

Topic: Suicidality: Drivers, Challenges and interventions in Nepal

- Mentee: Sarita Sapkota (Nepal)
- Mentor: Philip Mefoh (Nigeria)

Global Psychology Learning Leadership Institute

Capstone Project

Introduction

More than 800,000 people die globally as a result of suicide every year and many more attempt it. Low- and middle- income countries (LMICS) are at particular risk, accounting for 75% of global suicides in 2012 and, among those, LMICS in Southeast Asia had the highest rate accounting for almost 40% of all suicides (WHO, 2016). In Nepal suicide is the single leading cause of death among women of reproductive age (Kasaju, Putten, 2011).

According to WHO (2021) in suicide rate estimates, age standardized estimates by countries, in 100000 population in 2019, age-standardized suicide mortality rates are generally lower in LMICs (ranging from 7.28 to 10.07 per 100,000 people) than in high-income countries (HICs; 10.95 per 100,000 population) However, the 11 countries with the highest suicide rates are LMICs, with rates ranging from 87.5 per 100,000 population (Lesotho) to over 23.0 per 100,000 (Central African Republic, Russia) and in context of Nepal the rate is 9.8.

Silwal, Pant and Gurung (2021), in Burden of suicide in Nepal: an analysis of police records, studied the records of Nepal Police for five years between 2015 and 2019. They found that during the five years, 25,316 cases of suicidal deaths were recorded which means an average of 14 people committed suicide each day. The data revealed that adolescents, youths, and females aged 19 to 35 years are the most vulnerable population for suicide and accounted for almost 60% of all suicide deaths. Hanging was the most common (70.13%) method followed by the consumption of poison (26.55%). Suicide is a serious but neglected public health problem in Nepal with Due to issues regarding the legality, social stigma, and logistical problems, there is an underreporting of suicide cases in Nepal.

Drivers:

Risk factors include personal economic adversity, displacement, interpersonal violence; Portrayals of suicide in the media particularly when suicide is romanticized or sensationalized; access to lethal means of suicide; psychological disorder; negative interpersonal relationships; limited access to proper mental health care facilities (Renaud, et al, 2022).

Key risk factors for suicide found were: mental disorders including depression, substance abuse, personality disorder, anorexia nervosa; previous suicide attempts, specific personality characteristics such as impulsivity, difficulties in managing the various, often strong and mixed emotions and mood fluctuations accompanying the confrontation with new and ever-changing challenges in different domains, rigid thinking process; Family factors including direct conflict, violence; exposure to inspiring models and availability of means of committing suicide (Bilsen, 2018).

Kasaju, Krumeich and Putten, (2021) in Suicide and deliberate self-harm among women in Nepal: a scoping review reviewed papers published or reports issued between 2000 and 2019 and found that, in Nepal, suicide rates are higher among younger individuals and married women. The most frequently used method of suicide is poisoning. Various psychosocial and economic factors, including abuse, interpersonal conflicts, marital disputes, relationship problems, adjustment difficulties, unpaid debts, and financial losses, contribute to suicide and deliberate self-harm among women in Nepal. Additionally, mental health conditions such as mood disorders, adjustment disorders, and substance abuse disorders are identified as contributing factors.

Suicide rates are higher among women and younger individuals. There is also an increasing trend of suicide among specific groups, including marginalized communities,

migrant workers, and those affected by disasters. Mental illness, particularly mood disorders, and various psycho-social factors such as interpersonal or marital conflicts, as well as socio-economic issues, play a significant role in triggering suicidal and self-harm behaviors (Thapaliya, Sharma, & Upadhyaya, 2018).

Hagaman, Khadka, Wutich, Lohani, and Kohrt (2018) state that the drivers for suicide included: lack of education, life stressors such as poverty, violence, migrant labor, and family disputes often resulting in isolation or shame, family histories of suicidal behavior with the majority involving an immediate family member, gender differences: female suicides were associated to hopeless situations, such as spousal abuse, with high degrees of social stigma and male suicides were most commonly associated with drinking and resulted from internalized stigma, such as financial failure or an inability to provide for their family.

There are social, economic, cultural, health, and behavioral risk factors associated with suicide including Relationship conflict, economic status, academic failure, issues related to mental health and physical health, deep unhappiness, and hopelessness, easy access to means of suicide such as pesticides, firearms, and medication (Karki, et. al., 2017).

Challenges:

To design, implement, and evaluate suicide prevention strategies, a reliable and accurate suicide surveillance is crucial but in context of Nepal there are various challenges including: The dominant role of police in collecting information, reporting suicide, and interacting with families affected by suicide; Limited engagement to report suicides due to concerns about potential legal complications, the expected social stigma faced by families of suicide victims, and the increased time and financial burdens involved compared to reporting deaths from natural causes (Hagaman, Maharjan, & Kohrt, 2016).

Suicide is generally perceived negatively. People who attempt suicide are often labeled as coward and/or disgraces to their families and communities. Perceptions differs based on gender, generally women who attempt suicide are often considered to be engaged in offensive activities such as extramarital affairs and Men are considered to be coward (Karki, et. al., 2017).

There are various challenges that must be addressed, such as inadequate distribution of mental health resources and societal attitudes towards mental illness and suicide, which require attention and action (Thapaliya, Sharma, & Upadhyaya, 2018).

Intervention:

In Nepal, according to prior research mental health is highly stigmatized and hence Anti-stigma efforts are needed to reduce discrimination of persons with self-harm behavior and among groups at risk for self-harm and Campaigns are needed to raise awareness about the causes of suicide (Hagaman, Maharjan, & Kohrt, 2016).

Bilsen (2018) Further unraveling and knowledge of the complex interplay of these factors is highly relevant with regard to the development of effective prevention strategy plans for youth suicide.

Hagaman, Khadka, Wutich, Lohani, and Kohrt (2018) recommend proper suicide surveillance, targeted interventions for family members of those that have died by suicide, migrants, and survivors of domestic abuse, Clinical screening and suicide disclosure encouragement, adopting and implementing interventions for suicide survivors (help-lines, support groups, school-based prevention).

According to Renaud, MacNeil, Vijayakumar, Spodenkiewicz, Daniels, Brent, & Turecki (2022), Suicide prevention and intervention strategies in LMIC should include Population-wide strategies (restricting availability of commonly used tools for suicide,

Decriminalizing suicide, reducing availability and accessibility of illicit substances, conducting campaign to reduce stigma) ; Community-based strategies (providing suicide hotlines and crisis centers, school based mental health promotion programs to enhance psychological resilience, problem-solving skills, and appropriate help-seeking behavior, implementing community are and zero suicide initiative); and health- and social care strategies (brief interventions for individuals who have made suicide attempts, Educating primary healthcare workers to identify and manage individuals at a high risk of suicidal behavior, Enhance healthcare professionals' ability to identify and treat depression, as well as alcohol or drug abuse, Offering consistent follow-up care, social support, and appropriate psychological treatments to individuals who have attempted suicide, Develop support services for individuals who have lost someone to suicide).

Karki, et. al. (2017) recommends: 1) Introducing suicide prevention programs with the need for individuals, families, communities, local organizations, and governments to work in collaboration to minimize the burden of suicide, 2) Providing Psychosocial Support, 3) Changing behavior and attitude towards suicide (People should try to provide adequate social support rather than criticizing the victim and their family members) and 4) Providing awareness through role plays, street dramas, campaigns, and meetings. Women groups, child clubs, and etc.

Statement of the Problem

Suicidality: Drivers, challenges and interventions in Nepal which aligns with SDG 3. In Nepal suicide is single leading cause of death among women of reproductive age. Between 2015 to 2019 there were 25,316 recorded cases of suicide which means around 14 people per day committed suicide. The data revealed that adolescents, youths, and females aged 19 to 35

years are the most vulnerable population for suicide and accounted for almost 60% of all suicide deaths.

Acc. to Nepal police report in 2021 the no. Increased to 7141 which accounts for 19-20 per day death. Compared to recorded Data there are many unrecorded suicide cases which obviously increases per day suicide rates.

In context of Nepal suicide/suicidal thoughts are still taken as something which are not to be discussed about as mental health aspect is mostly ignored in Nepal. To develop the proper intervention strategy knowing the contributing factors, challenges is a must for which this project is created.

Data Collection method

Data was collected with both open and close ended questions/ Google form was created to collect the data.

Findings:

Sociodemographic information

Respondents mostly belong to Bagmati province, with 20's being the age group of most of the respondents.

1. Province

46 responses

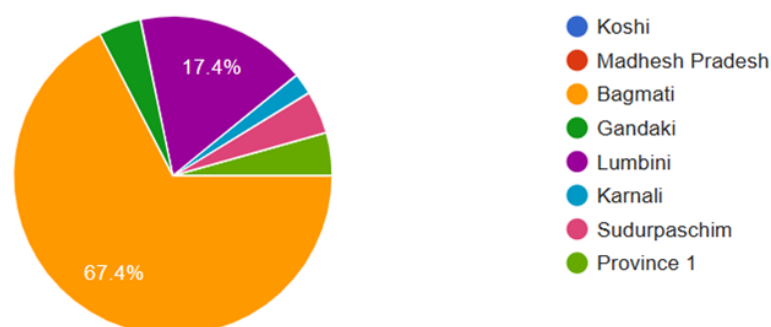


Fig. 1: Province of the respondents

2. Age

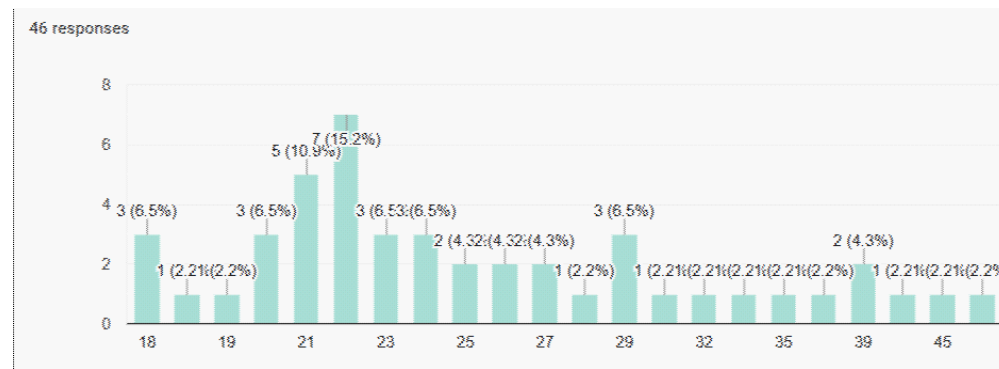


Fig. 2: Age of the respondents

60.9% of female responded. Heterosexual followed by atypical was sexual orientation of the majority of the participants. Most of the participants have bachelor's degree and are students' participants with 28.3% being employed and the same percentage being unemployed. 60.9% of the are single.

3. Gender

46 responses

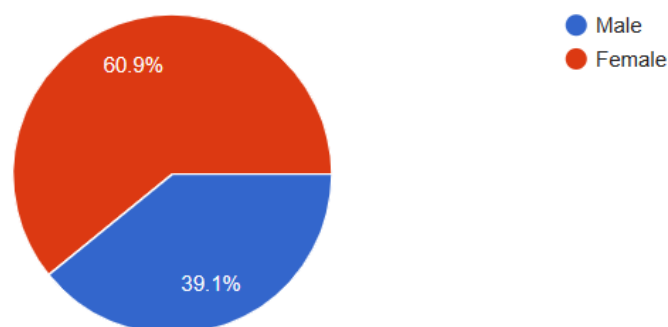


Fig. 3: Gender of the respondents

4. Sexual Orientation

46 responses

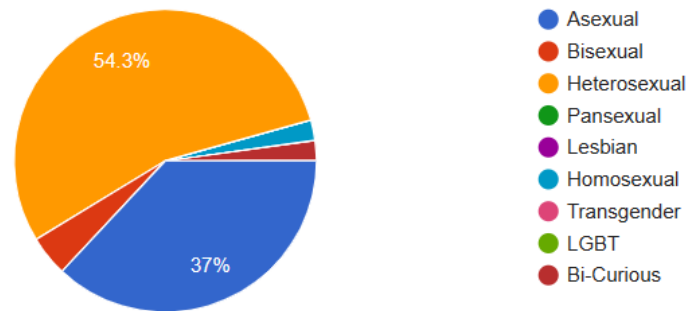


Fig. 4: Sexual orientation of the participants

5. Education Level

46 responses

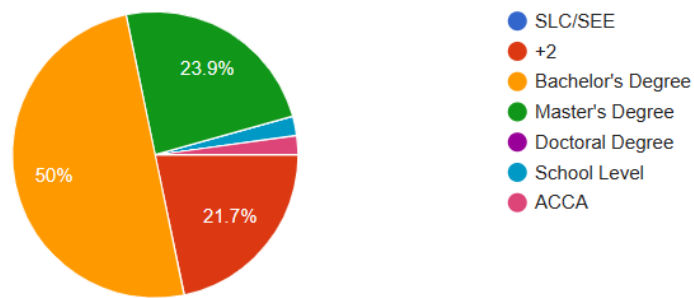


Fig. 5: Education level of the respondents

6. Employment Status:

46 responses

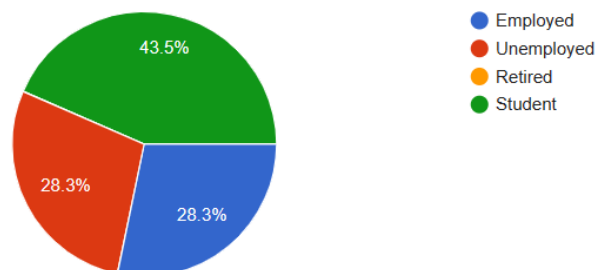


Fig. 6: Employment status of respondents

7. Relationship Status:

46 responses

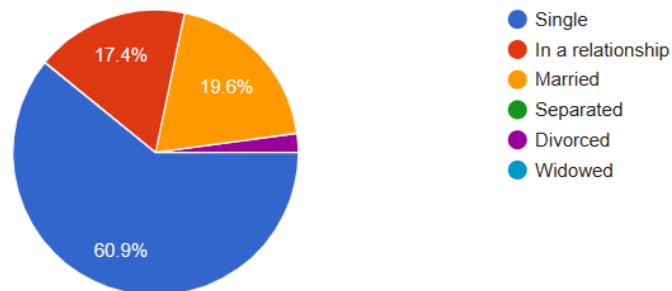


Fig. 7: Relationship status of respondents

Suicidality drivers

Among the participants 65.2% participants or someone they knew had experienced thoughts of harm with loneliness being the most repeated precipitating factor for suicide followed by feeling of worthlessness, relationship issues, mental health conditions etc.

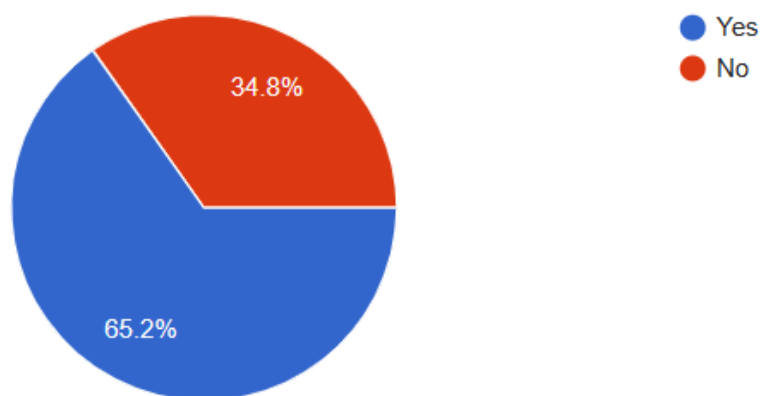


Fig. 8: Thoughts of Self harm

Other triggering factors are:

- Failure of marriage/ Separation from normal life and friends and family
- Abuse/Incest
- Overthinking

- Grief
- Anger
- Low self- esteem.
- Withdrawal from substance use
- Insecurity

Factors that may contribute to suicidality include Mental health conditions, relationship issues, loneliness, economic issues, bullying and harassment, self-esteem issues etc.

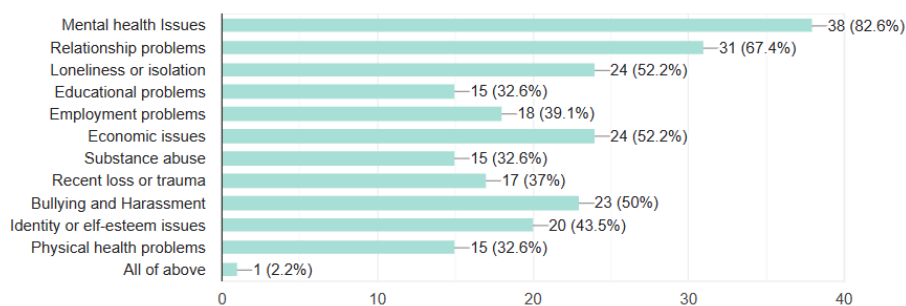


Fig. 9: Factors that may contribute to suicidality:

Most frequent mental health diagnosis for suicidality include Depression and anxiety disorder.

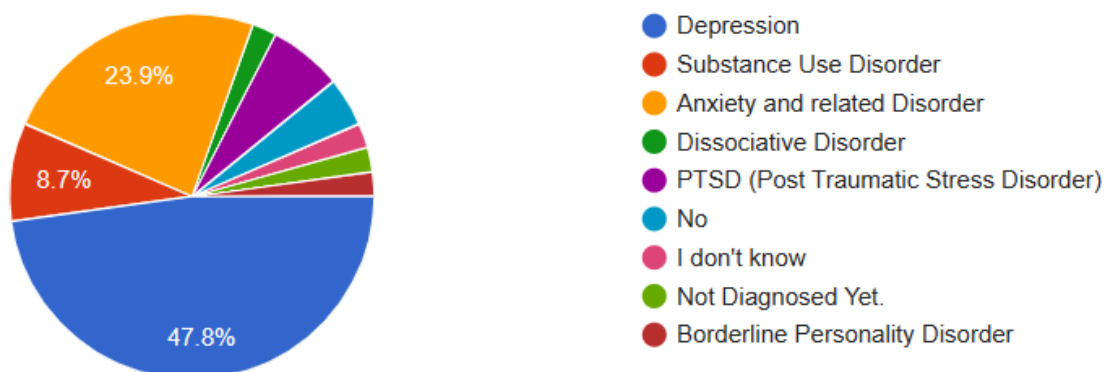


Fig. 10: Most frequent mental health diagnosis

Other potential drivers according to respondents included:

- Comparison with others
- Society
- Age factor (Adolescents)
- Abuse
- Social Exclusion
- Stigma
- cybercrime related issues
- The gap between self-image and Ideal image
- Internet making suicide as some kind of trend
- Mental pressure
- Attention seeking behaviours
- Expensive mental health treatments and stereotype towards mental health

Suicidality Challenges

In context of Nepal lack of social support is one of the biggest challenges for those who have attempted suicide followed by fear of judgement by others, cultural barriers along with other challenges.

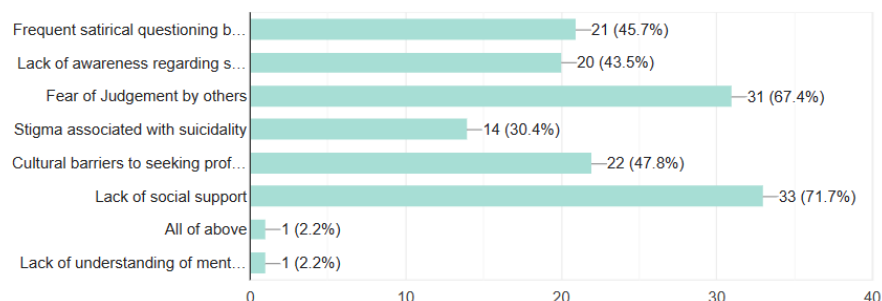


Fig. 11: Challenges faced by people who attempted suicide

Around 32.6 % had to face challenges after self-harm and challenges included problems with expressing self to others, social isolation, people thinking that it's just an act, adjustment issues.

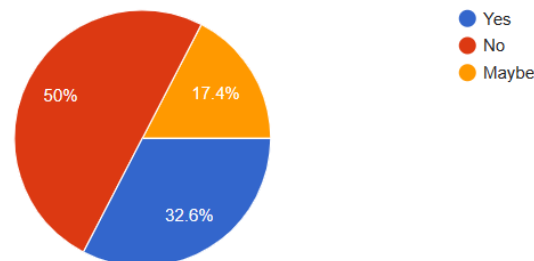


Fig 12: Respondents who faced challenges due to suicide attempt

They had overcome these challenges by seeking mental health professional help, sharing feelings, engaging in different activities.

Suicidality interventions

From the collected data, in context of Nepal support from family and friend is found to be most effective intervention then only comes the professional help. Hence, there seems a need for mental health professionals to provide psychoeducation to family of people who have tried to self-harm. Only 34.8% had sought professional help and most found the intervention very effective.

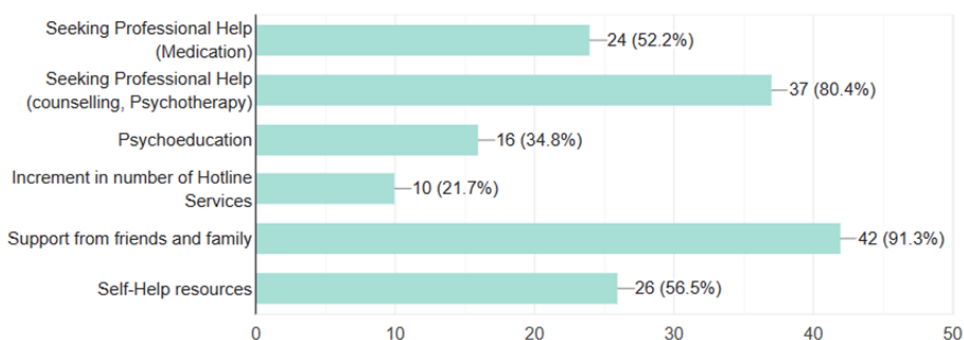


Fig. 13: Suicidality interventions

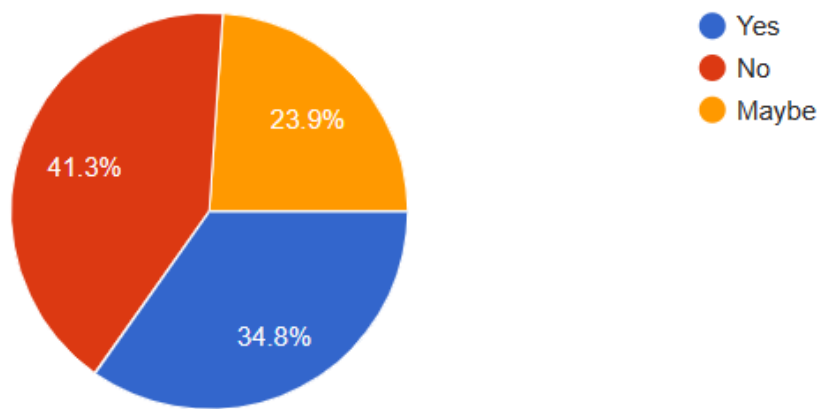


Fig. 14: Effectiveness of Professional help

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