Young Women's Suicide in Sri Lanka: Cultural, Ecological, and Psychological Factors

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In recent decades, Sri Lanka has recorded one of the highest rates of suicide in the world. Its rate of female suicide is second only to China. Suicides and acts of self-harm are concentrated in rural areas and among economically disadvantaged groups. Many occur in the context of family disputes and other conflicts with intimates. They are largely unpremeditated and driven by feelings of anger, humiliation, frustration, and desire to strike back against wrongful treatment. This article describes the social ecology of young women's suicide in Sri Lanka, its cultural meanings, and the relational dynamics involved. Implications of the cultural, ecological, and psychological factors are discussed, with recommendations for counselors and human service workers.

Suicide, once regarded as a problem of the industrialized world, has now become a concern for developing countries. According to the Global Burden of Disease study, 75% of suicides take place in

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developing societies (Murray & Lopez, 1997). Some 200,000 of these deaths are in Asia (Jeyaratnam, 1990). Here, suicides are concentrated in rural areas and pesticides are a common means of self-harm (Phillips, Yang, et al., 2002; Ponnudurai, Jeyakar, & Saraswathy, 1986). Furthermore, in contrast to the strong predominance of male suicides in Europe and the United States (U.S.), the gender disparity in Asia is far less pronounced and sometimes even reversed. In China, four times more women die by suicide than men (Phillips, Li, & Zhang, 2002). In both North and South India, among younger people, females are at higher risk than males (Joseph et al., 2003; Waters, 1999). In Sri Lanka too, the rate of suicide for young women is particularly high, although overall more Sri Lankan men than women die by suicide. This article focuses on the social ecology and cultural meanings of young women's suicide and self-harm in Sri Lanka.

Sri Lanka is a small island off the southeast coast of India. Although the population is multiethnic and multi-religious, Buddhism is the predominant religion. Sinhala people, who represent some 75% of the population, are the largest ethnic group. In 1995, Sri Lanka recorded nearly 48 deaths per 100,000, the highest rate of suicide in the world (Levi et al., 2003). This represented an increase of more than 700% during the first 50 years since the British granted Sri Lanka sovereignty. Although the numbers of suicides have declined since 1995, high rates of suicide and self-harm remain a serious public health problem. Concentrated among teenagers and young adults, suicides signify personal distress among individuals and strains in the fabric of rural communities. Large caseloads of self-harm patients have also overburdened the country's limited medical resources. One study reported that 41% of the patients in the Intensive Care Unit of a large rural hospital had been admitted for pesticide poisoning, nearly all of which was deliberate and self-inflicted (Eddleston, Rezvi Sheriff, & Hawton, 1998).

Sri Lanka's high rates of self-harm and suicide must be placed against the backdrop of its recent history. In the 1950s, many considered Sri Lanka as the model for developing societies of South Asia. In succeeding decades, however, Sri Lanka's fortunes soured. Today, Sri Lanka remains a poor country. Its per capita income is only US$1,000 per year; moreover, this aggregate figure conceals dramatic disparities between the wealthy elite, who are concentrated in the city, and the poor masses. In much of the hinterland, income for an entire household averages about US$70 per month (Department of Census and Statistics, Sri Lanka, 2002/2003). Suicides are two-and-a-half times more common in the countryside than in the metropolitan area surrounding the capital city (D. de Silva & Jayasinghe, 2003).

In the post-Independence era, social cleavages — between ethnic communities, between religious communities, between the city and the rural hinterland, between class and caste groups, and even between regions — have generated persisting tensions, social unrest, and repeated outbursts of deadly communal violence in the form of urban riots and village massacres. There have been two prolonged, large-scale anti-government uprisings in the southern portion of the island, while an armed insurgent group (the LTTE) has waged war against the government armed forces in the north and east. In these conflicts, thousands of people have been killed or "disappeared" by rebel groups, state police, and government armed forces; many others have been subjected to harassment, torture, or extra-judicial imprisonment. Moreover, many families have suffered forced migration, loss of their means of livelihood, and separation from kin. The tsunami of December 2004, which left 39,000 dead and one million people (roughly 5% of the population) homeless, was an additional blow to a country already in turmoil.

The Epidemiology of Women's Suicide and
Self-Harm in Sri Lanka

In the aggregate, roughly three times more men than women die by suicide. Nonetheless, the suicide rate among women is high in absolute terms. In fact, it is second only to that of women in China (D. de Silva & Jayasinghe, 2003). Furthermore, suicide rates for women vary dramatically across the age span. They are highest for teenage girls and young women, a pattern also seen in North India, South India, and China. Among young people (aged 16–29), the male-female ratio drops to 1.7:1. Put another way, women in this age group have accounted for between 40–55% of female suicides over the past ten years, though they are only 27% of the total population of women. These data counter the common assertion that Sri Lanka faces an "epidemic of youth suicide." It is not "youth" who are at risk, but rather young women and girls.

Most acts of self-harm do not end in death, although it is hard to say with any precision how many people survive an act of self-harm. Some studies have estimated as many as twelve or thirteen acts of self-harm for each death (H. J. de Silva et al., 2000; Eddleston, Sudarshan, et al., in press). Another study of patients hospitalized for pesticide poisoning (a significant subset of those hospitalized for self-inflicted harm) found roughly five acts of self-harm for each death (Van der Hoek & Konradsen, 2005). One study (Marecek & Ratnayeke, 2001) analyzed data on admissions to two rural hospitals in the Western Province of Sri Lanka over a six-year period. These data included all patients admitted for self-inflicted harm, not just those who had taken poison. This set of data showed that for every death, between six and eight patients survived an act of self-harm. The male-female ratio of the survivors was close to equal (1.34:1). Moreover, in younger age groups the proportion of females was higher. Among young adults (those aged 16–29), the male-female ratio was essentially at parity (1.07:1). Among children

(those under the age of 16), more than four times more girls than boys engaged self-harm (male-female ratio = 1.6:7).

Hospital and police records, no matter how carefully collected, underrepresent the actual incidence of deliberate self-harm. Acts of self-harm bring shame to the individual and the family; therefore, patients and families often conceal them by claiming that the injuries occurred accidentally. Moreover, in many cases, acts of self-harm are interrupted before injury occurs. When physical treatment is not necessary, no outside help (whether from biomedicine or from a local healing system) is sought, no matter how lethal the means used. In rural Sri Lanka, suicidal acts are not seen as mad behavior, but as bad behavior — a sign of impulsiveness, a hot temper, or a rebellious character.

Reflecting the concentration of suicide and self-harm in the rural population, most instances of suicide and deliberate self-harm (perhaps 85–88%) involve poisonous agricultural chemicals, poisonous plants, or poisonous household substances like kerosene and paint thinner. Ingestion of poisons is equally common to men and women. Other methods of self-harm are hanging, drowning, burning oneself, or overdosing on medicine.

A Note on Terminology

For the purposes of this article, the term "suicide" is used to refer to a death that is deliberate and self-inflicted, whereas the term "self-harm" refers to acts of deliberate harm to one's body. The phrases "suicide attempt" and "attempted suicide" are avoided because they presume that the act of self-harm was intended to lead to death. This may or may not be the case; self-harm — even when it leads to death — has many possible motives. Moreover, the term "suicide attempt" inadvertently implies that individuals who survive an act of self-harm have failed and those who die have succeeded, an implication to avoid.

Researchers often draw a sharp line between suicide deaths and survived acts of self-harm. However, we must remind ourselves that we cannot impute motives on the basis of outcome. Those who die may not have intended to die and those who survive may not have intended to survive. This is certainly true in rural Sri Lanka, where heavy drinking is involved in most male suicide and self-harm and where many extraneous factors can determine whether self-harm is fatal or not. For example, self-harm most often involves swallowing any of a wide array of poisons that vary greatly in lethality; ordinary people are unlikely to know which ones are always fatal and which ones respond readily to medical treatment. Moreover, survival often depends on chance factors, such as how quickly bystanders can locate motorized transport to convey the victim to a hospital, whether the hospital stocks the antidote, and whether the medical officer on duty is competent to administer the necessary treatment. Surviving versus succumbing to an act of self-harm may say little about the individual's intention.

The Cultural and Social Ecology of Suicide and Self-Harm

The cultural template through which Sri Lankans understand suicide is distinctly different from that of the West. Western psychology and psychiatry typically explain suicide and self-harm in terms of mental illness, especially depression. Indeed, in the U.S., suicide is virtually synonymous with mental illness. For example, the National Institute of Mental Health (2003) of the U.S. claimed that "90 percent of people who kill themselves have depression or another diagnosable mental or substance abuse disorder …." In Sri Lanka, mental disorders play a much smaller part in suicide and self-harm. One study of 97 patients hospitalized for self-poisoning reported that less than 14% had a psychiatric illness (Hettiarachchi & Kodituwakku, 1989). In hospitals with psychiatric services, only 4% of self-harm patients were referred to psychiatrists (Kathriarachchi & Manawadu, 2002). Individuals who

harm themselves are most often driven by explosive feelings of anger, frustration, humiliation, and annihilation, not by long-standing depression. Most contemplate harming themselves for only a few hours. One study, for example, found that 70% of self-poisonings were contemplated for less than four hours (Hettiarachchi & Kodituwakku, 1989). Many acts of self-harm are carried out in a dramatic fashion, often in the presence of others. These suicidal acts take place in the course of domestic disputes, quarrels between intimates, and other crises of an intimate nature. Therefore, if we hope to understand the reasons behind the drastic increase in young women's suicides and self-harm, we must look to the conditions of rural life that make domestic relations contentious and the circumstances and events that are emotional flashpoints in personal relationships.

The Rural Setting of Self-harm and Suicide

Most Sri Lankans who engage in suicide and self-harm live in rural areas, where the standard of living is quite modest. Homes have neither piped water nor telephones and, more likely than not, no electricity. Rural roads are unpaved and rutted; travel is by foot or bicycle. In some locales, wild elephants or bears make it too dangerous to travel at night. Many rural individuals are able to acquire only a basic education. Rural schools are understaffed and under-resourced. Moreover, even if parents value education, they may pull their children out of school because the family needs their labor or because they have no money for shoes, clothing, and school supplies.

Traditionally, farm work has been the means of livelihood for most rural people — the cultivation of rice, vegetables, and fruit or labor on coconut, tea, and rubber plantations. Others work in small-scale enterprises, making mud bricks or clay pots, working in saw mills or quarries, or processing crops for market. A variety of economic changes have diminished the prospects of farm families. Many families no longer

own their own land. Steady work is hard to find; some can only eke out a living by day labor. Male unemployment is high. Increasing numbers of women have been forced to leave home for work as housemaids in the Gulf States. At present, roughly one household in twelve sends a family member to the Gulf for work, typically a mother whose children are left in the care of female relatives (Gamburd, 2000). In addition, some 300,000 teenage girls and young women have turned to employment in garment factories, most of which are located away from their villages in urban areas.

As rural people find ways to adapt to economic change, they face a variety of changes in traditional roles, family and community structures, and social norms. These include changes in women's gender roles, threats to men's dominance in the family, and challenges to conventional gender and generational hierarchies in the family. On the positive side, paid work has offered women and girls a means of survival, as well as a degree of economic self-sufficiency and control over their lives. It also has afforded them a broader horizon than that of their men folk who have not left the village. Moreover, when women have money, they may gain more leverage in negotiations with their husbands or fathers. Furthermore, jobs as housemaids or garment workers take women away from home; they can be a means to escape a violent or sexually abusive husband or father (Gamburd, 2000). This is one of the few ways that women can circumvent the coercive power of male violence.

These shifts in the economic roles open to women and in gendered power relations may well benefit women and girls in the long run, but they also are a source of social and familial tensions. When a daughter, wife, or sister seeks paid employment, there is likely to be disagreement about this in her family. The disagreements may involve whether she is allowed to work, who will do the family labor she had done, who

gets the money she earns, and whether the family's reputation will be besmirched by her labor force participation. Moreover, when women and girls step out of the protective custody of home, anxieties about their sexual morality and reputation boil up. "Garment girls" often clash with their elders over their choice of clothing, cosmetics, and hairstyles (Lynch, 1999). Increased freedom of movement and time spent away from home means that family members no longer are able to regulate women's interactions with men. This opens girls and women to charges of sexual impropriety and loss of their virginity. Both "garment girls" and housemaids carry the taint of infidelity, wanton sexuality, rape, prostitution, HIV infection, and abortion in the popular imagination (Gamburd, 2000; Hewamanne, 2003). Although in actual practice, freedom of movement, boyfriends, and love affairs have become more common, the ideals of womanhood continue to emphasize sexual respectability and chastity (de Alwis, 1995). We should not be surprised that conflicts over sexuality and threats to sexual honor figure prominently in young women's suicide and self-harm.

Changes in men's roles have also been a source of conflict in families. Debt and loss of economic productivity lead men to shame and despondency. There are ample reports of male suicides following upon loan defaults, crop failures, and repossession of land. Moreover, as the masculine identities of worker and breadwinner have moved out of reach of many rural men, drinking *kasippu* (home-brewed liquor) has become a ubiquitous feature of everyday life in rural areas. Drinking is nearly exclusively a male pursuit. It often takes place away from home, in the company of other men. It thus signifies men's resistance to domestic control. Drinking is often an occasion for gambling and spending money lavishly, further assertions of masculine autonomy and entitlement. In these ways, drinking is an alternate form of masculinity, albeit one with severe deleterious effects.

Drunkenness figures prominently in suicide and self-harm, as well as in domestic violence. By loosening the normal restraints on words and deeds, intoxication causes a spiral of violence (Spencer, 2000). Rage runs out of control; destructive things are said; verbal disputes quickly turn into physical ones, with women and children beaten, crockery broken, and furniture destroyed. Between 60% and 70% of men who are admitted to the hospital for self-harm are under the influence of alcohol on admission; a similar per cent of women implicate a male family member's alcohol use in their suicidal behavior (Ratnayeke & Marecek, 2003; Van der Hoek & Konradsen, 2005). Furthermore, children's self-harm is often connected to their father's drinking, whether because of violence, sexual abuse, or shame.

Women's Suicides and Self-harm: Some Case Examples

With this background in mind, we now turn to the psychological and relational dynamics of women's suicides and self-harm. Although depression and other mental illnesses may be involved in some suicides, much of young women's self-harm fits the pattern described above. Severe stress at home or conflicts with family members, loved ones, and friends incite tempestuous feelings. Self-harm follows, often with little premeditation and sometimes in the presence of others. Following are some examples (with pseudonyms) collected from field observations.

Vidyamali, who was 15 years old, was accused by her mother of speaking to a boy on the school bus. She denied the accusation, but her mother continued to scold her. She told the researcher, "My head got hot and I felt like it would explode." She went into the kitchen and poured kerosene over her body. Her mother entered just in time to knock the box of matches out of her hand.

Nilmini was married to a man who was a drunk. One evening he came home drunk, demanded that she cook for him, and then, in a rage,

threw the plate of rice in her face. An hour later, when he and his friends were sitting outside the family's hut sipping *kasippu*, Nilmini appeared before them with a small bottle of highly concentrated insecticide and put it to her lips. They knocked it out of her hands, but she needed medical treatment for burns produced by the splashing liquid.

Kanthi, a 19-year-old garment factory worker, hung herself and wrote this note to her sister: "I never dreamed my job would be my death certificate. Because of Nishanthi's false accusations, I cannot go to work anymore." [Nishanthi was a co-worker who had told others that Kanthi was involved in a romantic liaison with the factory manager.]

Muthumenike, 45, was fed up with her 27-year-old son's drinking. She took a lethal dose of poison and left this note: "Sunil *Putha* (my son) drinks daily. He gets drunk and quarrels with others. I sacrifice my life so he can drink in peace."

Rameela was a 19-year-old woman from a poor family of brass makers. She wanted to take a job in a garment factory, but her older brother objected. They argued on several occasions, but he could not be moved. Finally, she swallowed rat poison. When she had recovered and returned home, her brother said, "Now we let her go wherever she pleases, as we are afraid she will take poison again."

Shanthi, a woman in her mid-thirties, returned home when her contract as a housemaid in the Middle East ended. To her dismay, she found that none of the money she had been sending to her husband had been saved. Furthermore, the in-laws who had been minding her children demanded more money from her. The ensuing quarrels involved physical violence and the police had been called to the family compound more than once. After a week, she swallowed some poisonous seeds from the *kaneru* (yellow oleander) plant. Following her

discharge from the hospital, she signed a contract for another stint as housemaid.

Farzana, who worked as a plucker on a tea plantation, had a secret relationship with a boy. When she became pregnant, he arranged an abortion. Later, however, he revealed this to some friends. Rumors began to swirl and eventually reached her family. When they pressed her to marry the boy, Farzana set herself on fire.

Women's Suicides and Self-harm: Psycho-cultural Dynamics

Suicide and Self-harm as Dialogue

In trying to understand the dynamics of suicide in Sri Lanka, it is useful to draw a contrast between suicides that are monologues and suicides that are dialogues. Monologue suicides are self-contained and solitary acts involving a wish to die as an escape from the self or from emotional pain. Dialogue suicides, by contrast, are expressive, directed outward, and intended as communications to others. Those who engage in dialogue suicides are not isolated; on the contrary, they are embroiled in interpersonal relationships.

In the U.S., the prototype for suicide is the monologue. Compared to dialogue suicides, monologue suicides are regarded as "good" suicides. They may even be romanticized as courageous acts of heroic, autonomous individuals (cf., Canetto & Lester, 2002). By and large, Americans see dialogue suicides as manipulative and immature. In the psychiatric literature, for instance, dialogue suicides are often associated with women and adolescents, groups who are stereotyped as impulsive, over-emotional, and lacking in self-control. In Sri Lanka, the prototype for suicide is the dialogue suicide. In a study in which Sri Lankan (Sinhalese) psychology students and medical students were asked to discuss and evaluate a variety of hypothetical suicide cases, a clear

pattern emerged in their responses (Marecek, 1997). They evaluated monologue suicides as cowardly, less morally justified, childish, and harder to understand. They saw dialogue suicides as "good" suicides and rated them as more understandable, braver, and more morally justified. Indeed, many suicides and acts of self-harm in rural Sri Lanka fit the description of a dialogue suicide. That is, they are directed toward other people and may be carried out in the presence of others. The act serves to communicate emotional pain, to protest ill treatment, and to register moral claims about the victim and the wrongdoer. Many times, such moral claims are made not only to the wrongdoer but to a larger group of witnesses as well.

Women's Suicide and Self-harm as Protest

Why is it that Sri Lankans, and particularly young women in Sri Lanka, might find it necessary to resort to suicide to communicate moral indignation and emotional pain? We can find clues to this question by considering some culture-specific norms of social behavior. In Sri Lanka (as elsewhere in South Asia), dramatized expressions of emotion — whether hearty laughter, explosive anger, profound sorrow, exuberant glee, or profuse gratitude — are discouraged. Self-control, emotional restraint, and equanimity are the valued modes of self-presentation. *Lajja*, a term whose meanings range from shyness, modesty, and restraint to shame, is a desired quality that is assiduously cultivated in children (Obeyesekere, 1984; Spencer, 2000). For women and girls, the norms of behavior associated with *lajja* prescribe that they remain in the background of social interactions, avoid direct eye contact, and refrain from forward behavior.

Traditional norms further prescribe respect for and deference to those higher in the family hierarchy. In families, generation and gender are the prominent axes of hierarchy. Thus, children — even adult children — should not confront or disagree with their parents. They are

enjoined from florid displays of emotion (positive or negative) in their parents' presence because such displays are deemed disrespectful. Elder siblings (and certain other members of one's kin network) also should be accorded respect, deference, and even obedience. In some societies, generational hierarchies flatten out when children become adults; in Sri Lanka, however, they remain more or less in place. With regard to gender hierarchies, women are expected to defer to men, at least in terms of public behavior.

When conflicts in families cut across generational, gender, age, or kinship hierarchies, direct confrontation by the person in the subordinate position is emotionally fraught and shameful. Standing up to (or shouting down) one's parents, older sibling, or husband violates norms of filial respect. For women, it also goes against norms of feminine comportment that counsel restraint, modesty, and amiability. In lieu of overt confrontation, suicide may offer a young woman a covert way to express what she cannot say aloud: that she has been unfairly treated or wrongly accused or her virtue falsely impugned. Suicide and self-harm communicate, in effect, "You shouldn't have said what you did" or "I do not deserve the treatment I have received" or "I am not the kind of person who will tolerate being treated this way" or "Look at the injury that [the other party] has done to me."

Young Women's Suicide and Self-harm as Retaliation

In everyday discussions about suicide, anger, revenge, and the desire to "get back" at one's antagonist are understood to be the most common motives. If suicidal acts often express powerful and perhaps forbidden emotions and also protest wrongful acts, one can take a further step to examine how suicide can be a means of retaliation. How does injuring or killing oneself "get back at" someone else? Acts of self-harm are often configured to call attention to a wrong that has been done

and to the culpability of the wrongdoer. Unpublished data from a study of Sri Lanka school children may shed some light on the cultural logic that underlies the use of self-harm as retaliation (Marecek, 2004). The children produced narrative accounts of responding to being harmed by others, which were analyzed for common themes. One such theme was that when one has been hurt by another and particularly when one's *aathma gauruvaya* (dignity or moral personhood) has been damaged, there is an obligation to retaliate in order to restore one's honor. Another was that the retaliation should be overt because this makes it clear that the victim did not deserve to be hurt. A third was that overt retaliation makes others aware of what the antagonist has done and what kind of person he or she is.

Biso, a young wife whose death by suicide was described by Silva and Pushpakumara (1996), provides an example of how self-harm can be a means to draw attention to wrongful treatment. Biso's husband had deserted her and their two children and moved in with another woman. Biso purchased a small vial of highly concentrated insecticide and went to the house where her husband was staying. With her two toddlers at her side, she lay in the road in front of the house, took the poison and perished. Several of the case vignettes given above also involve acts of self-harm that protest ill treatment and point the finger of blame at the wrongdoer. Nilmini, for example, chose to protest her husband's maltreatment by swallowing insecticide in front of his drinking buddies. Kanthi and Muthumenike wrote suicide notes that laid blame at the feet of a wrongdoer. Kanthi's suicide note, quoted above, blamed her co-worker Nishanthi for her death; she wrote the note to her sister. Muthumenike's note, which placed the responsibility for her death on her son, was addressed to the police inspector.

To be publicly held accountable for another person's suicide would be distressing in any culture. However, in Sri Lanka, fear of social

disapproval or public criticism (*lajja-baya* or shame-fear) is especially powerful (Obeyesekere, 1984). When self-harming individuals arrange their actions to bring public shame to an antagonist, they are arranging for that person to experience profound pain. However, the situation is arranged so that the witnesses are the agents of harm. The self-harmer thus obtains her revenge without personally striking out against the wrongdoer. Setting up third parties to do harm to one's enemies calls to mind a number of everyday practices that Sri Lankans use to retaliate against those who have given offense. Many people, for example, retaliate against others by sending poison pen letters to bosses, professors, potential marriage partners, and so on. Many Sri Lankans engage sorcerers, malevolent deities, and magico-religious specialists to bring ill fortune, disease, or death to their enemies (Obeyesekere, 1975). Moreover, in situations of political terror and armed conflict, many people settled personal grudges by making false accusations about their enemies to the police or the army; such false information might well have led to torture, imprisonment, or death (Argenti-Pillen, 2003).

In summary, in many instances, suicides and acts of self-harm are communicative acts. They arise abruptly in situations of high emotion, typically provoked by conflicts with family members or intimates. Such suicides are performed for an audience — whether for the antagonist or for a larger group of witnesses. They may serve many interlocking ends. They register on the body what cannot easily be expressed in words. They protest wrongful treatment or unfair domination. In addition, they cause harm and humiliation to the antagonist by public shaming. These relational dynamics of suicide are not specific to women or to young people. However, young women may face more prohibitions against direct modes of retaliation; thus, they may turn to suicide and self-harm instead.

How Counselors and Human Service Workers Can Help

Sri Lanka is a poor country with miniscule mental health services. Fewer than thirty psychiatrists serve some 20 million people; the press of their work limits them to prescribing medication for people with severe mental illnesses. The psychiatrists are concentrated in two urban areas; for most people, mental health care is a day's journey away. There are no more than a dozen clinical psychologists trained beyond the bachelors' level and they too are concentrated in urban areas. University education in psychology has languished at a preliminary stage for decades. The number of trained social workers and counselors is even smaller. Although paraprofessionals and lay volunteers have stepped into the breach, there is an acute need for more mental health workers, for more professional standards, and for regular training programs.

The tiny cadre of mental health workers (professionals and volunteers) is largely drawn from the urban, Westernized elite. In many cases, English is their first language; some do not speak either of the vernacular languages. Of necessity, those with training received that training in the West and hence what they learned fits Western sociocultural models. Consequently, there is a considerable cultural and social distance that must be bridged if they are to work in rural areas where the risk of suicide and self-harm is high. Moreover, they must set aside the aversion and disdain that elites have traditionally held for the rural masses. Urban-based doctors and other experts often render public judgments about self-harming individuals that seem like little more than invidious stereotypes. For example, medical personnel and others interviewed for local newspapers have declared that suicide victims are impulsive, foolish, deficient in coping skills, bad decision-makers, swayed by television programs, and driven by thwarted dreams of city life beyond their proper station.

Rather than such distancing stereotypes, mental health workers need accurate knowledge of the cultural values, social constraints, and material realities of rural life. This knowledge is necessary both to give them insight into the life experiences of those they hope to help and to enable them to develop acceptable modes of intervention. To date, only a few studies have addressed the motives, psychological dynamics, and social context of suicide and nearly all of these are published in professional journals that are not available in Sri Lanka. Much more research is necessary, as are means of disseminating accurate knowledge to local practitioners. The results of that research must be taken into account in designing intervention and prevention programs. Current proposals for programs that typically address such generic (and sometimes misguided) goals as improving decision-making, raising self-esteem, teaching coping skills, and warning about the danger of insecticides are not likely to have an impact on suicide and self-harm.

In working with young women and girls, counselors and human service workers must come to terms with the extraordinary constraints and limitations that rural life imposes on women. On the one hand, they must resist the temptation to blame victims for failing to choose options that they do not have. Staying in school, refusing an arranged marriage, seeking police protection from an abusive father or violent husband, leaving a violent marriage — all these may be impossible or come at a price that is too high to pay. At the same time, it is easy to become demoralized and helpless in the face of stark realities that young rural women must endure. One way to stave off such demoralization may be to balance individual work with distressed individuals with work that promotes collective change. The latter may include advocating for changes in laws about domestic violence and sexual abuse, advocating for more rights and greater protection for garment workers and housemaids, and promoting women's economic solidarity in the form of cooperatives, trade unions, and micro-credit schemes (Risseeuw, 1980).

Mental health workers can also encourage women's groups to pressure local officials and police to enforce laws regarding domestic violence and the brewing and sale of illegal liquor. They can encourage Buddhist clergy (whose religion has an explicit prohibition against drinking) to take an active stance against intoxication.

Barriers to Counseling: Stigma and Unfamiliarity

For most Sri Lankans, getting psychological help for personal troubles is a source of stigma, both for the individual and the family. Even among Westernized urban dwellers, such a premium is placed on secrecy that people who seek help may give false names or travel to distant locales to protect their anonymity. Even in war-affected areas, where civilian populations have faced shelling, landmine explosions, and repeated displacements, many families do not allow distressed members to seek counseling (Divakalala, 2005). With such concern about stigma and secrecy, counselors must be scrupulous about guarding clients' identity. In some cases, counselors have attached themselves to agencies offering jobs, housing, or other forms of material aid, so that clients may consult them surreptitiously (G. Samarasinghe, personal communication, July 2004). Sometimes, counselors have concealed their names and deliberately chosen to work in communities at a distance from where they live. By doing so, they hope to give reassurance that they are not part of local gossip networks.

Sri Lanka has a rich array of traditional healers whom people consult in times of trouble. These include astrologers and other soothsayers, ritual experts, mediums, and other magico-religious practitioners. Consultation with these healers provides the template for counseling relationships and that template is quite different from models of counseling in the West. A consultation with a traditional healer often requires only a single visit. The healer reveals an external cause of the trouble, such as a confluence of bad planetary influences or a spell cast

by one's enemies. There is no need for the individual to divulge private thoughts and feelings and no expectation of developing a personal relationship with the healer. Moreover, the healer prescribes a concrete remedy, such as an amulet or other protective devices, a pilgrimage, or a cleansing ritual. Such remedies do not involve prolonged examination of clients' thoughts or feelings or their relationships with others.

Psychological counseling is, of course, based on a different framework and it involves different processes. Counseling requires several visits, extended conversation, a relationship of trust, and disclosure of private feelings and thoughts. Clients are encouraged to engage in self-reflection, with the goal of learning about themselves. They are encouraged to express emotional pain, with the belief that such disclosure brings relief. In addition, clients may be expected to make deliberate efforts to change their patterns of thinking, being, and relating to others. In short, counseling does not match the template and expectations of ordinary Sri Lankans. Therefore, there is a significant cultural gap to be bridged if counselors hope to work with clients from traditional backgrounds. They must be prepared to explain in detail what counseling entails, what its goals are, and why it works. Counselors must also be prepared to adjust their practices to fit their clients' expectations. Among other things, they need to think in terms of brief, problem-focused interventions. With regard to suicide prevention, a human service worker might consider offering practical measures, such as instructing families to move poisons out of reach and to trim the poisonous fruit from their plants. Although these measures do not address the underlying causes of suicide, they are useful first steps. Moreover, they may build confidence among potential clients.

Perhaps more important, counselors need to re-think (and perhaps relinquish) several taken-for-granted axioms about counseling. One example is the idea that troubling feelings should not be "bottled up,"

but will be alleviated if they are expressed. Another is the presumption that forthright communication of one's needs and feelings to others is necessarily helpful. A third is the idea that people necessarily benefit from sharing stories of distressing or painful experiences with others. A fourth is the presumption that gestures of forgiveness, direct apologies, or other overt efforts to repair spoiled relationships are beneficial — or even possible — courses of action. All of these, at least if taken as blanket edicts, fly in the face of cultural wisdom and everyday social practice in Sri Lanka. Moreover, it is hard to envision how family counseling (as Western therapists understand it) might proceed in the context of traditional Sri Lankan values. To push for frank and forthright communication between parents and children or to try to foster more democratic family functioning would violate moral sensibilities.

Strengthening Young Women to Resist Suicide

Given the spontaneous nature of many suicides, counselors and community workers will seldom engage with actively suicidal individuals. Nonetheless, there are many ways that human service workers can help women resist suicide. For example, women's suicides often happen in the context of men's drinking and ensuing violence. Although there may be few ways out of a violent marriage, counselors can help women to develop plans to keep safe during violent episodes. These include hiding knives, bottle lamps, and poisons when a man has been drinking and instructing children on places to hide. Such plans not only reduce the risk of serious injury and death, but may also bolster women's sense of agency. Counselors can also encourage women to seek support and solace from female confidants, even if confiding troubles means loss of face. Confiding in others also requires setting aside rural norms of privacy and family loyalty, norms that keep neighbors and even members of extended families at arm's length. It may be helpful to remind women that idealized images of harmonious

family life and female chastity are regulatory fictions. A counselor might ask female clients to recollect instances in which neighbors, acquaintances, and kin have failed to live up to those ideals. Realizing how often such ideals are honored in the breach may help a woman break her own silence. A further step is to assist women to form groups (or to make use of existing women's groups) to take collective action.

The high frequency of self-harm in rural communities means that many people know someone who has engaged in self-harm or died by suicide. As suicide becomes more and more a mundane occurrence, normative constraints on it may be lifted. A study we conducted in summer of 2005 suggests that children, especially girls, may have come to view threatening self-harm as a fairly ordinary practice. We asked over a hundred middle-school students to evaluate six possible ways to respond to a situation in which a friend suddenly and without explanation becomes angry with you and refuses to have anything to do with you. One of the six options we gave was "Bring a [poisonous] *kaneru* seed to school. Tell the other children what has happened, show them the seed, and threaten to swallow it." Although few students endorsed this as their first choice, several endorsed it as their second choice. More girls than boys endorsed this option and the number of girls who did so increased with age. In the oldest cohort of girls (14-year-olds), roughly 30% rated showing the *kaneru* seed as one of their first two choices. If these data are indicative, they suggest that girls might benefit from discussions focused on ways of managing conflicts. They could be helped to conceptualize the drawbacks of threatening or resorting to self-harm, as well as to imagine and perhaps role-play other ways of responding.

In the long term, it seems important to help girls and young women expand their horizons: to have life possibilities beyond marriage and to have varied avenues to economic self-sufficiency. Such goals

demand concerted programs of economic and social development, not psychological interventions. Nonetheless, human service workers can work to expand girls' opportunities in more modest ways. For example, they can encourage families to allow their daughters to complete sufficient schooling to qualify for wage work. Also, they can discourage very early marriages (whether these marriages are arranged or the result of love affairs). A bride typically takes up residence with her husband's family; being at a physical distance from her family leaves a new wife without support if things go badly in the new household. This may be especially hard for a 15- or 16-year-old girl with little social experience and limited self-confidence. An older girl may enter marriage with a stronger sense of self, wider social experience, and a better set of interpersonal skills. These may equip her better to deal with her new partner and her in-laws. If human service workers can offer school-going girls clubs, sports programs, and other recreational activities, girls may develop interests and friendships that offset the allure of forbidden love affairs.

Rural Outreach and Community Interventions

Counselors and human service workers face many logistical barriers to providing services in rural areas. Settlements are isolated and without telephone communication; thus, hotlines, drop-in centers, and clinics are not feasible. One strategy is to make use of existing community institutions such as places of worship, schools, and weekly markets, as well as existing community groups such as farmers' associations and death donation societies. Another logistical barrier is that Sri Lankans, when faced with devastation, displacement, and death, give priority to practical assistance, not psychologically oriented forms of help (Divakalala, 2005). They focus on education for their children, jobs, housing, and restoration of irrigation tanks, bridges, and roads. Human service agencies must acknowledge and respect such priorities, perhaps

by combining material aid with psychological interventions. In the field of suicide prevention, the rural outreach program of the Sri Lanka *Sumithrayo*, a volunteer organization devoted to suicide prevention, offers an example. The program blends one-to-one "befriending" (that is, empathic listening) with other services, such as classes in cooking and sewing, English classes for children, and emergency provision of medical care, food, and other goods. Through these services, the *Sumithrayo* workers have become known and trusted by the community. Moreover, as workers' presence has become routine, it has become possible to visit families in crisis without singling them out as recipients of psychological help.

Given the personal and interpersonal devastation produced by men's drinking, one would expect that alcohol abuse would be a prime concern of public health officials, human service workers, and development workers. Yet, alcohol abuse is rarely mentioned in public or professional forums; liquor consumption is largely unrestrained and unregulated. What little data are available suggest that the number of male consumers and the amount they consume have grown at a dramatic rate in the past decade. Moreover, the number of teenage and young adult men who drink alcohol jumped 37% in just six years (Department of Census and Statistics, Sri Lanka, 2005). In rural areas, men actively and vocally defend their "right" to drink to excess, speaking of alcohol as a quasi-medical necessity, the antidote to a day's hard work or to sexual deprivation (Baklien & Samarasinghe, 2003). Few men drink in moderation when they drink. Few try to limit their alcohol consumption, even when it has wreaked havoc on their health, their jobs, their marriages, and their family relations. As we have seen, men's alcohol consumption has close connections to suicide and self-harm. Given this connection, suicide prevention efforts must address excessive alcohol consumption. Unfortunately, many powerful parties benefit economically from the sale of legal and illegal alcohol; they have

actively (and sometimes violently) blocked efforts to curb heavy drinking. Moreover, if drinking is the means by which economically disenfranchised men salvage a modicum of manly status and masculine identity, perhaps we cannot expect men to give up drinking until their life chances are improved and opportunities for dignified work are within their reach.

Conclusion

Many aspects of suicide and self-harm described here are not unique to Sri Lanka. Worldwide, suicide has become a rural problem, not an urban one. In agrarian societies in South Asia, Africa, and China, pesticides have become a common means of self-harm. Moreover, in both East Asian and South Asian contexts, women's risk of suicide is high. As in Sri Lanka, women's suicides in China and India are closely connected to family quarrels, not to psychopathology (Aaron et al., 2004; Pearson, Phillips, He, & Ji, 2002; Waters, 1999). Further, several ethnographic accounts (Lee & Kleinman, 2000; Meng, 2002; Pearson, 1995) interpret the suicides of young Chinese women as expressions of indignation, protest, and revenge, somewhat akin to the pattern described here for Sri Lanka. This suggests that we should set aside the Western emphasis on psychopathology as the cause of suicide. However, it does not imply that there is one single model of suicide that fits all Asian women. Rather, researchers need to understand the culture-specific structures of feeling, family obligations, and symbolic meanings that operate in different locales.

To understand women's suicides, we need to identify specific settings and circumstances in which suicide and self-harm are likely to occur. In cases such as Sri Lanka where high rates of suicide are a recent phenomenon, we need to consider what has changed in women's lives and in gender arrangements. We also need to ask why it is *suicide* (rather than some other form of action) that is the response that so many

women and girls choose in the face of difficult circumstances, threats to their dignity or reputation, or relational impasses. What are the symbolic meanings that suicide enacts? Why are other avenues of action closed off? Are young women more likely than others to find themselves in situations where suicide is the socially "correct" course of action? In sum, we must work toward complex accounts of suicide and self-harm that embrace individual psychology, culture-specific meaning systems, and large social and economic forces. Such accounts make evident that mental health requires more than individual coping skills and improved self-esteem; it also depends on social justice, economic equity, and human rights.

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斯里蘭卡年輕婦女自殺的文化、生態及心理因素

近數十年，斯里蘭卡的自殺率位居世界首位，而其女性的自殺率亦位居第二，僅次於中國。自殺及自殘行為集中在鄉郊地區，以及經濟條件不利的社群，起因大都與家庭糾紛有關，或與親人發生衝突所致。這些自殺及自殘行為大都沒有計劃，而是由憤怒、受辱、挫敗等情緒，或對不公平對待作出反擊的欲望所驅使。本文描述斯里蘭卡年輕婦女自殺的社會生態，其文化意涵，以及當中所涉及的互動關係。本文亦會討論文化、生態、生理因素的影響，並會向輔導人員及社會服務工作者作出處理這些問題的建議。