

## CHAPTER 2

### **Socio-economic, Cultural and Religious Factors Affecting Suicide Prevention in Asia**

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#### **Abstract**

A range of socio-economic, cultural, and religious factors influence patterns of and responses to suicide in the Asian countries involved in the Strategies to Prevent Suicide (STOPS) project. As a general rule, suicide rates are highest among relatively more prosperous countries, particularly those which have developed rapidly. Within these countries, suicide rates are highest for sub-groups that have remained socio-economically disadvantaged. Economic development has seen movement from rural villages to urban centres, and this has been associated with a heightened risk of suicide among those remaining in rural settings, perhaps because of economic hardship, lack of social support, isolation and access to lethal means like pesticides. Cultural factors also play a role in shaping the profile of suicides in participating countries. For example, cultural attitudes towards the woman's role in marriage have been implicated in the comparatively high ratio of female to male suicides seen in several participating countries. The easy availability of pesticides resulting in death in cases that might otherwise have been non-fatal also plays a role. Religion – or the absence of religious belief – also exerts an influence on the pattern of suicides: it may be protective in circumstances where a given faith expressly forbids suicide or it may be permissive of suicide. Religious, legal, and cultural factors also affect the willingness to report a death as a suicide and contribute to the under-reporting and misclassification of suicides which, as we have seen in Chapter 1, are significant in a number of the participating countries. Taken together, these social factors may be more salient as risk and protective factors for suicide than they are in Europe or the United States of America.

Socio-economic, cultural, and religious characteristics of the countries participating in the Strategies to Prevent Suicide (STOPS) project appear to play a role in the epidemiological profile of suicide described in Chapter 1. In some cases, these factors may have a direct influence on rates of completed and attempted suicide (e.g., when a country's religion forbids suicide). In other cases, they may have an indirect influence in that they contribute to the degree to which people acknowledge their own suicidal behaviour and/or that of individuals in their families, and

consequently affect the accuracy of official suicide statistics. The current chapter outlines the key socio-economic, cultural and religious factors identified by the STOPS project.

### **Economic factors**

Economic prosperity varies across participating countries, according to the Human Development Index (HDI), which is a composite index that factors in life expectancy, literacy, education levels, and standard of living (United Nations Development Programme, 2006). As Table 1 shows, around half of the participating countries score well on the HDI (ranked 63<sup>rd</sup> or better among 177 ranked countries), indicating that they have a strong economic base; the remainder fall into the medium range (ranked between 64<sup>th</sup> and 146<sup>th</sup>). Among the STOPS countries Australia is ranked highest (3<sup>rd</sup>) and Pakistan the lowest (134<sup>th</sup>). All of the participating countries have experienced relatively rapid economic growth over the past 30 years; the HDI for several of the countries, e.g. Pakistan, India, and China, increased by almost 50% between 1975 and 2004.

There is substantial variability in the within-country levels of prosperity, as evidenced by the Gini Index, an index used to measure income inequality, with a value of 0 representing perfect equality and a value of 100 representing complete inequality. Scores on the Gini Index range from 24.4 in Japan to 49.2 in Malaysia (see Table 1). High levels of inequality can occur in both rich and poor countries; so even in countries with rapid economic growth there are still many people facing severe economic hardship (United Nations Development Programme, 2006).

Suicide rates are higher in Asian countries that have achieved a high HDI quite rapidly (China, Hong Kong Special Administrative Region; Japan; and the Republic of Korea) than in those that experienced more gradual development (Australia, New Zealand and Singapore). For instance, the suicide rate of the Republic of Korea increased between 1990 and 2004 by 250% for the general population and by over 400% for those over 70. Sri Lanka would seem to be the exception since it has had one of the highest suicide rates in Asia for forty years but is only in the mid-range on the HDI. The social and political turmoil in the country has been considered a determining factor since extremely high rates are found in the northeast which is the most unstable part of the country. The 700 percent rise in the suicide rate since 1960, however, has almost entirely involved an increase in the use and availability of

pesticides as a result of a revolution in agriculture during this period (Eddleston et al., 2004).

Within highly developed countries the highest suicide rates are found among those who have not been able to take advantage of the rapid development. Higher expectations accompanying economic prosperity may play a role here. Suicides in these countries are more likely to occur among individuals experiencing poverty, unemployment and/or debts (Collings, 2004; Gururaj et al., 2004; Kim et al., 2006; Zhang et al., 2004). Other groups who seem to be at particular risk include young people who have migrated to the cities but have had problems in establishing themselves and older people in rural areas who have been left behind in increasingly difficult economic circumstances without the support of their children who have left for city life. Inability to afford health care, even if it is available, is likely to be a significant factor.

### **Rurality/urbanity**

Participating countries vary in their degree of urbanization, from 100% in Hong Kong SAR and Singapore to 21% in Sri Lanka. The proportion of the total population living in urban areas is increasing rapidly in countries with the fastest economic growth, as people move from rural villages to metropolitan towns and cities to seek educational and employment opportunities (Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, 2006).

Rurality seems to be a risk factor for suicide in developing Asian countries with large rural populations. In China the suicide rates are three times higher in the rural areas than they are in urban areas (Cao et al., 2000; Phillips et al., 2002a; ). In Sri Lanka, the average suicide rate in rural farming areas is more than twice that of Colombo, the commercial capital of the country (De Silva and Jayasinghe, 2003). In India, the suicide rate in rural areas is also three times higher than the overall national rate (National Crime Records Bureau, 2000; Joseph et al., 2003; Gajalakshmie et al., 2007).

Those who have studied the problem suggest that this may relate to the difficulties associated with making a living in rural areas, particularly in the face of stressors like drought, fire, and flood. They provide evidence from studies of particular occupational groups, noting particularly high rates of suicide among agricultural and fishery workers in countries like India (Sundar, 1999). Problems facing rural workers

may be exacerbated by a lack of services in rural areas. As noted above, the movement from rural to urban areas may also mean that those left behind, especially older people, are particularly vulnerable because of poverty, loneliness, and lack of family support. They also have greater access to more lethal means of suicide (e.g., pesticides) with the result that many impulsive, low-intent suicide ‘attempts’ become fatal because of the lethality of the method and the lack of high-quality resuscitation services (Eddleston and Phillips, 2004).

### **Cultural factors**

With the exception of Australia and New Zealand, which share similarities with European countries and the United States of America, participating Asian countries have traditionally been characterized by the dominance of extended family systems, dependence on the family, and the fact that family loyalty overrides individual concerns.

These factors may help to explain some of the patterns of suicide that are characteristic of participating countries. In countries that have developed rapidly, the role of the family seems to be changing. Being married, for example, appears to be less protective against suicide in developing Asian countries than it is in Europe and the United States of America, with studies in China and India finding that single individuals are no more vulnerable to suicide than their married counterparts (Phillips et al., 2002b; Rao, 1991).

Cultural attitudes toward the woman’s role in marriage may also partially explain the comparatively higher ratio of female to male suicides found in Asian countries as compared to Europe and the United States of America (see Chapter 1). In countries like India, Pakistan, and Sri Lanka where arranged marriages are common, the social and familial pressure on a woman to stay married even in abusive relationships appears to be one of the factors that increases the risk of suicide in women (Gururaj et al., 2004). Dowries, which involve a continuing series of gifts before and after marriage, complicate the problem. When dowry expectations are not met, young brides can be harassed to the point where they are driven to suicide (Kumar, 2004). In some cases young couples prevented from marrying by family opposition, who face the unresolvable conflict of either living apart or severing ties with their families, choose suicide—either together or alone (Vijayakumar and Thilothammal, 1993).

## SOCIO-ECONOMIC, CULTURAL AND RELIGIOUS FACTORS

In China the suicide rate for women is higher than that for men. This is the result of the high suicide rate for women in rural China where over three quarters of suicides in China take place. The high suicide rate of women in rural China has been attributed to the situation of women in the traditional patriarchal structure of Chinese society which causes the woman's social and economic status to be problematic in and out of marriage (Lee et al., 2000). In a study of women treated in hospital emergency rooms after a suicide attempt, over 40 percent were young rural women 15-34 years of age. An unhappy marriage (over 60%), financial problems (over 40%), and having been beaten by a spouse (almost 40%) were the most frequently cited stressful events they had experienced (Pearson et al., 2002). The situation may be exacerbated by the polarization of rural and urban areas due to different rates of economic development (Pearson et al., 1995).

Another explanation for the high rate of completed suicide in rural Chinese women is that the ready access to highly lethal pesticides results in an increased fatality of impulsive, low-intent suicidal behaviour. In China, as in most countries, suicide attempts in women are much more frequent than in men (2.5:1), so as the proportion of 'attempts' that become fatal increases so, too, does the relative proportion of suicides among females (Yang et al., 2005; Conner et al., 2005).

The pressure to do well on exams and the shame associated with failure have been cited as the cause for suicide among young people in countries like Sri Lanka, India, China, Japan and Malaysia. There is considerable concern about suicide among this group in these countries, even though Sri Lanka is the only one of them with a notably high youth suicide rate. Researchers have noted that there is heavy competition for college/university places, and considerable media hype associated with final school exam results. As a result, the shame associated with failure has been felt to have pushed distressed adolescents to attempt and complete suicide (Vijayakumar et al., 2005).

There are strong cultural prohibitions regarding suicide in many of the Asian countries. In some countries, (e.g., India, Malaysia, and Pakistan) there are also legal sanctions; attempted and completed suicide are regarded as crimes. These actions can consequently bring much shame and stigma to families. Funeral rites may be denied or conducted differently, and relatives of the person who died by suicide may have trouble finding a marriageable partner. Religion in these countries (discussed below) is a significant factor in determining these attitudes. These prohibitions make it

extremely difficult to get accurate estimates of completed and attempted suicides in these countries.

Suicide is nevertheless accepted in certain circumstances. In China, for example, it is treated sympathetically if it is done for the family, the community or the country, in response to a chronic physical illness, or to redeem oneself from disgrace. Similarly, in Japan, suicide practiced out of loyalty or to restore injured honour (harakiri) is respected and may even be glorified. Suicide has also been used in India and other Asian countries as a means of social protest over political, economic or cultural issues, particularly by those who are marginalized and powerless and who have no other means of protesting. However, such 'acceptable' suicides usually account for only a small minority of all suicides; in most Asian countries community members condemn suicide and consider the majority of suicides the result of personal weakness. If the family is felt to have contributed to the suicide they may be blamed, and may therefore be inclined to conceal the suicide whenever possible. For example, there are anecdotal reports in India (where suicide is both culturally stigmatized and illegal) of enticements given by families to the police not to report an attempted suicide and to report a suicide death as due to some other cause. Mental health professionals believe these attitudes contribute to a reluctance to seek help on the part of many who are suicidal or by families struggling with the loss of a loved one.

### **Religion**

The major religions practised in participating countries are Islam, Hinduism, Buddhism and Christianity, and additional religions include Taoism, Sikhism, Jainism and Shintoism (see Table 1). Religion may be protective against suicide, both at the individual and societal level, and this effect may be mediated by the degree to which a given religion sanctions suicide (Vijayakumar, 2002). This suggestion is consistent with ecological studies that have observed suicide rates to be high in countries where religious beliefs are not actively promoted by the state, and to be low in countries where they are (Neeleman and Lewis, 1999). It also coincides with individual-level studies which have found variables such as lack of religious conviction to be a risk factor for suicide (Gururaj et al., 2004).

Islam provides clear rulings against suicide. The Koran strictly prohibits suicide, maintaining that it is an unforgivable sin. Islam also forbids the use of alcohol, which is a known risk factor for suicide. In Pakistan, where the vast majority of the

population (over 95%) are Moslem, hospital and police statistics suggest that the suicide rate is very low (although national suicide statistics are not kept). In Malaysia, which also has a predominantly Moslem population (around 60%), the overall suicide rate is low and is higher among Buddhists, Christians and Hindus than among the majority Moslems. Religious (and legal) imperatives in countries like Malaysia may lead to some under-reporting, but Moslems living in non-Moslem countries such as Thailand also have lower suicide rates than the Buddhist population (which itself has a low rate), suggesting that the effect is not just an artifact of the degree to which countries acknowledge suicides in their formal statistics.

Hinduism is less clear about suicide. In general, it strongly condemns suicide, but suicides committed in the name of religion or for religious purposes have been tolerated and even accepted. Patterns of suicide as they relate to the Hindu religion are unclear. The reported suicide rate in India, which is predominantly Hindu, is relatively low at 10.8 per 100,000 although, as noted in Chapter 1, there is evidence that the actual rate is considerably higher. Hindus in Malaysia have higher rates than other religious groups (Maniam, 2003), but this may be related to their marginal social and economic status in the country.

Buddhism extols the value of human life, for birth as a human being is the culmination of the individual's efforts through many previous cycles of birth, and a step on the way to ultimate enlightenment. Suicide is therefore seen as an empty act, which will lead to unpleasant consequences such as the loss of a child in the next rebirth. Predominantly Buddhist countries, however, have relatively high suicide rates. For example, the rates in Japan, the Republic of Korea and Sri Lanka are 25.3, 26.1 and 23.9 per 100,000, respectively (see Chapter 1). The exception is Thailand, where the rate is 6.3 per 100,000, and where taking one's own life is believed to lead to condemnation to hell for 500 lifetimes.

Christianity forbids suicide, viewing it as an act which is contrary to God's plan for each individual's life. However, there are a number of examples of suicide in the Bible, and Christian teachings do not explicitly preclude a person who dies by suicide from entering Heaven, providing he or she has faith in God. Both Australia and New Zealand are predominantly Christian, although neither country has a state religion and many people who list themselves as Christian are not 'practising'. Suicide rates in these countries fall in the lower to middle range among participating countries (see Chapter 1).

### **Summary and conclusion**

Suicide in Asia is a significant and complex phenomenon. The epidemiological profile of suicide in Asian countries differs from the typical profile reported in the scientific literature, because the latter has generally been gleaned from studies conducted in European countries and the United States of America. This may be explained, at least in part, by the complex web of socio-economic, cultural and religious factors in Asian countries. Suicide prevention activities in these countries clearly need to take these contextual issues into account.

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## SOCIO-ECONOMIC, CULTURAL AND RELIGIOUS FACTORS

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## SUICIDE AND SUICIDE PREVENTION IN ASIA

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SOCIO-ECONOMIC, CULTURAL AND RELIGIOUS FACTORS

**Table 2: Socio-economic, cultural and religious profiles of participating countries**

Country	Total <sup>a</sup>	% Urban <sup>a</sup>	% Rural <sup>a</sup>	Human Development Index (HDI) (and rank) <sup>b</sup>	Gini Index <sup>c</sup>	Gender-related Development Index (GDI) (and difference between HDI and GDI rank) <sup>d</sup>	Major religions
AUSTRALIA	20.2 million	92.7	7.3	0.957 (3 <sup>rd</sup> )	35.2	0.956 (0)	Christianity
CHINA	1.3 billion	40.5	59.5	0.768 (81 <sup>st</sup> )	44.7	0.765 (+2)	Atheism, Buddhism, Christianity, Islam, Taoism
CHINA, HONG KONG SAR	7.0 million	100.0	0.0	0.927 (22 <sup>nd</sup> )	43.4	Not available	Buddhism, Taoism
INDIA	1.1 billion	28.7	71.3	0.611 (126 <sup>th</sup> )	32.5	0.591 (0)	Hinduism, Islam, Christianity, Sikhism, Buddhism, Jainism
JAPAN	128.0 million	65.7	34.3	0.949 (7 <sup>th</sup> )	24.9	0.942 (-5)	Shintoism, Buddhism
MALAYSIA	25.3 million	65.1	34.9	0.805 (61 <sup>st</sup> )	49.2	0.795 (0)	Islam, Buddhism, Taoism, Hinduism, Christianity, Sikhism
NEW ZEALAND	4.0 million	86.0	14.0	0.936 (20 <sup>th</sup> )	36.2	0.932 (0)	Christianity
PAKISTAN	157.9 million	34.8	65.2	0.539 (134 <sup>th</sup> )	30.6	0.513 (-4)	Islam
REPUBLIC OF KOREA (THE)	47.8 million	80.8	19.2	0.912 (26 <sup>th</sup> )	31.6	0.905 (-1)	Buddhism, Christianity
SINGAPORE	4.3 million	100.0	0.0	0.916 (25 <sup>th</sup> )	42.5	Not available	Taoism, Buddhism, Islam, Christianity
SRI LANKA	20.7 million	21.0	79.0	0.755 (93 <sup>rd</sup> )	33.2	0.749 (+4)	Buddhism, Hinduism, Islam, Christianity
THAILAND	64.2 million	32.5	67.5	0.784 (74 <sup>th</sup> )	42.0	0.781 (+2)	Buddhism
VIET NAM	84.2 million	26.7	73.3	0.709 (109 <sup>th</sup> )	37.0	0.708 (+2)	Buddhism

- a. 2005 population estimates taken from Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (2006).
- b. The Human Development Index (HDI) provides a composite measure of three dimensions of human development: living a long and healthy life (measured by life expectancy), being educated (measured by adult literacy and educational enrollment at the primary, secondary and tertiary level) and having a decent standard of living (measured by purchasing power parity income). 2004 figures taken from United Nations Development Programme (2006). Rankings ascend from most developed to least developed.
- c. The Gini index measures income inequality, with a value of 0 representing perfect equality and a value of 100 representing perfect inequality. Figures calculated from surveys conducted between 1993-2003, reported in United Nations Development Programme (2006).
- d. The Gender-related Development Index (GDI) adjusts the average achievement measured by the HDI to reflect inequalities between men and women. 2004 figures taken from United Nations Development Programme (2006). HDI ranks used in the calculation of HDI-GDI differences recalculated for countries with a GDI value. Positive differences indicate relatively low levels of inequality; negative differences indicate high levels of inequality.