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Structuring Roles and Gender Identities within Families Explaining Suicidal Behaviour in South India

--Manuscript Draft--

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Abstract:	Background: This paper examines the social structures, culture, gendered roles and their implications for suicidal behaviour in South India. Exploring the cultural process within the structures of family and society to understand suicide and attempted suicide from the perspectives of survivors, mental health professionals and traditional healers have not been achieved in the existing suicide related research studies conducted in India so far. Aims: This study aimed to explore the cultural implications of attempted suicide by examining the survivors' life stories, their perceptions and service providers' interpretations of problem situation. Methods: A qualitative design was used drawing on constant comparison method and thematic analysis. The analysis was underpinned by the theoretical concepts of Bourdieu's work. In-depth interviews were conducted with fifteen survivors of attempted suicide, eight mental health professionals and eight traditional healers from Southern India. Results: The study found interactions among visible and invisible fields such as faith, power, control, culture, family, religion and social systems to have strengthened the disparities in gender and role structures within families, societies and impacted survivors' dispositions to situations. Conclusions: The role of culture in causing suicide and attempted suicide is explained by unravelling the negative impact of interacting cultural and structural mechanisms.
Author Comments:	The findings discussed in this manuscript is part of a larger study that explored the cultural and structural mechanisms of suicide in India. The manuscript identifies a gap in perception and comprehension of risk factors which need to be positioned within the context of social and cultural process. This has potential to inform prevention and intervention programs in India and worldwide.

Suggested Reviewers:	Erminia Colucci, PhD The University of Melbourne ecolucci@unimelb.edu.au
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Opposed Reviewers:	
Response to Reviewers:	Reviewer #1: 1. Page 4, paragraph 1 and line 4: We have included references for both thematic analysis and Bourdieu's theoretical concepts. We have also provided a foot note to explain Doxa. 2. Page 4, paragraph 2 and line 1: We have revised the sentence to prevent repetition and replaced the first author's full name with initials as suggested. 3. Page 4, paragraph 2 and line 8: We have deleted the brackets. 4. Page 5, paragraph 2 and line 6: We have added quotations from the survivors group, traditional healers - Page 5, paragraph 3 and line 9 and mental health professionals – Page 6, paragraph 1 line 5 to support the theme under discussion. 5. Page 8, paragraph 2 and line 6: The sentence has been revised and split into two 6. Page 11, paragraph 2 and line 9: References are included from more recent literature on the topic of suicide and menstruation 7. We have reworded and restructured the sentences in the first paragraph of the discussion section on page 11 and 12 to make the argument clearer. 8. We considered reviewer's suggestion and deleted the brackets along with its content in conclusion section to avoid repetition. Reviewer #2: 1. A short description is added towards the end of the first paragraph on page 1 explaining what is meant by 'structuring roles' in this study. 2. A brief section on limitations is included on page 14, paragraph 2. This acknowledges the challenges associated with transferability of study findings. 3. The manuscript has been proof read to check for any typographical and grammatical errors.

Structuring Roles and Gender Identities within Families Explaining Suicidal Behaviour in South India

Introduction

Understanding risk factors for suicide is not just an actuarial process, but it is also about exploring the life process that leads to such decisions and actions. This paper analyses how a series of life events and everyday situations lead men and women to attempt suicide while examining the interactions of culture, structure, gender and constantly structuring roles as both antecedents and explanations of suicidal intent and behaviour. Structuring roles in this paper refers to the process of constant changes between agency and structure in the formation and structure of an individual's roles within families and society. The structure dictates a set of dispositions which has the power to generate and influence perceptions and practices of the present and the future (Bourdieu, 1994).

The vast majority of existing literature concerning suicide in India has tended to focus on epidemiology and risk factors (Vijaykumar, 2007). Very limited attention has been given to understanding the influence culture plays (Colucci et al., 2013). In India suicidal behaviour receives biomedical attention rather than psychosocial interventions (Adityanjee, 1986; Rao, 1978; Vijaykumar, 2007). The National Crime Records Bureau in India records statistics in relation to deaths through suicide, however no records are kept in cases of attempted suicide. According to their recent reports (NCRB, 2014) nearly 43% of suicides for the year 2013 were attributed to reasons such as family problems and illness but they fail to define or explain what constitutes family problems and how they might lead to suicides.

The epidemiological studies indicate a wide variety of reasons associated with completed suicides such as economic hardships including in rural, agricultural areas, relationship problems, farmer suicides, student suicides, caste discrimination, military suicides,

1 alcoholism, depression, mental and physical illness (Manoranjitham et al., 2010; Maselko and
2 Patel, 2008; Milner et al., 2013; Nath et al., 2012; Radhakrishnan and Andrade, 2012;
3 Vijayakumar, 2007; Patel, 2007; Patel, 2005). Most of these studies have used quantitative
4 methods emphasising statistical analysis, that are useful in helping to illuminate risk factors
5 but do not offer an in-depth exploration into risk factors from the perspectives of survivors.
6 These data predominantly provide epidemiological findings and reports from medico-legal
7 autopsies. Very few studies have used qualitative methods to explore life situations of
8 individuals who have experienced attempting suicide and few have sought to situate suicide
9 within a cultural explanatory model. The relevance of using qualitative methodologies is
10 evidenced, for example, in Staple's (2012b) ethnographic study of suicides in a leprosy
11 colony of Bangalore. He recognised how social situations and cultural beliefs shared within
12 the region posed a risk of suicide for young healthy men with parents affected by leprosy,
13 who held high aspirations but lacked opportunities and resources.

14 In line with the NCRB report (National Crime Records Bureau, 2012), the independent
15 survey by Patel and colleagues (Patel et al., 2012) highlighted that male rates of suicide were
16 higher than female rates in India, however the overall rates for both male (26.3 per 100,000)
17 and female (17.5 per 100,000) in the independent study were higher than those recorded by
18 the NCRB. This led to the conclusion that the national records underestimate male suicide
19 rates by 25% and female rates by 36%. It has been widely reported that the NCRB rates
20 underestimate the true rates of suicide (Vijayakumar et al., 2005; Manoranjitham et al.,
21 2007). The reasons for this underestimation are thought to relate to the stigma and shame that
22 families may face if the cause of death is reported as suicide. Equally the illegality of suicide
23 in India also leads to many cases of suicide getting misreported as accidental death. The
24 variation in male and female suicide rates calls for a better understanding of gender dynamics
25 from the perspectives of survivors and those who treat survivors of attempted suicide.

1 The overall aim of this study was to explore the cultural implications of attempted suicide
2 and its prevention in South India. The study aimed to achieve this by exploring the
3 experiences of survivors of attempted suicide and perspectives of mental health professionals
4 and traditional healers. However, in this paper we focus specifically on cultural dynamics
5 within the context of family with specific reference to the cultural process and gendered
6 notions that have implications for suicidal behaviour.
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15 **Methods**

16 In-depth interviews were conducted with survivors of attempted suicide (Male = 6, Female =
17 9), mental health professionals (MH) (n=8) and traditional healers (TH) (n=8) in a range of
18 urban, semi urban and rural locations including Bangalore, Mysore and Kodagu districts in
19 Karnataka, Southern India. Interviews took place within the settings of a hospital/ clinic/
20 temple/ church/ office or home. The survivors were sampled purposively, within the age
21 group of 18-44years, and inclusive of any gender, religion, caste and class, regardless of
22 schooling level, means of livelihood and professional background. The sample was accessed
23 through mental health professionals who acted as gatekeepers. The mental health
24 professional participants were recruited purposively and included psychiatrists (2), general
25 practitioners (1), psychologists (2) and social workers (3). The healers were sampled from
26 Hindu (3), Muslim (3) and Christian (2) religions, using a snow ball method, with the help of
27 previous users of healing services, believers of services and personal contacts from across the
28 Karnataka region in South India. It was important that participants understood and spoke
29 either English or Kannada to facilitate the interviewing process and obtain rich data. The
30 researcher RL is fluent in both. Informed consent was obtained from participants in writing
31 or audio recorded in case of illiterate participants.
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1 The conversational approach of the in-depth interview method made exploring sensitive data
2 possible which may have posed challenges if using structured methods (Patton, 1990). The
3 data were organised and analysed using constant comparison methods (Corbin and Strauss,
4 1942) and thematic analysis (Aronson, 1995; Braun and Clarke, 2006). At later stage
5 Bourdieu's theoretical concepts such as doxa¹, cultural capital, symbolic power and violence
6 were used to interpret and test the findings through critical discussion of the data (Bourdieu,
7 1996; Bourdieu, 2000; Bourdieu, 1999).

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9 The first author (RL) who carried out data collection and analysis is a South Indian woman
10 and a registered mental health social worker in India. She was therefore identified by
11 participants to some extent as a cultural insider for being an Indian national. However she
12 was also identified as a cultural outsider by some participants in that she did not share the
13 religious backgrounds of some participants and her caste/class/education/professional identity
14 set her apart from some participants. Being able to position both as an insider and an outsider
15 facilitated this study to be culturally sensitive and provided a space for the voices of survivors
16 to be heard alongside the voices of mental health professionals and healers who treat them.

17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 **Results**

39
40 In this paper the data are discussed under the category of gender and role structures within
41 families as these are the themes that emerged from the data. The quotations from participants
42 are used to illustrate their perceptions with regard to the themes under discussion.

43 44 45 46 47 48 49 **Gender and role structures within families**

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58 ¹ Doxa refers to a deep system of beliefs that are naturalised through the process of unconscious mechanism where
59 individuals accept and practice many things without even knowing them as though they were legitimate (Bourdieu, 2000;
60 Bourdieu and Eagleton, 1994).

Cultural prescriptions towards gender-based roles within the structure of family were a key focus in all three sets of data. In particular, the influence of gender assigned roles in causing distress and suicidal behaviour became repeatedly evident through the course of analysing participants' accounts.

The survivor participants' accounts revealed that the duality and polarisation of cultural practices subjected them to internalize cultural norms and made day-to-day living with set boundaries challenging, distressing and gradually contributing to suicidal behaviour. For instance, there were many examples of women survivors describing situations within their roles as a wife, mother and daughter, in which they felt forced to continue in the marriage, for the good of children or to preserve parents' reputation. "My mother got me married, I didn't want her name to be spoilt. I was young, I didn't understand things" (S 14). These compromises often included being abused. Abuse included examples of domestic violence, sexual abuse, physical abuse, sexual jealousy, neglect and encouraging another individual to inflict torture on the victim.

In the healers and mental health professionals' accounts, gender roles and influences were also apparent in their explanations of clients' attempted suicide. However, these were presented largely in terms of stressors. Furthermore the definition and interpretation of what was a gender-related or role-related stressor usually reflected their own socio-cultural, religious, economic, educational and professional background. For example, healers associated most of the reasons with religious aspects such as lack of faith, ill effects of magic, spells, 'Rahu kala' ('bad times') and evil effects on women during menstruation. They also indicated that conflicts within families are a result of 'western influence' which guide men and women to adopt new cultures and cultural behaviours. 'Our land is called a land of toil (karma bhumi). There is a system in the society, especially the family system which we have inherited from our ancestors. However, the younger generation hardly follow these They

are driven by the 'foreign culture' (referred to as a land of pleasure), creating more desires which can't be fulfilled' (Field notes -TH 7). Mental health professionals associated suicidal events with depression and other mental health conditions. They explained challenges and frustrations experienced by their clients as a result of gender and family structures as precipitators of the presenting mental states. ".....family members have complaints and the expectations are higher than what can be achieved, this leads to increased levels of stress and women are victimised into abuse and torture most of the time" (MH 1). Both healers and professionals focused primarily on the immediate events that preceded the attempt.

Abuse, Violence and torture within set boundaries

The participants from all three groups discussed intimate partner and family member violence as the most common form of violence that affected survivors' physical, mental, emotional and psychological wellbeing. Conflicts within families were a significant precursor of attempted suicide as also identified in epidemiological studies. A deeper understanding of participants' accounts revealed that an individual's gender role within a family had an influence on their behaviours and interactions with other members of the family. For example certain roles within the family structure (father, son-in-law, son, and mother-in-law) come with power through tradition and are often associated with responsibility. Most of the participants highlighted the cultural tradition of assumed roles and responsibilities that various members within a family share which is said to have assigned them with power. As in the case presented by one of the mental health professionals in the following extract, the mother and the brother-in-law of the survivor who was under treatment, felt it was their responsibility to get her married in order to secure her future even if this was against her wish.

1 “Her father passed away mother was managing the family and her brother-in-law was
2 taking care of the family needs, her mother forced her to get married to another guy
3 who was well off, they tortured her and got her married. Family abuse, in this case
4 particularly mostly sister’s husband, uncles, mamas (mother’s brothers), they take
5 right over the family, they have asked them to listen to them” (MH 5)
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13 The survivor participants' accounts revealed instances of repeated violence perpetrated by
14 their husband, parents-in-law and other members of the extended family. One of the
15 survivors explained that although she and her husband lived separately from her parents in-
16 law, their interference and influence was persistent which impacted her relationship with her
17 husband and resulted in more violence and abuse.
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25 The data depict the exercise of power by taking on particular roles within the family. There
26 is a constant interaction between the structural settings, which define an individual’s position
27 and orient perceptions and behaviours. For example, husbands and in-laws hold power and
28 utilise this by control and domination demonstrating the interplay of power in this process
29 through symbolic and physical violence where women (daughters-in-law) are subjected to
30 violence. The findings revealed that gender and age were instrumental in determining who
31 held power in the family. However, cultural capital (practices, norms, traditions) opened up
32 margins for manoeuvring field (family, community, society) and agency (status-educated,
33 employed) that could be used to redistribute power according to assigned cultural roles. As
34 Bourdieu (1999: 123-129) explains “power over social or physical space/field comes from
35 possessing various kinds of capital, takes the form in appropriated physical space.” For
36 instance, despite being educated and employed, female survivors translated their social
37 position as a wife and daughter in-law into being subjects of social and cultural domination,
38 which in turn left them with less power. However, there is a dichotomy where the position of
39 the mother in-law is in spatial opposition and is substantiated with cultural domination and
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1 power. These oppositions are asserted in a social space of family with symbolic distinctions
2 of cultural capital assigning power. With this understanding of how culturally assigned roles
3 share power and responsibility we now move on to explain how it varied for men and women
4 that transformed everyday situations to stressful events leading to attempted suicide .
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10 **Men and Suicide**

11 The distressing nature of cultural expectations are clearly expressed through survivors'
12 accounts where male participants expressed how their identity of being a man, husband and
13 son was linked to economic responsibilities and professional success. One of the male
14 survivors was particularly distressed when he felt that his power and authority in the family
15 was threatened when his wife took over the responsibility due to his failure to earn money
16 and look after the family. The participants from the mental health professional's group added
17 to this by expressing that culturally it is unmanly for a man to express his emotions or cry
18 and share his feelings. This notion of masculinity leaves men with fewer options for support
19 in the family and in society. A similar finding was evident in Staples (2012a) ethnographic
20 study where healthy young men from a leprosy colony in Bangalore felt distressed when
21 they failed to fulfil their responsibilities and lacked opportunities for employment. Healer
22 participants expressed that stress among men and women is caused due to the changes in life
23 style, a desire for more wealth and unending demands of wives upon their husbands which
24 contribute to men attempting suicide.
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48 Gender differences were particularly distressing for one of the survivors who was transgender
49 and gay. His situation worsened when no one in his family, school, community or friends
50 understood him. Instead, he was beaten up by his family for cross dressing and mocked in
51 his school. Although there was a history of transgenderism in previous generations of the
52 family, it did not seem culturally appropriate to talk about this in the family or in public.
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1 Most survivors experienced stress and internal conflicts because of cultural expectations
2 towards their roles as a husband, son and a father. The interplay of power in exercising each
3 role was dynamic and was influenced by cultural practices and social norms. Roles as a
4 husband, son, father are imbued with power that are based on practices, gender and what is
5 happening in the field of family, this was challenging for survivor participants.
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13 **Women and suicide**

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16 For women survivors there was a constant struggle and conflict with self and their
17 surroundings to reach the high expectations of being a perfect daughter, wife, daughter in-law
18 and mother. The vast majority of survivor interviews contained accounts of abuse, assault and
19 torture within marriage and those involved in heterosexual relationships outside marriage.
20 Marriage is a significant institution in Indian society (Milner Jr, 1994). Culturally, there is a
21 strong emphasis on marriage and it is seen as women's responsibility to make a successful
22 marriage. There were also accounts from women who were under a lot of pressure from the
23 family to continue in an abusive marriage as leaving it would affect the family reputation.
24 Participants from all three groups acknowledged the dominant stereotype that impact on
25 women and their parental family. This extension of damage to reputation is directed
26 particularly to the mother of the bride as the community are likely to berate her for conflicts
27 within marriage and/or broken marriages. This therefore functions as an additional layer of
28 pressure to keep women in abusive or otherwise unsatisfactory relationships. In addition, life
29 as a single woman in India is difficult:
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51 'I feel I can live a peaceful life only if I leave him, but my mother and neighbours say
52 that it is difficult to live without a husband.' (Survivor 11)
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57 In the case of women survivors who were brought up by a single parent (mother), they had
58 been persuaded not to split away from their husband because their mother did not want the
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1 daughter to face the hardships of a single woman. There was an implicit reference here to the
2 ways in which community and society categorises women to be of loose character, shameless
3 and disrespectful when they break away from marriage and live as singletons. In the context
4 of women survivors who were in premarital sexual relationships, they encountered a lot of
5 pressure to marry the person with whom they were involved to justify their act of sexual
6 involvement. Marriage is seen as legitimising sexual relations and offering protection against
7 victimisation or ill-treatment within the community.
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9 Being surrounded with this pressure, participants insisted on marriage regardless of whether
10 or not they loved the man they had had a sexual relationship with. The cultural binding and
11 different standards for sexual behaviour based on gender explains why women feel culturally
12 bound to marry the person with whom they are sexually involved despite abuse, torture and
13 misuse, and when they fail to marry this may lead to attempted suicide. On the other hand,
14 men's reputations are not usually tarnished for their sexual relationships in comparison to
15 women as indicated by the participants during the interviews. A few of the healers in
16 connection with relationships questioned 'why are girls held accountable for involving in a
17 relationship or being seen with a man?' (TH 2). They questioned the social and cultural
18 norms that discriminate between men and women and perpetuate double standards.
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20 'He has spoiled (sexually exploited) me. I can't leave it at this; I shall live or die with
21 him alone. I cannot marry anybody else and neither do I wish to.' (Survivor 2)
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23 Participants discussed that it was important for women to be married by a certain age to avoid
24 being stigmatised in the community. Unmarried women were particularly affected by stress
25 and desperation when their family failed to find the right partner for her to marry as this was
26 critical in avoiding stigma and could lead to suicidal behaviour. It is implicit in the data that
27 a woman gains her identity and status through a man (father/husband/son) in Indian culture.
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1 Professionals and healers acknowledged the issue of stigma that forces women to suffer in
2 silence and when faced with sufferings beyond their ability to cope result in attempted
3 suicide. A few of the male Muslim healers were unsympathetic of women who were in pre-
4 marital or extra marital relationships and they blamed women for their sexual involvement
5 and problems in relationship. While a woman professional also blamed women for conflicts
6 in the family stating that ‘women have reduced tolerance and coping abilities in modern days’
7 (MH 4). It brings to light how participants’ own religious and cultural backgrounds
8 influenced the way they perceived risk factors and treated their clients.
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10 Among other reasons, healers (Muslim and Hindu) indicated that occurrence of suicide
11 among women were high during menstruation. They believed that women are more
12 susceptible to the effects of bad omens during this period. They were of the opinion that
13 women are generally weaker than men which is the reason for the higher number of suicides
14 among women than men – but this is contradicted by the evidence from suicide surveys
15 (NCRB, 2014; Patel et al., 2012). The Christian healers did not draw any relation between the
16 higher rates of suicide among women and menstruation. Professionals discussed
17 menstruation and suicide on the basis of hormonal changes indicating possibilities of
18 depression and low moods. There is a wide body of literature which discuss the association
19 between suicide and menstruation from a biomedical perspective (Brockington, 2001;
20 Leenaars et al., 2009; Saunders and Hawton, 2006; Afzali et al., 2012; Tasto and Insel, 2013).
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22 Discussion

23 The gender identity of men being men, and women being women, within the boundaries of
24 cultural prescriptions, laid a heavy burden of morality upon women survivors, whilst at the
25 same time men were reported to have the cultural power to regulate or deregulate female
26 behaviour. The social standards which attach morality to a woman’s conduct and behaviour
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are a result of cultural capital. However these social standards for behaviour are questioned through the process of on-going interactions between agency (education, financial independence, career- woman) and social setting/field. Skeggs' (1997) concept of 'frameworks of representations and values' are appropriate in understanding a number of women survivors in this study. These women materialised cultural capital, power and practices, which in turn produced structures within families and society to recognise a woman as a mother, daughter, professional, wife and daughter in-law with her own identity and set of values. This was possible when a woman's agency, social, cultural and economic capital interacted with family and social structures. It is these frameworks that establish what it is to be a woman and not just a woman with "cultural baggage" as described by Skeggs (1997).

The evidence of social and cultural domination is exposed through the accounts of some of the healers who were under the influence of doxa. They for example, perceived women during menstruation as inauspicious, affected by a bad omen, emotional, weak and prone to suicidal thoughts. In this way healers were involved in what Spivak (1988) calls ideological reproduction through the misreading of Holy (Hindu) Scriptures that legitimised their perception of women as sexually 'subaltern' subjects, inauspicious and prone to the effects of bad omens. However, some healers also recognised physical and emotional frailty during menstruation and its relevance to suicidal behaviour. Although healers' perceptions were dominated by cultural and religious capital they recognised physical and mental health conditions from biomedical perspectives as well.

On the other side of the debate of women's identity are the women survivors' experiences of premarital relationships, physical and symbolic violence expressed in terms of fear, resentment, humiliation, perceived and actual loss of power and being treated as an object of pleasure. In this context women survivors attempted to persuade men to marry them with the aim of preserving honour, cultural capital and re-establishing themselves within a social field.

1 However, failure to achieve the desired outcome resulted in adopting a suicidal habitus.
2 Attempted suicide, in this case, is used not only as a means of persuasion but as a measure to
3 safeguard and politicise a woman's identity and rights in order to influence her movement
4 through social space. The act of attempting suicide to politicise women's identity and rights
5 is a way of demonstrating symbolic capital.
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11 Framing gender identity for men is interpreted in terms of masculinity through the
12 symbolisms of cultural institutions and practices that define power, authority, independence
13 and sexuality. Cultural representation of masculinity was an important aspect in the lives of
14 male survivors. They expressed distress about being unemployed, having to wait upon
15 parents for consent to marry, lack of power and not being able to control their environment as
16 a sign of diminishing social positioning which led to them perceiving themselves as 'being a
17 loser, failure and a loner'. Butler recognises "being a man and being a woman are internally
18 unstable affairs. They are set with ambivalence precisely because there is a cost in every
19 identification, the loss of some other set of identifications, the forcible approximation of a
20 norm one never chooses, a norm that chooses us but which we occupy, reverse, re-signify to
21 the extent that the norm fails to determine us completely" (Butler, 1993: 126). The enforcing
22 nature of doxa, cultural prescriptions for behaviours, appearance and dressing based on
23 gender was particularly distressing for a survivor who was transgender, but also for other
24 survivors. Society failed to empathise with the survivor and exercised symbolic violence by
25 excluding him from respectable social positioning, limiting opportunities for career advances
26 and making it impossible to engage in a relationship. This was distressing for the survivor
27 who struggled to understand and accept the cultural norms and the harassment sanctioned by
28 cultural power.
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58 Conclusion

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1 In conclusion this study has shown how crucial it is to recognise the role of cultural capital
2 and power in understanding survivors' experiences within the context of family and suicidal
3 dispositions. It further analyses the influence of cultural beliefs and doxaic norms upon
4 service providers' approaches to treating suicidal behaviour. The study clarifies that it is not
5 in identifying specific risk factors but in exploring the socio-cultural process that affects
6 social, emotional, physical and mental wellbeing that bears the potential to explain suicidal
7 behaviours and plan appropriate interventions.
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10 As a qualitative study, the aims are not generalizability but transferability. Transferability
11 refers to the ability of a study's findings to speak to and resonate with other similar contexts
12 (Lincoln and Guba, 2000). We do not claim that the transferability of this study would
13 include those people who died by suicide.
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