



**THE UNIVERSITY OF ZAMBIA
SCHOOL OF HUMANITIES AND SOCIAL SCIENCES**

**Gender and Suicide: A Gendered Analysis
Of Suicidal Behaviour Among Lusaka Residents.**

MUTALE PETER

**Dissertation submitted to the University of Zambia
in partial fulfillment of the requirements for the degree
of Master of Arts in Gender Studies.**

The University Of Zambia

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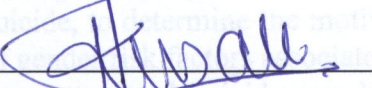
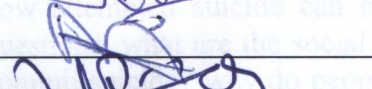

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The study population comprised 46 para-suicides of whom 28 were women and 18 men and was undertaken at the University Teaching Hospital (UTH) between October, 2006 and February, 2007. The study was therefore, hospital-based. A semi-structured questionnaire was used to collect quantitative data. In-depth interviews were used for collecting qualitative data. The study also relied on books and documents to collect secondary data. Quantitative data was analysed using statistical package for social sciences (SPSS). Qualitative data was analysed manually.

The major findings drawn from this study were that young people, between 20 and 30 years of age attempted to commit suicide at a higher rate. This study established that the majority of the para-suicides were females, 60.9% and males were 39.1%.

This study established that suicidal behaviour is not always associated with the presence of mental illness. This study ascertained that the main motive which led, female respondents to attempt to commit suicide was strained relationship which caused them emotional pain and psychological distress. This study revealed that gender and power relations played a critical role towards female respondents' quest to attempt to commit suicide. Female suicidal behaviour was linked to domestic violence, vulnerability, hopelessness, whereas men's suicidal behaviour was linked to rising rates of unemployment, financial insecurity and loss of identity.

This study in conclusion identified drug overdose and poisoning as the commonest methods used by respondents to attempt to commit suicide. The study recommends that raising social and economical status for both women and men and eliminating gender disparities will gradually reduce incidences of suicide.

ABSTRACT

The main objective of this study was to ascertain a gender perspective among para-suicides in the City of Lusaka. The study makes the observation that suicide has become one of the major social problems globally, where it is estimated that 8 to 14 people per 100,000 commit suicide each year. However, the magnitude of this problem in Zambia is not well known due to lack of statistics. Information obtained from University Teaching Hospital (UTH) and Zambia Police Service suggested that between 1998 and 2004, the number of attempted deaths from suicides among males and females nearly tripled.

The specific objectives of the study were therefore, to establish the pattern of para-suicide, to determine the motives for attempting suicide, to present a descriptive account of gender risk factors associated with attempted suicide and to make recommendations on how attempted suicide can be addressed. The study sought to answer the following questions: what are the social and demographic characteristics of people who attempt to commit suicide? why do people attempt to commit suicide? what are gender risk factors associated with attempted suicide? and how can the problem of parasuicide be addressed?

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DEDICATION

Power is both the source of oppression in its abuse and the source of emancipation in its use.

Power is inherent in social structures, language, bodies as well as in relationships.

Power is the very foundation of social life.

Power is inscribed in the rituals and practices of gender yet it is more or less than gender.

To all Champions of social justice on gender issues I give due dedication.

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It is a well known fact by most scholars that university students are always in dept to their lecturers for inspiration, criticism and plain straight forward help. Conscious of this academic truth, I whole heartedly acknowledge Dr. T. Kusanthan my supervisor for his foresightedness to come up with this type of research which has never been done in this country, Zambia.

A work of this sort could not have been written without the active and willing assistance of other academicians. In all my writing, when I was labouring to come up with clear topic and objectives, I owe an immense dept of gratitude to Mr. Jason Mwanza lecturer in Social Development Studies (UNZA) who as the first reader of the research proposal helped me enormously with his critical remarks and linguistic alterations which eliminated much of ambiguous semantics.

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CHAPTER ONE—THE RESEARCH PROBLEM

I just wanted to take my life. You know it is not just easy to be Positive.

He was cheating on me and every one at work new. So that was the best option.

1.0 BACKGROUND

The above quote from a woman, who was admitted at Chainama Hills Hospital, sets the theme of this study which is about gender and suicide. Almost everyone at some time in his or her life experiences periods of anxiety, sadness and despair. These are normal reactions to pain or loss, rejection or disappointments. Some people with serious problems often experience much more extreme reactions, reactions that may leave them mired in hopelessness and when all hope is lost, feel that suicide is the only solution.

Suicide is a tragic event. It is also an act that is very complex to comprehend. The factors that impact on an individual that may lead him or her to choose committing suicide as an alternative action to take are multidimensional. Numerous factors frequently occur simultaneously providing a bio-psycho-social model for the causes of suicide. Such a model indicates that biological, psychological and sociological factors in combination may have an adverse effect on an individual and may lead him or her to commit suicide. As Stoff and Mann (1997) have noted suicide is now an object of multidisciplinary scientific study with sociology, anthropology,

psychology, and psychiatry disciplines each providing important insights into intricacies of suicide. Stoff and Mann (1997) further concluded that certain questions about suicide seem to fall at least partially outside the domain of science. To look therefore, for one particular cause and state that it was the reason for the person's suicidal intent can be simplistic and wrong in the vast majority of suicidal cases. Suicide is not a disease. It is an expression of a host of emotions, hopelessness, guilt, sorrow, loneliness, rage, fear, shame, that have their roots in psychological, social, medical and biochemical factors (Psychological Society of Ireland, 1992).

Suicide is perceived to be a major social problem in most countries nowadays and the rate of suicide cases increased globally throughout the 1990s and 2000s (Price, 2006). It is estimated that between eight and fourteen people per 100,000 kill themselves each year. WHO (2002) puts its estimates at 1 million deaths occurring every year and it is projected at 1.5 million by the year 2010. As for USA in 2006, suicides outnumbered homicides by three to two and deaths from AIDS by two to one (Price, 2006). However, it has been pointed out that the incidences of suicide are in most countries under-reported due to both religious and political reasons (Lester, 1997). In fact, many researchers have suggested that the reported magnitude of the suicide sex differential is not accurate, because of the difficulties inherent in collecting valid data about completed suicides (Madge and Harvey, 1999). Less valid official data is thought to occur because of the classification

biases of individual coroners and physicians as well as differences in state and national laws regarding suicide determination. There are also problems in relation to classification of suicide based on decision rules to label an accidental death as suicide. Even without excessively stringent decision rules, it is possible that a number of suicides are labelled “accidents” because there is not enough evidence to conclude that they were suicides. It has been estimated that the actual incidences of suicide in groups with a high rate of accidental death might be up to three times the official recorded level (Madge and Harvey, 1999). Since ‘accidental death’ may be more associated with women than men, female suicides may be more likely to be underreported than male suicides. In any case, suicide is no longer an unusual kind of death. The first systematic study of suicide was conducted by Emile Durkheim, and published in 1897 in his classic volume *Le Suicide* (Durkheim, 1952). In recent years major studies have been done but most of these studies on suicide have concentrated in the Western Countries. However, some researchers have also undertaken suicide studies in Africa notable among them are: Kinyanda et al (2005), Kinyanda et al (2004) in Uganda, Abede (1991) in Ethiopia, Eferakeya (1984) in Nigeria.

There have been many reports of suicide and suicidal behaviour by the media, in an effort to show that suicide is also a social problem in Zambia. Information obtained from University Teaching Hospital (UTH) and Zambia Police revealed that between 1998 and 2004, the number of attempted deaths from suicides among

males and females nearly tripled. Males were found to be more likely to commit suicide than females. In 2003 alone males accounted for 26 deaths from suicide compared to 16 females, although these statistics are not up-to-date. There are also debates within the Zambian community that the reporting of specific methods of suicide by the media can shape the behaviour of individuals who are already at risk and these assumptions are not different from studies conducted in United States (Shiang, 1998). The fictional portrayal of specific methods of suicidal behaviour in television drama for instance, is believed to add to a considerable increase in the use of those particular methods (Petrie, et al., 1988).

1.1 STATEMENT OF THE PROBLEM

Suicide may take one life, but it affects the whole community. It is a human tragedy, especially when it involves the lives of young people. One of the most perplexing facts about suicide typology in Zambia is that there are no reliable statistics to rely on if we were to understand this phenomenon. Discussions with hospital staff and police officers tend to suggest that women and youths attempt suicide at a substantially higher rate than men, but more men succeed in ending their lives. Discussions advance assumptions that the difference in men's and women's suicide rates is more striking among young people than adults. A review of literature, however, shows that at the moment little research has been done to account for gender attributes and the claim that more females attempt to commit suicide than males but more males than females succeed in committing suicide.

This study on suicide is worth doing because no one in Zambia has conducted a study focusing on gender attributes in relationship to suicide. Based on the statement of the problem, this study therefore, seeks to answer the following research questions:

1.2 RESEARCH QUESTIONS

1. What are the social and demographic characteristics of people who attempt to commit suicide?
2. Why do people attempt to commit suicide?
3. What are the gender risk factors associated with attempted suicide?
4. How can the community and social scientist address the problem of para-suicide?

1.3.0 GENERAL OBJECTIVE OF THE STUDY

The main objective of undertaking this study was to ascertain a gender perspective among para-suicides in the city of Lusaka, Zambia.

1.3.1 THE SPECIFIC OBJECTIVES OF THE STUDY

The study seeks to meet the following specific objectives:

1. To establish the pattern of parasuicide.
2. To ascertain the motives for attempting suicide.
3. To present a descriptive account of gender risk factors associated with attempted suicide.
4. To make recommendations on how attempted suicide can be addressed.

1.4 JUSTIFICATION

First and foremost this study is significant because it is a pioneer study on parasuicide in Zambia and it will therefore, generate basic knowledge and provide methodological processes which would be beneficial to students, academicians and other scholars who may wish to undertake future research on suicide. Secondly, the study is significant in that it highlights the gender issues and make available information that would assist stakeholders in developing policies and workable strategies in order to mitigate many problems that surround both women and men. Thirdly, the study provides a framework that will assist in addressing gender and suicide related problems.

1.5.0 DEFINITION OF KEY TERMS

In any academic writings, it is prudent from the onset that key words which form the building blocks of any subject matter are identified and defined. There are benefits for doing this; essentially it makes the reader appreciate concepts when they reappear later in the text. It also makes things flow linearly so that intra-textual definitions do not obstruct the reader. Below are definitions of key concepts that are the building block of this study.

1.5.1 SUICIDE

In this study, the term suicide means an act of intentionally ending one's own life. Suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself or herself, which he or she knows will

induce death. From this, we can say that the person who commits suicide must be the central component and the only intention of an act is to induce death to him or herself.

1.5.2 ATTEMPTED SUICIDE OR PARA-SUICIDE

Attempted suicide or para-suicide refers to deliberate act of self destruction or other life threatening behaviour that does not result in death.

1.5.3 GENDER

Gender refers to socially constructed attributes, roles, activities, and responsibilities that women and men should have in their daily lives in any given society.

1.5.4 SEX

Sex is the biological difference between men and women. Sex differences are concerned with men's and women's bodies.

It is worthwhile to note that sexual differences are the same throughout the human race. Sex is thus, a fact of human biology where as gender is not. The experience of being a male or a female differs dramatically from culture to culture.

CHAPTER TWO — LITERATURE REVIEW

2.0 THEORIES OF SUICIDE

2.1 INTRODUCTION

Many theories have been developed to explain the causes of suicide with no strong consensus with one. This researcher finds it prudent to consider the inclusion of many theories towards the study of suicide because there is a need to gather as much data as possible from various theoretical interpretations in the overall understanding of this complex subject matter. While the researcher's major interest is primarily a gender perspective in para-suicides, he has decided to use sociological and psychological based theories even if they are not the province of his excellence. Nevertheless, the study looks at sociological and social psychological theories such as Durkheim's theory, Shneidman's theory, Stress and Crisis theories, and lastly sex based research on suicide.

2.2 SOCIOLOGICAL THEORIES OF SUICIDE

2.2.1 DURKHEIM'S THEORY AND CLASSIFICATIONS OF SUICIDE

Durkheim's study on suicide was first published in 1897 and the study has had exerted enormous influence on the discipline of sociology and provided explanation for the causes of suicide. Durkheim's theory on suicide is chosen not because it details an action similar in some ways to self-mutilation. Instead,

Durkheim's theory is chosen because it is the only extensive theory of its kind on this subject matter.

By proposing a sociological theory on suicide, Durkheim (1952) paved the way for more open thought on the implications of sociology as a discipline. Durkheim's approach seems to form a precursor to psychological aspects of suicide, rather than eliminating psychological aspects altogether. Social forces are viewed as general causes of suicidal behaviour that are then internalised and individualized, resulting in the act of suicide. In his discussion of suicide, Durkheim (1952) distinguishes between psychopathic states and normal psychological states. Within the psychopathic state, he identifies four types of suicide namely: maniacal suicide, melancholy suicide, obsessive suicide and impulsive or automatic suicide. Maniacal suicide is most common among those suffering from hallucinations, usually schizophrenia. Melancholy suicide is characterized by extreme depression, created or imaginary and often unrelated to a person's circumstances. Obsessive suicide usually lacks authentic motive. A person may be fixated with the idea of suicide and thus, for them committing suicide becomes an instinctive drive. Impulsive or automatic suicide also frequently lacks motive and is characterized by an irresistible impulse to commit suicide. Within normal psychological states, Durkheim (1952) classifies suicide into three main types: egoistic suicide, altruistic suicide and anomic suicide. Fatalistic suicide was a fourth type but was only described briefly by Durkheim.

2.2.1.1 EGOISTIC SUICIDE

The first type of suicide that Durkheim analysed was egoistic suicide. Egoistic suicide occurs when an individual's ties to society and morality are too laxity. Egoism is commonly defined as self-centeredness, thus people in this state are concerned with themselves over anything else. This results from individual's insufficient integration within the society to which he or she belongs. Individuals who are not sufficiently bound to social groups usually lack well-defined values, traditions, norms and goals. These individuals are left with little social integrative support or guidance and as a result tend to commit suicide on an increased rate. But quite aside from integrating its members, society must control and regulate members' beliefs and behaviour and Durkheim insisted that there is a relationship between a society's suicidal rates and the way it performs this important regulative function.

2.2.1.1.1 EGOISTIC SUICIDE, RELIGION, FAMILY SIZE AND EDUCATION

Durkheim (1952) proposed that those religions which encouraged free thought experienced fewer suicides than others. If individuals do not subscribe to the higher beliefs of a religion, they are left to make sense of the world on their own. When individuals cannot make sense of the world in which they live, they may simply lose the desire to live and contemplate committing suicide.

Durkheim (1952) also cited family size and education as forces that influence egoistic suicide. Families, if large and closely-knit, can also provide the necessary ties to society through their own traditions and common beliefs. Durkheim's discovery was that unmarried people, particularly males with less to bind and connect them to stable social norms and goals, committed suicide at higher rates than married people.

Education, according to Durkheim (1952), may increase the occurrence of egoistic suicide. Laxity ties to society causes extreme individualism and individualism leads to a desire to learn. Often, in the course of learning, common beliefs and traditions of a given society are called into question. Once again, the individual is left to make sense of the world on his or her own.

2.2.1.2 ANOMIC SUICIDE

Anomie was a second type of suicide to be studied by Durkheim. Durkheim (1952) used the term anomie to refer to a state of normlessness or conflicting norms and this is where anomic suicide got its name. In the instance of egoistic suicide, the individual's relationship to society is the cause. With anomic suicide, it is an individual's interaction with society that is the cause. Every human being has basic needs such as food and water. When individuals set unattainable goals they produce for themselves a constant state of discontent and possibly depression. Durkheim (1952) observed that a state of anomie was brought by changes in society. Economic changes such as depression or inflation cause individuals to re-examine

their needs and adjust accordingly. This change can lead to an internal struggle regarding what one can afford versus what one desires. Occupational change, another type of economic change, affects the individual in the same way and can also cause anomie. Becoming un-employed is a prime example of such anomie. When individuals fail to readjust to changes in their social environment, suicidal behaviour becomes rampant.

Durkheim (1952) further used the term anomie to describe temporary condition of social deregulation and anomic suicide to describe the resulting type of self-inflicted death. Anomic suicide was of particular interest to Durkheim, for he divided it into two categories: economic anomie and domestic anomie. Each involved an imbalance of means and needs; where means were unable to fulfil needs. Economic anomie was brought about due to disruption in economic or financial well being of an individual whilst domestic anomie afflicted widows and widowers as well as those who had experienced separation or divorced. These groups according to Durkheim were more apt to commit suicide than others. Separation or divorce weakens matrimonial regulation and wherever law and custom permit its "excessive" practice; the relative immunity to self-inflicted death which is guaranteed in marriage is undermined and suicide increases (Durkheim, 1952). Marriage, Durkheim explained, ought to be understood as the social regulation not only of physical instinct, but also sexual and behavioural means-needs balance among women and men. Bachelors, however, tended to commit

suicide at higher rates than married men because of a lack of regulation and established goals and expectations. On the other hand, marriage traditionally served to over regulate the lives of women by further restricting their already limited opportunities and goals. Unmarried women, Durkheim concluded did not experience chronic domestic anomie as often as married women did.

2.2.1.3 ALTRUISTIC SUICIDE

Altruistic suicide, which is the third type of suicide analysed by Durkheim, is often seen as the opposite of egoistic suicide. According to Durkheim (1952) altruistic suicide may occur when a person becomes deeply integrated into a social group and suicide becomes a 'duty' for the members of that group. An individual who commits altruistic suicide does so because his or her ties to society or a particular group in society are too strong. On the contrary, an individual who commits egoistic suicide does so because his or her ties to society are lacking. Durkheim (1952) moreover argues that people who commit altruistic suicide perceive their own lives as secondary to the interest of the society. Hence, the tendency to commit suicide will increase if the person believes that by sacrificing his or her life, it will help society achieve its goals. Altruism, therefore, means for the good of the group, in this case, the individual is placing the group's agenda above his or her own.

Durkheim's discussion of altruistic suicide allows privileged access to some of the intricacies of his approach. He has often been accused of having an overly anti-

individualistic philosophy, one that is mainly concerned with the taming of individual impulses and the harnessing of the energies of individuals for the purposes of society. Although it cannot be denied that there are such tendencies in his work, Durkheim's treatment of altruistic suicide indicates that he was trying to establish a balance between the claims of individuals and those of society, rather than to suppress individual strivings. Acutely, aware of the dangers of the breakdown of social order, he also realized that total control of individuals by society would be detrimental to individual's creativity.

2.3 SHNEIDMAN'S THEORY

Shneidman's (1993) theory on suicide is an outcome of Shneidman's (1985) model of suicide (it will be discussed later under unendurable psychological pain). The theory suggests that suicide is a social phenomenon, a dynamic process that includes relationships with others in three patterns: egotic, dyadic and ageneratic (Shneidman, 1993). Egotic suicide is derived from an intra-psychiatric source the person expresses misery and carries his or her own misery index (Maris, 1992). The misery index typically increases the person's misery, that is to say, individuals who are feeling downtrodden and dejected view the world from a perspective of pessimism and hopelessness. The world view is typically reinforced by his or her prevailing mood and cognitive states. Feelings of loneliness, aloneness and alienation are dominant in this type of suicide. Dyadic suicide on the other hand arises when there is a plethora of unmet needs and wishes linked to another person,

who potentially could satisfy these needs but fails. This person generally has a dominant and influential role in the individual's life (Shneidman, 1993). Suicide then becomes a dynamic process where two people are engaged in the act; one who commits suicide and the other who could have 'prevented' suicide had he or she provided what the victim wanted. In short dyadic suicide represents a relationship failure. Ageneratic suicide occurs when the individual disconnects from significant others and also alienates or separates from history, including ancestors, culture and folklore (Kettl, 1998; Shneidman, 1993).

2.4.0 PSYCHOLOGICAL FACTORS AND SUICIDE

2.4.1 HOPELESSNESS

Hopelessness is defined by Beck et al (1979) as negative expectations of the future, where a hopeless individual expects or believes nothing will turn out right for him or her, nothing he or she does will succeed, his or her important goals are unattainable and worse problems will never be solved. Minkoff et al (1973) also found that hopelessness as an aspect of depression was a better predictor of suicidal intent than depression itself. In clinical studies hopelessness has been found to predict completed suicide (Beck et al., 1979); suicide attempts (Wetzel et al., 1980); suicide intent (Minkoff et al., 1973) and suicide ideation (Steer et al., 1993). Hopelessness is also an important feature because it focuses on the future. It is important to recognize that hopelessness is not defined as no expectation of the

future but as negative expectation of the future. This suggests that the presence of hope does not necessarily imply the absence of hopelessness. For instance, when faced with an illness that is potentially disfiguring, undignified, painful and stigmatized the idea that one has a last hope of control (to commit suicide) can be a very powerful one (Beckerman,1995). Therefore, the ability to take control and end one's own suffering can give an individual hope without alleviating hopelessness.

Hopelessness is thought to be the component of depression that is most often associated with suicidal ideation or thinking (Nekanda-Trepka et al., 1983), repetition of deliberate self-harm (Kerkhof 2000; Petrie et al., 1988) and completed suicide (Beck et al., 1979). Defined as the degree to which an individual is pessimistic about the future, hopelessness is thought to mediate the relationship between depression and suicidal behaviour (O'Connor et al., 2000b). In order to measure the degree of hopelessness, Beck et al., (1979) operationalised hopelessness exclusively via the Beck Hopelessness Scale. This is a 20-item true or false choice questionnaire, the higher the score the more hopeless the respondent is thought to be, for example, 'My future seems dark to me' or 'Things just don't work out the way I want them to'. MacLeod et al., (1997) also devised a personal future fluency task, an objective measure of the degree to which an individual can generate positive or negative future thoughts. They found that para-suicides were impaired in their ability to generate positive future thoughts, compared with controls drawn from either hospital or non-hospital populations.

Hopelessness also takes an interesting connotation within the terminal illness context. A study by Schneider et al (1991) of gay and bisexual HIV/AIDS positive patients highlights the particular importance of hopelessness in this context. Schneider et al (1991) found depression and hopelessness were indeed the best predictor of suicidal ideation. Mood disturbances, loneliness, lack of perceived control of AIDS risks and AIDS related life events such as death of a partner were better predictors of suicidal ideation. In other words, there is some evidence to suggest that suicide may be related to hopelessness in people living with HIV/AIDS. Hopelessness also incorporates the current emotional state of the individual; the negative expectation of the future and lack of social support which all have salience in the HIV/AIDS context. However, because this model focuses primarily on effect, it needs to be combined with other notions such as unendurable psychological pain and meaning in life which capture the behaviour and cognitions of the individuals. Nonetheless, it does provide a relevant starting point for intervention and has been shown to be very amenable to cognitive therapy (Beck et al., 1979).

2.4.2 MEANING IN LIFE

Meaning in life as a psychological construct originated from the work of Tillich (1952) and was then developed by Frankl (1967). Today, this construct has become the focus of a sub discipline of psychology created by Yalom (1980) called

“existential psychology”. Meaning in life has been defined in a number of ways: Battista and Almond (1973, pp. 410) suggested that meaning in life is “an individual’s belief that he or she is fulfilling a life framework or life goal that provides him or her with a highly valued understanding of his or her life”. Maddi (1967, pp. 313) on the other hand took an opposite angle when he stated that meaninglessness is a “chronic inability to believe in the truth, importance, usefulness or interest value of any of the things one is engaged in or can imagine doing”. Thus, rather than asking the question “what is the meaning of life?” these definitions suggest asking the question “what is the meaning of my life?”

Studies indicate that a lack of meaning in life increases the risks of suicide (Zika and Chamberlin 1992). Petrie and Brook (1992) found low scores on meaning in life on coherence scale to be predictive of suicidal ideation for para-suicides admitted in the hospital. Also Klinger (1977) cited in Ruffin (1984) found that 20% of suicide notes included references to wanting to die because the authors’ lives no longer held meaning for them. The question which may be asked is; how can the idea of meaning in life be used to understand suicide? Within this conceptualization of meaninglessness, Maddi (1967) provided an answer when he highlighted an important stressor that facilitates a crisis of meaning. He stated that “the accumulated sense of failure which arises when a person fails to lead a desirable life amount to meaninglessness” (Maddi 1967, pp. 322). It is possible that victims may have a sense of failure in their endeavours. There may be a sense of failure of

not playing by society's traditional roles (i.e. by not playing gender roles as expected (Meena, 1992) and of not achieving life time goals because of illness.

Meaninglessness can also result from the loss of sources of meaning, sources such as interpersonal relationships, family, friends and work (Baum and Stewart, 1990). Being deprived of interpersonal relationships, particularly by lack of social interactions and support is a frequent feature of depressed people (Beck et al., 1979). Losses associated with interpersonal relationship are many and may result in a loss of meaning. Work as a source of meaning also has losses associated with it. When an individual becomes physically ill and or begins to show physical signs of illness, he or she may retreat from work, again resulting in a loss of meaning. Therefore, the number and range of losses of sources of meaning including work and interpersonal relationships may be substantial and may result in the experience of meaninglessness. This in turn may influence suicidal behaviour. In short, suicide might be related to lack of meaning in life.

2.4.3 UNENDURABLE PSYCHOLOGICAL PAIN

Unbearable psychological pain, unendurable anguish, intolerable suffering describe the central component of Shneidman's (1985) model of suicide, most commonly called unendurable psychological pain or psychache. Psychache is the condition that a suicidal individual seeks to escape and which Shneidman (1985) considers to be a frequent characteristic of any suicidal act. The barrage of emotions such as

anxiety, despair, depression, guilt, shame and sadness are commonly experienced. Shneidman (1985) suggested that unendurable psychological pain derives from unfulfilled needs. For instance, gender needs for self-esteem, control, health, support, companionship, a relationship or even respect and dignity are often denied (Lang, 1991; Nicholson and Long, 1990). A further feature of Shneidman (1985) account of unendurable psychological pain is that of a limit. He noted that the individual makes a qualitative judgment about pain, 'this far and no farther'. Should the pain exceed an individual's limit a decision is made to end the pain by any means and in most cases by committing suicide.

There seems to be three ways in which the limit may be experienced. Firstly, an individual suddenly experiences unendurable psychological pain, feels unable to bear such pain (i.e. has reached previously unthought-of limit) and commits suicide (O'Dowd et al., 1993; Rundell et al., 1992). The individual here makes a sudden decision to commit suicide. There is no premeditation about committing suicide it is just an 'impulsive suicide'. The second way in which the limit may be experienced suggests some pre-existing psychological pain which is built upon and then reached by an individual. Here the individual may already be experiencing some psychological pain but is managing. Then a precipitating event is experienced and is felt to be the 'last straw'. This pushes the individual over his or her limit and suicide results. Consequently, the individual makes a judgment that the situation is no longer endurable and suicide is the answer. Ambivalence, the occurrence of

opposing emotions is the third way of unendurable psychological pain of committing suicide (Shneidman 1985). Shneidman (1985) noted that the individual is in two minds about suicide and is attempting to integrate the choice between life and death. The decision is between no suffering (death) and living with unbearable suffering (life).

2.5 STRESS AND CRISIS THEORIES

When we examine stress and crisis theories they semantically appear to be different and yet they are the same. They both focus on stressful situations and in this study they will be merged. Hans Selye developed stress theory drawing heavily from Merton's paradigm (Selye, 1956). Selye (1956) argues that generally people cope with the anxiety that stress creates in adaptive and maladaptive ways. There are a number of stressors that may be linked to suicidal act and suicidal attempts and these are enumerated below:

Routine stressors are present in the physical and social environment and people cope with the anxiety that stress creates in different ways which can either be adaptive or maladaptive. Adaptive methods of reducing anxiety include exercise, relaxation techniques, expressing feelings or engaging in task-oriented behaviour. These behaviours help an individual to maintain emotional and functional equilibrium. Maladaptive behaviours that people may use to reduce the effects of stress include inter alia suicide attempts (Selye, 1956). In addition to routine

stressors, people may also experience *extraordinary stressors* that in combination with routine stressors can cause intense stress. Extraordinary stressors may include loss of a loved one, loss of a job or leaving a community (Selye, 1956). *Developmental stressors* which are related to transitions in life such as: adolescence, marriage, parenthood and retirement are experienced by some people and can cause intense stress for a prolonged period of time. *Chronic stressors* occur repeatedly and can produce high levels of anxiety and disrupt a person's equilibrium. These might include abusive relationships or stressful job situations. Depending upon the coping abilities of the individual involved and the combination of multiple stressors, an individual may experience a temporary state of psychological crisis. *Catastrophic stressors* are described as sudden, overwhelming and often dangerous either to one's self or significant other(s). Catastrophic stressors often cause trauma, emotional state of discomfort and stress resulting from memories of an extraordinary catastrophic experience. Examples of such powerful stressors include violent crime victimization, airplane crashes and other life threatening events. In summary, stress theory contains the following premises: individuals exist in normal states of equilibrium where they establish their own personal boundaries, usually based upon a certain order and understanding of the world. Occasional stressors will move the individual out of the state of the equilibrium but most of the time people stay within a familiar emotional range. Trauma throws people out of their range of equilibrium and it becomes difficult for them to restore a sense of balance in life. When they do establish a new sense of

balance it is often different from prior situation, with its new boundaries and new definitions. When certain people are found in this situation with no coping mechanism, suicidal intent overwhelms them.

Roberts (1995) on the other hand defined crisis as a temporary state of upset and disequilibrium, characterized chiefly by an individual's inability to cope with a particular situation using customary methods of problem solving. In earlier research by Burgess and Baldwin (1981), it was stated that when an individual experiences an emotionally hazardous situation and is unable to effectively utilize previously learned coping behaviours, then emotional crisis may ensue. Butcher and Maudal (1976) also provided an overview of the assumptions of crisis theory when they stated that crisis is a state characterized by high level of subjective distress and inability to modify the source of stress that produced the crisis. Secondly, crisis can be produced by a variety of stressful life situations such as the death of a spouse or natural disasters have a high probability of provoking a crisis reaction in some people.

2.6.0 SEX BASED RESEARCH ON SUICIDE (BUT REPORTED AS GENDER DIFFERENCES)

Historically, the vast majority of research on suicidal behaviour has focused on socio-demographic and clinical risk factors examined within a biomedical framework ignoring the gender aspect. This emphasis on the biomedical model has resulted in the ‘medicalisation and abnormalisation’ of suicidal behaviour. To this day suicidal behaviour is still wrongly included in ‘abnormal’ psychology texts and psychiatry book chapters. This (mis) representation of suicidal act as abnormal contributes to the maintenance of the stigma associated with suicidal behaviour (O’Connor et al., 2000b). This researcher believes that irrespective of the criterion for ‘normality–abnormality’, suicide is not abnormal but rather it is an effect of unfortunate consequence of a complex interaction of various risk factors which includes gender risk factors. The last two decades encouragingly have witnessed an almost universal acceptance of the bio-psycho-social model and a growing recognition of the role social, cultural as well as gender factors play in health and illness. In any case, major researches on suicide focusing on sex have been considered as gender based studies. Literature has reviewed that gender has not been studied in totality so to speak, what has been studied relates to super imposing sex as gender and this is shown below under several variables in terms of completion rates across sex.

2.6.1 SEX DIFFERENCES IN SUICIDE COMPLETION RATES

Based on suicide completion rate differences, it has been shown that more men than women commit suicide. However, some researchers have debated the extent, nature and interpretation of the suicide rate differences between men and women. For example, the method hypothesis asserts that men and women are equally prone to self-destruction but merely chose different methods of suicide expression because of their sex that result in different levels of fatality (Garland and Zigler, 1993). Researchers argue that gender roles dictate that males do not “fail” at suicide which leads them to choose highly lethal methods of self-destruction. Conversely, gender roles for women encourage delicacy and attention to appearance even in death. As a result, women may be more likely to choose a method that will not result in blood or disfigurement (e.g., pills rather than guns). These methods tend to be less likely to result in fatality even if the intention to die was equally high for the woman. Certainly, since suicide completion rates rely solely on outcome they fail to account for intent (Langhinrichsen-Rohling et al.; 1998 Kushner, 1985). Individuals who unexpectedly survive an intentional and lethal suicidal act are not counted in the completed suicide rates. Since women appear to be more likely than men to select suicide methods that allow time for discovery and intervention (e.g., overdose), women might be more likely than men to survive what could be a completed suicide. Not counting these occurrences would result in an underreporting of females’ potentially lethal suicidal behavior. A notable limitation with researchers like Langhinrichsen-Rohling et al. (1998) and Kushner (1985)

who attribute suicide differences to gender roles in their studies is that they do not describe any gender role to affirm their claims.

It is also remarkable to note that in a study conducted by Kerkhof (2000) revealed that suicidal behaviour in the Western countries was more prevalent among females than males except in Finland, with a female to male ratio varying between 1:5:1 to 3:1, whereas, in developing countries multisite intervention study undertaken by World Health Organisation (WHO) recorded more female cases than male cases with the proportion of females ranging from 51.3% in India to 71% in South Africa (Fleischmann et al., 2005). From the few studies that have been carried out on the African continent, the emerging picture is that suicidal behaviour is more common in females than males, the lowest female to male ratio is in Kenya at 1.1:1 and highest in Zimbabwe at 5:1 (Pillay et al., 2001; Ndosi and Waziri, 1997). On the other hand more males than female's cases of suicidal behaviour have been reported in Egypt with male to female ratio of 1.6:1 (Abede, 1991), in Uganda and Ethiopia 1.2:1 (Kinyanda et al., 2004; Abede, 1991) and in Nigeria 1.2:1 (Eferakeya, 1984). The suggestion advanced in explaining male preponderance in these countries is that suicidal behaviour involving females are under reported due to stigma (Abede, 1991).

2.6.2 SEX DIFFERENCES AND COMPLETION METHODS

A comparison of male and female adolescent suicide completers in Norway revealed that female completers were more likely to leave a suicide note and used less violent

methods (Groholt et al., 1999). Men in The United States of America are more likely to use guns than women. Conversely, women are more likely to attempt to poison themselves than men. Similarly, for women in Bangladesh and in India, poisoning is a common suicide method (Fleischmann et al., 2005). Rather than aspirin, Valium or antidepressants, however, the most frequently used poisons include pesticides and insecticides which are readily available in many households in these regions and are highly lethal. Consequently, women in these regions may be more likely to die from poisoning than women in countries with less lethal poisons to ingest and have greater access to immediate medical attention (Fleischmann et al., 2005).

2.6.3 GENDER RISK FACTORS ASSOCIATED WITH SUICIDE

Suicidal behaviour has been associated with family instability, parental conflict, parental divorce, physical abuse, sexual abuse, and lack of perceived parental support (Langhinrichsen-Rohling et al., 1998b). Other social factors that have been identified as risk factors include peer conflicts, boy friend / girl friend difficulties, loneliness and social withdrawal.

Within the social and family dysfunction domain (Langhinrichsen-Rohling et al., 1998b) observed that there are several factors that may be uniquely associated with female suicide and these are: domestic violence, lone motherhood, rape, and illegitimate pregnancy. These factors are best understood within a gender and culture specific analysis as the rate of domestic violence, the occurrence of lone

motherhood and the frequency of illegitimate pregnancy and rape are all related to cultural norms for masculinity, femininity and sexuality as well as degree to which power is distributed in a patriarchal or matriarchal society (Langhinrichsen-Rohling et al., 1998b). For example, in rural Bangladeshi, suicide is thought to be a frequent consequence of illegitimate pregnancy among young unmarried women (Fauveau and Blanchet, 1989). In Sweden, lone mothers were found to be at increased risk for suicide because of the psychological stress, stigma and financial concerns that frequently occur with single parenthood (Weitoft et al., 2000). With regards to battering, (Weitoft et al., 2000) revealed that battered wives had an eight times higher incidence of suicide attempts than women who were not battered.

Furthermore, conflicts with the husbands were the most common triggering factors for the suicide attempt. In Sri Lanka, a study conducted by Hettiarachchi and Kodituwakku (1989) revealed that love affairs and domestic disputes were two of the main precipitating causes of suicide. In a similar study conducted by Patel and Gaw (1996) high suicide rates of young women from the Indian subcontinent (India, Pakistan, Bangladesh, Sri Lanka) were attributed to family conflict and domestic violence, rather than mental illness per se. In another study of the association between female suicidal behaviour and the battering of women, Stark and Flitcraft (1995, pp. 43) concluded that "battering may be the single most important cause of female suicidality, particularly among blacks and pregnant women". These researchers highlight the necessity of considering the gender and

societal context in which suicidal behaviour occurs. For women in particular, suicidal behaviour may emerge when there is an absence of options to a partner's coercive control and isolating tactics in conjunction with economic hardship and culturally accepted female inequality Stark and Flitcraft (1995).

2.6.4 METHODS APPLIED IN SUICIDE CASES

In a study conducted by Kerkhof (2000) on para-suicides it was reported that in Western countries 64% males and 80% females used drug overdose for attempting to commit suicide. In the same study it was reported that wrist-cutting was employed by 17% males and 9% females. Kerkhof (2000) further revealed that pesticides and other agricultural poisons were used by 19% males and 15% females in Hungary. In Norway, Kerkhof (2000) reported that 6% male and 5% female para-suicides took alcohol overdose. In the multicultural WHO SUPRE-MISS study, self poisoning with pesticides and drugs was the predominant method and accounted for 69% to 98% of all cases seen at all study sites (Fleischmann et al., 2005). In China pesticide ingestion was the most frequently reported method used by both males and females while in Colombo, Sri Lanka and India was the most commonly used method among women (Fleischmann et al., 2005). On the continent of Africa, the predominant methods used were drug overdose (benzodiazepines, tranquilizers, analgesics and antimalarials) and poisons (organophosphates, kerosene and battery acid) (Pillay et al., 2001; Ndosi and Waziri, 1997; Eferakeya, 1984). Abede (1991) reported that hanging was a common method employed in both rural and urban Ethiopia.

CHAPTER THREE – METHODOLOGY

3.0 INTRODUCTION

This Chapter presents the research methodology used in this study. It discusses the sources of data and the instruments used for data collection. It also outlines study limitations of the study.

3.1 RESEARCH DESIGN

In order to collect data that addressed all issues demanded by the research questions and to meet the research objectives, this study used both quantitative and qualitative methods, the justification for selecting mixed method was based on the recognition that any method used on its own has limitations and biases which could be reduced by employing multiple approaches (Creswell,2003). Quantitative method involved a comparison of responses in the questionnaire as answered by both men and women, whereas qualitative method provided narrative accounts by offering the respondents personal reflections on suicide (Denzin, 1997). This is because events about suicide in the social world can only be understood adequately if they are pictured from more than one contextual viewpoint.

3.2 RESEARCH SETTING

This study was done in the city of Lusaka. The city was chosen because Lusaka has an advantage over other cities in the sense that its population is cosmopolitan and

heterogeneous. This attribute provided the researcher with a greater chance of reaching out to various categories of respondents at a minimal logistical impediment. The research was conducted at the University Teaching Hospital (UTH) between October, 2006 and January, 2007.

3.3 POPULATION AND SAMPLE

The study population comprised 46 para-suicides of whom 28 were women and 18 men.

3.3.1 SAMPLING

The sample for this study could not be obtained by randomization because there is no place where one finds para-suicide population rather than when they are discharged from the hospital wards after a failed suicidal attempt. Given this nature of sample, the researcher got any client who was available after being discharged from University Teaching Hospital wards and referred to counselling unit for counselling sessions. The study was therefore hospital based. Counselling sessions were conducted by medical personnel who were trained in psycho-social counselling.

3.4 DATA COLLECTION

There were three main data collection tools used namely: semi-structured questionnaires, in-depth interviews and document analysis.

3.4.1 SEMI-STRUCTURED QUESTIONNAIRE

A semi-structured questionnaire was used to collect quantitative data from para-suicides (respondents). This was useful in a number of ways: firstly, it was administered in a short period of time and presented in the same format to collect individual's background information such as age, sex and other demographic data. Secondly, this tool made it possible to make comparisons of responses from female and male respondents. Thirdly, the open ended questions in the questionnaire allowed respondents to freely express themselves and raised issues which were further investigated in the in-depth interview.

3.4.2 IN-DEPTH INTERVIEW

An interview guide was used for interviews for the purpose of collecting qualitative data, especially those issues which arose from open ended questions in the questionnaire. This meant that, although freedom was given to para-suicides to discuss and express themselves freely, the interviews were guided by a set of questions. Questions started by exploring para-suicides' background before moving to their specific suicidal experiences such as please tell me what prompted you to consider attempting suicide? what was going on in your mind for you to think of committing suicide?, after going through the experience of attempting to commit suicide what can you say about suicide in relationship to your challenges in life either as a woman or a man?. The respondents were invited to talk about issues that were critical on the topic of suicide. Interviews proved useful because they helped the researcher to understand

suicide from the actors' point of view. Interviews were also conducted with medical personnel who were counselling para-suicides for medical opinion on suicide. The researcher also held a discussion with three traditionalists and two gender activities in order to have their insights on power relations in marriages.

3.4.2.1 APPROACHING PARA-SUICIDES

The researcher had little difficulty in approaching para-suicides, this is because both the Nursing Staff and the Head of the counselling unit were workmates to the researcher and introduced the researcher to all clients at the unit. The doctor formally introduced the researcher to the client by explaining that the researcher was a student pursuing his master's degree. It was made clear to each client that they could choose not to have the researcher present during counselling sessions. None of the clients minded the presence of the researcher to listen to the conversation. After the session, those who were willing to meet the researcher were asked whether they would stay for an interview and answer a short questionnaire.

3.4.3 DOCUMENT ANALYSIS

The researcher also relied heavily on books, published and unpublished documents and other reports on suicide to collect secondary data. Most of the documents provided useful information on the causes and theoretical aspect of the subject matter. Document analysis guided research design and development of research tools. The internet search was also useful and provided latest information.

3.5 DATA ANALYSIS

The two types of data that were collected were analysed as follows: quantitative data was analysed using statistical package for social sciences (SPSS) software version 12 to produce descriptive analysis and frequencies. Cross tabulation was used to make comparisons between females and males. Data on continuous variables such as age and educational levels were re-coded into categorical variables. Age was put into eight categories (10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, and 60-64). Educational level was grouped as follows: no school, primary, junior secondary, senior secondary and college. Qualitative data was analysed manually. This involved condensing and structuring of data into forms that allowed patterns to be identified.

3.6 LIMITATIONS OF THE STUDY

The study is fraught with one methodological limitation and that was finding previous research on suicide in Zambia so as to look at the study design of other researchers. The possibility of getting adequate records on attempted cases of suicide was an awesome task as institutions that attend to suicide cases do not have reliable records. The other problem the researcher encountered was that most para-suicides were not giving reliable residential address due to fear of reprisal. It was not every one who was referred for counselling after discharge actually came. Some para-suicides went straight home after being discharged leaving false addresses with the receptionists. It would have been interesting to follow them and

sample as many respondents as possible so that the theoretical assumptions on suicide could be analysed in totality.

3.7 ETHICAL CONSIDERATION

Permission to conduct a study was sought in writing from University Teaching Hospital Management. Para-suicide patients were approached and objectives of the study explained to them. The researcher also obtained consent from para-suicides and their relatives who accompanied them for counselling. It was made clear to the respondents that refusal to participate in this study did not in any way influence their ability to access counselling services. The researcher emphasised that they were free to refuse to answer some of the questions or end the interviews if they were uncomfortable. The respondents were also assured that the information that would be provided would be treated with utmost confidentiality and would not be available to any person. This was to allay fears in the minds of respondents because suicidal behaviour is considered as a criminal act.

As already mentioned this study was hospital based and depended on para-suicides who were discharged from wards and referred for counselling. Answering the questionnaire and interviews took place after counselling sessions. This led to increased exhaustion on the part of respondents who were already emotionally exhausted after stressful event. It felt like punishment to some and the researcher was able to notice traces of remorsefulness on their part. Others felt outright guilty

and regret and the researcher with his background as a Clinical Officer and a Counsellor was able to offer empathy.

CHAPTER FOUR - PRESENTATIONS OF FINDINGS

4. 0. INTRODUCTION

This chapter discusses the findings of the study. The findings are presented in three main sections, according to themes which are based on the questions that were asked in a questionnaire and interviews. The findings were analyzed and interpreted by means of tables and figures. The first section will look at the social backgrounds of the respondent, providing demographic data that will enhance our understanding of the respondents in relationship to their suicidal behaviour. The second section discusses reasons for suicidal behaviour among the respondents; highlighting such issues as crisis and psychological factors, state of health and methods used in attempting suicide. The last section will look at gender risk factors associated with suicide.

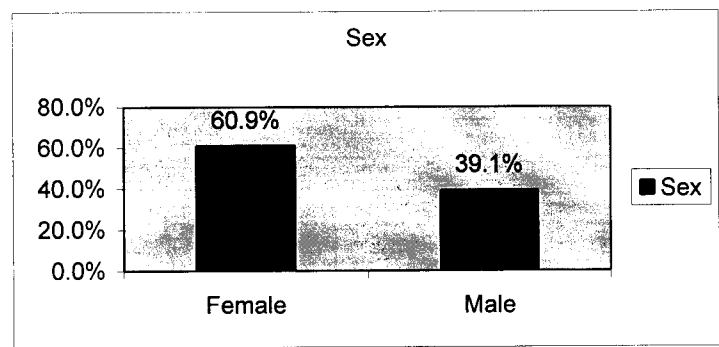
SECTION: 4.1 DEMOGRAPHIC DATA.

For the purpose of anonymity, all respondents were given numbers. All the respondents were Zambians with various social backgrounds.

4.1.1 SEX

The majority of the respondents were women 28 (60.9%) and males were 18 (39.1%).

Figure 1: Percentage distribution of respondents by sex.



4.1.2 AGE

Data show that there were more females 11 (23.9%), in the age group 20-24 who attempted to commit suicide than males 6 (13%) in the same group. Interestingly, in the age group 25-29, there was an equal proportional 7 (15.2%). In the age group 15-19, more females 4 (8.7 %) attempted to commit suicide than males 1 (2.2 %). All in all, respondents under the age of 30 years were 38 (82.6 %) of all para-suicides who were admitted in the University Teaching Hospital during study period distributed as follows: 24 women (52.2 %) and 14 men (30.4 %), (table 1). The implication is that this age group may be more susceptible to suicidal tendencies due to the pressure of life found in the adolescent stage. In fact, one girl aged 10 years who was the youngest respondent in the study when asked in the interview why she attempted to commit suicide at that tender age, she answered quote *“my boy friend relocated to Kitwe without informing me and my relatives and friends instead of sympathizing with me teased me so much that I opted to leave them for good”* (10 year girl respondent of Kabwata Compound).

Table1: Percentage distribution of respondents by age ranges.

Age Range	Male		Female		Cumulative Percentage (%)
	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)	
10 - 14	0	0	2	4.3	4.3
15 - 19	1	2.2	4	8.7	10.9
20 - 24	6	13	11	23.9	36.9
25 - 29	7	15.2	7	15.2	30.4
30 - 34	2	4.3	3	6.5	10.8
35 - 39	2	4.3	0	0	4.3
40 - 44	0	0	0	0	0
45 - 49	0	0	0	0	0
50 - 54	0	0	0	0	0
55 - 59			1	2.2	2.2
Total	18	39	28	60.9	100

4.1.3 LEVEL OF EDUCATION

Educational attainment is generally considered to be one of the key determinants of the status of both women and men in society. Education determines the lifestyle and the orientation an individual enjoys in society. During the study, information on educational attainment was collected from every respondent. The findings are presented in table 2 below. Data on the educational attainment among para-suicide show that the majority of female had primary education 13 (28.3 %), those with

junior secondary education were 11 (23.9 %), senior secondary 2 (4.3 %), college 1 (2.2 %), while men with primary education were 9 (19.6%), junior secondary education 7 (15.2%) and 2 (4.3 %) were college graduates. During the interview, the researcher endeavoured to establish whether or not level of education had any effect on the respondents' attitude towards suicide. Most respondents alluded to the fact that you only feel comfortable when you are educated and employed. However, some respondents were of the view that even if they were educated the problems they faced were insurmountable. One male respondent with college education said quote *"I completed National Accounting Technician accountancy course in 2002 but up to now I am unemployed. As fate can have it I impregnated a girl, instead of her staying with her parents she shifted into my aunt's house where I was being kept despite my objection and trouble started with my guardians. I had no one to lean on, the only solution was suicide"* (28 year old male respondent of Libala Compound). A 25 year old married female respondent of Chawama during in interview also said quote *"I stopped school in grade 7 because there was no one to take care of my school requirements. 'Nalefwaya ukusambilila' (I really wanted to further my education). I had problems with my husband and no one was willing to help. If I was educated and working I would have looked after my self but I depended on him, I got fed up with suffering"*.

Table 2: Percentage distribution of respondents by educational level.

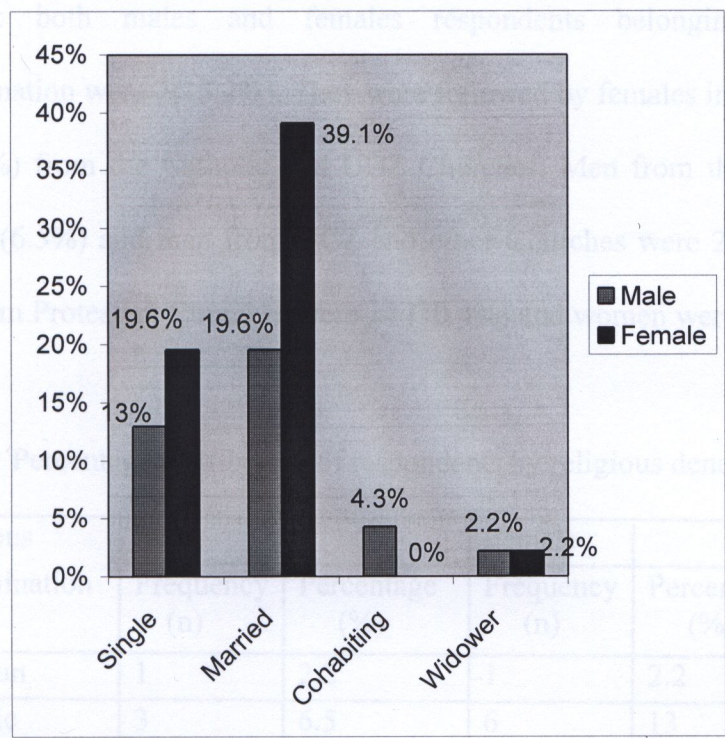
Educational Level	Male		Female		Cumulative Percentage (%)
	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)	
No School	0	0	1	2.2	2.2
Primary	9	19.6	13	28.3	47.9
Junior Secondary	7	15.2	11	23.9	39.1
Senior Secondary	0	0	2	4.3	4.3
College	2	4.3	1	2.2	6.5
Total	18	39.1	28	60.9	100

4.1.4 MARITAL STATUS OF RESPONDENTS

The most striking finding of this study on marital status variable as shown in figure 2 was that the majority of para-suicide respondents were married. 18 (39.1%) female respondents were married and the married male respondents were 9 (19.6 %). The respondents who were single were the next with higher incident rate of attempting to commit suicide. Female respondents who were single were 9 (19.6 %) and males who were single were 6 (13 %). Males who were cohabiting were 2 (4.3%) and the widowed had an equal proportion of 1 (2.2%). There is no doubt

that a family plays an important role in the lives of people because family members depend on each other for social support. It is also true that socialisation process starts within the family circles and become inculcated in later life. In this study, family issues were discussed in detail in the interviews. When asked to state their family life experiences one 20 year old male respondent of Kanyama Compound narrated quote *“I was the only child in the family, my parents divorced when I was 8 years old. My father took me and when he re-married my life became unbearable. My step mother hated me so much that I opted to leave her home and stayed with street kids for 5 years. I stopped school in grade 7 because there was no support. Every time I confided in my father, he only took what my step mother said and always blaming me. After 5 years on the street, I thought of going back hoping relationship between me and my step mother would have improved with time. But it was worse than I had anticipated even my father said I was an adult I should not be kept by them. I decided enough was enough and I took poison”*.

Figure 2: Percentage distribution of respondents by marital status.



4.1.5 RELIGIOUS DENOMINATION

Respondents were also asked to state their religious affiliations. Christianity was the only religion that respondents were affiliated to and spread across seven main denominations as indicated in table 3 but for the sake of this study, all six denominations will be grouped under Protestant Churches versus the Roman Catholic Church and they will be analysed as such. The reason is that historically most Christian Churches came from the Roman Catholic Church. The study revealed that the converts from Protestant Churches were more prone to attempt to commit suicide than their counter parts from the Roman Catholic Church. 78.2% respondents from Protestant Churches attempted to commit suicide in comparison

with 19.5% from the Roman Catholic Church. The percentages were distributed as follows: both males and females respondents belonging to Pentecostal denomination were 7(15.2%). They were followed by females in equal proportional 6 (13 %) from the Catholic and UCZ Churches. Men from the Catholic Church were 3 (6.5%) and men from UCZ and other Churches were 2 (4.3%). All in all, men from Protestant Churches were 14 (30.4%) and women were 22 (47.8%).

Table 3: Percentage distribution of respondents by religious denomination.

Religious Denomination	Male		Female		Cumulative Percentage (%)
	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)	
Anglican	1	2.2	1	2.2	4.4
Catholic	3	6.5	6	13	19.5
Jehovah's Witness	1	2.2	1	2.2	4.4
New Apostolic	1	2.2	2	4.3	6.5
Pentecostal	7	15.2	7	15.2	30.4
SDA	0	0	1	2.2	2.2
UCZ	2	4.3	6	13	17.3
Other	2	4.3	4	8.7	13
None	1	2.2	0	0	2.2
Total	18	39.1	28	60.8	100

SECTION 4.2.0 REASONS FOR ATTEMPTING SUICIDE

There are several causes for suicide and it is very rare that someone attempts to commit suicide because of one cause. It is generally suggested that many people

attempt to commit suicide because depression is triggered by several negative life events in the absence of adequate social support system. Below, some of the reasons the respondents gave for attempting to commit suicide are presented.

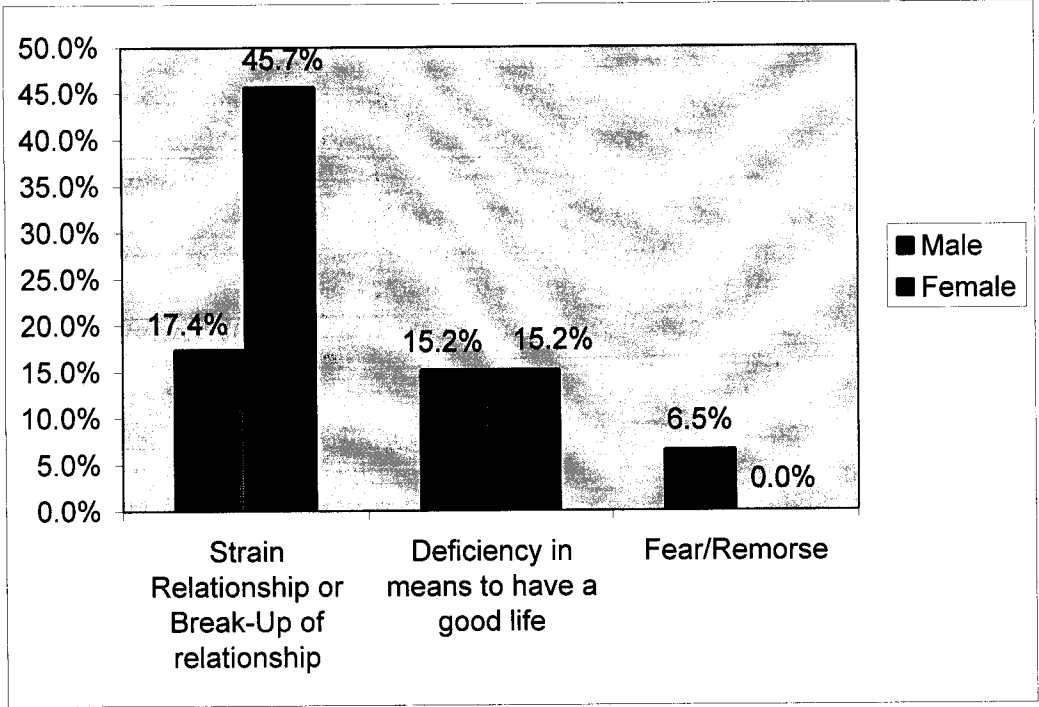
4.2.1 EMOTIONAL PAIN

Respondents were asked to state the reasons that led them to think of attempting to commit suicide. This study revealed that the main reason which led respondents to attempt to commit suicide was strained relationship or break up of relationship. Majority of respondents, 29 (63.1%) mentioned strained relationship as the cardinal reason for attempting suicide (figure 3). 21 (45.7%) women out of 28 in the study revealed that strained relationship with their spouses caused them emotional pain which led them to attempt suicide. 8 (17.4%) men also affirmed that emotional pain due to strained relationship or break up was the main reason for wanting to kill themselves. This study also found that men and women who mentioned deficiency in having a good life (lack of resources) as a reason for attempting to commit suicide were in equal proportion 7 (15.2%). 3 (6.6 %) men said they attempted to commit suicide due to fear or remorse because of unpleasant action they did and their inability to deal with a perceived humiliating situation.

When probed during interview a 30 year old female respondent of Chelstone Compound said quote *“the problem started 2 years ago when I discovered a lady’s passport size photo in my husband’s wallet, he refused infidelity. When we got*

married seven years ago my husband was charming and caring and used to be home by 18:30 hours but in the last two years things changed he started coming as late as midnight and appeared exhausted. I complained to his relatives and my relatives but nobody seemed to care about my complaints. I took an overdose of chloroquine (20 tablets) when he came around 03:00hours smelling woman's perfume". Another woman said quote "my husband, even if I am useless, brought a woman in our matrimonial house and shouted at me 'chikwati chasila enda kwanu' (our marriage has ended, go to your parents'). So I took rat poison so that he can remain enjoying him self with his new girl friend" (25 year old female respondent of Matero Compound.)

Figure 3: Percentage distribution of respondents who reported having attempted suicide due to emotional pain.



4.2.2 PSYCHOLOGICAL DISTRESS AND ANGER

Anger can be self directed as well as directed at others and can lead to depression which may be a reinforcing force to some people. In this study, respondents were further asked to corroborate their reasons for attempting suicide. The study revealed that anger, desperation, worries, misery and humiliation were the contributing factors for some respondents' suicidal behaviour. 7(19.6%) males said they attempted to commit suicide because they were angry; females who attempted to commit suicide due to anger were 13 (28.3%). Males who attempted suicide due to desperation in life were 4 (8.7%) and 3 (6.5%) of them were miserable. 2 men represented by 4.3% revealed that worry was reason behind their suicidal behaviour. Female respondents who mentioned desperation as a contributing factor for their suicidal behaviour were 7 (15.2%) and 6 (13.1%) said worry about their future was the root cause for their suicidal behaviour whereas 2 (4.3%) mentioned misery. Respondents who cited humiliation were 3 (6.5%) males and 2 (4.3%) females. When asked why they were angry, 10 (21.7 %) males answered that they were angry against themselves due to failure in life and they directed their anger against themselves through suicide. Males who directed anger against somebody else as the cause for their failure in life were 8 (17.4%). More than half of female respondents 24 (52.2 %) directed their anger against somebody else and only 4 (8.7%) female respondents directed anger against themselves (figures 4 and 5) below. When asked in the interviews to clarify their anger a 24 year old female

respondent said quote “my husband humiliates me lot. He treats me like a doll. I wonder if my marriage will last another one year”.

Figure 4: Percentage distribution of respondents who reported having attempted suicide due to psychological distress.

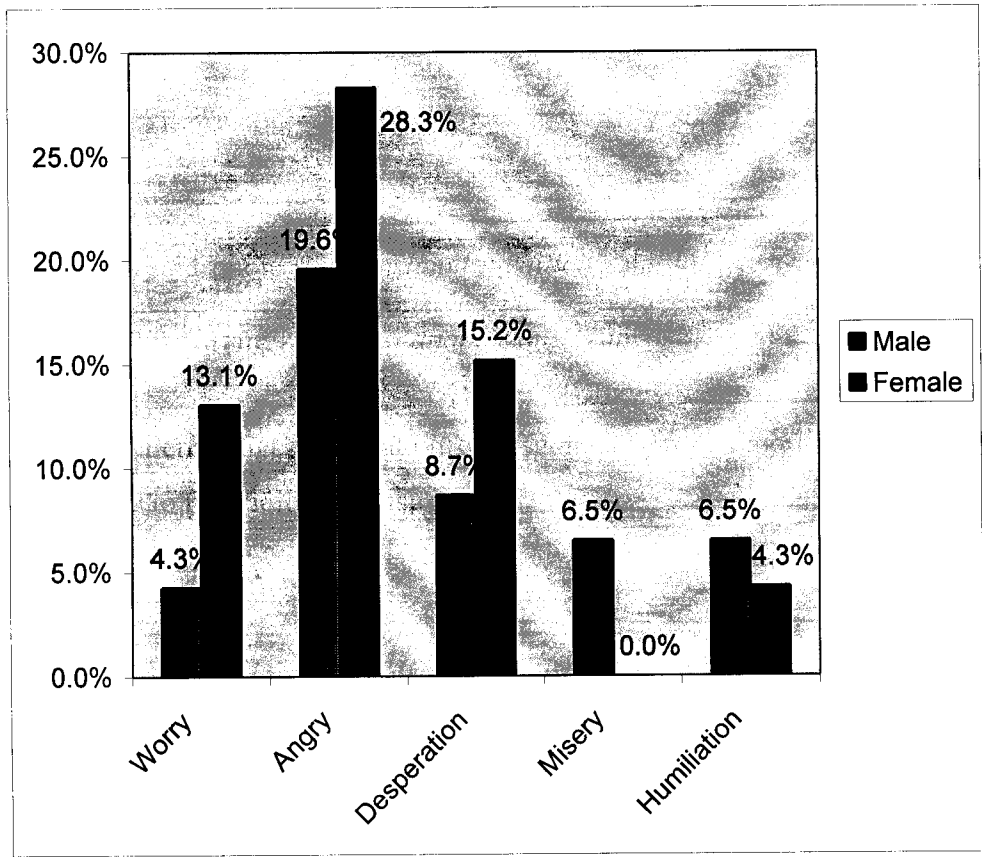
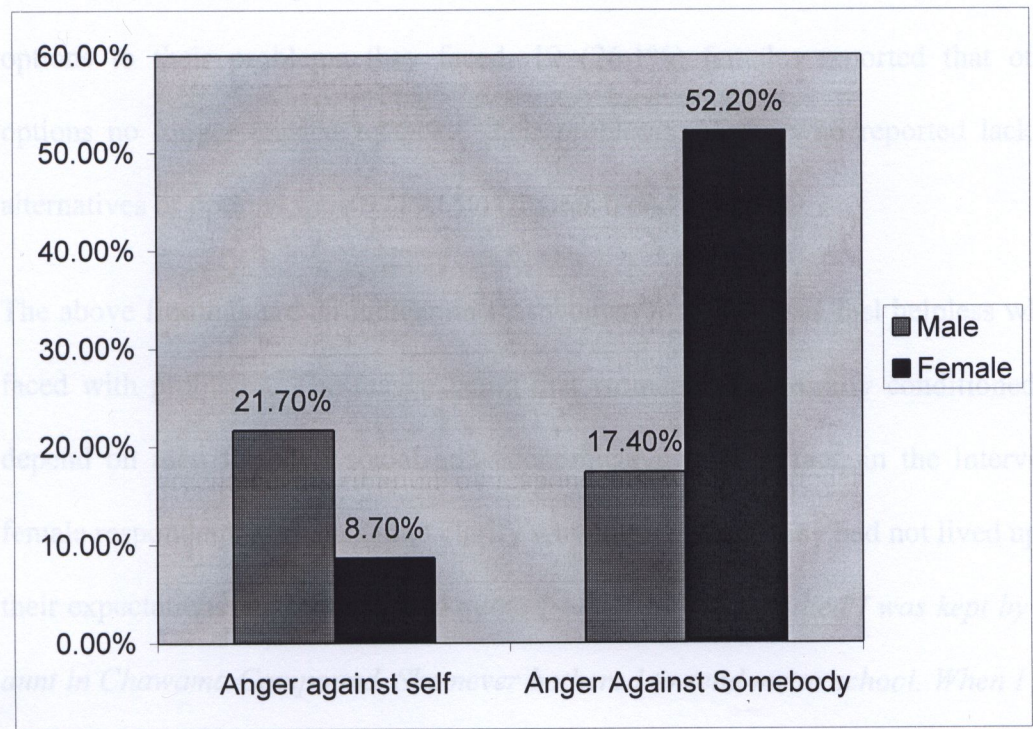


Figure 5: Percentage distribution of respondents who reported having attempted suicide due to anger.



4.2.3 DEPRESSION AND HOPELESSNESS

The study further revealed that 18 (39.1%) female respondents attempted to commit suicide due to unendurable pain which was brought about by hopelessness. Males with similar reason were 6 (23.9%). Para-suicide females who cited anguish as a reason for their suicidal behaviour were 7 (15.2%) and 6 (13%) were males. Loss was also another reason respondents cited for their suicidal behaviour; 3 (6.5%) females and 2 (4.3%) males alluded their suicidal behaviour to loss of livelihood. The study further revealed that 14 (30.4%) females opted to terminate their lives because they felt that solutions to their problems no longer existed.

Males who also felt that solutions to their problems no longer existed were 7 (15.2%). When the respondents were asked if they considered alternatives or other options to their problems they faced, 12 (26.1%) females reported that other options no longer existed to tackle their problems. Males who reported lack of alternatives or options were 9 (19.6%) (figures 6 and 7).

The above findings are an indication that women in most cases feel helpless when faced with problems. The reason being that women are culturally conditioned to depend on men for their social and economical needs. In fact, in the interview female respondents were asked to clarify why they felt as if they had not lived up to their expectations, one female said quote “ *when my parents died I was kept by my aunt in Chawama Compound. She never bothered to send me to school. When I got married I thought my life would be better of but just after one year my husband started mistreating me*” (18 year old female respondent of Chawama Compound). Another female respondent noted quote “*when you are married and have marital problems you are on your own because your parents cannot accept you back home unless your husband surrenders you. Men do not surrender their wives to their parents; they just keep them and continue mistreating them like domestic servants.*” (27 year old female respondent of Chilenje Compound).

Figure 6: Percentage distribution of respondents who reported having attempted suicide due to depression.

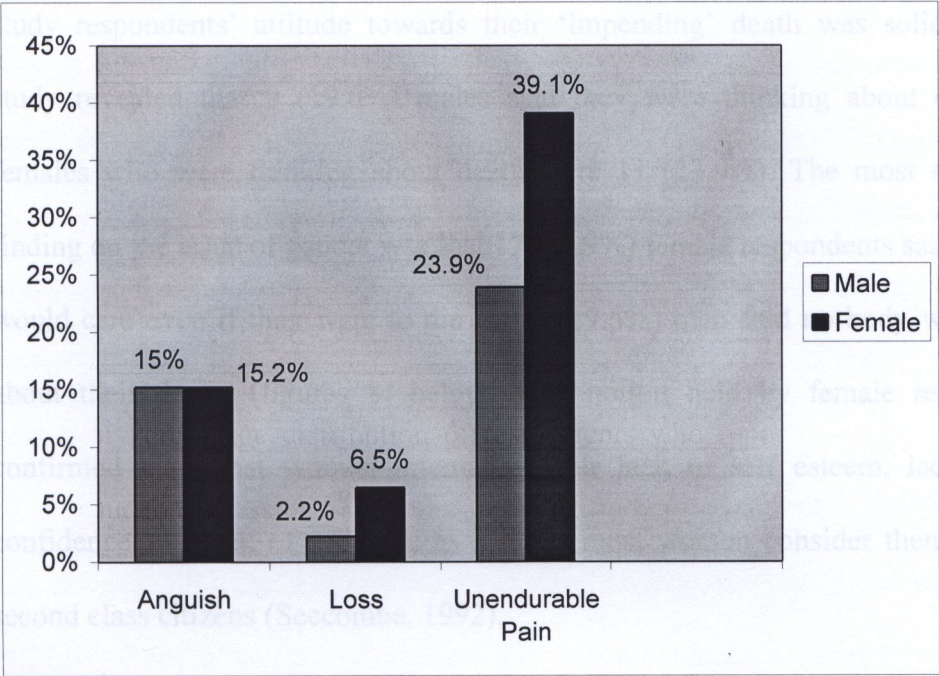
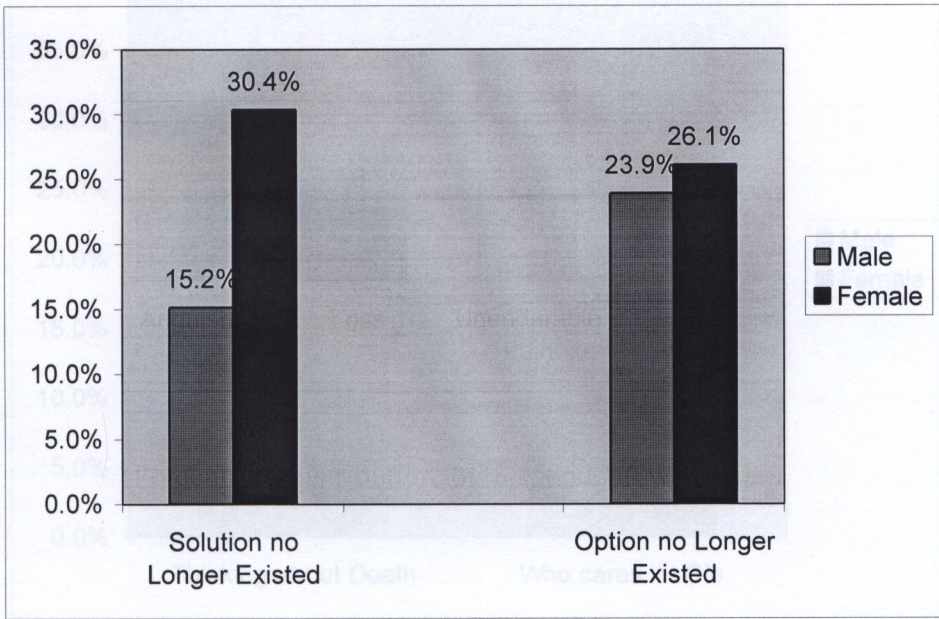


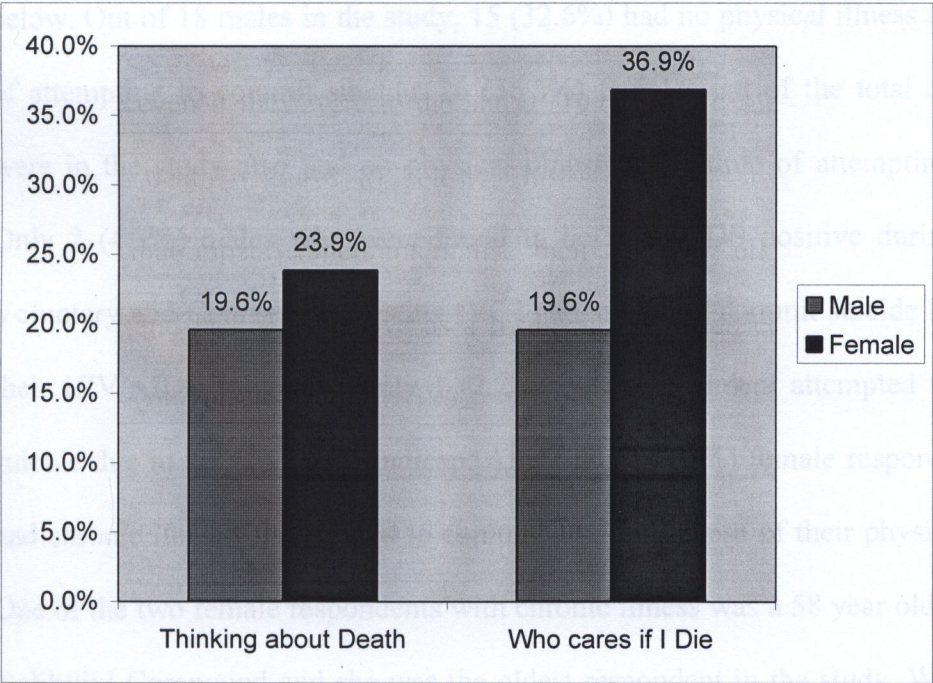
Figure 7: Percentage distribution of respondent who reported having attempted suicide due to hopelessness.



4.2.4 STRESS

Some people withstand misfortunes while others think of killing themselves. In this study respondents' attitude towards their 'impending' death was solicited. The study revealed that 9 (19.6%) males said they were thinking about death and females who were thinking about death were 11 (23.9%). The most significant finding on the issue of gender was that 17 (36.9%) female respondents said no body would care even if they were to die and 9 (19.6%) men said no body would care about their death, (figures 8) below. This notion held by female respondents confirmed that most women internalise their lack of self esteem, lack of self confidence and lack of self love as a result most women consider themselves as second class citizens (Seccombe, 1992).

Figure 8: Percentage distribution of respondents' attitudes towards death.



4.2.5 PHYSICAL AND MENTAL ILLNESSES

Suicide has been associated with mental disorders or physical illness. Untreated mental illness such as depression, bipolar disorders, schizophrenia and other medical conditions have been cited as causes of suicide (Maris, 1992). It should be borne in mind, however, that there are a number of interacting factors which include social factors in suicide causation and not necessarily mental illnesses or indeed physical illnesses (Patel and Gaw, 1996).

In order to establish whether there was a prominent relationship between suicide and physical illnesses, respondents were asked to state the type of illness they were suffering from at the time of attempting to commit suicide. This study has revealed that physical illness does not necessarily cause people to commit suicide, (table 4) below. Out of 18 males in the study, 15 (32.6%) had no physical illness at the time of attempting to commit suicide. 26 (56.5%) females out of the total of 28 who were in the study also had no physical illness at the time of attempting suicide. Only 2 (4.3%) males who were found to be HIV/AIDS positive during routine Voluntary and Counselling Testing (VCT) attempted to commit suicide because of their HIV/AIDS status and only 1 (2.2%) male respondent attempted to commit suicide due to his physical handicap. Also only 2 (4.3%) female respondents who had chronic illnesses attempted to commit suicide because of their physical health. One of the two female respondents with chronic illness was a 58 year old widow of Kalikiliki Compound and she was the oldest respondent in the study. When asked



during interview why she attempted suicide she said quote *“I was fed up with illness. I had been to UTH but no improvement. I had consulted traditional healers they also failed. I just said, oh the time was up, I should go to place of eternal peace”*.

Most literature on suicide have concentrated on mental illnesses as the main cause of suicide. This study, however, has revealed to the contrary that sociological reasons or factors played a decisive role to most respondents who attempted to commit suicide unlike mental illnesses as emphasised by psychiatrists. 22 female respondents out of the total of 28 represented by 47.8% had no signs and symptoms of mental illness at the time of attempting to commit suicide. Even during counselling sessions no signs and symptoms of mental illnesses were found. In case of male respondents, 15 (32.6%) out of total of 18 who were in the study also had no mental illness. Only 4 (8.7%) female respondents had minor depressive disorders which were attributed to stress and could not warrant an admission to Chainama Hills Hospital (Psychiatry Hospital). Males who also had minor depressive disorders were 2 (4.3%) and only 1 (2.2%) male who tried to slash his throat using a knife had psychotic disorder and 1(2.2%) female had anxiety disorder and the other 1 (2.2%) female had personality disorder, (table 5).

Table 4: Percentage distribution of respondents according to physical illness.

Physical Illness	Male		Female		Cumulative Percentage (%)
	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)	
HIV/AIDS	2	4.3	0	0	4.3
Physically Handicap	1	2.2	0	0	2.2
Chronic pains	0	0	2	4.3	4.3
No physical illness	15	32.6	26	56.5	89.1
Total	18	39.1	28	60.9	100

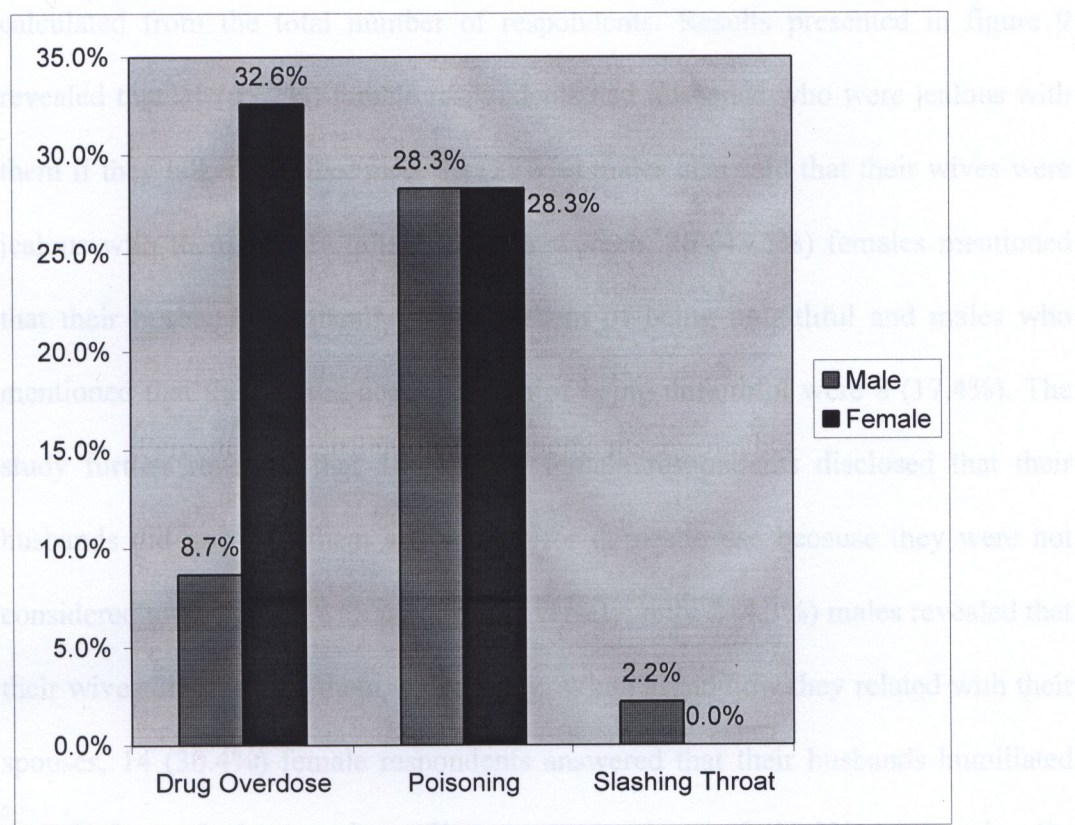
Table 5: Percentage distribution of respondents according to mental illness.

Mental Illness	Male		Female		Cumulative Percentage (%)
	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)	
Anxiety Disorder	0	0	1	2.2	2.2
Depressive Disorder	2	4.3	4	8.7	13
Psychotic Disorder	1	2.2	0	0	2.2
Personality Disorder	0	0	1	2.2	2.2
No mental illness	15	32.6	22	47.8	80.4
Total	18	39.1	28	60.9	100

4.2.6 METHODS USED IN ATTEMPTING SUICIDE

In attempting to commit suicide, the method employed plays a critical role in deciding the outcome of the act. In this study the researcher identified two main methods the respondents used namely: drug overdose and poisoning as shown in figure 9. 15 (32.6%) female respondents used drug overdose and both men and women in equal proportion 13 (28.3%) used poisoning. Men who chose drug overdose were 4 (8.7%). Only 1 (2.2%) male tried to slash his throat using a knife. It was later discovered in the in interview through the relatives that he had history of mental illness (psychotic disorder). The principal reason for the para-suicide to use these two methods was that drugs and poisons were readily available and within the reach of the victims. One female respondent when asked during the interview why she used rat poison she said quote *“I stay in Kanyama Compound so I just walked to City market and bought rat poison at K1,000 and drunk it”* (22 year old female respondent of Kanyama Compound).

Figure 9: Percentage distribution of respondents by methods used in attempting suicide.



SECTION 4.3.0 GENDER RISK FACTORS ASSOCIATED WITH SUICIDE

This section presents various gender risk factors associated with suicide. It is important to note that gender is a critical variable which affects the distribution of psychological distress in both women and men.

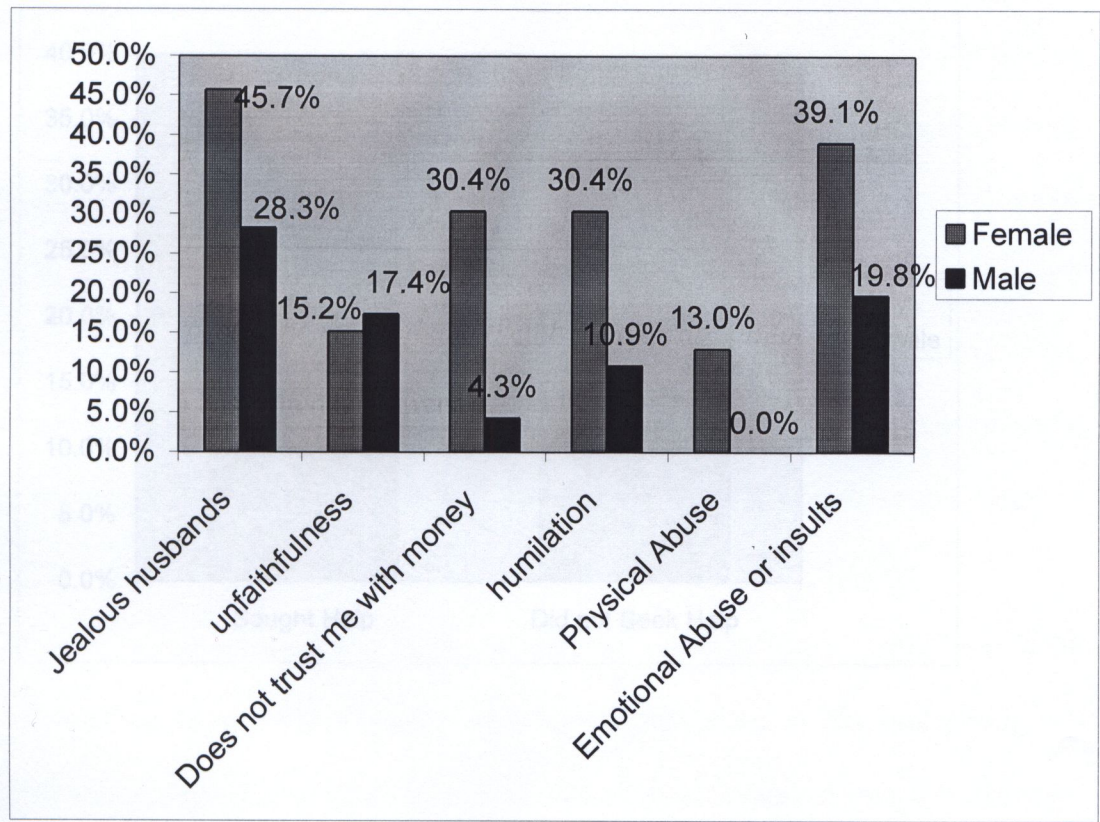
In this study, gender risk factors were categorised as follows: jealousy, unfaithfulness, lack of trust, humiliation, emotional abuse and physical abuse.

Respondents were asked about the power relationship that exists between themselves and their spouses. Each response was given a percentage value calculated from the total number of respondents. Results presented in figure 9 revealed that 21 (45.7%) female respondents had husbands who were jealous with them if they talked to other men. 13 (28.3%) males also said that their wives were jealous with them if they talked to other women. 20 (43.5%) females mentioned that their husbands frequently accused them of being unfaithful and males who mentioned that their wives accused them of being unfaithful were 8 (17.4%). The study further revealed that 14 (30.4%) female respondents disclosed that their husbands did not give them any money for domestic use because they were not considered to be trusted with money. Conversely, only 2 (4.3%) males revealed that their wives did not trust them with money. When asked how they related with their spouses, 14 (30.4%) female respondents answered that their husbands humiliated them in front of other people on flimsy reasons, whereas 5 (10.9%) were males. On the issue of gender violence, respondents were asked to state the nature of domestic violence they had encountered with their spouses. 18 (39.1%) female respondents revealed that they had suffered emotional abuse from their husbands, whilst 9 (19.6%) male respondents suffered emotional abuse from their wives. 15 (32.6%) females were physically abused by their husbands and no male among the respondents in the study said he was physically abused by his wife.

In the interview it became clear that men force women into intolerable situations and compel them to remain in those situations through the use of men's own greater power at their disposal, usually economical power as most women as the study had revealed were not working. A female respondent during in interview succinctly put it quote "*we are poorer than men in money and psychological well being because for us women self esteem depends on approval from society*" (34 year old female respondent of Northmead). It is this same low self esteem that sustains the cycle of emotional abuse because women tend to acknowledge their vulnerability in society. A Bemba traditionalist and marriage counsellor, when asked to comment on women's position in marriage concisely put it quote "*we live in a culture in which marriage is defined in terms of dominance and submission. Marriage is a relationship between power and powerless, oppressor and oppressed. Marriage is socially constructed on the basis of power relation or subordination. Marriage involves male power and female subordination. Culturally, the language of marriage is the language of dominance and subordination*". Clearly, the essence of this statement is that culturally wives were subject to their husbands and when a woman consented to marriage it entailed total obedience to the husband. One gender activist when asked to make a response to above statement said quote "*it may be suggested that the pattern of marriage as it is institutionalised in our society is an old one. It was designed and developed to suit a kind of life and a kind of society which do not exist any more. The time when*

a girl could expect to be married and then be taken care of for the rest of her life is gone” (Lusaka based gender activist).

Figure 10: Percentage distribution of gender risk factors associated with suicide.

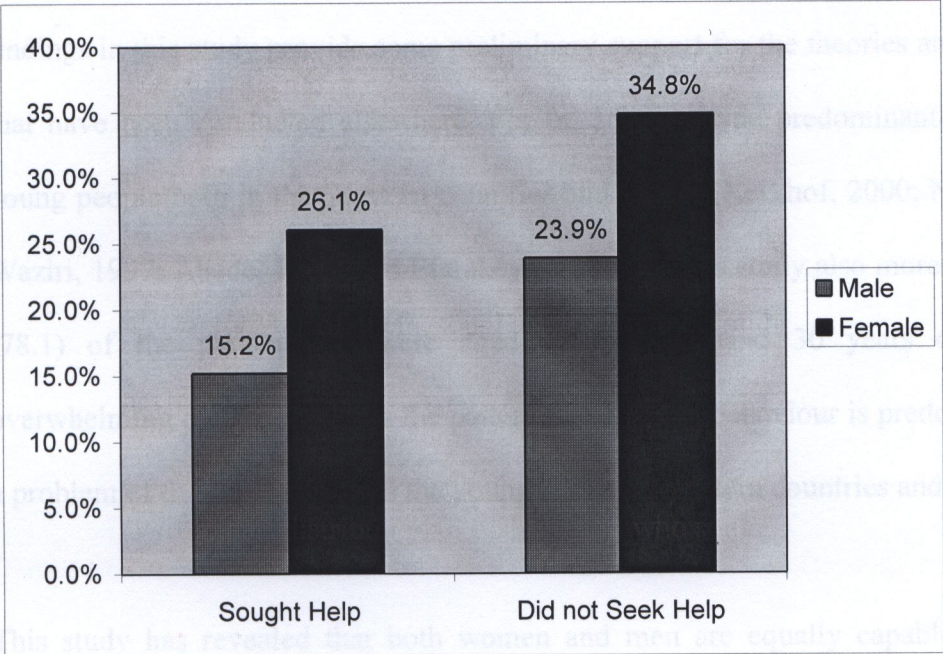


4.3.1 SOCIAL SUPPORT SYSTEM

Durkheim (1952) the pioneer in the field of suicide found that lack of social integration and support in society was the main reason for committing suicide. The study has revealed that 16 (34.8%) female respondents did not seek help for the problems they faced. 12 (26.1%) female respondents sought help but the solutions were not tangible. 11 (23.9%) males did not seek any help for their problems they

were facing, 7 (15.2%) of them sought help but the solutions were not to their satisfaction, (figure 11).

Figure 11: Percentage distribution of respondents who sought for social support



CHAPTER FIVE – DISCUSSION

Taken as a whole the findings in this study suggest that there may be some gender specific patterns of the expression of suicidal behaviour that extend beyond differences in the method selected for suicide completion. First and foremost findings in this study provide some preliminary support for the theories and studies that have been conducted elsewhere. For instance, suicide predominantly affects young people both in the Western countries and Africa (Kerkhof, 2000; Ndosi and Waziri, 1997; Abede, 1991; and Eferakeya, 1984). In this study also more than half (78.1) of the para-suicide were aged between 20 and 30 years old. This overwhelming picture confirms the pattern that suicidal behaviour is predominantly a problem of the adolescent and the young adults in Western countries and Africa.

This study has revealed that both women and men are equally capable of fatal suicidal behaviour psychologically speaking and may share similar precipitants for their suicidality. But suicidal behaviour was more prevalent among females than males (60.9% and 39.1% respectively). These findings also relate to the findings of Kerkhof (2000); Ndosi and Waziri (1997); Abede (1991) and Eferakeya (1984). It follows therefore that gender specific norms for women in conjunction with low social status and lack of economic and personal power have been noted to result in more suicidal behaviour. Secondly, as Langhinrichsen-Rohling et al (1998b) indicated in their study, suicidal behaviour has been associated with family instability, parental conflicts, parental divorce, physical abuse, sexual abuse and

perceived lack of parental support as the special case of 10 year girl who attempted to commit suicide in this study due to perceived lack of parental support. Other social factors which have risen from this study and which can be identified as risk factors include: peer conflicts, boy friend / girl friend misunderstandings, loneliness and social withdrawal. Similarly, these risk factors have been found in other studies such as Kinyanda et al (2004) and Pillay (2000). Within the social and family dysfunction sphere, there are several factors that may be uniquely associated with female suicidal behaviour and these are: domestic violence, lone motherhood, rape and illegitimate pregnancy. These factors as Kinyanda et al (2004) emphasised can be understood within gender and culture specific analysis. The rate of domestic violence, the occurrence of lone motherhood and rape are all related to cultural norms of masculinity, femininity and sexuality as well as the degree to which power is distributed in society.

The most striking finding of this study on marital status variable was that the majority of para-suicide respondents were married. 18 (39.1%) female respondents were married and the married male respondents were 9 (19.6 %). The findings sharply differ with what Durkheim (1952) found in his study. Durkheim revealed that single people showed higher rates of suicide than married people of the same age group due to the fact that single people lacked social integration. The aspect of power relations between women and men as a cultural notion is reinforced in marriage. Marriage, henceforth, reflects the subordinate-dominant relationship of

female and male. The axis of household authority is therefore gender based with male headship at the helm. Quite often the question which has been raised by most feminist theorists is that “if marriage is an oppressive institution for women, why do the vast majority of women marry or remain married? Seccombe (1992, pp.31) perhaps provided the answer when he stated that “male dominance in marriage is sustained by means of the degradation of alternatives to marriage, and the individuation of women’s experience within it”. The foregoing answer is based on the idea of constrained choices. Women generally have limited range of available options. For instance a wife who is physically abused in marriage may decide to leave or stay. There are costs and benefits entailed in either course of action. The consequences of leaving one’s husband may lead to a lower living standard and the poverty which may result from being cut off from household resources may also lead further to lowering her status in society. Therefore, whatever improves women’s life opportunities outside marriage and whatever makes it easier for wives to leave their husbands, will strength women’s bargaining power within marriage. As alternative improves the threat to leave abusive husbands becomes increasingly possible.

In conformity with Durkheim’s (1952) concept of altruism which reinforces high levels of social integration in society, women are not expected to leave matrimonial homes and go back to their parents without being surrendered by their husbands.

The tradition insists that the husbands must surrender their wives to their parents. Women in this case become frustrated and stressed. They suffer psychological pain and torture and if women cannot hold frustrations any longer, they think of suicide due to lack of space to vent their anger just as Selye (1956) noted. Selye (1956) noted that when certain people are found in the situation with no coping mechanism, suicidal behaviour overwhelms them.

Needless to say that low educational levels lead to lack of formal employment as well as deficiency in having life saving skills which may be essential in running income generating activities. It follows, therefore, that women with low educational levels get married early in the hope of being taken care of by their husbands. Women in this case end up as house wives with no formal employment and practically depend on their husbands for livelihood. In fact, in this study most house wives (89%) who attempted to commit suicide had junior secondary education (grade 9) and below and incidentally these married women attempted suicide at a higher rate than unmarried women.

Comparatively, women have lower educational levels than men and in reality, women with low educational levels are unable to find formal employment or engage in any meaningful income generating activities in the form of informal sector and as already alluded to, rely entirely on men for sustenance. It implies that issues of employment and sustainable livelihood are associated with good

education. In situations where men curtail sustenance due to marital conflicts, women become vulnerable to deprivation, desperation, depression, hopelessness and in the end lose meaning in life and consider suicide as the only option of escaping misery, as Zika and Chamberlin (1992) indicated in their study. As already mentioned, most para-suicide women were house wives who depended absolutely on their husbands for survival. Separating with the 'bread winner' left a vacuum which was perceived to be a great deficiency of having a relatively better life. The vacuum was then a precursor to some women's emotional pain, hence attempted suicide.

As a matter of emphasis, gender is a critical variable affecting the distribution of psychological distress. One prominent approach to this issue identifies the stress that accompanies female social roles in modern society as the key explanatory concept (Roberts, 1995). Roberts (1995) theory contends that the variables which intervene between stress and outcomes regulate not simply the occurrence of deviance but the type of deviant response as well. Consistent with this view, it is argued that the normative prescriptions and proscriptions governing men's and women's behaviours lead to production of negative life events which may lead to stress, hence suicide.

The study revealed that the converts from Protestant Churches were more prone to attempt to commit suicide than their counter parts from the Roman Catholic

Church. 78.2% respondents from Protestant Churches attempted to commit suicide in comparison with 19.5% from Roman Catholic Church. The findings show that suicide varies according to religious denomination. These findings correlate with what Durkheim (1952) found in his study. Durkheim found that communities that were predominantly Catholics had lower rates of suicide in general, than those which were clearly Protestants. According to Durkheim, the main difference between the two Church denominations was that Catholic Church had traditionally established closely woven set of beliefs and ritual practices into which a convert was closely bound, while Protestant Churches emphasised on individualism based on the principal of free inquiry. Durkheim concluded that lack of social communication left social safety net loose and explained high propensity for suicide in those churches. Durkheim called that type of suicide, egoistic suicide since it came about due to excessive individualism where by an individual was detached from closely unit contact with others. In short, it was due to lack of integration in society. In any case, Durkheim's (1952) study was conducted in Europe in the 19th Century. There is therefore, a need to carry out a systematic and detailed research to corroborate his findings in the modern African context.

The findings in this study have revealed that the main reason which led respondents to attempt to commit suicide was strained relationship or break up of relationship. Majority of respondents 29 (63.1%), mentioned strained relationship as the cardinal reason for attempting suicide. 21 (45.7%) women out of 28 in the study revealed

that strained relationship with their spouses caused them emotional pain which led them to attempt suicide. 8 (17.4%) men also affirmed that emotional pain due to strained relationship or break up was the main reason for wanting to kill themselves. The findings in this study relate to the findings of Patel and Gaw's (1996) study done in the Indian subcontinent (India, Pakistan, Bangladesh, Sri Lanka) as well as Hettiarachchi and Kodituwakku's (1989) study conducted in Sri Lanka. All these findings correlate with Shneidman's (1993) dyadic type of suicide which occurs due to relationship failure. Dyadic suicide occurs when a dominant or influential person in this case a husband fails to meet needs and aspirations of another person, usually a wife. This study further revealed that female respondents attempted to commit suicide due to unendurable pain which was brought about by hopelessness. The findings also relate with what Hendin (1971) found in this study. Hendin (1971) found that being deprived of interpersonal relationships resulted in loss of meaning to some people which led to hopelessness. The above findings are therefore re-affirming Shneidman's (1985) another type of suicide known as 'psychache'. Psychache is a condition that a suicidal person seeks to escape which involves emotions such as anxiety, desperation, worry or anger.

Most literature on suicide have concentrated on mental illness as the main cause of suicide. This study, however, has revealed to the contrary that sociological reasons or factors played a decisive role for most respondents who attempted suicide unlike mental illness as emphasised by psychiatrists (Patel and Gaw, 1996). 22 female

respondents out of the total of 28 represented by 47.8% had no signs and symptoms of mental illness at the time of attempting to commit suicide. Even during counselling sessions no signs and symptoms of mental illnesses were found. This shows that suicide is complex and no single cause may be isolated as the prime cause. In case of male respondents, 15 (32.6%) out of total of 18 who were in the study also had no mental illness. These findings re-affirm the findings of Patel and Gaw (1996) in their study conducted in India, Pakistan and Sri Lanka. They found that family conflicts and domestic violence rather than the mental illness were the main cause of suicidal behaviour among the young women.

Hendin's (1971) study is relevant in this context. Hendin based his study on the theory of depression set out in Sigmund Freud's psychoanalytic. Hendin noted that "not all suicidal individuals by any means show the typical depressive melancholic pattern, and not all depressed people manifest any recognisable suicidal tendencies" (Hendin 1971, p.321). Hendin's statement implies that a lot of suicidal people do not manifest the clinical features associated with depression. The most important point to keep in mind is the fact that many depressed people are just not suicidal. This alone as Hendin (1971) maintained should emphasise the fact that the psychodynamics of depression are necessary but not sufficient enough to explain suicide and thus the study of depressed patients as shown in psychiatry text books cannot be used as a substitute for directly studying suicidal people. In investigating depressed patients, one often sees patients who appear to view their death as

internalised murder while suicidal behaviour for others is an act of expiation reinforced by social factors.

To sum up, it may be noted that women's experiences of 'being females' are mediated by their bodies, their minds and their social interactions. These experiences are structured and constituted by sets of relationships. One of the major sets of relationships is the gender relationship of a patriarchal system of social reproduction. Women are born into material and ideological conditions of domination and subordination set out by these relationships and reinforced by the concepts of maleness and femaleness (Radtke and Henderikus, 1994).

CHAPTER SIX – CONCLUSION AND RECOMMENDATION

6.0 CONCLUSION

This chapter will try to provide answers to research questions set out earlier in this study namely: what are the social and demographic characteristics of people who attempt to commit suicide, why do people attempt to commit suicide, what are gender risk factors associated with attempted suicide and how can the community and social scientist address the problem of para-suicide?

This study has established that the majority of the para-suicides were females, 60.9% and males were 39.1%. Female rates of attempted suicide outnumbered male rates by a ratio two to one. According to this study it may be deduced therefore that women attempted to commit suicide at a higher rate than males. This study has also established that the rates of attempted suicide were highest in those between 20 and 30 years of age (78.1%). The study revealed further that females (45.6%) between 20 and 30 years of age were more vulnerable to attempt suicide than their counterparts in this same age group (32.5%).

The study has revealed that converts to Protestant Churches were more prone to commit suicide than their counter parts in the Roman Catholic Church. 78.2% respondents from Protestant Churches attempted to commit suicide in comparison with 19.5% from the Roman Catholic Church. The reason which could be

attributed to differences in suicidal behaviour between converts of these two church denominations could be that the Catholic Church has traditionally established closely woven set of beliefs and ritual practices into which converts are closely bound, while Protestant Churches emphasise individualism based on the principal of free inquiry.

This study has established that suicidal behaviour is not always associated with the presence of mental illness as emphasized in psychiatry text books. The three males and six females in the study who were diagnosed with common minor disorders were not at all put on psychiatric treatment but were only counselled. It would be erroneous to always link para-suicide with mental disorders. The study further found no correlation between physical illnesses and suicidal behaviour as there was no respondent with reported signs and symptoms of any physical ailment apart from two males who had tested positive for HIV/AIDS and two female respondents who had chronic illnesses.

This study identified drug overdose and poisoning as the commonest methods employed by respondents to attempt to commit suicide. The study found that 15 (32.6%) female respondents preferred drug overdose to poisoning which was comparatively a method of choice by males 13 (28.3%). The explanation was that drugs and poisons were readily available on the black market.

This study has ascertained that the main motive which led, especially, female respondents to attempt to commit suicide was strained relationship or break up of relationship. 21 (45.7%) out of 28 women in the study revealed that strained relationship or break up with their spouses caused them emotional pain which later led them to attempt to commit suicide. Psychological distress was another reason given by some respondents for their suicidal behaviour. Psychological distress was expressed in the form of anger, desperation, worry and misery. Depression and hopelessness also played a critical role for some respondents' suicidal behaviour. Respondents alluded to the fact that solutions to their various problems they were facing no longer existed. Respondents were pessimistic about their future hence attempting to commit suicide.

This study has also revealed that gender and power relations played a critical role towards suicidal behaviour of female respondents. Majority of female respondents revealed that uncontrollable jealousy by their husbands was the reason for their suicidal behaviour. Accusation of being unfaithful was another reason given by female respondents for their suicidal behaviour. In actual fact 20 (43.5%) female respondents mentioned that their husbands frequently accused them of being unfaithful. The study also found that emotional abuse was another reason which led some female respondents to attempt to commit suicide. 18 (39.1) female respondents mentioned that they had suffered emotional abuse from their husbands. Female respondents also suffered physical abuse from their spouses.

This study has also found a clear correlation between gender and suicidal behaviour in terms of educational attainment. The study has established that female respondents with low educational attainment and who were also house wives attempted to commit suicide at a higher rate than those with higher educational attainment. It may be construed from the findings in this study that poverty and suicide among female respondents was not mutually exclusive. Poverty as inferred in this study played a critical role in women's quest to attempt suicide because most female respondents could not fend for themselves.

The findings from this study, therefore, suggested that there were several explanations that could be advanced as the reasons why some people attempted to commit suicide. This researcher insists that to look for one cause and state categorically that it was the prime reason for some one's suicidal behaviour could be too simplistic and misleading in the majority of suicidal cases. After analyzing a gender perspective in suicide, it may be emphatically concluded from this study that emotional pain, psychological distress, frustrations, feelings of worthlessness, stress, hopelessness, vulnerability, humiliation, marital jealousy, and mistrust were some of the root causes in combination that, in the absence of adequate and strong social support, led most women to consider attempting suicide. Put simply female suicidal may be linked in combination to the following precipitating factors: domestic violence, vulnerability, hopelessness, social discrimination, deprivation,

desperation, frustrations, anxiety, and lack of economical power. Whereas men's suicidal behaviour may be linked to rising rates of unemployment, financial insecurity, loss of identity and self respect especially young men if they face obstacles to achieve life long goals.

Finally, the most important point to keep in mind is the fact that many depressed people are just not suicidal. The psychodynamics of depression are necessary but not sufficient enough to explain suicidal behaviour and thus, the study of depressed patients as shown in most psychiatry text books cannot be used as a substitute for directly studying suicidal people. In investigating depressed patients, one often sees patients who appear to view their death as internalised murder while suicidal behaviour for others is an act of expiation reinforced by social factors which include gender risk factors.

6.1 RECOMMENDATIONS

6.1.1 Since female suicide is linked in combination to domestic violence, vulnerability, hopelessness, social discrimination, deprivation, desperation, hopelessness, frustrations and lack of economical power. Raising both social and economical status of women through expansion of both formal and informal economical support will gradually reduce incidences of female suicide. This can be done through provision of micro- finance credit facilities.

6.1.2 Since suicidal behaviour afflicts predominantly the young people both females and males, suicide interventions should be incorporated into all health promotional programmes for the adolescent and young adults. For the future suicide research, there is a need for more research into the vulnerability factors among adolescent and young adults.

6.1.3 Our ability to prevent suicidal behaviour among women and men may be enhanced by becoming aware of gender risk factors such as gender violence, domestic violence and emotional abuse. Efforts, therefore, should be made to provide adequate psycho-social interventions, social support and crisis counselling to both women and men through Young Women's Christian Association (YWCA) and Young Men's Christian Association (YMCA). These associations have been formed to look at the plight of young women and men. There is a need to strength these associations in order to meet the challenges of young people.

6.1.4 The link between suicidal behaviour and gender disparities in terms of educational attainment is well established. Suicide prevention efforts should be directed towards eliminating gender disparities such as increasing school enrolments for girls and enact a law that will prohibit early marriages for girls. Skills training such as tailoring, carpentry and home economics should be encouraged in the communities for both women and men.

6.1.5 Since University Teaching Hospital (UTH) and Police Service Headquarters have no reliable statistics on suicide. Suicide data bank should be established to monitor and record all suicidal cases. This will enhance surveillance on suicide mortality rates and provide statistics or disaggregated data on all types of suicides.

6.1.6 There is a need to develop centres which will be offering intervention programmes for para-suicides and at the same time provide prevention strategies. The centre should work hand in hand with counselling units which are spearheaded by the Ministry of Health. At the moment there is no known centre which handles suicide cases in Lusaka District.

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Appendix - Questionnaire:

A Gender Perspective in Suicide: A Case Study of Parasuicide in the City of Lusaka.

SECTION 1: Back Ground information

1.

Sex

a. Male

b. Female

2.

Age

3.

Level of Education

a. Never been to school

b. Primary level

c. Junior secondary

d. Senior secondary

e. College

f. University

4.

Please indicate your occupation.....

5.

Marital Status

a. Single

b. Married

c. Cohabiting

d. Widowed

e. Separated

f. Divorced

6.

If you are married, what type?

a. To one partner

b. To two partners

7.

If you are single, do you have a boyfriend/girl friend?

Yes

No

8.

How many are you in you family?

9. Are your parents alive?

- a. Mother
- b. Father

Yes	No

10. If both parents are deceased, who brought you up?
.....

11. Religious belonging

- a. Christian
- b. Hindi
- c. Muslim
- d. Other
- e. None

12. If you are a Christian, which is your denomination?

- a. Catholic
- b. Seventh Day Adventist
- c. New Apostolic
- d. Jehovah’s Witness
- e. United Church of Zambia
- f. Anglican
- g. Pentecostal
- h. Other

13. How often do you attend church?

Always	Frequently	Occasional	Rare	Never
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14: To what extent do you agree with this statement ‘I adequately get spiritual and moral support from the church’.

I strongly Agree	I Agree	Somewhat Agree	I Disagree	I Strongly Disagree
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SECTION 2: Suicide Intent

(a) Crisis Factors

15. What problem (s) led you to consider taking your life?

- a. Deficiency in means to have a good life
- b. I lost a job
- c. I had a strain relationship or break up of relationship
- d. I had a mental illness
- e. Fear or remorse
- f. I faced political pressure
- g. I had a physical illness
- h. Loss of a beloved one
- i. Other specify

{b} Psychosocial distress

16. When you had this experience (question 13) which factor (s) pushed you to consider taking your life?

- a. I had been worried for sometime
- b. I was angry
- c. I was hopeless
- d. I felt low
- e. I felt shame / embarrassed

{c} Anger

17. I was overcome with immediate anger against:

- {a} Myself
- {b} Somebody

{d} Depression

18. I was depressed due to:

- {a} Grief
- {b} Loss
- {c} Unendurable pain

{e} Hopelessness

19. I was in the state of hopelessness because:
- {a} I felt that solutions to my problem (s) no longer existed
 - {b} Those solutions I tried failed
 - {c} Other options no longer existed

{f} Stress

20. When you noticed that you had a problem {s} and decided to take your life, what was actually happening within you? (Select one process)
- {a} I was thinking about death through and through
 - {b} I had a feeling within me “who cares if I die”
-

{g} Reinforcing Factors

21. To what extent do you take any one or all of the following?

Level of agreement		Variable	Level of agreement	
Always	Frequently		Occasionally	Never
		Beer		
		Marijuana		
		Drugs		

22. Was your decision to commit suicide influenced by beer?
- {a} Yes
 - {b} No
 - {c} To some extent
23. Was your decision to commit suicide influenced by Marijuana?
- {a} Yes
 - {b} No
 - {c} To some extent
24. Was your decision to commit suicide influenced by drugs?
- {a} Yes
 - {b} No
 - {c} To some extent

{h} Methods

25. In attempting to commit suicide, which method did you attempt?

a.	Burning oneself (Self – Immolation)	
b.	Car collision	
c.	Drowning	
d.	Electrocution	
e.	Hanging	
f.	Jumping	
g.	Overdosing with tablets	
h.	Plastic bag method	
I.	Poisoning	
j.	Shooting	
k.	Slashing throat	
l.	Starving to death	
m.	Suffocation by using some gas (e.g. Carbon monoxide)	

{i} Previous Suicidal Behaviour

26. How do you rate the number of attempts you have had to take your life?

{a}	The first time	<input type="text"/>
{b}	The second time	<input type="text"/>
{c}	Indicate other times	<input type="text"/>

27. {a} Is there any family member who attempted to take his or her own life?

Yes	<input type="text"/>	No	<input type="text"/>
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{b} if yes, who.....

Section 3: State of Health

{a} Physical Illness

28. Have you ever suffered from any physical illness listed below?

a.	HIV/AIDS	<input type="text"/>
b.	Cancer	<input type="text"/>
c.	TB	<input type="text"/>
d.	Physical handicap	<input type="text"/>
e.	Other (Specify)	<input type="text"/>
f.	None	<input type="text"/>

29. If you have any physical illness listed above, to what extent did you experience shame or disgrace?

Always	Frequently	Occasional	Rare	Never
--------	------------	------------	------	-------

30. {a} Was your decision to commit suicide influenced by any physical illness you had?

{a} Yes

{b} No

{b} If yes, which one.....

{b} Mental illness

31. History of admission to Chainama Hills Hospital

Yes	No
-----	----

32. If you had Mental illness at the time you wanted to take your life, what did the doctors say it was? {Patient's Files}

a.	Anxiety Disorders	<input type="text"/>
b.	Depressive Disorders	<input type="text"/>
c.	Psychotic Disorder	<input type="text"/>
d.	Physical Ailment	<input type="text"/>
e.	None	<input type="text"/>
f.	Other	<input type="text"/>

33. If you had any mental illness listed above, to what extent did you experience shame or disgrace?

Always	Frequently	Occasional	Rare	Never
--------	------------	------------	------	-------

34. {a} Was your decision to commit suicide influenced by any mental illness you had?
 {a} Yes
 {b} No
 {b} If yes, which one?

35. {a} Is there any family member who has a mental illness?
 {b} If yes,, who?.....

Yes	No
-----	----

36. What have you experienced before?

- {a} Sexual Abuse
 {b} Torture

Yes	No

Section 4. Gender Risk Factors

37. Please indicate if any apply in your relationship with your husband / boyfriend.

- {1} He is jealous or angry if you talk to other men {a} Yes {b} No
 {2} He frequently accuses you of being unfaithful {a} Yes {b} No
 {3} He doesn't trust you with money {a} Yes {b} No

38. Please indicate if any apply in your relationship with your wife / girlfriend

- {1} She is jealous or angry if you talk to other women {a} Yes {b} No
 {2} She frequently accuses you of being unfaithful {a} Yes {b} No
 {3} She doesn't trust you with money {a} Yes {b} No

39. Does your husband / boyfriend ever:

- {1} Say or do anything to humiliate you in front of others {a} Yes {b} No
 {2} Threaten to hurt or harm you {a} Yes {b} No
 {3} Insult you or make you feel bad about yourself {a} Yes {b} No

40. Does your husband / boyfriend ever:

- {1} Say or do anything to humiliate you in front of others {a} Yes {b} No
- {2} Threaten to hurt or ham you {a} Yes {b} No
- {3} Insult you or make you feel bad about yourself {a} Yes {b} No

Section 5: Social Support

41. From what you have experienced or gone through in life, have you ever tried to seek help?

- {a} Yes {b} No

42. {a} If yes, from whom?.....

- {b} If no, why
.....

Thank you so much

INTERVIEW GUIDE

1. Tell me in detail about yourself and what you have gone through in life? (Personal History and Childhood Experiences).
2. Please tell me about your family and how you relate with each other? (Family History).
3. Please tell me what prompted you to consider attempting suicide? (Suicide Intent or Critical Life Events).
4. What was going on in your mind for you to think of committing suicide? (Crisis Factors)
5. Please describe for me in detail your experience in attempting to commit suicide? (Psychological pain).
6. Do you know of any person who attempted or committed suicide and how you felt about it? (Reinforcing Factors).
7. Did you involve other people to help you in solving the problems you were facing? (Counselling / Social Support).
8. Looking back at what have happened in your life do you have any ideas on what you could have done to prevent yourself from being hurt by others? (Targeted Intervention).

GENDER ISSUES

9. Please tell me in detail how your husband talks to you or relates to you in terms of talking and interaction?
10. In your marriage or relationship who has greater say in making major decisions between you and your spouse?
11. Do you face any challenges at home as a woman and what kind of challenges if any?
12. Do you face any challenges in society as a woman and what kind of challenges if any?
13. After going through the experience of attempting to commit suicide what can you say about suicide in relationship to your challenges in life as a woman?
14. Do you have any ideas on what you would do to prevent yourself from being hurt by others? (Prevention).