದ್ದರೆ ಅದರ ಖರ್ಚಿನ ಹಣವನ್ನು ಗರಿಷ್ಠ ೧೦೦ ರೂ ಕೊಡಲಾಗುತ್ತದೆ.

**What if something goes wrong?**

ಏನಾದರೂ ತಪ್ಪಾದಲ್ಲಿ ನಾನೇನು ಮಾಡಬೇಕು?

It is very unlikely that you will come to any harm as a result of taking part in this research. In the unlikely event that you undergo distress you will be directed to the counsellors or organizations that extend support. In case you undergo further distress and are still thinking of attempting suicide, I will be obliged to break confidentiality with the relevant support services to ensure your safety and wellbeing. The university insurance scheme provides indemnity cover for this research study.

ಈ ಸಂಶೋಧನೆಯಿಂದ ನಿಮಗೆ ಯಾವುದೇ ರೀತಿಯ ಹಾನಿ ಉಂಟಾಗುವುದಿಲ್ಲ. ಸಂದರ್ಶನವು ನಿಮ್ಮ ಮನಸ್ಸಿನ ಮೇಲೆ ಪರಿಣಾಮ ಬೀರಿದಲ್ಲಿ, ನಿಮಗೆ ಕೌನ್ಸಿಲಿಂಗ್ ಸೇವೆಯನ್ನು ಒದಗಿಸಲಾಗುತ್ತದೆ ಅಥವಾ ಬೇರೆ ಸಂಸ್ಥೆಯಿಂದ ಸಹಾಯವನ್ನು ಒದಗಿಸಲಾಗುತ್ತದೆ. ನೀವು ದುಃಖದ ಮನಸ್ಸಿನಲ್ಲಿರುವ ಪುನಃ ಆತ್ಮಹತ್ಯೆ ಮಾಡುವುದರ ಬಗ್ಗೆ ಚಿಂತಿಸುತ್ತಿದ್ದರೆ, ನಿಮಗೆ ಒಲಿತನು ಉದೇಶಿಸಿ ಆಯ ಸಂಘದ ಅಥವಾ ನಿಮಗೆ ಸಹಾಯ ನಿಧುವವರ ಹಿತರ ಹೇಳಲಾಗುತ್ತದೆ.

**What do I do if I have a complaint?**

ಯಾವುದೇ ದೂರು ಇದ್ದಲ್ಲಿ ಏನು ಮಾಡಬೇಕು?

If you are unhappy about any aspect of this study then in the first instance, please let me know. If you do not feel comfortable doing this then you can contact my supervisor, Dr Khatidja Chantler ([khatidja.chantler@manchester.ac.uk](mailto:khatidja.chantler@manchester.ac.uk)), at The School of Nursing, Midwifery and Social Work The University of Manchester Room 4.309, Jean McFarlane Building University Place Oxford Road Manchester M13 9PL. Every step will be taken to deal with your complaint quickly and appropriately.

ನಿಮಗೆ ಏನೇ ತೊಂದರೆ ಆದಲ್ಲಿ ನನಗೆ ತಿಳಿಸಬಹುದು. ನನಗೆ ತಿಳಿಸುವುದು ಅನುಚಿತವೆಂದು ತಿಳಿದರೆ ನನ್ನ ಗುರುಗಳನ್ನು ಸಂಪರ್ಕಿಸಬಹುದು. ಅವರ ಈಮೇಲ್ ವಿಳಾಸ ಈ ಕೆಳಗಿನಂತಿದೆ:

EMAIL: [khatidja.chantler@manchester.ac.uk](mailto:khatidja.chantler@manchester.ac.uk)

**Future research**

ಮುಂದುವರಿಯುವ ಸಂಶೋಧನೆ:

You will not automatically be expected to take part in any future research. The details you provide will not be used to contact you regarding other studies.

ನೀವು ಬೇರೆ ಸಂಶೋಧನೆಯಲ್ಲಿ ಭಾಗವಹಿಸುವ ಅಗತ್ಯವಿಲ್ಲ. ನೀವು ಹೇಳಿದ ವಿಚಾರಗಳನ್ನು ಬೇರೆ ಸಂಶೋಧನೆಯಲ್ಲಿ ಬಳಕೆ ಮಾಡಲಾಗುವುದಿಲ್ಲ.

**What do I need to do next?**

**ಈಗ ನಾನೇನು ಮಾಡಬೇಕು?**

If you are happy to help with the research, please complete all sections of the enclosed reply slip. If I receive a response to tell me that you are willing to take part, then I will telephone you to arrange the interview. The interview will take place at a time and place convenient to you.

ನೀವು ಭಾಗವಹಿಸಲು ಇಚ್ಛಿಸುವುದಾದರೆ, ಉತ್ತರ ಜೇಟಿ ಸಂಪೂರ್ಣಗೊಳಿಸಿ ನನಗೆ ಕಳುಹಿಸಿ. ನಿಮ್ಮ ಉತ್ತರ ಸಿಕ್ಕಿದರೆ ನಾನು ನಿಮ್ಮನ್ನು ಸಂಪರ್ಕಿಸುತ್ತೇನೆ.

If you would like more information or want to ask some questions about this research please contact:

ಬೇರೆ ಮಾಹಿತಿ ಬೇಕಿದ್ದಲ್ಲಿ ನನ್ನನ್ನು ಕೆಳಕಂಡ ವಿಳಾಸದಲ್ಲಿ ಕಾಣಬಹುದು ಅಥವಾ ದೂರವಾಣಿ ಕರೆ ಮಾಡಬಹುದು.

**Reena A Lasrado**

ರೀನಾ ಅ ಲಸ್ರಾದೋ

PhD Student (Social work)

Nirmala Hostel

1 Davis Road

Bangalore – 560084

Tel: 9481772224 E-mail: reena.lasrado@postgrad.manchester.ac.uk

**Thank you for taking the time to read this.**

ವಂದನೆಗಳು

# Appendix I : Participant Information Sheet – Traditional Healers

The University  
of Manchester

MANCHESTER  
1824

School of Nursing, Midwifery and Social Work  
The University of Manchester  
Jean McFarlane Building  
Oxford Road  
Manchester  
M13 9PL

+44(0)161 306 7767  
www.nursing.manchester.ac.uk

## Participant Information Sheet – Traditional Healers ಭಾಗವಹಿಸುವ ಬಗ್ಗೆ ಮಾಹಿತಿ ಚೀಟಿ

**A study on the cultural implications of attempted suicide and its prevention in India**  
ಆತ್ಮಹತ್ಯೆಗೆ ಯತ್ನ ಮತ್ತು ಅದನ್ನು ತಡೆಯುವುದರಲ್ಲಿ ಭಾರತೀಯ ಸಂಸ್ಕೃತಿಯ ಪಾತ್ರದ ಬಗ್ಗೆ ಸಂಶೋಧನೆ.

**Invitation to participate in research study.**  
ಸಂಶೋಧನೆಯಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಿಮಂತ್ರಣೆ:

You are being invited to take part in a research study. Before you decide it is important for you to understand, why the research is being done and what it will involve. Please take time to read this information carefully. Please ask if anything is not clear (contact details are given at the end of this form). Thank you for taking time to think about taking part in this research.

ಈ ಸಂಶೋಧನೆಯಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಿರ್ಧಾರ ಮಾಡುವ ಮುನ್ನ ಇದರ ಉದ್ದೇಶ ಏನೆಂದು ತಿಳಿದುಕೊಳ್ಳುವುದು ಅಗತ್ಯ. ಈ ಮಾಹಿತಿ ಚೀಟಿಯನ್ನು ಚೆನ್ನಾಗಿ ಓದಿ, ಯಾವುದೇ ಸಂದೇಹ ಇದ್ದಲ್ಲಿ ನನ್ನನ್ನು ಕೆಳಕಂಡ ವಿಳಾಸ ಅಥವಾ ದೂರವಾಣಿಯ ಮೂಲಕ ಸಂಪರ್ಕಿಸಬಹುದು.

**What is the purpose of the research and interviews?**  
ಸಂಶೋಧನೆ ಮತ್ತು ಸಂದರ್ಶನದ ಉದ್ದೇಶ ಏನು?

The purpose of this research is to explore the *implication of culture* in attempted suicide and its prevention. This research is being completed as a part of my doctoral studies and has been reviewed by the University of Manchester Research Ethics Committee.

ಈ ಸಂಶೋಧನೆಯ ಮುಖ್ಯ ಉದ್ದೇಶ ಭಾರತೀಯ ಸಂಸ್ಕೃತಿಯ ಯಾವ ರೀತಿಯಲ್ಲಿ ಆತ್ಮಹತ್ಯೆಗೆ ಯತ್ನ ಮತ್ತು ಅದನ್ನು ತಡೆಯುವುದರಲ್ಲಿ ಪರಿಣಾಮ ಬೀರಿದೆ. ಸಂದರ್ಶನದಲ್ಲಿ ನಿಮ್ಮ ಮಾನಸಿಕ ಸ್ಥಿತಿ ಮತ್ತು ಮನೋವ್ಯಾಧಿಗಳ ಬಗ್ಗೆ ವಿಚಾರಿಸಲಾಗುತ್ತದೆ. ಆತ್ಮಹತ್ಯೆಗೆ ಕಾರಣ ಹಾಗೂ ಇಂತಹ ಮನೋಭಾವದಿಂದ ಹೊರಬರಲು ತೆಗೆದುಕೊಂಡಂತಹ ಕ್ರಮದ ಬಗ್ಗೆ ಕೂಡ ವಿಚಾರಿಸಲಾಗುತ್ತದೆ. ಈ ಸಂಶೋಧನೆಯು ಪಿಹೆಚ್‌ಡಿ ಪದವಿಯ ಅಂಗವಾಗಿದೆ ಮತ್ತು ಇದು ಉನಿವರ್ಸಿಟಿ ಆಫ್ ಮ್ಯಾನಚೆಸ್ಟರ್‌ನ ವಿಕಿರಣ ಸಂಗಡಿಂದ ಅನುಮತಿ ಪಡೆದಿದೆ.

**Why have you asked me to take part?**  
ಇದರಲ್ಲಿ ಭಾಗವಹಿಸಲು ಏನು ಒಳಗೊಂಡಿದೆ?

You have been invited to take part in this study because you have experience of treating survivors of attempted suicide. In addition, you also live and work in a cultural setting similar to that, experienced by your patients. This experience and insight will be of benefit to this study. ನಿಮ್ಮ ಭಾಗವಹಿಸುವಿಕೆ ತುಂಬಾ ಅಗತ್ಯವಿದೆ. ಯಾಕೆಂದರೆ ನೀವು ಈ ಸಮಾಜದ ನೀತಿ ನಿಯಮಗಳನ್ನು ಚೆನ್ನಾಗಿ ಅರಿತಿದ್ದೀರಿ ಮತ್ತು ಅದಕ್ಕೆ ಅನುಸಾರವಾದಂತಹ ಚಿಕಿತ್ಸೆಯನ್ನು ಒದಗಿಸುತ್ತೀರಿ. ನಿಮ್ಮ ಅನುಭವವನ್ನು ಹೆಳುವುದರಿಂದ ಈ ಸಂಶೋಧನೆಗೆ ತುಂಬಾ ಸಹಾಯವಾಗುತ್ತದೆ.

**Do I have to take part in the study?**  
ನಾನು ಇದರಲ್ಲಿ ಭಾಗವಹಿಸಲೇಬೇಕಾ?

No taking part is voluntary. It is up to you to decide whether to take part. If you do not want to participate, you do not have to give a reason and it will not have any impact on your or your

career. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part and later change your mind that is ok, also, as you can stop taking part in this study at any time and without having to give a reason.

ನಿಮ್ಮ ಮೇಲೆ ಯಾವುದೇ ರೀತಿಯ ಒತ್ತಡ ಅಥವಾ ಬಲವಂತ ಇರುವುದಿಲ್ಲ. ನೀವು ಇಚ್ಛಿಸಿದಲ್ಲಿ ಮಾತ್ರ ಇದರಲ್ಲಿ ಭಾಗಿಯಾಗಬಹುದು. ಸಂದರ್ಶನದ ಮಧ್ಯದಲ್ಲಿ ನೀವು ಮುಂದುವರಿಸಲು ಇಷ್ಟಪಡದಿದ್ದರೆ, ಸಂದರ್ಶನವನ್ನು ಅಲ್ಲಿಗೆ ರದ್ದುಗೊಳಿಸಲಾಗುತ್ತದೆ.

#### **How do I take part in the Study?**

**ಇದರಲ್ಲಿ ಭಾಗವಹಿಸಲು ನಾನು ಏನು ಮಾಡಬೇಕು?**

I will contact you by telephone, email or in person to fix a suitable date and time to obtain your consent once you have given permission for me to do so by informing me of your contact details by filling in the reply slip at the end of this information sheet. When I contact you I will arrange a time for us to meet so that I can interview you if decide you want to take part in this study. If you decide you want to take part in the study you will also be asked to sign a consent form based on the information given in this information sheet to say that you agree to taking part in the study and that you are willing to be interviewed. Researcher will be accompanied by another person while visiting you to conduct the interview.

ನಿಮ್ಮ ಉತ್ತರವನ್ನು ರಿಸ್ಪಾನ್ಸ್ ಜಾಗದಲ್ಲಿ ಇಟ್ಟಂತಹ ಬಾಕ್ಸ್‌ನಲ್ಲಿ ಹಾಕಬಹುದು ಅಥವಾ ನನಗೆ ಅಂಚೆ ಮುಖಾಂತರ ಅಥವಾ ಫೋನ್ ಮುಖಾಂತರ ತಿಳಿಸಬಹುದು. ಇದರಲ್ಲಿ ಭಾಗವಹಿಸಲು ತಮ್ಮ ಮೇಲೆ ಯಾವುದೇ ರೀತಿಯ ಒತ್ತಡ ಅಥವಾ ಬಲವಂತ ಇರುವುದಿಲ್ಲ. ಭೇಟಿಯಾಗಲು ದಿನ ಮತ್ತು ಸಮಯವನ್ನು ನಿರ್ಧರಿಸಲು ಸಂಪರ್ಕಿಸುತ್ತೇನೆ. ನೀವು ಭಾಗವಹಿಸುವುದಾದರೆ ಅನುಮತಿ ಪತ್ರದ ಮೇಲೆ ಸಹಿ ಮಾಡತಕ್ಕದ್ದು. ಈ ಮಾಹಿತಿಯನ್ನು ನಿಮ್ಮ ಎದುರು ಓದಲಾಗಿದ್ದರೆ ತಮ್ಮ ಅನುಮತಿಯನ್ನು ರೆಕಾರ್ಡ್ ಮಾಡಲಾಗುತ್ತದೆ. ನಿಮ್ಮ ಉತ್ತರ ಸಿಕ್ಕಿದ ನಂತರ ನಾನು ನಿಮ್ಮನ್ನು ಸಂದರ್ಶನ ನಡೆಸಲು ವ್ಯವಸ್ಥೆ ಮಾಡುತ್ತೇನೆ. ಸಂಶೋಧಕರೊಂದಿಗೆ ಮತೋಬ ವ್ಯಕ್ತಿಯೇ ಇರ ಬಹುದು.

#### **What will taking part involve?**

**ಇದರಲ್ಲಿ ಭಾಗವಹಿಸಲು ಏನು ಒಳಗೊಂಡಿದೆ?**

The research involves one face-to-face in depth interview lasting a maximum of two hours exploring why you think people attempt to commit suicide, what aspects and situations in life cause distress leading to suicide, as well as treatment/healing methods that are used when managing distress and/or attempted suicides. The interviews will be mainly directed towards these issues, but there may be other things, which you consider equally important and so there will be an opportunity to discuss these as the interview is designed to be flexible to allow issues that are important for you and your patients to be explored. As your participation is voluntary at no point will you be forced to share information which you do not wish to. Furthermore, you also have the choice to withdraw from the interview at any time and without giving any reason for wanting to stop or withdraw.

ಸಂಶೋಧನೆಯು ಏಕವಿಧದ ಜೀವನದ ಘಟನೆಗಳ ಬಗ್ಗೆ, ಅವರ ಮಾನಸಿಕ ಸ್ಥಿತಿಯ ಮೇಲೆ ಯಾವ ಪರಿಣಾಮ ಬೀರಿದೆ, ಅವರ ಆರೋಗ್ಯವನ್ನು ಕಾಪಾಡಿಕೊಳ್ಳಲು ಆತ್ಮಹತ್ಯೆಯ ಯತ್ನದಿಂದ ಹೊರಬರಲು ತೆಗೆದುಕೊಂಡಂತಹ ಕ್ರಮಗಳ ಬಗ್ಗೆ ಸಂದರ್ಶನದಲ್ಲಿ ಕೇಳಲಾಗುತ್ತದೆ. ಆತ್ಮಹತ್ಯೆಗೆ ಕಾರಣ ಹಾಗೂ ಇಂತಹ ಮನೋಭಾವದಿಂದ ಹೊರಬರಲು ತೆಗೆದುಕೊಂಡಂತಹ ಕ್ರಮದ ಬಗ್ಗೆ ಕೂಡ ವಿಚಾರಿಸಲಾಗುತ್ತದೆ. ಇದರಲ್ಲಿ ಭಾಗವಹಿಸಲು ತಮ್ಮ ಮೇಲೆ ಯಾವುದೇ ರೀತಿಯ ಒತ್ತಡ ಅಥವಾ ಬಲವಂತ ಇರುವುದಿಲ್ಲ.

The interview will take place either at your place of work or in a secure location. It will last up to two hours at the maximum and will be recorded with your permission. The reason why it is best to record the interviews is to facilitate accurate analysis and reporting of the findings. After the interview, the recording will be listened to carefully and every word that is said will be typed up. We do this to help us remember what you have said, to analyse the interview and to ensure

there is a full and accurate account of your views. If you prefer not to be recorded, a detailed notes will be taken.

ಸಂದರ್ಶನವನ್ನು ಕಛೇರಿಯಲ್ಲಿ ಅಥವಾ ತಮ್ಮ ಮನೆಯಲ್ಲಿ ಅಥವಾ ತಮಗೆ ಸರಿ ಅನ್ನಿಸುವ ಸ್ಥಳದಲ್ಲಿ ನಡೆಸಲಾಗುತ್ತದೆ. ಇದು ಒಂದರಿಂದ ಎರಡು ಗಂಟೆಗಳ ಕಾಲ ನಡೆಯಬಹುದು. ತಾವು ಒಪ್ಪಿಗೆ ಕೊಟ್ಟಲ್ಲಿ ಸಂದರ್ಶನವನ್ನು ರೆಕಾರ್ಡ್ ಮಾಡಲಾಗುತ್ತದೆ. ತಮ್ಮ ಹೇಳಿಕೆಯನ್ನು ರೆಕಾರ್ಡ್‌ನಿಂದ ಕೇಳಿ ಬರೆಯಲಾಗುತ್ತದೆ. ಆದರೆ ತಮ್ಮ ಹೆಸರು, ವಿಳಾಸ ಅಥವಾ ಯಾವುದೇ ರೀತಿಯ ಪರ್ಸನಲ್ ಮಾಹಿತಿಯನ್ನು ಬರೆಯುವುದಿಲ್ಲ. ನಿಮ್ಮ ಹೇಳಿಕೆಯನ್ನು ರೆಕಾರ್ಡ್ ಮಾಡಲು ಇಚ್ಛಿಸದಿದ್ದಲ್ಲಿ ಸಂದರ್ಶನದ ಸಮಯದಲ್ಲಿ ಪರಿಪೂರ್ಣ ನೋಟ್ಸ್ ತೆಗೆದುಕೊಳ್ಳಲಾಗುತ್ತದೆ.

**Will my taking part in the study be kept confidential?  
ನನ್ನ ಭಾಗವಹಿಸುವುದರ ಬಗ್ಗೆ ಯಾರಿಗೆ ತಿಳಿಸಲಾಗುತ್ತದೆ?**

Yes. Your personal data (name, address) will be anonymised. All papers, notes and interview records will be kept in a locked cabinet. Typed notes, electronic audio files will be stored on a password-protected, encrypted computer within a locked cabinet. Notes and computer files will not be played or shown to anyone other than me the researcher and my (two) faculty supervisors Professor Alys Young and Dr Khatidja Chantler. After the completion of this project, your personal data will be destroyed however; the notes and transcripts, which are digitised, will be stored for 10 years at the University of Manchester. When I type up the recordings made during the interviews and write about the results of the research, all personal details will be removed so that no one will know who you are. No real names will be used on any publications.

ಈ ಸಂದರ್ಶನದಲ್ಲಿ ನೀವು ಹೇಳಿದಂತಹ ಯಾವುದೇ ವಿಚಾರವನ್ನು ತಮ್ಮ ಹೆಸರಿನೊಡನೆ, ಯಾವುದೇ ಸಂದರ್ಭದಲ್ಲಿಯೂ ಹೊರತರಲಾಗುವುದಿಲ್ಲ. ನಿಮ್ಮ ಹೆಸರು, ವಿಳಾಸವನ್ನು ಯಾರಿಗೂ ಹೇಳಲಾಗುವುದಿಲ್ಲ. ಬರೆದಂತಹ ನೋಟ್ಸ್, ರೆಕಾರ್ಡ್ ಐವುಗಳನ್ನು ಪಾಸ್‌ವರ್ಡ್ ಹಾಕಿ ಸಂರಕ್ಷಿಸಲಾಗುತ್ತದೆ. ಈ ಮಾಹಿತಿಯನ್ನು ನಾನು ಮತ್ತು ನನ್ನ ಗುರುಗಳೊಡನೆ ವಿಚಾರಿಸಲು ಉಪಯೋಗಿಸಲಾಗುತ್ತದೆ. ಸಂಶೋಧನೆ ಪೂರ್ಣಗೊಂಡ ನಂತರ, ಈ ಎಲ್ಲಾ ಮೆಟೀರಿಯಲ್ 10 ವರ್ಷಗಳ ತನಕ ವಿಶ್ವವಿದ್ಯಾನಿಲಯದಲ್ಲಿ ಸಂಗ್ರಹಿಸಲಾಗುತ್ತದೆ. ನಿಮ್ಮ ಪರ್ಸನಲ್(ಹೆಸರು, ವಿಳಾಸ) ಡಿಜಿಟೈಲ್‌ನ್ನು ಯಾರಿಗೂ ಕೊಡಲಾಗುವುದಿಲ್ಲ.

**Distress Policy**

In case you become distressed during the course of the interview, I will be able to actively listen to your thoughts and, I will be able to provide you with the contact details of agencies which accept self referrals. Alternatively, the interview will be stopped and re-arranged for another time if you wish to continue.

ಈ ಸಂಶೋಧನೆಯಿಂದ ನಿಮಗೆ ಯಾವುದೇ ರೀತಿಯ ಹಾನಿ ಉಂಟಾಗುವುದಿಲ್ಲ. ಸಂದರ್ಶನವು ನಿಮ್ಮ ಮನಃಸ್ಥಿತಿಯ ಮೇಲೆ ಪರಿಣಾಮ ಬೀರಿದಲ್ಲಿ, ನಿಮಗೆ ಕೌನ್ಸಿಲಿಂಗ್ ಸೇವೆಯನ್ನು ಒದಗಿಸಲಾಗುತ್ತದೆ ಅಥವಾ ಬೇರೆ ಸಂಸ್ಥೆಯಿಂದ ಸಹಾಯವನ್ನು ಒದಗಿಸಲಾಗುತ್ತದೆ. ಅಥವಾ ಸಂದರ್ಶನವನ್ನು ಮುಂದುವರಿಸಲಾಗುತ್ತದೆ.

**Are there any benefits in taking part?**

ಇದರಿಂದ ನನಗೇನು ಒಳಿತು?

Although there may be no direct benefits to you personally, the interviews will help me to understand if culture has an impact on suicide attempts and the role of traditional methods in suicide prevention.

ನಿಮ್ಮ ಹೇಳಿಕೆಯು ಈ ಸಮಾಜದ ಪರಿಸ್ಥಿತಿ ಮತ್ತು ನಿಮ್ಮ ಜೀವನದ ಅನುಭವಗಳ ಮೇಲೆ ಸಂಸ್ಕೃತಿಯ ಪರಿಣಾಮವನ್ನು ಅರ್ಥೈಸಿಕೊಳ್ಳಲು ಸಹಾಯಕವಾಗುತ್ತದೆ. ಆತ್ಮಹತ್ಯೆಗೆ ಕಾರಣ ಹಾಗೂ ಇಂತಹ ಮನೋಭಾವದಿಂದ ಹೊರಬರಲು ತೆಗೆದುಕೊಂಡಂತಹ ಕ್ರಮದ ಬಗ್ಗೆ ಮಾಹಿತಿ ಆತ್ಮಹತ್ಯೆ ತಡೆಯುವುದರಲ್ಲಿ ಸಹಾಯವಾಗುತ್ತದೆ.

**Are there any disadvantages or risks to helping with this research?**

ಇದರಿಂದ ನನಗಾಗುವ ದುಷ್ಪರಿಣಾಮ ಏನು?

The interviews are likely to last for up to two hours, which you might consider to be time consuming. However, the interviews can be split over two sessions if you prefer. Although the actual length of the discussion will depend on how much or how little you have to say, so they may last much less than the two hours stated here.

ಸಂದರ್ಶನವು ಒಂದರಿಂದ ಎರಡು ಘಂಟೆ ತೆಗೆದುಕೊಳ್ಳಬಹುದು. ನೀವು ಇಷ್ಟ ಪಟ್ಟಲ್ಲಿ ಈ ಸಂದರ್ಶನವನ್ನು ಎರಡು ಭಾಗವಾಗಿ ನಿರ್ವಹಿಸಬಹುದು. ನಿಮ್ಮ ಉತ್ತರದ ಮೇರೆಗೆ ಕಾಲವನ್ನು ನಿರ್ದೇಶಿಸಲಾಗುತ್ತದೆ.

It is anticipated that you operate within professional and ethical guidelines however in the unlikely event that information is revealed during the interview about any criminal activity, this will need to be reported to the relevant authorities (e.g. police or mosque/temple authorities).

ಈ ಸಂದರ್ಶನದ ವೇಳೆಯಲ್ಲಿ ಯಾವುದೇ ರೀತಿಯ ಖಾನೂನಿನ ಅಥವಾ ಮಾನವ ಹಕ್ಕನ್ನು ಉಲಂಘಿಸಿದಲ್ಲಿ ಧಾರ್ಮಿಕ ಮುಖಂಡರಿಗೆ ತಿಳಿಸಲಾಗುತ್ತದೆ.

**Will I be paid for taking part?**

No you will not be paid for taking part in the research study. However if you incur any additional expenses as a result of taking part in this study, travel expenses, up to a maximum of Rs100 will be paid.

ಸಂದರ್ಶನಕ್ಕಾಗಿ ನೀವು ಬಸ್ಸು ಅಥವಾ ರಿಕ್ಷಾದಲ್ಲಿ ಬಂದಿದ್ದರೆ ಅದರ ಖರ್ಚಿನ ಹಣವನ್ನು, ಗರಿಷ್ಠ ೧೦೦ ರೂ ಕೊಡಲಾಗುತ್ತದೆ.

**What do I do if I have a complaint?**

If you are unhappy about any aspect of this study then in the first instance, please let me know. If you do not feel comfortable doing this then you can contact my supervisor, Dr Khatidja Chantler ([khatidja.chantler@manchester.ac.uk](mailto:khatidja.chantler@manchester.ac.uk)), at

ನಿಮಗೆ ಏನೇ ತೊಂದರೆ ಆದಲ್ಲಿ ನನಗೆ ತಿಳಿಸಬಹುದು. ನನಗೆ ತಿಳಿಸುವುದು ಅನುಚಿತವೆಂದು ತಿಳಿದರೆ ನನ್ನ ಗುರುಗಳನ್ನು ಸಂಪರ್ಕಿಸಬಹುದು. ಅವರ ಈಮೇಲ್ ವಿಳಾಸ ಈ ಕೆಳಗಿನಂತಿದೆ;

The School of Nursing, Midwifery and Social Work  
The University of Manchester  
Room 4,309, Jean McFarlane Building  
University Place  
Oxford Road  
Manchester  
M13 9PL. Every step will be taken to deal with your complaint quickly and appropriately.  
EMAIL: [khatidja.chantler@manchester.ac.uk](mailto:khatidja.chantler@manchester.ac.uk)

**Future research**

You will not automatically be expected to take part in any future research. The details you provide will not be used to contact you regarding other studies.

ನೀವು ಬೇರೆ ಸಂಶೋಧನೆಯಲ್ಲಿ ಭಾಗವಹಿಸುವ ಅಗತ್ಯವಿಲ್ಲ. ನೀವು ಹೇಳಿದ ವಿಚಾರಗಳನ್ನು ಬೇರೆ ಸಂಶೋಧನೆಯಲ್ಲಿ ಬಳಕೆ ಮಾಡಲಾಗುವುದಿಲ್ಲ.

**What do I need to do next?**

If you are happy to help with the research, please complete all sections of the enclosed reply slip. If I receive a response to tell me that you are willing to take part, then I will telephone you to arrange the interview. The interview will take place at a time and place convenient to you.

ನೀವು ಭಾಗವಹಿಸಲು ಇಚ್ಛಿಸುವುದಾದರೆ, ಉತ್ತರ ಚೀಟಿ ಸಂಪೂರ್ಣಗೊಳಿಸಿ ನನಗೆ ಕಳುಹಿಸಿ. ನಿಮ್ಮ ಉತ್ತರ ಸಿಕ್ಕಿದರೆ ನಾನು ನಿಮ್ಮನ್ನು ಸಂಪರ್ಕಿಸುತ್ತೇನೆ.

If you would like more information or want to ask some questions about this research, please contact:

ಬೇರೆ ಮಾಹಿತಿ ಬೇಕಿದ್ದಲ್ಲಿ ನನ್ನನ್ನು ಕೆಳಕಂಡ ವಿಳಾಸದಲ್ಲಿ ಕಾಣಬಹುದು ಅಥವಾ ದೂರವಾಣಿ ಕರೆ ಮಾಡಬಹುದು.

**Reena A Lasrado**

ರೀನಾ ಅ ಲಸ್ರಾದೋ

PhD Student (Social work)

Nirmala Hostel

1 Davis Road

Bangalore - 560084

Tel: 9481772224 E-mail: reena.lasrado@postgrad.manchester.ac.uk

**Thank you for taking the time to read this.**  
ವಂದನೆಗಳು

# Appendix J : Participant Information Sheet – Mental Health Professionals

The University  
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MANCHESTER  
1824

School of Nursing, Midwifery and Social Work  
The University of Manchester  
Jean McFarlane Building  
Oxford Road  
Manchester  
M13 9PL

+44(0)161 306 7767  
www.nursing.manchester.ac.uk

## Participant Information Sheet – Mental Health Professionals

### A study on the cultural implications of attempted suicide and its prevention in India

#### Invitation to participate in research study.

You are being invited to take part in a research study. Before you decide it is important for you to understand, why the research is being done and what it will involve. Please take time to read this information carefully. Please ask if anything is not clear (contact details are given at the end of this form). Thank you for taking time to think about taking part in this research.

#### What is the purpose of the research and interviews?

The purpose of this research is to explore the *implication of culture* in attempted suicide and its prevention. This research is being completed as a part of my doctoral studies and has been reviewed by the University of Manchester Research Ethics Committee.

#### Why have I have been invited to take part?

You have been invited to take part in this study because you have experience of treating survivors of attempted suicide. In addition, you also live and work in a cultural setting similar to that, experienced by your patients. This experience and insight will be of benefit to this study.

#### Do I have to take part in the study?

No taking part is voluntary. It is up to you to decide whether to take part. If you do not want to participate, you do not have to give a reason and it will not have any impact on your or your career. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part and later change your mind that is ok, also, as you can stop taking part in this study at any time and without having to give a reason.

#### How do I take part in the Study?

I will contact you by telephone, email or in person to fix a suitable date and time to obtain your consent once you have given permission for me to do so by informing me of your contact details by filling in the reply slip at the end of this information sheet. When I contact you I will arrange a time for us to meet so that I can interview you if decide you want to take part in this study. If you decide you want to take part in the study you will also be asked to sign a consent form based on the information given in this information sheet to say that you agree to taking part in the study and that you are willing to be interviewed.

#### What will taking part involve?

The research involves one face-to-face in depth interview lasting a maximum of two hours exploring why you think people attempt to commit suicide, what aspects and situations in life cause distress leading to suicide, as well as treatment/healing methods that are used when



managing distress and/or attempted suicides. The interviews will be mainly directed towards these issues, but there may be other things, which you consider equally important and so there will be an opportunity to discuss these as the interview is designed to be flexible to allow issues that are important for you and your patients to be explored. As your participation is voluntary at no point will you be forced to share information which you do not wish to. Furthermore, you also have the choice to withdraw from the interview at any time and without giving any reason for wanting to stop or withdraw.

The interview will take place either at your place of work or in a secure location. It will last up to two hours at the maximum and will be recorded with your permission. The reason why it is best to record the interviews is to facilitate accurate analysis and reporting of the findings. After the interview, the recording will be listened to carefully and every word that is said will be typed up. We do this to help us remember what you have said, to analyse the interview and to ensure there is a full and accurate account of your views. If you prefer not to be recorded, we may not be able to conduct the interviews, as it is difficult to get the detailed account of your views, from non-recorded material.

**Will my taking part in the study be kept confidential?**

Yes. Your personal data (name, address) will be anonymised. All papers, notes and interview records will be kept in a locked cabinet. Typed notes, electronic audio files will be stored on a password-protected, encrypted computer within a locked cabinet. Notes and computer files will not be played or shown to anyone other than me the researcher and my (two) faculty supervisors Professor Alys Young and Dr Khatidja Chantler. After the completion of this project, your personal data will be destroyed however; the notes and transcripts, which are digitised, will be stored for 10 years at the University of Manchester. When I type up the recordings made during the interviews and write about the results of the research, all personal details will be removed so that no one will know who you are. No real names will be used on any publications.

**The Distress Policy:**

In case you become distressed during the course of the interview, I will be able to actively listen to your thoughts and advise you where to gain the most appropriate professional support (e.g. through line management, clinical supervision or counselling). Alternatively, the interview will be stopped and re-arranged for another time if you wish to continue.

**Are there any benefits in taking part?**

Although there may be no direct benefits to you personally, the interviews will help me to understand if culture has an impact on suicide attempts and the role of modern methods in suicide prevention.

**Are there any disadvantages or risks involved in helping with this research?**

The interviews are likely to last for up to two hours, which you might consider to be time consuming. However, the interviews can be split over two sessions if you prefer. Although the actual length of the discussion will depend on how much or how little you have to say, so they may last much less than the two hours stated here.

It is anticipated that you operate within professional and ethical guidelines however in the unlikely event that information is revealed during the interview about practices, which breach ethical/professional standards, this will need to be reported to the relevant authorities (e.g. organisation employing you or the appropriate professional body).

**Will I be paid for taking part?**

No you will not be paid for taking part in the research study. However if you incur any additional expenses as a result of taking part in this study, travel expenses, up to a maximum of Rs100 will be paid.

**What do I do if I have a complaint?**

If you are unhappy about any aspect of this study then in the first instance, please let me know. If you do not feel comfortable doing this then you can contact my supervisor, Dr Khatidja Chantler ([khatidja.chantler@manchester.ac.uk](mailto:khatidja.chantler@manchester.ac.uk)), at The School of Nursing, Midwifery and Social Work The University of Manchester Room 4.309, Jean McFarlane Building University Place Oxford Road Manchester M13 9PL. Every step will be taken to deal with your complaint quickly and appropriately.

**Future research**

You will not automatically be expected to take part in any future research. The details you provide will not be used to contact you regarding other studies.

**What do I need to do next?**

If you are happy to help with the research, please complete all sections of the enclosed reply slip. If I receive a response to tell me that you are willing to take part, then I will telephone you to arrange the interview. The interview will take place at a time and place convenient to you.

If you would like more information or want to ask some questions about this research, please contact:

**Reena A Lasrado**  
PhD Student (Social work)  
Nirmala Hostel  
1 Davis Road  
Bangalore - 560084  
Tel: 9481772224 E-mail: [reena.lasrado@postgrad.manchester.ac.uk](mailto:reena.lasrado@postgrad.manchester.ac.uk)

**Thank you for taking the time to read this.**

# Appendix K : Consent Form

The University  
of Manchester

MANCHESTER  
1824

School of Nursing, Midwifery and Social Work  
The University of Manchester  
Jean McFarlane Building  
Oxford Road  
Manchester  
M13 9PL

+44(0)161 306 7767  
www.nursing.manchester.ac.uk

## CONSENT FORM

ಒಪ್ಪಿಗೆ ಪತ್ರ

Title of Project: Exploring the implication of culture in attempted suicide and prevention in India.

ಸಂಶೋಧನಾ ವಿಷಯದ ಹೆಸರು:- ಆತ್ಮಹತ್ಯೆ ಯತ್ನ ಮತ್ತು ತಡೆಯ ಸಂಬಂಧ ಭಾರತೀಯ ಸಂಸ್ಕೃತಿಯ ತೊಡಗಿಸುವಿಕೆಯ ಕುರಿತಾಗಿ ಪರಿಶೋಧನೆ.

Name of Researcher : Reena Lasrado

ಹೆಸರು: ರೀನಾ ಅಸ್ತಾದೋ

Please initial

ದಯವಿಟ್ಟು ಗುರುತಿಸಿ

1. I confirm that I have read and understood the information sheet and had the opportunity to ask questions.

ನಾನು ಮಾಹಿತಿ ಪಟ್ಟಿಯನ್ನು ಓದಿ ಅರ್ಥಮಾಡಿಕೊಂಡಿರುತ್ತೇನೆ ಮತ್ತು ಪ್ರಶ್ನೆಗಳನ್ನು ಕೇಳಲು ನನಗೆ ಅವಕಾಶ ನೀಡಲಾಗಿತ್ತು ಎನ್ನುವುದನ್ನು ಈ ಮೂಲಕ ದೃಢೀಕರಿಸಿದ್ದೇನೆ.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.

ನನ್ನ ಭಾಗವಹಿಸುವಿಕೆ ಸ್ವಯಂಸೂಚಿತವಾಗಿದೆ ಮತ್ತು ನಾನು ಯಾವುದೇ ಸಮಯದಲ್ಲಿ ಯಾವುದೇ ಕಾರಣ ಕೊಡದೆ ಹಿಂದೆಗೆಯಲು ಸ್ವತಂತ್ರವಾಗಿ/ನಾಗಿದ್ದೇನೆಂಬುದು ನನಗೆ ಅರ್ಥವಾಗಿರುತ್ತದೆ.

3. I agree to the researchers using anonymised direct quotes from my interview for the purpose of research.

ನನ್ನ ಸಂದರ್ಶನದಲ್ಲಿ ಹೇಳಿರುವ ನೇರ ಉಲ್ಲೇಖಗಳನ್ನು (ಹೆಸರು ಬಳಸದೆ) ಸಂಶೋಧನೆಗೆ ಬಳಸಲು ಸಂಶೋಧಕರಿಗೆ ನಾನು ಒಪ್ಪಿಗೆಯನ್ನು ನೀಡಿರುತ್ತೇನೆ.

4. I agree to the digital audio recording of the interview.

ನನ್ನ ಸಂದರ್ಶನದ ಡಿಜಿಟಲ್ ಧ್ವನಿಮುದ್ರಿಕೆ ನಡೆಸಲು ನನ್ನ ಅನುಮತಿ ಇರುತ್ತದೆ.

5. I agree to take part in an interview lasting between 1 -2 hours.

ಒಂದರಿಂದ ಎರಡು ಗಂಟೆಯ ಶುದ್ಧವಾಗಿ ಭಾಗವಹಿಸಲು ಒಪ್ಪಿರುತ್ತೇನೆ.

6. I agree to take part in the above study.

ನಾನು ಮೇಲಿನ ಅಧ್ಯಯನದಲ್ಲಿ ಭಾಗವಹಿಸಲು ಒಪ್ಪಿರುತ್ತೇನೆ.

Name of participant

ಭಾಗವಹಿಸುವ ಹೆಸರು

Signature

ಸಹಿ

Date

ತಾರೀಖು

Name of Researcher

ಸಂಶೋಧಕರ ಹೆಸರು

Signature

ಸಹಿ

Date

ತಾರೀಖು

1 for participant ಭಾಗವಹಿಸುವರಿಗೆ :

1 for researcher ಸಂಶೋಧಕರಿಗೆ :

# Appendix L : Reply Slip

The University  
of Manchester

MANCHESTER  
1824

School of Nursing, Midwifery and Social Work  
The University of Manchester  
Jean McFarlane Building  
Oxford Road  
Manchester  
M13 9PL

+44(0)161 306 7767  
www.nursing.manchester.ac.uk

## Reply slip ಪ್ರತ್ಯುತ್ತರ ಚೀಟಿ

Study title: A study on the cultural implications of attempted suicide and its prevention in India

ಸಂಶೋಧನಾ ವಿಷಯದ ಹೆಸರು:- ಆತ್ಮಹತ್ಯೆ ಯತ್ನ ಮತ್ತು ತಡೆಯ ಸಂಬಂಧ ಭಾರತೀಯ ಸಂಸ್ಕೃತಿಯ ತೊಡಗಿಸುವಿಕೆಯ ಕುರಿತಾಗಿ ಪರಿಶೋಧನೆ.

Yes, I would be interested in finding out more about the research.  
ಹೌದು, ನಾನು ಸಂಶೋಧನೆಯ ಬಗ್ಗೆ ಹೆಚ್ಚು ಸರಿಯಾಗಿ ತಿಳಿದುಕೊಳ್ಳಲು ಆಸಕ್ತಳು/ನಾಗಿದ್ದೇನೆ.

If yes, please write your contact telephone number.....  
ನಿಮ್ಮ ಉತ್ತರ ಹೌದು ಆರ್ಡ್ಸ್, ದಯವಿಟ್ಟು ಮೊಬಿಲ್ ಸಂಖ್ಯೆ ಕೊಡಿ

No. I do not want to be involved with this research.  
ಇಲ್ಲ, ನಾನು ಈ ಸಂಶೋಧನೆಯಲ್ಲಿ ಭಾಗಿಯಾಗಲು ಇಚ್ಛಿಸುವುದಿಲ್ಲ.

All information given in this form is strictly confidential and will only be used for the purpose of this study.

ಈ ಪ್ರತ್ಯುತ್ತರ ಪತ್ರದಲ್ಲಿ ನೀಡಲಾದ ಎಲ್ಲ ಮಾಹಿತಿಗಳೂ ಗುಪ್ತವಾಗಿರುತ್ತವೆ ಮತ್ತು ಈ ಅಧ್ಯಯನಕ್ಕಾಗಿ ಮಾತ್ರ ಬಳಸಲಾಗುತ್ತವೆ.

Signed.....  
ಸಹಿ

Date.....  
ತಾರೀಖು

Please print name.....  
ಹೆಸರನ್ನು ಮುದ್ರಿಸಿ

Thank you for completing this reply form. Please drop the form in the response box placed in reception area or return this form to Reena Lasrado in the freepost envelope provided. There is no need to attach a stamp.

ಈ ಪ್ರತ್ಯುತ್ತರ ಪತ್ರವನ್ನು ತುಂಬಿರುವುದಕ್ಕೆ ವಂದನೆಗಳು. ದಯವಿಟ್ಟು ಈ ಪತ್ರವನ್ನು ಸ್ವಾಗತ ಸ್ಥಳದಲ್ಲಿ ಇಟ್ಟಿರುವ ಪ್ರತಿಕ್ರಿಯಾ ಪಟ್ಟಿಯಲ್ಲಿ ಹಾಕಿರಿ ಅಥವಾ ಈ ಮೂಲಕ ನೀಡಿರುವ ಅಂಚೆವೆಚ್ಚರಹಿತ ಲಕೋಟೆಯನ್ನು ಅಂಚೆ ಮೂಲಕ ರೀನಾ ಲಸ್ರಾದೋರವರಿಗೆ ಕಳುಹಿಸಿರಿ. ಅಂಚೆಚೀಟಿ ಹಚ್ಚುವ ಅಗತ್ಯವಿಲ್ಲ.

Please return this form to:  
ಈ ಪತ್ರವನ್ನು ಹಿಂತಿರುಗಿಸಿರಿ:

Reena Lasrado ರೀನಾ ಲಸ್ರಾದೋ  
Nirmala Hostel  
1 Davis Road  
Bangalore - 560084

## Appendix M : Reflexive Notes – Extracts

### Extract 1: Interview with survivor 4

I understand, that he did not feel comfortable to share those issues which he considered to be very personal to him. He presented low mood gave reports of being disinterested in things. After about 20 minutes of the interview, I took a short break and glanced through my topic guide and his response during the interview. I realised I had moved towards looking for signs and symptoms of depression, patterns of mental health risk assessment during the interview rather than exploring all those situations which he found distressing. During the second half of the interview I concentrated more upon his life as a student within a family, college and with his friends, than a patient in the hospital. And I started talking to him as a friend who wants to help him..... He then started narrating instances that lead him to feelings of hopelessness, aggression, challenging, ashamed and sorrowful. He also mentioned why situations made him feel that way for example, he felt ashamed when his parents quarrelled in front of neighbours because of which he was being mocked by his friends and less respected in college.

### Extract 2: Interview with survivor 1

I was quite enthusiastic about interviewing the first survivor participant. As I went on with the interview, I felt he was trying to hide things from me. How could it be true that someone attempts suicide because of stomach ache.....Am I judging him no but he doesn't tell me anything about being diagnosed for serious illness or on medication. I felt strongly that I wish to confront him saying no it is not true, you are saying this because you want to hide the truth from me. But later I understood reasons for his response. His family had instructed him not to tell anybody about the girl (love issue). I felt he was under pressure to please his family.

### Extract 3: At coding and analysis stage

I was in conflict with my ideas to want to code data that speaks of conflict, fear and abuse under the category of social attitude and response, cultural role, fear of society..... but I was afraid if I were casting my opinions on the data. So at the first stage I chose to code by picking core words from the interviews such as ' I am spoilt', 'abused', 'accept assault', 'need a father'....., I developed a list of hierarchy of themes and discussed with my supervisors.