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Perspective Study

Suicide in Haiti

Abstract

"Suicide is a complex global public health problem, yet few studies have examined local socio-cultural explanatory models and other contextual factors surrounding suicide in low-and-middle income countries (LMIC)" (Hagaman et al., 2013). Haiti is one of many LMIC's where suicide has not been studied until now. Strong cultural beliefs and fear of stigma has played a large role in the lack of attention paid to this crisis. This article focuses on a qualitative data analysis study which included a multi-year ethnographic and epidemiological study conducted in Lahoye, Haiti. The study was conducted between May and June of 2011 by a non-governmental organization (NGO) which included the assistance of eight biomedical healthcare workers and 16 lay community members. It compared the two group's ability to recognize potential suicidal risk factors and the actual intent to commit suicide.

Background

According to the article, Suicide in rural Haiti: Clinical and community perceptions of prevalence, etiology, and prevention, over one million people a year die from self-inflicted injury, with 85% of these deaths taking place in LMIC. While that number may not sound impressive worldwide, the actual amount of people who attempt suicide, although not successful is 10-20 million annually. With staggering number such as these, one would think that studies on this topic would take precedence. Only about half of those who experience suicidal ideations are likely to seek help, even less, at 14% if they are living a LMIC. Suicide is thought to be "cowardly and immoral" [1], in places like Ghana and India. The amount of education an individual has, has a direct correlation with their viewpoints on suicide. This theory was illustrated in the Ghanaian culture, where it was found that "psychology students, nurses, and the lay individuals framed suicide as a moral issue and suicidal individuals as blameworthy" [1], whereas practicing psychologist viewed it as a mental illness. This theory however is not straight forward and cannot account for everyone. Traditions and believes are very much embedded in such culture and is hard to change. Although it appears that change is happening, it is a slow process. The stigma of suicide leaves those at risk reluctant to seek help in fear of the repercussions. Some LMIC even view the act as a crime, placing the individual further at risk if the attempt is not successful.

Cultural sensitivity will play a large role in the development of any program geared towards providing services for to prevent suicide attempts. The ability to understand another's culture and view on the world can help doctors, nurses, and psychologist recognize risk factors. More specifically, the article described in detail the family dynamic in Haiti, and the risk factors leading one to believe they had no other option. The educational and financial facts of Haiti was a shocking one. Hagaman et al. divulges that less than one third of the country has education pass primary school and the majority of the country is impoverished, half of which lives in extreme poverty. Although Haiti is poor financially, it is rich in religion. The three major religions in Haiti are Catholicism, Voodoo, and Protestants. Due to the high stigma associated with suicide and the strong religious presence in the country, not even the World Health Organization is able to report statistics on suicide in Haiti. There is almost an out-of-sight out-of-mind mentality. If no repots are being made, it's not occurring. However, the fact remains, it is in fact occurring. In my research of the topic I came across an article entitled "The Life and Death of Anna Gardie". Anna was a Haitian refugee who was famous for bringing "distinctive Creole theatrical practices to US stages and other public spaces—intercultural forms such as pantomime, melodrama, and racial masking" [2]. She was murdered by her husband on July 20, 1798, who later committed suicide.

Methods

An NGO took interest in providing mental health care in Haiti in addition to medical support, which was approved by the Institution Review Board of Emory University and the Haitian Ministry of Health. They began to provide training to community health workers (CHW) in health communication. The staff resided on a compound along with the sole doctor, nurse and social worker in this rural town. Through a mobile clinic, they were able to visit patients on an average of once every three months per patient. The two-part study, first through the ethnographic study, observed communication between healthcare workers and patients. The second part,

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the epidemiological aspect of the study, focused on the ability for Haitians to adapt to a mental illness assessment tool and collected data on depression and suicidal ideation. Risk factors included "depressive symptom burden, alcohol use, lack of care when sick, and having visited a Vodou priest" [1]. Although seeing a Voodoo priest was significantly more expensive, the residence chose to do so anyway, leaving the NGO with reason to reevaluate their approach. The workers of the NGO included doctors, nurses, social worker, CHW and the CHW manager. Research assistants (RA's) were used to translate between English, Creole and French. All of the RA's were born and had family ties in the same area. I found this surprising. One would assume that using people from the same village would discourage the patients from admitting any suicidal ideations in fear that this information would get back to family and friends. Once those at risk were identified through a referral system, they would meet with a licensed American counselor for further assessment. No financial incentive was offered for participation in the study further maintaining the efficacy of the findings.

Results

The findings were divided into four categories, "contrasting perspective of frequency and veracity of suicidal claims, gender differences and social drivers of suicide, religious aspects of suicide, and course of action for suicidal prevention" [1]. In the contrasting perspective of frequency and veracity of suicidal claims, where 75% of health care workers (HCW) did not see suicide as a real problem and denied its occurrence altogether, 88% of community members (CM) admitted that it was indeed a problem and occurred frequently. Both groups surprisingly agreed that there were suicidal ideations, yet the the HCW's downplayed the seriousness of the claims and acknowledged them as mere threats that wouldn't come to fruition. CM's felt the claims were a real cry for help that would lead to suicidal attempts if not addressed. The loan doctor in the group was quoted saying, "I am Haitian, I know the Haitian mentality. No one kills themselves" [1]. In the gender differences and social driver of suicide category, women were more likely to us a less violent method when attempting to commit suicide by consuming pesticides, where the men would use either knives to stab themselves or cord for hangings. Shame was a major cause of suicide attempts in Haiti. Women would be shameful due to pregnancies if it was unwanted and premarital. Men would be shameful for financial reasons such as owing debt and not being able to provide for his family. In the condemnation or justification, religious aspects of suicide, those who did not attend church was at a greater risk of committing suicide. The Catholics were intolerant of those who attempted to commit suicide and believed that those who were successful would go to hell, while the voodooist were more forgiving if they believed it was the spirit that caused the person to commit suicide. HCW were bias and would encourage prayer to a catholic who was terminally ill, yet wouldn't acknowledged those who were "affected by a spirit". In the course of action for prevention category, the Haitian government, although denying a problem with suicide in the country all together, band the purchasing of pesticide to individuals who were not known farmers. This seemed to be an apparent attempt to decrease pesticide induced suicide. In the end, HCW recommend psychiatric treatment for those with suicidal ideation and the CM's want to encourage a more "community-led intervention" [1], including prevention and intervention programs.

Another article I came across in my research entitled, "Social Determinants of Depression and Suicidal Behavior in the Caribbean" noted that depression was a major cause of suicide in the Caribbean. A systematic review of the evidence concluded that Haiti had "higher depression prevalence and scores in males than females, higher depression scores among those with more education than less, and higher depression scores with increasing age than decreasing age" [3].

Discussion

This remains a sensitive and difficult topic for discussion, mainly due to the lack of evidence to support it. The goal of this topic and summary of the article is to help bring awareness to the subject. No one in Haiti wants to be associated with the term "reflechi twop" or thinking too much. "Thinking too much is associated with 8 times greater odds of suicidal ideation" [4]. Early recognition of the signs will promote early treatment and therapy. Bonnie et al. describes "thinking too much" as a syndrome with symptoms consisting of sadness, severe mental disorder, suicide, and social a structural hardship.

Conclusion

As a DNP, it will be difficult to change the culture of a country that is so deeply rooted in their believes. The goal would be to understand their view points of suicide while encouraging education of illnesses like depression. Most suicides are attempted because the person feels hopeless. It may be as simple as setting up support groups for those who are at a higher risk to attempt suicide to meet weekly. Education of a NGO group here in the United States on recognizing the signs of depression, hopelessness, and possible interventions to take back to Haiti would be a start.

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