PAIN PATHWAY

# The Pain Pathway

## Why & How It Was Made

Self-directed violence is a spectrum of self-harming thoughts and behaviours, which may or may not be suicidal in nature or result in death. Not enough has been done to understand what we can do to help women and girls around the world who hurt themselves, or to prevent them from using self-harm at all. Calls persist for targeted research among women to inform gender-sensitive prevention efforts.

This briefing sheet describes the background rationale for exploring self-directed violence in women and the methodology of the research that informed the development of *The Pain Pathway* model.

## Background

Women's use of self-harm is routinely portrayed as impulsive, manipulative, attention-seeking and unserious. Common perceptions among the public often suggest women's vulnerability to self-harm is due to "natural" feminine flaws of being "delicate" or "hot-tempered".

Little research explores women's experiences globally and in South Asia specifically to understand how, why, and with what consequences women choose and use self-directed violence. Even less has been done to explore the cultures within which it occurs, or to acknowledge women's life circumstances and the interpersonal aspects of their lives over their life course which may play a role.

Gender is an especially important determinant of physical and mental health outcomes, shaping them directly and indirectly by interacting with personal and social characteristics, influencing health behaviours and how health systems respond to people in need. The social construction of gender can affect individual health trajectories. Gender-conscious research has been long overdue to consider the factors and interactions that frequently operate in women's lives, influencing women's vulnerability to and use of self-harm and suicide. The research behind *the Pain Pathway* explores the ways in which gender shapes women's roles, behaviours, responsibilities, expectations, care-seeking and access to resources and support for self-directed violence. The research also includes experiences along the full spectrum, from thoughts of self-harm through deaths from suicide.

## Facts about self-directed violence

*Low- and middle-income countries:*

- account for 79% of suicides globally, as well as increasing occurrence of non-fatal self-harm

*South(east) Asia:*

- is seeing a growth in self-harm
- has exceptionally high rates of self-harm amongst women
- has higher suicide rates amongst adolescent girls (28 per 100,000 population) than adolescent boys (21 per 100,000 population)
- recognises that suicide accounts for a high proportion of preventable deaths in pregnant and postpartum women and girls

*India:*

- accounts for 40% of the world's suicides amongst women
- launched their first National Suicide Prevention Strategy in 2022, but gender-conscious prevention guidance remains absent

*Sri Lanka:*

- 1 in 4 women (aged 15-49 years) say they've either thought about, or actually done something to hurt themselves in the past
- has an estimated 13-18 non-fatal events for every death by suicide
- has made important progress in reducing suicide by pesticide poisoning, but less progress addressing other methods and drivers, particularly for women and girls

# Methodology

### Study setting:

Data collection focused on Gampaha, a western district in Sri Lanka which was intentionally chosen to generate evidence from an increasingly urban and industrial population, though rural, semi-urban and urban areas all participated. Gampaha has three Free Trade Zones, mainly employing young women living away from their families, and it contributes heavily to female emigration, commonly to the Gulf States.

Gampaha is also home to Sri Lanka's second biggest public hospital, Colombo North Teaching Hospital, serving a large urban and referral population, enabling women experiencing self-directed violence from across the district to be identified. The National Hospital in Colombo provided an additional setting for the research with patients coming from around Sri Lanka to receive specialist treatment for self-harm.

### Sampling and data collection:

A prospective surveillance system was established in Colombo North Teaching Hospital, where all females 12 and older admitted following possible self-harm were identified. Through this process, we collected new health records and reviewed existing hospital data for 210 identified women and girls (ages 13-67) and interviewed 170 who wished to tell their story.

We also interviewed women at the National Hospital who were receiving care in a specialist ward. Thirty-two cases of women who died by suicide in Gampaha were analysed in the same period. These core sources of data were triangulated by interviews with 25 diverse health and social care providers working with women and families affected by self-directed violence, and a novel survey documenting lifetime and current-pregnancy experiences of self-harm in 1000+ women attending antenatal services.

### Data collection tools:

The research tools captured women's experiences across their life cycles.

Psychological and sociological autopsy methods were combined in an original tool designed for this research, which explored individual and social circumstances surrounding self-harm for surviving and deceased women. Additionally, surviving women used unstructured storytelling to recount their paths to hospital, and explored (gendered) issues often missed or minimised by the standard tools used in suicide research (e.g. psychological autopsy). Health records and the hospital surveillance system captured information on sociodemographic characteristics, life circumstances, methods and histories of self-directed violence, intended and actual outcomes of self-harm.

### Analysing the data:

Using thematic analysis, and cross-cultural reflection within the research team, themes were identified, refined and grouped hierarchically to reflect how they related to one another (aided by specialist software, NVivo). What was derived from the evidence is an interpretation and organisation of living and deceased women's pathways through the self-harming experience, which showed a cumulative and gendered process termed *The Pain Pathway*.

### Ethical considerations:

All living women demonstrated an ability to provide written and oral consent.

Girls under 18 years gave their consent as did a parent or guardian. All participants were approached only once they were medically stable and study information and conversations were held in their preferred language (Sinhala, Tamil or English). We did not give incentives to women or medico-legal authorities to participate or share suicide inquest files to ensure no one felt pressured to take part. Ethics approval was given by University of Kelaniya's Faculty of Medicine Research Ethics Committee (Ref. P/135/08/2015), hospital administrators, consultants responsible for all participating wards, and the London School of Economics Ethics Review Committee.

### Find other resources at painpathway.org:

- Model description
- Film screening promotional flyer
- Screening facilitation guide
- Screening facilitation slide deck

For more information about the research or other resources related to *The Pain Pathway*, please contact
Dr Alexis Palfreyman at painpathway.org.