ISSN: 2230-9926

Available online at http://www.journalijdr.com

IJDR

International Journal of Development Research
Vol. 5, Issue, 11, pp. 6039-6046, November, 2015

International Journal of
DEVELOPMENT RESEARCH

Full Length Research Article

GENDER RISK FACTORS ASSOCIATED WITH PARASUICIDE IN THE CITY OF LUSAKA

[1]Peter Mutale, [1]Dr. Thankian Kusanthan and [2,*]Dr. Ravi Paul

[1]Department of Gender Studies, School of Humanities and Social Sciences, University of Zambia, Zambia
[2]Department of Psychiatry, School of Medicine, University of Zambia, Lusaka, Zambia

ARTICLE INFO

Article History:
Received 26th August, 2015
Received in revised form
29th September, 2015
Accepted 11th October, 2015
Published online 30th November, 2015

Key Words:
Parasuicide,
Gender,
Lusaka.

ABSTRACT

Suicide is perceived to be a major social problem in most countries nowadays. The rate of suicide increased globally throughout the 1990s and much of the 2000s. It has been estimated by researchers that between eight and fourteen people per 100,000 kill themselves each year. With that, researchers encouragingly have witnessed an almost universal acceptance of the growing recognition of the role social, cultural as well as gender factors play in health and illness. Research on suicide focusing on sex has been considered as a gender based study. However, historically, the vast majority of research on suicidal behavior has focused on socio-demographic and clinical risk factors. These have been examined within a biomedical framework ignoring the gender aspect. It is because of this that this study's main objective was to ascertain a gender perspective among individual with parasuicide in the city of Lusaka. Based on 46 participants of whom 28 were women and 18, men, the study used both quantitative and qualitative methods in the collection of data. This study established that the majority of the individuals with parasuicide were females, 60.9%, and males were 39.1%. Female rates of attempted suicide outnumbered male rates by a ratio two to one. This study also established that the rates of attempted suicide were highest in those between 20 and 30 years of age. The study further revealed that females (85.7%) between 15 and 30 years of age were more vulnerable to attempt suicide than their counterparts in this same age group. This study also found a clear correlation between gender and suicidal behavior in terms of educational attainment.

INTRODUCTION

Suicide is a tragic event with strong emotional repercussions for its survivors and for its victims. WHO (2002) puts its estimates at 1 million deaths occurring every year and a prediction of 1.5 million by the year 2010. As for USA in 2006, suicides outnumbered homicides, by three to two, and AIDS related deaths by two to one (Price, 2006). It is a social phenomenon and 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 where 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; and view the world from a perspective of pessimism and hopelessness. This 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). In this case, suicide then becomes a dynamic process where two people are engaged in the act, that is 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. Lastly, 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).

Aside from that, suicidal behavior is influenced as negative expectations of the future are contemplated. This is 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 worst problems will never be solved (Beck *et al.,* 1979).) Hopelessness therefore, is thought to be the component of depression that is most often associated with suicidal ideation or thinking, repetitive

Corresponding author: Ravi Paul,
Department of Psychiatry, School of Medicine, University of Zambia, Lusaka, Zambia.

parasuicide that is engaging in deliberate self-harm irrespective of the intention; and completed suicide (Nekanda-Trepka *et al*., 1983; Petrie *et al*., 1988; 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).

Additionally, it has been noted that hopelessness as an aspect of depression is a better predictor of suicidal intent than depression itself. In clinical studies, hopelessness has been found to predict completed suicide; suicide attempts; suicide intent and suicide ideation (Beck *et al*., 1979; Wetzel *et al*., 1980; Minkoff *et al*., 1973; Steer *et al*., 1993). However, hopelessness is also an important feature because it focuses on the future. It is important to recognize that hopelessness in this case 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 (i.e. suicide) can be very powerful (Beckerman, 1995). Therefore, the ability to take control and end one's own suffering can give an individual hope without alleviating hopelessness.

Other than that, researches indicate that a lack of meaning in life increases the risks of suicide (Harlow *et al*., 1986; Petrie and Brook, 1992). Ruffin (1984) found that 20% of suicide notes included references to wanting to die because the authors' lives no longer held meaning for them. Within this conceptualization of meaninglessness, Maddi (1967) 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 amounts to meaninglessness." It is then possible that victims may have a sense of failure in their endeavors. There may be a sense of failure of not playing by society's traditional roles (i.e. by not playing gender roles as expected) and of not achieving life time goals because of illnesses (Remafedi etal., 1991).

In addition, meaninglessness can also result from the loss of sources of meaning such as interpersonal relationships, family and friends; and work (Baum and Stewart, 1990). Being deprived of interpersonal relationships, particularly by a lack of social interactions and support is a frequent feature of suicidal behavior among depressed people (Beck *et al*., 1979). Work as a source of meaning also has losses associated with it in the sense that when an individual becomes physically ill and or begins to show physical signs of illness, he or she may retreat from work thus 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 which in turn may influence suicidal behavior. In short, meaning in life is a construct and is empirically related to suicide. It also provides a clear focus and understanding of the cognitive aspects of suicide. Furthermore, unbearable psychological pain, unendurable anguish, intolerable suffering describe the model of suicide most commonly called unendurable psychological pain or psychache (Shneidman's, 1985). Psychache is the condition that a suicidal individual seeks to escape and is 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). It is further noted that an individual makes a qualitative judgment about pain, that is 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. Therefore when certain people are found in this situation with no coping mechanism, suicidal intent overwhelms them.

Nevertheless, suicidal behavior is still wrongly included in 'abnormal' psychology texts and psychiatry book chapters. This misrepresentation of suicidal act as abnormal contributes to the maintenance of the stigma associated with suicidal behavior (O'Connor *et al*., 2000b). It is believed that irrespective of the criterion for 'normality–abnormality', suicide is not abnormal but rather is the unfortunate consequence of a complex interaction of various risk factors which includes gender risk factors. 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 *et al*.; 1998 Kushner, 1985). Individuals who unexpectedly survive an intentional and lethal suicidal act are not counted in the completed suicide rates. Nevertheless, since women appear to be more likely than men to select suicide methods that allow time for discovery and intervention (e.g., overdose), they might be more likely than men to survive what could be a completed suicide.

In an effort to show that suicide is also a social problem in Zambia, the media has made many reports of suicide and suicidal behaviors. Information obtained from the 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 females who accounted for 16, although these statistics are not up-to-date. Debates conducted within the

Zambian community through the media, report of specific methods of suicide that can shape the behavior of individuals who are already at risk. The fictional portrayal of specific methods of suicidal behavior in television drama for instance, is believed to add to a considerable increase in the use of those particular methods (Petrie *et al*., 1988).Despite that, suicidal behaviors would still not be counted and not counting these occurrences would result in an underreporting of females' potentially lethal suicidal behavior.

However, 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 as noted above(Madge and Harvey, 1999). Less valid official data occurs 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 labeled "accidents" because there is not enough evidence to conclude that they were suicides. It has however been estimated that the actual incidence 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 actual sense, suicide is no longer an unusual kind of death. The overall objective of the present study was to examine various gender risk factors associated with attempted suicide.

MATERIALS AND METHODS

This study was done in the city of Lusaka. The study population comprised of 46 individuals admitted at the University Teaching Hospital (UTH) with Attempted Self-Harm (parasuicide) of whom 28 were women and 18 men. The study used both quantitative and qualitative methods. A semi-structured questionnaire was used to collect quantitative data and an interview guide was used for in-depth interviews for the purpose of collecting qualitative data which was then analyzed manually. The age of the respondents was put into eight categories (5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40+) and their educational level was grouped as no school, primary, junior secondary, senior secondary and college. All this involved condensing and structuring data into forms that allowed patterns to be identified.

Ethical Consideration: Permission was sought from the Head Department of Community Medicine and consent was obtained from all participating students. Confidentiality was kept with every participant.

RESULTS AND DISCUSSION

The majority of the respondents were women, 28 (60.9%) and males, 18 (39.1 %). Data collected shows 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 proportion of 7 (15.2%). In the age group 15-19, more females, 4 (8.7 %), attempted to commit suicide than males, 1 (2.2 %) (Table 1). The implication is that this age group, that is ages 15-19, may be more susceptible to suicidal tendencies due to the pressure of life found in the adolescence stage. In fact, one girl aged 8, who was the youngest respondent in the study, when asked in the in-depth interview why she attempted to commit suicide at that tender age, she answered that "my boy friend relocated to Kitwe without informing me and my relatives and friend instead of sympathizing with me teased me so much that I opted to leave them for good" (8 year girl).

Data on the educational attainment among parasuicide shows that 13 (28.3 %) females had primary education, 11 (23.9 %) had junior secondary education, 2 (4.3%) had senior secondary education and 1 (2.2%) had attained the higher educational level. On the other hand, 9 (19.6%) males had attained primary education, 7 (15.2%) junior secondary education and 2 (4.3 %) were college graduates (Table 1). The findings show that respondents with low educational levels attempted suicide at a higher rate than those with higher educational levels. This may imply that suicidal behavior is also influenced by an individual's educational status as issues of employment and sustainable livelihood are associated with education.

Table 1. Background characteristics of respondents

Background Characteristics	Female (%)	Male (%)
AGE		
15-19	13.1	2.2
20-24	23.9	13.0
25-29	15.2	15.2
30+	12.2	8.6
EDUCATION LEVEL		
Primary	19.6	28.3
Junior secondary	15.2	23.9
Senior secondary or higher	4.3	4.3
MARITAL STATUS		
Single	19.6	13.0
Married	39.1	19.6
Cohabiting	1.1	4.3
Widower	2.2	2.2
Total	60.9	39.1

Additionally, as regards to the relationship between an individual's level of attainment and suicidal behavior, most respondents alluded to the fact that an individual can only feel secure when educated and employed. However, some respondents were of the view that even if they were educated, the problems they faced were insurmountable. One college graduate said, "I completed a course in National Accounting Technician Accountancy in 2002 but up to now I am unemployed. As I searched for a job, I impregnated a girl who instead of staying with her parents, shifted into my aunt's house where I was being kept despite my objection. In the course of time, trouble started with my guardians. I had no one to lean on hence the only solution was suicide" (28 year old male). A 25 year old married female also said, "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 myself but I depended on him, I got fed up with suffering and suicide became the only way of salvation."

The most striking finding of this study on marital status variable as shown in Table 1 was that the majority of parasuicide 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 were 9 (19.6 %) while male respondents, 6 (13 %). Males who were cohabiting were 2 (4.3%) while female respondents reached 1.1%. The widowed had an equal proportion of 1 (2.2%). The findings sharply differ with Durkheim (1958) who 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. There is then 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 can further be concluded that the socialization process starts within the family circles and becomes inculcated in later life. In this study, family issues were discussed in detail in the in-depth interview. When asked to state their family life experiences, one 20 year old male respondent narrated that "I was the only child in the family. My parents divorced when I was 8 years old then I taken to live with my father who later re-married. My life became unbearable as my step mother hated me so much. The relationship between my step mother and I was so bad that I opted to leave her home and stay with street kids. I stayed with them for 5 years and was forced to stop 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 blamed me. After 5 years on the street, I thought of going back hoping the relationship between me and my step mother would have improved with time. But it was worse than I had anticipated. This time even my father said I was an adult and cannot be kept by them. I decided enough was enough and attempted to commit suicide."

The study also revealed the factors that affect suicidal behavior. It was discovered that that the main reason which led respondents to attempt to commit suicide was the strained relationship or break up of relationship. Majority of respondents, 29 (63.1%), mentioned strained relationships 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. These findings correlate with Shneidman's (1993) dyadic type of suicide which occurs due to relationship failure. This study also found that men and women who mentioned deficiency in having a good life as a reason for attempting to commit suicide were in equal proportional, 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 (Table 2).

When probed, a 30 year old female respondent said "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 appearing exhausted. I complained to both his 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 of woman's perfume". Another woman said "my husband 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 himself with his new girl friend" (25 year old female).

Table 2. Factors affecting parasuicide by sex

Factors Affecting Parasuicide	Female	Male
Emotional factors		
Strain in relationship or break-up of relationship	45.7	17.4
Deficiency in means to have good life	15.2	15.2
Fear/Remorse	1.2	6.5
Psychological factors		
Worry	13.1	4.3
Angry	28.3	19.3
Desperation	15.2	8.7
Misery	1.2	6.5
Humiliation	4.4	6.5
Depression factors		
Anguish	15.2	15.0
Loss	6.5	2.3
Unendurable pain	39.1	23.9
Gender related factors		
Unfaithfulness	17.4	15.2
Does not trust me with money	30.4	4.3
Humiliation	30.4	10.9
Physical abuse	13.0	2.3
Insults	39.1	19.8
Attitudes towards death		
Thinking about death	23.9	36.9
Who cares if I die	19.6	19.6

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 behavior. 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 the reason behind their suicidal behavior. While female respondents who mentioned desperation as a contributing factor for their suicidal behavior were 7 (15.2%) and 6 (13.1%) said worry about their future was the root cause for their suicidal behavior where as 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 (Table 2).

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 reasons were 6 (23.9%). Parasuicide females who cited anguish as reasons for their actions were 7 (15.2%) and 6

(13%) were males. Loss was also another reason respondents cited for their suicidal behavior. It was found that 3 (6.5%) females and 2 (4.3%) males considered loss as a suicidal factor; they also associated their actions to loss of livelihood. The findings also correlate with Hendin (1971) who found that being deprived of interpersonal relationships resulted in loss of meaning to some people. Aside from that, the study 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 while males were 9 (19.6%) (Table 2).

The above findings are an indication that women in most cases felt helpless when faced with problems. The reason behind this is that women were culturally conditioned to depend on men for their social and economical needs. In fact, during the study, female respondents were asked to clarify why they felt as if they had not lived up to their expectations and one said, " when my parents died I was kept by my auntie in Chawama Compound. She never bothered to send me to school. When I got married I thought my life would be better off. But after a year of marriage, my husband started mistreating me" (wife aged 18). Another female respondent noted that "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).

Furthermore, some people withstand misfortunes while others think of killing themselves. In this study, the respondents' attitude towards their 'impending' death was solicited. The study revealed that 9 (19.6%) males said they were thinking about death and females were 11 (23.9%). The most significant finding on the issue of gender was that 17 (36.9%) female respondents said nobody would care even if they were to die while 9 (19.6%) men agreed with the women (Table 2). This notion held by female respondents confirmed that most women internalize 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.

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 at the time of attempting to commit suicide. 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 positive during routine Voluntary and Counseling Testing (VCT) attempted to commit suicide because of their HIV 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 a chronic illness attempted to commit suicide because of their physical health. One of the two female respondents with chronic illness was a 67 year old widow of Kalikiliki Compound and she was the oldest respondent in the study. When asked during the study as to why she attempted suicide she said "I was fed up with this illness. I had been to UTH but no improvement. I had consulted traditional healers but they also failed. I just said 'time is up, I should go to a place of eternal peace'".

In harmony with this study, Hendin (1971) noted that "not all suicidal individuals by any means show the typical depressive melancholic pattern, and not all depressed people manifest any recognizable suicidal tendencies." 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 maintained should be emphasized and that the psychodynamics of depression are necessary but not sufficient enough to explain suicide. 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 internalized murder while suicidal behavior for others is an act of expiation reinforced by social factors.

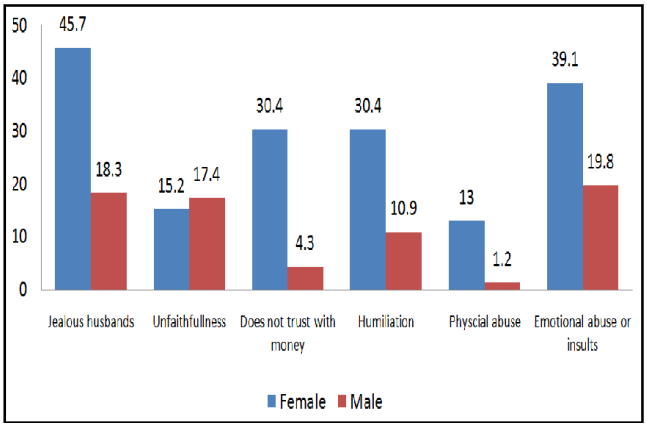

Figure 1. Gender risk factors associated with parasuicide

Respondents were asked about the 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 4 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, where as 5 (10.9%) males answered affirmatively.

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.

The study made it 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 did not work. A female respondent briefly put it that "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). In relation to this response, extreme low levels of self esteem among women make them conclude that they are not worth much and probably deserve marginalization from men. It is this same low self esteem that sustains the cycle of emotional abuse because women tend to accept their vulnerability. A traditionalist and marriage counselor concisely put it that "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 said "it may be suggested that the pattern of marriage as it is institutionalized in our society is an old one. It was designed and developed to suit a kind of life and a kind of society which does not exist anymore. The time when a girl could expect to be married and then be taken care of for the rest of her life is gone." To sum up, it may be noted that women's experiences of 'being female' are, henceforth, 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).

Conclusion

This study established that the majority of the parasuicide 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 men. This study also established that the rates of attempted suicide were highest in those between 20 and 30 years of age. The study further revealed that females (85.7%) between 15 and 30 years of age were more vulnerable to attempt suicide than their counterparts in this same age group. This study also found a clear correlation between gender and suicidal behavior in terms of educational attainment.

The study established that female respondents with low educational attainment and who were also housewives attempted to commit suicide at a higher rate than those with higher educational attainment. 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 are married off at tender ages in the hope of being taken care of by their husbands. Women in this sense end up as housewives with no formal employment and practically depend on their husbands for livelihood. In fact, most housewives (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. It may be construed from this findings 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.

Comparatively, women have lower educational levels than men and in reality women with low educational levels are unable to find formal employment or have the means to engage in any income generating activity in the informal sector without relying entirely on men for sustenance. In situations where men curtail sustenance due to marital conflicts, women become vulnerable to deprivation, desperation, depression, hopelessness and in the end find life to be meaningless thus considering suicide as the only option of escaping misery. The study further established that suicidal behavior is not always associated with the presence of mental illness as emphasized in psychiatry text books. It would be erroneous to always link parasuicide with mental disorders. This is so as the study revealed that almost all the respondents had no known case of mental illness at the time they attempted to commit suicide. The findings showed that only three male respondents out of a total number of fifteen had signs and symptoms of mental illness and only six female respondents out of twenty-eight had signs and symptoms of mental illness. Both respondents who had signs and symptoms of mental illness were not on any medication. Since the conditions were considered to be minor mental disorders arising from social pressures of life, only psychosocial counseling was needed. The study further found no correlation between physical illness and suicidal behavior as there was no respondent with reported signs and symptoms of any physical ailment.

It has been ascertained that the main motive which led respondents, especially female, to attempt to commit suicide was strained relationship or break up of the relationship. 21 (45.7%) out of 28 women in the study revealed that a 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 behavior. 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.

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. It is then essential during researches to look for one cause and state categorically that it was the prime reason for one's suicidal behavior failure to this 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 that, in the absence of adequate and strong social support, led most women to consider attempting suicide. Put simply female suicide may be linked to 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 as they try to achieve lifelong goals.

REFERENCES

Shneidman, E. S., 1993. Suicide as Psychache: A Clinical Approach to Self-Destructive Behaviour, Northvale, N. *J.: J. Aronson*.

Maris, R. 1992. "How are Suicides Different?" In Assessment and Prediction of Suicide, R. Maris (ed.), New York: Guilford Press.

Kettle, P., 1998. Alaska Native Suicide: Lessons for Elder Suicide. International Psychogeriatrics, 10(2), 205-211.

Nekanda-Trepka, C. J. Bishop, S. and Blackburn, I. M., (1983). Hopelessness and depression, *British Journal of Clinical Psychology*, 22, 49–60.

O'Connor, R. C., et al., 2000b. Fifty Cases of General Hospital Parasuicide, *British Journal of Health Psychology*, 5, 83–95.

Durkheim, E., 1958. Suicide, Translated By Spaulding and Simpson, 1951. New York: The Free Press.

Adler, F., and Laufer, W.S. 1995. Advances in Criminological Theory: The Legacy of Anomie Theory. New Brunswick, NJ: Transaction.

Baechler J. 1979. Suicides. New York: Basic Books.

Berger, C., and Tobeluk, H. 1991. Community-Based Suicide Prevention Programs in Rural Alaska: Self determination as a new Approach. Arctic Medical Research, 291-293.

Bernard, H. R. (2000). Social Research Methods: Quantitative and Qualitative Approaches. Thousand Oaks: Sage.

Blaikie, N. (2000). Designing Social Research. Oxford: Polity Press.

Bless, C., and Higsson, S., 1997. Fundamentals of Social Science Research Methods. Cape Town: Juta and Company.

Borowsky, I. W.*et al*. 1999. Suicide Attempts among American Indian and Alaska Native Youth: Risk and protective factors. Archives of Paediatrics & Adolescent Medicine, 153(6), 573-580.

Bryman, A. 2004. Social Research Methods. Oxford: Oxford University Press.

Clinard, M. B. 1968. Sociology of Deviant Behavior. New York: Holt, Rinehart and Winston.

Durkheim, E. 1951. Suicide: A Study in Sociology. New York: The Free Press.

Favazza, A. 1996. Bodies under Siege: Self-mutilation and Body Modification in Culture and Psychiatry. Baltimore, MD: Johns Hopkins University Press.

Gary, F. A. *et al*. 2003. Suicide among African Americans: Reflections and a call to action. Issues in Mental Health Nursing. 24(3), 353-375.

Gibbs, J. T. 1997. African-American Suicide: A cultural paradox, Suicide and Life-threatening Behaviour. 27(1), 68-79.

Gibaldi, J. 2003. MLA Handbook for Writers of Research Papers. 6th ed. New York: The Modern Language Association of America.

Giddens, A. 1971.The Sociology of Suicide: A Selection of Readings. London: Frank Cass ltd.

Hilbert, R. A. 1989. "Durkheim and Merton on Anomie": An Unexplored Contrast and its Derivatives and Social Problems. 36:242–50

Hodgson, S. 2004. "Cutting Through the Silence": A Sociological Construction of Self-injury. Social Inquiry 74:162-79.

Holmes, J. 1997 'Women, Language and Identity', Social Linguistics. 1 (2): 195-223.

Leenaars, A. A., 1996. Suicide: A Multidimensional Malaise, Suicide and Life threatening Behavior. 26, 221–235.

Lester, D. 1997a. The Sex Ratio in American Indian Suicides. Psychological Reports, 81(2), 506.

Lewinsohn, P. M. *et al*. 1994. Psychosocial Risk Factors for Future Adolescent Suicide Attempts. *Journal of Consulting and Clinical Psychology*, 62, 297-305.

Lorraine, H. R. and Henderikus J. S. (ed.) 1995. Power and Gender: Social Relations in Theory and Practice. London: Sage Publications.

MacLeod, A. K. *et al*. 1997. Parasuicide, Depression and the Anticipation of Positive and Negative Future Expectations. Psychological Medicine, 27,973–977.

MacLeod, A. K., *et al*. 1993. Components of Hopelessness and the Future in Parasuicide. Cognitive Therapy and Research, 17, 441–445.

Maltz, D. and Borker, R. 1982. 'A Cultural Approach to Male-Female Miscommunication', in Language and Social Identity. Cambridge: Cambridge University Press.

Manion, C. and Cohen, L. 1998. Research Methods in Education. London: Routledge.

Maris, R. 1969. Social Forces in Urban Suicide. Homewood, IL: Dorsey Press.

Meena, R. (ed.) 1992. Gender in Southern Africa: Conceptual and Theoretical Issues. Harare: Sapes Books.

Merton, R. K. 1968. Social Structure and Anomie. New York: The Free Press.

Miles, M.B. and Huberman, A.M. 1994. Qualitative Data Analysis: A Sourcebook of New Methods. Newbury Park: Sage.

Neuman, L.W. 2000. Social Research Methods. Boston: Allyn and Bacon.

Nkhata, L. 1998. Methodological Options in Policy Relevant Social Research. Lusaka: The Study Fund.

O'Connor, R.C. *et al*. 2000a. Hopelessness: The Role of Depression, Future Directed Thinking and Cognitive Vulnerability. Psychology, Health and Medicine, 5, 155–161.

O'Connor, R. C. *et al*. 1999. A Thematic Suicide note Analysis: Some Observations on Depression and Previous Suicide Attempts. CRISIS, Journal of Crisis Intervention and Suicide Prevention, 20, 106–114.

Oakley, A. (1972). Sex, Gender and Society, London: Temple Smith.

Passas, N and Agnew, R. (ed.) 1997. The Future of Anomie Theory. Boston: Northeastern

Pescosolido, B. and Georgianna, S. 1989. Durkheim, Suicide and Religion: Toward a Network Theory of Suicide. American Sociological Review, 54(1), 33-48.

Poussaint, A. and Alexander, A. 2000. Lay my Burden Down: Suicide and the Mental Health Crisis among African-Americans. Boston: Beacon Press.

Rakow, L. 1986. Rethinking Gender Research in Communication. 36 (4): 11-26.

Rodgers, D.D. 1991. Community Crisis Intervention in Suicide Epidemics. Arctic Medical Research Supply, 276-280.

Shaffer, D.J. 1988. The Epidemiology of Teen Suicide: An Examination of Risk Factors. *Journal of Clinical Psychiatry* 49 (supp.): 36–41.

Sherman, R. and Webb, R. 1988. Qualitative Research in Education: Focus and Methods. London: Falmer Press.

Thompson, K. 1982. Emile Durkheim. London: Tavistock Publications. University Press.

****