Culture and suicide

An exploration of cultural factors involved in suicide

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This dissertation examines how cultural factors relate to suicidal behavior. Several routes are explored to identify cultural factors among the research group from the Indian diaspora. First, the prevailing cultural explanations for suicide in the Indian diaspora are assessed. Next, the concepts of cultural script of suicide and habitus are explored for their potential to single out cultural contributors to suicidal behavior. For the ex-post identification of cultural factors involved in suicide, the concept of cultural autopsy of suicide is introduced.

Indra Boedjarath is a psychologist-psychotherapist who performed current research as an external PhD candidate. She has gained extensive expertise in the field of culture and health during her long experience of working as a practitioner and as a manager in the mental health care. In a variety of ways (e.g., lectures and publications) she advocates the inclusion of cultural diversity in health issues.

CULTURE AND SUICIDE

INDRA BOEDJARATH

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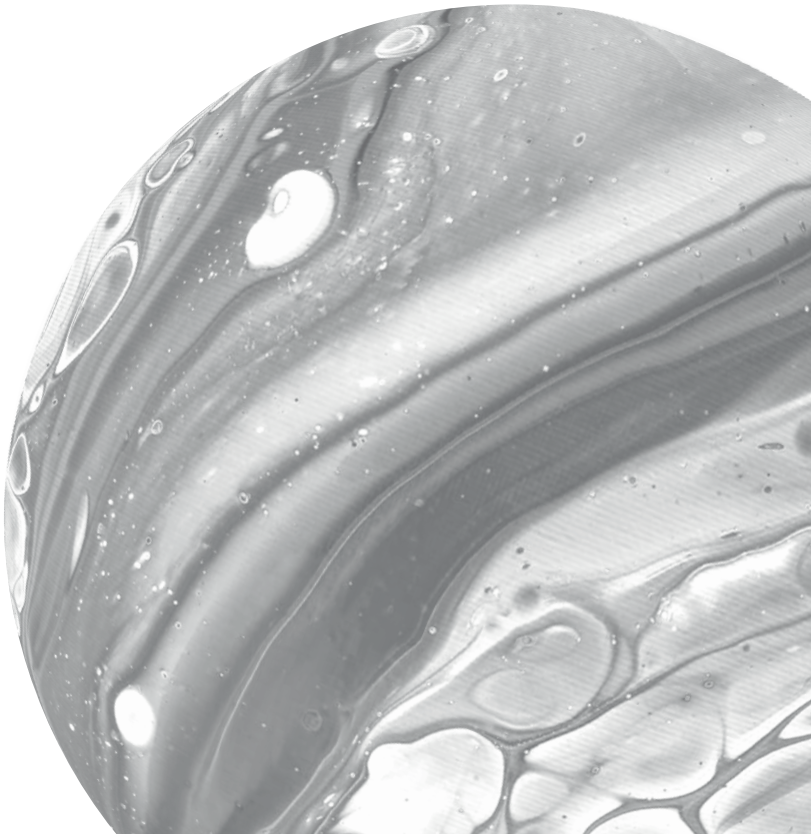
Contents

Glossary

Abhiman	Sanskrit for pride or vain glory
Aili Gaili	Indian dialect spoken in Guyana
Ájá	Grandfather from father's side
Átman	The unaltered, non-material self
Awadhi	Indian language prevalent in the Uttar Pradesh region
Bhojpuri	Refers to one of the Indian languages spoken in the Bhojpur-Purvanchal region or to the regional origin
Bhut	Ghost
Dádá	Father's older brother
Dharma	Religious/moral law for individual duties, rights, virtues and so on
Dharna	A fast held at the door of an offender as an appeal for justice
Diwáli	Festival of lights
Eid	Islamic holiday connected to Ramadan or the feast of sacrifice
Gawn ke nata	Relational ties of people from the same neighbourhood
Girmitiya	Indians under contract during the colonial period under British rule
Harám	Islamic concept that points at forbidden or sinful activities
Hindustáni	Indians or their descendants; also refers to their language
Imám	Muslim predecessor
Ijjat	'honour' (Sárnami spelling)
Izzat	'honour' (Urdu spelling)
Jahaji-bahan	Ship-sister
Jahaji-bhai	Ship-brother
Jauhar	Mass self-immolation or suicide of women in response to defeat in a battle
Kadar	Divine predestination
Káfir	Unbeliever
Káka	Father's younger brother
Káki	Wife of father's younger brother
Kantraki	Indians under contract during the colonial period under British rule
Karma	Combination of cosmic and moral cause and effect that transcends lifetimes for spiritual growth
Khálá	Mother's sister
Kismat	Fate or destiny
Koelie	Offensive term; originally used for a low-wage labourer during the colonial period
Lajjá	Bashfulness connected to shame
Mahabharatha	One of the two major Sanskrit epics of ancient India

Mámá	Mother's brother
Manai ká boli	What will people say
Máng	Parting hairline
Mandir	Hindu temple
Mantra	A Sanskrit word, short phrase for prayer
Máthá pe likhal or sine pe likhal	Written on the forehead
Moksha	Liberation from the cycle of life and death altogether
Nána	Grandfather from mother's side
Náni	Grandmother from mother's side
Nasib	Fate or destiny
Nirwáná	Liberation from the cycle of life and death altogether
Pandit	Hindu priest
Paráyá dhan	Other's richness; this concept refers to the short stay at the parental house as she moves after marriage
Prayaga	Confluence of the rivers Ganga, Yamuna and Saraswati
Pujá	Hindu offering ritual
Ramáyana	One of the two major Sanskrit epics of ancient India
Ramleela	Hindu re-enactment of the life of Rama
Sallekhana	Practice of dying by starvation prevalent among Jains and Buddhists
Sanskrit	Ancient and classical language of India
Saram	Shame
Sarnámi	Indian dialect spoken in Suriname
Sati	Banned Indian tradition of widows' self-immolation after their husband's death
Seppuku	A form of Japanese ritual suicide
Sewá	The act of selfless service
Sindhur	Vermilion red powder
Sranang tongo	Lingua franca of Suriname
Stridharma	The duty of the wife
Takdir	Fate or destiny
Upanishads	Late Vedic Sanskrit texts of Hindu philosophy
Vedas	Large body of religious texts from ancient India



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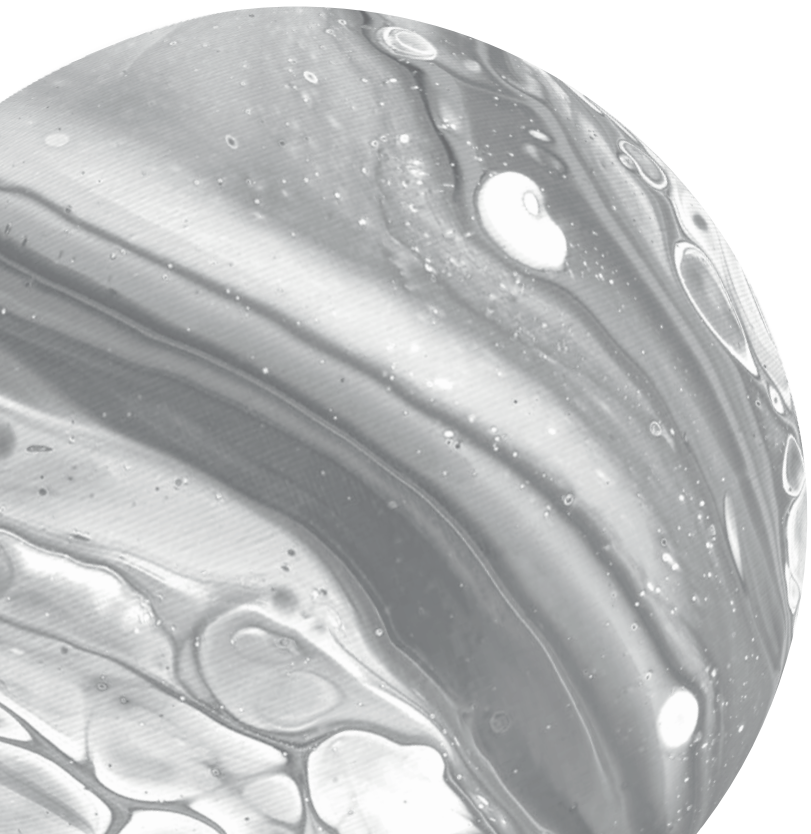

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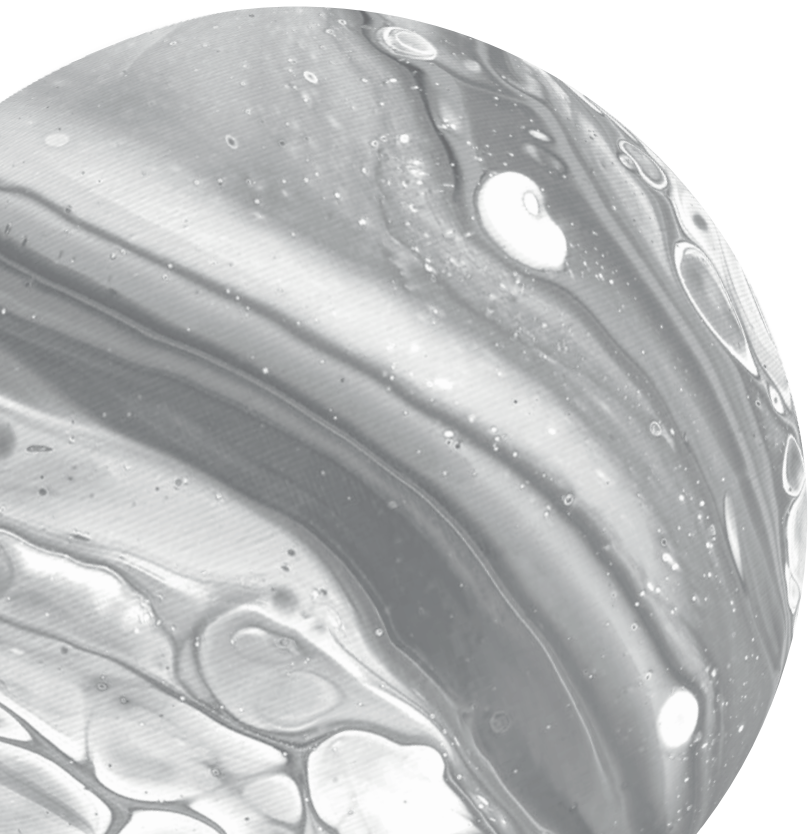

Chapter 1

Culture in suicide research

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Culture in suicide research

1. Introduction

> Four years ago, a Surinamese-Hindustani[1] woman died of a perforation of the stomach and peritonitis. She had swallowed concentrated acetic acid. Her suicide was thought to be the result of years of spousal abuse. He is now on trial for wilfully driving her to her death. A special case, as never before in Dutch history was someone accused of inciting to commit suicide. (Kerber, 1992; my translation)

Normally, the death would be seen as a suicide[2]. The coroner and doctors involved, however, who normally establish suicides, could not explain the woman's death unequivocally. The critical question was whether this was a self-inflicted death or an indirect murder (Maris, 1995, 2003). In the trial, a cultural expert witness explained that the husband and the wife were socialized in the traditional Surinamese Indian culture, in which suicide was not exceptional (Lamur, 1992). In this testimony, a relation between the suicide and cultural values was suggested, but the nature of the relation was unclear. Another expert witness argued that the woman failed to ask for help from her family, which he considered the norm in her culture, and that is why it went wrong (Kerber, 1992). This case illustrates that the relation between culture and suicide is not self-evident. Though the role of culture in the suicide was suggested, it appeared difficult to identify cultural forces in suicide. This difficulty to ascertain cultural factors engendering suicide is not limited to the discussed case. It is part of a much larger problem which is contained in the prevalent academic view on suicide.

The current academic interpretation of suicide is rooted in the historical development of religious and ethical views in Europe (Battin, 2015). The classical Greek-Roman culture interpreted death as a collective destination without moral connotation, and suicide (*mors voluntaris i*n Latin) was accepted and sometimes even recommended. In the wake of the Christian tradition, the notion of suicide acquired connotations of sin and crime. Several authors state that the pre-modern writings on suicide were philosophical, historical literary and interested primarily in the way suicide reflected cultural norms and meanings (Fitzpatrick, Hooker & Kerridge, 2015;

2 I adhere to the guidelines of the International Association for Suicide Prevention (IASP) in avoiding descriptions that have been noted to be stigmatizing as well as distressing to survivors, such as 'committed suicide'. See Appendix I for an overview of stigmatizing versus appropriate terminology, taken from Beaton, Forster, and Maple (2013).

Minois, 2001; Mulhall, 2001). In the age of Enlightenment, the individual and his or her autonomy, self-determination and the personal responsibility were emphasized. Since the French doctor Esquirol (1772–1840) named suicide a symptom of a psychiatric illness in 1821, suicidal behaviour (that is: suicidal ideations, suicide attempts and suicides) is foremost seen as a symptom or outcome of mental illness (Pridmore, 2015).

Worldwide, there is a strong focus on the individual in suicide research, regardless of the discipline that studies suicide. This is noticeable in the prevalent nomenclature. The very word 'suicide' is a Western neologism, which is composed of the Latin roots *suus* (own, self) and *caedere* (to murder) (Brancaccio, Engstrom, & Lederer, 2013). The focus on the individual is reflected in the prevalent view of suicide in suicide research, notably suicide as a process within the individual (Thompson, Dewa, & Phare, 2012; Turecki & Brent, 2016). This process is assigned a non-observable part and an observable part. The non-observable part, also called 'suicidal ideation', consists of suicidal thoughts and wishes. Passive ideation may become active, concrete and/or acute with ideas about taking action to end one's life, including identifying a plan, a method or an intent to act. The observable part of the suicidal process consists of the expression of the ideation, the execution of the plan by means of (preparation for an) attempted suicide and actual suicide. The length of the suicide process may vary from mere hours or even less to years.

The emphasis on the individual is reflected in the several definitions of suicide with a focus on the autonomy and agency of the individual. This is noticeable in the most prevalent definition of suicide: 'a fatal self-injurious act with some evidence of intent to die', as well as in the definition of suicide attempt: 'a potentially self-injurious behaviour associated with at least some intent to die' (Turecki & Brent, 2016, p. 1228). In these conceptions of suicidal behaviour, the individual is centred with his or her presupposed intention to perform a suicidal act deliberately and consciously. Euthanasia is a different practice of intentionally ending life, which is self-chosen but not self-caused. Euthanasia is legalized in some countries such as the Netherlands, where it is understood as termination of life by a doctor at the request of a patient (Kerkhof & van Luyn, 2016).

Suicide, nowadays, is predominantly seen as a result of an individual mental disturbance (Barzilay-Levkowitz & Apter, 2014; Klonsky, May, & Saffer, 2016). Suicide 'has become' a consequence of a (treatable) psychiatric disorder, a disease, and the suicidal person a patient, an object of investigation and treatment, rather than, perhaps even rationally, an acting subject, who has suicide at his or her disposal as an existential possibility. The non-psychocentric expressions of suicide, however, are – similar to the concept of a completed life – difficult to fit in the dominant view of suicide. In general, the suicidal person is being 'protected against the danger from him or herself'. This social sanctioning is assigned to psychiatry and psychology, who 'takes care' of the mentally disturbed by identifying risk factors and organizing prevention

and intervention activities. This worldwide spread conception originates from the Western culture.

The psychocentric view on suicide is inherent to the dominance of the main disciplines of suicide research, notably psychiatry and psychology. These two disciplines share the following characteristics: predominantly Western-oriented with corresponding standards and values, strongly individual-oriented, focus on respondents who receive(d) psychological assistance, focus on a cause-effect explanation and increasingly studied from a biomedical-psychiatric disease model (Hjelmeland & Knizek, 2017; Marsh, 2010). Within this psychocentric view, suicide as a phenomenon is invested in individual people. As an autonomous human being, the individual is attributed several characteristics that contribute to suicide, such as traits (e.g., impulsivity), personality (e.g., borderline) and behaviour (e.g., substance abuse). The strong focus on the individual is read in the ongoing medical-biological perspective of suicide (Hjelmeland, 2010). Hereby, researchers seek for disturbances in the genes that may explain suicide, and some speak of 'suicidal brains' rather than 'suicidal persons'.

The assumptions embodied in the dominant notion of suicide that centres around the individual and the psyche, however, implicate that collective forces engendering suicide, such as culture, have little room to be included. Consequently, cultural factors engendering suicide are marginalized. In addition, this results in a dominance of the researcher's perspective in expense of the actor's view. See Appendix II for an outline of the most used theories within psychology and psychiatry as well as a further discussion on the hegemony of the medical-psychiatric model. The hegemony of the medical-psychiatric model forms a partial explanation for the omission of culture in suicide research. The hegemony is the result of a broader phenomenon that is rooted in the Western society where the individual and ratio are centred and then reflected in all social and life sciences.

Some manifestations of suicide are difficult to fit in the ruling individualistic and psychocentric conceptions of suicide. This accounts for self-inflicted deaths related to social or cultural factors, such as hunger strikes, political and social protest suicides, collective or mass suicides, ritual suicides, honour suicides and copycat suicides. Related phenomena are rampage shooters, and voluntary, intentional martyrdom, self-sacrifice and heroism, such as jihadist suicide bombers, Japanese kamikaze units or Buddhist self-immolation (see Battin, 2015). Incidentally, rampage shooters (most prevalent in the United States) are often depicted as mentally unbalanced, whereas suicide bombers are labelled as extreme, but rational, political actors (Lankford, 2018). Suicides can be provoked too, such as death/suicide by a cop when a person provokes to be shot death by a police officer.

In several Asian cultures, some deaths had traditional associations with prevalent cultural views about death and dying, such as *Sati* in India and *seppuku* in Japan (Battin,

2015; Bhugra, 2004; Canetto, 2017). An additional example is the use of *sallekhana* among Jains, a voluntary choice to die by starvation to achieve redemption from the cycle of life and death. According to the Native American Mojave, the death of both mother and foetus at childbirth as a result of breech presentation is caused by the intention of the foetus to die by suicide and kill the mother so that they may be united in the spiritual world (Lester, 2012). These forms of suicide, however, unsettle the dominant individualistic and illness-based conceptions of suicide. In that vein, Windt (2015, p. 711) concluded that it is a mistake to suppose that suicide always has 'a clearly definable meaning, or that deaths can be clearly classified as suicide or not'. He points out that in some cases, opponents call the act 'suicide', whereas proponents use terms such as 'self-sacrifice', 'self-caused accident', 'martyrdom', 'heroism', 'self-deliverance', 'self-defence' or 'aided dying'. Battin (2015) provided a collection of views of suicide around the world, both historical and contemporary. The presented views vary from suicide as profoundly morally wrong, or a grave sin, to the view that it is a rational choice, or a basic human right.

However, despite the medical-psychiatric model's hegemony, the disciplines such as sociology and anthropology and some subdisciplines such as transcultural psychiatry do focus on sociocultural factors of suicide. The latter has recently launched a thematic issue on suicide in the cultural context (Kirmayer, 2022). Although a promising ecosocial approach is suggested, the articles remain framed in the medical-psychiatric model. Within sociology, Durkheim's *Le suicide* ([1897] 1951) still influences sociological research on suicide. Durkheim attributed suicide patterns to the effects of general social conditions evident at specific times and/or among certain population groups. He argued that dramatic social change made some groups more vulnerable to suicide and suggested that suicide is a symptom of insufficient or excessive levels of 'social integration' and/or 'social regulation'. Durkheim developed four types of suicides: altruistic suicide (too high social integration), egoistic suicide (too low social integration), fatalistic suicide (too high social regulation) and anomic suicide (too low social regulation). See Wray, Colen, and Pescosolido (2011) for an overview of other, less influential, sociological theories.

Anthropological suicide research tradition provides growing evidence for the far-ranging impact of cultural variables on suicidal behaviour. Several scholars argue that the conceptualization, meaning, nature and causes, motives and risk factors and the methods used are shaped by cultural factors (e.g., Broz & Munster, 2015; Colucci & Lester, 2013; Hjelmeland & Knizek, 2017). Although culture is often used in a compelling way, this relatively small body of cultural research on culture and suicide has some characteristics that can be classified into three categories. The first and largest group of these studies is located on an aggregate level and demonstrates statistical correlations between different factors within the variety of suicidal behaviour. These studies demonstrate that the prevalence and nature of suicide vary according to time, place,

gender, age and ethnicity (Hjelmeland & Knizek, 2017; World Health Organization (WHO), 2014).

The culture relatedness of some epidemiological findings is pointed out too. This is the case with the so-called gender-paradox in suicidal behaviour, which refers to the strong predominance of men in suicide, whereas women outnumber men in suicide ideation and attempts (Canetto, 2017). This phenomenon, however, appears to be predominantly prevalent in Europe and the United States. The gender disparity in suicide in Asia is far less pronounced and sometimes even reversed, such as parts of China and India, where young women tend to have higher suicide rates. Other studies provide evidence for culturally and religiously differing permissiveness and acceptability of suicidal behaviour (Stack & Kposowa, 2015). Explanations for the noticed cultural forces, however, are lacking or are merely hypothetical and mostly framed in a medical model.

The second category of cultural studies is performed (psychiatrically diagnosed or hospitalized) among ethnic minorities in Western and non-Western countries. These studies often depart from the medical-psychiatric perspective or from sociological conceptions based on Durkheim ([1897] 1951) and as such focus on individual or social pathology. Although some manage to uncover cultural beliefs and attitudes (Colucci & Lester, 2013; Marecek & Senadheera, 2012), most of them apply models and theories, diagnostical manuals and questionnaires, which are designed to identify mental illnesses (Stack & Kposowa, 2015; Van Bergen, Montesinos, & Schouler-Ocak, 2014). As a result, while acknowledging the impact of culture on suicide, the operation of cultural forces remains uncovered.

The third category of studies, mostly from an anthropological perspective, centres the perspective of the research group. Scholars accentuate that as cultures differ in their constructions of reality, their meaning systems and their socialization patterns, differences emerge in all aspects of behaviour, including suicidal behaviour (Broz & Munster, 2015; Staples & Widger, 2012). These studies provide insight into the actor's world, though they are merely empirical and often based on single cases (Marecek & Senadheera, 2012; Staples & Widger, 2012). Although westerners have a culture and an ethnicity too, anthropological studies on their suicidality are virtually absent. Neither is the Western culture elaborated; it is often implicitly referred to.

The cultural studies on suicide increasingly establish associations between culture and suicide. However, these studies suffer from some problems. The main problems are the following: the studies mostly generate knowledge on an aggregate level and lack thorough understanding of operation of culture at a case level; the researcher's academic perspective prevails at the expense of the actor's view, which means that the examined behaviour is fit in the existing models often larded with the mainstream individualistic view; theorization is lacking; and culture is often used in a way that has compelling implications. Consequently, despite the burgeoning literature on culture

and suicide, it remains unclear *how* culture fosters suicide.

2. Centring culture

Culture is a highly debated conceptual construct with hundreds of definitions that are formulated over time. Kroeber and Kluckhohn (1952) listed more than 160 definitions. Ever since, some definitions are adapted or rejected, and new ones are formulated. Next to time-bound influences, the conceptualization of culture is largely influenced by the academic disciplines, whereof sociology, anthropology, psychology all have their own accents in defining culture.

Throughout the years, some major contested issues stand out in the way culture is addressed. The static notion of culture is one of those issues, wherein cultures are observed as instilled or frozen. Especially non-Western cultures in the West were typified as such in the literature (Van Dijk, 2020). Migrant cultures were reduced to a static image of the culture as present in the country of origin, and the dynamics of migration were not taken into consideration, or the individual and social contexts were left out due to the focus on 'the' culture. Nowadays, it is generally accepted that culture is dynamic and complex. From this perspective, some processes that bring about major changes in cultures, such as migration and acculturation, are better understood (Kirmayer & Ryder, 2016; Van Dijk, 2020).

A dominant notion of culture is that it characterizes a group of people who are homogeneous. This conception has a compelling implication that all people in a culture will behave and react more or less in the same way. However, sociodemographic aspects such as gender, religion and class lead to a large heterogeneity within cultures. Due to these intracultural variations, not all persons of a cultural group do abide, at least not equally, by the prevailing cultural conventions. In addition, an often-neglected aspect is the differing power structures, which is most apparent within kith and kin and in the larger community. The specific constellation that arises from the intersection of features such as gender and age impacts behaviour. This implies that behaviour is also influenced by the differential (power-related) position of a person in the family or community (Kagawa Singer et al., 2016).

To avoid outdated definitions of culture or those with a partial focus, I strive for a notion of culture that should include a focus on culture from the actor's perspective, as well as how culture operates in the individual and the group, and a notion that has a non-compelling character.

A theoretical framework that fits these requirements is that of Strauss and Quinn (1997). According to Strauss and Quinn (1997), some modes of sharing stand for culture. They adduced three modes of culture sharing, notably cultural exemplars (an object referred to as a prototype of an idea), cultural templates (a shared, coherent and internalized set of ideas) and shared goals (goals of a community). A community, then,

is characterized by relatively stable shared interpretations of situations, objects and so on. In the cultural sharing, the cultural meaning is of importance. Strauss and Quinn's notion of cultural meaning is based on cultural schemata, which are shared mental representations among people with the similar socially mediated experiences. As such, cultural meaning is the interpretation induced in a person at a certain moment by an object or event. Next to being shared, Strauss and Quinn (1997) regarded the schemata and interpretations as cultural when they tend to be consistent over a period of time, thus with similar, self-reinforcing, interpretative results. Given the sustainability of the schemata, cultural meaning tends towards stability too. Strauss and Quinn considered this tendency towards stability a characteristic of the generalized, public culture and the individual's personal hold on it.

Strauss and Quinn's theory contains another relevant aspect. They advocate that culture is both public and private, both in the world and in people's minds. They denote the inner and outer worlds as interlinked but distinctive spheres. This way of thinking about culture is present among other scholars too. Kirmayer and Ryder (2016) outlined that nowadays the mutual constitution of culture and mind is common knowledge. Culture, then, is found as a characteristic 'inside' the person (affecting psychological and behavioural processes) as well as 'outside' the person (present in collective rules, norms, meanings, etc.). The 'inside' is formed through day-to-day interaction with people of the same group by which cultural practices are acquired, learned and internalized. The 'outside' consists of shared ideas, customs, norms and so on; thus, a certain degree of collectiveness. This comprehensive thinking about culture can be helpful in studying suicide.

Some scholars argue that the operation of culture as manifest in the 'inside' and the 'outside' is present in the cultural meaning of suicide (e.g., Colucci & Lester, 2013; Kral, 2011). They suggest that in the cultural meaning, the motivation for suicidality is enclosed. Kral (2011) and Lester (2012) argued that it is the cultural meaning people attach to a disturbing life event that makes them engage in suicidal behaviour. Strauss and Quinn (1997, p. 6) stressed that 'a cultural meaning is the typical (frequently recurring and widely shared aspects of the) interpretation of some type of object or event evoked in people as a result of their similar life experiences'. This implicates that the cultural meaning includes the embedding, internalization, interpretation and mental representation of suicidal behaviour, as well as cultural comments on it, the associated attitudes and the way a (cultural) group communicates about it (Colucci & Lester, 2013). By suggesting a mode of operation of cultural meaning in suicidality, these scholars accentuate that suicide does not (solely) emerge from the 'inside' or in the mind; rather, they underline the role of the historically and culturally inherited practice of suicide.

Aligning with Shneidman (1996), Krall (2011) stated that suicide is a cultural phenomenon, which is learned and expressed in the same way as other culturally

learned ideas and behaviours. He accentuated the role of cultural mimesis in suicidal behaviour (2011, p.7): 'If mimesis, imitation, is how culture works, and is how we learn almost everything we do and how our identities are formed, there is no reason to think that suicide is any different.' With the idea of cultural mimesis, Kral underscores Shneidman's distinction between perturbation and lethality. Rather than leading to suicide, perturbation merely motivates people to decrease or stop it: the way people do this differs. This implicates that the lethality of suicide, then, is situated in the culturally available (scripted) option of suicide as a way to stop the perturbation. By adhering a crucial role to the cultural meaning in suicidality, Kral (2011) following Marsh (2010) stated that the dominant psychocentric view is a mistake.

3. The research questions

Most of suicide research arises from two main disciplines, notably psychology and psychiatry, which are framed in a medical-psychiatric model with roots in the Western world. The worldwide application of this individualistic model infused with Western standards creates a biased understanding of suicide. As a result, culture has a marginal position in suicide research. Nonetheless, some disciplines such as anthropology and sociology and subdisciplines such as transcultural psychiatry do focus on culture in suicide research. The bulk of this cultural research claim to produce correlations between different factors within the (ethnic) variety of individual suicides. Some manage to gain qualitative understanding of culture and suicide.

In addition, the cultural studies mostly produce knowledge on an aggregate level, with a lack of substantive understanding. Often the researchers' academic perspective prevails. As a result, the actor's perspective is neglected. Furthermore, the relation between culture and suicide lacks theorization. Consequently, despite the burgeoning literature on culture and suicide, it remains unclear *how* culture fosters to suicide. This gap in scholarly knowledge suggests inquiring about the underexposed cultural factor in suicide. Given the unclear relation of culture and suicide, an explorative research is most suitable to approach the cultural factors engendering suicide. Acknowledging the protective influence of cultures for suicidal behaviour, the main focus will be on the cultural contributors. To that end, the following main research question is formulated:

How do cultural factors foster suicidal behaviour?

To answer this main question, an exploration is needed of the cultural factors of a group with sufficient homogeneity in their cultural distinctiveness. Such an exploration may contribute to highlighting the specific cultural forces fostering suicide, as a significant portion of societies' suicidal behaviour is concentrated in specific ethnic groups. To that end, the Indian diaspora is selected as the research group. The Indian diaspora comprises about 30 million people living in several countries as non-resident

Indians (NRIs) and (descendants of) Persons of Indian Origin (PIOs) (NRIOL, 2022). I focus on a specific part of this widespread diaspora, notably a group that consists of descendants of people from North-East India who migrated in the 19th and the 20th centuries to several countries, the so-called girmitiya[3] or kantraki. This group has high rates of suicide combined with low rates of psychiatric disorders causing suicidal behaviour (Bhugra, 2004; Burger, 2013). And they have own cultural conceptions of suicide. Acknowledging the protective influence of cultures against suicidal behaviour, the main focus will be on the cultural contributors.

There are two categories of explanations to research this population: the prevailing explanations of the Indian diasporic people themselves and those prevalent among the researchers who have examined these groups' suicidal behaviour. Next to the prevailing explanations in the diaspora, I resort to some theoretical concepts to account for the cultural forces. This is necessary as theorization is flawed in cultural suicide research. From the scholarly literature, I have selected some concepts to work with. These concepts seem to be culturally sensitive and centre the actor's perspective. I have singled out the concepts of script and habitus that focus on conditioned behaviour.

In addition, I have selected a concept that is prevalent among practitioners in the medical and psychological fields. Professionals use an analysis method in the post-mortem determination of the cause of death, called 'autopsy', whereof the psychological autopsy is dominant and the sociological autopsy is scantly applied. The psychological autopsy's focus on mental issues, however, neglects cultural factors engendering suicide. And the sociological autopsy mimics the psychological autopsy while focusing on sociological factors. The availability of an autopsy method that focuses on cultural aspects may be extremely useful for practitioners. With such a cultural analysis method, professionals can broaden the focus of post-mortem examination of suicides. They may reveal cultural forces that were involved in the studied suicide, which may contribute to a comprehensive understanding of suicides – hence, an attempt to construct a cultural autopsy method.

Considering the chosen research group and the need to explore the relation between culture and suicide, the answer to the central question will be indicated by the answers on the following sub-questions:

3 The denominations girmitiya (derived from 'agreement') or kantraki (derived from 'contract') both refer to Indians under contract during the colonial period under British rule.

1. What are the prevailing explanations of suicide in the Indian diaspora?
2. How useful is the concept of cultural scripts of suicide to comprehend suicide?
3. How suitable is the concept of ethnic habitus to account for cultural factors involved in suicidal behaviour?
4. Is it useful to develop a cultural method for suicide examination?

The first sub-question aims to identify prevailing explanations of suicide in the research group and among the researchers who have examined this group's suicidality. Although high suicide rates in the Indian diaspora are repeatedly mentioned in the literature, the suicide phenomenon as well as the communal explanations are hardly mapped out. To disclose the prevailing explanations as present in the research group and among the researchers, literature from six *girmitiya* countries in the Indian diaspora is targeted for examination. I will search for the perspectives, the similarities and the differences in the explanations and their inherent assumptions.

The second sub-question enquires whether the concept of script is useful to deepen the understanding of cultural factors contributing to suicide. The scholarly literature has offered the concept of cultural script of suicide. This concept seems promising as it centres the perspective of the actor, and it seems to offer a lead to reveal culturally rooted behavioural patterns related to suicide. However, its individual foundation urges to rework the concept first and subsequently probe its potential. To that end, a stretch stretch of the concept is attempted to substantiate its cultural character and use it as an instrument in exploring cultural forces that foster suicide.

The third question explores the concept of habitus to account for cultural factors related to suicide. The habitus concept theorizes the conditioning or internalization of culture as well as the (re-)production and enactment of it in the public cultural world of artefacts, texts and practices. The attractiveness of the concept of habitus is that, unlike many usages of the culture concept, it leaves the outcomes open. For that purpose, the habitus concept as suggested by Bourdieu is reworked to ethnic habitus, hoping that it will catch cultural forces without being compelling in its outcome.

While the first three questions arise directly from the central question, the fourth sub-question focuses on a somewhat different topic with its own argumentation, discussion of relevant literature and explanation of the methods, and so on. The focus of the last question is on the ex-post suicide examination and aims to construe an analysis method to determine 'post-mortem' the cultural forces that were involved in the suicide. The monopoly of a psychological autopsy in this field, hampers the possibility to identify cultural forces after the suicide. The cultural autopsy may complement the current autopsy methods. It is a tempting and challenging exercise but worthwhile trying, because the suicide-professional field lacks tools to capture ex post cultural factors fostering suicide.

4. Relevance

By centring the relationship between culture and suicide, this thesis contributes to the scholarly literature on suicide, in general, and on cultural knowledge of suicide, specifically. This thesis strengthens the cultural pillar in suicide research by offering the scholarly field alternatives to study suicide. This is a rare exercise in the field of suicide studies. Specifically, the revised concepts of cultural scripts and ethnic habitus, which can be applied to any research group, may ease the identification of cultural forces engendering suicide. The construction of an analysis method of cultural autopsy is also a novel exercise. Irrespective of the outcomes, the exploration is in itself a stepping stone in the scholarly endeavour to disclose the relation between culture and suicide.

From a social and policy perspective, this research adds to the body of practical knowledge for professionals and practitioners in the field. The discussion of culturally different views contributes to the awareness of the limits of the dominant view in suicide approach. This thesis offers important clues for developing prevention and intervention strategies for migrant groups, in general, and for Indians, specifically. Both (mental) health and educational professionals can derive directions from the findings to recognize and identify cultural aspects involved in suicide. Moreover, a gap is filled on substantive knowledge of specific groups of Indians, such as the knowledge related to male Dutch-Surinamese Indian suicides, which is hardly qualitatively examined. Furthermore, the examined group may benefit from this research, for example, by addressing the incidence of suicide and by discussing the cultural obviousness of suicidality.

A specific relevance of this research lies in the attempt to develop a method as an alternative to examine suicide from a cultural perspective. Herewith, a gap is addressed in ex post suicide examination that lacks a cultural analysis method. The endeavour to construe a tool, and the results of a first try-out, offers the field of practitioners a tool for suicide examination that aligns with the cultural specificities of the examined group. Although the construed analysis method needs validation in the field, it offers a focus to search for cultural factors involved in the suicide. Such a method, moreover, may perform as a complement to the prevailing individual-oriented analysis method of psychological autopsy.

In describing the operation of forces involved in suicide in the Indian diaspora, additional information on Indians is revealed. Much of the information may be relevant for researchers and practitioners of several disciplines. The heterogeneity of this group's cultural history is featured, and at the same time, intrinsic aspects of the culture are described in their glocalized form. Herewith, the dynamic character of the Indian diaspora is addressed. Furthermore, this thesis provides insights into family structures and gender-specific socialization, because suicide among Indians often is related to interpersonal relationships within the family context and has a pronounced

gender differentiation.

5. Structure and outline

Because of the exploratory nature of this research, the chapters can be methodologically described, without specifying the expected outcome as in hypothesis testing. Yet, the expectation is that the chosen route with the diversity of research questions will indicate how cultural factors foster suicide. Each chapter describes its appropriateness for studying cultural factors engendering suicide from differing perspectives as well as the methodology and required data to answer the relevant research question.

In the second chapter, I discuss the theoretical concepts, the research group and the methodology of the research. After having delineated why explorative research is most suitable, I discuss the nature of the theoretical concepts, which are finally typified as sensitizing concepts (Blumer, 1954). Next, the fit of the research group is discussed in relation to answering the research questions. In the methodology section, I devote some notes on my positionality, reflexivity and situated knowledge as a researcher that shares the cultural background with the research group. The diversity of data collection from different sources is discussed too in terms of data and method triangulation.

The third chapter aims to answer the first research question. By focusing on *girmitiya* countries, the prevalent explanations are explored as is held by the examined group and the researchers. Time and place are both discussed, by exploring the explanations from the indenture period to the present in six countries. In so doing, important characteristics of the suicidal behaviour of the studied countries in general, and more specifically for Indians, are detailed (e.g., Burger, 2013; Graafsma, Westra, & Kerkhof, 2016). Various perspectives are disclosed, and the differences and similarities in the identified explanations are discussed. In mapping the explored explanations prevalent in the *girmitiya* countries, their perspectives and limitations are discussed.

Chapter 4 addresses the second question by examining whether the concept of cultural script of suicide captures cultural factors as claimed by some scholars (Abrutyn, Mueller, & Osborne, 2019; Canetto, 2017). I discuss the script concept and broaden the cultural dimension of the cultural script of suicide, as well as strengthen its theoretical foundation, which makes empirical probing possible. The cultural scripts of suicide concept will be applied on the male Dutch-Surinamese Indian diasporic community in the Netherlands. I conclude with an evaluation of the appropriateness of the revised version of the cultural script concept.

The third question will be answered in Chapter 5, which employs the concept of habitus that recognizes individual processes as well as conscious and unconscious forces (Bourdieu, 1990). This concept aims to identify culturally conditioned elements of suicidal behaviour by focusing on dispositions originating from internal representations of external structures. However, given the concept's focus on individuals and classes,

I redefine the concept into ethnic habitus. The revised concept enables to highlight collective forces, that is, cultural dispositions as embodied in ethnic habitus rendering suicidal behaviour.

Chapter 6 deals with the fourth question. Considering that post-mortem examination of suicides is performed predominantly by psychological autopsies, which merely examines the individual contributors (Hjelmeland & Knizek, 2017; Shneidman, 1996), this chapter conceptualizes and introduces a cultural complement for the examination of suicide. The aim is to uncover ex post cultural factors of suicide. Next to constructing the method of cultural autopsy, results of a first try-out of the cultural autopsy will be presented.

The concluding chapter provides an answer to the central question. It evaluates whether the theoretical concepts and employed methods have yielded a suitable outcome. The findings are set against the problems that are delineated in this introductory chapter. This confrontation highlights the shortcomings of the current scholarly practice concerning the culture–suicide relation. The chapter includes a discussion about the research results' meaning and implications for the field of suicide study, both academically and practically. In so doing, the research engages with current conceptions and practices in suicide research and closes with pointing out some limitations and suggesting a few lines for further research.

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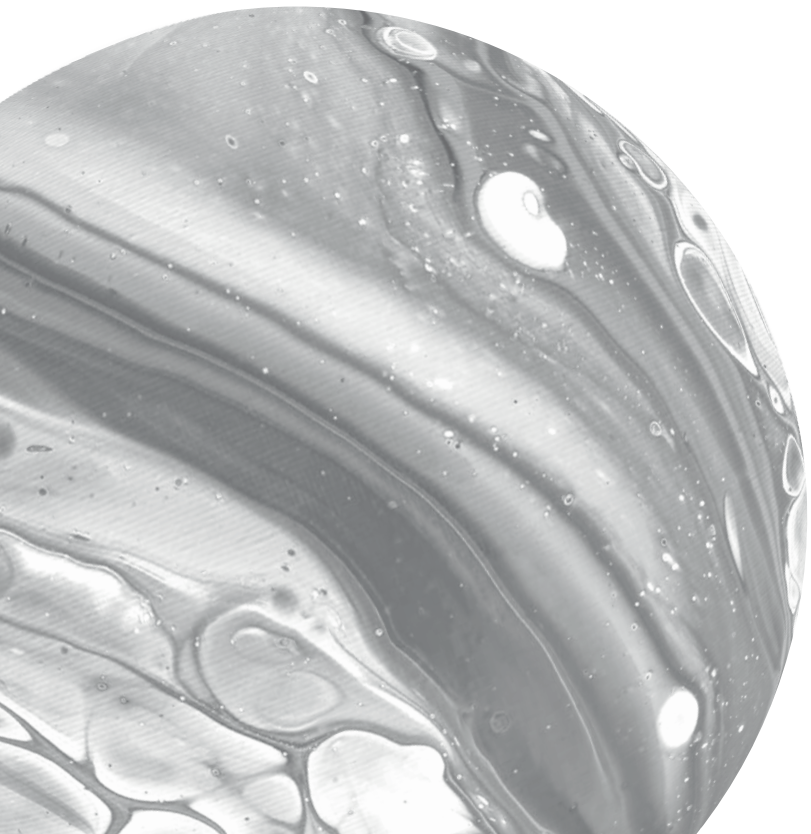

Chapter 2

Theoretical concepts, research group and methodology

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1. Introduction

This research design differs from the majority of suicide research that adheres to the medical-psychiatric model with a psychocentric orientation (Hjelmeland & Knizek, 2017). On the contrary, the current research required an alternative research strategy, one that allows the examination of cultural factors involved in suicide. The alternative should pursuit an understanding of the relation between culture and suicide with an open search strategy. An exploratory research strategy seemed most suitable, because it allows to examine concepts and relations that are not crystallized beforehand, in an attempt to acquire further understanding (Charmaz, 2012; Creswell & Plano Clark, 2007). The adherence to an explorative approach impacts the major elements of my research, notably the strategy, the conceptual framework, the identification of research group as well as the methods and procedures used for collecting and analysing data. The explorative strategy combined with the non-compelling notion of culture was centralized and used as a starting point for the selection of theoretical concepts.

The potential to explore the relationship between culture and suicide was foregrounded in the selection of theoretical concepts. This implied that the concepts either had to meet the explorative nature of the research and the non-compelling notion of culture or had the capacity to be infused with it. Therefore, the concepts of script, habitus and autopsy were selected from the scholarly literature (Bakst, Braun, & Shohat, 2016; Bourdieu, 1990; Canetto, 2017). Despite these concepts' suggested receptiveness for the study of culture, they had to be made fit for explorative use. The concepts' somewhat definitive characteristics (a precise and clear description with a built-in direction to the outcomes) had to be turned to sensitizing ones with a general sense of reference and guidance to the outcomes (Blumer, 1954).

To apply the adjusted concepts to identify cultural factors active in suicide, the Indian diaspora was selected as research population. Like all diasporas, the Indian diaspora is heterogenous in terms of migration, place of departure and of arrival, acculturation and so on. Despite the heterogeneity, this diaspora fits the intended exploration because of some important similarities, including their distinct cultural features and the high suicide rates all over the Indian diaspora (Gautam, 2013;

Gowricharn, 2021b; WHO, 2022). The most important similarity was the group's internal ethnocultural continuity. Diaspora Indians have established a transnational community with local specifications such as languages and religion or the consumption of Indian cinema (see Chapter 3).

The undefined relation between culture and suicide required a variety of data and methods to explore the Indians' suicidal behaviour, such as literature study, case file examinations, in-depth interviews and participatory observation. This variety offered the opportunity to cross-check and to pursuit a comprehensive understanding of the suicide phenomena. This triangulation helped to confirm or refute the findings, and it increased the credibility and validity. Moreover, triangulation is considered more suitable to study the complex phenomena of suicidal behaviour (e.g., Hjelmeland, 2010; Kral, Links, & Bergmans, 2012). As part of the data triangulation, opportunistic research was appropriate, notably, the use of inside knowledge I have built up over time as Dutch-Surinamese Indian and as a psychotherapist. Yet, these positions needed extra consideration in terms of researchers' reflexivity and positionality.

In the following sections, the rationale for the selection of the concepts of script, habitus and autopsy is discussed first. The concepts' nature is delineated as well as the adjustments made to make them fit to examine cultural aspects of suicide. Subsequently, the research group and the methodology are outlined, and their suitability for the exploration is discussed. Although each empirical chapter includes a tailored method section and a description of the research group as relevant to that chapter, at this point, both are discussed comprehensively in relation to the explorative search strategy. Some reflexive remarks are added on my position as a researcher-practitioner who shares a cultural background with the research group. In the conclusion, I present an evaluative reflection on the major issues of this chapter.

2. The nature of the theoretical concepts

In the search of suitable concepts to unravel cultural aspects of suicide, the fundamental concepts of my research, notably, culture and suicide, provided some directions. Hereby, Strauss and Quinn's (1997) theoretical framework was considered useful (see Chapter 1). Their concept of culture implies that the theoretical focus should give room to the actor's perspective to unravel cultural factors active in the research group. In addition, the concept should capture the prevalent cultural aspects involved in suicide as well as account for internal variation prompted by gender and age. The latter factors are known to influence the incidence of suicidal behaviour as worldwide men die more often by suicide and women attempt suicide usually, and similarly, some age groups are more vulnerable to suicide (Jaworski, 2010; WHO, 2022).

The selected theoretical concepts, notably, script, habitus and autopsy, or rather the adjusted versions, have the nature of sensitizing concepts. Blumer (1954) argued

that concepts are sensitizing when they are loosely defined and can give a general sense of reference and direction to collect and analyse data. Sensitizing concepts often align with the actor's perspective and sensitize the researcher for routes of enquiry. This contrasts with what he called definitive concepts which have fixed and specific procedures that prescribe what to look for and how to study a phenomenon. In this thesis, the sensitizing nature of the concepts implies that the specification of each concept differs per (sub-)culture and is empirically established. Only by examining the applicability of the concepts on the research group in an explorative way, thus only afterwards, it was possible to define whether the concept worked for the research group. Except for the focus on culture, little directions for inquiry existed beforehand.

The first concept I selected from the scholarly literature is the concept of cultural script of suicide (Abrutyn, Mueller, & Osborne, 2019; Canetto, 2017). Several scholars mention that they observe culturally scripted behaviour. Marecek and Senadheera (2012) noticed canonical narratives of suicidal behaviour that exist in all (sub-) cultures. This indicates obvious storylines that provide members of a cultural group with specific significance of suicidal behaviour. These storylines may get internalized and form a cultural template, one of the modes of culture sharing as mentioned by Strauss and Quinn (1997). This cultural template may guide the specific behaviour that may become scripted. Some scholars speak of cultural scripts of suicide.

In preparing the concept of cultural script of suicide to be empirically used, I first deconstructed the concept to make it fit for explorative use. In this process, the concept's theoretical foundation is enhanced. By starting at the core part of the concept, notably script, I rebuilt the concept to cultural concept and subsequently to cultural script of suicide. In this rebuilding, I theoretically substantiated how an individual concept such as script that resides in the memory of a person becomes cultural. In so doing, the concept's deterministic ring, as if everyone in the cultural group will resort to the suicidal scripts and act, was replaced by a loosely defined notion of culture, which neutralizes the compelling connotation and allows different outcomes due to in-group differences. Herewith, I align with Nordqvist (2021, p. 680) who states that scripting is both dynamic and given and should not be understood as determining human conduct but rather as 'fluid improvisations involving ongoing processes of interpretation and negotiation'.

The second concept I selected that needed reconceptualization recognizes both individual (conscious and unconscious) and structural processes, notably, the concept of habitus as used by Bourdieu (1990). Simply put, according to Bourdieu, habitus is a sustainable way of perceiving, thinking and acting. Whereas scripts focus on behavioural outcomes, habitus targets the underlying socialization and conditioning processes. As habitus centres the agent within the wider context of social structures, it allowed to bridge the gap between suicidal behaviour as a category of analysis and as a lived category of practice (Brubaker, 2013). Categories of analysis are experience-

distant categories that are utilized and examined by researchers, whereas categories of practice point at everyday lived experiences of social actors.

Although the habitus concept is less definitive compared to the other two concepts, script and autopsy, it needed some reworking before it could be exploratively used. Foremost, the class-based orientation of the habitus concept needed reconceptualization. Despite its representation of tendencies, the class focus needed to be replaced to focus on culture. Therefore, the concept was expanded and specified into ethnic habitus to capture culturally conditioned suicidal behaviour of the Indian diaspora. Because each group has its own specific ethnic factors, the operationalization has to be established separately according to its unique ethnic habitus. This approach leaves the individuality or uniqueness of the group intact, which eases to focus on the cultural factors of suicidal behaviour (Kachtan, 2019).

With their descriptions of internalization, dispositions and social reproduction, Strauss and Quinn (1997) aligned with Bourdieu's habitus concept. These processes, however, could not be grasped directly. The study of cultural processes in general, which involves the inner and outer, is to be done indirectly via the individual manifestations. Therefore, the interpretation of the observed phenomena was foregrounded in the study of the experiences of the actor who has internalized the shared interpretations or cultural meanings (Strauss & Quinn, 1997). This applies for both the script and the habitus concepts.

The third concept I selected is that of autopsy. An autopsy is the golden standard when the cause of death is uncertain. From the medico-legal and forensic settings, autopsies are expanded to other domains. This move has led to a well-established tradition in suicide research with the so-called psychological autopsy studies (Bakst et al., 2016). Although these psychological autopsies have a worldwide prime position in suicide examination, its psychocentric focus hampers the examinations of cultural factors. To overcome this problem, I addressed the shortcomings of current suicide autopsy studies, and I conceptualized cultural autopsy to identify ex post cultural factors. In so doing, an alternative method was created for the field of suicide examination.

By making the three selected concepts suitable for exploration and then applying them exploratively to capture cultural drivers of suicide, an alternative is offered to the field of suicide research. With the alternatives, suicide research can be culturally aligned to the research group. Next to the main concepts, I used some concepts culture specific to the researched group, such as reincarnation and related concepts, for example, *karma*. The concept of *izzat* (a gendered virtue, loosely translated as 'honour') is the other concept that is frequently used (Baig, 2012; Gunasinghe, 2015). Each of the main concepts (script, habitus and autopsy) was used in concert with some culture-specific concepts or its specifications. This combination appeared fruitful to garner the cultural drivers of suicide in its manifestations in the research group.

The Hindu religious concepts, reincarnation and *karma* and *moksha*, are used in some empirical chapters. The concept of *karma* points at the combination of cosmic and moral cause and effect that transcends lifetimes for spiritual growth. In the vernacular, however, it is used in the sense of fate or destiny. Among Muslim Indians, *kismat*, *nasib* or *kadar* is used to refer to fate or destiny too. These culture-specific concepts are applied together with the concepts of script, habitus or autopsy, predominantly in the vernacular sense. In other words, the way Indians use these concepts as an ethnocultural group instead of only in a religious sense.

The *izzat* concept, which is prevalent in several Middle Eastern and Asian countries, is used to a greater or lesser extent in every empirical chapter. The English translation of *izzat* to 'honour' does not cover the multilayered and gendered construct. As a multidimensional concept, *izzat* (or *ijjat* in *Sarnámi*, which is the Hindi dialect spoken in Suriname) is embedded in the Indian community as a communal virtue and value. *Ijjat* has implications on the societal, situational, relational and personal levels (Baig, 2012; Boedjarath, Vaassen, & Spaans, 2021; Gunasinghe, 2015). To a varying degree, each community member has the duty to uphold the community's *ijjat*. *Izzat* is the prevalent wording in Urdu. This wording is used Chapter 3 where several countries in the Indian diaspora are addressed. In the remaining empirical chapters that focus on Dutch-Surinamese Indians, the *Sarnámi* wording *ijjat* is used. Moreover, the *Sarnámi* wordings and spelling are used throughout the chapters that address Dutch-Surinamese Indian population.

Ijjat is also personal with two accents: *ijjat* is related to the extent one considers oneself virtuous and worthy of (self-)respect and related to the extent the community values one's moral worth. *Ijjat* is a complex concept and involves other concepts such as *face* and *failure*. Face is connected to *ijjat* as one can lose face when *ijjat* is threatened, tarnished or lost. The latter can be seen as a failure and lead to loss of face and induce *shame* and *guilt* in turn. Contrary to Western cultures where *loss of face* is primarily individualized (Goffman, 1955), in Eastern cultures, reciprocity is emphasized with a mutually restrictive, sometimes coercive, power that is exerted upon each member (see Baig, 2012; Boedjarath et al., 2021; Gunasinghe, 2015).

3. Research group

The focus on the Indian diaspora to explore the operation of cultural factors of suicide was challenging given this group's large diversity. The heterogeneity of this transnational group is characterized by differences in period of migration (from centuries ago to recently), reason for migration (business, indenture, education, labour), place of migration (regional origin as well as receiving country), group characteristics (e.g., religion, language, acculturation) and so on (Gautam, 2013; Gowricharn, 2021b). Moreover, the very concept 'diaspora' in a classical sense refers to a group of people

with a shared connection to one 'homeland'. For many in the Indian diaspora, however, India is not the (only) country of origin because they have migrated to other countries from the country of arrival of their parents/ancestors. Many of these people refer to the last (or previous – in case of two of more migrations) country as homeland as well.

The large heterogeneity raises the question to what extent diasporas in general, and especially the Indian diaspora, are suitable for the purpose of my research. I selected the Indian diaspora based on assumptions distilled from the scholarly literature that suggest some degree of homogeneity (e.g., Choenni, 2016; Gautam, 2013; Gowricharn, 2021b; Kumar, 2017). The assumed homogeneity can be summarized in three components. First, the Indian diaspora displays a continuity in their ethnocultural group formation in virtually all countries. This continuity is underlined with several internally, that is, within the group, organized forms of ethnocultural activities on several levels, such as education (special schools), cultural expressions (dance and theatre) and religion (mandirs and mosques).

Second, the Indian diaspora forms a transnational community. Despite the connection to the second or third homeland, India as the (ancestral) homeland functions as a reference. Although processes such as migration erode the classical version of the Indian culture, Indians carry a certain underlying sense of 'Indianness' in them, which was relevant for my research. Indianness is about similarities produced by an overarching Indic civilization, pre-eminently but not exclusively Hindu (Bal & Sinha-Kerkhoff, 2007; Gautam, 2013). This is noticeable in the features that are reinforced from institutions from India, such as Indian cinema, fashion and so on. In this vein, Gowricharn (2021b) argued that there are multiple forms of homemaking and that each generation creates its own home.

Third, locally, in the individual countries, Indians develop a specification of the overarching Indian culture, wherein processes of acculturation, cultural hybridization and individualization have a role. Gautam (2013) named these the external expressions (in organized ethnic associations once the interaction with the host society becomes negligible), in which Indians 'subscribe consciously to the broad principles of the countries' laws, code of conduct, language and public behaviour of the colonizing masters' (p. 3). Both Gautam (2013) and Gowricharn (2021b) suggested the co-existence of internal and external forces within this part of the Indian diaspora, notably, an inclination to change and to preserve the culture. This implies that the two forces of change and preservation are in flux, which results in differing connections to homeland India.

The observed internal cultural continuity in the Indian diaspora formed the main reason to select this transnational group. To increase the homogeneity, and with it the feasibility of the research, I focused on a selection of the Indian diaspora that arose in the 19th and early 20th centuries. This group consists of descendants of indentured laborers, the so-called girmitiyas (derived from *agreement*, referring to people under

contract) (Clarke, Peach, & Vertovec, 1990). The focus of this research was on the *girmitiyas* and their descendants in a selected number of countries, notably, Suriname, the Netherlands, Guyana, Trinidad and Tobago, Mauritius and Fiji. Except for the answering of the first research question in Chapter 3, this subset of the Indian diaspora was further narrowed down to the group of Indians that arrived in Suriname and whose descendants moved to the Netherlands, the so-called Dutch-Surinamese Indians.

The selected subset of the Indian diaspora has a diversity too. These differences are mostly related to the political, economic and social specificities of the receiving country, which influenced acculturation processes of the groups. Moreover, Guyana, Trinidad and Tobago, Mauritius and Fiji are Anglo-Indian as they were British colonies, whereas Suriname was a Dutch colony. The Netherlands is included as a large group of Indians from Suriname reside there. The specificity of each country has impacted to differing extent the Indians' language, food practices, fashion, religion and so on (Gautam, 2013; Gowricharn, 2021b). Concerning the religious affiliation, I focused on the two main Indian religions, notably, Hinduism and Islam, but inevitably most of the cases were of Hindu background, given the large share of the Hindus (about 75%) in the research group. Despite the internal differences in this subset of the Indian diaspora, the observed similarities in both adaptation to the 'new' land and preservation of (aspects) the Indian culture account for these countries too. In Chapter 3, the characteristics of the six selected countries are further discussed.

The fit of the Indian diasporic group for the examination of the potential of the adjusted concepts to capture cultural factors engendering suicide was underlined by some other arguments. With a share of 20% of all suicides worldwide as registered by the World Health Organization, India alone belongs to the biggest contributors of suicide (India State-Level Disease Burden Initiative Suicide Collaborators, 2018; WHO, 2022). The suicide numbers in the Indian diaspora are high too (see Chapter 3). Concerning the diasporic Indians, I ruled out that the high suicide rates were engendered by a specific situation in the 'host' society, as the group had high rates of suicidal behaviour in the whole diaspora (e.g., Silverman, Barnaby, Mishara, & Reidenberg, 2020; Toussaint, Wilson, Wilson, & Williams, 2015; Vijayakumar, 2015). Regarding the causes of suicide, relatively low percentages of psychiatric disorders are registered (Burger, 2013; Vijayakumar, 2015). This warranted a focus on the 'intrinsic cultural forces'. This focus is underlined with the group's inclination to cultural continuity.

A relevant characteristic is connected to the strong differentiation in gender. Indians know pronounced gender roles imbued with gender-specific cultural values and behavioural conduct. This gender differentiation is important considering that culture influences the gender specificity of suicidal behaviour. Gender embodies the normative distinction between men and women, which impacts suicidal behaviour (Canetto, 2017; Jaworski, 2010).

In addition, an argument – not necessarily linked to the group characteristics of

Indians – relates to the way they are represented in the scholarly literature on suicide research. As the Indian diaspora is historically and culturally not a part of the standard Western group whereupon various suicide research theories are based, their cultural specificity is not reflected in the prevailing suicide research and resulting theorization. To include their cultural specificities in this research, the culture-specific concepts (i.e., reincarnation, izzat) are used next to the main concepts (script, habitus, autopsy).

4. Methodology

The exploratory qualitative research approach has influenced the selection of the methods used to collect the diverse data and its analysis. I started with the general idea of a possible relationship between culture and suicide and used the exploratory research strategy to identify the operation of cultural factors in suicide in the Indian diaspora. Herein, the exploratory approach's built-in opportunity to adjust or change the search direction was supported by using several methods (Charmaz, 2012; Creswell & Plano Clark, 2007). This procedure resulted in a method and data triangulation, which suggests a more thorough research base and an increase in trustworthiness (Denzin, 1978). One part of the data was obtained by opportunistic research. The latter includes subjectivity, situated knowledge and reflexivity, and these issues are explicitly discussed.

4.1. Opportunistic research, researcher's positionality and reflexivity

Conventionally, ethnographic research was performed by Western (White, privileged) researchers in a non-Western (non-White, subordinate) research group, usually with a non-Western research assistant performing a mediating role. These traditional practices are challenged in the past decades incited by processes such as migration that gave birth to a globalized academic world, with a diversifying effect on the research setting as well as the relationship between the researcher and the research group (Adu-Ampong & Adams, 2020; Kempny, 2012; Narayan, 1993; Serrant-Green, 2002). As a result, changes in the traditional 'distance' between researcher and research group in knowledge, cultural background, resources and so on have led to a re- or dispositioning of the researcher, in some cases to an acknowledged participant (Denzin & Lincoln, 2003 Kempny, 2012). The reasoning of Montgomery and Pool (2017) fits here, who advocated a shift in 'from communities as the passive recipients of research to publics as actively and dynamically co-created with medical research and its findings.' Moreover, the research setting is not limited to a country's boundaries, because transnationalism makes migrants' lives simultaneously related to the host and the home society.

The change in the ethnographer's position is noticeable in the field of suicide research too, especially in the acknowledgement of the importance of 'native' or bicultural researchers. A native researcher examines a group from and/or in their shared own country, whereas a bicultural researcher is a migrant researcher who is

(equally) familiar with the native and the 'host' culture. Both are used interchangeably in the literature. In suicide research, several scholars (e.g., Garssen, Hoogenboezem, & Kerkhof, 2007; Hjelmeland, 2010) have called for same group researchers to perform suicide research among ethnic minorities. This would help to overcome an enfeebled cultural perspective, which may arise due to the Western cultural view that often serves as a standard. A shared ethnocultural background, or the insider position, is believed to have a position of intimate affinity, which makes a researcher more attuned to cultural nuance and better able to draw on experiential understanding. These calls, however, hold several problematic assumptions.

Certainly, the inside perspective adds to a richer and more nuanced context for understanding research data (Reyes, 2020). However, the cultural benefits are often overemphasized and tend to conceal the complex and often ambiguous position of the native researcher. Not seldom, being native or bicultural is equated to an insider. It assumes that the native or bicultural researcher is free from the dominant view and that he or she is self-evidently able to align with the research group. Moreover, the call for native or bicultural researchers assumes that the native or bicultural researchers will seamlessly align with the research group.

A further assumption is that native and bicultural researchers are able to shed the Western view they are virtually all schooled with (just because of the dominance of the Western view), whereas the Western researchers supposedly are not obliged or able to do that. The calls – often made by scholars in the discussion sections of their studies – suggest that the scholars have insufficiently considered the researchers' position and the subsequent complex dynamics in the interaction with the research group. It assumes that a shared ethnocultural background means that one is automatically familiar with the prevailing norms and values. These issues indicate that the native and bicultural researcher's position is complex and that he or she has to navigate actively between the different realities. Despite being an insider, or just because of it, the interaction of the positionalities of both the researcher and the researched needs active consideration, for the relation between the native or bicultural researcher and the researched is not unambiguous.

Narayan (1993) and Serrant-Green (2002) pointed out that the notion of the insider is inherently complex. Especially, the worn-out binaries such as insider–outsider or observer–observed are too simplistic because these positions are constantly shifting and subject to negotiation and interpretation in the research setting. The positionalities depend on (the encounter of) the intersections of education, experiences, gender, sexual orientation, class, acculturation and so on. In addition, the crosscutting identifications of both may differ slightly to enormously. Therefore, being an insider requires alertness on possible biases. In fact, all researchers (e.g., Western, non-Western, Black, White) should consider their own position in the research process and reflect on it. This accounts 'particularly in research into race and ethnicity', as Serrant-Green (2002) put

it, who experienced that as a Black researcher, she had to be more accountable for her actions from her different positions (researcher, Black, woman, insider) than her White colleagues.

Befitting the interwoven nature of my personal and professional roles in the research, notably, a researcher, a member of Indian diaspora and a practitioner, some considerations are appropriate here (Hay-Smith, Brown, Anderson, & Treharne, 2016). These considerations are related to the use of my inside knowledge. With it, some reflections are needed on my position as a native or a bicultural researcher as well as on my position as researcher-clinician within an ethnographic research context. Ethnography was an important part of my qualitative research design, because it enhanced the understanding of participants' behaviours from the actor's perspective, that is, centring their shared patterns of beliefs, values and behaviours. Herein, my insider's view was helpful, in giving room to, as well as in understanding, the participants' unique descriptions and interpretations, beliefs and experiences of suicidal behaviour. This approach was of importance because little is known about cultural drivers of suicide among the research group from their own perspective.

In my research, I have built on the cultural inside knowledge I had gained by being part of the research community and having decades of interaction with(in) the research group. This kind of fieldwork is a specific form of ethnographic research with an ex post strategy and is, among others, called 'emic research', 'research in own community', 'endogenous anthropology' or 'opportunistic research'. Each term has a slightly different connotation. I adhere to the term 'opportunistic research' (Gowricharn, 2019; Riemer, 1977). In opportunistic research, the initiative to conduct research arises in hindsight, without a beforehand available formal research design. Although the method of opportunistic research is well known, it is not widely used. Opportunistic research promotes the use of the vast stock of first-hand knowledge a researcher has access to while being an insider in one or more communities.

Especially the data collection benefits from the advantages of opportunistic research: easy entry into the research setting, larger rapport between researcher and researched and better interpretation due to prior knowledge of the research group. The uniqueness of the researcher is valued too, as Riemer (1977, p. 475) noted: 'Not only are the observations partially unique to the investigator, but the investigator himself is unique by virtue of being an insider.' Gowricharn (2019, p. 10) aligned with Riemer and stated that 'the participation over a long period and discussion about the observations with community members offer repeated opportunities to "cross-check" data and preclude or minimize distortion in their representation.' My command of the inside knowledge of the research group as part of my biography and life experiences eased the access to the group as well as the collection, verification and the interpretation of the data.

Opportunistic research may have methodological disadvantages, such as the

difficulty to replicate the research. In this vein, Pool (2017) discussed the hybridity of ethnographic data, as these data can be hard (verbatim transcripts) or soft (memories). Though there is not a clear line between the two, hard data can be verified and soft data cannot. Although soft data are essential for ethnographic understanding, the ways to make these explicit (and verifiable) by inserting quotes, dates and so on represent a limited option. Moreover, I noticed that the soft data reproduction is related not only to the memory of the researcher but also to that of the researched population. I tried to avoid the disadvantages of opportunistic research, such as losing an objective view and taking things for granted by regularly discussing the findings with researchers and professionals from a group of interdisciplinary and multi-ethnic peer researchers.

The duality of remembering and forgetting often leads to partial memories and thus partial understanding of the examined issue (Haripriya, 2020). The question arises, though, whether it is not an illusion to strive to fully understand an experience in the past by exploring the memories in the present. This seems an impossible task. I endeavoured to minimize the inherent disturbances of the soft data, that is, memories, by applying data triangulation, peer review and consultation to enlarge the trustworthiness. See Sections 4.2 and 4.3.

Nonetheless, extracting an event from the memory to use it as data in the here and now can be challenging. This was the case with respondents who recalled suicidal behaviour from years ago. I tried to deal with this kind of challenges to provide the context and time in the processed data as much as possible. At the same time, when I noticed 'outdated' information (i.e., outdated to me), I first checked the meaning it had for the respondent and cross-checked it with peers to weigh the data. For example, the case of stifling practices of a mother-in-law towards her daughter-in-law; these practices have become rare in the past decade among Dutch-Surinamese Indians, whereas it is prevalent among Indians in some of the other studied countries.

Positionality requires reflexivity. Kempny (2012, p. 42) described reflexivity as 'a self-conscious reflection of how one is located within certain power structure and how this may influence methods, interpretations, and knowledge production'. My personal background differs in several ways from the respondent's background. In migration circumstances we differed, for example. Whereas the majority of Dutch-Surinamese people migrated just before the independence of Suriname in 1975, mostly in a nuclear family setting, I migrated earlier to grow up in a recomposed and blended family.

The traditional Surinamese Indian values and norms were transmitted by family members in the Netherlands and by my parents from Suriname via telephone calls, letters and spoken tapes. In these (international) upbringing practices, educational performances and gender-specific values were emphasized. At the same time, growing up in a Dutch environment, with Dutch peers, I got familiar with the Dutch values and conventions. I developed a bicultural identity and learned to switch flexibly between the two cultures and several languages. This creative balancing was useful in

the research, as I had to balance between the different roles (i.e., researcher, Dutch-Surinamese Indian, female, psychotherapist). Besides my family, I didn't have much contact with other Indians, until I became a committee member of a multicultural women's organization during my study. Herein, I differed from the majority of Indians too. Whereas others were like a 'fish in the water', I had a selective knowledge of the Indian community until my study. The effect this process had on me was that I was curious to understand customs and traditions and therefore asked a lot of questions. This inherent combined distance and proximity characterized my position in the Indian group throughout my life.

Moreover, during my study, I developed a social engagement with countering gender- and ethnicity-related exclusions in general, and specifically among Indians, by partaking in public debates, publications and so on. After my study as a psychologist and psychotherapist, I continued speaking on conferences and other meetings, also within the Dutch-Surinamese Indian community and on Dutch-Surinamese Indian TV channels, on different subjects.

I noticed ambiguous reactions of the Dutch-Surinamese Indians on some subjects I discussed. Mostly, I was proudly appreciated for my work, and the 'educational position and bravery', especially for discussing subjects that were taboo, such as suicidal behaviour and sexual abuse. On the contrary, I was countered by other Indians for appointing publicly these sensitive subjects. Some of them questioned my findings and asked for proof, which I came to understand as being held responsible for breaking the code to not wash the dirty linen in public, which is connected to the Dutch-Surinamese Indian social steering code manai ká boli? ('what will people say?'). The latter attitude of the community reduced over time, probably because the sensitive subjects were increasingly discussed in the society (Gowricharn, 2021a; Marhé, 1995).

For me, the shared ethnocultural background with the respondents implied that I had to be alert and flexible at the same time, to situate the uncovered data in time and place and account for the inherent diversity and hybridity. This means that I could not take the provided information for granted, only because I shared the ethnocultural background with the research group. To speak with Bourdieu (1990), the native researcher may know the rules of the game, but at the same time, one should be aware that the feel for the game can vary. Reflexivity of my own positionality was needed, to understand 'the familiar', as present in the research group, from my researcher's point of view. Hereby, peer group consultation was very helpful. The role of the peer debriefer was defined by Lincoln and Guba (1985) as a devil's advocate, who keeps the researcher honest and alert by asking hard questions about methods, meanings and interpretations.

Being reflexive made me realize that my knowledge was situated, historically, structurally, culturally and so on. Because knowledge is situatedness in time, place and context, it is not value- and context free. I align with Narayan (1993) who stated

that all knowledge is partial and situated in the relation to people we study. Haraway (1991, p. 192) underscored that situated knowledge is more dynamic and hybrid than other epistemologies that take the position of the knower seriously and involves 'mobile positioning'. She posits that knowledge is determined and framed by the social situation which includes race, gender, class and so on and becomes body-specific and site-specific. Herewith, researchers' claim of being neutral observers is contested. By acknowledging the situatedness of my knowledge and my position, I have endeavoured to contribute to the production of more reliable knowledge. This was predominantly done by frequent peer consultation, and not seldom I was incited to be self-conscious of my positionality.

Each role I embodied – a member of Indian diaspora, a researcher and a practitioner – had challenging aspects in terms of positionality. As a member of the same community, I realized that I had to routinely consider my specific socialization in the Surinamese Indian culture when interacting with Dutch-Surinamese Indian respondents. I had to consider the similarities and differences per respondent. Assumptions of the respondents, too, could have a role, as was the case a few times in interviews during a Hindu festival: some respondents assumed I was vegan or fasting to conform with the religious rules. On my side, this inclination to assume or take information for granted was present too, which I tried to minimize by constantly asking the questions 'what do I know and how do I know it' (Creswell & Plano Clark, 2007). Helpful was the regular check with the respondents as well as with the peer group.

The respondents and I differed in terms of educational level and profession, which are inherently power related. Therefore, I had to be reflexive on my professional role as a psychotherapist, who also treats Indians. Often the Dutch-Surinamese Indians are referred to me by word of mouth, which is to be interpreted positively. People recommend someone they trust and are content with. However, this positive connotation and the attached cultural value among Dutch-Surinamese Indians of having respect for people they look up to can hold specific expectations and withhold people to speak freely. This is because of the learned respect for authorities, who are seen as the one to get advice or help from and not the other way around.

Some challenges were subtle and ancillary. This was the case when my psychotherapist background sometimes evoked the usual reactions laypeople tend to have towards a psychotherapist, such as 'you can see through me' and 'you may consider me crazy'. Herein, the ascribed characteristics – based on myths about the psychotherapist's profession – could negatively influence the spontaneity to engage in the interview. Or the reactions held an expectation 'tell me, what do you see', which was reinforced by seeing me as an advocate of group rather than a researcher. Incidentally, sometimes I encountered an appeal to give my opinion on 'shared' issues based on 'our' minority position, such as racism.

In addition, a specific situation is that Indians easily asked me whether I was family of such and such, or more directly 'are you the daughter of …'. These kinds of questions did not solely arise out of curiosity. From my experiences in working with Indians, I know that this type of questioning is part of a process of getting more connected. It also has to do with a need for identification and situate oneself in the relation with me. This type of questioning, and thus connecting, lowers the threshold to engage and cooperate. In these cases, a certain degree of self-disclosure from my side was helpful to get access as a researcher. This was beneficial for the research as it led to more openness and contributed to the data collection.

4.2. Respondents, data collection and analysis

Some data involved my person as data source, respectively, as member of the community and as a psychotherapist[4]. Each position provided another type of data related to a different (sub-)group of respondents. These data were analysed in tandem with the other data sources, such the literature studies and the examination of cultural expressions.

As a member of the community, I gathered information from a group of respondents that was diverse. Much of these information was gathered in the past decades, whereas participating in several meetings and conferences where Indian suicidal behaviour was one of the topics or the main topic. These meetings were organized by professional institutions (i.e., several mental health care organizations, municipality of The Hague) or by Dutch-Surinamese Indian organizations (i.e., the Dutch Hindu council, OHM television, the foundation Vobis, women's foundation Sarita) or by international organizations (i.e., International Association for Suicide Prevention or The International Federation for Psychotherapy). Most of these meetings were in the Netherlands, whereas a few in Suriname, one in Malaysia and one in New Zealand. Among the participants, Indians were always present, sometimes exclusively. I participated in these meetings either as a participant or as a lecturer. During the informal parts of the meetings, substantive information about suicide in the Indian culture was collected too, because in the less public setting, people felt freer to talk about sensitive subjects.

From the other position, as a psychotherapist, I had access to data from the clinical practice. I used these data in two ways. First, I used the patterns of the data as present in my memory to cross-check the other datasets. This checking was done with a focus on the general patterns I had noticed throughout the years, without relating it to particular clients. And second, I examined a few case files in answering the second research question. To do that, I selected a few closed case files which I examined thoroughly with informed consent of the clients involved. I approached

4 Although I have published before about suicide among immigrants, none of these publications (as listed in the references in the chapters) were based on the research for this thesis; they were simply part of earlier work before the start of the PhD trajectory.

several former clients of my psychotherapy practice personally. After an explanation of the purpose of my research, I asked for their permission to use their case file. They were given the opportunity to mark which parts of their story they did not want to be used in the research. In addition, they were offered the possibility to approve the written ethnographies before I processed it in the thesis.

None of these case files were of active clients in my practice; all case files were closed, and I abided by the ethics of my profession and as a researcher. The criterion that the file has to be closed at least a year ago was related to the ethical professional codes to respect a minimum of 6 months as a 'cooling down' period after the end of a psychotherapeutic relation, whereafter other contacts than for psychotherapeutic purposes are possible (NVP, 2018). The required informed consent from the ex-patients differed from the 'regular' informed consent they sign at the start of the therapy. The latter served the purpose of quality maintenance and enhancement of the psychotherapy and to discuss their stories anonymously in peer consultation with colleagues.

For the face-to-face interviews, the participants were recruited via an enhancement of network or snowball sampling (Heckathorn & Cameron, 2017). Concerning the selection of respondents or cases, I kept the numbers small, to allow for detailed exploration of the subjects' experience. In the final selection of these respondents, I excluded people with severe psychiatric problems (i.e., risk for psychoses or severe depressions) and addiction problems, because the severity and acuteness of the psychiatric problems and possibly the crisis-proneness could hamper the needed cooperation and the veracity of the data. Severe intellectual disabilities were excluded, too, for feasibility reasons. Also, the respondents were ought to be able to decide for themselves to participate in this research; thus, following the Dutch legal rules, I excluded persons younger than 16 years old. The interviews, which took place between September 2018 and January 2019, were recorded with a digital audio-recording device for processing afterwards and were deleted after a period that was agreed upon with the respondents.

In conducting the interviews, I started in the Dutch language, but as soon as I noticed that the respondents preferred to talk in *Sarnámi* (the Surinamese Indian Hindi dialect), we switched language. Sometimes I noticed that the respondents had difficulties in finding the correct Dutch words, or sometimes I had a hunch, and I probed first by using some *Sarnámi* or Indian verbs. As soon as they reacted positively, we continued in *Sarnámi* or a mixture of Hindi (an official language of India), *Sranang Tongo* (the lingua franca of Suriname) and Dutch, as it played out.

The data processing differed per research question and is described in the relevant chapters, as is the case with methods and data collection too. All first-hand data (literature, case file study results, interviews) were subjected to thematic analyses and subsequently categorized by theme, larded with quotes that served either as illustration

or as clarification of the described theme or category of themes. The explorative nature of the research played a role here in adapting the themes by adding newly uncovered data. The analyses' main purpose, however, was to answer the research questions. Another general issue in the data processing was that I presented the preliminary results of my research on several international conferences.[5] The feedback I gained included many elements to enhance the research, and I processed the relevant feedback as much as possible.

At all times when personal information of the respondents was used either via interviews (Chapter 6) or case file studies (Chapter 4), informed consent was obtained first. The data were anonymized, and ethical considerations were made to conform to the procedures of the Netherlands Code of Conduct for Research Integrity (KNAW et al., 2018) and the Dutch professional code for psychotherapists (NVP, 2018).

4.3. Method and data triangulation

The use of multiple methods or data sources is advocated by several scholars in studying a complex phenomenon such as suicide (Creswell, 2013; Creswell & Plano Clark, 2007; Hjelmeland, 2010; Kral et al., 2012). Mixed methods are considered beneficial too in case of examining unexplored areas, as is the case with the relation between culture and suicide. The combination of two or more methodological approaches to study the same phenomenon is covered by triangulation. Denzin (1978) described four types of triangulation: (1) data triangulation: the use of various data sources in a single research to enhance the data strength and increase the validity and reliability by cross-checking; (2) investigator triangulation: the use of several researchers who (independently) study and/or interpret a phenomenon to decrease bias in studying the research data; (3) theory triangulation: the use of multiple perspectives to identify various aspects of the studied phenomenon; and (4) method triangulation: the use of various research methods to decrease deficiencies and biases given the possibility of compensation weaknesses of one method by the strength of another.

The triangulation fits the explorative nature of my research to reach a comprehensive understanding of the unexplored cultural aspects of suicidal behaviour. Of the four types of triangulation, I used method and data triangulation to a certain extent. Each research question required other sets of methods for the exploration of different kinds of data. Indeed, enclosing information from literature requires other methods than interviewing family members of someone who died by suicide. I used several methods, such as literature study; participatory observation; informal conversations; file studies

5 Some of the conferences I presented the preliminary results (in talks, not as papers) were:
- Conference on slavery, indentured labour, migration, diaspora and identity formation. 19–23 June 2018. Paramaribo, Suriname
- World Congress of Psychotherapy. 7–9 June 2018. Amsterdam, the Netherlands.
- IASP Asia Pacific regional conference. 2–5 May 2018. Bay of Islands, New Zealand.
- Challenging perspectives on Indian diaspora. International conference, October 2017. The Hague, the Netherlands.
- International Conference on Adolescent Medicine & Child Psychology. 28–29 September 2017. Berlin, Germany.
- 29th World Congress of the International Association for Suicide Prevention (IASP). 18–22 July 2017. Kuching, Sarawak.

and formal interviews; analysis of newspapers, movies and stories; and knowledge enclosed in me as researcher with an Indian background. The methods were applied either separately or in combination. Similarly, the data sources too differed per research question. Different sources were required for the study of suicide attempts compared to suicides, each with their own method to uncover the operation of cultural factors. In case of suicide attempts, the attempters were the respondents, whereas in case of suicides, people close to the deceased were the respondents.

The combination of differing sources and methods of data collection including the variation in time and space made the gathered information richer, contextualized, textured and deeper developed (Creswell & Plano Clark, 2007). Each method disclosed data in a certain way from certain data sources. The combination of all the methods and sources together led to a rich amount of data of varying types. Sometimes the data were valid for only a certain time period or place, and sometimes it exceeded time and place. Sometimes an alertness was needed given the fact that data from long ago had to be interpretated and weighed in a different way than contemporary data. Anyway, the diversity in the data was helpful for the exploration, either by confirming the findings or by refuting them when the presumption of one dataset invalidated the one generated by another dataset. In this way, the same topic could be studied from different perspectives. Moreover, I had the possibility to cross-check the field notes with thematic analysis, for example, or the narrative findings from the literature with the feedback of experts.

Concerning the data triangulation, I focused on several types of data (e.g., academic and grey literature, cultural expressions such as cinema, (auto-)ethnographies and case files), gathered in different times and settings. Data from every source were used in combination with knowledge from literature study and knowledge enclosed in the researcher and expert team. The answering of the first sub-question is virtually fully based on a literature survey. I examined the general literature on the Indian diaspora and specific literature on their suicidal behaviour. The literature surveys for answering the other research questions had a main focus on the Dutch-Surinamese Indians. Given the fact that the relation between culture and suicide of this group is hardly explored, the expectation of the limited availability of academic research search came true. Therefore, I included other sources, such as grey literature and newspapers. In these data, I looked for suitable information for answering the relevant question.

A specific source of data consisted of a knowledge base which I have built up during two and half decades of my experience as a psychotherapist specialized in suicidal behaviour. I have treated hundreds of Dutch-Surinamese Indians who either had either attempted suicide and were referred to me for that reason or had suicidal ideation or plans. Some of my clients knew other Dutch-Surinamese Indians close to them who had died by suicide or had undertaken a suicide attempt. These data consisted of first-hand narratives of people who had direct or indirect experience with

suicidal behaviour. Next to that, I included my experiences in participating formally and informally in professional and community gatherings where the issue of Dutch-Surinamese Indian suicidal behaviour was discussed. The participatory observation and informal conversations were performed during a long period that covers three decades. The topics were diverse, ranging from themes like gender inequality, upbringing practices and acculturation to more specific issues like arranged marriages or suicide.

An additional data source consisted of several cultural artefacts and cultural expressions I screened, such as oral history, proverbs and sayings, religious expressions and popular cultural expressions. I also used the popular Indian cinema called Bollywood, which both reflects and sets trends in attitudes, beliefs and values related to varying themes (Deakin & Bhugra, 2012; Manohar & Kline, 2014). These cultural images were included as they sometimes display suicidal behaviour. The cultural expressions and images of suicidal behaviour are present in the Indian folk traditions too, and they often form a part of the research group's socialization, at least to some extent.

5. Conclusion

The organization of this research required dealing with uncertainties that are inherent to examining uncharted territories, such as the undefined relation between culture and suicide. An explorative research design suited the nature of my research topic, wherein the search for cultural factors involved in suicide is centralized. Just because little was known in advance, the theory and methodology befitted that starting point. The theoretical concepts – scripts, habitus and autopsy – were selected for their capacity to be reworked to sensitizing concepts to capture cultural factors. In order to find cultural factors, the group had to have enough homogeneity in several characteristics to be considered as a culture. The explorative nature of the research was reflected in the methodology, wherein method and data triangulation were needed to enhance the findings. And, given the ethnographic character of the research, the researcher's reflexivity and positionality needed active considerations.

The advantages of the selected approach lay predominantly in creating as much room as possible to identify cultural factors fostering suicide as present in the lived reality of the research group. This is reflected in the emphasis on the sensitizing nature of the selected concepts and the endeavour to involve several methods and data. It also resonates in the ethnographic method and opportunistic research. The latter, the insider position, was beneficial is several ways. Not only did it lower the threshold for the respondents to participate, but it also eased the data collection. Familiarity with the cultural norms, values and traditions, the (verbal and non-verbal) language, contributed to a smooth communication with less risk for stereotyping or other misconceptions. Being an insider was helpful in gaining acceptance, trust and

commitment. These advantages had a positive effect on the efficiency and the (cost-) effectiveness of the research.

Nonetheless, there were challenges too related to the insider's position. The multilayered position of being an insider and a researcher combined with other roles (psychotherapist) and characteristics (female) required a balancing between distance and proximity, objectivity and subjectivity (self-disclosure), questioning and assuming and so on. Given this complex position, I had to call upon my creativity to be understanding at a moment and have to negotiate about interpretation at another moment, or even experience outright misunderstanding. A specific element is this research is that the data had to be processed twice; the respondents and I had a shared cultural understanding of the uncovered and identified information that I subsequently had to make more explicit to be understood by non-insiders. In this operation, some information may have been lost in (cultural) translation.

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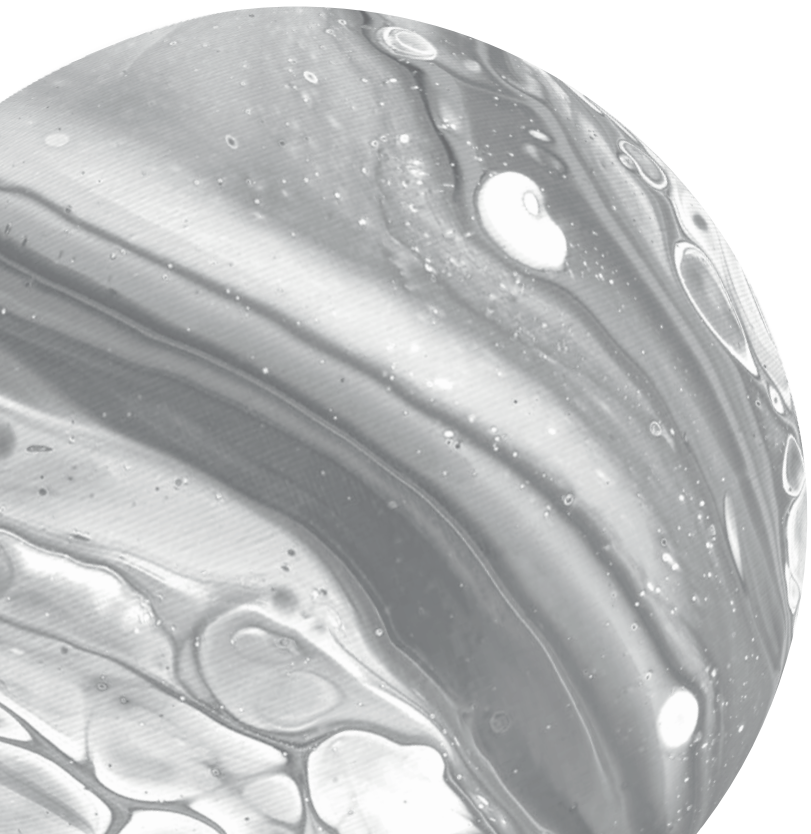

Chapter 3

Suicide in the Indian diaspora: Perspectives and limitations

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Suicide in the Indian diaspora: Perspectives and limitations

1. Introduction

The objective of this chapter is to map the explanations for suicide in the Indian diaspora as held by the Indian community itself, on the one hand, and by the researchers, on the other hand. Each category has its own cultural view characterized by its prevalent shared cultural meanings. Although the researchers do not form an ethnocultural group, they do form a cultural subgroup that shares some values and norms that can be labelled as cultural. Each of these two categories has its own perspective on suicide: the Indian community from within and the researchers as observers. Herewith, a differentiation is made between the academic explanations of researchers and those prevalent among the Indians themselves, each with their own perspective, frame of reference and assumptions.

The identification of the prevalent explanations of both groups is incited by the lack of explanations for the high suicide rates among Indians. The registered high rates point out that suicide is an issue in the Indian diaspora (WHO, 2021a, 2021b). Yet hitherto, it remains unclear what the cultural explanations are. Strauss and Quinn's (1997) notions of culture as described in the previous chapters are relevant here as a lens for identification of the prevailing cultural explanations of suicide. In their framework, culture exists in the 'inner' and 'outer' worlds and can be traced in collective rules, norms, meanings, customs and shared ideas. The shared elements are considered relatively stable and consistent over time and have a focus on objects, situations, events or conditions. These cultural notions require a certain homogeneity in the group.

However, the Indian diaspora is very heterogeneous with several sub-diasporas. Each sub-diaspora has its own heterogeneity rooted in place of origin, country of arrival, languages and so on. Despite the diversity, the Indian diaspora has several characteristics in common (Gautam, 2013; Gowricharn, 2020b, 2021b). Indians form a transnational community that shares several ethnocultural features, such as the language, religion, cinema and music. Several commonalities lead to group formation and internal continuity, which are reflected among others in several cultural, religious and educational institutions. The similarities have a local flavour too, as the Indian

diaspora in the separate countries has developed their own specifications of the Indian culture. These three elements enable an approach of the Indian diaspora as an ethnocultural group.

For reasons of feasibility, I focus on a handful of Indian diaspora countries which are part of a subcategory of the Indian diaspora, the so-called Bhojpuri diaspora that has a shared past in the era of indentured labour (Desai & Vahed, 2010; Oonk, 2007; Roohi, 2017). Of the six selected countries (Suriname, the Netherlands, Guyana, Trinidad and Tobago, Mauritius and Fiji), the Netherlands is the only Western country because it inhabits a large part of the *Bhojpuri* diaspora that moved from Suriname.

The next section elaborates on the historical and cultural background of the Indian diaspora, with a focus on the *Bhojpuri* diaspora. The cultural fitness of this diaspora as a research population will be underlined. The third section describes the applied search methods to elicit the data and the data sources, which mainly consist of a literature study and screening of some media. The fourth section discusses the identified explanations. By highlighting the existing explanations in the Indian diaspora with the possible similarities and differences between the researchers' and the actors' views, the possibilities and the limitations of the prevalent perspectives are addressed. In the fifth section, the screening of select Bollywood movies is included as it both reflects and sets trends in attitudes, beliefs and values related to varying themes including suicide. The final section evaluates the prevailing explanations and perspectives and discusses the implications.

2. The Indian diaspora

The traditional concept of diaspora is based on the Jewish diaspora, which started as an exile. The later diasporas were caused by different phenomena, such as the African diaspora that is predominantly caused by the slave trade. Other diasporas arose from economic reasons and so on. The Indian diaspora emerged due to multiple causes and in several time segments. The first migration of Indians began centuries ago from trade and business. Oonk (2007) delineated that a key characteristic of this so-called trade diaspora was its 'temporary' or 'circular' migration, which included a return to India. This type of migration existed in ancient times, with profitable ties with ancient Greece, East Africa, East and Central Asia. The first largest permanent migration was between the 5th and the 10th centuries AD from Northwest India and led to the current Romani diaspora that covers about 10 million people (previously known as the Gypsies). Linguistic and genetic studies have revealed ancestral links between the European Romani and India (Gómez-Carballa et al., 2013). These precolonial migrations are not (actively) included in the current conceptualization of the Indian diaspora.

The current Indian diaspora arose in two main segments: during the colonial period and during the postcolonial period, which are called the old and the new diaspora,

respectively. In the old diaspora, in the 19th and 20th centuries, the indentured labour system led to the move of millions of Indian people to different parts of the world (NRIOL, 2022; Tinker, 1974). The new diaspora is formed by entrepreneurs, traders, unskilled laborers and (highly) skilled professionals, who have retained direct ties with India. After the formation of the Republic of India, the main move took place to Western regions (e.g., the United States, Canada, Australia, New Zealand, the United Kingdom and other European countries). The largest part of the Indian diaspora, however, lives in Asian countries and the Gulf area (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates). The last decennia the Indian population has increased tremendously in that region due to the job opportunities in petroleum, finance and other industries.

Nowadays, the Indian diaspora consists of 30 million people spread over 125 countries (NRIOL, 2022). Appendix III provides an overview of the worldwide Indian diaspora in numbers per country. The Indian government registers the Indian diaspora as non-resident Indians (NRIs), Persons of Indian Origin (PIOs) or Overseas Citizens of India (OCIs).[6] Herewith, India is positioned as the homeland that retains and amplifies the links between home and way (Sahoo & Shome, 2020). This befits the classic conceptualizations of diaspora, like that of Brubaker (2005) who suggested three characteristics of a diaspora: (1) dispersion of people across space and borders, (2) orientation to a real or imagined 'homeland' as a source of identity and connection and (3) maintaining identity and sense of community. The traditional conceptualization of a diaspora, however, is limited. For some Indian diaspora communities, the homeland is not India in the first place but the (first, second or third) land their ancestors moved to. Referring to the settling of the 'twice migrants', Gowricharn (2021b) spoke of multiple homemaking. Herewith, the conventional dichotomy between 'home' and 'elsewhere' is challenged. This especially accounts for Indians from the colonial diaspora.

The connection of the old diaspora with India at first depended on the Indian culture and a sense of community they carried with them and the information supply about India as provided by the colonial government (Kumar, P. P., 2015). In the past decades, the possibilities have increased to maintain and revive (new diaspora) or to 're-connect' and 'renew' (old diaspora) ties with India, due to the increased opportunities in transportation and communication technology. As a result, the contact of the Indian diaspora with India has grown in the past decades, by tourism, cultural exchange and academic conferences, and often by stimulation of the Indian and other governments (Gautam, 2013; Lal, 2021; Sahoo & Shome, 2020). The transnational bonding with

6 Indians in the diaspora are categorized by the Indian government as NRI: an Indian citizen residing outside India for a combined total of at least 183 days in a financial year; PIO: a person living outside India who by virtue of the Constitution of India or the Citizenship Act, 1955, held an Indian citizenship by birth or their descendants or their spouses; and OCI: with an OCI card, a foreign citizen of Indian origin is authorized to live and work in India for an indefinite period. The OCI includes a person who was previously an Indian citizen or whose parent, grandparent or great-grandparent is/was an Indian citizen or one who is married to an Indian citizen or an existing OCI for at least two continuous years. The PIO card was replaced in 2015 by the OCI card (BoI, 2021). In these formal categories, however, people of Indian descent whose ancestors moved from India generations ago are difficult to fit.

compressed space and time incited by the information technology, especially among the younger generations, created a so-called neo-diaspora (Koshy & Radhakrishnan, 2008; Sahoo & Shome, 2020).

An additional issue related to the diaspora concept is that the overarching term 'Indian diaspora' suggests homogeneity in the Indian community. The Indian diaspora, however, harbours a diversity (of subsets) of diasporas. Often the region or state in India is used to point out a distinct diaspora, such as the *Gujarati* diaspora (from Gujarat) or *Punjabi* diaspora (from Punjab) or Tamil diaspora (from Tamil Nadu). Sometimes the language forms the key aspect, such as the *Marathi* diaspora (spoken in Maharashtra) or *Bhojpuri* diaspora (chiefly spoken in Bihar and Uttar Pradesh). Or, the religion is leading, such as the *Sikh* diaspora (which is a subset of the *Punjabi* diaspora). Next to the sociodemographic characteristics, the sub-diasporas are characterized by their causes (trade, labour migration, colonialism, high-skilled migration) and time period (from ancient times to present time) (Oonk, 2007; Roohi, 2017).

2.1. The girmitiyas and the Bhojpuri diaspora

The focus of this chapter is on the Indian diaspora that arose during the colonial period. The critical labour shortage on the plantations in the colonies after the abolition of slavery gave birth to the indenture system that lasted till the 1920s (Gautam, 2013; Lal, 2000; Tinker, 1974). The indentured laborers, the *girmitiyas*, were recruited from different states in India and were sent to work on the plantations in the British, Dutch and French colonies and also to – albeit to a lesser extent – Danish and Portuguese colonies. Denmark and Portugal had colonies or enclaves in India, whereas the other countries had colonies spread around the world.

The *girmitiyas* were brought to Africa (South Africa, Kenya, Uganda, Mauritius, La Reunion), South America (Guyana, Suriname and French Guyana), several Caribbean islands (Trinidad and Tobago, Jamaica, Guadeloupe, Martinique, Belize, Barbados, Grenada, Saint Vincent and the Grenadines, Saint Lucia), some Pacific islands (Fiji, Seychelles) and Asia (Sri Lanka, Malaysia, Myanmar and enclaves in India itself) (Kumar, P. P., 2015; Desai & Vahed, 2010). Appendix IV provides an overview of indentured Indian immigration by colony in the 19th and 20th centuries.

After the indenture period, most of the *girmitiyas* chose to stay in the countries of arrival. The majority of these countries have gained independence from the former colonizer. Several groups of Indians, descendants of the *girmitiyas*, have moved from the former colonies to Western countries, mostly that of the colonizer. For example, in the Netherlands, about 1% of the total population is of Indian origin, whereof most are descendants of Surinamese indentured labourers, thus migrants from the colonial diaspora. Apart from the land of the colonizers, Indians moved to other Western countries too, such as the migration of the Indo-Guyanese to North America or the Indo-Fijians to New Zealand and Canada (Gautam, 2013; Kumar, P. P., 2015; NRIOL, 2022).

The *Bhojpuri* diaspora mainly consists of the descendants of the *girmitiya* who were recruited from present-day Uttar Pradesh and Bihar in India (Gautam, 2013; Lal, 2000). *Bhojpuri* also refers to the common language spoken in North and East India. Next to *Bhojpuri*, some *girmitiyas* spoke *Avadhi*, another language from that region. Part of the *girmitiyas* were proficient in the Indian language Hindi, and in Urdu too, which is passed over to their descendants. The retention of the languages is also enabled by the advent of the Indian cinema in the 30s and 40s of the last century (Banerjee & Srivastava, 2019; Klerk, 1951; Gautam, 2013; Oonk, 2007). In some *girmitiya* countries, the *Bhojpuri* language has undergone *koineization,*[7] a process that leads to the formation of new dialects (e.g., *Sarnámi* in Suriname) (Jayaram, 2000; Siegel, 2008). And, in some countries (Trinidad, the Netherlands), the *Bhojpuri* language is less vivid than in others (Suriname, Fiji).

The start of the *Bhojpuri* diaspora varies in the six *girmitiya* countries I focus on. Mauritius was the first in 1834 where the Indian indentured labourers were sent to. British Guyana was next in 1838, followed by Trinidad and Tobago and other Caribbean islands in 1845. In 1873, the migration to Suriname started and, in 1879, to Fiji. Next to people from North and East India, people from other states were recruited too for these countries, such as Tamil Nadu. However, in the *girmitiya* countries of my focus, *Bhojpuri* prevails, such as in Suriname where *Bhojpuri* is the virtually the only Indian diaspora. Or, the several diasporas have mixed, as is the case in Fiji in which the Indian diaspora is actually the mixture of *Bhojpuri* (the largest group of Indians) and Gujarati, Tamil, Telugu, Sindhi and people from other parts of Indian sub-continent like Nepal (Lal, 2000; Oonk, 2007).

At first, the differences among the *girmitiyas* were too large to speak of an ethnic group (Gowricharn, 2020a). Rather, they formed a quasi-group, and the ethnic group formation began after departure from India. Contributory to the group formation were some major transformations in the Indian identity and customary practices of the *girmitiyas*, as several practices were renegotiated (e.g., Kumar, A., 2017; Lal, 2000). People from different castes and religions became peers who had to share meals and who sought solace in the hold of the ships and on the plantations. One of the largest transformations was the disappearance of the Indian caste system among the Indian labourers and their descendants, including most of the prohibitions and requirements of the subsequent rules of purity.

A. Kumar (2017) described how the disregard of the caste-based dietary regime in India – people from the lower castes could not eat with others from the high castes – freed many *girmitiyas* from prejudices as they forged new 'shipmate' relationships (*jahaji-bhai/jahaji-bahan*, translation: ship-brother/ship-sister, respectively). Later the

7 Koineization differs from pidginization in social contexts and time (Jayaram, 2000; Siegel, 2008). In koineization, based on free social interaction, a new variety of language emerges over time from the process of mixing, levelling and simplifying of different dialects. Pidginization, on the other hand, is incited by a need for immediate and practical communication and is characterized by restricted social interaction.

relationships continued with the neighbourhood relations (*gawn ke nata*, translation: relational ties among people from the same neighbourhood). This preliminary 'new' bonding contributed to the formation and/or continuation of an ethnocultural community that grew further during and after the indenture period into 'a relatively coherent community, independent, egalitarian, pragmatic, resilient and self-reliant, with a melded culture and language' (Lal, 2021, p. 8).

Some characteristics typify the *Bhojpuri* diaspora as consisting of ethnocultural and transnational groups. It forms a transnational group that shares ethnocultural features such as the regional origin, the ethnic and sociocultural backgrounds and the migration trajectories. The similarities are also found in the comparable languages, cultural norms, customs, family structures, cuisine, music and so on (Gowricharn, 2021b; Kumar, P. P., 2015; Oonk, 2007). The religious affiliations too, with the majority being Hindu and Muslim, are present in the *Bhojpuri* diaspora. For the Hindus, especially the stories from epic *Ramáyana* were relevant, which is still present in the *Bhojpuri* diaspora in several art forms, such as the annual theatre performances of the *Ramáyana* called *Ramleela* (Mahabir, 2013). Desai and Vahed (2010) added that religion, entertainment and theatre were intimately linked activities, which were both a leisure outlet and a forum for social bonding.

The registered common features of the Indian diaspora fit in the notions of Strauss and Quin (1997) who stated that shared interpretations typify a community. The group formation is based on commonalities, and internal continuity of ethnocultural practices, which are institutionalized in cultural, religious and educational organizations (Eldering, 2005; Gowricharn, 2020a; Kumar, P. P., 2015). In addition, the relatively stable characteristics are reflected in the shared cultural meaning within the community.

Even though four of the six selected countries were under British colonial rule (Guyana, Trinidad & Tobago, Mauritius and Fiji) and one under Dutch colonial rule (Suriname), they all maintained more or less their cultural identity in their 'new' multi-ethnic society, often with a *couleur locale*. In each country Indians have their own cultural infrastructure with temples and mosques and schools based on religious values, facilities for Indian classical dance and Indian cinema, radio and television stations and so on. The group formation has gained the local flavour due to processes like acculturation and enculturation and the sociopolitical climate of the country. However, as Gowricharn (2020b, p. 4) asserted, '[A]long with the tendency towards hybridization, an everlasting tendency exists to retain Indian culture.'

3. Method of search and analysis

The search for the prevailing explanations of suicide in the Indian diaspora aimed to identify two categories of explanations: one category harbouring the explanations from the perspective of the researcher, and the other category consisting of explanations that prevail among the research population. To explore both categories' prevailing perspectives on suicidal behaviour in the Indian diaspora, I reviewed several data, notably, a literature search, newspaper articles, Bollywood cinema and data from opportunistic research.

Next to identifying prevalent explanations among Indians and researchers, the literature survey served to give a global picture of the suicide prevalence in the Indian diaspora in present times. An additional search targeted the indenture period, both on suicide data and prevalent explanations. Several online databases were used, notably, DOAJ, JSTOR, Medline/PubMed and Web of Science. The six selected countries were used as standard part of the search process. The search terms were '[Country] AND suicid AND indenture AND India'. Almost all studies were written in English, some in French and Dutch, and most of them were published in a peer-reviewed journal and contained the search term(s) in the title or abstract. For those countries with more than one eligible publication, articles were included that explicitly mentioned several features of the Indian group, such as ethnicity and culture, and/or covered different aspects of suicidal behaviour.

Some authoritative books were used too, such as that of Klerk (1951) and Lal (1985, 2000), who respectively wrote about the Indians in Suriname and Fiji during the indenture period. These authors managed to provide an image of the lived reality of the people themselves by the use of their narratives and lived reality. But Thakur (1963) too was included, for his extensive elaboration of suicide from a Hindu perspective. Next to that, grey literature (material produced outside the traditional academic setting) was retained for comparative reference and additional information, especially important for countries where no or scarce scholarly literature on the topic was available. Excluded were articles that had no full text available; were not written in English, Dutch, German or French; and did not explicitly mention Indians.

I surveyed the literature for explanation models and endeavoured to unravel the inherent assumptions of possible theories used by the Indian community and the researchers. Next to reading with the grain, the selected literature was read against the grain (Bartholomae, Petrosky, & Waite, 2017). This was useful in uncovering the identified explanations' frame of reference, assumptions, perspectives, images, biases and so on. In the presentation of the explanations, the conceptualization as present in literature was used, which also contains culture-specific concepts (e.g., *izzat*, *face loss*, shame and guilt), as delineated in Chapter 2.

It was challenging, though, to uncover the prevalent explanations for a number

of reasons. First, in the literature the Indian community's view was less identifiable at first sight, as it is mostly reported by researchers. Then, the academic focus was filtered by close reading, and this way the community's explanations could be extracted, mostly from the presented cases. Second, it was difficult to give the literature the same weight as they were of differing quality. Some literature elaborated extensively on the applied perspective on suicidal behaviour in a specific country, whereas others just hypothetically and briefly mentioned them. Often the literature focused on explanations coined by other scholars. Third, the literature search led to little qualitative studies with extensively elaborated explanations in general and even less on cultural explanations. Then, the assumptions were leading. A different issue was that some of the literature was based on suicide rates of disparate quality.

Newspaper articles were screened per country published in the last years. I used LexisNexis to accomplish this search, by entering 'suicide' and 'country name' as the search terms combined with Indian or Hindustani or South Asian or East Indian or Indo. These search terms, however, often led to results in newspapers from India. And when hits were found within the relevant newspapers, it often referred to general or universal information about suicide. Sometimes the ethnicity was not traceable. Therefore, I made a list of some newspapers per country and searched in their online databases for cases of suicide. The cases were selected when based on the name it could be determined whether the person was Indian (the first name of the victim is often mentioned in several newspapers). Or, when some features were pictured that pointed at the Indian culture, such as some holidays or certain religious customs, if the news article was elaborated enough.

In addition, a data source whereof cultural representations of suicide were extracted were Bollywood movies. A group of Indian people who were familiar with consuming Bollywood movies were asked for movie titles produced in the past decades that depicted suicide. Some movies were selected for screening, when more than two people mentioned that title. The movies were analysed and discussed with the people who had nominated the movie to interpretatively select the important themes.

4. Prevalent explanations of suicide

The suicide rates in India and the Indian diaspora as registered by the World Health Organization (WHO) and by several scholars in different countries give off an impression of being disproportionately high. Although the estimated global average rate of suicide is 10.5 per 100,000 population in 2019, the suicide rates in the Maharashtra and Tamil Nadu are up to 45.5 per 100,000 and belong to the highest in the world (*National Crime Records Bureau, 2019; WHO, 2021b*). In the Indian diaspora, the rates are high too, whereof the suicide rates of Guyana and Suriname (40.9 per 100,000 and 25.9 per 100,000, respectively) belonged to the second and sixth highest in the world

in 2019 (WHO, 2021a, 2021b). Some countries in the Indian diaspora have low national suicide rates, whereas the specific suicide rates – if available – for Indian inhabitants are persistently higher compared to other groups in the same country. For Fiji, Forster, Kuruleca, and Auxier (2007) found up to 5 times higher rates among Indians compared to the average national suicide rate, notably, 25 per 100,000 versus 5 per 100,000. The high suicide rates are not limited to present times but are noticed in some historical periods too (Lal, 1985, 2000; Thakur, 1963).

Next, the identified explanations are presented in two subcategories: as held by the researchers and by the research group, respectively. The identified explanations are supported by some appendices. Appendix V presents the suicide incidence in the past and present and also discusses some registration problems. This appendix clarifies that reading the average suicide rates per country does not provide a clear image, as subgroups can differ immensely from the national average. A detailed outline of the characteristics of the six *girmitiya* countries are presented in Appendix VI. In Appendix VII, an overview is presented of the studied literature per selected country together with some characteristics of the studies, such as the type of research. The diversity of the explanations from the cultural perspective is presented next in two overarching themes they fit in, notably, religious convictions and strains in traditional practices.

4.1. Academic perspective

The researchers' cultural lens is imbued with the shared values and norms that prevail in the academic world, in general, and in the relevant academic discipline, specifically. Mostly their viewpoint holds that suicide results from mental illnesses. The underlying assumption then is that suicidal behaviour is 'treatable' and preventable. This is reflected in researchers' a priori search for psychocentric disturbances and explanations using ditto instruments, which are initially developed for and standardized on the North American and West European population (e.g., Groh, Anthony, & Gash, 2018; Morris & Maniam, 2001). Some researchers, however, do include the influence of environmental factors, such as sociological, socio-economic and political explanations.

Despite the dominant belief of the relation between suicide and psychocentric factors, most of the studied literature mention that – compared to the regular (read: Western) suicide profiles – psychiatric illnesses were less prevalent as causal factor for suicides among Indians (e.g., Burger, 2013; Harry, Balseiro, Harry, Schultz, & McBean, 2018). Still, some researchers, such as Graafsma, Kerkhof, Gibson, Badloe, and van de Beek (2006) and Groh et al. (2018) held on to the psychocentric explanations and suggested that psychiatric disorders may have been underdiagnosed among Indians. Herewith, they ignore indications that refute the connection of suicide with mental disorders, such as the absence of prior suicide attempts, which is seen as a major indicator for suicides in mainstream suicide research (Burger, 2013; Turecki & Brent, 2016). Other studies, such as CASR (2015), Hutchinson (2005) and Spijker, Graafsma,

Dullaart, & Kerkhof (2009), base the psychocentric explanations – often depression – on the results of psychological autopsies. In most studies, however, depression is merely suggested, often accompanied with a reference to general literature on suicide, or specific studies among hospitalized Indians.

Literature on the indenture period, too, suggests a relation between depression and suicide. During the sea passage, although a temporarily situation, suicides were registered, as some Indians threw themselves overboard. Haynes (1987) described that people threw themselves into the *Hughli* River to escape the dreadful conditions on the emigrant ship. Most of the explanations for these suicides point at loneliness and despair and guilt, or fear of the ocean (Haynes, 1987; Lal, 1985, 2000). According to A. Kumar (2017), the possible traumatic effect of the voyage to the new country and the psychological impact of the breaking of caste rules may have caused depression. Several scholars mention harsh living conditions of the indentured labourers during the voyage and on the plantations and relate them causally to despair and depression (Desai & Vahed, 2010; Lal, 1985, 2000). However, this suggested relation of suicide with trauma and depression is not based on historical records of formally assessed diagnoses but mere hypotheses of these researchers (mostly historians). This kind of layperson or popular knowledge is regularly conveyed in the literature.

A relation that is repeatedly registered among Indians is that of alcohol and suicide (e.g., Graafsma et al., 2006; Harry et al., 2016 Maharajh & Abdool, 2010). Alcohol addiction is known as a psychiatric disorder, which leads to a twofold increase of the suicide risk (Turecki & Brent, 2016). The use of alcohol exacerbates the underlying risk for suicide, especially when there is a comorbidity with depression or other disorders. Non-psychiatric alcohol abuse forms a risk too, as it influences the sense of judgement and gives room to impulsive and reckless behaviour. Boedjarath (2016) reviewed that although Indians tend to be teetotallers more often compared to other ethnic groups in the same country, the percentage of excessive drinkers (binge drinkers and habitual heavy drinkers) among Indians is high. Maharajh and Abdool (2010) reported that alcoholism in Trinidad is highest among the Indian population and stated that excessive alcohol use is prevalent since the indenture period. Although historical proof is lacking for the latter, Choenni (2009), too, suggested that alcohol abuse formed one of the many problems on the plantations in Suriname that served to forget problems and combat fatigue. How the indentured labourers gained access to alcohol as they had little to spend remains unclear.

Genetics are suggested to have a role in both the susceptibility for alcohol and for impulsivity (Turecki & Brent, 2016). Impulsivity is described as an individual characteristic that lowers the threshold to suicidal behaviour, because potential consequences are not considered, and the actions are unnecessarily risky and prematurely expressed. Practically, all studies that discussed the use of alcohol by suicidal male Indians also mentioned a 'Indian male propensity to impulsivity'. Spijker

et al. (2009) found that pesticides are mostly used in unplanned suicides by Indian Surinamese males and suggested that the suicidal acts are impulsive. Forster et al. (2007) noticed a relation between the type of alcohol and impulsivity (that enlarges suicide risk); native Fijians tend to drink Kava, a plant-based relaxant that makes impulsive behaviour less likely, whereas Indo-Fijians drink alcohol and react more impulsively. Naga (2007) noticed that, in Mauritius, the Indian impulsive suicidal acts with poisonous substances were in response to social problems. In Guyana, Anthony, Groh and Gash (2017) registered that many suicide attempts are impulsive and a cry for help rather than a wish to die. Although impulsivity is an individual characteristic, scholars relate it to the cultural group as if it is a cultural phenomenon.

Some scholars relate the impulsivity they register among (male) Indians, and the inherent hampered frustration tolerance, to Indian cultural upbringing practices. In case of Surinamese and Dutch Indian men, Graafsma et al. (2006), Garssen, Hoogenboezem, and Kerkhof (2007) and Spijker et al. (2009) hypothesized a similar theory. According to Spijker et al. (2009, p. 104), the lack of restrictions in their upbringing 'may result in not learning to delay gratification and in not learning to tolerate feelings of frustration. This may contribute to impulsive acts, including the act of suicide.' In a BBC report on suicide in Guyana, dated 16 October 2016, a professional suggests similar conclusions. The professional states that in the upbringing, a lack of frustration tolerance emerges, which makes Indo-Guyanese vulnerable when they meet adversities or unfulfilled expectations: 'Culturally, Indo-Guyanese folks are babied. For example, I have three children in their 20's all living at home; I still make my son's breakfast every morning. Afro-Guyanese tend to have less close families and are taught to be strong and resilient' (Handy, 2016).

An individual characteristic that is often related to suicide among Indians is inward-turned anger. In Guyana, McCandless (1968) mentioned anger turned inwards as a cause for suicide among Indian men. A later study from Guyana of Groh et al. (2018) mentioned the same. In Suriname, Graafsma et al. (2006) also observed that (suppressed) anger played a role in the suicidal behaviour. Unfulfilled wishes and aspirations seemed to be the leading cause for the anger. In Guyana, the lack of feeling loved and the lack of the expected support when facing problems are registered by Groh et al. (2018) as anger provoking. These scholars stated that most at risk were the 'angry youngsters' in the age group 12–25, which was explained by dysfunctional family issues and harsh parenting styles combined with impulsivity. Harry et al. (2016), too, mentioned that men who died by suicide in Guyana were victims of unfulfilled aspirations and the loss of prestige and control over their lives.

McCandless (1968) probed cultural interpretations for the noticed anger among suicidal Indians. He coined the *abhiman* syndrome (*abhiman* is Sanskrit for pride or vain glory), in which the suicide is aimed to hurt an (intimate) other by hurting oneself. He registered this behaviour with Guyanese Indians of both gender, who attempted

suicide. According to McCandless, the lack of acceptable techniques to express aggression in verbal interaction with family members with whom they had a dispute made people suppress the felt anger, which ultimately found an outlet in suicidality. The literature presents several examples that resemble these findings. Spijker et al. (2009 p. 104) noted that among Surinamese men, the lack of communication of thoughts and feelings may ultimately 'result in frustration and feelings of not being understood – unless by extreme means'. In Fiji, Adinkrah (2003) found that some homicide-suicide arose from rage of men who were rejected (e.g., for their marriage proposal).

Some researchers offer explanations that relate to social, economic and even political factors. Low educational achievement, financial problems and lack of perspective are often mentioned as indirect contributors to suicidal behaviour. The socio-economic disadvantages seemingly lead to psychosocial and interpersonal problems, whereof poverty, unemployment and breakdown in relationships are mostly mentioned. Migration, too, or rather migration stress caused by the move from rural to urban areas or the move to another country, and social migration are mentioned as explanations for suicidal behaviour. Often, these factors are just mentioned as contributing to suicide without further explication (e.g., Balraadjsing & Graafsma, 2010; Groh et al., 2018; Harry et al., 2016. Others provide more information, such as Goorah et al. (2013) who showed that the Mauritian suicide rates decreased with improvement of living standards. Some scholars break the social phenomenon of migration down to how it affects daily life by isolation, stigmatization, discrimination and changes in status and gender roles, which, in turn, contribute to suicidal behaviour (e.g., Ali & Maharajh, 2005; Anthony et al., 2017; Haynes, 1987).

Some of the studied literature give the registered contributory factors to suicide a couleur locale by linking it to the country's ecological circumstances, specific history or governmental policy. Ecologically, for instance, weather circumstances influence the agricultural opportunities which may affect people's well-being. Guyana and Suriname have four seasons and no slack period, whereas Trinidad has only two seasons with unemployment in between for many. The assumption is that unemployment in Trinidad led to financial problems and arguments in the domestic situation and eventually to suicide (see Eldering, 2005). Forster et al. (2007, p. 1) too described comparable phenomena among Indo-Fijian agricultural workers who may experience loss of status with the move from being 'accepted members of well-ordered rural communities to the chaotic and impersonal atmosphere of urban life'. They stated that the move to urban areas is related to expired sugar cane land leases, whereafter the workers simultaneously lost their livelihood and their homes. According to the scholars, people often ended up being displaced and disenfranchised, which led to strains in family relations, increase in domestic violence and eventually suicide.

The relation of suicide and loss of status and power is mentioned by several scholars. Gowricharn (2021a) related suicide to the fall on the social and financial

ladder, stigmatization and stereotyping. He set the addressed suicide against the socio-historical background of Indians in Suriname, next to the individual and cultural perspectives, such as maintaining dignity. In Fiji, Haynes (1987) noted that the low status of the Indo-Fijians was considered a cause for the high suicide rates. Haynes (1987) sketched a social and political vulnerability among Indians as he stated that (Fijian) Indians were historically accorded low status. He described the accompanying stereotyping by other groups as a legacy of the indenture period. Lal (1985, 2000) stated that the loss of Hindu caste system affected Brahmins because the castes diluted during indenture. Discrimination seemingly played a role too –among themselves, based on skin colour or caste, and by the White rulers.

Lal (2000, p. 234) stated that the high rates of male suicides on the Fijian plantations had to do with the harsh conditions, with suicide as a way out for some. He described the suicides as both 'a cry of despair and an act of protest directed ultimately at the principles and ethics of the indenture system itself'. According to Hoefte (1998), suicide was the most radical form of protest against the harsh conditions in Suriname, and she described that in the historical records, these suicides were considered as typical for Indians. Desai and Vahed (2010), too, described suicides on the plantations as individual acts of resistance against the harsh conditions such as emotional, physical and economic abuse. They stated that next to the rare collective resistance, people mostly resorted to individual acts of resistance, which ranged from absenteeism to suicide. Although the findings of Desai and Vahed are related to the indentured labour of Indians in South Africa, it is likely that it reflects the conditions in other countries too. However, here too, the relation between the harsh living conditions and suicide is based on assumptions.

In addition, the literature mentions the shortage of women during the indenture period as a suicide-contributing phenomenon. This shortage is said to have led to sexual jealousy, which is regularly mentioned as a cause for suicide (Forster et al., 2007; Lal, 1985, 2000). On most plantations, women formed less than 30% of the adult labourers. Lal (2000, p. 16) presented the wordings from records of that time, wherein the women's supposed 'licentiousness and infidelity produced such a degree of sexual jealousy that the males were frequently driven to commit suicide or else to murder the women'. The women's (and men's) own perspective is absent in the historical written records of that time, by which 'their faces are shrouded by a veil of dishonour drawn by men', as Lal (2000, p. 222) put it. Fokken (2015) framed this type of images ascribed to Indian women by the colonizer as stereotypes.

Researchers also relate several changes in life to suicidal behaviour. Next to the already-discussed loss of status and loss of financial and social resources, changes due to migration that affect gender roles and family relations are often mentioned. Migration stress and other Durkheimian disruptions in integration and regulation are often mentioned as a contributing factor (Garssen et al., 2007; Van Bergen, 2009). These

contributors are mostly hypothesized. Garssen et al. (2007), who statistically examined Dutch-Surinamese Indian suicide rates, suggested that individuals who migrate from a collectivist to an individualist society experience an identity crisis, which makes them susceptible to suicidal behaviour. Based on some qualitatively examined cases, Boedjarath (2016) confirmed male identity crises or erosion of the traditional male gender role, as contributory to suicidal behaviour among Dutch-Surinamese Indian men.

Forster et al. (2007) reported comparable findings: women become more educated and more financially independent, and they marry at a later age and pursue prolonged education and become more independent; these factors pressurize traditional values and especially traditional gender expectations. Mayer (2010) demonstrated a strong correlation between the increase in equality of education in men and women in India and the increase in male suicide. This is in contrast with studies among Western populations that show a clear link between growing male–female equality and an overall decline in the number of suicides.

Concerning the female gender, some scholars suggest two sides to Indian women's suicidal behaviour (Boedjarath, 2016; Guzder, 2011). One side is well known, where women are seen as the assaulted victim, who suffers from pressure from her parents, husband or in-laws and finds her way out in suicidal behaviour (e.g., Salverda, 2004; Van Bergen, 2009). The other side is the defiant, triumphing woman who fights against injustice. The latter has to do with interpersonal and intrapsychic autonomy (Saharso, 2000). In the act of self-inflicted death, the woman supposedly expresses a power she could not express to fight the problems because of a lack of interpersonal autonomy. Noteworthy, the victim role ascribed to women is mostly described in Western literature by Indians, whereas literature from the Indian diaspora often considers both sides. Nevertheless, as Guzder (2011, p. 599) theorized, both sides stand for 'transcending social impasses in which women feel oppressed, silenced, limited, diminished, or blocked in their routes to conflict resolution or negotiation'. Guzder (2011) demonstrated that the capacity to set limits on their self-sacrifice is a characteristic that is culturally passed over, albeit sometimes by suicide gestures or acts.

4.2. Actor's perspective

Some of the studied literature refer to the nature of Indians by ascribing a certain proneness to suicide to Indians. Lal (1985, 2000) described that during the indenture period, 'a proneness to suicide' was registered by the colonial authorities, albeit often in a condescending tone. Related to the proneness, Haynes (1987) referred to an everlasting legend that has evolved during the indenture period that Indians are prone to suicide, which may well have affected the perceptions of the public and of officials such as coroners. Nowadays, the 'proneness' to suicide seems to be replaced by culturally framing the suicides as 'prevalent coping styles' to deal with adversities

(Graafsma et al., 2016; Groh et al., 2018; Maharajh & Abdool, 2010).

The identified conceptualizations and practices from the actor's perspective include several religious notions and gender-specific roles with accompanying virtues, proscriptions and behaviours. These cultural aspects can be reduced to two main cultural themes: reincarnation and *izzat* (honour). The *izzat* concept that is embedded in the community seems to be either directly or indirectly expressed in gender-based morals and behaviours with a communal steering, as is noticeable in several cases in the literature. The (religious) Indian scriptures and other cultural expressions are passed down from generation to generation through oral or written traditions. The identified narratives are apparently reflected in upbringing practices and in popular discourse too. Although not connected to religion, supranatural explanations (spirits, ghosts) are included as it is referred to repeatedly.

4.2.1 *Religious convictions*

Many scholars suggest – sometimes mere hypothetically, sometimes as a fact – that the Hindu belief in reincarnation lowers the threshold for suicidal behaviour. Reincarnation holds a cycle of birth and rebirth until the ultimate goal is achieved, notably *moksha*, which is the merging of the soul with the divine. Within this perspective, the body is merely the earthly housing of the soul and is shed at death. Reincarnation has a significant role in so-called religious suicides present in the ancient Indian scriptures like the Hindu epics *Ramáyana* and *Mahabharata* that date from centuries ago (Thakur, 1963 Vijayakumar & John, 2018). The suicide cases and related explanations are still found in literature, arts, media, cinema, sayings and so on (Lal, 2021; Manohar & Kline, 2014).

Vijayakumar and John (2018) reviewed some literature about the major Hindu religious texts (*Vedas, Upanishads, Ramáyana* and *Mahabharata*), cultural practices and suicide. They stated that the ancient texts are ambivalent on suicide, as some condemn it, and others condone it. Herewith they followed Thakur (1963) who provided a meticulously detailed overview of Hindu scriptures and suicide. Thakur delineated that the scriptures describe or even proscribe what good and bad deaths are. He described in the chapter 'Religious Suicides' the good death (including suicide) in Varanasi (pilgrimage place) or at *Prayaga* (the confluence of the rivers Ganga, Yamuna and Saraswati). However, people who abandoned their old parents or a young wife and children who required support were not allowed to die by suicide by jumping in the water at the *Prayaga*. This implies a strong connection between social structures, family relations and individual obligations, which is part of the Hindu concept of *dharma*, a religious and moral law governing individual conduct, which includes duties, rights, virtues and so on.

The suicides in the historical scriptures are often related to avoiding shame, disgrace, (threatened) honour, losing face and sacrifice (Thakur, 1963; Vijayakumar &

John, 2018). A well-known example is that of Lord Rama in the *Ramáyana*. When Rama died, an epidemic of suicide among both sexes ensued in his kingdom Ajodhya. In hindsight, this can be called copycat suicides. A next example of (indirect) suicide is that of Sita, the wife of Rama. Sita embodied the *izzat* (honour) of her husband by virtue of her purity and piety (Bhugra, 2005; Guzder, 2011). Sita was abducted, and after she was freed, her husband Rama – unable to withstand the pressure of gossip – commands her to submit to a fire ordeal to prove her chastity. Sita, the standard of selflessness and loyalty, then sacrifices herself to save Rama's face. This self-sacrifice, called *Sati*, is related to a banned tradition, known for widows' self-immolation after the dead of their spouses.

The literature mentions that the Hindu religious narratives are prevalent and vivid in the six *girmitiya* countries in several forms, such as drama, song and dance, and as role models in traditional upbringing practices. Bhat (2008), who examined the communicative aspects of domestic violence, stated that with the telling and retelling of stories such as that of Sita's, women and men learn to read gendered behaviour through this frame. The story of Sita, as the marker of ideal womanhood, highlights how cultural narratives are shaped and, at the same time, how it disciplines and controls female identity in many Indian communities (see also Guzder, 2011). Bhat (2008) stated that although these narratives date from centuries ago, they are transmitted from generation to generation up to now. Nonetheless, it remains unclear to what extent and how it affects contemporary suicidal behaviour. Most literature from the six *girmitiya* countries do not elaborate as extensively as above on the relation of religion and suicide but briefly refer to the belief in reincarnation, destiny and fate (e.g., Garssen et al., 2007; Maharajh & Abdool, 2010; Morris & Maniam, 2001).

Explicit empirical support for the theoretical explanations concerning religion and suicide is lacking. Some studies present cases that hint incidentally to the influence of religious convictions. Maharajh and Abdool (2010), for example, described a situation of a Trinidadian Indian girl who died by suicide after her father rejected her relationship with an Afro-Trinidadian. Afterwards, the father displayed little guilt. Rather, he justified his actions referring to Hindu religious texts on purity and avoidance of honour loss and subsequent shame. Henson, Taylor, Cohen, Waqabaca, and Chand (2012) mentioned comparable findings in their exploration of triggers for suicide attempts, but they added that race and not religion typified the high suicide numbers among Indo-Fijians. Arora, Persaud, and Parr (2020) mentioned in their study on protective and risk among youth in Guyana that religion could be used to blame or shame girls if they overtly talked about their suicide ideation.

McCandless (1968), who studied the suicidal attempts of Guyanese men and women, explicitly stated that none of the clients mentioned religion or reincarnation related to their suicide attempt. Nevertheless, he made a connection between the *abhiman* syndrome he coined and the *Ramáyana*, by stating that Rama, in separating

from Sita (who was abducted), hurt himself to hurt her as a result of damaged pride. However, McCandless did not elaborate this *abhiman* concept, nor the possible face loss of Rama.

Some scholars refer to the spiritual world in terms of spirits and ghosts. Choenni (2009) mentioned explanations related to the belief in witchcraft and ghosts in Suriname; yet, how it is connected to suicide remains unclear. The connection with religion in these cases lays in the practice that people seek help of the pandit (Hindu priest) or the imam (Muslim predecessor). In other countries too, such as Trinidad and Tobago and Fiji, scholars refer to similar explanations (e.g., Forster et al., 2007; Maharajh & Abdool, 2010). According to Guzder (2011, p. 601), '[T]he prevalence of beliefs in *bhuts* (ghosts) further pervades the social space and lends impact from the suicide victim.' Although Guzder's analysis is based on the study of Indian women who died by incited and/or self-chosen suicide during the partition of India and Pakistan, it reflects the explanations in most of the *girmitiya* countries. Albeit a woman's suicide does not legally punish the abuser (in case domestic violence was the cause), it does culturally, as the Indian culture is familiar with shame and social disapproval connected to reputation.

4.2.2 *Strains in traditional practices*

Several traditional practices and customs that lead to discontinuity, and sometimes to strains, are (indirectly) causally connected in the literature to suicidal behaviour. Strains are mentioned all over the Indian diaspora in some (overlapping) recurring themes: changes in gender roles, generational conflicts, non-adherence to traditions and pressure to perform. The strains and the explanations presented as 'cultural' are embedded in family issues, which can be disaggregated into constraints by cultural traditions and the effects of changes in gendered family traditions. The following information is predominantly extracted from the presented cases in the literature.

Changes in traditions and traditional gender roles are related to suicidal behaviour. During the indenture period, the colonizer ascribed sexual jealousy as causal to male suicides, as Lal (2000, p. 216) restated: 'Unable to obtain or, worse still, keep their women, who supposedly exploited their sexuality to promote their own material interests, the men – so the argument ran – descended into despondency and melancholia and committed suicide.' Lal (2000) himself ascribed an important part of the suicide problem to the changing role of women due to emigration and indenture, whereas the men expected them:

> to follow the age-old ideals of Indian womanhood: silent acceptance of fate, glorification of motherhood and virginity, deference to male authority and, above all, worship of the husband. … The women's subordinate role, sanctioned by the sages of Indian civilization as well as the religious scriptures, was reinforced by their early marriage and the patrilineal and

patriarchal structure of agrarian Indian society. (p. 221)

A. Kumar (2017) reviewed colonial scriptures on the indenture period and described that after the arrival in the new country, in all diaspora countries, the *girmitiya* women were free to leave their husbands; their relations weren't legally registered, and the women had their own sources of income and were thus more autonomous compared to the situation in India. This liberty of the women was traditionally seen as an affront and loss of face for the male. Lal (1985) mentioned unsuccessful attempts by men in Fiji to restore the Indian patriarchal family system. These 'failures' are supposed to have formed the reason that leads to suicidal behaviour.

Studies of suicidal behaviour in contemporary time mention comparable findings on changes in gender roles in the Indian diaspora. The literature predominantly suggests that failure to fulfil the traditional role of the provider and uphold the male honour impacts Indian male suicidal behaviour (Garssen et al., 2007; Mayer, 2010). The changes in the female role seem to affect the marital relationship and lead to changed outcomes of expectations between the spouses. This association was made by Maharajh and Abdool (2010) too, who attributed the noticed suicidal behaviour to different changes in the family that pressurize traditional practices and relations of the Indo-Trinidadian society. In Fiji, Henson et al. (2012) pointed out that male Indians were more likely to endorse financial loss, which negatively impacted the traditional male role as main financial providers.

Several domestic issues are linked to explanations of women's suicidal behaviour. This includes marital problems and issues with family-in-law, which often resulted in domestic violence, whereafter the suicidal behaviour occurred. Hutchinson (2005) examined suicides in South Trinidad and demonstrated that the majority consisted of Indo-Trinidadians from rural areas, with a large share of women in the younger age groups, who suffered from family disputes and marital problems. Maharajh and Abdool (2010) confirmed these findings and added that transgenerational cultural conflicts, media exposure, problems with interethnic and interreligious relations and (effects of male) alcohol abuse (in domestic violence) form the explanations for the high suicide rates among Indo-Trinidadian women. In Fiji, suicidal behaviour is related to the high rate of arranged marriages, which is associated with marital conflicts and conflicts with in-laws in the early years of the marriage (Forster et al., 2007).

Conflicts that arise in the relation between adolescents and their parents are often mentioned as cause for suicidal behaviour of young Indians in all six countries. In fact, it concerns a clash between the parents' longing for cultural continuity and the youngsters' wish for change. The expectations that (grand)parents or family at large holds towards the children implicitly give age- and gender-related directions for proper behaviour. If the directions are not followed, it may lead to arguments, and the subsequent disputes sometimes lead to suicidal behaviour (e.g., CASR, 2015; Van Bergen & Saharso, 2016).

Harry et al. (2016) mentioned that women and young people in Guyana were trapped in their homes by a culture of control. These kinds of cases are often reported by newspapers in the Indian diaspora. A newspaper in Guyana mentions the case of a 15-year-old girl, who died by ingesting several carbon tablets, commonly referred to as 'rat poison'. She had allegedly 'informed her friends that she was experiencing problems at home … her parents had barred her from speaking to a man with whom she was having a relationship unknown to them' (*Demerara Waves,* 11 January 2014). In Guyana, too, Anthony et al. (2017) stated that the high numbers of attempted suicides among Indians in the age group 12–25 were due to family issues. Often the youngsters were expected to behave in a certain way, and with it fulfilling the aspirations of their parents. Hereby, the parents were controlling their adult children too. The latter, however, was not mentioned as such in studies from the other countries.

Maharajh and Abdool (2010) described the case of an Indo-Trinidadian girl whose family chose a partner for her, as had been the custom in the family for generations, but the girl did not want to comply to the choice of her parents. This 18-year-old Hindu female student ingested Gramoxone (the pesticide paraquat) after a dispute with her father about the arranged marriage. These issues are present in all studied countries and are more prevalent in traditional families in rural areas than in urban areas. Problems with in-laws were also more prevalent in traditional groups. Here, probably processes like education, emancipation and acculturation may have played a role in the observed differences. It remains unclear to what extent the specific triggers like parents' persistence for arranged marriage affect the male gender.

In Mauritius, family disputes account for the lion's share of youth suicide, followed by love breakdown and domestic violence (CASR, 2015). Similarly, young Indian women in the Netherlands, known for their high numbers of attempted suicide, experienced clashes with their parents (Boedjarath & Ferber, 2016; Salverda, 2004; Van Bergen & Saharso, 2016). The explanations for the suicide attempts range from conflicts arising from strict upbringing practices, with youngsters who fail to meet the (cultural) expectations of the parents to acculturation, and communication problems. Henson et al. (2012) mentioned the same findings in their study on Indo-Fijian suicide. For example, when moving to cities, the youngsters often want to adopt the urban lifestyle, whereas the parents reject that. Although in the Netherlands, young Indian men show an increase in the number of suicide attempts in the last decade, no explanation is provided for this phenomenon.

Next to the gender-related expectations, the tacit pressure to perform well, academically and socially, is mentioned in all countries as a cause for disputes between youngsters and parents. Sometimes a dispute is absent, and acquiring low grades or failing to pass school exams in itself seems to form a reason for suicidal behaviour. In Fiji, based on anecdotal evidence, Forster et al. (2007) mentioned that the number of suicides of young Fijians after failing to pass the school exams are mostly ascribed to

Indo-Fijians.

5. Bollywood[8]

The Indian cinema or Bollywood is included as one of the popular cultural expressions. Bollywood's representation of suicide and the inherent explanations are addressed here by discussing a few movies that depict suicide. The Indian film industry produces the highest number of films in the world and has more than 2.8 billion viewers in the world (Hong, 2021; Manohar & Kline, 2014). Bollywood cinema forms the largest part of the Indian film industry with a production of more than 1,000 films per year. Bollywood movies mirror the historical and cultural perspectives of the Indian society, with extensive display of family values, gender roles, norms and traditions, religious beliefs and so on. Bollywood, being a significant cultural resource, is consumed in India and all over the Indian diaspora, Hindus and Muslims alike (Lallmahomed-Aumeerali, 2014), and seems to have a socializing effect (Manohar & Kline, 2014). The Bollywood movies and related TV channels as well as other means of accessing Bollywood productions that vary from devotional-religious productions to glocalized imaging contribute to a global Indianness.

As cultural images, Indian cinema both reflect and set trends in attitudes, beliefs and values, varying from religious themes to the challenges of daily life (Deakin & Bhugra, 2012; Manohar & Kline, 2014). Suicidal behaviour is also presented in Bollywood movies, as suicides or attempts or contemplations and plans. Several unbearable situations are pictured as precipitants for the suicidal act. Mostly, the precipitants are gender related and embedded in interpersonal relations. Some recurring themes for the suicides pictured in the movies are unfulfilled desires in love relations, experienced pressure from others to perform and harsh economic living situations. A recurring theme is the threatened or tarnished *izzat* (honour). Often the forthcoming face loss forms the precipitant for suicide. These themes are present in the songs with which most Bollywood movies are larded. Not seldom, the nostalgic songs about (the threat of) losing the loved one hint to suicide by emphasizing the pain of separation that is unbearable and that takes away the meaning of life.

Diverse themes can be distinguished in the cinematic portrayal of female suicides, such as sacrifice or resistance, respecting traditional values, saving honour and face and so on. The Bollywood blockbuster *Padmaavat* (2018) pictures the practice of *Jauhar* (the mass self-immolation or suicide of women in response to defeat in a battle). In this movie, the female suicides had the function of protecting their honour before the enemy could loot it. It was referred to as an act of dignity, courage, resistance and sacrifice at the same time (Rajadhyaksha, 2018). Sacrifice as deference towards parents,

8 Some of the preliminary results of this section were presented at the international conference on slavery, indentured labour, migration, diaspora and identity formation. 19–23 June 2018. Paramaribo, Suriname

among others, can be read in the Bollywood movie *Mohabbatein* (2000). This movie features the heroine dying by suicide after her father rejected her love because of his lower status. Because she could neither be disobedient towards her father nor live any longer without her love, she died by suicide. These movies reflect the prevalent cultural notions related to a woman losing her honour, her position and status in the traditional Indian society; it often holds a 'dead end' for them. The loss of honour is not seldom related to the sexual honour of women, even in case of sexual abuse. Manohar and Kline (2014) illustrated how female suicide in Hindi cinema is often portrayed as the aftermath of sexual assault.

Face loss or saving face is a common and an explicit theme in many Bollywood movies, which sometimes activates suicidal behaviour. In the movie *3 Idiots* (2009), a student dies by hanging himself because he could not deliver a project in the given time. Yet another character in the same movie jumps out of the window of a building out of the threat of being rusticated. In both cases, the pressure for academic achievements appears to be the precipitant. In the movie *Chal Chalein* (2009), a student dies by jumping off the roof of the school building, after his father disagreed with his choice for a study. He wanted to study literature, whereas his father insisted that he should become an engineer.

Sacrifice is also a theme related to suicide in Bollywood movies, such as in *Aashiqui 2* (2013). In this movie, the alcoholic hero dies by jumping off a bridge, after he had heard that the woman he was in love with would give up her career to help him with his alcoholism. In several movies, the male characters resort to alcoholism as part of the act of suicide. In the movie *Devdas* (2002), the hero, failing to secure his love, leaves the world by drinking himself to death.

Failure, not seldom caused by financial problems, is frequently depicted as a cause for male suicide. In the movie *Anjaana Anjaani* (2010), one of the main characters got bankrupted and stuck with high debts. As a way out, he plans to jump off a bridge. In *Dhoom 3* (2013), one of the heroes chooses to die in front of the banker he was misled by. This type of suicide is connected to an old Indian custom of door-sitting or *dharna*. With *dharna*, one threatens with (suicide by) starvation, where creditors sit fasting at the door of the debtor until the claim is paid (Laidlaw, 2006). In *Dhoom 3*, the hero turns his personal face loss by creating face loss to the banker by dying in front of him.

In *Peepli Live* (2010), a poor farmer decides to commit suicide after he consulted the rural headmen who suggested him that committing suicide is a good way to get money waived. After his death his family receives heavy compensation for his death. With his suicide he saved face, by fulfilling his duty as a provider and 'taking care' of his family. Farmer suicides due to financial problems form a common issue in real time in India and are incorporated in the meta-narrative of scarcity, the agrarian development with techno-institutional changes and multinationals' hegemony. Münster (2015) called these suicides public protest suicides, as the dead body carries a meaning and a

posthumous message for the public and mainly the politics.

The movies and their relevant themes discussed above are no more than the result of a quick scan. This means that the impact of Bollywood on suicidal behaviour is merely suggested, and thereby, it has a highly interpretative character and does not address whether Bollywood affects the Indian culture. The other way around is more likely that Bollywood reflects the image of suicide as prevalent among Indians. This befits the findings of Stack and Bowman (2017) who stated that scripts in the cinema provide a cultural definition of suicide, including where suicide takes place. Nonetheless, as Bollywood movies are consumed intensively, it is imaginable that it may have a socializing impact. Several studies do mention the impact of Bollywood on other areas of daily lives, such as being encouraged to travel to Europe after seeing Bollywood movies set in Europe (Balabantaray, 2020). However, such studies on suicide are lacking.

6. Discussion and conclusion

To understand the explanations for suicide in the Indian diaspora, I first provided an image of the Indian diaspora, in general, and of six *girmitiya* countries, in particular. The latter led to descriptions of the main demographic characteristics combined with the suicide prevalence and an overview of relevant suicide literature. I uncovered an array of explanations, which I categorized into the academic explanations of the researcher and that of the research population. A selection of Bollywood movies was screened for their reflection of the prevailing themes related to suicide. The results show a variety of explanations present in the Indian diaspora. Both the researchers' and the examined groups' explanations can be called cultural, for both use a frame of reference with shared norms, values and meanings.

In the explanations of the researcher, the psychocentric explanations prevailed, followed by a focus on environmental explanations. Both were mainly described on an aggregate level. Herein, the lived reality of the research population received little room. A relevant element of the cultural perspective of the researcher is that it is formed in the Western world and therefore larded with elements standardized on the Western population, such as most of the questionnaires used to obtain data. Not only the literature that arose from Western countries and performed by Western researchers carry these features with them, but the studies from non-Western countries and performed by non-westerners too are imbued with it. Herewith, the two dominant views in the study of suicide, notably, the psychocentric view in the first place followed by the sociological (read: Durkheimian) view, have travelled around the world. This implicates that virtually all studies on Indian suicidal behaviour, the explanations included, are biased to a certain extent.

Most of the identified explanations from the actor's perspective can be boiled

down to the culture-specific themes, *izzat* and reincarnation. The cultural meanings attached to these concepts are seemingly reflected in several collective rules, norms, customs, ideas and so on and in several life domains. The *izzat* concept that is embedded in the community seems to be either directly or indirectly expressed in gender-based morals and behaviours with a communal steering, as is noticeable in several cases in the literature. The unlocked explanations are reflected in cultural customs, norms and values and 'survived' in the studied colonial diaspora. Since only the past decades, the contact between most of the countries, and with India, has intensified, and it is plausible that the survived practices and conceptualizations point at an intrinsically conserved cultural legacy. The common denominator of the screened cases was a deviation from the established values and norms, followed by attempts of the family to either restore the deviation or try to correct it with punitive actions. These conclusions, however, have to be further examined empirically.

Next to the similarities found in the examined countries, some differences between the countries are registered too. The age and gender groups with high numbers of suicidal behaviour seem to vary across the six countries. In Suriname, young men and female adolescents are at risk to die by suicide, whereas in the Netherlands, the middle-aged Indian men form a risk group, and in Guyana, the females in age group 10–19 outnumber the males with their suicide rates. Often the literature refers to rural areas, (lack of) education, social mobility, traditional gender roles and values as aspects coupled with suicidal behaviour. Herein lies an assumption that the opposites would be less vulnerable, which is not the case. In the Netherlands, for instance, educated and acculturated families with less hierarchical relations between parents and children form a part of the families that contribute to the high rates of suicide attempts.

I can state that the exercise of identifying the prevailing explanations for suicide in the Indian diaspora was fruitful given the rich amount of explanations this chapter extracted from the literature. Nonetheless, there are some points of discussion related to the data as well as to the way the data are interpreted. The latter leads to conclusions that challenge some prevailing findings on culture and suicide.

First, the literature on suicidal behaviour that included explanations varied in the six countries, whereof least literature was available for Mauritius. And most literature on suicide during the indenture period originated from Fiji. Remarkably, little to no literature about Indian suicidality was available for 1920–1960, for none of the countries. This hampered drawing a fluid line from the indenture period up to now. As for the quality of the literature, the more the researchers were affiliated to Western countries or had ties with medical, psychiatric or psychological professions, the more individual mental health issues and less cultural themes are mentioned as explanations. Moreover, it was noticeable that the literature from the Netherlands, Suriname, Guyana and Trinidad and Tobago tend to echo and refer to each other. A further aspect is that the available literature primarily focuses on Hindus, if religion

was mentioned at all.

Second, the historical data about the indenture period are not free from bias either. These data are predominantly accessed from colonial archives and contain time- and culture-bound interpretations, wherein the view of the colonizer overrules the voice of the Indians. The unquestioned use of these data validates the one-sided view of the colonizer. A tendency – mainly observed with Indian researchers – is the (unquestioned) use of data from the oral tradition, which are seemingly not seldom coloured by ethnic group emotions. Researchers' bias is also noticeable when the researchers (often historians) ascribe emotions (i.e., anxiety) and even syndromes (i.e., depression or alcoholism) based on contemporary interpretations to the indentured laborers without further explanation.

Third, researchers tend to culturalize aggregated data and ascribe the observed phenomena to group characteristics. A frequently noticed bias is that they equate the registered frequency of a behaviour to a cultural characteristic. The frequent use of pesticides as a means is often coupled by the researchers with a predilection of the Indians for those means, instead of relating it to the availability of the means. Similarly, the use of wordings like 'proneness' of Indians for a certain behaviour refers to frequently noticed behaviours rather than to a cultural expression. Still, this type of explanations that ascribe certain aspects to the Indian culture, such as the reluctance to communicate about feelings too, may indicate group-related inclinations that are worth examining.

Fourth, some of the explanations tend to be repeated by several scholars, whereas its basis is not founded. For example, the literature suggests that the belief in reincarnation, and the male domination and the subordination of female models in the ancient scriptures, becomes part of one's belief system, which, in turn, may lower the threshold to suicidal behaviour. However, there are some difficulties in these explanations. The scholars implicitly depart from the transfer of a static image of the characters in the narratives. This may be partly true, as the *Ramáyana*, for example, is recited from books written centuries ago. Nonetheless, processes like acculturation and emancipation may have changed the way the narratives influence daily lives. This diversity, however, is not reflected in the studied literature. Neither are other female characters from the ancient scriptures depicted, who are known to display power, such as *Kali*, the Hindu goddess of death, time and doomsday.

In addition, some findings of the scholarly literature can be challenged for its validity for Indians. Some studies performed in Western countries display certain beliefs and perspectives about precipitants among Indians (Salverda, 2004; Van Bergen & Saharso, 2016). Migration stress is often mentioned as a factor that increases suicidal behaviour. Indians, however, who are inhabitants for centuries in several countries and even form the largest ethnic group, such as in Guyana, still have the highest rates of suicide. The premise that migrants are influenced in their suicidal behaviour over

time by the hosting country is contradicted by the suicide rates of Indians in Western countries. The same accounts for the supposed protective factors, such as marriage. For young Indian women, marriage is a critical risk factor. These challenged findings imply that researchers and practitioners who adhere to the dominant perspectives in suicide research may not (have) aligned culturally with Indians.

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Chapter 4

Exploring cultural scripts of suicide

Chapter 4

Exploring cultural scripts of suicide

1. Introduction[9]

One of the main observations this thesis departed from is the lack of theoretical focus on cultural forces fostering suicide. The lion's part of suicide research is based on empirical knowledge, mostly accomplished without a theoretical framework (Barzilay-Levkowitz & Apter, 2014; Hjelmeland, 2010). The need for culturally suitable concepts is reflected in scholars' continuous use of the same scant available concepts, such as the classic concepts of Emile Durkheim. Although Durkheim's conceptualizations are useful, for the purpose of this thesis, it falls short. This thesis needs concepts that are not definitive, but rather open and loosely defined, to be exploratively used. Relatedly, a limitation of present cultural research on suicide is that it is substantially conducted from an outsider's perspective that centres the frame of reference of the investigator. As a result, the cultural perspective and the actor's view are either marginally discussed or not at all.

A concept that suggests overcoming both shortcomings is the concept of cultural scripts of suicide (Canetto, 2017; Winterrowd, Canetto, & Benoit, 2017). A script, as a structured cognitive representation, describes a stereotyped sequence of events within a certain context (Morrell, 2010; Schank & Abelson, 1977). Winterrowd et al (2017, p. 173) claim that the concept of cultural scripts of suicide reflects group members' attitudes and beliefs about suicidal behaviour and that it predicts that 'suicide is most likely among individuals and in communities where it is expected and most acceptable'. They state that individuals draw upon these scripts to make sense of suicidal behaviour. The scholars' argument is prompted by the 'observation that there is substantial and stable variability across cultures in the prevalence of suicidal behaviour' as well as in profiles (age, gender) and the methods used (Winterrowd et al, 2017, p.173). Indeed, these variations have been reported by several scholars (Colucci & Lester, 2013; Turecki & Brent, 2016). However, the variations are predominantly quantitatively registered on an aggregate level as differences between cultural groups around the world. The cultural scripts of suicide concept may shed more light on the operation of cultural factors related to suicide.

The literature on the concept of cultural scripts of suicide, however, displays

9 An earlier draft of the revised version of cultural scripts of suicide as described in section 2 of this chapter, is presented at the IASP Asia Pacific regional conference, 2–5 May 2018 in Bay of Islands, New Zealand.

some conceptual inconsistencies which are sustained by the absence of a theoretical foundation. First, 'script' as a concept is a stock of knowledge in a person's memory and suggests that the individual is an autonomous entity. Therefore, the step from 'script' to 'cultural' is audacious, because 'cultural' promises characteristics of a collective, a community. The concept of cultural scripts of suicide does not explain how an apparent individualistic concept as script acquires its cultural flavour. It raises the question how the cultural scripts of suicide capture collective forces. Second, the adjective 'cultural' in the concept implies a compelling outcome, suggesting that most individuals will display (at least) a tendency to engage in suicidal behaviour. As that is hardly the case, the question arises what 'cultural' means in the concept and more specifically how it is to be rescued from its deterministic implications. The goal of this chapter is to address these issues and explore whether a revised concept of cultural script of suicide is useful.

The relevance of this chapter is that is it adds to the body of theoretical concepts in suicide research in general. More specifically, it adds a revised and theoretically substantiated concept to the means of examining cultural factors involved in suicide by centring the cultural perspective and the actor's frame of reference. The process of de- and reconstruction of the concept of cultural script of suicide to make the concept suitable for exploration of cultural factors may serve as an example to make other concepts culturally fit too. It may be exemplary for the removal of deterministic rings to a concept. Thus, this chapter suggests how to make a concept useful for exploration.

In the next section, the flaws of the concept of cultural scripts of suicide will be addressed. By successively discussing the concepts of script, cultural script and cultural scripts of suicide, the two inherent problems of the concept are dealt with and repaired. At the same time, the theoretical fundament of the concept will be substantiated in the reconstructed concept. The method section describes how the revised concept is used to probe its usefulness in capturing cultural aspects of suicidal behaviour by focusing on male Dutch-Surinamese Indians. In Section 4, the scripts are sought for in the way they are mentally and behaviourally present. The results are presented in three temporal phases of the suicide attempt process: before, during and after the suicide attempt. In the conclusion, I will reflect on the workability of the revised concept.

2. Scripts and culture

The concept 'script' is a specification of the schema concept. Schema theory has its roots in the cognitive developmental psychology as proposed by Jean Piaget (1896–1980) in 1952. Based on previous experiences, schemata are organized in long-term memory as an associative network with different associative levels, wherein sublevels hold more specific information or subschemata (Demorest, 2012; Green, 2008; Wiederman, 2005). Schemata regarding a person, animal, object or event aid to understand and organize

the world. An event-specific schema is called a script. Similar to schemata, scripts are a stock of knowledge that is ready to be recalled when necessary to predict and interpret familiar situations and act accordingly. The denomination script is derived from the metaphor of drama and theatre: the world is a stage, where individuals (actors) have certain roles (to play) according to specific scripts.

Scripts are temporally patterned, stable cognitive representations of events (Chentsova-Dutton & Maercker, 2019; Morrell, 2010). To understand a situation and act adequately to it, a search in memory (cognition) is needed to activate the temporal associative series of actions (behaviour) which are stored as scripts based on representations of previous similar experiences. If there is an evoking context for the script, the required script is activated. The activated script then is 'entered' by the person who may or may not be aware of the activation of a script. Subsequently, the script guides the expected behaviours within a sequence of expected actions. The basic unit of a script is a 'scene'. The script for the needed 'appropriate' verbal and non-verbal behaviour for a customer in a traditional Western restaurant, for instance, consists of the scenes taking a seat, placing an order, being served, consuming the meal and paying the bill. Not the other way around. In the same situation, the restaurant script for the waiter or the cook differs according to his or her perspective and role.

Scripts can be read in a dual way (Albarracin, Constant, Friston, & Ramstead, 2021). The first reading is internalist, wherein cognitive processes lead to script appropriation and storage in the memory that serve to understand situations based on previous experiences. The second reading is externalist, wherein behavioural enactment of the script is centred. The needed behaviour then is guided by the script in a temporal sequence of actions. The literature is not clear about a possible variability that may arise due to differences between script appropriation and enactment. For theoretically, it is possible that people do learn several scripts they don't have to enter and enact, either by lack of the event or by choice. The possibility that a person does enter the script but acts differently (not as prescribed by the script or not the whole script) is not described in the literature either.

The concept of script is applied by a variety of disciplines in varying ways, and with differing definitions often used interchangeably without specification or reference to the underlying theory. In addition, researchers often use script synonymously with denominations of schema, action, pattern or even with customs and roles (see Albarracin et al., 2021; Chentsova-Dutton & Maercker, 2019; Wiederman, 2005). The lack of demarcation of the concept in the scholarly literature gives the script concept a fuzzy image.

The focus on the individual and his or her memory and behaviour, respectively, as the site of storage, processing and appropriation of scripts suggests an autonomous individual process. It suggests an individual self-contained unit that is programmed to perform actions, without reference to the external world. Nonetheless, scholars

expanded the script concept into 'cultural scripts' (Morrell, 2010; Schank & Abelson, 1977). The specification of script into cultural script seems to hold several untenable presumptions. It presumes that similar individual mental representations exist in the minds of all members of a group. This presumption suggests a far-reaching homogeneity in a group: the existence of and familiarity with the same scripts among all individuals and that all group members will follow (the same) script. As people in a group differ due to several characteristics, such as gender and age, it is to be concluded that they will not enact the same scripts in the same way, even if they all are familiar with the prevalent scripts. An illusionary presumption is that cultures are well demarcated and statically incorporated in a script.

Scripting theories lack a sufficient account of social structure (Albarracin et al., 2021; Green, 2008). Often, the scripting literature frames frequently registered behaviour in a group as cultural, befitting the Weberian analogy: a group of people may put up their umbrellas when it rains, yet it does not indicate cultural behaviour; rather it is a collective response to the elements (Schroeder, 1992). To bridge the gap between individual script and culture, most scholars tack on an additional concept from outside the scripting framework, such as contagion. Herewith, they leave the structural shortcomings intact (see Green, 2008). Other scholars do refer to the prevailing cultural values and norms involved and to cultural scripts as a shared repository of representations of appropriate behaviour that guide individual decisions (Meng, H., 2008; Mueller & Abrutyn, 2015). An illustration provided by H. Meng (2008) is the gift-giving cultural script that engenders an average American to open a gift immediately, whereas an average Chinese will open it after the giver has left. This type of examples describes *what* cultural scripts supposedly are, but it does not clarify *how* the individual script becomes a cultural script, thus shared by a collective.

Leaving aforementioned ambiguities on cultural scripts intact, scholars apply the concept of cultural script to several phenomena, such as suicide. The proponents of the cultural scripts of suicide depart from the assumption that individuals tend to engage in behaviours that are expected and meaningful for themselves (Canetto, 2017; Eisenwort, Hinterbuchinger, & Niederkrotenthaler, 2014). Combined with the findings that there are cultural patterns of suicidal behaviour across the world, they developed the proposition of cultural scripts of suicide. This concept narrows cultural scripts down to suicidal behaviour. It implies that people with the same cultural background share prevailing beliefs, attitudes, meanings about suicide and the knowledge about the prevailing suicide triggers and methods.

The 'evidence' the scholars supply for the proposition of the cultural scripts of suicide concept relies heavily on former anthropological studies that suggest a relation between suicidality and culture. Especially the empirical works of Rubinstein (1985) and Counts (1991), respectively in Micronesia and Papua New Guinea, are cited to prove that the individual act of suicide is to be seen as a culturally constructed act

performed in the context of a cultural system of meaning. Hereby, 'the rules of suicide determine', as Counts (1991, p. 215) stated, 'who may legitimately commit suicide, why, and how it is done'.

Both Rubinstein (1985) and Counts (1991) found that suicide was an acceptable option in certain circumstances for certain people. For the survivors, they reported, the suicidal acts included a cultural 'code' of understanding and reacting to the message that the suicide conveyed. For example, in some areas in China and New Guinea, female suicides related to domestic violence often activate a script of revenge after their passing. Hereby the relatives seek compensation, either by financial restitution from the perpetrator or by physical penance (Counts, 1987; Meng, L., 2002). Counts (1991) even posited that:

> a person who is contemplating suicide will refer to these publicly shared understandings for, by so doing, he can legitimize and give meaning to his own death, both for himself and for others. He may also be able to control the consequences of his suicide and establish an agenda for his friends and kin to follow in response to his death. (pp. 215-216)

Analogous to Counts' (1991) reasoning, suicide script scholars claim that individuals draw upon cultural scripts of suicide in deciding *when*, *how* and *why* to engage in suicidal behaviour (Canetto, 2017; Eisenwort et al., 2014; Winterrowd et al., 2017). Winterrowd et al. (2017, p. 173) stated that an individual may draw upon a cultural script of suicide to determine 'whether (i.e., depending on cultural beliefs about acceptable conditions for suicide), and then how (e.g., via what method) to engage in suicidal behaviour'. Canetto (2017, p. 59) presented a broader description of cultural scripts of suicide which seems to cover the whole phenomenon of suicide: 'A suicide script also includes the person expected to engage in suicidal behaviour, the suicide method, the emotions and motives.' She also includes the environment's reactions and 'the outcome of the suicidal act', that is, the nonfatal versus fatal outcome, as well as 'the social consequences of the suicidal behaviour'.

Furthermore, she describes scripts of suicide as both descriptive and prescriptive, and implicitly influential instead of consciously adopted.

Next to the pretence of being comprehensive, the scholars of the cultural script of suicide omit to provide a clear conceptualization of the concepts 'culture' and 'scripts', both separately and in interaction. This poses two challenges that resemble the flaws in the cultural scripts theories in general. First, the cultural script of suicide concept points at individual behaviour with a collective rooting but fails to explicate how the collective is anchored in the scripts. In other words, it remains unclear how an individual concept as script gets cultural. Second, the way culture is used in the concept of cultural script of suicide seems to be compelling.

Regarding the first challenge (how scripts become cultural scripts), the social

learning theory (Bandura, 1977) and symbolic interactionism (Blumer, 1969) may shed some light. The social learning theory holds that through social interactions and modelling, people learn behavioural conventions, cultural norms and social standards for several situations and life domains. The premise is that the more an individual is exposed to certain behaviour, the larger the acceptability and feasibility of that behaviour and the lower the threshold to display similar behaviour in a similar context. Scripts, then, are acquired directly as well as indirectly. It is learned directly from observation and imitation of actions demonstrated by interpersonal contacts with behavioural models like parents and peers and indirectly from several media or books, for example. But as Abrutyn, Mueller, and Osborne (2019) delineated, the social learning theory does not clarify how structural or cultural milieus facilitate or constrain social learning.

Symbolic interactionism gives more leads, because it emphasizes the idea that behaviour is based on the meaning people attribute to social interactions. This theory suggests the dependency of human behaviour on the social interactions in a shared culture. The intersubjective meanings that people acquire through these interactions are decisive to comprehend their everyday life and their place in society. This thinking aligns with the cultural framework of Strauss and Quinn (1997), who emphasize the shared interpretations of situations, objects and symbols as characteristics of a community wherein culture is both in the world and in people's minds. Herein, the cultural meaning people attach to different phenomena is crucial. Similar to Strauss' and Quinn's (1997) rationale of the presence of culture in the inner and outer world, Chentsova-Dutton and Maercker (2019, p. 4) emphasized that scripts reside 'in the head as intersubjective norms of what happens (e.g., norms of behaving during a funeral), as well as in the world as observable and structured steps (e.g., burial rituals)'.

As the individual operates as the bearer of cultural scripts and acts as an agent of the collective, infusing the cultural script of suicide concept with the precondition of group-specific norms, values, beliefs and so on will enhance its theoretical foundation. A cultural script of suicide, then, points at sequential cognitive behavioural structures acquired during socialization and interaction within a group with culture-specific norms, attitudes and beliefs related to suicide.

The second challenge is that the notion of culture in the suicide script concept has a compelling connotation. The concept suggests that all members of a (sub)cultural group are driven by the same scripts of suicide. Using the suicide scripts concept, Stice and Canetto (2008) and Winterrowd et al. (2017) examined beliefs about precipitants for suicidal behaviour as held by students and older adults, respectively, in America. All of them used fictitious obituary as material and suggested a 'gendered cultural suicide script for older Euro-American adults'. Likewise, Eisenwort et al. (2014), who studied media portrayal of male and female suicidal behaviour, concluded that 'Austrian cultural scripts of suicide' reflect prevailing sexist cultural attitudes in the

Austrian society (sociable, mentally disturbed women and angry, rejected men). Apart from the fallacy of the scholars to collapse attitudes and preferences into scripts, not all Euro-American older males and not all Austrians familiar with the cultural suicide scripts are inclined to display suicidal behaviour. As all individuals are seemingly subjected to the prevailing cultural scripts, the statements in these studies assume a deterministic and compelling nature of culture.

Although groups both shape and are shaped by the tenets of their culture, this does not apply equally for all its members. Based on a single cultural feature, be it language, religion, gender or region, one cannot make statements for the whole cultural group, as groups are not homogeneous. Surely, culture is not static, nor an immutable 'thing'. Rather, as Kagawa Singer et al. (2016, p. 242) argued, culture is 'a constantly evolving, multidimensional, multi-level process that encompasses all aspects of the human condition'. In similar vein, Spivak (2006, p. 359) described culture as 'a package of largely unacknowledged assumptions, loosely held by a loosely outlined group of people, mapping negotiations'. This implies that the cultural script of suicide concept can be indemnified from its uniform implications by explicitly adopting a broad notion of culture.

To safeguard the cultural script of suicide concept from its compelling connotation, the notion of culture should be loosely defined. A non-mandatory, non-compelling notion of culture leaves room for divergent outcomes connected to the heterogeneity of the group. Moreover, cultures are not compelling, nor are the cultural scripts of suicide, not even when incentives for adherence to cultural norms lead to internal and external positive affirmation of the scripts. Therefore, the 'guidance' from the scripts may actually be tendencies and inclinations, for an individual can follow the cultural script, manipulate them, subvert them or rebel against them. The subsequent variations in script, then, are attributable to the characteristics of the notions of both script and culture.

The notion of script as an individual cognitive storage capacity points at a capacity of the 'inner' world that operates without intervention of the 'outer world'. Cultural script, however, implicitly presupposes the existence of a culture, that is, an outer world. Otherwise, it would not be possible to maintain the existence of scripts with cultural content. As a result, the individualistic view of script is not a tenable position. But assuming that there is a culture that provides the content of scripts leaves the question unanswered of how variations in outcomes of the scripts are to be explained. This is only possible if the scripts are not the same for everyone. That is, individuals slightly influence the scripts by adhering different meanings to the script or express it differently. Therefore, script is not a mould in which everyone is equal to each other. A second varying factor is that the concept of culture offers more room for script variation. Therefore, both script and culture separately offer variations in meaning and expression. This variation of script as well the variation in culture in my revised version

befits the notions of Strauss and Quinn (1997).

Thus, for an explorative use, the concept of the cultural scripts of suicide requires two preconditional add-ons: a (sub)cultural group that shapes the scripts of suicide with its prevailing norms and values and a loosely defined notion of culture. Cultural groups, then, are heterogeneously composed groups of people that share beliefs, traditions and practices. Even if one is familiar with the prevailing cultural scripts, the cultural heterogeneity, variation and hybridity must be considered (Green, 2008; Kagawa Singer et al., 2016; Strauss & Quinn, 1997). Given that groups are not homogenous, cultural scripts may exist with differing accents and outcomes for subgroups. That is, the cultural scripts can show variations per subgroup, because of internal differences like gender, religion, class, sexual orientation and so on. Nevertheless, within the subgroups, some standardized features should be traceable, to speak of cultural scripts of suicide. The scripts should be relatively stable in time so that it is recognizable, and it should be socially learned and guide the behaviour.

Some indications to study the operation of the cultural scripts of suicide empirically can be drawn from the revised concept of cultural scripts of suicide (with the two preconditional add-ons), combined with the three conditions for script-driven behaviour as described by Abelson (1981, p. 791): 'First, the individual must have a stable cognitive representation of the specific script. Second, an evocative context must be presented for the script. Third, the individual must enter the script.' This sequence of conditions is time-related as it follows a relatively fixed order of actions that is part of the script concept, as illustrated with the example of dining in a restaurant.

Applied to studying suicidal behaviour, the cultural script of suicide concept should capture culturally shared notions about suicide. Cultural scripts of suicide exist as (families of) schematic sequences that are dynamic rather than static. These cultural scripts can be assessed as present in the inner and outer worlds (Chentsova-Dutton & Maercker, 2019; Strauss & Quinn, 1997). In the inner world, scripts are present as mental concepts (for understanding a situation) and, in the outer world, as (rules for) behaviour. The latter two, the mental and behavioural representations of the suicidal act, may serve as indicators to identify cultural scripts.

3. Research population and methodology

The research group consisted of male Dutch-Surinamese Indians. As delineated in the previous chapters, the Indian group has distinctive cultural features with enough pronounced gender differentiations despite hybridization and acculturation. The male gender is often socialized with specific norms and values, which made this group suitable for the examination of the usefulness of the revised concept of cultural script of suicide. The focus on the male gender is inspired by the prevailing preference for Indian Dutch-Surinamese females (see Montesinos, Heinz, Schouler-Ocak, &

Aichberger, 2014). Hence, a study of Dutch-Hindustani males represents an addition to the existing literature, the more so when considering that they have significant higher suicide rates in the Netherlands compared to other males. Especially, middle-aged Dutch-Surinamese Indian men are known to have significant higher suicide rates, and young Dutch-Surinamese Indian men display elevated rates of suicide attempts in the last decennium (e.g., Burger, 2013; see Chapter 3).

To probe the cultural scripts of suicide concept, I selected cases from my psychotherapy practice where I treat people above 18 years old. In the selection of the cases, I used the following criteria: men of Dutch-Surinamese Indian origin, a balanced distribution of age, a history of attempted suicide and the case file should be closed for at least one year. I approached several former patients personally and explained them by phone the purpose of the research and asked their permission to use their case file, anonymized. No one had objections and provided informed consent. Some even reacted with 'it might help others', but also 'are you sure I won't be recognized?'. I asked them explicitly whether there were parts of their file/story they objected to be used in the research. I offered them the possibility to approve the written ethnographies (on unrecognizability) before I processed it in the thesis. Only one person accepted this offer. Finally, I selected seven cases of ex-patients, whose therapy had ended 1–3 years ago.

Of the seven examined cases, three were referred by their general practitioner for psychotherapeutic assessment and subsequent treatment because of their recent suicide attempts. The others had attempted suicide in the past, varying from 2 to 12 years before the start of the therapy. The latter group's (former) suicidal behaviour was not (directly) related to the reason of the actual referral. None of the cases had attempted suicide more than one time. See Table 4.1 for some more characteristics of the cases.

Table 4.1. Characteristics of the cases (*as registered at the time they were in therapy*)

Name*	Age	Marital status/ number of children	Age of suicide attempt	Religious back-ground	Precipitants	Means
Shafiq	34	Married/2	28	Muslim	Interpersonal issues	Prescribed medications
Ma-hesh	29	Married/0	17	Hindu	Legal conviction	Medications and alcohol
Vijay	26	Married/0	23	Hindu	Interpersonal issues	Alcohol and prescribed medications
Roy	26	Married/0	26	Hindu	Interpersonal issues	Alcohol and chlorine
Paul	59	Divorced/4	53	Hindu	Interpersonal issues	Hanging, alcohol
Anand	42	Married/1	42	Hindu	Traumatic event	Chlorine
Ishaan	45	Divorced/2	39	Muslim	Problems at work	Alcohol and prescribed medications

** Fictitious names Source: own construction*

All cases were socialized in Indian families, and all were part of the Dutch-Surinamese Indian community. The variations (e.g., age, religion, marital status) were considered as they intersected in a specific way for each case. All cases carried implicit information about their ethnic, cultural and religious background and possible subsequent values, which may have influenced the suicidality. To avoid stereotyping and essentialization, during the therapies I had verified with the patients several of my assumptions. For example, while Shafiq's name clearly referred to a Muslim background, I had to explore if and how religion had a place in his life. Or, the opposite was present, such as Anand who had become non-religious. But even then, I had to explore if and how their religious socialization was related to the way one deals with the current problems. Religion appeared to be active in four cases. Paul was a practising Hindu, as were Vijay and Mahesh, and Shafiq was a practising Muslim. The rest practised religion only on the major religious happenings (like *Dìwáli* or *Eid*), or they considered themselves as non-practising.

Next to the data extracted from the case files, inside knowledge as part of opportunistic research was applied. This triangulation was especially applied in the extraction of the data from the case files as well as in the interpretation of the data. Hereby, I consulted the research team regularly, which consisted of professionals and Indian experts. The latter aided in identifying the cultural elements and interpreting the used proverbs and sayings and religious expressions.

I analysed the selected cases based on the theoretically revised cultural scripts of suicide concept. To identify the cultural scripts of suicide, I focused on their presence in the inner world and in the outer world. That is, the mental representation of the script was searched for in the narratives, as far it was present in the case file notes. Next to that, scripts were looked for in the behavioural acts in the outer world. The indicators for the scripts were that they had to be shared, patterned, recurring, somewhat standardized mental and/or behavioural representations of the suicidal act as present in the narratives.

The search focused on three separate temporally ordered phases, each with their own scripts with temporally patterned sequences of action. The content of the phases of suicidal behaviour is mentioned in the (aggregated) literature as culturally varying across the world (Turecki & Brent, 2016). The first phase consisted of the evoking event that preceded the actual suicidal act. The evoking events were triggers or precipitants that led to the suicide attempt. Of the surfeit of triggers or causes of suicidal behaviour (often denoted as risk factors) delineated in the literature, some are examples of culture-specific triggers, such as an honour tarnishing event.

The second phase consisted of the performance of the suicidal act, which includes the circumstances, location and the methods used. The familiarity with the means and locations, its availability and the social acceptability result in a varying predilection for certain methods and locations around the world (Callanan & Davis, 2011; Spijker,

Graafsma, Dullaart, & Kerkhof, 2009). In the United States, most suicides occur by using firearms, whereas in rural areas of developing countries, using pesticides is common (WHO, 2014). Gender has a role too in the method choice. Callanan and Davis (2011) found that in suicides, women in the United States were more likely than men to avoid facial disfiguration. They also found that the higher the number of stressful precipitating events, the greater the likelihood that men in the United States will die by suicide by means of a lethal disfiguring weapon.

The third phase was formed by the reactions afterwards. This included the reactions of the person who had attempted suicide and the reactions of the bystanders. The latter were included as they too are part of a cultural script of suicide, from their own perspective and with a different role. The reactions of bystanders may also reflect the cultural meaning that is attached to suicidal behaviour afterwards. The cultural meaning is found in the narratives of the family and other people close to the person who enacts the suicidal behaviour (Colucci & Lester, 2013). However, given that case files were examined, the bystanders' view is inherently indirect for it is presented by the examined case and limited to the information available in the files.

4. Dutch-Surinamese Indian men's cultural scripts of suicide

With a focus on each phase of the suicide attempt, the cultural scripts are identified, as present in the narratives of the cases, either as mental representations or as behavioural acts. Scripts are included as such as they met the indicators for the scripts, notably, shared, patterned, recurring, somewhat standardized mental or behavioural representations of the suicidal act.

The results are presented in three subsections. The subsections are guided by the three successive temporal phases of the process of suicide attempts I focused on in the analysis of the case files. Before the suicide attempt, the precipitants that triggered the attempt are centralized. During the act of suicide, the methods, location and circumstances of the suicide attempt are discussed. And after the suicide attempt, the reactions are addressed. One enters a script of suicide relevant for each phase in a certain order. For instance, if one consumed a poisonous substance to perform the act of suicide, the following sequence of actions was present mentally as well as behaviourally: one is in a certain location with or without the presence of others and locates the poison, opens the package, consumes the poison and then the body reacts in a certain way and so on.

4.1. Precipitants of the suicide attempts

Before the suicide attempt, scripts related to the precipitants or triggers can be singled out per case. Paul, who recently turned 59, was referred to me for assessment of his

mental condition and subsequent treatment by his general practitioner. The letter of referral noted: 'mood swings, frequent relapses in alcohol use, poor sleep, no work, few social contacts'. Paul is divorced, and only one of his four children, his eldest daughter, maintained contact with him. He spends his days watching television, mostly Indian satellite TV. Occasionally, he goes out to get some groceries, but often his daughter brings him the daily necessities. The contacts with his friends have diminished: 'All my friends have their jobs and families; I don't want to bother them.' Gradually he has got socially isolated. This gradually worsened situation started since he lost his job as a car mechanic a year ago. After a major reorganization, the firm had to let go of many employees, including Paul.

During one of the assessment sessions, I asked him what his thoughts were regarding his future; he seemed to avoid answering that question by referring to the unpredictability of life with the remark *upparwálá kháli jáne hai, ká báki hai* [only the One above knows what's left to experience]. This answer made me explore possible suicidal ideations, given the implicit resignation. My question, 'Do you ever think of suicide?', incited him to talk about his suicide attempt of 7 years ago.

> Yes, sometimes I think *jiye ke kaun fáidá hai?* [what's the point of living?]. *Lekin, ká kari?* [But what will I do?] I have to put up with this life. Maybe it will be better in the next life. Don't worry, I won't hurt myself. Not anymore. Not like then. Back then, I didn't see any other way out. I couldn't bear the situation anymore and I tried to hang myself.

In this short phrase of Paul's answer, I hear a few topics that I had to explore further. I note several questions: 'is he still suicidal?', 'are those thoughts about "the point of life" part of a suicidal ideation?' and 'is the way he says to deal with the suicidal thoughts part of a rationalization of his suffering, a coping or a way to reassure his environment?' The answers to these questions may hold cultural scripts. An important theme I will come back to is his implicit reference to his Hindu background. His wording 'better in a next life' makes me think of reincarnation. But I have to check what that means to him, whether he used those words just vernacularly without any reference to suicidality, and as soothing subtitles for his current unpleasant condition. I have to check if this kind of reference to a next life is part of his coping style to deal with negative situations in general. Likewise, whether 'don't want to bother others' stands for something else, such as feeling ashamed for his situation. When invited to tell me more about his suicide attempt in the past, he says:

> A few days before I tried to hang myself, my wife had announced to divorce me. We had our quarrels, but our relation was ok, I mean we were together for almost 30 years. … Our parents had arranged our marriage and we grew to love each other. We raised our children, had our jobs, had holidays; we did well, compared to many other couples. At least, that's what I thought.

> For me, it was a complete surprise that she wanted to end the relation. She had her mind made up; she was unhappy for a long time already she said. I couldn't reason with her. My whole world collapsed. It was like I was nothing. A complete loser, who couldn't keep his wife happy. I was angry, sad, felt abandoned, felt guilty, ashamed; all at the same time. I didn't sleep for days and one evening when I was alone, I thought it would be better if I was dead.

Paul describes some aspects that I noticed in the other cases too, which seem to be culturally scripted, notably, the feeling of being overwhelmed by the suddenness of an event and the feeling of failure. From other cases in my practice, I knew that being overwhelmed, thus not having control, often causes helplessness and frustration, which can end in a suicide attempt. The suddenness of an event does not equal the lack of suicide ideation. Rather, one may have been latently suicidal, and an event may form the trigger to the suicidal act. The feeling of failure may be related to scripts as it often followed after an adverse event whereafter the suicidality became manifest.

In Anand's case, a variation of the script of being overwhelmed and subsequent failure was manifest. He was unable to work and to be the provider, although his inability to work was a result of force majeure. Anand was referred to me with a short note of the general practitioner: 'attempted suicide last week, not able to work since severe accident at work, several surgeries, PTSD [post-traumatic stress disorder]'. Half a year ago he had a severe accident at his work at the fish auction. His shift was over, and he was on his way home when a forklift truck with pallets full of frozen fish made a sharp turn and heavy boxes with frozen fish fell on Anand. Anand had a crushed vertebra and fractured pelvis, and several operations were needed. Now he follows a revalidation programme. When I asked whether Anand had planned his suicide attempt, he told me the following.

> No, I did not plan it in advance. I came home from the hospital where I follow the revalidation program. The physiotherapist had told me that progress was minimal and that I had to prepare myself for a future with impairments. That touched me, I remember that I experienced a kind of drain of all my energy at that moment. What was my worth as a man? Should my girlfriend support me? I didn't think of ending my life at that moment. The idea grew, I guess in half an hour after I arrived at home. At that moment I wanted everything to end, I couldn't think of anything else. The thought of not being in this world just came into my mind as the solution and it was stuck in my mind. Then I started searching for something to end my life with.

In Anand's narrative, I recognized cultural elements from other cases I had met before, such as the importance of the role of the male provider. This made me look closer at his socialization in the next session. Anand was raised with pronounced gender

roles, and although he didn't typify himself as traditional, he did value the example his father gave him by being the provider of the family. He wanted to make his parents proud. An aspect that touched him in his masculinity was the erection problem he experienced since the accident; that enlarged his feelings of failure. His girlfriend was very patient with him, like the rest of the family, but Anand was full of self-criticism and self-devaluation. In the course of the assessment, it appeared that Anand had indeed developed post-traumatic stress disorder (PTSD), which was neglected as all professionals focused on the severe somatic injuries. Although PTSD is a psychiatric diagnosis, the manifestation, the symptoms as well as the route to recovery can be culturally coloured (Chentsova-Dutton & Maercker, 2019). For example, nightmares are often part of a PTSD and are seen as an expression of trauma, yet in some cultures, the explanation prevails that a spirit is bothering a person in their sleep.

The other two cases with a recent suicide attempt had experienced interpersonal problems, which points at another script of suicide related to the precipitants. Roy, the son of a successful businessman, had a relation with a Dutch-Surinamese Indian girl since high school. In the biographical anamnesis, it appeared that a year ago they were married according to the Hindu rites, whereafter they lived together in an apartment his father bought for them. The Hindu marriage was important so that the couple could live honourably together. The legal marriage was subordinate to it, for both families, so they did not marry legally. The couple abided by the traditional values to conform to the wishes of their parents. The wedding was planned for a year, and the parents of both sides invested a lot of money in the large-scale wedding; they went to India to buy the wedding costumes and the jewellery, the wedding cards were printed in India, a popular band was hired and so on. The big wedding led to huge appraisal from the community; people talked about it for quite a long time.

However, their relation started deteriorating soon after. It started with little quarrels about the interior of their apartment. Then she stopped joining him on their weekly visits to his parents. When I asked how these changes impacted him, Roy narrated:

> I didn't recognise her anymore; she had changed a lot. She was no longer the sweet Asha I knew; she was grumpy and sulking all the time. Two weeks ago, the word got out: she no longer loved me. No other man was involved she assured me. She just wanted to live on her own, it all had happened too quickly, we were married too soon according to her. And then she was gone. She just packed up and went to her parents. I was desperate. Some of my friends came over and we sat together all evening and had a few drinks. They tried to comfort me; 'don't worry, she will come back'. It didn't comfort me.

Next, Roy explains how his thought caught him in a downward spiral. Here, I tried to identify the influence of his socialization in the Dutch-Surinamese Indian community.

Given that culture is loosely defined, I could not assume that he would have been socialized in the same way as the other cases. Moreover, his family's much appraised image in the community could have an influence too, in terms of not wanting to bring about negative changes to that image. When I explored these possible influences by asking him to tell more about his thoughts, he replied:

> I went to the bathroom and several thoughts raced through my mind: 'How can I face my family? After all my parents have invested, *manai ká boli* [what will people say]? They will be laughed at. How can I live without Asha?' These thoughts were overwhelming. Then I opened the bathroom cabinet and took the bottle of chlorine.

More than was the case with Paul and Anand, the role of *manai ká boli* seemed to be present in Roy's case (*manai ká boli* is extensively discussed in Chapter 5). The mental activation of this steering code in Roy's case seemed to be related to the expectations created by the large-scale wedding, which cannot be fulfilled anymore. Roy was not only concerned about his own image; rather the first thing that came to his mind was the societal effect on his parents. This points at the effect on the individual of the interconnectedness within the family. He had the idea that he had failed in the relation and felt obliged to prevent that his parents would experience the negative consequences. Roy knew that the forthcoming frustration and embarrassment would be felt by the family at large, given the collectiveness of the marriage.

Next to the cases described previously, Ishaan, Mahesh, Shafiq and Vijay too experienced failure. However, there is a variation in the causes as well as the extent of the experienced failure. Ishaan experienced discrimination at his work, based on his Muslim background: under the guise of jokes, his direct colleagues often made remarks like 'do you carry a bomb?'. And he was blamed by his management not to be assertive enough and to 'men up'. He felt not being heard by the company doctor he had to visit in a sick leave 'you have to work, you're not ill'. Ishaan experienced failure as he could not manage the situation at his work. Mahesh, on the other hand, who came for therapy to process the traumatic experiences of domestic violence in his youth, had attempted suicide after he lost his job in the security sector, after he got convicted for having abused a police officer; 'I snapped after a night out, I don't know how come, it is so embarrassing.' And Shafiq's attempted suicide was accompanied with embarrassment and failure related to his 'self-caused' situation, as he had a restraining order and couldn't see his children because he had had hit his wife in a fight. Concerning the suicide attempt of Vijay: he felt suffocated by his mother and his wife and felt stuck between their wishes. He wanted to please them both but couldn't manage it and felt that he had failed.

This registered variation of the same theme, failure, fits in the reworked notion of cultural scripts of suicide, wherein culture is non-compelling and script has a

certain durability with room for variation. The same goes for the related phenomenon, notably, face loss. In virtually all cases, I registered the operation of face albeit to a varying degree. Face is a ubiquitous concept that exists in all cultures, yet its meaning differs inextricably per culture. In Western cultures, face is primarily an individual matter (Goffman, 1955), whereas in several non-Western cultures, the interpersonal reciprocity is emphasized with a mutually restrictive, sometimes coercive, power that is exerted upon each member (Ho, 1976). Face is closely related to constructs such as status, dignity, honour and prestige. Face is not necessarily strived for, as it is achieved by doing good or ascribed by the community (Baig, 2012; Ho, 1976; Kinnison, 2017). Losing face in some cultures is much more intense than suffering embarrassment or shame, which is the common expression for westerners in case of face loss. Face loss occurs when the individual, by own action or that of the closely related group, fails to meet essential requirements placed upon him or her by the social position he or she occupies (Ho, 1976). This implies that failure can lead to face loss of the person and/or the family.

Face is related to honour or *ijjat*. Traditionally, in the Dutch-Surinamese Indian community, enhancement of face by protecting the *ijjat* is seen as a (tacit) duty of the individual, the family and sometimes the community. Not abiding to the rules of upholding the *ijjat* can lead to a tarnished *ijjat* and face loss. Losing face can negatively affect one's ability to function effectively in the family or community. In extreme cases, loss of face can be experienced like losing one's place in life (Kinnison, 2017). Murray (1999) delineated that strategies people use to avoid loss of face vary from social isolation to retreating permanently from potential face-losing situations, and sometimes resorting to suicide. This phenomenon was in greater or lesser extent noticeable in all examined cases.

In the past among Dutch-Surinamese Indians and to date in India, the negative effects of damaged *ijjat* and subsequent face loss are known to have far-reaching consequences. Damaged sexual reputation (of women), for example, can lead to suicidal behaviour or honour-related violence and even honour-related killings (Vishwanath & Palakonda, 2011). The latter seems to be extinct among Indians in the Netherlands; however, the face-saving steering code *manai ká boli* is very much active, for example, in domestic violence (Boedjarath, Vaassen, & Spaans, 2021). The implications of *ijjat* are extensively elaborated for women, yet the consequences of this cultural norm for Indian men's suicidal behaviour have remained unclear. This is due to the practice that women (read: women's sexual honour) – as an objectified touchstone of the family *ijjat* – are often targeted. Nevertheless, men, too, must comply with *ijjat*, often connected to an undisputed reputation in general sense.

4.2. Circumstances, location and methods during the suicide attempt

The actual act of the suicide attempt displays some characteristics, of which some are

valid for each case. A distinctive characteristic of the examined cases is that they all kept their suffering from the problems they encountered silenced or hidden. An exception was formed by Roy, who talked about it with his friends. This fits the idea that one can deviate from the script, leading to different outcomes. But like all the others, Roy kept his suicidal thoughts private too. The hidden suicidal ideations gave the suicidal acts an impulsive impression (see also Chapter 3). In observable behaviour, the silencing is reflected in a shorter duration of the observable part of the suicide process. In other words, there is often a short time from the manifest suicide idea to actual suicide act. Both findings are in line with findings in the literature. Leenaars, Girdhar, Dogra, Wenckstern, and Leenaars (2010) found that Indians compared to Americans appeared to have more indirect or masked expressions, primarily in the intrapsychic domain. The authors ascribed the difference to the more collective nature of the Indian culture, with features like humility, submission, devotion and subordination (see also Chapter 5). This implicates that Indians don't tend to seek help for this kind of suffering and thus remain largely unnoticed by the health care (Gunasinghe, Hatch, & Lawrence, 2019).

However, several verbal expressions that point at suicidal acts are not unfamiliar in the communication of Dutch-Surinamese Indians, often as part of hopelessness resulting from adversities. This type of passive utterances I encountered in the vernacular in the Surinamese-Dutch Indian community in general. It can address one's own position, such as 'I will depart from this world'; or underline an interpersonal relation 'If you act like this or that, I just as well may kill myself'; or it may address survivors' responsibility after someone's suicidal act, 'Her husband let her die'. In the cases I studied, it was not clear to what extent these kinds of expressions were part of their experiences. It did become clear, however, that the silencing of the suicidal thoughts was present in all cases, albeit with some variation. This may point at a script of hidden ideation. The question of what made them silence their suffering led to varying answers. Anger and sorrow were mentioned by some, but shame and/or guilt were present in all reactions in a varying degree. For Mahesh, shame was leading:

> You know, it was so embarrassing what I had done. My mother was nice, and she asked me frequently how I was doing. My wife too. But I felt so ashamed, that I avoided the topic [being arrested after the anger outburst]. I even avoided the area where it had happened and the people who had witnessed me hitting the police officer. … Besides that, I am not used to talk about painful issues. When I was little, often my father came home drunk and started a fight with my mother. Then, I put the pillow over my head and tried to think of something else. Or I prayed that he wouldn't hit my mother. My wife suggested that maybe it was due to my past that I snapped.

In the narratives I noticed a variation of the shame script which is referencing to the script of failure. The experienced shame differed in the causes, notably shame induced by one's own doing and shame evoked by others' doing. The shame Mahesh experienced resembled that of Shafiq, for both had undertaken something that led to shame. The others, on the other hand, experienced suffering, also in the form of shame, due to the doing of others. The intensity of the experienced shame differed too. Still, failure was the common denominator for all of them. The position of Roy is different though; he experienced failure and shame too, but he did talk to his friends about his pain. Compared to the other cases, he had a close network of friends who looked after each other.

The presence of other people and the location had comparable features in all cases; all were at home and other people were present. Exceptions are formed by Paul who was alone at first and by Shafiq, who stayed at a friend's house. Shafiq says the following:

> Erik [his friend] offered me to stay at his apartment. Erik often stayed at his girlfriend's, so I was often alone. Like that night. I had checked Facebook for any news about my wife and children, I looked at WhatsApp all the time to see whether she was online. I felt like a stalker, who was restrained to stalk. I felt really bad and felt so enormously guilty, I could feel it physically, a terrible feeling. … In one of those moment of overwhelming guilt I decided to gather all the medications I could find in the house; I found painkillers and tranquillizers. I removed it from the packaging and looked at it for a time while I sat on the couch. Then I took all of them. The next day, in the evening Erik woke me up. He saw the empty packaging and insisted to bring me to the hospital. There they advised me to drink a lot of water as it was too late for emptying the stomach, and they said I would be ok and that I was lucky.

Paul was home alone too when he attempted suicide. That evening his wife and his youngest daughter went to the movies. The other children did not live at home anymore. Paul had a few drinks, and his thoughts dragged him into a downward spiral:

> I was completely lost. I decided to hang myself in the stairway. I already had made the construction to hang myself and put the rope around my neck. Just as I started to climb over the bannister, my daughter opened the front door. She immediately started screaming. Her mother rushed to me and took the rope off my neck. if they had not come home, I would have been gone, *tab ham apane-áp ke tang leti* [then I would have hung myself].

Paul was the only one who applied hanging in his suicide attempt. The most used method was ingesting substances (prescribed medication and chlorine). And, except for Shafiq and Anand, they all had consumed alcohol, whereafter the suicidal thought

became active. However, the alcohol was not the main means for the suicide attempt. Rather, the alcohol seemingly affected critical thinking and judgement, enlarged impulsivity and lowered the threshold to the suicidal act.

The scripts for the methods used seemed to be transferred by social diffusion, thus by modelling by observation or hearsay. Paul uttered in one the sessions: 'You know, you hear those stories, that someone has hung himself or drunk *jahar* [poison], *Sarnám men pahile ásin piyat raihlen, isáit Gramaxone* [in Suriname people used to *drink* acetic acid, now they ingest Gramaxone]'. The process of learning about methods mostly happened unconsciously, as none of the cases could argument or recall why they used the specific means. Traditionally, the main method for suicidal behaviour among Indians all over the diaspora seems to be poisoning, followed by hanging, jumping from heights and burning (Arora, Persaud, & Parr, 2020; Spijker et al., 2009) (see Chapter 3). This suggests that Indians are familiar with cultural scripts for these methods used.

Previously, for Indians in Suriname as well as in the Netherlands, ingesting bleach or acetic acid was the most common means. So much so that decades of familiarity with Indians using acetic acid as means led to the vernacular wording of '*koelie-cola*' referring to the dark (Coca-Cola) colour of the acid and the Indian group (in the historical perspective of other ethnic groups originating from 'coolies'). Over the past decades, in Suriname these means have been overruled by pesticides, notably the herbicide Gramoxone. In the Netherlands, medicinal drugs seem to have been replaced by bleach or acetic acid (Burger, 2013). Nonetheless, two of the examined cases in the present study had ingested chlorine. These changes and variations indicate that scripts for the methods used change due to time and place.

In the Indian diaspora, there is a variation noticeable in the poisonous substances Indians tend to use. The literature displays a 'preference' for certain types of substances that varies from poisonous plants in Sri Lanka, acetic acid and bleach in Suriname and the Netherlands, caustic soda in England to pesticides in Fiji, Guyana, Suriname, Mauritius, Trinidad and Tobago and India (WHO, 2014). The use of pesticides is predominantly the preferred method in rural areas, where the extreme lethal agricultural pesticides and herbicides (paraquat, Gramoxone) are easy to access. Pesticide self-poisoning accounts for about one-third of the world's suicides and is most prevalent in Sri Lanka, Fiji, Malaysia, India, Singapore and in Suriname, Guyana and Trinidad & Tobago (Spijker et al., 2009). Given these records, Indians in rural areas seem to have scripts of suicide consisting of poisoning as a method. This review points at differing scripts of methods used in the Indian diaspora.

4.3. Reactions after the suicide attempt

In the aftermath of the suicide attempts, varying reactions were discernible in the examined cases. Those patients who had received treatment in a hospital due to their suicide attempt had at least one consultation with a psychiatrist, as part of the protocol of the hospital; none of them were assessed as 'high risk' for suicide and were sent home with the advice to seek mental help via the general practitioner. The cases with the recent suicide attempts received follow-up care by the referral to me. One person had consulted a mental health professional for a longer period, not necessarily connected to his suicide attempt; and another person had contact with a psychiatrist who prescribed him tranquilizers and sleeping pills. The situation after the suicide attempt differed enormously between the examined cases. Shafiq was the only one who kept his suicide attempt hidden. Except for his friend, he had told no one about it. He had asked his friend to keep it secret. In the hospital they had offered him help, but he refused it by saying that he would manage. But Shafiq was tormented:

> Well, I don't know whether I was happy to be alive or I felt sorry that my attempt did not succeed. I do know that I was torn apart with guilt towards my faith. You know, in Islam it is *harám* [sinful] to try to kill yourself. I did not know how to deal with it for a long time. I went to a Mosque to find solace and answers. I had a lot of conversations with the imam of that Mosque. That was very helpful. He helped me out of my impasse with his wise words, without knowing he did, because I never told him about my suicide attempt. I am ok with my deed now, I was lost back then, now its ok, that's past time. My faith in Allah is helpful whenever I experience negativity.

Religion had a role in Paul's and Vijay's lives too, albeit in different ways. For Vijay, it was his family, and especially his mother, who brought religion into his life as an explanation for his suicide attempt and as a solution too for the pain he experienced.

> My family was shocked to see me in the hospital. They could not understand that I could have tried to kill myself. So, they came with explanations like I was under influence of black magic, and that certain ghosts were bothering me, and so on. Finally, my mother suggested that I would see a pandit [Hindu priest] because she had a strong feeling that I was under the influence of a graha [a specific constellation of the planets that has a negative influence on the person, either financial, relational, mental or somatic]. I followed her advice and had all kinds of pujá's [Hindu rituals]. Now, years later, I still feel gloomy, but I am not suicidal.

In most cases the suicide attempt brought about changes. But the communication did not show major changes; in most cases the suicide attempt and the preceding feelings

were not talked about. Rather, the family undertook actions to bring about changes. Therefore, the silenced suffering continued in a different form, notably silencing of the suicidal act. This is in line with findings of Graafsma, Westra, and Kerkhof (2016, p. 639) who noticed the lack of communication among Surinamese Indians after suicides and stated that 'repression of what happened set in very fast'.

In Vijay's case, major changes were absent. The position he had in his family that led to feeling mangled between his mother and his wife still gave him the feeling of failure. He tried to please them both and succeeded in it to a certain extent but at the cost of himself. For this – still existing – interrelation and intrapsychic problems, he was referred to me. The other four cases experienced big changes in their lives after the suicide attempt. Mahesh who had experienced unbearable shame was embraced with support by his family and friends. They openly apologized him for his fault. His girlfriend who encouraged him to seek help for his youth traumata was supported by his mother. The latter was very important for Mahesh, as his mother's acknowledgement of his traumatic youth experiences meant recognition and that he did not have to carry the pain of the past all by himself. It was the (inter-)connection he needed to start processing the past.

Roy discovered after his suicide attempt that his family did not reject him. On the contrary, the family gave him the idea that the *manai ká boli* code was more present in his mind than with his parents. This was remarkable, as those steering codes are often implicitly transferred by socialization. Seemingly, the dynamics of the Indian family relations and the importance of interconnectedness had a role here. The parents seem to be prevented to react from *manai ká boli*, once they had faced the 'worst case scenario' of the threat of losing Roy by suicide, which was now averted. The other two cases experienced changes too; Anand accepted that his suicide attempt was a reaction to the impact of a traumatic event and decided to have trauma treatment. As for Ishaan, he learnt to be more assertive, felt supported, gained more self-esteem and decided to look for another job.

The variations in outcomes after the suicide attempts are large, and herein it was difficult to trace elements of cultural scripts of suicide. Other than the large effect the suicide attempt had on the person and their relations with their family, the effects differed. I endeavoured to identify the cultural meanings attached to suicide attempts, yet that was not feasible as the available information was limited to that present in the case files. Nonetheless, the variable outcomes do fit in the loosely defined notion of culture in the cultural scripts of suicide.

5. Discussion and conclusion

The search for suitable concepts to reveal cultural drivers of suicidal behaviour led to the promising concept of cultural scripts of suicide. The concept's unsubstantiated theoretical foundation was dealt with by resolving two problems. The lack of clarity about how a seemingly individualistic concept holds culture was resolved by infusing the cultural script of suicide concept with the precondition of group-specific cultural norms, values and beliefs. The other issue, notably the compelling connotation of culture, was sorted out by adding a loosely defined notion of culture to the concept. In so doing, the concepts' theoretical foundation was enhanced and prepared for explorative use.

In this revision process, it is clarified that both concepts, notably script and culture, which are embedded in the cultural scripts of suicide concept, have their own particularities that operate inextricably together. The presence of culture assumed by 'cultural script' means that the content comes from the outer world. However, culture cannot be assigned an exclusiveness in explaining behaviour; otherwise, everyone would act the same. Rather, the influence of the individual based on his or her characteristics may bring about changes in the outcome of the script, which is possible given the loosely defined notion of culture. The revised concept of cultural scripts of suicide appeared adequate in capturing cultural factors involved in the studied suicide attempts, because it allows variation in the outcomes. These variations were predominantly related to the personal characteristics of the cases. I cannot rule out that acculturation may have changed the scripts and explain the noticed variation, but I do not have any indications for it.

The functionality of the revised concept is probed in the examination of seven psychotherapy case files of male Dutch-Surinamese Indians who had attempted suicide. Some remarks are needed on the data and the data interpretation. The case files I studied contained more information than about the suicidal act alone. This influenced the interpretation of the data. On the one hand, I could relate the suicidal behaviour to the life history and socialization. This offered the opportunity to relate the person's cultural learning process to the suicidal behaviour. On the other hand, the examined cases were 'general' psychotherapy case files and did not centre the suicide attempt. Combined with the fact that the case files were closed and the research method did not provide additional interviews, in some cases, parts of the studied sequence of actions that entail a script were lacking. The latter was especially true for the last phase, notably the period after the suicide attempt. Efforts to identify cultural scripts of suicide were least fruitful in this phase. These findings implicate that for future studies, it is recommendable to focus on narratives that could be completed by additional information.

In the identification of the scripts, a challenge emerged, notably, whether to

look for particular scripts of suicide in the suicide attempt as a whole, or scripts in the several identified phases of the suicidal attempt. I chose to focus on the scripts as present mentally and behaviourally per phase. The script concept allows to speak of different subscripts within an event, with each subscript containing several scenes. The concept had the potential to divide the event of a suicide attempt into phases with each containing their own (sub)scripts and scenes. By using this lens, the scripts which are subject to the diversity of the group could be traced per phase (before, during and after the suicide attempt). Practices were related to possible scripts if they displayed culturally shared, patterned, recurring, somewhat standardized narratives.

The probing of the revised concept singled out practices and narratives that indicated cultural scripts of suicide. In the phase before the suicide attempt, thus related to the triggers or causes that prompted the attempt, I discerned a few patterns. The first was that the men were overwhelmed by the suddenness of an event, whether it was incited by others' or their own doing. The second was that they all experienced failure to a certain extent. Relatedly, they experienced face loss, often accompanied with shame and guilt. These three scripts were found in all cases, with a variation in the expression related to the differences in age and acculturation. The experienced 'blemishing actions' and 'shortcomings' and 'failures' were mostly related to interpersonal problems, but not in all cases. The cultural scripts appeared to have differential drivers (interpersonal problems, discrimination, traumatic event) but the same -– suicide attempt inducing – outcome (failure and face loss). An additional pattern, present in all cases and which may be seen as a script, was that of hidden ideation and silenced suffering as none of the cases informed others about their suicide ideation.

During the suicide attempts, in all cases except one, the script of suicide displayed a preference for medications and/or poisonous substances as the methods used. Here, compared to the former generations, a change was noticeable in the cultural scripts, notably, a change from poisonous substances to the use of medications after the migration to the Netherlands. A relatively stable aspect in the scripts of suicide throughout the generations seems to be the use of alcohol in advance of the suicide attempt, although alcohol cannot be typified as the (main) means for suicidal behaviour. The period after the suicide attempt is characterized by the major changes that occurred in the lives of virtually all cases. This may point at a cultural coping script as a way to bring about changes.

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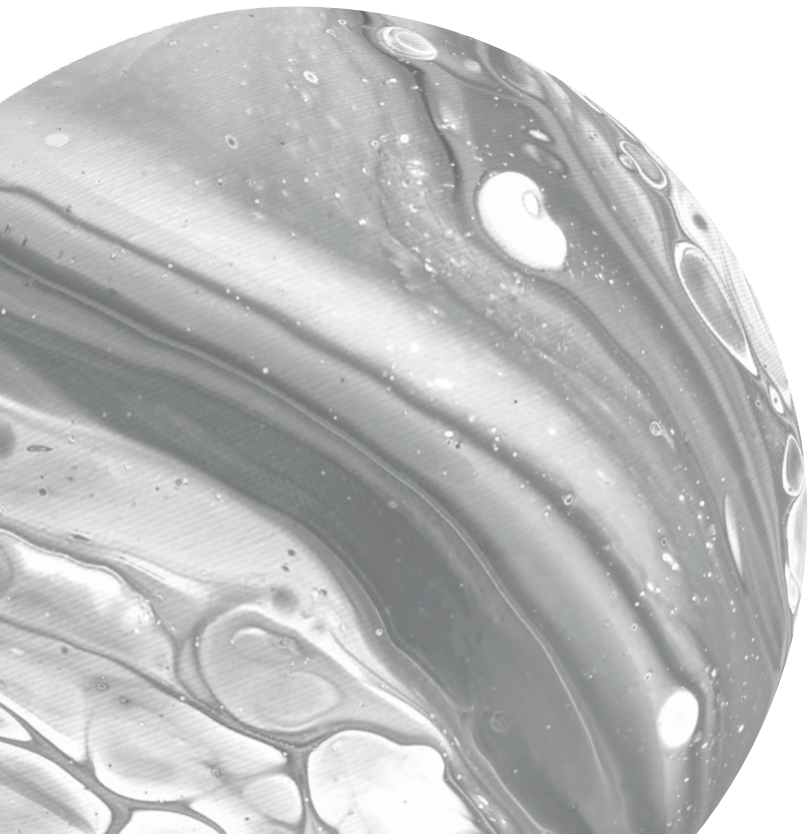

Chapter 5

Ethnic habitus: Exploring suicide's cultural embeddedness

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1. Introduction[10]

Most theoretical concepts used in suicide research fail in capturing cultural specificities because of their psychocentric orientation. The neglect of the actor's perspective and the limited acknowledgement of cultural forces in the study of suicide urge for a concept that captures both. The envisaged concept should display or reveal the operation of cultural forces. Bur the concept cannot capture all forces fostering suicidal behaviour, for this would mean that 'culture' is the only force driving towards suicidality. These two considerations imply that there should be cultural tendencies at work to suicide. As cultural forces (or ethnic forces for that matter) are group forces, the concept should exceed the level of the individual.

Taking the aforementioned considerations into account, I selected the concept of habitus (Bourdieu, 1990) to identify cultural factors involved in suicidal behaviour. Bourdieu (1990, p. 53) referred to habitus as '[s]ystems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices and representations'. This points at the conditioning or internalization of culture that is theorized by the habitus concept as well as the (re-)production and enactment of it in the public cultural world of artefacts, texts and practices. The habitus concept is used by many scholars in several ways, yet predominantly in educational research and the study of upward mobility, which aligns with the emphasis on social classes in the concept of habitus (Edgerton & Roberts, 2014; Silva, 2016). Habitus has been subject to criticism based on its supposed latent determinism, whereas the concept is – ironically enough – constructed to transcend dualisms like agency-structure and objective-subjective (Reay, 2004).

The attractiveness of the concept of habitus for my research is its described ability to capture changes and continuity, and foremost, it is not compelling in its outcome. A next attractive element of the habitus concept is that it includes the process of embodiment, which demonstrates that the body is in the social world as well as the social world is in the body (Reay, 2004). This rationale aligns with the notions of culture I adopted, notably, that culture is in the inner and the outer worlds (Strauss & Quinn,

10 An earlier draft of the conceptualization of ethnic habitus as described in this section 2 is presented at the 29th World Congress of the International Association for Suicide Prevention (IASP). 18–22 July 2017 in Kuching, Sarawak, as well as at the international conference *Challenging perspectives on Indian diaspora* in October 2017 in The Hague, the Netherlands.

1997). For these reasons, I selected the habitus concept, trusting that in an exploration it will highlight cultural forces and leave several outcomes open. However, although the concept points to dispositions that unites internal and external tendencies, its main focus is on class. This limited focus hampers dealing with cultural forces fostering suicidal behaviour (Connolly, Kelly, & Smith, 2009). In addition, specific intersections of social features, notably, ethnicity, gender, age and religion, are neglected. To make the habitus concept fit to capture cultural forces, some adjustments are required.

I suggest that expanding and specifying Bourdieu's habitus concept's limiting focus on class conditioned behaviour into ethnic habitus makes it suitable to capture culturally conditioned suicidal behaviour. The concept of ethnic habitus, then, is not specific to any ethnicity; rather it has to be specified anew per ethnic group. This adjusted concept theoretically transcends the burgeoning descriptive studies on cultural forces of suicidal behaviour. The concept of ethnic habitus may be applied on suicidal behaviour, and the specific ethnic factors should be established separately. If the ethnic specificities are not specified, the individuality or uniqueness of the group is overlooked, and subsequently, in this case, the cultural factors of suicidal behaviour are neglected (Kachtan, 2019).

The relevance of this chapter is threefold. First, it offers a theoretical concept, ethnic habitus, to study the cultural forces conducive to the suicidal behaviour. Second, it demonstrates to what extent the proposed concept discloses cultural forces, as ethnic habitus is different across ethnic groups. The concept thus acts as a window opening specific forces per ethnic group and enables to account for varying levels of suicide incidence. Third, this study offers a specification of ethnic habitus for the research population, the Dutch-Surinamese Indians. That is considered an added value in its own right and useful for practitioners. The application on other ethnic groups will require different features of the group fostering suicide. That is to say, the concept of ethnic habitus, despite its usefulness, remains a sensitizing concept (Blumer, 1954). Ethnic habitus, as a sensitizing concept then, is not strictly defined and definitive, and therefore, it offers the flexibility to sensitize to different realities.

In the next section, the habitus concept is discussed and specified into ethnic habitus. In Section 3, I describe the method and the data that comprise a description of the research group and an outline of the data sources. In Section 4, I apply the concept of ethnic habitus on the research group's suicidal behaviour, both suicide and suicide attempts. The first subsection of the results focuses on the operation of the vernacular use of two – religion-connected – themes, notably, *karma* and *kismat*. The results of the operation of a steering code for good conduct *manai ká boli*, which is part of the ethnic habitus of Dutch-Surinamese Indians, will be presented next. The evaluation of the fruitfulness of the ethnic habitus concept in capturing cultural forces is discussed in the last section.

2. Ethnic habitus

Bourdieu (1990) endeavoured to overcome dichotomies like structure-agency, subjectivism-objectivism and theory-practice. This quest led to his 'theory of practice' consisting of field, capital and habitus. Bourdieu reasoned that societies consist of different (interdependent) fields or structured systems of social relations (e.g., school, work, church, family). In each field, actors act according to their position and corresponding amount of capital. Habitus presupposes the collective belief in the rules of the social game. The concept of habitus offers a tool to understand the agent's embodied and dispositional schemata within the wider context of social structures. This implies that habitus constitutes two inseparable components: habitus as the 'mediator' through which individuals comprehend, evaluate and depict reality and habitus as the producer of practices (Asimaki & Koustourakis, 2014).

Embodiment is a crucial element in the habitus concept. It emphasizes the way social rules and discourses are internalized and the various effects thereof. Bourdieu (1997, p. 467) argued: '[S]ocietal values, norms, and ideas come to be fixed in the body as "ways of being" which manifests in postures, gestures, ways of standing, walking, thinking, and speaking.' This implies that it is through the body that habitus is expressed in each context. Embodied inclinations, features and deportments, as well as dispositional schemata and cognitive representations, are part of habitus. The learned set of inclinations account for social behaviour and social reproduction (Asimaki & Koustourakis, 2014; Silva, 2016). As a result, the habitus concept bridges the gap between the individual and the collective and between the internal and the external worlds. This connects with the notion of culture as described by Strauss and Quinn (1997), who underlined the existence of culture in the inner and the outer worlds.

Habitus describes 'the rules of the game' and 'knowing the rules', as well as the embodiment of the rules in subconscious individual judgements on tastes, norms and behaviours (Bourdieu, 1990; Schneider & Lang, 2014; Silva, 2016). The 'game and the rules' and the 'feel for the game' in Bourdieu's abstract thinking offer more practical understanding of habitus (Asimaki & Koustourakis, 2014; Bourdieu, 1990, 1997). An agent's practice or action, then, is according to their 'feel for the game'. The 'game' refers to social practices in a field, and 'feel' roughly indicates the habitus. The 'feel' is manifested in inclinations or dispositions to certain practices. The dispositions are, in part, rational and, in part, intuitive understandings of fields and social order. This game metaphor leads to acknowledgement, legitimation and reproduction of certain practices, and it becomes self-evident and unconsciously performed, without being deterministic.

Bourdieu featured two types of habitus: a primary and a secondary habitus (Asimaki and Koustourakis, 2014; Bourdieu, 1990). The primary or generic habitus is acquired during early age and is less susceptible to change. In this period, the external

is internalized into the child's habitus, mostly through upbringing practices. Next to the primary habitus, a secondary habitus is developed as part of later socialization. The secondary habitus is more prone to change. Thus, habitus is a set of ingrained habits, skills and, above all, dispositions formed by cumulative historical and collective practices throughout the life cycle.

Scholars tend to study habitus primarily by focusing on class-related themes, educational performances and upward social mobility (Friedman, 2015; Schneider & Lang, 2014). This is related to the neglect by Bourdieu of the elaboration of factors such as age, gender and ethnicity. Bourdieu considered the operation of these factors subordinate to a class-based habitus (Kachtan, 2019; Silva, 2016). As a result, Bourdieu's oeuvre hardly shows any awareness of the role of ethnicity. The ubiquitous class-consciousness and neglect of ethnicity led to criticism. Even in his works on the reproduction of inequalities and social structures in Algeria, Bourdieu relegated ethnicity to a secondary plane. Bourdieu is also criticized for his emphasis on social reproduction, therefore underexposing social change and spatiality (e.g., Friedman, 2015; Schneider & Lang, 2014). He only discussed the general consequences of displacement and marginalization that resulted from a mismatch of the body and field, a habitus cleft, which he fleetingly explored by explaining it as social clumsiness (Noble, 2013).

For the aim of this chapter, I replace the lens of class in the habitus concept with ethnocultural group to arrive at 'ethnic habitus'. Ethnic habitus, then, is a product of similar ethnocultural existence, thus individual as well as collective in nature. It is unconscious but has a partly observable homogenization: it is harmonized, patterned and regular, but without any explicit steering or conscious reference to shared norms. The ethnic characteristics of a group thus produce different habitus. The ethnic habitus is acquired, internalized and interwoven through socialization into the daily lives of the members of the ethnic group (Kachtan, 2019; Rapoport & Lomsky-Feder, 2002).

Although the concept of ethnic habitus is hardly elaborated on, it has been occasionally employed before. Connolly et al. (2009) used ethnic habitus as the totality of often taken-for-granted social practices and cultural dispositions that are generated by and become generative of the ethnic group to which the individual belongs. Kachtan (2019) added ethnicity to the research of gendered habitus to study the construction of different masculine identities. Staples (2012) demonstrated how particular sets of bodily dispositions generate certain styles of suicidal behaviour in a South Indian leprosy colony. Similarly, Isin and Finn (2007) described with hindsight the development of a specific habitus of suicide bombers by detailing how suicide violence becomes practice and then habitus. Most of these studies address ethnic group characteristics but do not specify the concept of habitus into 'ethnic habitus'.

Migration and acculturation may bring about changes in the cultural forces operative in the ethnic community or cultural groups. Given these changes it is just

that it will affect the ethnic habitus, which will show changes too. These changes, however, have a different impact on the group related to their age and length of stay in the new land as well as the degree of acculturation. This implies that within one family, differences in ethnic habitus should be traceable. Erel (2010) and Schneider and Lang (2014) addressed the impact of changes in the habitus on several generations. Edgerton and Roberts (2014) asserted that dispositions' susceptibility to change depends on the habitus-field congruence. They stated that change is unlikely or minimal if habitus aligns well with the field conditions. An agent is like 'a fish in the water' with intuited and instantaneous responses when habitus is congruent with the field.

On the contrary, a lack of alignment may lead to disruption which affects success in the relevant field, depending on the extent of change or adjustment within the habitus. Erel (2010, p. 656) found that the traditional habitus of immigrant groups may become blurred, brightened or fragmented, depending on the social forces to which they are subjected. He demonstrates that migrants might temporarily experience disorientation, displacement and social suffering in an unfamiliar environment while drawing on their creativity and flexibility to maintain (parts of) their habitus. Moreover, agents' power and position in a field are influenced by an intersection of gender, ethnicity, class and other characteristics. These aspects influence the reaction to change. In other words, migration and acculturation either highlight or give rise to changes in habitus, as an ongoing structuring process (Friedman, 2015; Silva, 2016).

Flexible, non-disruptive adaptations to change in ethnic habitus are possible too. Conscious deliberate action may come to the fore, when an actor is faced with specific (new) constellation of habitus and field(s) (Edgerton & Roberts, 2014). Indeed, Schneider and Lang (2014) found flexible bridging strategies and active switching between old and the newly emerging habitus in their study of upward social mobility and identity formation among Turkish-German second-generation migrants. They named this process habitus diversification and described it as the 'diversification of the repertoire of social practices, "languages" and modes of behaviour', with 'the possibility of "switching" between social practices within a dynamic set of "multiple habitus", according to the given social context' (Schneider & Lang, 2014, p. 103). The condition, accounting for the specific inclinations, also shifts and converges with the habitus of the host population. This implies that the ethnic habitus should adjust in each case.

One caveat is in order. Neither ethnic habitus nor tendencies to suicidality are uniform or compelling. As age, gender, religion and health are entangled with ethnicity, the ethnic habitus cannot be uniform. A thorough study of the series of entanglements would require a fine-grained analysis to unravel the different sets of intersections of ethnic habitus, which is beyond the limits of this chapter. Here, the goal is modest. I only aim to develop a theoretical concept to capture cultural forces conducive to suicide. From this perspective, not every individual difference is relevant. I will mainly

focus on age, gender and religion within the dynamics of one cultural group to account for cultural forces rendering suicide.

Bourdieu (1984, p. 446) stated that habitus is situated 'below the level of consciousness and language, beyond the reach of introspective scrutiny or control of will'. This implies that habitus should be apprehended interpretatively. So, the ethnic habitus of suicide will be read in the propensity of people from a specific cultural group to engage in suicidal behaviour in a way comparable with others in their group with the same characteristics (ethnicity, age, gender and religion). Put differently, patterns and regularities of the external social reality are durably instilled in the individual cases as ethnic habitus. As the specific indicators of the propensities differ per cultural group, it needs a characterization per studied group that has its own particular social relationships, shared social norms, cultural values, religious perspectives and other cultural characteristics.

3. Method and data

In this study, I focused on Dutch-Surinamese Indians in the city of The Hague in the Netherlands, where they represent 8% (40,000) of the city's population. The Dutch-Surinamese Indians form the largest group of Indians of the European mainland (see Chapter 3). Since the '60s and early '70s, about 175,000 Surinamese Indians migrated to the Netherlands (Choenni, 2014). They settled in the major Dutch cities, and the largest group ended up in The Hague. There is a large diversity in this group, due to aspects like religion, acculturation, education level, age, maintenance of the Indian language and length of stay in the Netherlands (varying from first-generation Indians up to the fourth). About 70% of the group profess Hinduism, about 20% adhere to Islam, whereas the rest consists of Christians or people who had no religion at all (Choenni, 2014). Except for gender and age, I didn't a priori discriminate in specific aspects, such as religion or length of stay in the Netherlands, in the selection of the research population for two reasons. First, the suicidal behaviour of Dutch-Surinamese Indians is unrelated to one or more of these aspects (Burger, 2013). Second, as my goal was to explore the ethnic habitus related to suicidal behaviour, thus an exploration of the aspects in the culture, I focused on the whole group.

Over the past decades, several studies have shown that in The Hague the numbers of female Dutch-Surinamese Indians' suicide attempts in age group 15–34 years appeared four to five times higher than in the corresponding native Dutch group (e.g., Burger, 2013; Burger, van Hemert, Bindraban, & Schudel, 2005; Van Bergen & Saharso, 2016). Furthermore, in the past decade, an increase in suicide attempts is noticeable among young male Dutch-Surinamese Indians too. The studies from The Hague showed that the socio-economic living conditions among the Dutch-Surinamese Indians were not related to their suicidal behaviour (Burger, 2013). As for suicides, nationally,

middle-aged Dutch-Surinamese Indian men die by suicide twice as often compared to peers from other ethnic groups (Garssen, Hoogenboezem & Kerkhof, 2007).

Some scholars have typified several characteristics of the Dutch-Surinamese Indian habitus. Gowricharn (2016) listed the following features: conflict avoidance, low offensiveness, flexibility, a relative lack of decisiveness, tolerance, endurance of adversity (including undeserved treatment) and a propensity to strike compromises. Ricke and Middelkoop (2013) enumerated humility, emotional control, fear for failure, avoidance of deviation, compliance with the standards of family and society at the cost of the self, unquestioned respect for authority and self-regulation. All these characteristics point at internal representations of social norms, thus upholding external structures. Although both studies did not address changes due to generational differences and migration and acculturation, it offered leads to detect Dutch-Surinamese Indians' dispositions that point at ethnic habitus.

I used three data sources to discern the operation of ethnic habitus in suicidal behaviour. The first source was a literature survey on Indian suicidality in general and more specifically the Dutch-Surinamese Indians' suicidality. The second source consisted of a knowledge base which was built up during two decades of my experience as a psychotherapist specialized in suicidal behaviour. These consisted of first-hand narratives of people who had attempted suicide and came in therapy and/or narratives about cases of suicide attempts or suicide in their close environment that affected them too. A third source of data consisted of my experiences in participating formally and informally in professional and community gatherings discussing the issue of Dutch-Surinamese Indian suicidal behaviour. In addition, several cultural artefacts and cultural expressions, such as oral history, proverbs and sayings, and other popular cultural expressions were critically examined. The latter were included as they form a part of Dutch-Surinamese Indian socialization. All data were discussed with the research group, which was useful in general and especially in interpreting the soft data I carried in my memory.

To examine the propensities of Dutch-Surinamese Indian ethnic habitus of suicide, I focused on two recurrent characteristics in the literature on the Indian diaspora, notably, the inclinations to refer to fate or destiny and to the opinion of other people. In the Dutch-Surinamese Indian group, these characteristics are manifest as *karma* and *kismat* (fate or destiny) and *manai ká boli* (what will people say). An important note hereby is that these themes were by no means meant to establish a one-to-one account for suicidal behaviour or suggest a linear relation between one of the elements and suicidal behaviour. One note relates to the way *karma* and *kismat* were used in this study. Although both concepts relate to religion, in this study the focus was on how they were vernacularly used, and not to account for religious influences.

With a focus on *karma*/*kismat* and *manai ká boli*, I examined 18 empirical cases of first- and second-hand narratives with variations in gender and age. Subsequently,

several elements of these data were tagged as having a large plausibility that it influenced the suicidality: either in causal relation or that it enlarged the permissiveness and acceptability of suicidal behaviour. The patterns and regularities of the external social reality that were durably instilled in the individual cases as ethnic habitus were sought for. I focused on mere tendencies to engage in suicidal behaviour related to the Dutch-Surinamese Indian characteristics I focused on. Those elements that were noticed repeatedly were included as the aspects of the operation of a system of dispositions or ethnic habitus in relation to the practice of suicide. Of the 18 cases, some exemplary cases were highlighted in the results section, as they contained elements that were more or less present in all cases.

4. Dutch-Surinamese Indian habitus and suicidal behaviour

The results are presented here in two subsections that correspond with the two categories of themes that emerged from the data: *karma* and *kismat* and *manai ká boli*. Both categories are present in the community at large as important constructs, which are known by virtually all members and applied by many individual members, either actively or passively, and strictly to loosely. Both are part of the ethnic habitus of Dutch-Surinamese Indians and underlined in the results with exemplary cases. The discussed cases form an illustration of the operation of *karma* and *kismat* and *manai ká boli,* which, in turn, are variants of ethnic habitus.

Out of the first category, the theme *karma* is related to Hinduism. Although the literature on Indians recurrently mention reincarnation as related to their suicidal behaviour, in the empirical cases I examined, reincarnation as such was rarely present. *Karma*, the related phenomenon, was more present. Mostly, references to *karma* were made in the sense of fate. The Dutch-Surinamese Indian Muslims spoke of a comparable phenomenon that refers to fate and destiny, notably *kismat*, and sometimes the wordings *takdir* or *nasib* were used, which have vernacularly the same connotation. Both *karma* and *kismat* are present with most Dutch-Surinamese Indians as an inclination towards adherence to a preordination, a pre-written divine fate that cannot be predicted. Often people believe that this fate cannot be challenged or changed (Gunasinghe, Hatch, & Lawrence, 2019; Kent, 2009).

The second category, *manai ká boli*, is related to a concept that is regularly mentioned in the literature, notably, the concept of *ijjat* (denomination for *izzat* [honour] in Sarnámi language) or *lajjá*/*saram* (bashfulness, shyness) as a gendered virtue of honour, which is coupled with anger or fear and guilt and shame (Gunasinghe et al., 2019; Sinha & Chauhan, 2013). *Ijjat* is valid for the group as a whole and the individual too. Both have their own 'task' in upholding the *ijjat*: the individual by following the

rules of *ijjat* and the community by keeping each other in line, mostly with the use of the steering code *manai ká boli*. Here, I focus on the specific manifestation of *ijjat* as is present in the behavioural conduct code *manai ká boli. Manai ká boli* is put at centre stage by using it as a part of the ethnic habitus of Dutch-Surinamese Indians. It guides the pursuit of 'appropriate' behavioural practices and serves to prevent straying from (striving for) the 'appropriate' behaviour.

4.1. Karma and kismat

Among Hindus, the notion of reincarnation is of importance as a circular pattern of life and death (Nrugham, 2017; Vijayakumar & John, 2018). Reincarnation holds that when a person dies, the *átman*, the unaltered non-material self, departs to find a new body to dwell in. Death, then, is the mere cessation of the functioning of the current body. The physical form of the next incarnation depends on *karma*. The *karma* concept refers to the combination of cosmic and moral cause and effect that transcends lifetimes for spiritual growth. A life with more good than bad deeds leads to an incarnation into a more fortunate existence. Thus, with karma, one can move up and down the hierarchy of living beings. The ultimate goal is to achieve *nirwáná* or *moksha*: liberation from the cycle of life and death altogether (see also Chapter 3).

In the Abrahamitic religions, such as Christianity and Islam, the belief in heaven and hell forms a conductive indicator for appropriate behaviour. Next to that, in Islam, the concept of *kadar* (divine predestination) points at the belief that everything is Allah's doing. This concept is vernacularly referred to by Dutch-Surinamese Indian Muslims with *kismat*. The *karma* and *kismat* ideology both point to birth-ascribed identities. That is, that who one is or becomes and his or her course of life is written by birth (Gunasinghe et al., 2019; Kent, 2009).

The literature on suicidal behaviour and religion repeatedly mention that the Hindu notions of reincarnation contribute to more tolerant attitudes and less moral objections towards suicidal behaviour compared to other religions (Nrugham, 2017; Stack & Kposowa, 2015; Vijayakumar & John, 2018). The literature relates the lower suicide rates among Muslims compared with Hindus to the condemnation of suicidal behaviour in Islam as an unforgivable sin, which leads to eternal life in hell and exclusion from heaven. The studies that noticed the differences between Hindus and Muslims registered religion quantitatively on an aggregate level as a demographic factor. Other studies tend to echo these findings, without empirical proof on case level of the relation of suicide and religion (see Chapter 3).

A focus on the suicide rates of Dutch-Surinamese Indians, however, shows that the differences between Hindus and Muslims are not significant. The protective effect of the prevailing prohibition of suicide in the Islam seems not to have a preventive effect on the Muslims among the Dutch-Surinamese Indians (Garssen et al., 2007). This may point at ethnocultural schemata (Hindus and Muslims alike) that transcend

religion among Dutch-Surinamese Indians. Suicidal behaviour seemingly has become part of the ethnic habitus of Dutch-Surinamese Indians regardless of their religion. It may have been conditioned in the ethnocultural group by practices, which eventually became part of their primary and secondary habitus. The conditioning, then, occurs through upbringing practices, peer modelling, group narratives, sayings and songs and so on, and with it, people produce, act upon and reproduce these practices. Although the number of Muslim cases I screened was smaller than the Hindus cases, which correspondents with the Hindu/Muslim ration in the Dutch-Surinamese community, most of the ethnocultural tendencies I registered were religion transcending.

4.1.1 *Predestination*

The following cases demonstrate the way *karma* and *kismat* as part of the Dutch-Surinamese Indian habitus are involved in suicidal behaviour. Farida, a 38-year-old Dutch-Surinamese Indian Muslim woman, received systemic therapy from me together with her family. The therapy started after her 17-year-old daughter, Karima, had attempted suicide with prescribed medications after a quarrel with her parents about her relationship with a Turkish boy. In the biographical assessment, it became clear that there were several cases of suicides and suicide attempts in her family, especially from Farida's mother's side. Farida was raised by her *náni* (mother's mother), because she had lost her mother when she was 6 years old. Her mother had drunk acetic acid after a row with Farida's father. One of the brothers of Farida's mother died by suicide by hanging after a break-up in his relationship. Farida was 12 years old back then. And her two cousins too had attempted suicide. This family history is important, as it makes me explore how these events may have precipitated in the socialization and thus in the ethnic habitus of this family. Farida clearly remembers the sorrow and pain she grew up with:

> Ever since my uncle hung himself, my *náni* (grandmother) was a broken woman. My *náná* (grandfather) tried to cheer her up, but he did it in a clumsy way, because he waved my *náni's* grief aside. He always ended conversations about my uncle with the saying: *dáne-dáne pe likhá hai khánewále ká nám* [literally: on every grain is written the name of the person who will eat it; figurative: fate is inevitable]. You know that fate-thing, *kismat*, that you have to accept what is written for you [she makes the quote sign with her fingers]. And most annoying was then, that he starting to sing, there is a song, you must know it, it's from the movie, *Baarish*, an old movie.

Farida's narrative about her *nána*'s referrals to fate in a Hindu song is an example of a religion-transcending cultural schema of fate or destiny. While Farida was telling

this story about the song, which I knew too, I noticed that the song itself is a typical Indian mixture; it uses Urdu and Hindi wordings in a Hindu context. As part of his ethnic habitus, her *nána* never questioned the song. Farida, however, was less familiar with the actual meaning. Although familiar with the concept of *kismat*, she did not know the context of the sayings used by her *nána*. These differences between Farida and her grandfather show the changes that can occur in the ethnic habitus over time. Farida became conscious of the ethnocultural rooting of her *nána*'s wordings because she contemplated about the several suicides and attempts in her family triggered by her own daughter's suicide attempt. She describes the active 'discovery' as follows:

> You know it is actually a Hindu song. I realised that not long ago that the second phrase of that song says *lenewále karor, denewálá ek Rám* [literally: eaters are many, the giver is only one lord Rama; figurative: God decides about everyone's fate].

A widely known belief among Indians (Hindus and Muslims alike) that relates to the expression expressed in this song is 'written on the forehead' (in Sarnámi: *máthá pe likhal* or *sine pe likhal*). This refers to a belief that what is 'written' at birth one has to bear that for rest of the life (Kent, 2009). This forehead writing, vernacularly equal to *karma* and *kismat*, can have a positive or negative connotation. In negative sense, thus in case of severe adversity and if such a belief is part of one's habitus, suicidal behaviour can serve as an ultimate expression of the Dutch-Surinamese Indians' habitus of accepting one's fate. This kind of widely attested beliefs in the folklore and family narratives, especially familiar among the elderly, then becomes part of the ethnic habitus. The positive notions are emphasized too, in case one experiences happiness or 'luck'; for example, if a suicide attempt failed, then one can express 'it was not in your kismet to die'.

4.1.2 *Comfort from religion*

The implicit referencing to religious notions in coping with their suicidality is described in Chapter 4 in the cases of Paul (Hindu) and Shafiq (Muslim). Both mentioned religious aspects especially in the aftermath of their suicide attempt: it offered them a grip and helped them with reprocessing the suicide attempt. Shafiq found directives in Islam to be safeguarded from suicide. Paul too found comfort in the religion, although his hinting to reincarnation and *karma* was in the sense of a mere vernacular use of 'the other life' than a conscious connection to the suicide attempt. In many other cases, where religion is a clear part of the socialization, I often notice that Dutch/Surinamese Indians tend to use this kind of vernacular references to reincarnation with all kinds of adversities. This referencing seems to offer them a meaning, something to hold on, and a way out of the experienced helplessness evoked by an adversity. These practices can be seen as inclinations that are part of the ethnic habitus.

Nonetheless, for Shafiq and Paul, the consultations with the *imám* and *pandit* were helpful to overcome suicidality and to move on. Paul narrates about his experience:

> The *pandit* explained to me that my soul will not find peace if I commit suicide. He said '*ápke átmá bhatki*' [your soul will wander around]. So, I will have to endure this life. *Baki hamke itráj ná hai jab bhagwán hamme uthá le jái* [But, I would not mind when God takes me with him]. I know my situation is depressing, but what can I do, I have to accept my fate. Maybe this situation is a punishment for my deeds in a former life.

In working with clients with suicide ideation in my psychotherapy practice, I noticed that sometimes religion (Hinduism and Islam alike) explicitly offered protection against transformation of the ideas into concrete actions. An illustration is the case of Niermala, a 38-year-old woman with a Hindu background, born and raised in the Netherlands, who experienced setbacks on emotional, interpersonal and financial levels after her divorce. In her narrative I noticed several inclinations as part of her ethnic habitus.

> It was a nasty divorce. He threatened to take the children away. Can you imagine that? After all he had caused. He caused our break-up by having an affair with a colleague. He caused my financial problems; If he hadn't invested our money in a shady company, I wouldn't be begging for money right now. We had no prenuptials, so I had to pay half of the debts. It is so difficult to pay all the bills. He doesn't pay alimony because he is formally declared bankrupt. I don't dare to ask my family for money anymore. I am desperate. I often think that it would be better if I was dead.

Niermala increasingly isolated herself, and she regularly skipped family gatherings. Although Niermala was not raised religiously, she did attend the *mandir* (Hindu temple) occasionally, often with her cousin. Her cousin is very religious and is connected to the mandir, where she does *sewá* (Sanskrit word for the act of selfless service). This cousin didn't see Niermala for a while and noticed her inclination to withdraw, whereafter she decided to address these issues in a conversation with Niermala. Niermala felt awkward but did finally tell the cousin how she felt, including her suicide ideations. She felt ashamed to talk about it, but her cousin insisted. Niermala's inclination to hold her suffering is a tendency I noticed in other cases too, as if they are driven by the same cultural script. Some felt ashamed to tell their stories, whereas others felt they were responsible for their situation and had to solve by themselves (see also Chapter 3).

Finally, Niermala was happy with her cousin's persistence. Because she felt better by being heard in a non-judgemental way, she dared to say that she believed that the setbacks were part of her fate in this life and that she believed it would be better in the next life. The cousin convinced Niermala to talk to the *pandit* about her thoughts.

> The *pandit* I consulted explained to me how *karma* works. He told me that even if I had built a negative *karma* in my former life, which could explain the negativity I was encountering, it should not be an excuse for me to accept the situation as it is. He explained to me that *karma* cannot be seen apart from *dharma* [religious and moral law governing individual conduct]; that is was my duty to build a positive *karma* by overcoming these troubles instead of accepting it without resistance.

The *pandit* gave Niermala a *mantra* (a Sanskrit word, short phrase for prayer) to recite for strength and peace of mind. Although her troubles did not disappear, the pondering and worrying did not rule her daily life anymore, and the suicidal thoughts diminished. The case of Niermala demonstrates the psychosocial role of the pandit; reciting the mantra is a form of meditation that made Niermala become mindful. Religion was not an overt part of the primary habitus of Niermala, as she was not raised with religious values. It was later in life that she learned more about it, and as such part of her secondary habitus. Although Niermala was not completely unfamiliar with the Sanskrit words of the mantra, as she participated in recitals before, it was difficult for her to do the recital by her own. An example on YouTube of the needed recital with correct pronunciations recommended by her cousin was useful.

4.1.3 *Habitus fragmentation and diversification*

The ethnic habitus of Niermala displays some fragmentations, which she creatively tried to overcome (i.e., YouTube). This habitus fragmentation as mentioned by Erel (2010) and Friedman (2015), and to a lesser extent the active switching between different habitus, is seen in the following case too. Sharmila, a Dutch-Surinamese Indian Hindu woman, died by suicide 12 years ago at the age of 35. Her story is narrated by her niece who was a client in my practice. She had heard the story of Sharmila several times as it is a narrative in the family.

> The story goes that my father's sister Sharmila lived with her in-laws who treated her harshly, abused her physically, especially when after some years there was still no son. My father repeatedly told her to leave and file for divorce. She was deeply religious and believed that bad luck was part of her *karma*. One afternoon she was scolded by her mother-in-law for being 'useless' and beaten by her husband because she had argued with her mother-in-law. My aunt went to the kitchen and drank acetic acid. She died the next day and left behind three daughters.

Sharmila's mother-in-law was very traditional minded and demanded a grandson, for it was a shame for the family if her eldest son did not have a son to carry on the family name. Traditionally, daughters were seen as *paráyá dhan* (literary: other's

richness, refers to the short stay at the parental house as she moves after marriage) as they became part of another family after their marriage. Sharmila's mother-in-law valued those traditions, and she blamed Sharmila for not giving birth to a son. For years, Sharmila found comfort and strength in her religion to endure her mother-in-law's harsh treatment. Sharmila was raised religiously. She did her daily *pujás* (Hindu rituals), went to the *mandir* and participated in the weekly gatherings to recite from the *Ramáyana*.

Next to being conditioned with *karma* and destiny, as the niece informed me, this case demonstrates a specific aspect of Sharmila's religious and ethnic habitus. According to the family, next to the pressure from her mother-in-law, it was Sharmila's wish too to have a son. In the traditional Hindu society, having a son is highly appreciated, among others, because of his important role in the burial rites of the parents. This 'reason' for resorting to suicide is typical for women, because – as far as I know – men do not resort to suicidal behaviour when they cannot conceive a son. This may point at the gendered aspects of ethnic habitus. However, in Sharmila's case, it is not clear whether she wanted a son for reasons connected to Hindu traditions, or out of fear for her family-in-law, or longing to be accepted in that way or other reasons may have driven her. Either way, it refers to cultural drivers or rather cultural scripts active in the ethnic group that she had conditioned with.

Moreover, in the exploration of this case, I noticed habitus diversification (Schneider & Lang, 2014). Sharmila and her brother were socialized in the same family, yet her brother had different thoughts about Sharmila's living conditions. He did not agree in the first place that Sharmila lived with her parents-in-law. And more important, he did not understand how she could endure the harsh treatment of her in-laws. He tried to get her out of that situation by emphasizing that it was not a shame if she chose for herself, for her well-being. The difference between Sharmila and her brother had to do with the fact that although both had the same primary habitus, their secondary habitus differed. Compared to Sharmila, her brother's secondary habitus was more influenced by the Dutch society. Contrary to Sharmila, he spent more time with Dutch friends ever since he went to secondary school. He was less religious and had different ideas concerning the position of a (Indian) woman. Nevertheless, he switched between the traditional inclinations he was familiar with when he was with his family and the tendencies he gained later in school and with friends.

The following case illustrates the blurring impact of migration and acculturation on the practice of *karma* and thus on the ethnic habitus. Carla, 23 years old, whose mother, a Muslim Dutch-Surinamese Indian, died by suicide 10 years ago, shortly after her parents got divorced, tells about a conflict with her Hindu grandmother of father's side. Carla considered her grandmother very religious and old-fashioned contrary to her parents who raised her with both religions.

> I did not have a close relation with my grandmother, because we did not see each other much, but foremost because she didn't speak Dutch and I don't speak Sarnámi. I guess my grandmother never accepted her Muslim daughter-in-law. One day, referring to my mother's suicide, my grandmother said: *sab koi ke karni ke dand mili* [literally: everyone will get what one deserves for his/her deed]. Her words were translated to me by a cousin as if it was my mother had deserved it to die. I got furious and I said things I wouldn't have said if I understood what my grandmother actually meant. Later on, my father explained to me that she had referred to deeds in *karmic* sense instead of earthly and personally.

Due to the migration, acculturation and generation gap, the ethic habitus had undergone changes. The intergenerational changes undermine the supposed uniform tendencies that are inherent to ethnic habitus. In an unchanged ethic habitus through the generations, the grandmother's words would not have got lost in translation. It was not only a matter of language differences caused by migration and acculturation, but Carla's experience was also not a complete alienation from the world of grandmother. Rather, troubling was the already existing negative sentiment in Carla towards her grandmother and the problems in communication in combination with the inadequate translation by the cousin.

Though mere hypothetically put (as I was not able to verify this), it is possible that in this case several accents in the ethnic habitus of three generations of Dutch-Surinamese Indians are active. The grandmother's ethnic habitus is primarily Surinamese Indian. Carla's father who grew up in the Netherlands has a primary habitus that is ethnically formed in the Surinamese Indian setting, whereas his secondary habitus is more dispersed with Dutch socialization. And Carla's primary habitus is formed in a Dutch-Surinamese Indian setting, whereas her secondary ethnic habitus due to her friends and study contains more aspects of a Dutch socialization. The three versions of ethnic habitus require active switching between the habitus to reach each other.

Thereby, the grandmother's ethnic habitus is less receptive to change and active switching, because it is firmly formed in one ethnic group. The father's habitus allowed most active switching between the generations above and next to him. Carla, on the other hand, could feel the rules required by the ethnic habitus of her grandmother because of her primary habitus, but it was of limited level. Because of her secondary habitus, she resisted to accept and respect unquestioned everything her grandmother said as was unspoken the rule in the family, which originated from the hierarchical relations and matching respect and deference.

4.2. Manai ká boli

Manai ká boli, as an excerpt of ethnic habitus, is a tacit cultural steering code, rule and practice within the Dutch-Surinamese Indian community. This cultural code tacitly serves to follow the rules set by the *ijjat* concept. Most Dutch-Surinamese Indians are socialized with this code either directly or indirectly (Boedjarath, Vaassen, & Spaans, 2021; Gajadin, 2006). As such, it is part of their ethnic habitus. In the vernacular, *manai ká boli* is often used without a reference to *ijjat*. As a result, this attitude has become an institution on its own. *Ijjat* itself, as a concept, is also less pronounced present among the Dutch-Surinamese Indians, compared to other diasporic countries, such as the United Kingdom or India itself (e.g., Baig, 2012; Gunasinghe et al., 2019).

I distilled from the examined data sources some typical characteristics and virtues that the group complies with or strives for, to enhance the *ijjat*. To a greater or lesser extent, the following indications are prevalent in Dutch-Surinamese Indian families: being obedient, progressive, pursuing good educational performance and good manners, being interdependent (contrary to the Western independency), being modest, having respect for superiors, cultivating a good (gendered) reputation, upholding the honour of the family (for women mostly translated as securing the sexual honour and for men as maintaining an impeccable reputation concerning crime and drugs), getting a good education with good career perspectives, marrying honourably and having a family and children, being a good wife or husband and provider and taking care of the elderly (Boedjarath, 2016; Krikke, Nijhuis, & Wesenbeek, 2000; Nanhoe, Lünnemann, & Pels, 2016). Though these characteristics may be valid for other ethnic groups too, they are found to be typical for Dutch-Surinamese Indians. The prevalence and manifestation of the mentioned features can differ, depending on the specific intersections of age, gender, acculturation and so on.

Manai ká boli as a social control mechanism guards the group's values. It has positive and negative aspects. The positive side is that the community at large and, more specifically, the family, is involved in aiding each other. This is seen with major as well as smaller life events, such as marriages, and when someone is ill or passes away. Then, the family is inclined to be present in large numbers and obliged to support and help. In this way, the *ijjat* is enhanced as the *manai ká boli* has a positive influence because the deeds lead to appreciation if people talk positively and with respect and deference. Herewith, *manai ká boli* helps to uphold and enhance *ijjat*. As *ijjat* is gendered, the required actions may be informed and influenced by what is deemed as accepted and appreciated as social, moral and sexual conduct for both genders (Gunasinghe et al., 2019).

The negative side of *manai ká boli* seems to have a prominent place in the daily practice of Dutch-Surinamese Indians. The negative effects are visible in controls of the compliance to the 'rules' and the implicit weighing whether the rules are followed. The application of the rules, then, is ingrained in interpersonal contacts as inclinations.

As *manai ká boli* is carried by the collective community at large, the family and the individual, all are conditioned to fulfil a task. The community and the family have the role of the (external) controller who checks whether one does not stray from the norms. The individual (and often his or her nuclear family) operates as the rule-abider or at least complies to not wash one's dirty linen in public. Given the collective or cultural practice of *manai ká boli,* the one who has to abide by the rules can be the controller in other cases (Boedjarath et al., 2021; Gajadin, 2006).

Thus, *manai ká boli* incites people to guard one another and themselves, and the guarded can be the guardian for others at the same time. As part of their ethnic habitus, families produce and reproduce this steering code while at the same time being subjected to them. In other words, the meaning of these codes is part of the ethnic habitus as are the rules that flow from it. When crossing 'the' line with a tarnished *ijjat* as a result, it is not just the individual who is judged but the whole family.

In the literature on Dutch-Surinamese Indian suicidal behaviour, the negative effect of the steering codes can be read in the psychosocial causes of suicidal behaviour, such as a lack of social support, group pressure, (imminent) loss of honour or reputation damage (Boedjarath & Ferber, 2016; Krikke et al., 2000; Salverda, 2004; Van Bergen & Saharso, 2016). This can be caused by all kinds of 'deviations' from the standard, ranging from wanting to go out to exogamous relationships and confessing homosexuality. In these cases, a person may experience negative feelings, sometimes even if something happens beyond their power, such as sexual abuse.

Manai ká boli can be active in all kinds of virtues that are connected to the obligation of upholding the *ijjat*, as listed previously. The following case of a former client illustrates how the steering code *manai ká boli* operates related to family reputation and which, in turn, relates to sexual honour. It demonstrates the operation of the steering code for both the person who resorted to suicidal behaviour and the bystanders. Rita (a mother 40 years old) raises two daughters who did well at school. Rita and her husband were immensely proud of the impeccable behaviour of both girls. She had the idea that her daughters knew how to behave honourably as a Dutch-Surinamese Indian girl and that they would tell her if they fancied a boy. Then, one day Rita's cousin told her that she had seen Shivani, her 17-year-old daughter, walking hand-in-hand with a boy in Scheveningen (a beach area in The Hague). Rita narrates that she felt terrible when she heard it.

> My first thoughts were 'I pray that Kamla [cousin] will not tell it to someone else', 'Aarti [sister-in-law] would love to hear this and will be first in line to laugh at me and make fun of us', 'What if my mother and father would hear it', 'they will accuse me with "*ie káidá sikhaile hai*?"' [are these the manners you taught her], 'What if Shivani is not a virgin anymore?', 'What future will she have?'.

The first thing she did was ask her cousin not to talk about it to anyone. She needed time to decide how to deal with it, by herself, and she decided not to inform her husband as he might get mad. Rita remembers that for two days, she was completely confused and distressed. The mixed feelings she experienced had to do with the many aspects to this news. Guided by the embodied *manai ká boli* that is part of the ethnic habitus, Rita's first inclination was – like a knee-jerk response – to think of the impact the news would have if it was known by her family. The thoughts of the worst-case scenarios made her distressed.

Shivani's case demonstrates the structural embedding of the gender-specific operation of *manai ká boli*, which is carried by the community at large and is part of Rita's family's gendered ethnic habitus. It shows how the individual and the collective as well as the internal and the external worlds are incorporated in the Dutch-Surinamese Indian habitus. In the obligation to keep the *ijjat* free of stains, the person in question and group both have a role, each from one's own perspective. It is Rita's cousin who informed her about Shivani's activities with a boy. Here, the cousin acted according to what was expected from her given embodied role in upholding *ijjat* by acting conforming to the *manai ká boli* code. In turn, Rita reacted conforming to what she had internalized as suitable for her mother role to keep her daughter in line. And Shivani herself, although she was not explicitly socialized with *ijjat*, 'knew the rules' of the social game. Therefore, all parties embodied the Dutch-Surinamese Indian habitus in this practice that led to a suicide attempt.

One day later, Rita decided to talk about it with Shivani in a calm and quiet manner in the evening when she was alone with Shivani.

> After we had done the dishes, I asked Shivani to sit down and asked her whether it was true what I had heard. She did not answer and kept looking at the ground. I lost my temper a bit and raised my voice. I told her that she was disgracing our family name and sent her to her room. A few hours later when I knocked on her door, she did not react. I found her lying on her bed, unconscious. I saw empty packages of paracetamol on her bedside table. I panicked as she would not wake up. My husband called an ambulance and Shivani was brought to the hospital where they emptied her stomach. After a few days Shivani recovered.

Some of the characteristics of the Dutch-Surinamese Indian habitus, mentioned by Gowricharn (2016) and Ricke and Middelkoop (2013), are apparent in the stories of Rita and Shivani. The operation of ethnic habitus is clearly recognizable: on the one hand, as it is present in the community as a structure, and on the other hand, as it is internalized by Rita and Shivani as well as the constant interplay of both.

Particularly, conflict avoidance was present. Anticipating rejection and condemnation from the family, Rita asked her cousin to silence what she had seen.

And Shivani kept the contact with the boy silenced for her parents as she 'knew' they would not approve it as they always praised her for her impeccable behaviour, which implicitly referred to the behaviour that wouldn't be impeccable. Endurance of adversity was present too. Rita sought for solutions all by herself; although she was in distress, she did not share it with anyone. Shivani endured too, instead of rebelling like her Dutch peers would have done. Instead, she displayed unquestioned respect for her mother and silenced her own wishes and pain. Fear for failure was seen in Rita's reflexive anticipation on what others might say about her upbringing practices. More or less the same occurred in Shivani as she knew that the family would talk negatively about it, and that's why she kept it secret. Avoidance of deviation was seen with both Rita and Shivani as they experienced fear for being deviant and being disgraced. As a result, both Rita and Shivani complied in their own way, appropriate for their position, to the prevailing standards of family and society at the cost of the self.

Shivani's case is exemplary for many female Dutch-Surinamese Indian adolescents. Several authors (Boedjarath & Ferber, 2016; Nanhoe et al., 2016; Salverda, 2004) suggest that compliance with the steering code *manai ká boli*, and thus avoiding shame and exclusion, prompts parents to enforce stifling rules to hold their children in line. These upbringing practices are often regenerated intergenerationally, even the stifling practices the parents experienced themselves in their own upbringing. The next case presented by a relative during a conference illuminates how acculturation renders conflicts between generations of migrants, notably, between an acculturated Dutch-Surinamese Indian youngster and her semi-acculturated parents. In other words, such as in the case of Carla discussed earlier, changes in the ethnic habitus of the subsequent generations are noticeable. Warsha, a 16-year-old, had attempted suicide after a period of quarrelling with her parents about individual freedom.

> My parents are both born in Holland, they are both well educated, they have more Dutch friends then *Hindustáni* friends. They know that I smoke, I even can have a beer occasionally. So, I do not understand the big deal they make out of me wanting to go on holidays with my friends to Chersoneses in Greece. They never gave me a reason why I can't go, they just said 'no, it is not proper for a girl', only because of the parties the island is known for? After days and days of quarrelling I became desperate. I had the feeling that nobody loved me. I cried for hours and at a certain moment I wanted to stop that awful feeling and I cut my wrist. I was in shock by the amount of blood and ran to my mum.

Warsha' parents denied her the freedom her Dutch or Dutchified peers were granted. On the one hand, Warsha's parents let her live the life like a Dutch adolescent (smoking, beer drinking), and on the other hand, they acted conforming to the Dutch-Surinamese Indian traditions ('it is not proper', implicitly referring to *manai ká boli*). Both parents

themselves were socialized with Dutch-Surinamese Indian values and norms but adopted the Dutch upbringing style. Now that Warsha's demands challenge their pliability, their ethnic habitus with traditional gender-specific cultural values comes to the fore as a reflex. They want to be 'modern' parents, and at the same time, they want to protect their daughter from hazards where her *ijjat* would be at stake. More specifically, they would experience failure as parents when *manai ká boli* becomes active. The fact that Warsha ran to her mother indicates that her suicidal behaviour was communicative of nature ('grant me my holiday') rather than a death wish.

In many cases of suicidal behaviour I came across during several years of experience in working with Surinamese-Dutch Indians, I found a relation with *manai ká boli* and compliance to or at least attempts to comply to traditional values, despite acculturation. This is in line with the literature and representations in meetings and documentaries on these issues (Gajadin, 2006; Nanhoe et al., 2016; NTR, 2016a, 2016b). Especially, respect for superiors and deference, subordination of individual wishes and needs, compliance with the familial standards and subsequent sub-assertiveness and conflict avoidance are conspicuous. The required respect and deference point at values that accompany the hierarchical relations in a family and are expected from children towards their parents and other elder family members (Baig, 2012; Gunasinghe et al., 2019). I noticed these traces of ethnic habitus especially among adolescents.

The next case of 18-year-old Rishi was discussed by a colleague during a consultation. It demonstrates how the virtues, respect and deference, as part of ethnic habitus and driven by *manai ká boli* are involved in the suicide attempt.

> I am born in the Netherlands, just as my father is. My father is a successful lawyer and the whole family is proud of him. I am not raised as a typical Dutch-*Hindustáni*. My parents are broad-minded. When I came out of the closet two years ago, both my parents had to adjust to it but eventually they supported me.

Contrary to the traditional reactions of Dutch-Surinamese Indian parents, Rishi's parents barely had objections to his homosexuality. For his parents, his educational career was more important. In the Dutch-Surinamese Indian community, pursuing academic and economic success is highly valued, which often activates a fear for failure (Boedjarath, 2016). As mentioned earlier, failure can be connected to an individual's actions but can be reflected to others in their environment. In Rishi's case, the subtle pressure to achieve a university degree became a big issue, primarily driven by his father. Despite the fact that his father is relatively acculturated, thus there could be room for negotiation and deviant behaviour, Rishi chose not to violate the deference and loyalty he was taught to have towards his father. Although the Dutch-Surinamese Indian habitus is seemingly blurred in case of Rishi, he has some dispositions that equal his parents' ethnic habitus. He did not express his discontent towards his father:

> There is but one thing in my father that frustrates me enormously. He expects me to do a comparable academic study like he did. One day I was very desperate, I felt my parents did not care about me, that's why I took the pills.

In Rishi's case, the traces of ethnic habitus features are less overtly discernible. Rishi did not share his father's inclinations to prefer an academic study as that is traditionally appraised and part of the ethnic habitus to strive for progress. Although Rishi's lack of expressing and defending his own desires and the lack of objecting his father's wishes fit in the Dutch-Surinamese Indian habitus unquestioned respect for authority and conflict avoidance, it could just as well be seen as lack of self-esteem. The latter, however, was not the case, and even if it was, that should not be an indemnification to examine the ethnic habitus. Rishi was not raised traditionally, yet he had acquired the tacit rules of compliance with the standards of family and the importance of group orientation. Thus, the *manai ká boli* is latently present in Rishi and in his father.

At first sight, the cases of Warsha and Rishi hold nothing ethnic Dutch-Surinamese Indian in it. That is, if one focuses on the individual experiences of both youngsters, which is a major pitfall of mainstream suicide research, especially in case of adolescent suicidal behaviour. These cases do not represent stand-alone experiences. Rather it occurs in an interpersonal context wherein the cultural influences are embedded in the ethnic habitus, which may impact the persons involved differently due to acculturation with different 'outlooks' of the ethnic habitus. Or, as Erel (2010) stated, the ethnic habitus may become blurred, brightened or fragmented, depending on the social forces to which they are subjected. Furthermore, habitus is below the level of consciousness and language. In both cases, I noticed diversification of the ethnic habitus. Both cases display an entanglement of age, gender, group-orientedness and acculturation in the ethnic habitus. Therefore, through the lens of an ethnic habitus, the cultural aspects are discerned.

The cases of Rishi and Warsha demonstrate that the operation of ethnic habitus is evident in the second- and third-generation Dutch-Surinamese Indians. These cases represent the Dutch-Surinamese Indian habitus, where conflicts arose between the tradition-oriented family members and the acculturated ones. Some of the conflicts within families can be typified as a transition from a 'commanding household' to a 'negotiating household' (De Swaan, 1997). It represents a westernization dotted with frictions. In terms of ethnic habitus, this case represents habitus diversification and fragmented habitus (Erel, 2010; Friedman, 2015).

5. Conclusion

Despite increasing evidence that cultural forces are powerful determinants of suicidal behaviour, the scholarly field lacks suitable theoretical concepts to capture these forces. This observation inspired the exploration with the concept of habitus. This concept, however, although referring to collective behaviour (i.e., classes), needed to be made fit to address ethnic groups or broader cultural forces. The relative looseness of the habitus concept enabled me to specify it to ethnic habitus and to explore the impact of ethnicity on suicidal behaviour as well as its intersectional factors, age and gender. With a focus on two concepts related to religion, notably *karma* and *kismet*, and a code for behavioural conduct, notably *manai ká boli*, I explored the concept's suitability in capturing cultural factors involved in suicidal behaviour. Both *karma* and *kismat* and *manai ká boli* form an expression of ethnic habitus.

The discussed cases illustrate the operation of ethnic habitus as a mediator for individual behaviour as well as a producer of practices related to the concepts *karma* and *kismet* and *manai ká boli*. Although these concepts or variants thereof are prevalent in other cultures too, the unicity of the concepts expresses itself in the lived reality per group related to specific constellations of the prevailing cultural norms, values and meanings. None of these concepts operates on their own; rather it is entangled in daily lives with other prevailing norms and values and relevant cultural meaning. Nonetheless, they were presented separately for clarity purposes and to highlight the specificity of each theme.

The cases demonstrated that the examined Dutch-Surinamese Indian group has some built-in tendencies to comply to the group-specific values and norms concerning *karma* and *kismat* and to *manai ká boli*, the cultural steering code for practice. These tendencies have become typical of their habitus and are related to suicidal behaviour. This chapter has highlighted how culture (particularly upholding *ijjat* steered by *manai ká boli*) creates distress and how it is experienced by individuals. However, relatively more female cases were available. This may be related to the fact that statistically more women are involved in suicide attempts and that the female gender is more than the male gender able or willing to share their experiences (Balt et al., 2021).

The application of the concept of ethnic habitus, however, was not clear-cut. This had to do with the fit of the conceptualizations of the concept of ethnic habitus with the research group who are the so-called twice migrants. Some elements of Bourdieu's classic description of habitus were difficult to sustain, notably, the concept's supposed durability and uniformity and the reproductive nature. In a significant number of cases, I encountered problems with the durability, the uniformity as well as the reproductive capacity of the concept. This was especially true for the changes in the habitus I observed or the habitus clefts. The existence of multiple habitus, too, was difficult to comprehend with Bourdieu's notions of habitus. This problem is noticed

by Friedman (2015, p. 144) who utters that Bourdieu 'rarely engaged empirically with the precise conditions under which the habitus is likely to be altered, adjusted and/or disrupted'. Some authors have endeavoured to overcome these issues by elaborating it into habitus diversification (Schneider & Lang, 2014) or habitus fragmentation (Erel, 2010; Silva, 2016).

The changes I noticed that hampered the distinguishment of a durable, uniform, reproductive habitus were related to three interlinked phenomena. There was a lack of continuity of the habitus throughout the generations induced by migration and acculturation. The spatial and time-related primary and secondary socialization differed (from slightly to enormously) between the different generations. Therefore, within one family, the primary and the secondary socialization of the elderly who were born and socialized in a Surinamese setting decades ago differed from their children and grandchildren. Their children were often born in Suriname and had undergone their primary socialization there and their secondary socialization in the Netherlands. And the grandchildren were born and socialized in the Netherlands. These differences resonated in their habitus. It led to problems when the reproduction of the Indian habitus was hindered by other habitus, especially due to the abiding impact of the primary socialization of the elderly, which was not 'recognized' by the younger generation. The changes also led to resilient strategies in which flexible and creative bridging between the differences was noticed.

Despite the range of empirical findings, the concept of ethnic habitus is not stable enough due to the many changes, and thus, the concept has only a limited value because it has to be constantly adapted or adjusted. In addition, this finding points at the increasing changes among the Dutch-Surinamese Indian group.

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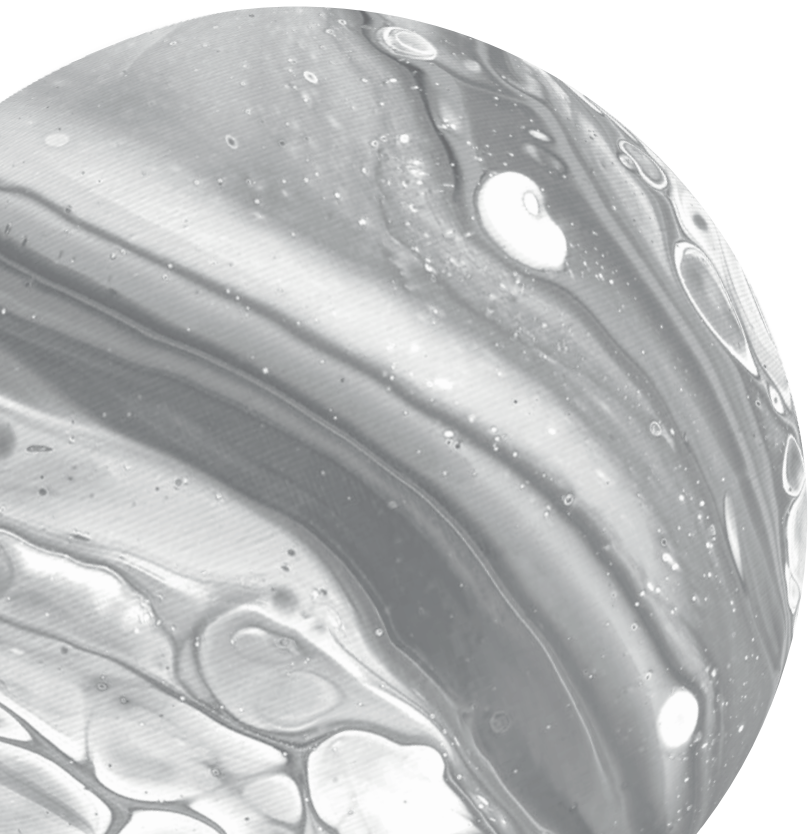

Chapter 6

Cultural autopsy of suicide

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1. Introduction[11]

In the exploration of the relation between culture and suicide, I have thus far focused on the prevalent explanations for suicide in the Indian diaspora and on theoretical concepts to capture cultural factors involved in suicidal behaviour. In this chapter the focus shifts to the post-mortem identification of cultural forces involved in suicides. This somewhat 'new' focus requires its own argumentation, discussion of relevant literature and explanation of the methods, and so on.

Factors varying from biological, psychological, social to cultural factors can contribute to suicide (Nugent, Ballard, Park, & Zarate, 2019). Despite the acknowledgement of the multifactorial aetiology of suicide, the prevailing post-mortem suicide examination is worldwide dominated by the so-called psychological autopsy that focuses on psychopathological contributors (Hjelmeland & Knizek, 2017; Shneidman, 1996). Psychological autopsy emerged as a complement to the medical autopsy in clarifying deaths that appeared equivocal as to their cause, and nowadays it has a prime position in ex post suicide examination. Psychological autopsy's development into a key position is not surprising, because it originated from the medical-psychiatric model, which is dominant in suicide research. In psychological autopsy, information about the deceased is gathered from multiple informants and records to draw diagnostical conclusions about the mental state and intent of the deceased prior to the death. Subsequently, the results are used for clinical and preventative ends by the identification of mental and biological risk profiles for suicide (Bakst, Braun, & Shohat, 2016; Pouliot & De Leo, 2006).

Another – less established – form of ex post suicide examination consists of the so-called sociological autopsy that focuses on social and ecological factors involved in suicide (Andoh-Arthur, Knizek, Osafo, & Hjelmeland, 2018; Hagaman, Khadka, Wutich, Lohani, & Kohrt, 2018). Sociological or social autopsies are more often applied in public health domains such as maternal mortality and to a lesser extent to post-mortem suicide examination (Andoh-Arthur et al., 2018; Mahato, Waithaka, van Teijlingen, Pant, & Biswas, 2018). The sociological autopsy method tends to mimic the psychological autopsy while it focuses on social and sociocultural factors such as

11 An earlier draft of the conceptualization of the cultural autopsy as described in section 2 of this chapter, is presented at the 22nd World Congress of Psychotherapy organized by the International Federation of Psychotherapy (IFP) in June 2018, Amsterdam, The Netherlands.

relation breakdown, education level and patriarchal structures (see Hagaman et al., 2018; Parkar, Nagarsekar, & Weiss, 2009; Scourfield, Fincham, Langer, & Shiner, 2012).

The abovementioned suicide autopsy methods display some problematic issues. First, the prevailing suicide autopsy focuses on either psychocentric or social and ecological contributors to suicide and lacks a focus on cultural forces. Second, the causal relation between mental disorders and suicidal behaviour whereupon the current suicide autopsies are based seems especially relevant for Western cultures, because psychological autopsy studies in non-Western cultures display significantly lower rates of mental disorders involved. This seems to be related to the cultural variety in the relationship between mental disorder and suicide (Hjelmeland, Dieserud, Dyregrov, Knizek, & Leenaars, 2012). In non-Western cultures, sociocultural factors, such as beliefs, values and traditional practices, are purported to be the significant domain for suicide risk factors (Kizza, Knizek, Kinyanda, & Hjelmeland, 2012; Pouliot & De Leo, 2006).

Third, ex post suicide examination based on single causes and without inclusion of cultural contributors may lead to disturbing conclusions. An example is the labelling of a woman as suffering from depression and a dependent personality disorder while glossing over the fact that her suicide was preceded by being banned by her family because of her relationship with someone from another religious background. The inclusion of cultural factors involved may give a nuanced image of the suicide. However, the current ex post suicide examination lacks instruments to examine the cultural factors involved. The sociological approach could have included cultural elements, but the psychological autopsy's hegemony pervades the sociological autopsy, and it impedes the development of a method to ex post examine cultural contributors to suicide (Hjelmeland et al., 2012; Pouliot & De Leo, 2006).

This chapter conceptualizes and introduces cultural autopsy, a method for ex post understanding of cultural factors involved in suicides, which serves as a complementary method for ex post suicide examination. A premise of cultural autopsy is that aggregate-level knowledge can be deepened by focusing on suicide's embeddedness in the local cultural settings. Therefore, the perspective of the actor is centred as is reflected in prevailing layperson theories of suicide in the researched group. The rationale of the focus on layperson theories is that the views held by the members of the community, instead of academic theories, broaden the scope of suicide autopsy. The cultural autopsy requires the examination of suicides based on several data (a literature survey, a verbal autopsy guided by a customized topic list and expert reviews). This culturally grounded approach that pursues a nuanced, contextualized ex post understanding of suicide intends to complement the other forms of suicide autopsy. Accordingly, the preventive ends of suicide autopsy can be culturally tailored from within rather than being imposed from without.

In the next section, the conceptualization of cultural autopsy is outlined. This is

done by delineating the relevant theoretical components, with the incorporation of some relevant aspects of the current autopsy methods. Thereafter, the construction of the cultural autopsy method is presented by delineating its main building blocks. The methodology section presents the set-up of a first try-out of the cultural autopsy. To that end, the conceptualized cultural autopsy will be concretized for the research group. Section 4 demonstrates the application of the cultural autopsy in a try-out on three Dutch-Surinamese Indian suicide cases. In Section 5, the development and the try-out of the cultural autopsy method are evaluated. The last section includes some concluding remarks and suggests further validation of the cultural autopsy.

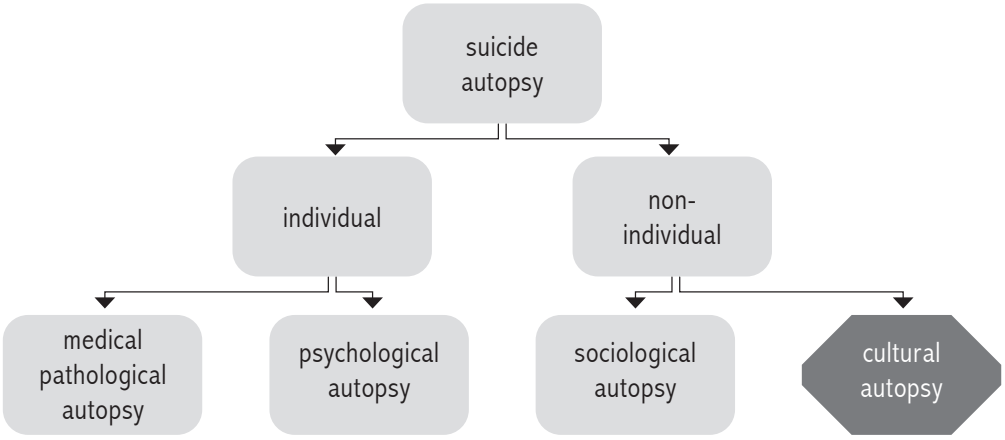
2. Conceptualization of cultural autopsy

The conceptualization of cultural autopsy is based on culturally grounded premises to create a firm basis for the concept. Contrary to the classical psychological autopsy, with a strong psychocentric focus, some of the sociological autopsy studies managed to capture sociocultural aspects of suicide. These studies' relevant elements are culturally substantiated and incorporated in the construction of the cultural autopsy, such as the verbal autopsy, which is a method for collecting information about symptoms and circumstances for a deceased person to determine the cause of death. The narrative approach and the focus on local cultural frameworks are other elements I derived from the sociological autopsy method. To enlarge the needed cultural perspective from the actor's point of view, I have centralized the cultural meaning and lay theories in the cultural autopsy.

2.1. Theoretical principles

Based on the scholarly literature on culture and suicide, some premises are formulated for the conceptualization of cultural autopsy. One of the main premises is that cultural autopsy departs from the finding that suicide is a multifactorial phenomenon (Colucci & Lester, 2013; Kirmayer, 2022). The introduction of the concept of cultural autopsy is not meant to ignore the share of the other factors, such as the role of psychopathology in suicides, nor to claim a superiortiy of culture in suicide research. Just as suicide cannot simply be reduced to a biological condition, culture cannot grant its full understanding. Rather, cultural autopsy is complementary to other forms of autopsy, whereof most focus on individual factors and some on non-individual factors. Cultural autopsy aims to contribute to a comprehensive suicide examination. Figure 6.1 pictures the envisioned positioning of cultural autopsy among the different types of suicide autopsy.

Figure 6.1. (Sub-)forms of suicide autopsy



Source: own construction

The figure demonstrates that the medical/pathological autopsy and the psychological autopsy focus on individual factors by respectively performing a bodily and psychopathological examination of the suicide to determine the physical and the mental cause of death respectively. Cultural autopsy, with the focus on cultural factors of suicide, is situated in the category that focuses on non-individual factors, together with the sociological autopsy. The latter focuses on the social aspects, such as the influence of gender on suicide (Scourfield et al., 2012). Each (sub-)type of suicide autopsy has its own perspective and operates rather independently from the others, but jointly, the perspectives may offer a comprehensive image of a suicide.

Another premise is that epidemiological findings indicate that suicide varies across the world. Although it is undefined how culture relates to suicide, cultural differences are reported in risk factors for suicide, the patterns of suicidal acts as well as the methods, precipitating factors and the cultural meaning (Hjelmeland, 2010; Colucci & Lester, 2013; Kirmayer, 2022). This implies that suicides are to be understood within the cultural context. The importance of culture in understanding suicide is underlined by many scholars. Boldt (1988, p. 106) stated, 'No one who commits suicide does so without reference to the prevailing normative standards and attitudes of the cultural community.' Therefore, in cultural autopsy, the cultural background of the deceased has an important weight. Next to knowledge about the suicide incidence and prevalence in the cultural group of the deceased, knowledge about the cultural group's cultural features is of importance, such as the cultural norms, values and beliefs related to gender and age.

Yet another premise is that as culture is present in the inner and outer worlds in a community (Strauss & Quinn, 1997), the local perspective of the group members holds the cultural information about suicide. Therefore, cultural autopsy focuses on

information from people who were close to the deceased. Their narratives may reveal the assumed cultural motives and causes that led to the suicide as well as information about the culturally influenced methods used and the impact of the suicide. In this way, attitudes, beliefs, and the cultural meaning of suicide can be uncovered to gain cultural understanding of the suicide. The theoretical importance of such a narrative approach is that it forms a gateway to local cultural frameworks. The latter is an element I derived from the review of the sociocultural autopsy studies. These elements, however, need to be further eleborated and incorporated in the cultural autopsy. Then, the local framework's culturally specific concepts can be singled out.

Two concepts are relevant to gain insight into the local cultural framework, notably, lay theories and the cultural meaning. Boldt (1988, p. 95) stated that 'meaning precedes [suicide] ideation and action'. In other words, it is due to the appended meaning to a life stressor why it becomes a risk for suicide and why one person continues to engage in suicidal behaviour while others do not. Strauss and Quinn (1997) stressed that 'a cultural meaning is the typical (frequently recurring and widely shared aspects of the) interpretation of some type of object or event evoked in people as a result of their similar life experiences' (p. 6). This implies that the cultural meaning of suicide exists in those who experience the suicides of others. The cultural meaning, then, is to be found in the attitudes of the bearers of a culture and thus in the lay theories of suicide.

Lester (2012) distinguished the individual meaning of suicide (personal senses) and the cultural meaning of suicide. According to him, the cultural meaning of suicide lays in motives, precipitants and ethnomedical theories but is best rooted in the lay theories of suicide in which the members of (sub)cultures believe. Chu, Goldblum, Floyd, and Bongar (2010) distinguished two critical junctures where cultural meaning operates. First, the person who ascribes certain culturally influenced meanings to the event leading up to suicidal behaviour. Hereby, possible cultural sanctions or messages of acceptability that go along with the event mediate the cultural meaning and direct coping. Second, the scholars stated that the final performance of a suicidal act is determined by the prevailing cultural meaning of suicide. Together, the personal and cultural meaning influence one's tolerance threshold for distress or despair.

To uncover the cultural meaning, the narratives of the people close to deceased are needed. These narratives hold lay theories, which is another central concept in cultural autopsy. Lay theories are opposed to academic theories. In the latter, researchers use 'culture' (which is an emic concept) in a way that does not necessarily coincide with the actor's perspective. On the contrary, lay theories include prevailing cultural aspects befitting the local cultural framework. These cultural aspects can be assessed from the vernacular, from the narratives of family, friends, neighbours and so on. Here, however, the assumption is not that group members can make their lived culture explicit when asked. Moreover, the gathered information may not be the most relevant cultural information about the group in general, and that is not necessarily

the purpose. Rather, the assumption is that lay theories hold cultural information about the deceased's specific lived reality from the local emic perspective.

The use of lay theories or 'common sense' is known to be a useful gateway to uncover attitudes and beliefs about several health issues, including suicide. For example, Osafo, Akotia, Hjelmeland, and Knizek (2017) and Knight, Furnham, and Lester (2000) unlocked lay theories of suicide and focused on sociocultural and personality aspects, respectively. However, these studies used random groups to unlock lay theories, whereas the cultural autopsy concept perceives closely related people of the deceased as the holders of the lay theories of suicide. These relatives may contribute to the cultural understanding of suicides, by examining the way they understand, describe, respond and make particular claims related to the suicide of their relative (Hagaman et al., 2018).

2.2. Building blocks

Although the traditional scope of suicide autopsies is limited to the medical-psychiatric domain, several scholars endeavoured to expand its reach. A few sociological suicide autopsy studies identified some social and ecological contributors to suicides. Scourfield et al. (2012) found that the gendered character of male suicides displayed the social meaning of suicide. However, they followed the psychological autopsy procedures, and the sociological factors were add-ons. Some suicide autopsy studies outside the Western world have focused – at least partly – on sociocultural factors in suicides. Andoh-Arthur et al. (2018) and Kizza et al. (2012) interviewed significant persons close to a sample of men who died by suicide in Ghana and Uganda, respectively. The study of Andoh-Arthur et al. (2018, p. 658) in Ghana revealed that 'experiences of shame related to loss of economic control, breach of patriarchal norms and threats to sexual competence contributed to the suicides'. In Uganda, Kizza et al. (2012, p. 696) found that 'Lost dignity and social value, lack of hope for the family's future, overwhelming family responsibility, and mental illness were circumstances found to have preceded the suicides'. The embedding of the suicides in the local context is emphasized in both studies.

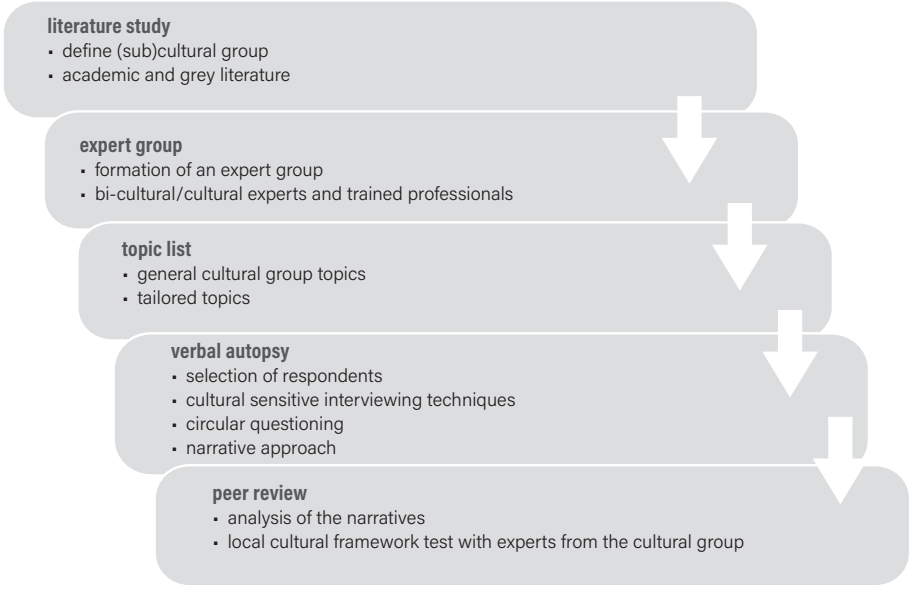
Parkar et al. (2009, 2012) and Hagaman et al. (2018) performed a mixed method research in India and Nepal, respectively. Parkar et al. (2009, p.192) disclosed themes related to suicide, such as 'victimization of women, the personal and social impact of problem drinking, marital problems, physical health problems' and 'possession, and sorcery'. Incidently, Parkar et al.'s (2012) findings illustrated the influence on the results of the specific relation relatives had with deceased. For instance, the accounts of a mother and mother-in-law differed immensely due to spousal problems the deceased had. Hagaman et al. (2018) included culture-specific topics in their inductive coding process, such as *ijjat* (translated by the authors as social status), perceived shame and relevant personality characteristics, such as *ghamandi* (translated by the authors as

egoistical). Together with the deductive codes from a survey, such as alcohol abuse, stigma and economic stress, the authors embedded their suicide research in local cultural frameworks involving social and spiritual forces.

In paying attention to the non-individual factors of suicide, the sociological studies focus on ecological and sociological, and/or they use the same theoretical base as the 'classic' psychological autopsy. Hereby, the preconceived psychopathological assumptions, such as the causal relation between suicide and mental disorders, coloured all these studies. This is noticeable either in their dependence on (already diagnosed) clinical samples or by their use of instruments based on the medical-psychiatric paradigm. For example, Parkar et al. (2009) used a survey list called the Explanatory Model Interview Catalogue (EMIC) to guide the semi-structured interviews. This list is a priori framed in an illness model, which is meant to explore narrative accounts of the experience, meaning and behaviour associated with a health problem. Nonetheless, for the conceptualization of the cultural autopsy, I have identified some useful elements of the former autopsy studies, such as the verbal autopsy.

The cultural autopsy consists of five building blocks as is displayed in chronological order in Figure 6.2. Each building block has its own characteristics and content. Together the building blocks pertain to the design of the cultural autopsy. Next, each building block is discussed for its necessity and relevance.

Figure 6.2. Building blocks of cultural autopsy



Source: own construction

The first building block holds the gathering of some prior knowledge about the deceased's cultural background. This is preceded by the identification of the cultural

group(s) the person belonged to. The latter is necessary, because people from the same ethnocultural group can differ because of their ethnicity or religion. The gathering of the literature leads a general knowledge base, which is primarily meant to aid in creating a topic list (building block 3). Second, the collected knowledge may serve to connect with the respondents which may ease the verbal autopsy (building block 4). The gathered knowledge should contain two types of knowledge: about the cultural group, in general, consisting of cultural norms and values and other relevant themes and – if available – about the suicide incidence and prevalence for the different gender and age groups. Likewise, literature on attitudes about the permissiveness of suicides whether or not related to religion or other values are important too.

To date, an abundance of literature is available about culturally differing prevalence of suicidal behaviour, the methods chosen for suicide and the distribution by age, sex and other sociodemographic variables (Chu et al., 2010; Marsh, 2015). For some cultural groups, this body of knowledge is enhanced by ethnographic studies. The gathered knowledge of the research group's culture and suicide particularities needs to be complemented with the knowledge from the cultural group itself. The uncovered information needs to include knowledge about the prevalent idioms of distress too. Even though 'distress' has a psychological connotation, idioms of distress refer to experiences or behaviours that are (only) understandable for members of a culture and that do not necessarily result from pathology (De Jong, Reis, & Poortinga, 2020). Examples include the *seizures de nervios* as idioms of distress among Latinas in the United States who attempt suicide (Zayas & Gulbas, 2012). All the information lead to a firm body of up-to-date knowledge, which serves as an underlay and guidance for the rest of the autopsy.

The second building block consists of an expert group that provides the researcher of consultation and advice throughout the whole process of cultural autopsy. The expert group should represent two types of knowledge. One type of knowledge is inside knowledge related to the cultural group of the examined suicide. Preferably, that knowledge is represented by a selection of (proto-professionalized) persons from the research group itself, the so-called cultural experts. These experts provide inside cultural know-how to the expert group and the researcher. The other type of knowledge pertains know-how about the factors that may contribute to suicide. These experts should have preferably a clinical training as a psychologist, psychotherapist or psychiatrist and/or training in cultural sensitivity. The researcher who performs the verbal autopsy part and is involved in the peer review (third and fourth building blocks) is obliged to have both expertise. Furthermore, it would be preferable if at least one of the professionals had the same cultural background as the culture under study. This choice is justified by their proficiency both in the local ethnic mores of the research group and in the mental health care.

The topic list forms the third building block of the cultural autopsy. This topic

list is based on the cultural information gathered from the literature study and complemented with the inside knowledge of the cultural experts. For the purpose of a cultural autopsy, the topic list serves to support an open investigation, without the guidance of any preconceived assumptions. Therefore, it is a topic list and not a questionnaire. The topic list is merely used as mnemonic to discuss cultural themes during the verbal autopsy. The content of the topic list needs to befit the cultural group's background. The topic list contains a part with topics about the cultural background in general (language, (bi)cultural identity, religion, family relations, migration history). Next to that there is a specificity in the topic list that zooms in on the diversity of characteristics of the deceased, such as gender, age and so on.

For example, if strict gender- and age-related cultural norms and values are prevalent in the deceased's cultural background, then the specific part of the topic list should contain items that inform about the specific constellation of those norms and values in the deceased's life. Illustratively, if the deceased's cultural background valued honour, the list should contain items that incite to inform about possible required gender-related behaviour the deceased was supposed to meet. Thus, the topic list varies per culture and within a culture.

The fourth building block is formed by the verbal autopsy. The verbal autopsy is used in the psychological and sociological autopsy in the sense of a interview that is mostly guided by a questionaire. I perceive the verbal autopsy as a useful concept to be incorporated in cultural autopsy, provided that it is freed from preconceived assumptions. The verbal autopsy can be performed with a selection of people close to the deceased. A variety of relations with the deceased is strived for, such as first- or second-grade family members (in law) and friends. Helpful can be the use of respondent-driven sampling wherein the first respondents themselves recruit the other respondents (Heckathorn & Cameron, 2017). Given the sensitive nature of the interviews, special precautions have to be taken before starting the verbal autopsy, such as an arrangement for possible emotional support and debriefing. The cultural verbal autopsy differs from the verbal autopsies in the other suicide autopsy forms, in that it is not primarily focused on the cause of death but on culturally understanding the suicide.

The last building block holds the processing of the gathered information. This process is not simply eliciting of the relevant themes from the narratives. It is an intensive procedure that requires to set the themes that emerge from the narratives against the themes that emerged earlier from the literature study. Subsequently, the outcomes are discussed with the expert group to reach a synthesis. An extensive review of the outcomes with the research group will enhance the reliability of the results and offer clues for prevention in professional setting and in the research group. The idea is that the cultural themes that emerge from the synthesis will give an image of the operation of cultural factors in the examined suicide.

3. Methodology

For the try-out of the cultural autopsy, I focused on the Dutch-Surinamese Indian group. First, a research team was formed out of three professionals from my network and three people from the Dutch-Surinamese Indian community. The professionals, a psychiatrist and two psychologists, all had experience in offering mental health care to Dutch-Surinamese Indians, and two of them were part of this community too. The experts from the Dutch-Surinamese Indian community were known as key persons. This expert group, further called the research team, commented on the research during the whole process. The literature survey, the construction of the cultural autopsy concept, the topic list construction, the data and findings were frequently discussed with the research team. They commented on the reliability and validity of the method too and reviewed the procedures as well as the content of the topic list and the unlocked themes, respectively.

Then, literature on Dutch-Surinamese Indian culture and suicide was surveyed. Based on this survey and with help from the research team, a topic list was customized for the Dutch-Surinamese Indians. Here, the features of the ethnic habitus were relevant too (see Chapter 5). The culture-specific themes were religion, predominantly Hinduism, followed by Islam and a little group of Christians, each with their own specifications; loyalty and deference, that is, in differing forms related to specific relations within the hierarchical family relations; indirect communication, avoidance of topics that could evoke shame and guilt; striving for harmony and avoidance of conflicts; and gendered norms and gender-specific issues such as *ijjat* (Sarnámi for *izzat*, honour), which is guided by the social control steering code *manai ká boli* (what will people say).

Each of the topics was elaborated with possible differentiations. For example, it was relevant to consider that of the Hindu religion, the *Sanatan Dharma* division is the largest, and that differs in several aspects from the *Arya Samaj*, the second-largest Hindu group. Later, the topic list was further tailored to the specific characteristics (gender, age, religion) of the examined suicides. If specific manifestations were present, the topic list was supplemented or adjusted accordingly. Although most of the selected themes were not exclusively valid for Dutch-Surinamese Indians, they were typified as culture specific, not per theme in itself, but only in conjunction with other themes and within the Dutch-Surinamese Indian context.

I asked a selected group of key informants in the Dutch-Surinamese Indian community in The Hague if they knew Dutch-Surinamese Indian people (who knew a Dutch-Surinamese Indian person) who died by suicide. For the selection of the study subjects (people who died by suicide) as well as the informants (people closely related to the deceased), an enhancement of network or snowball sampling was used (Heckathorn & Cameron, 2017). The objective was to interview two to five informants per suicide, older than 16 years and with a varying degree of relatedness to the deceased, such as first- and

second-degree family members, in-laws, friends and neighbours. The first round led to a total of three informants, each connected to one suicide case. Next, these informants were contacted and asked for more informants. Eventually, from September 2018 to January 2019, in total, 11 informants from The Hague were interviewed about three identified suicides (two times four and one time three informants per case). The time elapsed between the examined suicides, and the interview ranged from 9 months to 5 years.

Subsequently, the verbal autopsy was performed. Given the sensitive nature of the interviews, the respondents were offered to stop participating at any moment during the research period, either temporarily or definitively. They were informed that the effect of the interview on their stress level would be monitored during the interview by regularly asking about it. A debriefing took place after each interview and after one month; in both instances, the interviewees were asked whether they needed any mental support or counselling. During the interviews and in the follow-up, a few clinicians were available to offer mental support if needed. The interviews were mostly conducted in Dutch, but, if necessary, we carried on in *Sarnámi* (the Surinamese Indian Bhojpuri dialect), *Sranang tongo* (the lingua franca of Suriname) or Bhojpuri/Hindi (official languages of India). Mostly, a mixture of these four languages was spoken. After obtaining informed consent from the informants, the interviews were recorded with a digital audio-recording device and processed afterwards.

The data were anonymized, and pseudonyms were used in illustrative quotes. The textual analysis – substantiated with supporting quotes – was done by the author-researcher and commented on by the research team. The latter helped with the interpretation of narratives that were open to multiple interpretations; the situatedness of the narratives was discussed extensively with the research team by explicitly observing the context (relation of the narrator to the deceased, his or her age and gender and so on). The reconstructed stories of the deceased narrated by the respondents were discussed thoroughly. Hereby, the assessed similarities, differences and contradictions were considered and, after several discussion sessions, integrated into one relatively coherent narrative about the deceased.

An important methodological element used in the verbal autopsy, as it aids to unlock lay theories, was circular questioning (Evans & Whitcombe, 2015). Instead of focusing on cause-effect and asking linear questions, circular questioning addresses relationships in a group of people. Instead of asking a son 'Do you love your father?', which is a linear question, the mother may be posed the circular question, 'How does your son show his love for his father?' Circular questioning is of major importance in cultural autopsy because it contributes to the understanding of the suicide from different bystanders' views. It also produces multiple narratives and perspectives, without the urge to look for one definitive answer. The required training to apply circular questioning in a proper way was acquired by the researcher during her professional training as a psychologist-

psychotherapist. The application of circular questioning in the interviews with several informants for each suicide offered an opportunity for information triangulation, which benefitted the reliability and validity of the data (Kizza et al., 2012).
The gathered information was categorized in themes and extensively discussed with the research team. This resulted in the synthesis of some themes that is presented in Section 4.2. The identified themes fitted in two container categories, notably, *ijjat*–related themes and to themes related to how adversities were dealt with.

4. Results of the try-out of the cultural autopsy

The results of the try-out of the ex post suicide examination with the use of the cultural autopsy are presented in the following two parts. First, some important characteristics of the studied suicides are summarized as well as the relation of the interviewees to the deceased. In Section 4.1, some biographical information of the three cases are presented, which are obtained from several respondents who knew the deceased closely. All respondents lived in the Netherlands, and almost all of them in the area of The Hague. This information serves as an underlay for Section 4.2, wherein the findings of the cultural autopsy are presented. The pre-formulated topic list formed a mere guidance, and the actual topics that were considered relevant per case were identified in hindsight. In the identification of the relevant themes, the information from the verbal autopsy is used, which was guided by the already customized topic list, together with the findings from the literature survey and the expert review.

4.1. Three cases

The three selected cases of Suresh, Nazia and Rahul are presented next, with a description of their history and some biographical information (see Table 6.1). There were several arguments to select these three cases for the try-out. First, their cultural background offers enough cultural unicity to explore the cultural factors involved. Another argument was the differentiation in age, gender and religion, as these factors are known to have their own particularities related to suicide. And, with the establishment of the suicide, these cases were not assigned evident psychopathological or social causes, which offered the opportunity to broadly explore the cultural factors.

Based on the names of the cases, the research group provided some information on the cultural and religious backgrounds. The rest of the information was collected from the respondents, who had personal relations with the deceased. None of the cases had a psychological autopsy, as is performed in cases of unequivocal deaths or as part of an academic research. The death by suicide was established by the police and the medical services. I only focused on the cultural autopsy as that is the prime goal of this chapter.

Table 6.1. Some characteristics of the studied suicide cases

	Suresh	Nazia	Rahul
Gender	Male	Female	Male
Age	54	32	17
Country of birth	Suriname	The Netherlands	The Netherlands
Education	Vocational training	Academic	High school
Occupation	Truck driver	Housewife	Student
Religion	Hinduism	Hinduism (converted from Islam)	Hinduism
Marital status	Married, one son, two daughters	Married, one son	Single
Previous mental problems	Unclear	Unclear	Unclear
Financial problems	No	No	No
Suicide attempts	None	Unknown	None
Familial suicide history	Uncle (father's brother) died by suicide	Suicide attempts by some female family members	Unknown
Year of suicide	2016	2014	2018
Suicide method	Hanging	Ingesting acetic acid	Jumping in front of the train
Interviewees' relation to the deceased[12]	Four persons: widow, two friends, one cousin	Three persons: aunty, mother-in-law, son	Four persons: aunty, two uncles, neighbour

Source: own construction

4.1.1 *Suresh, died by hanging at age 54*

Suresh was born in Suriname in the district of Nickerie. His parents had a small farm, and next to that both of them worked for a big rice farm in the neighbourhood. Suresh was the eldest of four children. His family is typified as traditional, who lived in Suriname in a joint family setting; the family lived together with the grandparents from father's side, and a younger uncle lived with them too. The grandparents took care of the children when Suresh's parents went to work on the rice farm. When Suresh was 5 years old, his father died by a car accident. His mother stayed with her parents-in-law and raised the children together with them. When Suresh finished the primary school, they migrated to the Netherlands.

Ever since Suresh finished high school, he had worked as a truck driver in the construction business. With the money he earned, he supported his family in Suriname, by sending parcels with several goods they needed and by sending money. Later on, he would save finances for the study of his three children he had with the woman he married when he was 23. He was introduced to her by his aunty who thought that she

12 The familial relations are explained in English and denoted with the terms used in Sarnámi, which is also colored by the religious background. For example, *ájá* is the Hindu denomination for grandfather of father's side, whereas the Muslim term is *dádá*. Yet, for Hindus, *dádá* refers to the older brother of the father.

would be a match for Suresh. Within a year they were married. His wife was a nurse. They both took care of the household, and Suresh often prepared the meals when she had evening shifts. Once a year the whole family went for holidays. Suresh had good contact with the family of his wife. Contact with his own family was less close. At the time Suresh died, his youngest son had just started studying at the university, and the other two were in an advanced stage of their studies. The children were independent and autonomous. Suresh died by hanging at age 54 in the year 2016.

4.1.2 *Nazia, died at age 32 by drinking acetic acid*

Nazia was born in the Netherlands, as the youngest in a Dutch-Surinamese Indian Muslim family with six children (four girls and two boys). When her parents came to the Netherlands in 1975, they already had three children. As they did not have housing when they arrived in the Netherlands, they were stationed nearby Breda in the southern part of the Netherlands, in a reception centre offered by the government. Once Nazia's father had a job, the family rented a house in the city of Breda. Nazia was born and raised in Breda. She was raised with Islamic traditions. Her parents did not object when Nazia decided not to attend the Koran school anymore. The family was familiar with traditional gender roles, and Nazia's brothers enjoyed more freedom of movement than herself and her sisters. Nazia did not mind that. She did well at school and wanted to become a lawyer.

When Nazia was 20 years old, she fell in love. After having had contact secretly, she told her parents that she had met someone and that both were serious and wanted to get married. The relation, however, was troublesome because the boy was a Hindu. Both families did not agree with the match. Nazia went through difficult times with a lot of arguments with her parents and her brothers too. After intervention of an uncle and aunty of Nazia who knew the boy's family, both families started to accept the relation. Both families wanted the traditional marriage according to their own religious wedding ceremonies. Finally, Nazia and her boyfriend decided to get married according to both traditions, the Muslim and the Hindu way. Nazia's parents, however, did not attend the Hindu wedding ceremony. Nazia chose for her husband and embraced Hinduism.

After five years of marriage, the couple decided to move to Suriname. Her husband started a business there, and they lived together with his parents who had also moved back to Suriname from the Netherlands a few years earlier. They lived there for almost 5 years. Her mother-in-law did not treat Nazia well, and the relation with her husband deteriorated. There were quarrels all the time, which increasingly ended in domestic violence by her husband. Nazia wanted to go back to the Netherlands, and they moved back with their 10-year-old son. Nazia died in 2014 at age 32 by drinking acetic acid after a quarrel with her husband.

4.1.3

4.1.4 *Rahul, died at age 17 by jumping in front of a train*

Rahul was born in The Hague and grew up in a suburb. He used to live with his parents and his younger sister of 15 years old. Two older siblings were living independently. Both his parents came to the Netherlands from Suriname when they were just a few years old. In their early 20s, they were introduced to each other by a cousin, and after having dated for a year, they got married in traditional Hindu style and settled down in a suburban area. Rahul grew up in a White environment, in his neighbourhood as well as at school, and with the sports he practised. He did not learn to speak the Surinamese or Indian language(s), and the only contact with other Dutch-Surinamese Indians consisted of his closest family. Once in a while, he went with his parents to other family gatherings like wedding parties. His parents used to organize a *pujá* (Hindu ritual) at home, with the ritual-coloured flags planted in the garden afterwards, which formed the only typical overt signs of their religion.

In both families many family members were academically schooled. His mother is a dentist, and his father is an engineer. Rahul was expected to study medicine and become a surgeon like his grandfather used to be. Rahul died at age 17 by jumping in front of a train in 2018.

4.2. The cultural themes

The pre-formulated general topic list (building block 3) used for the verbal autopsy (building block 4) contained the following prevalent themes among Dutch-Surinamese Indians: religion, loyalty and deference, indirect communication, hierarchical family relations, gendered norms, *ijjat* (honour) and the social control steering code *manai ká boli* (what will people say). These themes had emerged from the literature survey and were confirmed by the research team as relevant (building blocks 1 and 2). In advance, based on the literature survey and the inside knowledge of the experts, the themes were loosely specified for the three cases' gender, age and religion. Therefore, the identified themes were substantiated by the literature survey to a large extent. After the analysis of the data gathered from the interviews, we concluded that most of the pre-formulated themes were present in the three cases yet to a largely differing extent. Each theme had specific manifestations related to the deceased's gender, age, religion and migration/acculturation.

Only after the interviews, the topics' final specifications could be established and concretized per case, which are presented next (building block 5). Several cultural themes came to the fore in the conversations with the respondents. In accordance with the research team, the data from the interviews were fitted in two container categories, which capture most of the characteristic cultural elements the respondents mentioned. Each category contains a variety of cultural elements extracted from the narratives. The first consists of the – to differing extent mentioned – *ijjat* concept including the differing forms of impact of *ijjat* had in each case. The second category

describes the cultural elements in the way each case is dealt with possible adversities, both by the person who died by suicide and by the relatives themselves.

4.2.5 *Differing forms of ijjat*

In hindsight, as became clear from the discussion with the research team, the manifestation of *ijjat* differed for each case, predominantly related to their gender. In Nazia's case, the gender-specific issues were present in the sense of complying with gendered virtues that contain good moral conduct, honour and obedience towards her family-in-law. For Suresh, *ijjat* was seen in the virtues that were connected to his male gender and his position of eldest son, such as being successful, building a good reputation by taking care of the family and avoiding failure. In Rahul's case, related to his age and possible acculturation throughout the generations, *ijjat* was concretized as building a good reputation as a good student and deference and respect towards his parents. The *ijjat* specifications per case were accompanied by a differing content and a varying impact of *manai ká boli*, one of the main items in the topic list. The latter kept Nazia captive in the harsh conditions and made Suresh continue trying, at all costs, to fulfil the role of male provider and eldest son. The impact of *manai ká boli* on Rahul was less pronounced, more acculturated and thereby easy to overlook. The literature only supported the general lines of *ijjat*; conclusions about the specific operation for the Surinamese-Dutch Indians (whether or not in acculturated forms) were drawn after intensive discussions with the research team.

The respondents described several implicit expectations related to *ijjat*. These expectations were present in different forms and always connected to what is seen as proper behaviour in the Dutch-Surinamese Indian community. These expectations were age and gender related and upheld by the Dutch-Surinamese Indian community as a whole. The individual had to comply too, often steered by the social code *manai ká boli.* The latter served to tacitly keep each other in line as in delineated in Chapter 5, which sometimes became a stranglehold like in Nazia's case. As a barometer of familial worth, *manai ká boli's* steering function as well as its examining and corrective function were clearly present in the cases. Especially, Nazia and Suresh were coerced to conform to the social expectations regarding *ijjat*. The examining and corrective function was predominantly executed by the family. This was done by having implicit or explicit expectations towards them. But it was also achieved by talking about their 'shortcomings' with others. These nuances came to the fore in the discussion with the research team.

Suresh is described by his family and friends as a friendly, humble family man, who worked hard as a truck driver. I noticed that the respondents often referred to his younger brother in describing Suresh. They used wordings like 'contrary to his brother'. When asked about it, all respondents gave a comparable answer, which points at a lay theory in the family, as is illustrated in the wordings of his nephew (brother's son):

> The story goes that from an early age on, *dádá* [father's older brother] and my father were called Rama and *Lakshman*. I suppose that they expected my *dádá* – as he was the oldest – to be like Rama, the wisest of the family, the smartest, the most successful, who guided the rest, like my *ájá* [grandfather from father's side] used to do. Those expectations must have weighed heavily on him, although he never complained.

The research team explained that in the Hindu epic *Ramáyana*, Rama was the king who was followed faithfully by his younger brother Lakshman. This narrative points at a form of *ijjat* that is embedding in the hierarchical relations and age- and gender-related roles within the family. The value of the eldest son in traditional Indian Hindu families is emphasized with these kinds of stories. This is also connected to the central role of the eldest son in the Hindu burial rites of the parents, but this reference was not made in the case of Suresh. Rather, the focus on the eldest son and the comparison with his brother had to do with the unfulfilled expectations the family had of both brothers. Contrary to the story of Rama and Lakshman, it was Suresh's younger brother who was seen as successful. The younger brother began as a real estate agent in a small firm and grew to have his own successful office with personnel. He earned a lot of money and had become a man of standing within the Dutch-Surinamese Indian community. Nonetheless, Suresh did act as the eldest son and did 'guide' others by giving them advice, helping them out and so on. His widow tells the following:

> Suresh did fulfil his role as oldest son. Our door was always open to everyone. They could walk in anytime. And when help was needed, no matter what time it was, how much time, energy or even money it would cost, Suresh was prepared to help and asked nothing in return. In my opinion he was too good. *Tabbo hamár dewar ke aur ijjat karat rahe log* [nevertheless, my brother-in-law received more honour].

Whereas the literature on *ijjat* focuses on the female gender, in the verbal autopsy of Suresh, a lay theory emerged related to the lack of *ijjat*. The widow refers to *ijjat*, or rather the lack of *ijjat*, for Suresh. Here, she refers to a specific characteristic of *ijjat*, notably, the deference and respect he should receive from others given his position and good behaviour. The little appraisal and some *ijjat* Suresh got for his kindness did not outweigh that of his brother received for his material success. In the narrative of Suresh's wife, an accusation is embedded towards the family. In her opinion, the family disrespected the several forms of *ijjat* Suresh valued most, notably, those related to the family relations. Rather, the *ijjat* Suresh 'earned', which is related to several virtues he possessed, was overrun by another type of *ijjat* his brother received from the society. In favour of the material success of the younger brother, the distinction between the different aspects of *ijjat* were hardly made. As a result, *ijjat* at societal, situational, relational and personal levels were equated. Incidentally, *ijjat* related to social success

and material achievements often 'compensates' for certain kinds of behaviour that would be normally seen as not *ijjat*-worthy, such as a Dutch-Surinamese Indian doctor who is excused by his community for his drinking problem. The highlighting of this type of double standards was based on the inside knowledge of the research team.

As *ijjat* has a communal embedding, both the negative and positive impacts of one's doing may reflect on the community. While in the case of Suresh, family members favoured the younger brother for his material success, as they profited from the positive effects of his *ijjat*, in the case of Nazia, the family members felt a negative effect. They blamed Nazia that their *ijjat* was negatively influenced by Nazia's 'condemnable' behaviour. The operation of several implicit and explicit expectations coupled with the gendered *ijjat* is illustrated by the account of Nazia's *khálá* (mother's sister):

> Nazia was considered 'the outcast' in our family because she had chosen for a Hindu boy. I remember that her mother yelled at her: 'this is *harám* [sinful], don't you have *saram* [shame], you are throwing away your *ijjat*!' Others in the family too, gossiped about the relation. Especially one aunty would approach other family members with the question 'did you hear Nazia has a relation with a *káfir* [unbeliever]?' Some family members suggested that her parents should save their *ijjat* by marrying her off to a decent Muslim boy.

Nazia was expected to behave according to the rules of the family and the Muslim Dutch-Surinamese Indian community. By socialization, she had learned what these rules were. Therefore, her not abiding to the rules damaged her *ijjat* and inspired others to treat her negatively.

In several studies, *ijjat* is mentioned as one of the pivotal cultural mediating factors related to distress and even suicidal behaviour among Indian women (Gunasinghe, 2015; Patel, 2005; Soni, 2012). Patel (2005) found that *saram* (shame), caused by not having *ijjat*, emerged as a significant mediating variable for suicidal behaviour among Indian women. Gilbert, Gilbert, and Sanghera (2004) found that reflected shame (shame reflected on others) and personal shame, as consequences of tarnished *ijjat*, led to entrapment in problematic situations and hampered help seeking. They even found that, to protect *ijjat*, some women felt it would be better to die by suicide than to leave an abusive relationship. These studies originated in the United Kingdom. Literature from the Indian subcontinent and other Indian diaspora countries, however, mention comparable findings (Baig, 2012; Patel, 2005). The literature study in Chapter 3, however, demonstrated that some cultural concepts were less strict present in the Netherlands compared to other countries. This literature finding, however, is contradicted by the registered strict traditional practices in Nazia's case, as is demonstrated in the implicit expectations of her mother-in-law:

> She wanted to marry my son, it was her own choice, nobody forced her. So, when things don't go well in the relation, she has to bare it. I heard her say in their quarrels that she would leave him if he hit her again. But she never did. *Kaun munh lee ke ját apan mái-báp ke ghar* [how would she go back to her parents; it would be face loss].

The mother-in-law refers to the obligation Nazia had in fulfilling her role as a wife in traditional setting, wherein endurance is implied. This is one of the characteristics that is present in the ethnic habitus of Dutch-Surinamese Indians. The expectations towards Nazia were not only held by others, but Nazia herself too had internalized those norms by socialization.

The cultural expectations are present in tacit ways and not only prevalent in traditional forms, as was the case with Rahul. The implicit expectations Rahul experienced were related to his academic performances. This is related to *ijjat* too, as getting ahead and gaining societal and academic success and achievements in society are appraised as *ijjat*-enhancers. According to his *káki* (wife of father's younger brother), Rahul's choices were guided by his inclination to please his parents:

> Rahul's parents are modern, but they hold some traditional ideas. I guess they pressurized him too much to study medicine. The poor boy, he could not pursue his own wishes. I know for sure that the study medicine was especially his father's wish. An unfulfilled goal of himself maybe? As far as I know Rahul wanted to be a journalist. And I do know for sure that Rahul was an obedient and courteous boy, who was always respectful towards his parents and would never argue with his parents.

In Rahul's case, the social expectations of the Dutch-Surinamese Indian community impacted the interpersonal expectations within his family, which are coupled with respect and deference as part of *ijjat*. Although Rahul was not overtly raised with these values, he had acquired it and displayed it. According to his *káki* and *káka* (father's younger brother), he was a good student, with excellent grades, and the plans were that he would attend the university to study medicine. The other uncle, Rahul's *mámá* (mother's brother), however, emphasized another aspect of the implicit expectations, notably that of respect and deference:

> That 'respect-thing' is so ingrained in all of us. 'You should respect your parents; listen to them; they want the best for you; do as they say', haven't we all learnt that?
>
> Rahul obviously did not want to disappoint his parents. But I cannot imagine that it is that what caused his suicide. I would expect such a young lad to argue against the obligatory respect norm.

Rahul's *mámá* discusses the respect or deference for elders as an important value among Indians. He shows some discontent with the *ijjat* a child should display towards parents, no matter what. He refers with it to the practice that there is an implicit stigma on counteracting the paramount authority of elders, which leads to an undisputed compliance from younger family members. Here, the uncle seems to project his dissatisfaction to the situation of Rahul. Moreover, he assumed that the obligatory *ijjat* towards parents he was socialised with would not be prevalent anymore in Rahul's generation who is born and raised in the Netherlands. He referred to the 'negotiating household' prevalent among native Dutch as opposed to the 'commanding household' he was raised with (see Chapter 5) (De Swaan, 1997). Rahul's uncle expected Rahul to be more assertive and negotiating, akin to his native Dutch friends. The uncle's attitude demonstrates that the communication was not very open and that he did not knew his nephew very well. It also displays generational differences which are not addressed in the family.

The uncle explicitly referred to a cultural concept too, consisting of filial piety. According to the research team, filial piety is part of *sewá*, which is an Indian concept that refers to selfless efforts on behalf of the welfare of others. The filial obligation is seen as part of *sewá* as it is an act of selfless service (Awasthi & Awasthi, 2017). Filial piety, in general, holds filial obligation towards parents, which is expressed in providing them with care (at old age), deference and obeyance of their preferences. This obligation can be experienced as pressure and lead to friction, especially in case of enculturation. However, it remained unclear to what extent this would have played a role in Rahul's case. Neither was present in the strategic solutions youngsters tend to apply in these cases, such as resorting to face-saving 'strategic' solutions, for example, lying or hiding by glossing over the truth when they feel parental pressure (Baig, 2012). It is possible that because of the implicitness of the expectations, it is not registered as pressure. His *káki* says:

> Our families saw each other frequently, once a week for sure, as we live close to each other. And I saw the interactions between Rahul and his parents. I never noticed anything wrong. Well, we're not the same as the *bakras* [the 'whites'], where the children rule, *muṛi par caharke bhaiṭe* [literally: sit on their head, figurative: children do anything they want]. … Rahul's parents did not impose anything on him. Never. Well, they sometimes teased him, that he would follow his grandfather and become a surgeon, because he looked like his grandfather. But that was playfully said, *pyár se* [with love].

In the narratives of the uncles and aunty, the implicit expectations are reflected too. For them, the upbringing practices of Rahul's parents are self-evident. Likewise, the referral to the family's academic success is not expressed by them as pressurizing Rahul, nor is the implicit rejection of the Dutch rearing practices. However, in the comparisons they

made from time to time with the native Dutch community, their Dutch-Surinamese specificities and expectations were implicitly underscored. These findings had to be identified between the lines, however, and paraphrased to be confirmed. The research team had difficulties in recognizing these cultural aspects. The literature did not offer a way out either, as it provides static images of cultural concepts and does not elaborate variations in cultural concepts due to migration and acculturation. The difference between the generation was noticeable in the lack of alignment with Rahul's living world; the family narrated as if the two worlds (the adults' and Rahul's) existed next to each other without connection.

The academic success Rahul's family strived for is interpreted in the community as positive and *ijjat* enhancing. The downside, however, is that deference combined with academic expectations and academic pressure may lead to stress. Bhugra (2004) stated that the Indian tradition harbours a premium on academic and economic success and thus a stigma attached to failure. Sarma (2014) found in India that parental pressure predicted academic stress, which, in turn, predicted depression and depression predicted suicidality. She asserted that parents may not have the intention to pressurize their children but indirectly, subtly and implicitly impact them through social comparison or bragging about their children's academic success. As a result, the youngster is reinforced in the belief that academic success is a very important aspect of their lives.

4.2.6 *Dealing with adversities*

All three cases of suicide had kept their suffering silent. That is, they didn't communicate verbally about what bothered them. Nor did they communicate about their suicide ideation. The latter is not surprising, as mentioned in the literature too (Bhugra, 2004; Soni, 2012). But not sharing their suffering is remarkable, according to the research team. The latter mentioned several cases they had encountered of Surinamese-Dutch Indian people who expressed their suicidal ideation in case of adversities yet without actual actions. In the examined cases, the silencing could be related to the pressure that was implicitly part of the expectations towards them. A clear answer for this issue was not found. It could be that the deceased ones may have told others who were not present among the respondents. Nonetheless, several elements in the narratives do provide partial cultural explanations for the examined suicide.

Nazia's *khálá* describes her as a modest and compliant woman who never complained. She endured the harsh living conditions with her husband and in-laws, which she was unable to object. The harsh situation started in Suriname and continued when they moved back to the Netherlands. Although her in-laws stayed in Suriname, they kept on saying bad things about Nazia, and her husband couldn't resist his mother's continuous blaming an accusations. Her *khálá* says:

> He did not abuse her as much as he did in Suriname, but he still did. Despite the 8.000 kilometres of distance, her mother-in-law kept on interfering in their lives. On daily basis she was in their house. By Skype! Sometimes she called twice a day. Nazia laughed about it, when she told me about her mother-in-law's behaviour, but it was shocking. Often the mother-in-law wanted to see things, for example the way Nazia had prepared a dish and then she would comment on it. And if Nazia was too late in responding her call, she would complain about it to her son, who in turn would reprimand Nazia. At worst that would end in a fight. … I tried to convince her to get help to change her situation, but she did not want to.

The specific part of the topic list that focused on the gendered issues revealed that by socialization, Nazia feared shame and blame that go along with threatened *ijjat*. As a result, Nazia suffered silently, and nobody could interfere. Next to that, the fact that she chose for her husband and with it rebelled against the family had a price, as she could not count on their support. This enlarged the isolation. Moreover, the family too had gendered cultural expectations, by socialization. Her *khálá* says Nazia was 'trapped' in her opinion:

> I pitied Nazia because she endured so much! And the worst thing was that she could not ask her family for help according to the customs in the family, nor leave her husband when he became abusive, because the relation was her own choice. Her family would see failure of her relation as a failure of Nazia as a person. It would also give rise to 'told you so-blames'. So, she was trapped.

A certain form of entrapment seemed to have been the case with Suresh too. According to one of his friends, it was a specific part the family who implicitly disqualified Suresh. This part of the family profited from the success of Suresh' younger brother as his *ijjat* reflected on them in the community. The repetitive appraisal of his brother by several family members implicitly implied a disapproval or disqualification of Suresh. Although the expectations towards Suresh were not carried by the whole family, it did pressurize him, as noted by his wife. She narrates:

> In my opinion, Suresh tried to compensate 'the shortcomings as the eldest son', by sending money and goods to the family in Suriname. Suresh' helpfulness was not appreciated either, at least not enough to compensate the 'shortcomings' in not being as successful in society as his brother. Whenever I tried to discuss this with Suresh, he would change subject.

The interpersonal matters brought up by his widow, two friends and a nephew all point at Suresh' position and related expectations in his family of origin. His nephew says about Suresh:

> Dádá was a sweet man, with a big heart and supportive to anyone who needed his help. Unfortunately, not everybody appreciated his kind character [respondent refers cynically to the negative attitude of some family members]. It made me mad. I mean, it's ok if you want to profit of someone's wealth, but don't downplay another person with it.

A complex interplay of hierarchical and gendered roles in the family with the cultural codes *manai ká boli* as well as doing sewá in the family seemingly led to a lone position of Suresh. His widow says:

> With family gatherings, his aunties always made remarks about how often Suresh's younger brother went on holidays and bragged about his big house and so on. Like Suresh was not worth anything. I even overheard them gossiping about Suresh doing the household and cooking. They said that the roles were inversed; that I had the upper hand, and that Suresh is docile like a woman, they would say '*u lahangá pahinis hai*' [literally: he wears the skirt]. Suresh always told me not to take notice of those gossipers. But it did hurt. It must have hurt Suresh too; I guess he just tried to comfort me by not talking about his emotions and pretended as if it did not offend him.

The narratives about the suicidal act and intense aftermath of all three cases contain specific information about the cultural meaning of the suicides. The messages or cultural meaning, however, varied depending on the relation the relative had with the deceased. For example, Nazia's mother-in-law emphasized the lack of compliance in Nazia's attitude. Here, the mother-in-law expresses her own discontent with Nazia as the wife of her son, by pointing at – in her opinion – the (lack of) respect Nazia displayed, by not being subordinate to the wishes of her parents:

> All of this would not have happened if she would have respected the customs of her family. And ours for that matter. If she only had not rebelled that much and had stayed in line. But she had set her heart on my son. And she betrayed her family, she had no respect for the values her family had held high. … She stained our *ijjat* too when she married my son.

Some of the members of the research team pointed at a post-mortem message Nazia left on her body. She had put *sindhur* in her máng (parting hairline), before drinking the acetic acid. *Sindhur* is a vermilion red powder worn by traditional Hindu married women in the parting hairline or as a dot on the forehead. Ceasing to wear it traditionally indicates widowhood. Among Dutch-Surinamese Indians, the *sindhur* tradition is virtually extinct, except during some ceremonies, such as weddings. The symbolic meaning of Nazia's act of applying the *sindhur* was clear to her family-in-law: she emphasized her position of a married woman. Her mother-in-law, with whom

Nazia had a quarrelsome relation, caustically praised her for the *sindhur*: 'at least she had some common sense to show her dignity of a married woman.' Her son and her *khálá* could not sympathize with it at all. Her son reacts agitated:

> What a medieval non-sense! Till death do us apart? Or show the world her faithfulness? She still could have lived if my father had the guts to stand up for her. Or if she had the chance to stand up for her rights. It is the backward *Hindustáni* system that kept her imprisoned and silenced her till death.

The *sindhur* on the suicided body of Nazia carried a posthumous message: that of Nazia's loyalty and devotion towards her husband and thus her innocence as a married woman. This message was derived from the lay theories formed in the narrative of the respondents combined with the expertise of the research team.

Nazia's parents and other family held her mother-in-law and her husband responsible for Nazia's death. They even tried to press charges against the family, but that was not legally admissible. The Surinamese-Indian community, on the other hand, already sentenced Nazia's family-in-law by talking negative about them, thus staining their *ijjat* (Gunasinghe, 2015; Soni, 2012).

The indirect communicative aspects present in Nazia's case resonate with Saharso's (2000) argument that Indian women have a well-developed intrapsychic autonomy but a lack of interpersonal autonomy. The latter would make them less able to oppose to oppression and abuse. But the intrapsychic autonomy enables them to protest against the oppression, in a culturally acceptable way, albeit at the expense of themselves. This is in line with what Knott (1996) described in her analysis of Indian *stridharma* (the duty of the wife): leaving the husband and his family after suicide, which represents a painful act of resistance or defiance. Although she did not (could not) possess and express power during her life in relation with others, she expresses her autonomy by her self-chosen death and with it leaving a cultural message of resistance against the harshness of her life (see Chapter 2).

Rahul seemed to have suffered in silence too. He is said to have longed to be seen and heard, as is told by one of his *mámás* (mother's brothers):

> For the outer world our sister's family had an ideal image. But there must have been something the matter with that boy. My brother says he might have been gay. He says he remembers in hindsight some significant remarks of Rahul when we talked about the movie *Brokeback Mountain*. We feel guilty we did not ask him. He was a calm boy, exemplary actually, there were no frictions. We all are puzzled.

His *káki* says that in hindsight she sees some other issues that might have bothered Rahul, such as the fact that he had the appearance of an Indian, but he lived a Dutch

life with his friends.

> He joined the pujá's his parents organised, but he did not understand anything, and it was not explained to him too. It was like he would know it by himself. That's strange, now I come to think about it. That reminds me that he once commented on the planting of the flags after a pujá. He asked if the flags could be planted in the backyard instead of out in the open in the front yard. Nobody paid attention to his words.

In retrospect, all four respondents had their ideas about possible causes of the suicide and can recall several hints and signals of issues that might have troubled Rahul. Remarkably enough, none of them talked about it with him. Another remarkable aspect is that people close to Rahul searched for explanations in the personal sphere without being judgemental or accusative. Not closely related people, such as the neighbour of Rahul's *náni* (grandmother from mother's side), who is seen as a part of the family for years, reacts differently and blames the parents. She said:

> They [the parents] were too busy with their careers and did not pay attention to that boy. He was lonely. I could see that. And I have seen a lot, that much I can tell you. That boy was not happy at all. He needed love and attention.

As for Suresh, only after his suicide, a part of his family obtained a negative image through the community grapevine, as was told by his widow. According to the relatives, Suresh had a deeply rooted longing for an approval and acceptance from his mother. The previous notes on autonomy apply on Suresh too. Suresh's case illustrates the Dutch-Surinamese Indian 'autonomy-in-connectedness' as opposed to the Western individualized notion of autonomy. This accentuates the importance of interconnectedness and implies a greater need for guidance and belonging in getting through life. At the same time, it points at a greater vulnerability to feelings of helplessness when these ties are strained.

5. Evaluation

The conceptualization and construction of the cultural autopsy as well as the try-out and its findings need some reflection. To do that, I focus on the try-out of the cultural autopsy and evaluate whether the cultural autopsy method has worked. The evaluation will be guided by screening the main building blocks and its procedural order of actions to perform the cultural autopsy, as is delineated in Table 6.2. This table presents the procedural actions as is used in the try-out, which resulted from the concretization of the building blocks presented in Figure 6.2. Table 6.2 contains more information than Figure 6.2 for two reasons: first, it presents the concretization of several steps, such

as the biographical information of the examined cases, and second, it serves a clear purpose to present the sub-steps too. Each action is presented in the table more or less in chronological order and consists of several components, which is delineated in the second column. The third column presents each procedural action's components as is concretized in the examined cases in the try-out. This information serves as a summary and underlay for the evaluation. Especially the last two rows are relevant for the evaluation.

Table 6.2. Cultural autopsy method

Procedure	Components	Try-out
Identification cultural group	Ethnicity, religion, language(s) Optional: name-analysis	Three Dutch-Surinamese Indians: One Muslim/Hindu, two Hindus
Literature survey	Survey of academic and grey literature, extracting information about cultural norms and values, and about suicide prevalence and incidence	Literature, both on culture and suicide, from the Netherlands, Suriname and other the Indian diaspora
Formation expert group	Combination of people from the same group and professionals familiar with the group	Three people from the Dutch-Surinamese Indian community known as key persons, and three professionals (a psychiatrist and two psychologists experienced in offering mental health care to Dutch-Surinamese Indians and two were part of this community too)
Biographical information	Age, gender, occupation, marital status, etc. Sources: family, friends, GP, social media	See also Section 4.2 (no information from the GP or social media)
Construction topic list	Extracting topics from the literature, discussing the selection of topics with the expert team, tailoring the topic list General part of the topic list: cultural background in general, language, (bi) cultural identity, religion, family relations, migration history Specific part of the topic list: specifying the deceased's age,	General part of the topic list: language (Dutch, *Sarnámi,Sranang tongo* and/or Hindi); (bi)cultural identity; religion (Hindu, Muslim, Christian) and religiousness; family relations (hierarchal to equal, tight to loose); migration history (first, second or third generation); cultural socialization (accent on Indian culture and/or other cultures); *ijjat* and related loyalty and deference; social control and *manai ká boli;* communication (direct to indirect); gender roles; marital status (in case of divorce: cultural impact) (gender-specific to neutral) and norms and values related to both gender; position in the family/community and related obligations Specified part of the topic list: Age: acculturation, generation gap, age-related obligations towards the family, loyalty and deference

	gender, acculturation and religion	Female gender: specific expectations from the family, endurance, obedience, perseverance, sexual honour, mother role Male gender: provider role, reputation, position in the family, expectations to fulfil, father role Religion: reincarnation for the Hindu cases and prohibition of suicide for the (originally) Muslim case
Verbal autopsy	Selection of informants, culturally sensitive interviewing techniques, circular questioning, narrative approach	As described in the method section
Review	Discussing the narratives with the research team, extracting cultural themes from the narratives, discussing and interpreting the cultural aspects	Extensive discussions with the research team especially in case of narratives that were multi-interpretable. The identified cultural themes were linked with (excerpts of) *ijjat* and with the way people dealt with adversities
Synthesis	Identifying cultural factors involved in the suicide	Valid for all three cases to varying degree: *manai ká boli, ijjat*, silenced suffering, indirect communication, family obligations, group orientation and loyalty (setting own needs aside in favour of the group) Specific per case: Case Suresh: male provider role, expectations relation to the position of oldest son in the family, endurance, *sewá*, striving for harmony (conflict avoidance) Case Nazia: gender specific traditional values, traditional hierarchical relationships, gendered implications of *ijjat*, shame inducing related, religion, perseverance, cultural symbol *sindhur* Case Rahul: implicit (and internalized) expectations regarding academic success in combination with *ijjat* related respect, deference and loyalty, generation gap, acculturation

Source: own construction

The most relevant question in the evaluation question is whether, as argued, it is possible to determine ex post the cultural forces involved in the examined suicides. To answer this question, especially the last two rows of Table 6.2 will be singled out. To provide an answer to the main evaluation question, I will discuss the try-out in three parts.

The first focus is on the question whether the constructed building blocks of the cultural autopsy as presented in Figure 6.2 has turned out to be correct, and whether I overlooked any area or steps. The building blocks were loosely defined in the conceptualization of the cultural autopsy. This offered enough room for the further concretization that had to be done per examined group. In this case of the try-out with a focus on the Surinamese-Dutch Indian group, the building blocks were concretized befitting for the examined group. Although the building blocks were sufficient and easy to follow, some points need a discussion. First, the building blocks are presented

in chronological order, which directs the timing for each block. The literature survey preceded the formation of the expert group, because the survey results were needed to decide what expertise the research team needed. However, it would have been better to start both more or less at the same time of the start of the literature survey the expert team was formed. This timing was of relevance because the experts could comment on the literature survey results and suggest further search strategies. Moreover, they were needed for the extraction of the culture-specific themes too.

As for the building block 'literature survey' in this try-out, the literature gave some direction, but less than expected, for it focused on the Indian culture in general or as is present in the United States or the United Kingdom. This information did not always fit the localized Indian culture of the Dutch-Surinamese Indians. Obstacles were formed by the diversity within the group too, and in particular, the needed alignment with the specificities of the specific lived reality of the Dutch-Surinamese Indians was limited. A helpful way out, at least as a start, was to ask the expert group for the dominant lay theories on suicide among Indians in the Netherlands, followed by intensive discussions about which element to include. In this weighing of the topics, the input of team members from the Dutch-Surinamese Indian origin was indispensable.

The discussed two points about the building blocks are not inherent to the construction of the cultural autopsy; rather it is connected to how it has to be handled. In the performance of the actual autopsy, flexibility and creativity are required to a certain extent. This finding could be incorporated in the directions of the cultural autopsy.

The second topic to evaluate is whether I obtained the results I needed to establish cultural forces. The results of the try-out give some insight into the cultural embedding of suicide among Dutch-Surinamese Indians. Some cultural themes were distilled as presented in the last two rows of Table 6.2. Other themes, although relevant, were not included as only one or two respondents mentioned them, such as the attribution of the suicide to fate or destiny. Next to the identification of the underlying cultural mechanisms involved in the examined suicides, the try-out exposed the cultural meaning of the suicides, especially in the embeddedness in certain culture-specific customs and symbols (i.e., *sindhur*). These results contribute to a broader understanding of the suicides and may help to promote awareness of risk for suicide and structure the support that relatives, communities and health professionals can have.

From the results, vignettes can be drawn, which may eventually form cultural risk profiles for suicide among Dutch-Surinamese Indians, if more cultural autopsies are performed. For example, Nazia-like cases would form a profile of 'young, married woman, for whom the internalised rules of *ijjat* form a trap to object against domestic violence'. This might counterbalance the possible individualized psychological view of cases like that of Nazia, such as 'young married woman, with low self-esteem and possible depression and trauma due to chronic abuse'.

Next to the richness of the unlocked information, there were some peculiarities related to the relationships of the respondents to the person who died by suicide. Some respondents differed in the way they talked about some topics as they avoided some subjects, which were surrounded by taboo. This was the case with shame about domestic violence when their relative was the perpetrator. Another aspect was that the type of relation with the deceased influenced the answers. For example, blaming the victim by Nazia's mother-in-law who did not agree with the relationship with her son at all. These findings were in line with Parkar et al. (2012). This type of specific information contains relevant clues that point at the way suicide is culturally embedded.

The third focus of this evaluation is on the data. The question is whether the data could be interpreted clearly and unambiguously. Most data were clear enough to be interpreted unambiguously. The data were included as results to be discussed with the research team as more than two respondents had mentioned a comparable issue. However, some data had to be discussed more extensively with the research team to reach consensus about the interpretation. This lack of clarity was related to a few factors. Some data, such as some gained information about Rahul's case, were considered not specifically cultural by some members of the research team. According to these experts, it could have been just as well valid for a native Dutch boy suffering from life phase related problems. This appeared to be an ill-founded argument.

Age, gender and other characteristics of people who died by suicide may display similarities across cultures, however, the contributors, the causes or precipitants may be culturally embedded. The latter is demonstrated in Rahul's case by the identification of the internalised cultural values and beliefs that were implicitly transferred to him as part of the familial and cultural socialization. The operation of the cultural factors then, are not only to be found in the mind of the individual, but among the family members too; in concert they present the cultural meaning of suicide. The operation of this dual process is present in the cases of Suresh and Nazia too. The fact that it was most discussed in Rahul's case can be related to the blurring or concealing effect acculturation has on the identification of cultural factors, and to the presentation of cultural factors in hybrid forms that are difficult to recognize as cultural at first glance. Moreover, the ambiguity in identification of cultural factors points at the relevance of assessing each suicide case in its context instead of focussing on individual features. Therefore, the review of the data to gain a synthesis forms an explicit building block in cultural autopsy.

Altogether, conducting the ex-post examination of suicides with cultural autopsy reveals how several cultural patterns involved in the suicides are understood and sustained by group members. The findings can be called beneficial by the virtue of the broadly outlined theoretical fundament of cultural autopsy.

6. Conclusion

In the field of suicide autopsy, the prime methods are the medical and the psychological autopsies and to a lesser extent sociological autopsies. In this range of autopsies, the cultural focus does not feature. The fact that cultural forces involved in suicide are not included in the current ex post suicide examination and the lack of a tool to identify the cultural factors were compelling arguments to develop a method to examine cultural forces in suicide. The idea behind this exercise was that an autopsy method that focuses on the ex post identification of cultural forces involved in suicides may be useful for practitioners. A cultural analysis method may broaden the focus of post-mortem examination of suicides by revealing cultural forces that were involved in the studied suicide. Hence, the goal of this chapter to construct a cultural autopsy method.

To conceptualize and construct such a method, the existing suicide autopsies were reviewed. Two categories of suicide examinations seem to prevail: one involving individual factors and the other involving social factors. The suicide examination method with a focus on cultural factors had to be complementary to the other forms, given the multifactorial character of suicide. Departing from this observation, the cultural autopsy was constructed by centring the cultural experience and narratives of the persons involved. The cultural autopsy method was loosely set up to explore uncovered ground. Because of the absence of standardized questionnaires attuned to the research group, the cultural autopsy relied on a topic list to enable the narratives to come to the fore.

The identification of the cultural forces engendering suicide was highly dependent on the combination of the following factors: the cultural factors recurrently mentioned in the narratives and the knowledge base available in the research team, including the literature. From each narrative, the research team identified elements as cultural factors, for which mostly confirmation was found in the literature. The next step was to identify whether those factors were recurring and present in other narratives too. The identified cultural factors that were present in all narratives were registered as culturally valid for the research group. In this way, the operation of 'common' cultural factors – that is, similar to those found earlier in this thesis – was recognized, such the operation of *ijjat* in suicide. Other cultural factors were only present in a specific case and provided information connected to the particular characteristics of that person, such as gender, age and acculturation.

The reconstruction of the examined suicides was possible by embedding the identified cultural factors in the family relations, the living conditions and the cultural beliefs and practices, combined with the knowledge base present in the research team and the literature. The assessed similarities, differences and contradictions of the narratives were considered and, after several sessions, integrated into a coherent

narrative about the deceased. This approach that pursues a nuanced, contextualized, ex post understanding of suicide differs from other methods, which mostly discuss the registered information thematically. More specifically, it differs from the other forms of autopsy as the cultural autopsy involves the context (family, relations) and the focus of the actors instead of a sole focus on the individual and the academic perspective.

Some of the limitations of the cultural autopsy method are the following. First, it remains unclear whether all cultural factors present in the narratives or layperson theories are to be identified, a question that applies especially for the acculturalized variations of cultural factors. Moreover, some narratives were open to multiple interpretations. Some elements in the narratives were not directly recognized by all members of the research group, such as the ex post meaning of *sindhur*. Second, the identified cultural factors are based on studied cases within the Dutch-Surinamese Indian group. This implies that the forces are only valid for this group. Moreover, the results may not equally apply to all members of the same group as processes such as acculturation often affect cultural values and beliefs unequally. Given the dynamic nature of cultures, the results may not be valid for related groups in other countries, simply because of their specific time- and place-bound lived culture. Finally, compared to other methods of suicide examination, the cultural autopsy depends highly on interpretations. Its findings are not clear-cut, and the method requires refinement.

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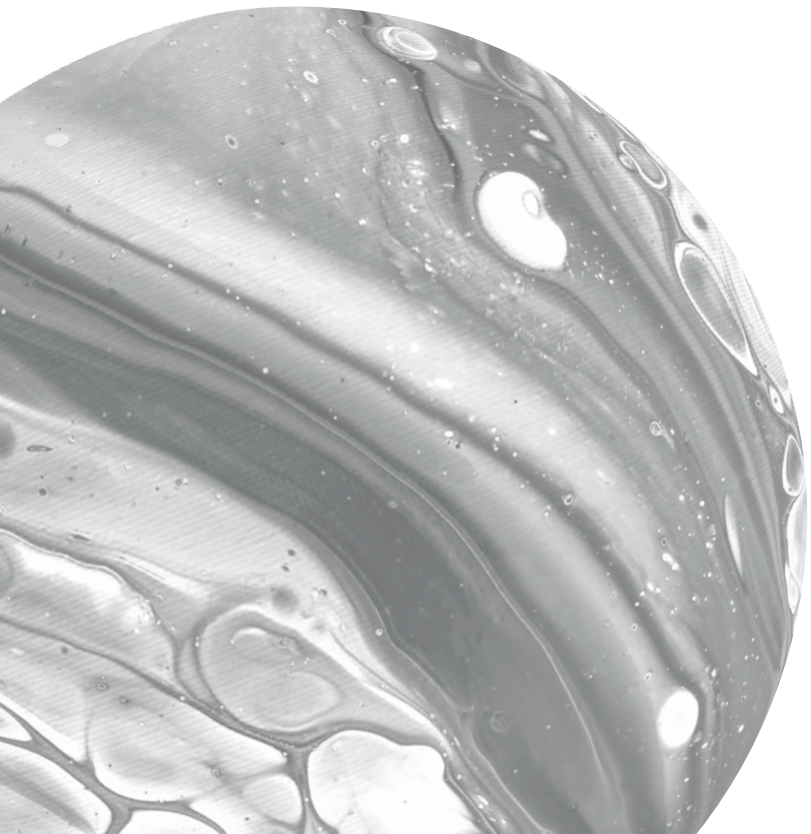
Chapter 7

Conclusion



Chapter 7

Conclusion

Suicide research is subject to the worldwide hegemony of the medical-psychiatric model. In this perspective, suicidality, the tendency to die by suicide, is allegedly caused by medical and mental health problems. The medical view is also reflected in the worldwide focus on prevention of suicide by detecting and treating mental risk factors. Other factors contributing to suicide, such as culture, gain less attention. In addition, the actor's perspective is subordinate to the researcher's view. As a result, the dominant academic lens prevails in suicide research at the cost of the actor's explanations from within their own lived cultural reality. Suicide research is also worldwide based on Western standards. This cultural bias is worrisome, not only because 60% of all suicides in 2019 occurred in non-Western communities but also because the scholarly literature indicate that suicidal behaviour varies across the world and is subject to cultural forces.

Studies focusing on cultural forces are not absent, but they are limited. These cultural studies mostly produce knowledge on an aggregate level. Moreover, the available cultural knowledge about suicide is often influenced by the psychocentric view that arises from the medical-psychiatric model, or it focuses on single cases without theorization. Although a relation between suicide and culture is suggested, it remains indeterminate how culture is involved in suicide. Therefore, the unclear relation between suicide and culture became the main focus of this thesis.

Considering the absence of culture in the suicide scholarship, a qualitative research with an explorative search strategy was considered most suitable. The selected research groups consisted of Indian diaspora communities. These groups turned out to be a suitable research group, for their high suicide rates and because they are considered to have both enough cultural distinctiveness and homogeneity. The similarities were needed to demarcate a cultural group to identify their specific cultural factors. Methodologically, the explorative search was substantiated by method and data triangulation that served to increase the trustworthiness of the findings. This applies to the use of inside knowledge too, which is commented on by a group of experts.

In answering the main question, notably, how cultural factors foster suicide, a number of routes have been followed, guided by the sub-questions of the research. Considering that the Indians have their own explanations as distinct from the scholarly accounts of suicide, the prevalent explanations of suicide of both groups were delineated. The Indians' views on suicide are related to group-specific factors, such

as cultural customs, norms and values and specific beliefs and practices. These forces have travelled throughout time and place, albeit that variation is noticeable, especially among the twice migrants in the Indian diaspora. Unlike the cultural explanations of Indians, the researchers' perspectives are dominated by psychocentric explanations.

The next route was incited by the observation of a lack of suitable theoretical concepts to study culture and suicide. Therefore, the sensitizing concepts and cultural scripts of suicide and habitus were deployed to capture cultural factors involved in suicide. The concept of cultural script of suicide concept was reworked to remove the compelling notion of culture. The subsequent probing of the revised concept on male Dutch-Surinamese Indians highlighted some gender-related cultural scripts of suicide, such as the failure and face loss inducing shortcomings in fulfilling the expected male role. The revised concept turned out to be useful in capturing cultural factors because it was less compelling and allowed for variation in the outcomes.

Compared to the script concept, the habitus concept was more sensitizing in nature and needed less revision. The reconceptualized concept of habitus into ethnic habitus was used to explore cultural forces. The exploration of several cases with the concept of ethnic habitus displayed some culturally rooted tendencies among Dutch-Surinamese Indians. Especially the operation of some prevailing culture-specific concepts turned out to be salient forces. However, the application of the concept of ethnic habitus was not clear-cut. The diversity of the research group hampered a smooth use of the concept. The group's large intergenerational differences, due to enculturation, for example, were reflected in the ethnic habitus in the form of habitus cleft or clash. Similar differences led to changes and breaches in the ethnic habitus, which, in turn, affected the durability and the uniformity of the concept. As such, it limited the concept's capacity to capturing cultural factors involved in suicide.

The last route was prompted by the lack of a cultural method to perform suicide examinations. The commonly used method consists of a psychological autopsy, analogous to medical autopsy. A cultural alternative, cultural autopsy, was conceptualized to capture ex post the cultural factors related to suicide. This concept centred the input of lay theories as opposed to academic theories. The instrument was tried out and appeared to be useful in capturing ex post the cultural factors involved in suicide, although further validation is needed.

A synthesis of the explored routes suggests an answer to the central question of this thesis, notably, how cultural factors are associated with suicidal behaviour. This answer consists of two elements. A first element is that to study the relation of culture and suicide, the concept of culture should be loosely defined to use it in an exploratorive way. This offers room to include variation. Moreover, as certain cultures have a high incidence of suicide, group members resorting to suicide can be considered more legitimate by their cultural group. As a result, dying by suicide serves as an example for a way out, a solution, which legitimizes the route to suicide in that culture. This

legitimation of suicidal behaviour is not because it is culturally compelling or incited by a commandment, a duty or a cultural code but because of its high incidence and familiarity.

Second, a loosely defined notion of culture impacts the concepts used to examine cultural drivers of suicide. The script concept appeared useful to arrive at the cultural script of suicide, due to the less strict description of the concept itself and due to the connection with the loosely defined notion of culture. However, this is different for the concept of ethnic habitus, which is intrinsically looser because it departs from tendencies. The tendencies are in line with the redefined concept of culture.

How do cultural forces contribute to suicide? The answer runs like this: cultural practices and experiences are scripted and become tendencies in responsive behaviour. That also applies to suicidal experiences and practices. Regarding the Indians, the cultural forces are incorporated in concepts (such as *ijjat*), language, religion, stories, movies, literature, memories, songs and the like. This group's suicidal behaviour has become a cultural heritage that is transmitted from generation to generation. As it is all-pervasive in the culture, it is almost impossible for members to evade these forces. This pervasiveness is rarely explicit and most often latently scripted behaviour and represents a latent habitus. It is activated under specific conditions that render suicidal behaviour and is enacted easily by the lower cultural threshold in the community. As a consequence, the incidence of (attempted) suicide is high, and members of the community become 'familiar' with suicidal practices. That lowers the threshold to die by suicide.

In addition to the reworked concepts of script and habitus, this book offers the scholarly field the of cultural autopsy to perform ex post suicide examination. It underscores that cultural forces rendering suicidal behaviour are operative and that these forces can also be identified ex post. The conceptualization of the cultural autopsy is loosely construed with several building blocks that makes it possible to be applied on different cultural groups. Once the building blocks are specified for a particulier group, the method and the results are solely valid for the examined group. The culturally grounded meaning of the suicide and the cultural explanations that arise from the cultural autopsy offers leads for culture-specific intervention and prevention strategies.

The findings of this thesis have implications for researchers, practitioners and policymakers. The scholarly field has offered two reworked concepts, notably, cultural scripts of suicide and ethnic habitus to explore cultural factors active in suicidal behaviour. These concepts can be used to identify cultural aspects of suicide among other cultural groups. Moreover, the emphasis on the sensitizing nature of the concepts used to capture cultural factors underscores the limits of definitive concepts, which are often used in the scholarly field.

This study also offers practical knowledge for professionals and practitioners in

this field. Addressing culturally different perspectives helps raise awareness of the limitations of the dominant perspective in the approach to suicide. Professionals in the field are offered important guidance to culturalize suicide prevention and intervention strategies that are hitherto devoid of cultural diversity as the current guidelines, standards and protocols, which are difficult to apply on groups having different cultural backgrounds. Both (mental) health and education professionals can derive clues from the results to recognize and identify cultural aspects of suicide.

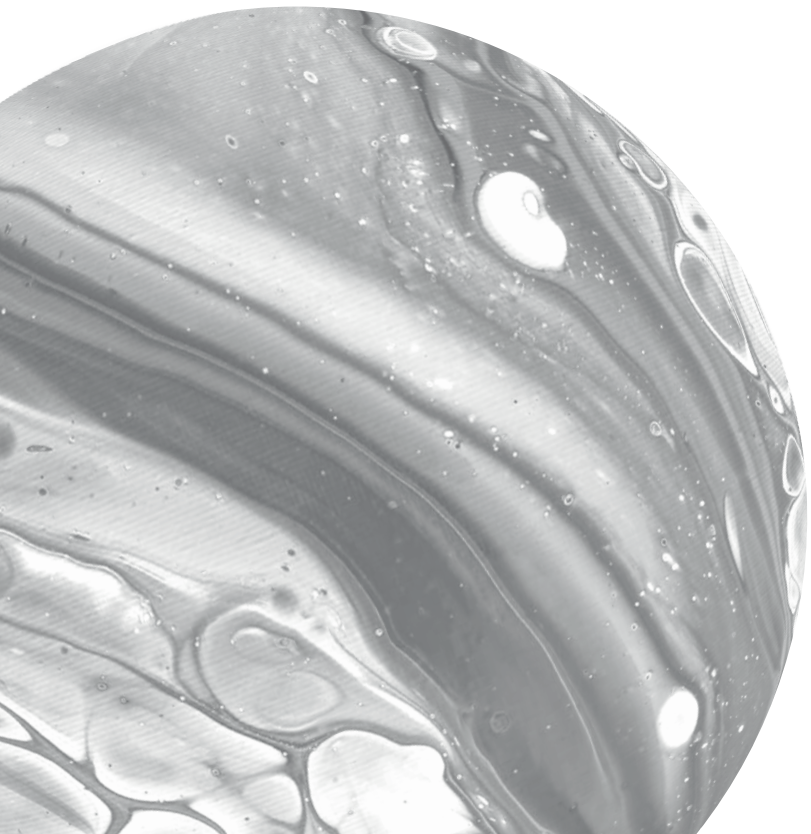
This thesis provides benefits for policymakers too. They can use the findings to address the problematic issues in the way the health care system is organized, which seldom includes a cultural focus. The persistent gap or rather mismatch between the individualized approach of suicidal behaviour and its cultural shaping is related to the hands-on knowledge used by policymakers. This biased knowledge which is handed over by the academia via the curricula of their educational programmes can be reworked to deal with cultural differences in the manifestation of suicidal behaviour. Moreover, the compelling suggestion for policymakers (including health insurance agencies that define health policies to a certain extent) is to develop inclusive guidelines that reflect the diversity of the population they work with.

Viewed at a broader level, the results can incite a debate about the definition of suicide. As the prevailing definitions fall short to capture the diversity of suicidal behaviour, it can be useful to reframe suicides as 'self-caused deaths'. This description, then, can be further specified as 'with or without mental cause' with room for specific causations (e.g., mental illnesses, interpersonal issues, spirits, ghosts) and manifestations (e.g., rational suicides, religious suicides, protests, incited suicides). The assisted forms, then, such as euthanasia, are admittedly self-chosen but not a self-caused death.

The research group in this book, the Indian diaspora groups, can also benefit from the results. A specific operationalization of the concepts is offered that it is tailored to this ethnic group. As the Indians suffer from a high incidence of suicide, the findings provide clues that stimulate awareness and debates. This can contribute to an increase of the understanding of the suicide issue and change from within, including specific cultural and gender-specific embedding of suicidal behaviour. This research has also uncovered specific knowledge about Indians. The delineated features of the Indian group shed light on family systems and gender-specific socialization related to suicide. The focus on gender adds to the current suicidological research on non-Western groups (in Western countries) that predominantly focus on women and neglect men.

Although the findings of this research show how culture is conducive to suicidal behaviour, some limitations can be mentioned. As cultural factors are specific, the findings do not apply to other cultural groups nor to the whole Indian diaspora. A second limitation might be that the internal diversity of the researched group has been glossed over. This is a general problem in qualitative social research, but only relevant

when the results are aimed at generalization. Third, I performed case studies of which the results are difficult to replicate given the specificities of time and place. Similar studies in other cultural or ethnic groups may require another operationalization of concepts because the groups contain different properties and have different histories. Despite differences between ethnic groups, an increase of qualitative studies dealing with suicide may corroborate, refine or even contradict previous arguments. This research is an invitation to that type of study.



Appendices

Appendix I

Stigmatizing versus appropriate terminology

The International Association for Suicide Prevention (IASP) provides guidelines to avoid descriptions that have been noted to be stigmatizing as well as distressing to survivors, such as 'committed suicide'.

Stigmatising terminology	Appropriate terminology
Committed suicide	Died by suicide
Successful suicide	Suicide
Completed suicide	Ended his or her life Took his or her own life
Failed attempt at suicide	Non-fatal attempt at suicide
Unsuccessful suicide	Attempted to end his or her life

Source:

Beaton, S., Forster, P., & Maple, M. (2013). Suicide and language: Why we shouldn't use the 'C' word. InPsych, 35(1). Retrieved from https://www.psychology.org.au/publications/inpsych/2013/february/beaton

Appendix II

The hegemony of the medical-psychiatric model

Suicide is mainly invested in the medical-psychiatric model. The construction of this medical discourse about suicide began with Dr Esquirol in 1821, whose assumptions gradually became 'facts': that suicide is in the province of the physician, because suicide is a kind of madness and madness is the province of the physician (Marsh, 2010). Because the ontology of pathology that clings to suicide is reproduced and worldwide disseminated, it is reflected in suicide research's ongoing emphases on the psyche in studying suicide as well as in the efforts to identify psychopathological risk factors for suicide. Next to the academia, in the vernacular, suicide is interpreted as a result of a mental disturbance. The prime position of the medical psychiatric model in suicide research also influences the small leeway given to others involved in suicide. Culture-related findings, for example, hardly resonate in mainstream suicide research. As such, the hegemony of the medical-psychiatric model hampers a comprehensive understanding of suicide.

The mainstream conceptualizations from the medical-psychiatric perspective roughly represent that personal and psychological state–trait interactions cause problems leading to suicide. 'State' points at a temporary way of being (e.g., bereavement), and 'trait' points at a more stable and enduring characteristic or pattern of behaviour (e.g., impulsivity). This thinking about suicide – in interaction between predisposing vulnerability factors and triggering stress factors – has led to the dominant psychiatric diathesis-stress theories in suicide research, which gave birth to some influential biomedical models as listed by Barzilay and Apter (2014): the social problem-solving vulnerability model (a vulnerability to emergent hopelessness and suicidal ideation under high life stress caused by cognitive rigidity in problem-solving) and the clinical-biological model of suicidal behaviour (low serotonergic activity and/or substance abuse increases impulsive aggression, with a likely genetic component that creates familial vulnerability to suicidal behaviour).

The commonly used psychological models to study suicide are variations of general psychological psychodynamic or cognitive theories; the most influential theoretical models are summarized next. Freud's psychodynamic work contributed to the conception of suicide as an expression of mental disturbance, particularly because of an internal conflict created by introverted aggression. Social learning theory (Bandura, 1977) sees suicidal behaviour and attitudes about suicide as a result of social learning

(in groups), which is used to explain, among other things, (repeated) suicide in a family, copycat suicide and mass suicide. Shneidman (1996) considered psychological pain ('psychache') as the core of suicidality. His concepts form the basis of many contemporary suicide models. He argued that if the psychological pain is unbearable or no longer tolerable, suicidal behaviour ensues. Beck's cognitive behavioural therapy theory links depression, despair, helplessness and negative cognitions, on the one hand, and suicide, on the other (Bryan, 2019).

The following models are derivatives of the psychological theories mentioned earlier. The interpersonal theory of suicide (Van Orden et al., 2010) suggests that suicide is likely to happen when people experience thwarted belonging and perceived burdensomeness. The cry of pain model (Joiner, 2005) conceptualizes suicidal behaviour as the response (the cry) to a situation that has three components: defeat, no escape and no rescue. Building on existing evidence and theoretical knowledge, O'Connor (2011) introduced the three-phased integrated motivational-volitional model (IMV), with a pre-motivational phase (e.g., environmental deprivation, vulnerabilities), a motivational phase (formation of suicidal thoughts and intention to end one's life) and a volitional phase (translation of suicidal thoughts into actual suicidal behaviour). A relatively new theory is Zhang's (2019) strain theory of suicide that examines the underlying causes of suicide, which are categorized into four types of psychological strain they exert upon an individual: value, aspiration, relative deprivation and coping strains.

The framing of suicide in the medical-psychiatric model is part of a much broader trend of treating all kinds of non-medical human issues as medical or psychiatric ones (Clark, 2014; Conrad, 2005). This trend began with the advent of modern science and the birth of the biomedical model in the West, and from there it has spread over time to the rest of the world. Medicalization is applied to behaviour that deviates from the social norm (e.g., hyperactive children) to everyday problems (e.g., stress), interventions in healthy people (e.g., cosmetic surgery) to natural life processes, such as birth, menstruation, menopause, baldness and death. Clark (2014, p. 2) stated that the biomedical model sees health as freedom from disease and that it is characterized by reductionism (decontextualization, biologism; e.g., alcoholism has turned from 'badness to sickness'), individualism (focus on the individual rather than on problem shaping and determining structures; e.g., the blame of 'lack of healthy choices' in overweight cases rather than paying attention to the socio-economic situation and food pricing) and a bias towards the technological (preference for drugs, medical devices to treat problems; e.g., the increasing medical control of death and dying with decreasing 'natural' death circumstances).

The dominance of the medical-psychiatric model in suicide research includes the risk of psychopathologization and medicalization. Medicalization is the process of defining and treating several human experiences and symptoms as a medical problem,

usually as a disease or ailment (Clark, 2014; Conrad, 2005). Psychopathologization is a comparable process with the difference that the problem under study is a priori defined as arising from a mental disorder. The linkage of suicide to pathology dominates researchers' and practitioners' views and actions, including those from other disciplines beyond psychiatry. As a result of the hegemony of the medical model, individual factors are examined extensively, whereas the examination of cultural factors engendering suicide is crowded away.

Drawing on the works of Foucault, Marsh (2010) delineated how historical and cultural forces have led to the contemporary 'self-evident' thoughts, practices and policies related to suicide. These practices are reflected not only in psychiatrists' clinical practices but also in their advisory roles on government policy and as editors of medical journals and authors of books. Hjelmeland (2013) pinpointed the increased 'biologyfication' in leading journals that reject articles that focus on culture and suicide. In line of the importance of evidence-based knowledge, which is increasingly preferred in mental health sciences, 'hard' evidence is easier to attain with biomedical research than with 'soft' subjects such as culture. The studies that centre on culture often find asylum in journals that focus on non-Western cultures, as if only non-Western groups have a culture.

The study of suicide is often referred to as 'suicidology', which is not a discipline on its own but an overarching denomination of suicide research used by researchers from several academic disciplines. Fitzpatrick, Hooker, and Kerridge (2014) denoted suicidology as a social practice with 'an internal authority structure that governs particular ways of seeing and doing' (p. 307). The authority structure of suicidology is strengthened by its established specific professional organizations, institutional structures and journals. Widger (2015) and Hjelmeland (2010) demonstrated that peer-reviewed journals often operate as suicidology's principal gatekeepers.

Hjelmeland (2010) described 'piggybacking', wherein obtaining funding for research is more likely when it is connected to the popular subject of the funding institutions, where – in the case of suicide research funding – the medical-psychiatric perspective dominates. Interests of related parties reinforce the biomedical view too, such as the pharmacology industry, which gains an increase in the sales market by the increased demand of psychotropics to restore the 'chemical imbalance in the brain' that supposedly causes suicidal behaviour. The phenomenon of one social group constructing and policing boundaries or creating inclusion and exclusion contributes to the fact that suicidology is virtually homogenous in the epistemologies it constructs (Fitzpatrick et al., 2014).

The hegemony of the medical model and its discursive power and (social, political and economic) influence increasingly results in reductionistic biologyficated language, such as 'suicidal brains' rather than 'suicidal persons' (Hjelmeland, 2013). Marsh (2010) illustrated how by drawing on a vocabulary of medicine and science new

claims to truth (suicide as an expression of mental illness) were made and wherefore subsequent expert knowledge (specialist medical services) is required. Therefore, as Marsh (2010) argued, the current medical-psychiatric perspective on suicide can be read in terms of the formation of a particular 'regime of truth', one that by 'rhetorical strategies' centres on the production and maintenance of a 'compulsory ontology of pathology'. The worldwide dissemination of these professional 'truths' through non-professional channels (media, movies) has contributed to the widespread belief of the relation between suicide and psychopathology in general.

One of the persistent 'truths' is the assumption that a list of psychiatric disorders, either overt or covert or un(der)diagnosed, causes 90% of all suicides, of which the major depression tops the list, followed by schizophrenia, anxiety and personality disorders (mainly borderline personality disorder) and addictions (Niculescu et al., 2017; Turecki & Brent, 2016). This often-cited and dubious claim of 90% reinforces the pathological ring to suicidal behaviour (Hjelmeland & Knizek, 2017; Pouliot & De Leo, 2006; Shahtahmasebi, 2013). Although the basis of the 90% claim is thin, repeating it as a 'truth' has made it a 'fact'. The origin of the 90% claim lies in Cavanagh, Carson, Sharpe, and Lawrie's (2003) systematic review of psychological autopsies (PA) of 76 suicide cases performed in Western Europe and North America.

PA studies arose from the medical-psychiatric model to examine suicides in retrospect by interviewing proxies. Hjelmeland and Knizek (2017) pointed out that Cavanagh et al.'s (2003) study dismissed a study that demonstrated only a 23% prevalence of mental disorders in the studied suicides by stating that this was a study of self-burning among Indian women. Similar arguments resonate in recent studies too. For example, in their psychological autopsy study on youth suicides, Mérelle et al. (2020, p. 8) excluded ethnocultural factors because of the small numbers of respondents with a migrant background. They did not define the ethnocultural factors and how they were measured except for mentioning the non-Western birthplace of the parent(s).

Of the many methodological flaws of PAs, one stands out, notably diagnosing a deceased person with a mental disorder by asking proxies and using instruments designed to be used by the person under study themselves (see Chapter 6). Based on this flaw, Hjelmeland and Knizek (2017) suggested abandoning PA as a diagnostic tool. This would align with deviating results especially from studies carried out in non-Western countries and among non-Western communities in the West that indicate lower numbers of suicides caused by psychiatric disorders (Patel et al., 2012; Vijayakumar, 2015). Thus, if valid, then the 90% claim is only generalizable for the context of Western research. This accounts for many studies that have the pretension to be generalizable by their universalist claims but pay no attention to the cross-cultural validity, wherefore it remains unclear for which cultures and to what extent the results apply.

The 'regime of truth' of the medical model is increasingly being critiqued for its

marginalization or even disposal of the historical and cultural contexts of suicide. These contexts, however, may harbour potential resources to counteract or resist suicide (Battin, 2015; Hjelmeland, 2010; Marsh, 2010). This criticism is factually aimed at the very ontology and epistemology of the medical model. As suggested before, the medical model and biomedicine and psychiatry are culturally constructed bodies of knowledge (Kirmayer, 2007). Even the (mental) health care system is a culturally constructed system based on prevailing communal and health-related values. The cultural view colours the interpretation of observed phenomena. Kirmayer and Ryder (2016) cautioned about taken-for-granted categories, social roles and positions, as they contribute to major social determinants of mental health such as racism and discrimination.

The limited validity of the psychopathologization of suicide is pointed at by several scholars. Mishara (2006) stated that a psychiatric disorder is not an exclusive explanation nor a necessary cause for suicidal behaviour even if it is a big risk factor for suicide. In other words, there are false positives (most mentally ill people do not die by suicide) and false negatives (the number of people who die by suicide who do not have a mental illness) (Hjelmeland & Knizek, 2017; Pouliot & De Leo, 2006). An additional contested 'truth' is the relation between suicide and depression. Although depression tops the list of psychiatric suicide risk factors, women in the West who are more often depressed than men are not over-represented in the number of suicides. The same goes for the causal link between schizophrenia and suicide. In the United States and the United Kingdom, men of Afro descent are more often diagnosed with schizophrenia, just like Moroccan men in the Netherlands (Bhugra & Bhui, 2007; Veling, Hoek, Wiersma, & Mackenbach, 2010), but these groups have low suicide numbers.

Several critics of the medicalization in suicidology have joined forces in the last decennium in the relatively new 'critical suicidology' that advocates cultural suicide research (Hjelmeland & Knizek, 2017; Marsh, 2015; White, Kral, Morris, & Marsh, 2016). They target the medicalization as well as the westernization of suicidology. Next to the psychocentric approach, they critique the fact that though gender and ethnicity are often included as variables or factors causing suicide, they are included without accounting for the respective gender and ethnicity related processes of the context, that is, the prevalent values and norms. Nuances like these are missed by adhering to the dominant biomedical model and its epistemology.

In the literature, culture is seldom defined. Cultural groups – if mentioned as such – are mostly referred to by their ethnicity, race, nationality (e.g., Indian), the region (e.g., South Asian) or even the continent (e.g., Asian). Using this kind of demographic characteristics as proxies for culture essentializes culture, with risks of over-generalizations and stereotypes, for example, a person born in China is named a Chinese who has the Chinese culture. I also noticed processes like exotism, orientalism and racism, which are institutionalized in science, whereby the 'other' is framed. This

phenomenon is related to Staszak's (2020, p. 25) argument that 'the otherness is due less to the difference of the other than to the point of view and the discourse of the person who perceives the other as such'. In other words, dominant groups define others and set themselves as the norm. Although all societies create otherness, the West stands out according to Staszak, because it has universally imposed its binary logic (e.g., healthy–ill, Black–White, soma–psyche) and categories of identity and otherness through colonialism. Processes like exotism, orientalism and racism, which are institutionalized in science too, frame the 'other' extensively.

The cultural 'othering' is visible in suicide research in the dominant practice that if culture is studied, it mostly concerns the study of non-westerners. But westerners have a culture and ethnicity too. Nonetheless, anthropological suicide research among westerners, that is, among people from North America and Western Europe, is virtually absent. Shrivastava, Kimbrell, and Lester (2012) pointed at distinct Western groups that are yet to be studied by suicidologists, such as the Welsh in English, the Flemings versus the Walloons in Belgium, the Basques in France and Spain. This point of view, however, searches for the minority groups in Western countries. Herewith, the cultures of the majority of Western countries stay out of range.

To sum up, the psychopathological, individualized, positivistic and medicalized understandings of suicide do not 'work' in different contexts, such as non-Western and indigenous cultures (White et al., 2016). Moreover, there is a neglect of specific cultural meanings of suicide, with their own historical situatedness and social significance. Categorizing suicidal expressions by default in terms of the predominant psychopathological and Western concepts of suicide obscure other, notably cultural, interpretations of suicidal behaviour. There is a large gap between the prevalent scientific notions of suicide and other understandings, such as suicide as an existential choice or as influenced by religion and culture. As a result, some aspects of the lived reality of some cultural groups are barely addressed scientifically, for example, whether or not suicide is considered to be a sin or the existence of rational suicide (Khan & Mian, 2010; Leach & Leong, 2018).

In my view, the fact that the cultural perspective is marginal in suicidology is not inherent to science itself; science holds no intrinsic limitations to exclude certain groups or respondents. The omission is rather ascribable to researchers' factors, such as a certain professional blindness, ingenuousness or even a lack of courage to change perspectives and a lack of skills to encounter a cultural other. That makes them gloss over the cultural dimension that is inherent in all human practices.

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Appendix III

Indian diaspora in numbers per country

Text from footnote 5 *The Indians in the diaspora are categorized by the Indian government as non-resident Indians (NRI): an Indian citizen residing outside India for a combined total of at least 183 days in a financial year; Persons of Indian Origin (PIO): a person living outside India who by virtue of the Constitution of India or the Citizenship Act, 1955, held an Indian citizenship by birth or their descendants or their spouses; and Overseas Citizen of India (OCI): with an OCI card, a foreign citizen of Indian origin is authorized to live and work in India for an indefinite period. The OCI includes a person who was previously an Indian citizen or whose parent, grandparent or great-grandparent is/was an Indian citizen or one who is married to an Indian citizen or an existing OCI for at least two continuous years. The PIO card was replaced in 2015 by the OCI card (BoI, 2015). In these formal categories, however, people of Indian descent whose ancestors moved from India generations ago are difficult to fit.*

In the following table, the number of NRI and PIO categories are listed per country. The last column presents the total number of overseas Indians, which is the sum of numbers of the previous two columns.

Population of overseas Indians				
Sl. No.	Country	Non-resident Indians (NRIs)	Persons of Indian Origin (PIOs)	Overseas Indians
1	Afghanistan	3,087	19	3,106
2	Albania	50	6	56
3	Algeria	5,700	10	5,710
4	Andorra	50	120	170
5	Angola	2,500	2,000	4,500
6	Anguilla	30	10	40
7	Ankara	1,278	111	1,389
8	Antigua & Barbuda	220	45	265
9	Argentina	800	1,800	2,600
10	Armenia	1,477	23	1,500
11	Aruba	600	400	1,000
12	Australia	241,000	255,000	496,000

13	Austria and Monte-negro	13,000	18,000	31,000
14	Azerbaijan	953	24	977
15	Bahamas	250	50	300
16	Bahrain	323,292	3,366	326,658
17	Bangladesh	10,385	6	10,391
18	Barbados	600	2,500	3,100
19	Belarus	854	100	954
20	Belgium	12,386	8,250	20,636
21	Belize	300	9,800	10,100
22	Benin	1,563	0	1,563
23	Bhutan	60,000	0	60,000
24	Bolivia	50	10	60
25	Bonaire & Smaller Islands	54	200	254
26	Bosnia & Herzegovina	20	6	26
27	Botswana	9,000	3,000	12,000
28	Brazil	4,729	344	5,073
29	British Virgin Islands	50	10	60
30	Brunei Darussalam	11,500	269	11,769
31	Bulgaria	250	47	297
32	Burkina Faso	200	5	205
33	Burundi	465	35	500
34	Cambodia	1,500	10	1,510
35	Cameroon	800	0	800
36	Canada	178,410	1,510,645	1,689,055
37	Cape Verde Islands	20	0	20
38	Cayman Islands	1,500	10	1,510
39	Central African Re-public	100	0	100
40	Chad	120	0	120
41	Chile	1,530	2,100	3,630
42	China	55,500	550	56,050
43	China (Hong Kong)	31,569	7,160	38,729
44	China (Rep. Of Taiwan)	3,068	378	3,446
45	Colombia	450	89	539
46	Comoros	30	200	230

47	Congo (Dem. Rep. of)	10,000	8	10,008
48	Congo (Rep. Of)	590	8	598
49	Cook Island	5	200	205
50	Costa Rica	1,011	20	1,031
51	Cote d'Ivoire (Ivory Coast)	1,500	0	1,500
52	Croatia	82	24	106
53	Cuba	600	1	601
54	Curacao	700	800	1,500
55	Cyprus	7,254	245	7,499
56	Czech Republic	4,590	360	4,950
57	Denmark	12,685	2,315	15,000
58	Djibouti	500	150	650
59	Dominica (Commonwealth of)	15	200	215
60	Dominica Republic	100	75	175
61	East Timor	100	0	100
62	Ecuador	300	55	355
63	Egypt	3,950	351	4,301
64	El Salvador	14	3	17
65	Equatorial Guinea	250	0	250
66	Eritrea	300	3	303
67	Estonia	741	422	1,163
68	Ethiopia	5,500	15	5,515
69	Fiji	1,400	313,798	315,198
70	Finland	5,652	7,739	13,391
71	France	19,000	90,000	109,000
72	France (Reunion Island)	300	297,000	297,300
73	France (Guadeloupe, Martinique, St. Martin)	420	66,800	67,220
74	Gabon	1,100	10	1,110
75	Gambia	700	16	716
76	Georgia	3,192	8	3,200
77	Germany	1,42,585	42,500	1,85,085
78	Ghana	10,000	0	10,000
79	Greece	12,300	1089	13,389

80	Grenada	200	5,000	5,200
81	Guatemala	50	33	83
82	Guinea (Republic of)	700	0	700
83	Guinea Bissau	100	4	104
84	Guyana	600	298,782	299,382
85	Haiti	580	0	580
86	Holy See	NA	0	0
87	Honduras	15	2	17
88	Hungary	1,026	124	1,150
89	Iceland	257	76	333
90	Indonesia	8,500	111,500	120,000
91	Iran	4,000	337	4,337
92	Iraq	18,000	7	18,007
93	Ireland	15,000	25,000	40,000
94	Israel	12,467	85,000	97,467
95	Italy	157,695	45,357	203,052
96	Jamaica	5,000	75,000	80,000
97	Japan	37,933	686	38,619
98	Jordan	20,569	191	20,760
99	Kazakhstan	6,785	100	6,885
100	Kenya	20,000	60,000	80,000
101	Kiribati	0	50	50
102	Korea (DPR)	15	1	16
103	Korea (Republic of)	13,236	349	13,585
104	Kuwait	1,028,274	1,587	1,029,861
105	Kyrgyzstan	11,200	4	11,204
106	Laos, PDR	450	78	528
107	Latvia	760	25	785
108	Lebanon	8,500	37	8,537
109	Lesotho (Kingdom of)	1,500	1,500	3,000
110	Liberia	1,500	0	1,500
111	Libya	1,500	2	1,502
112	Liechtenstein (Principality of)	5	5	10
113	Lithuania	1,000	42	1,042
114	Luxembourg	2,331	500	2,831
115	Macedonia	7	3	10

116	Madagascar	2,500	15,000	17,500
117	Malaysia	227,950	2,760,000	2,987,950
118	Malawi	2,500	8,500	11,000
119	Maldives	25,000	108	25,108
120	Mali	436	1	437
121	Malta	4,850	150	5,000
122	Marshall Islands (Republic of)	14	1	15
123	Mauritania	150	0	150
124	Mauritius	10,500	884,000	894,500
125	Mexico	6,000	500	6,500
126	Micronesia	35	0	35
127	Moldova	600	8	608
128	Monaco	30	40	70
129	Mongolia	150	5	155
130	Montserrat	40	200	240
131	Morocco	250	105	355
132	Mozambique	2,300	22,500	24,800
133	Myanmar	9,207	2,000,000	2,009,207
134	Namibia	200	59	259
135	Nauru	20	0	20
136	Nepal	600,000	0	600,000
137	Netherlands	40,000	200,000	240,000
138	Netherlands Antilles	2,581	3,700	6,281
139	New Zealand	80,000	160,000	240,000
140	Nicaragua	39	1	40
141	Niger	150	0	150
142	Nigeria	40,000	35	40,035
143	Niue	9	0	9
144	Norway	8,732	13,748	22,480
145	Oman	779,351	1,790	781,141
146	Pakistan	0	0	0
147	Palau (Republic of)	27	0	27
148	Palestine (PLO)	20	0	20
149	Panama	4,000	11,000	15,000
150	Papua New Guinea	2,900	100	3,000
151	Paraguay	200	400	600

152	Peru	399	55	454
153	Philippines	105,000	15,000	120,000
154	Poland	10,162	798	10,960
155	Portugal	11,393	70,000	81,393
156	Qatar	745,775	775	746,550
157	Romania	1,741	231	1,972
158	Russian Federation	21,354	2,236	23,590
159	Rwanda	2,940	60	3,000
160	Samoa	21	9	30
161	San Marino	0	0	0
162	Sao Tome and Principe (Rep. of)	50	1	51
163	Saudi Arabia (Kingdom of)	2,592,166	2,781	2,594,947
164	Senegal	500	32	532
165	Serbia	303	17	320
166	Seychelles	5,200	12,000	17,200
167	Sierra Leone	900	50	950
168	Singapore	350,000	300,000	650,000
169	Slovak Republic	500	50	550
170	Slovenia	126	56	182
171	Solomon Islands	50	0	50
172	Somalia	100	0	100
173	South Africa	60,000	1,500,000	1,560,000
174	Spain	49,084	20,904	69,988
175	Sri Lanka	14,000	1,600,000	1,614,000
176	St. Kitts and Nevis	500	50	550
177	St. Lucia	550	18,600	19,150
178	St. Martin	2,171	3,000	5,171
179	St. Vincent & the Grenadines	50	7,700	7,750
180	Sudan	1,500	100	1,600
181	South Sudan	1,100	0	1,100
182	Suriname	205	237,000	237,205
183	Swaziland	1,000	500	1,500
184	Sweden	15,349	10,370	25,719
185	Switzerland	17,403	7,164	24,567

186	Syria	94	0	94
187	Tajikistan	1,500	0	1,500
188	Tanzania	10,000	50,000	60,000
189	Thailand	20,000	175,000	195,000
190	Togo	500	10	510
191	Tonga	6	40	46
192	Trinidad & Tobago	1,800	555,000	556,800
193	Tunisia	121	16	137
194	Turkey	1,609	99	1,708
195	Turkmenistan	240	0	240
196	Turks & Caicos Islands	200	35	235
197	Tuvalu	0	50	50
198	Uganda	23,500	6,500	30,000
199	Ukraine	7,541	422	7,963
200	UAE	3,419,875	5,269	3,425,144
201	UK	351,000	1,413,000	1,764,000
202	USA	1,280,000	3,180,000	4,460,000
203	Uruguay	570	30	600
204	Uzbekistan	350	49	399
205	Vanuatu	10	800	810
206	Venezuela	50	30	80
207	Vietnam	5000	500	5,500
208	Yemen	500	10,000	10,500
209	Zambia	6,000	24,000	30,000
210	Zimbabwe	500	9,000	9,500
Total		**13,459,195**	**18,683,645**	**32,100,340**

Source: Indian Ministry of External Affairs. (2021). Population of overseas Indians. Retrieved from https://www.mea.gov.in/overseas-indian-affairs.htm

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Appendix IV

Indentured Indian immigration by colony in the 19th and early 20th centuries

Colony (country)	Period	Indian immigrants
Mauritius	1834–1912	453,063
British Guyana (Guyana)	1838–1917	238,909
Natal (South Africa)	1860–1911	152,184
Trinidad	1845–1917	143,939
Reunion	1829–1924	118,000
Fiji	1879–1916	60,969
Guadeloupe	1854–1885	42,326
East Africa (Kenya/Uganda)	1895–1901	39,771
Jamaica	1854–1885	36,420
Dutch Guyana (Suriname)	1873–1916	34,000
Martinique	1854–1889	25,509
Seychelles	1899–1916	6,319
St. Lucia	1858–1895	4,350
Grenada	1856–1885	3,200
St. Vincent	1861–1880	2,472

Source: Clarke, C., Peach, C., & Vertovec, S. (Eds.) (1990). *South Asians overseas: Migration and ethnicity (p. 9). Cambridge: Cambridge University Press.*

Appendix V

Suicide prevalence and registration issues

A growing body of literature indicates high rates of fatal and non-fatal suicidal behaviour on the Indian subcontinent (i.e., India, Pakistan, Afghanistan, Sri Lanka, Bangladesh, Nepal, Bhutan and the Maldives) and in the Indian diaspora. The numbers appear to be disproportionately higher compared to other countries or other ethnic groups. Suicidal behaviour in parts of India (especially in southern and eastern states) scores among the highest in the world (e.g., Aggarwal, 2015; Arya, Page, River, Armstrong, & Mayer, 2018; Patel et al., 2012). Several studies from the Indian colonial diaspora reveal comparable findings of high numbers of suicidal behaviour and the groups most at risk (e.g., Quinlan-Davidson, Sanhueza, Espinosa, Escamilla-Cejudo, & Maddaleno 2014; Toussaint, Wilson, Wilson, & Williams, 2015). Albeit that some diaspora countries have low suicide rates, the particular rates for Indians – if available – are tenaciously higher, especially among Hindus. According to the World Health Organization's (WHO) suicide data, the world average for suicide in 2016 is 10.5 per 100,000 inhabitants (WHO, 2021). The scores of countries with at least a substantial part of Indians are the highest. For example, Guyana scores 29.2 per 100,000 (Bhugra, 2004; Mayer, 2010; WHO, 2021).

A specific group is formed by male Indian expatriates in the Gulf that represents a large share of suicides in that area. For example, Madadin, Mahmoud, Alsowayigh, and Alfaraidy (2013) found that of all the suicides in Saudi Arabia, only 15.07% consisted of Saudis, whereas Indians constituted the largest group (42.8%). In Kuwait, too, foreign workers represented the highest percentage of suicide by hanging (94.1%) with an Indian precedence (54.8%) (Abd-Elwahab, Ghaleb, Kotb, Agamy, & Kharoshah, 2013).

In the literature on the history of the Indian culture, suicidal behaviour is regularly mentioned too. In several ancient Hindu texts and medieval and historical reports, suicidal behaviour is discussed. Thakur (1963) provided an extensive elaboration of different suicidal practices that contain cultural, political and religious characteristics. He mentioned culture-specific forms of suicidal behaviour, such as *Sallekhana* (the practice of dying by starvation, prevalent among Jains and Buddhists) and *Sati* (the banned Indian tradition, known for widows' self-immolation after the death of their spouses). In addition, a form of suicide by mass self-immolation by women, which is related to *Sati* according to Thakur, was prevalent in the middle ages. This so-called Jauhar was practised by Hindu women when facing defeat during wars between Hindu Rajput kingdoms in Rajasthan and the Muslim armies. Some reports mention that

all women of a court along with their children died by *Jauhar* (Vijayakumar & John, 2018). A comparable phenomenon occurred during the partition of British India into India and Pakistan. Khan (2009) described that many women were killed by their own families or were forced to commit suicide to protect their honour and preventing abduction and rape by men of the other religion.

During the indenture period, many people attempted suicide or succeeded in suicide, all over the Indian diaspora (e.g., Bhugra, 2004; Kumar, 2017; Lal, 1985, 2000; Mayer, 2010). Suicide attempts were punished at that time, even by prison sentences because ending one's life was a breach of the contract. Nevertheless, documentations show that many people at the time attempted suicide or died by suicide (Kumar, 2017; Mayer, 2010). Haynes (1987) stated that suicides occurred frequently before the migration, when being 'stored' in the so-called coolie depots in India; Haynes (1987, p. 21) noted that 'many throw themselves into the Hughli [river] to escape the emigrant ship'. During the sea voyage, that took 3–6 months to arrive to the destination, suicides were registered too, whereby people threw themselves overboard (Kumar, 2017). Most of the people who died by suicide were males, albeit that at first, men far outnumbered women. Haynes (1987) described that some died by suicide out of despair and fear fostered by crossing the ocean, and defilement and loss of caste for Hindus.

Once on the plantations, many suicides were prevalent. The Fiji Indian suicide rate in between 1900 and 1915 was the highest among all Indian labourers' importing colonies and 132 times higher compared to native Fijians and much higher than in India itself (Haynes, 1987; Lal, 1985, 2000). The rate in Fiji was 78/100,000 in 1903, which increased to 83.1/100,000 in 1910. To compare, this figure was 8 times higher than the rates recorded in British Guyana and twice as high than recorded in Trinidad and Jamaica, and 16 times as high than recorded in the Indian states Madras and the United Provinces. According to Bhugra (2004), in Fiji and Mauritius, labourers from South India were more likely to engage in suicidal behaviour than the north Indians. Haynes (1987) stated that some peaks in the high suicide rates in Fiji coincided with an influx of workers from South India, recruited in Madras. Lal (1985, 2000), too, registered this phenomenon and attributed it to discrimination – for example, on skin colour – by the workers from North India, which led to an isolated position of the newcomers.

Of the available suicide data from the indenture period, most chronicled seems to be the suicide numbers in Fiji (Lal, 1985, 2000). Nonetheless, it is known that in Mauritius, many labourers died by suicide, among others, by jumping from a particular hillock during the indenture period, which acquired the name of 'Suicide Hill', now turned into a monument. In Suriname, Guyana and the Caribbean, many suicides were witnessed too (Bhagwanbali, 2010; Choenni, 2009, 2014).

The suicide numbers, however, both in the past and present times, are not free from registration problems. Especially, under-registration is suspected, due to problems that are related to religion (suicide is a sin, thus not mentioned as such), legal issues (in

some countries, suicidal behaviour is criminalized) or cultural factors (stigma, shame) (WHO, 2014). The current suicide rates are worldwide registered by the WHO, but the WHO registrations do not account for ethnicities per country. The differentiation between the Indian subcultures in the diaspora countries, such as Bhojpuri, Sikh and Tamil diasporas, is absent too.

Occasionally, some scholars do differentiate the national suicide rates according to the different ethnicities. In Suriname, Graafsma, Kerkhof, Gibson, Badloe, and van de Beek (2006) found much higher suicide rates for the Indian groups compared to the other ethnicities. They found a suicide rate for Indians of 48 per 100,000 Surinamese inhabitants, twice as high as the national Surinamese average for all ethnic groups. And, in Fiji, Forster, Kuruleca, and Auxier (2007) found up to 5 times higher rates among Indians compared to the average national suicide rate (25/100,000 versus 5/100,000).

In general, the suicide rates as provided by the WHO need to be accompanied with some remarks on their veracity (Aggarwal, 2015; Arya et al., 2018). The WHO registers the suicide numbers of 183 countries. However, there is a large variety in the way suicide is denoted and registered per country. In some countries, a medical doctor or coroner determines the suicide, whereas in other countries, the police performs the registration. Graafsma, Westra, and Kerkhof (2016, p. 639) discussed that in Suriname, every death must be registered by a physician and reported to the police, including suspicion of suicide. Although the systems seem reliable, Graafsma et al. (2016, p. 639) stated that because of stigma, 'it cannot be ruled out that some deaths by suicide actually are reported to have a different cause and thus are not included in the suicide statistics'.

The data often offer an average of all groups, and ethnicity is not considered. This holds that despite the high suicide numbers among Indians, the average country numbers are not the same as suicide rates of Indians. A next registration issue is that not every country collects the data thoroughly. This may be reinforced by religious and legal aspects, and people may choose not to report suicides as such, out of fear for punishment or shame. In countries where suicide is considered a punishable offence, often leading to time-consuming investigation and stigma, scholars expect under-reporting.

Yet another problem with the registration is that Indians who moved from a multi-ethnic country to a Western country are denoted by former nationality and not by ethnicity. This leads to an unclear image. For example, in the Netherlands, mostly the category 'Surinamese' is used without differentiation between the more than eight Surinamese ethnicities. Sometimes, the local demographics are helpful. In case of the Netherlands, it can be assumed that in The Hague – where some important studies on suicidal behaviour of Surinamese originated – it mostly concerns the Indian group, because they form the largest Surinamese group in that city.

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Appendix VI

The studied girmitiya countries

	Suriname	The Netherlands	Guyana	Trinidad and Tobago	Mauritius	Fiji
Global position	Northeast of South America	West Europe	Northeast of South America	Caribbean islands	Island in the Indian ocean	Archipelago in Pacific Ocean
Year of arrival	1873	Predominantly around 1975	1838	1845	1834	1879
Former colony of	The Netherlands	-	England	England	England/ France	England
% of Indian inhabitants	27.4%	1%	43.5%	40.2%	40.1%	68.3%
Language	Dutch and *Sranang Tongo; Sarnámi* and Hindi	Dutch, *Sarnámi* and *Sranang Tongo*, Hindi	English, Guyanese Hind, Guyanese Creole	English, Trinidadian, Hind, Hinglish	Bhojpuri, Hindi, Tamil, Marathi, Telugu, Urdu, Mauritian Creole, English, French	English, Bhojpuri-Hindi, Fijian
Religion	About 75% Hindu, 18% Muslim, rest Christian	About 75% Hindu, 18% Muslim, rest Christian	About 75% Hindu, 18% Muslim, rest Christian	About 50% Hindu, 12% Muslim, rest several Christian religions	About 73% Hindu, 26% Muslim, rest Christian	About 77% Hindu, 16% Muslim, rest Christian
Other ethnicities living in the same country	Native Indians (in Dutch: Inheemsen), Afro, Indonesian, Chinese, Dutch, Lebanese, Portuguese descendants	Multi-ethnic: Native Dutch, Turkish, Moroccan, Dutch Antilles, and several other Western and non-Western migrants	Afro-Guyanese, English descendants	African, Chinese and European descendants	African, Chinese and French descendants	Native Fijians, Polynesian, European and Chinese descendants
% of Indians in national suicide numbers	60%	Unknown	Up to 80%	Up to 80% (?, based on old studies)	Unknown	Unknown

Prevalent means for (attempted) suicide	Pesticides mostly. Hanging (adult men). Other toxics like acetic acid and chlorine. Jumping from a high bridge	Drug overdose, Poisonous substances	Pesticides (65%) and hanging (<20%)	Poisonous substances followed by hanging. Adolescents: drug overdose	Pesticides, hanging	Pesticides, hanging

Source: own construction based on the studied literature as mentioned in the references of this Appendix

Suriname

Suriname, a country in the northeast of South America, used to be a Dutch colony. Suriname includes several ethnicities, notably, the Native Indian Surinamese, Afro-Surinamese, Indo-Surinamese, Indonesian Surinamese, Chinese Surinamese and Dutch-Surinamese diaspora. It is estimated that 27.4% of the Surinamese population belongs to the Indian group in 2012 (Rijksvoorlichtingsdienst, 2022). The Surinamese Indians maintained their culture, cuisine, music, family traditions and language (Gautam, 2013; Oonk, 2007). The *Sarnámi* language is the common language which is a mixture of *Bhojpuri* and *Awadhi* in addition to Dutch, English and Creole wordings. Gowricharn (2019) emphasized that although Dutch Indians are part of the Indian diaspora, they are at a large distance from India compared with the English-speaking Indian descendants. This is because they don't share the recent British colonial history, and therefore, they lack the obvious command of Hindi or English. Overall, the Indians in Suriname have managed to integrate themselves in the Surinamese society. Next to their own ethnic lifestyle, they mix to a certain extent with other groups. Indians are active in the country's farming, trade, commerce, transport, financial, judiciary, political, medical and other sectors.

As for suicides, Suriname ranks with its suicide rates in the year 2016 on the fifth-highest place of all countries worldwide (Silverman, Barnaby, Mishara, & Reidenberg, 2020; WHO, 2021). Graafsma, Westra, and Kerkhof (2016) noted that the national suicide rate in Suriname has doubled during 2000–2013. The national rate is far above the world average with 23.2 per 100,000 in 2016. But Nickerie, a district in Suriname, heads the list with an average suicide rate of 47 per 100,000 inhabitants and with high numbers of attempted suicide (207 per 100,000) on average in the years 2002–2012 (Graafsma, Kerkhof, Gibson, Badloe, & van de Beek, 2006; Mohan & Punwasi, 2013. In the same period in Nickerie, high numbers of attempted suicides were found among males (49%), and the use of pesticides in both fatal (55%) and non-fatal suicidal behaviour (44%) was prominent.

The share of Indians in the national Surinamese suicide numbers used to be 70%, but the rate has dropped since the last decennium to 60% (Graafsma et al., 2016). In

2016, the suicide mortality was higher among Indian men compared to Indian women (male–female ratio was 3:1) (WHO, 2021). The adolescent group forms an exception, as during 2001–2008, Indian female suicides in the age cohort 10–19 outnumber men. For this age group, Suriname ranks second-highest of all countries registered by the World Health Organization (WHO; Quinlan-Davidson, Sanhueza, Espinosa, Escamilla-Cejudo, & Maddaleno, 2014).

The Netherlands

In the only European country of the six selected countries, the Netherlands, Indians form 1% of the total population of 17 million, and they live mainly in the four largest cities. They maintained their cultural norms, values, customs, religion and language. These characteristics fade among some youngsters, whereas some display a revival of their cultural roots (Gowricharn, 2019). Indians are one of the most successful ethnic groups in the Netherlands (Choenni, 2014). They are active in several areas of the society. Next to their success, Dutch-Surinamese Indians are familiar with some troublesome issues such as the pressure to perform, especially academically, and the negative social control with risks of being stigmatized when not adhering to the group norms (Nanhoe, Lünnemann, & Pels, 2016; NTR, 2016).

Pointing at generations of distance from India and referring to Indians from Suriname who live in the Netherlands, Gowricharn (2019, p. 9) stated that 'the idea of a homeland in the diaspora is ambiguous: for most Indians, Suriname, the Netherlands and India perform the function of a homeland'. This implies that Surinamese-Dutch Indians belong to at least two diasporas: the Surinamese diaspora and the Indian diaspora. Gowricharn (2019) registered a development among the Dutch Indians who came to use India as a 'source culture' through tourism, internet, movies, music and dance. Thus, some Surinamese-Dutch Indians built a renewed and intensified relation with their Indian roots in the past three to four decades.

The average national suicide in the Netherlands is 12.6 per 100,000 in 2016. However, studies on suicides of non-native groups in The Hague show that Surinamese men stand out with high numbers of suicide (Burger, 2013). Of all non-native men, the Surinamese men were over-represented with nearly 10% of all suicides from 2001 to 2010. The same study found that among non-native women, the Surinamese women formed the largest group in this period (8.7% of the total number of suicides). A different study, which differentiated between the Surinamese ethnicities, found significantly higher suicide figures among middle-aged Indian men: twice as often as males compared to other groups (Garssen, Hoogenboezem, & Kerkhof, 2007). With the numbers of suicide attempts too, Surinamese score high; within the age group 15–34, 4–5 times more Surinamese women attempted suicide compared to the corresponding native group (Burger, 2013; Burger, van Hemert, Bindraban, & Schudel, 2005).

Guyana

Guyana, Suriname's neighbouring country, has 787,000 inhabitants in 2020 as is estimated by the United Nations (2021). The Indian inhabitants account for 43.5% of the total population and form the largest ethnic group in the country. Guyana used to be a British colony and gained its independence in 1970. Guyana and Suriname have comparable features as the inhabitants are almost equally ethnically heterogeneous with many cultures and ethnicities, languages and religions. About 238,909 indentured Indian immigrants came to Guyana, and about 25% of them returned to India. The vast majority came from the same northern areas in India as the Surinamese Indians, and they speak a comparable dialect, which is called *Aili Gaili* in Guyana. The Indo-Guyanese account for 80% of all suicides in Guyana.

Noteworthy, in Guyana, the national suicide rate is on average 29.2 per 100,000 in 2016, but the average for the male sex is 46.6/100,000, the highest in the world (WHO, 2021). Of all suicides, 50% were Indo-Guyanese men between 20 and 49 years old. Almost 65% of cases died by ingesting pesticides. The numbers for attempted suicide are 20–25 times higher than the suicide numbers. Guyana belonged during 2001–2008 together with Suriname to the countries with the highest total suicide mortality rates among young people (10–24 years) in the Americas (Arora, Persaud and Parr, 2020; Quinlan et al., 2014). Of the six selected countries, Guyana is the only country that has legislation that declares suicidal behaviour illegal, thus punishable; in the literature, however, this legislation is barely represented.

Trinidad and Tobago

Trinidad and Tobago, the island country in the Caribbean Sea, which used to be British colonies until 1962, has an estimated total population of 1,399,000 in 2020 (UN, 2020). Like other colonial diaspora countries, the history of conquest and immigration is reflected in the ethnic composition of Trinidad and Tobago (CIA, 2022). Indians form with 40.2% of the total population who mainly live in Trinidad. They form the largest group, followed by the Afro-Trinidadians and Tobagonians, Chinese immigrants and the native groups. Trinidad and Tobago differ from Suriname and Guyana in their language. The Indo-Trinidadian language is more dispersed with English than *Sarnámi* and *Aili Gaili*. The distinctive heritage and culture, while also functioning in a multi-racial milieu, has been retained, such as in Suriname and Guyana.

With a percentage of 13.6 per 100,000 in 2016, the suicide rate in Trinidad and Tobago is some above the world average and ranks number 41 globally but has the fifth-highest suicides rates in the region, after Guyana and Suriname (Silverman et al., 2020). Here too, the Indians account for the lion's share of the suicides, and the method used consists of ingesting poisonous substances, notably, pesticides and herbicides (Hutchinson, 2005; Maharajh, Abdool, & Mohammed-Emamdee, 2008; Toussaint, Wilson, Wilson, & Williams, 2015). The male–female suicide ratio, however, differs; with

5:1 in 2016, Trinidad and Tobago tops the list of South American/Caribbean countries. Toussaint et al. (2015) found that from 1978 to 1992, male suicide rates increased by 319%, whereas female rates remained lower and relatively constant.

Mauritius

Mauritius, an island nation in the Indian Ocean near the south-east coast of the African continent, was under British rule until 1968, and before that the French colonized the island, but influences are still noticeable in the language among others. Mauritius was the first of the six discussed diaspora countries that knew indentured labour. The Indian group has grown to 68.3% of total 1,272,000 inhabitants (NRIOL, 2022; UN, 2021). Indentured laborers were mostly brought from the states of Bihar and Uttar Pradesh as was the case with the already-discussed countries, with Bhojpuri as the main language. Many Tamils, Telugus and Marathas were part of the indentured labour too, who brought their customs, languages, cuisine and the like with them.

The suicide rate in Mauritius is below the world average with 7.8 per 100,000 in 2016, but with a significant difference in rates between the sexes. The male–female ratio was 5:1 in 2016 (13.3/100,000 for male versus 2.4/100,000 for female) (Forster, Kuruleca, & Auxier, 2007; Goorah et al., 2013; WHO, 2021). Goorah et al. (2013) studied trends in suicide rates from 2000 to 2010. In line with the other countries, they found that Indians were most vulnerable and that male suicides were higher, and the 20–29 age group was more vulnerable to suicides. They found that the suicide rates varied from 6.2 to 8.9 during the 10-year period and decreased with improvement in living standards over the decade. They also noticed a decrease in poisoning cases and an increase in hanging as the preferred mode of suicide.

Fiji

The country of Fiji is an archipelago with hundreds of islands in the South Pacific Ocean, 2,000 kilometres northwest of New Zealand. In 1970, they gained independence from Britain. The country has an estimated number of 896,000 inhabitants in 2020 and has a substantial percentage of Indian inhabitants, notably 40.1% of the total (NRIOL, 2022; UN, 2021). The lion's share of the Indo-Fijians have their roots in the north-eastern part of India, the same as the other countries discussed here. The Indo-Fijians live in the so-called Sugar Belt and in cities and towns on the northern and western coasts and barely in the southern and inland areas. They speak Fiji Hindi, which is a mixture of eastern Hindi dialects and some native Fijian and English words. Fiji is known to have encountered tensions between the Indo-Fijians and the native Fijians.

The official national suicide rate of Fiji as recorded by the WHO is under the world average with 5 per 100,000 in 2016, with a 3:1 male–female ratio. Several studies found other figures. Forster et al. (2007), for example, found that the national rate in 2002 was 13 per 100,000 (15 per 100,000 population for males and 11 for females).

But the rate for the different ethnic groups differed considerably: 4 per 100,000 for the Indigenous Fijians and 24 per 100,000 for Fiji Indians, who formed at that time with 51% and 44% of the population, respectively. In an older study, Haynes (1987) stated that historically, the suicide rates for Indo-Fijians were always higher compared to other groups in Fiji. Haynes registered suicide numbers from 1971 to 1972 thus: male Indo-Fijians 24.9/100,000 versus 2.1/100,000 for the male native Fijians; female Indo-Fijians 23.1/100,000 versus 0.7/100,000 for female native Fijians. And from 1981 to 1982: male Indo-Fijians 45.2/100,000 versus 9.2/100,000 for the male native Fijians; female Indo-Fijians 33.1/100,000 vs 9.3/100,000 for female native Fijians.

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Appendix VII

Characteristics of the surveyed articles

	STUDIES	CHARACTERISTICS *(research type, main findings)*
SURINAME	Balraadjsing et al., 2010	Analysis of statistics of suicide by jumping from a high bridge in Paramaribo providing some demographic features (Surinamese Indians die more by jumping, Afro-Surinamese do more attempts) and five vignettes (without specification of the ethnocultural background). Based on interviews with relatives. Mere speculative explanations or referring to other studies, such as relational problems, high expectations of men as well as emotional restraint and depression.
	Choenni, 2009	Literature study and fieldwork in Nickerie (observations, focus groups, conferences) on attempted suicide. Several cultural explanations are suggested. Data not connected to the several work forms nor to the mentioned references.
	Graafsma et al., 2016	Descriptive exploratory and epidemiological research on national data, with a focus on Nickerie, years 2004–2012. Suicide: N = 161; attempts: N = 646. Some (speculative) cultural explanations. Results applicable for suicide attempts, not for suicides. No in-depth interviews. Use of Western- and psychopathology-based questionnaires, such as Beck's Suicide Intent Scale (SIS) that measures suicide intent and is standardized on European hospitalized patients.
	Graafsma et al., 2006	Quantitative, exploratory, epidemiological study in Nickerie, using death registers, hospital registers and semi-structured interviews of a sample of persons admitted to the hospital after attempted suicide. Data comprising numbers, rates, age and gender, method and ethnicity are described. No description of data of the open part of the interview. Hypothetically mentioned cultural explanations, predominantly referring to Indian literature.
	Mohan et al., 2013	Statistics of trends in suicide and suicide trends (age, gender, means) from the Bureau of Public Health in Suriname.
	Spijker et al., 2009	Exploratory psychological autopsy among 19 relatives of 13 suicides (pesticides and hanging) in Nickerie. Western/medical perspective. Some cultural explanations are hypothesized. Use of pesticides is significantly more less-planned, impulsive, whereas hanging is more common in more-planned suicides.
	STUDIES	**CHARACTERISTICS** *(research type, main findings)*
THE NETHERLANDS	Boedjarath, 2016	Case studies in cultural and historical perspectives aimed to describe gender specificity of suicidality among Dutch Indians.
	Boedjarath et al., 2016	Vignettes of youngsters who attempted suicide, followed by descriptions of the cultural embedding with the purpose to educate professionals who work with this group.
	Burger, 2013	Statistical analysis of suicide and suicide attempts of Dutch, Surinamese, Turkish and Moroccan migrants in The Hague. The data over the years 1987–2010 were derived from medical reports of emergency departments of hospitals, the crisis service and forensic physicians. Differences between the groups are described in prevalence, age, gender, social economic status, location and methods used.
	Burger et al., 2005	Comparable with Burger (2013; previous partial study).
	Garssen et al., 2007	Retrospective, statistical analysis of suicide mortality of Dutch-Surinamese migrants. Via name analysis, the Surinamese ethnicities are differentiated and compared to the native Dutch. Significantly higher suicide rates were found among Indian men and young Creole men. In the discussion section, medical and cultural explanations are hypothesized, such as strict gender roles, huge familial expectations, pressure, reputation damage, feelings of failure, pent-up frustrations expressed in alcohol abuse, impulsivity and aggression, addiction and depression.

THE NETHERLANDS	Gowricharn, 2021	Documented family history to rehabilitate the author's father who died by suicide. Sociological factors (lack of moral support and integration in the family) and cultural factors (stigma and silencing) are described from within the culture.
	Krikke et al., 2000	Qualitative study into the backgrounds and motives of suicide attempts among immigrant girls and young women in The Hague derived from in-depth interviews and literature study. Cultural accounts are given, such as the obligation to abide by traditional gender roles, communication problems, parental pressure.
	Rambhadjan, 1995	An explorative study of the causes of suicidal behaviour among Dutch-Surinamese Indian youngsters and main concerns for prevention and psychoeducation. Culture-specific accounts are given, such as the cultural gap and clash between parents and youngsters, strict gender roles.
	Saharso, 2000	Qualitative academic study of the suicide of a Dutch-Surinamese Indian woman, based on literature review. Gender- and culture-specific elements are mentioned, such as lack of interpersonal autonomy due to the traditional gender roles.
	Salverda, 2004	Using interviews and questionnaires, a follow-up research among 30 Dutch-Surinamese Indian girls between the ages of 15 and 20, who had previously attempted suicide. Culture-related aspects are mentioned similar to Krikke et al. (2000) and Rambhadjan (1995) yet interpreted from a Western individual perspective.
	Van Bergen et al., 2010, 2012, 2016	Series of studies: 2010: Logistic regression on a dataset of self-reported health and well-being questionnaires filled out by 4,527 adolescents of Dutch, South Asian-Surinamese, Moroccan and Turkish origins. The rates of attempted suicide among Turkish and South Asian-Surinamese young women were higher than of Dutch females, whereas Moroccan females had lower rates than Dutch female adolescents. The identified risk factors (physical and sexual abuse, an impaired family environment, parental psychopathology or parental substance abuse as well as low social economic class and level of education) did not fully explain the vulnerability of Turkish and South Asian-Surinamese females. Western-medical perspective. - 2012: Qualitative research to identify ethnic and gender-specific patterns of suicidal behaviour among South Asian-Surinamese, Turkish and Moroccan young women. Respondents received mental health care. Suicidal behaviour was related to the ability and right to act autonomously regarding strategic life choices, as well as by the questioning of cultural values of self-sacrifice and protection of honour. Individualistic interpretations prevail. - 2016: Qualitative interviews with 15 young women (of four ethnicities) who either had attempted suicide or contemplated suicide. Analysis based on narrative psychology tradition. Associations were found with despair and frustration over the violation of the autonomy and self-integrity regarding strategic life choices. Durkheimian study from Western feminist perspective.
	STUDIES	**CHARACTERISTICS** *(research type, main findings)*
GUYANA	Anthony et al., 2017	Qualitative study of nurses' attitudes and experiences with suicidal behaviour. Cultural explanations are provided, such as family issues related to unemployment, alcoholism and harsh parenting styles.
	Arora et al., 2020	Qualitative data on risk and protective factors retrieved from focus groups. Grounded theory approach. Risk factors included demographic characteristics, pressures and expectations, adults' responses to youth, limited coping with stressful life events and exposure to suicide. Protective factors included positive social support and involvement in community activities.
	Groh et al., 2018	Qualitative study to explore how 10 family members (in a focus group) coped and understood a relative's suicide. Although all respondents were East Indians, scant to no elaboration on the cultural background and its influence. Focus is Western-medical.
	Harry et al., 2016	Statistical analysis of the national suicide rates regarding **age, sex, ethnicity, geographic origin and method used in the suicide. Suicide attempts where investigated using questionnaires. Strong focus on the medical perspective, but some cultural interpretations are provided too. Risk factors:** depression, availability of herbicides and pesticides, alcohol and drug use, and family dysfunction.

	McCandless, 1968	Qualitative report of interviews with 36 suicide attempts. Medical perspectives combined with cultural interpretations from psychodynamic view.
	Quinlan et al., 2014	Statistical analysis of suicide mortality data of young people (10–24 years old) from the Americas. Highest rates were found in Guyana, Suriname, Nicaragua, El Salvador, Chile and Ecuador, respectively. Male suicides outnumber females, but not in Surinamese adolescents. Cultural explanations are offered speculatively.
	STUDIES	**CHARACTERISTICS** *(research type, main findings)*
TRINIDAD & TOBAGO	Ali et al., 2005	Statistical analysis of a large community survey (age group 14–20) with an emphasis on causation and prevention of suicidal behaviour. Correlations were found with gender, religion, family structure and alcohol abuse in the family. Some cultural explanations are offered in the discussion section, either hypothetically or referring to other studies.
	Hutchinson, 2005	Examination of homicide and suicide data available from police records. Homicide was positively associated with high population density, low marriage rates and African ethnicity and showed a trend towards association with school drop-out rates. For suicide, low population density, low income, East Indian ethnicity and alcohol consumption were significantly correlated. The found correlations are not culturally explained.
	Maharajh et al., 2008	Qualitative examination (cases and literature) of the effect of culture on suicide. Cultural factors are suggested.
	Toussaint et al., 2015	Statistical analysis of data on 4,448 young adults, concerning religiousness and its connection to suicidal thoughts, plans and attempts, among others. Scant cultural analysis.
	STUDIES	**CHARACTERISTICS** *(research type, main findings)*
MARUTIUS	Ameerbeg, 2005	Qualitative and quantitative study on risk/protective factors related to suicide attempts, whereby gender, age, ethnicity, religion and other demographic features are considered. Medical-psychiatric perspective prevails, but some cultural features are described too.
	CASR, 2015	Quantitative and qualitative study on the causes and consequences of suicidal behaviour among teenagers as well as an exploration of the consequences on family and friends of attempters and completers of suicide. Mixed-methods approach. Main focus is on medical-psychiatric perspective, and some cultural aspects are highlighted.
	Goorah et al., 2013	Quantitative retrospective analysis of all suicide cases recorded by the police from 2000 to 2010. Suicide rates were higher in males and in the 20–29 age group. A shift in the method of suicides was registered with an increase in suicide by hanging while suicides by poisoning were on a declining trend. No cultural explanations.
	Naga, 2007	Quantitative review of 147 suicide attempts by self-poisoning who were referred to the hospital. Medical-psychiatric focus. Some ethnic and religious features are highlighted.
	STUDIES	**CHARACTERISTICS** *(research type, main findings)*
FIJI	Adinkrah, 2003	Statistical analysis of homicide–suicides in 10-year period. The disproportionate representation of Fiji Indians in homicide–suicides parallels their generally high suicide rate in the population. Some cultural explanations are elaborated.
	Aghanwa, 2004	Quantitative examination of sociodemographic and clinical factors influencing gender-specific attempted suicide. Medical-psychiatric view
	Forster et al., 2007	Qualitative exploration of causes and needed intervention regarding suicides. Some cultural explanations are suggested.
	Haynes, 1987	State-of-the art article with a historical review of suicide in Fiji and current data. Social and cultural factors are addressed.
	Henson et al., 2012	Quantitative analysis of data on people who were referred to the hospital after a suicide attempt and comparing them with non-suicidal patients. Among the suicidal were more non-Indigenous Fijian male of younger age, unmarried and who had higher education and who experienced different kinds of loss. Cultural explanations are suggested.

FIJI	Lal, 1985, 2000	Studies concerning the Indian indenture period, including suicidal behaviour.
	Morris et al., 2001	Literature review on the high suicide rates among Indo-Fijians compared to the Indigenous Fijians. Religious and cultural beliefs, higher suicide risk in rural areas, use of toxic biocides as a method of suicide and relatively high suicide rates in young Indian women are discussed. Evidence for Indian vulnerability to suicide is suggested.
	Roberts et al., 2007	Statistical analysis of case records was reviewed of 132 people referred for counselling after an attempt at suicide. Most of them were young Indo-Fijian females. The findings correspond with the literature on selective demographic risks for attempted suicide, that is, young age, Indian ethnicity, female gender and social stress. No cultural explanations are attached to the findings.

Source: own construction based on the studied literature listed in the references

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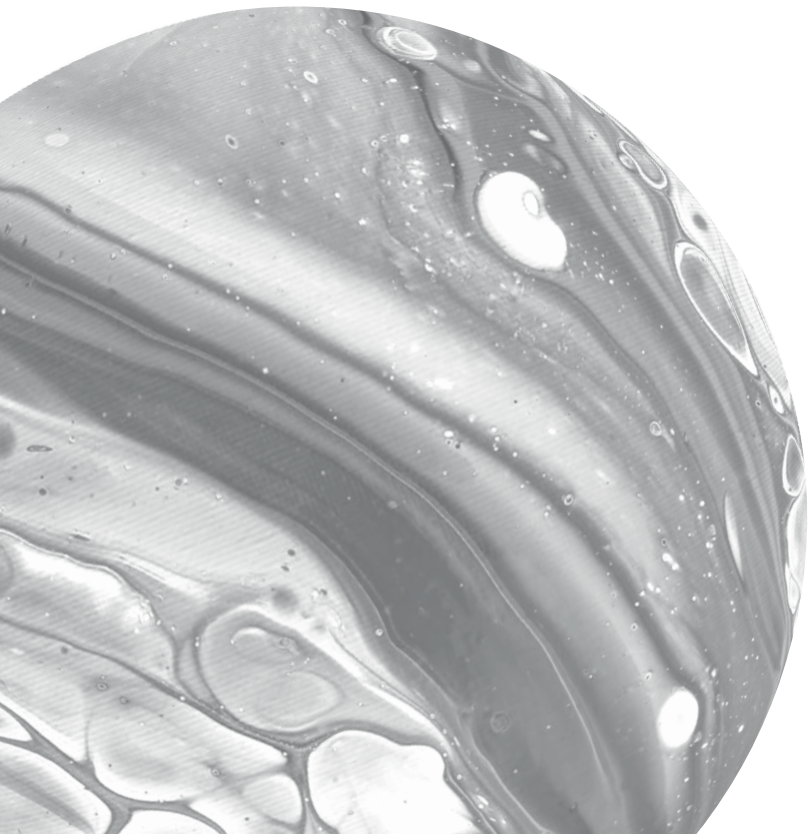

Summaries

English summary

Summary

Of the many factors that can contribute to suicide, the psychological drivers are most examined. This focus on mental factors is supported by the global hegemony of the medical-psychiatric model. In this perspective, suicidality, the tendency to die by suicide, is reportedly caused by medical and mental health problems. The medical vision is also reflected in the global focus on preventing suicide by detecting and treating mental risk factors. Other factors that contribute to suicide, such as culture, receive less attention. In addition, the perspective of the actor is subordinate to the vision of the researcher. As a result, the dominant academic lens prevails in suicide research at the expense of the actor's explanations from their own lived cultural reality. Suicide research is worldwide also based on Western standards. This cultural bias is concerning, not only because 60% of all suicides in 2019 occurred in non-Western communities, but also because the scientific literature indicates that suicidal behaviour varies around the world and is subject to cultural forces.

A consequence of the focus on psychological factors in suicide research is that the regularly suggested relationship between culture and suicide remains undetermined. Studies that focus on culture and suicide are not absent, but they are limited. These cultural studies usually produce knowledge at an aggregated level. Moreover, the available cultural knowledge about suicide is often influenced by the psychocentric view that emerges from the medical-psychiatric model or it focuses on a few cases without theorizing. Although a relationship between suicide and culture is suggested, it remains indeterminate how culture is related to suicide. Therefore, the unclear relationship between suicide and culture became the focus of this thesis.

To answer the research question, an exploratory study turned out to be the most appropriate, precisely because of the largely unexplored field of culture and suicide. After all, an exploratory research strategy offers the opportunity to explore concepts and relationships. This research strategy has influenced the key elements of my research, such as the conceptual framework, the identification of the research group, and the methods and procedures used to collect and analyze data.

To answer the central question a research group was needed with sufficient homogeneity and enough distinguishing characteristics to be differentiated from other groups in order to speak of a cultural group. Such an exploration can help identify the specific cultural forces related to suicide, as a significant portion of societies' suicidal behaviour is concentrated in specific ethnic groups. The Indian diaspora was selected as a research population. Like all diasporas, the Indian diaspora is heterogeneous in

terms of migration, place of departure and of arrival, acculturation and so on. Despite its heterogeneity, this diaspora fitted the intended exploration due to some important similarities, including their different cultural characteristics and the high suicide rates throughout the Indian diaspora. An important similarity was the internal and cultural continuity of the group. The Indian diaspora forms a transnational community that shares several features, like language, religion or consumption of Indian cinema but also has local specifications.

The exploratory strategy in combination with a dynamic, loosely defined notion of culture that I embrace, served as a starting point for the selection of theoretical concepts used in identifying the cultural factors active in suicide. The theoretical concepts were selected because of their inherent sensitizing capacity or because of their suitability to be made sensitizing to unlock the intended cultural factors. This implied that the concepts either had to fit in the exploratory nature of the research and the non-compelling notion of culture or they possessed the ability to be infused with it. Therefore, the concepts of script, habitus and autopsy were selected from the scientific literature. Despite the suggested receptivity of these concepts to study culture, they had to be made suitable for exploratory use. The somewhat definitive, fixed characteristics of the selected concepts (i.e. the delineated description with a built-in direction for potential outcomes) had to be converted into broader concepts that, although they had some reference in them, left room for a variety of outcomes.

Four sub-questions have been formulated to answer the central question. The first sub-question focused on the prevailing explanations for suicidal behaviour in the Indian diaspora, both among the people themselves and among the researchers. Because, while in the Indian diaspora the suicide incidence is high, the statements of those involved themselves are insufficiently visible. It turned out that the Indian diaspora itself uses its own statements, such as reincarnation and ijjat [honor]. These explanations have traveled through time and place, although variation is noticeable. The researchers' statements, on the other hand, are dominated by psychocentric explanations from the Western medical model.

For the second and third sub-questions, the sentisizing theoretical concepts cultural script of suicide and habitus have been adapted and examined for their usefulness in identifying cultural factors in suicide. The concept of cultural scripts of suicide was reworked to remove the compelling nature of the concept of culture. The subsequent research with the revised concept of suicidal behaviour among male Surinamese-Hindustani men brought to light some gender-related cultural scripts of suicide, such as the feeling of failure and loss of face-causing shortcomings in fulfilling the expected male role.

The adaptation of habitus into ethnic habitus also proved fruitful in unlocking cultural factors. The exploration of various cases with the concept of ethnic habitus showed some culturally rooted tendencies among Surinamese-Hindustani Dutch. In

particular, the workings of some prevailing culture-specific concepts, such as karma and kismat (fate) and manai ká boli (what will people say), turned out to be salient forces in the suicidal behaviour studied. However, the application of the concept of ethnic habitus was not unambiguous. The large intergenerational differences of the group, due to cultural changes for example, were reflected in the ethnic habitus in the form of habitus cleft. Similar differences led to changes and fractures in the ethnic habitus, which in turn influenced the durability and unambiguous application of the concept.

The last exploration was prompted by the lack of a method to examine cultural factors involved in suicide in hindsight. In current ex post suicidal examination, the commonly used method is a psychological autopsy, analogous to medical autopsy. A cultural alternative, cultural autopsy, was conceptualized in this thesis, to capture ex post the cultural factors related to suicide. This concept focuses on the input of theories of laymen (family, friends) as opposed to academic theories. The instrument was tried out and proved useful in subsequently recording the cultural factors involved in suicide, although further foundation is needed.

A synthesis of the findings answers the central question, namely how cultural factors are related to suicidal behaviour. To study the relationship between culture and suicide, the concept of culture must be loosely defined and used in order to be able to use it in an exploratory way. This offers room to include variation. Moreover, since certain cultures have a high incidence of suicide, the resort to suicide of a group member may be considered legitimate by the cultural group in question. Because of this, dying by suicide can serve as an example for a way out, a solution, that legitimizes the route to suicide in that culture. This legitimization of suicidal behaviour then, is not because it is culturally coercive or instigated by a commandment, a duty, or a cultural code, but because of its high incidence and familiarity.

How do cultural forces contribute to suicide? The answer runs as follows: cultural practices and experiences are scripted and manifest as tendencies in behaviour. This also applies to suicidal experiences and practices. As for the Indian diaspora, the cultural forces are incorporated into concepts (such as ijjat), language, religion, stories, films, literature, memories, songs and the like. The suicidal behaviour of this group has become a “cultural heritage” that has been passed down from generation to generation. Because culture is ubiquitous, it is almost impossible for members of these communities to avoid the cultural-suicidal forces. This ubiquity is rarely explicit and usually latent scripted behaviour and a latent habitus. It is activated under specific circumstances that lead to suicidal behaviour and is “easy” to perform due to the lower cultural threshold in the community. As a result, the incidence of (attempted) suicide is high and community members become “familiar” with suicidal practices.

In addition to the concepts of script and habitus, this book offers the scientific field the cultural autopsy to conduct suicide research afterwards. This instrument

starts from the assumption that cultural forces have been active and that these forces can also be identified in hindsight. The conceptualization of the cultural autopsy involves several building blocks that make it possible to be applied to different cultural groups. The culturally based meaning of suicide and the cultural explanations arising from the cultural autopsy form the building blocks for culture-specific intervention and prevention strategies.

The findings of this thesis have implications for researchers, professionals in the field and policy makers. The scientific field is offered two revised concepts, namely cultural scripts or suicide and ethnic habitus to examine cultural factors active in suicidal behaviour. This research also provides practical knowledge for professionals in the field. They are given important clues to make suicide prevention and intervention strategies more inclusive, as current guidelines and protocols are difficult to apply to groups from different cultural backgrounds. Both (mental) health and education professionals can distil clues from the results to recognize and discuss cultural aspects of suicide.

This dissertation also offers advantages for policy makers. They can use the findings to address the problematic issues in the way the health care system is organized, which is often devoid of a cultural focus. The persistent gap or rather mismatch between the individualized approach to suicidal behaviour and its cultural embedding is related to the practical knowledge that policymakers use (and vice versa). This biased knowledge transmitted by academia through the curricula of their educational programs can be adapted to recognize cultural differences in the manifestation of suicidal behaviour. The results provide important guidance for policymakers (including health insurers who define health policies to some extent) to develop inclusive guidelines that reflect the diversity of the population they work with.

Viewed at a broader level, the results can spark a debate on the definition of suicide. Because the prevailing definitions fall short of capturing the diversity of suicidal behaviour, it may be helpful to reformulate "suicide" as "self-inflicted death." This description can be further specified as "with or without mental cause" with room for other specific causes (e.g., interpersonal problems, the workings of "spirits," religious forces) and manifestations (e.g., rational suicides, religious suicides, protest suicides, third-party induced suicides).

The research group in this book, the Indian diaspora, can also benefit from the results. A specific operationalization of the concepts tailored to this ethnic group is offered. Because people in the Indian diaspora suffer from a high incidence of suicide, the findings provide clues that can stimulate awareness and debate. This can contribute to an increase in understanding of the suicide issue and a change from within, including specific cultural and gender-specific embedding of suicidal behaviour. This research has also uncovered specific knowledge about the Indian diaspora. The outlined characteristics of the Indian diaspora shed light on family systems and gender-specific

socialization related to suicide. The focus on gender contributes to the current suicide research on non-Western groups (in Western countries) that mainly focus on women, and who neglect men.

While the findings of this study show how culture is related to suicidal behaviour, it should be noted that cultural factors are specific and thus do not apply to other cultural groups or to the entire Indian diaspora. A second limitation is that the internal diversity of the group studied has remained underexposed. This is a common problem in qualitative social research, but only relevant when the results are focused on generalization. Third, the case studies are difficult to replicate given the specificities of time and place. Finally, comparable studies in other ethnic groups may require a different operationalization of concepts. Despite differences between ethnic groups, an increase in qualitative studies on suicide may confirm, refine, supplement or contradict previous arguments. This dissertation is an invitation to that kind of research.

Dutch summary

Samenvatting

Van de vele factoren die kunnen bijdragen tot suïcide, zijn de psychische kenmerken het meest onderzocht. Deze optiek is kenmerkend voor medici en psychologen. In hun wereldwijde visie wordt suïcidaliteit, de neiging om te sterven door suïcide, naar verluidt veroorzaakt door individuele medische en geestelijke gezondheidsproblemen. Het gevolg hiervan is dat hun focus ligt op het voorkomen van suïcide door het vaststellen en behandelen van mentale risicofactoren. Andere factoren die bijdragen aan suïcide, zoals cultuur, krijgen minder aandacht. Opvallend is dat in het medisch-psychologisch perspectief de visie van de 'patiënt' ondergeschikt is aan de visie van de onderzoeker. Als gevolg hiervan overheerst de academische optiek in suïcide-onderzoek, meestal ten koste van de verklaringen van de betrokkenen. Tenslotte, onderzoek naar suïcide is wereldwijd gebaseerd op westerse normen. Deze culturele vooringenomenheid is zorgwekkend, niet alleen omdat 60% van alle suïcides (in 2019) plaatsvond in niet-westerse gemeenschappen, maar ook omdat de wetenschappelijke literatuur aangeeft dat suïcidaal gedrag over de hele wereld varieert en onderhevig is aan culturele krachten.

Een gevolg van de focus op psychische factoren in suïcide-onderzoek is dat de regelmatig gesuggereerde relatie tussen cultuur en suïcide onbepaald blijft. Studies gericht op cultuur en suïcide zijn niet afwezig, maar ze zijn beperkt. Deze culturele studies produceren meestal kennis op een geaggregeerd niveau. Bovendien wordt de beschikbare culturele kennis over suïcide vaak beïnvloed door de psychocentrische visie die voortkomt uit het medisch-psychiatrische model, of richt het zich op enkele gevallen zonder theoretisering. Hoewel een relatie tussen suïcide en cultuur wordt gesuggereerd, blijft het onbepaald hoe cultuur gerelateerd is aan suïcide. Daarom werd de onduidelijke relatie tussen suïcide en cultuur de centrale vraag van dit proefschrift. Voor het beantwoorden van de onderzoeksvraag bleek een exploratief onderzoek het meest passend, juist vanwege het grotendeels onontgonnen terrein van cultuur en suïcide. Een exploratieve onderzoeksstrategie biedt immers de mogelijkheid om concepten en relaties te onderzoeken. Deze onderzoekstrategie heeft de belangrijkste elementen van mijn onderzoek beïnvloed, zoals het conceptuele kader, de identificatie van de onderzoeksgroep en de methoden en procedures die gebruikt zijn voor het verzamelen en analyseren van gegevens.

Om de centrale vraag (hoe dragen culturele factoren bij aan suïcide?) te beantwoorden was een onderzoeksgroep nodig die voldoende homogeniteit bezit en zich onderscheidde van andere culturele groepen. De Indiase diaspora werd

geselecteerd als onderzoekspopulatie omdat suïcide in deze populatie opvallend vaak voorkomt. De Indiase diaspora vormt voorts een transnationale gemeenschap die een taal, religie of de consumptie van Indiase cinema delen, maar ook lokale specificaties ervan kennen.

De exploratieve strategie in combinatie met een 'lossere' en dynamische notie van cultuur die ik omarm, dienden als uitgangspunt voor de selectie van theoretische concepten om te kunnen exploreren. De theoretische concepten werden geselecteerd vanwege hun inherente vermogen tot plooibaarheid of vanwege de sensitiviteit om culturele factoren te ontsluiten. Om die redenen werden de concepten van script, habitus en autopsie geselecteerd. Maar deze concepten moesten theoretisch geschikt worden gemaakt voor exploratief gebruik.

Voor de beantwoording van de centrale vraag is een aantal deelvragen geformuleerd. De eerste deelvraag richtte zich op de vigerende verklaringen voor suïcidaal gedrag in de Indiase diaspora, zowel bij de mensen zelf als bij de onderzoekers. Want terwijl in de Indiase diaspora de suïcide incidentie hoog is, zijn de verklaringen van de betrokkenen zelf onvoldoende in beeld. Het bleek dat de Indiase diaspora zelf eigen verklaringen hanteert, zoals reïncarnatie en ijjat [eer]. Deze verklaringen hebben door tijd en plaats gereisd, hoewel er variatie merkbaar is. De verklaringen van de onderzoekers daarentegen worden gedomineerd door psychocentrische verklaringen uit het westers-medisch model.

Voor de tweede en derde deelvraag zijn de sentisizing theoretische concepten cultural script of suicide en habitus aangepast en onderzocht op hun bruikbaarheid om culturele factoren bij suïcide te identificeren. Het concept van cultural scripts of suicide werd bewerkt om het dwingende karakter van het begrip cultuur eraf te halen. Het daaropvolgende onderzoek met het herziene concept naar suïcidaal gedrag onder mannelijke Surinaams-Hindostaanse mannen bracht enkele gender gerelateerde cultural scripts of suicide aan het licht, zoals het gevoel van falen en gezichtsverlies veroorzakende tekortkomingen bij het vervullen van de verwachte mannelijke rol.

De bewerking van habitus naar etnische habitus bleek eveneens vruchtbaar om culturele factoren te ontsluiten. De verkenning van verschillende cases met het concept van etnische habitus vertoonde enkele cultureel gewortelde tendensen onder Surinaams-Hindostaanse Nederlanders. Vooral de werking van enkele heersende cultuurspecifieke concepten, zoals karma en kismat (lot) en manai ká boli (wat zullen mensen zeggen), bleken saillante krachten te vormen in het bestudeerde suïcidale gedrag. De toepassing van het begrip etnische habitus was echter niet eenduidig. De grote intergenerationele verschillen van de groep, bijvoorbeeld als gevolg van culturele veranderingen, werden weerspiegeld in de etnische habitus in de vorm van habitus kloof. Soortgelijke verschillen leidden tot veranderingen en breuken in de etnische habitus, die op hun beurt de duurzaamheid en de eenduidige toepassing van het concept hebben beïnvloed.

De laatste exploratie werd ingegeven door het ontbreken van een methode om achteraf culturele factoren te onderzoeken. Bij suïcide onderzoek achteraf, is de veelgebruikte methode een psychologische autopsie, analoog aan medische autopsie. Een cultureel alternatief, culturele autopsie, werd geconceptualiseerd in deze thesis, om ex post de culturele factoren gerelateerd aan suïcide vast te leggen. Dit concept focust op de input van theorieën van leken (familie, vrienden) in tegenstelling tot academische theorieën. Het instrument werd uitgeprobeerd en bleek nuttig te zijn bij het achteraf vastleggen van de culturele factoren die betrokken zijn bij suïcide, hoewel verdere fundering ervan nodig is.

Een synthese van de bevindingen vormt een antwoord op de centrale vraag, met name hoe culturele factoren gerelateerd zijn aan suïcidaal gedrag. Om de relatie tussen cultuur en suïcide te bestuderen dient het concept van cultuur losjes te worden gedefinieerd en gehanteerd om het op een exploratieve manier te kunnen gebruiken. Dit biedt ruimte om variatie op te nemen. Bovendien, aangezien bepaalde culturen een hoge incidentie van suïcide hebben, kan de toevlucht tot suïcide van een groepslid door de desbetreffende culturele groep als legitiem worden beschouwd. Hierdoor kan sterven door zelfdoding dienen als voorbeeld voor een uitweg, een oplossing, die de route naar suïcide in die cultuur legitimeert. Deze legitimatie van suïcidaal gedrag is niet omdat het cultureel dwingend is of wordt aangezet door een gebod, een plicht of een culturele code, maar vanwege de hoge incidentie en vertrouwdheid ervan.

Hoe dragen culturele krachten bij aan suïcide? Het antwoord luidt als volgt: culturele praktijken en ervaringen worden gescript en manifesteren zich als tendensen in gedrag. Dat geldt ook voor suïcidale ervaringen en praktijken. Wat de Indiase diaspora betreft, zijn de culturele krachten verwerkt in concepten (zoals ijjat), taal, religie, verhalen, films, literatuur, herinneringen, liedjes en dergelijke. Het suïcidale gedrag van deze groep is een 'cultureel erfgoed' geworden dat van generatie op generatie is overgedragen. Omdat cultuur alomtegenwoordig is, is het bijna onmogelijk voor leden van deze gemeenschappen om de cultureel-suïcidale krachten te ontwijken. Deze alomtegenwoordigheid is zelden expliciet en meestal latent gescript gedrag en een latente habitus. Het wordt geactiveerd onder specifieke omstandigheden die leiden tot suïcidaal gedrag en 'gemakkelijk' uit te voeren door de lagere culturele drempel in de gemeenschap. Als gevolg hiervan is de incidentie van (poging tot) suïcide hoog en raken leden van de gemeenschap 'vertrouwd' met suïcidale praktijken.

Naast de concepten van script en habitus biedt dit boek het wetenschappelijke veld de culturele autopsie om achteraf suïcide onderzoek uit te voeren. Dit instrument vertrekt vanuit de assumptie dat culturele krachten werkzaam zijn geweest en dat deze krachten ook achteraf kunnen worden geïdentificeerd. De conceptualisering van de culturele autopsie omvat verschillende bouwstenen die het mogelijk maken om te worden toegepast op verschillende culturele groepen. De cultureel gefundeerde betekenis van de suïcide en de culturele verklaringen die voortkomen uit de

culturele autopsie vormen de bouwstenen voor cultuurspecifieke interventie- en preventiestrategieën.

De bevindingen van dit proefschrift hebben implicaties voor onderzoekers, professionals in het veld en beleidsmakers. Het wetenschappelijke veld krijgt twee herziene concepten aangeboden, met name cultural scripts of suïcide en etnische habitus om culturele factoren te onderzoeken die actief zijn in suïcidaal gedrag. Dit onderzoek biedt ook praktische kennis voor professionals in het veld. Zij krijgen belangrijke aanwijzingen tot het inclusiever maken van suïcide preventie- en interventiestrategieën, omdat de huidige richtlijnen, normen en protocollen moeilijk toe te passen zijn op groepen met verschillende culturele achtergronden. Zowel (geestelijke) gezondheids- als onderwijsprofessionals kunnen aanwijzingen destilleren uit de resultaten om culturele aspecten van suïcide te herkennen en uit te werken.

Beleidsmakers kunnen de bevindingen gebruiken om het gebrek aan een culturele focus in het gezondheidszorgsysteem aan te pakken. De kloof, of liever mismatch, tussen de geïndividualiseerde aanpak van suïcidaal gedrag en de culturele krachten hangt samen met de praktische kennis van beleidsmakers. Hun kennis kan worden aangepast om culturele verschillen in de uiting van suïcidaal gedrag te erkennen en te verwerken in beleid. De resultaten bieden belangrijke aanwijzingen aan beleidsmakers (inclusief zorgverzekeraars die tot op zekere hoogte het gezondheidsbeleid definiëren) om richtlijnen te ontwikkelen ten behoeve van een cultureel diverse bevolking.

Op een breder niveau bekeken, kunnen de resultaten een debat over de definitiering van suïcide op gang brengen. Omdat de heersende definities tekortschieten om de diversiteit van suïcidaal gedrag vast te leggen, kan het nuttig zijn om 'suïcide' te herformuleren als 'zelf veroorzaakte dood'. Deze beschrijving kan verder worden gespecificeerd als 'met of zonder mentale oorzaak' met ruimte voor andere specifieke oorzaken (bijvoorbeeld interpersoonlijke problemen, de werking van 'geesten', religieuze krachten) en manifestaties (bijvoorbeeld rationele suïcides, religieuze suïcides, protest suïcides, door derden aangespoorde suïcides).

Ook de onderzoeksgroep in dit boek, de Indiase diaspora, kan profiteren van de resultaten. De operationalisering van de concepten is toegesneden op deze doelgroep. Omdat mensen in de Indiase diaspora lijden aan een hoge incidentie van suïcide, kunnen de bevindingen een bewustwording tot gevolg hebben en debatten stimuleren. Dit kan bijdragen aan een toename van het begrip van het suïcidevraagstuk en een verandering van binnenuit. Het onderhavig onderzoek heeft ook specifieke kennis over de Indiase diaspora aan het licht gebracht. De geschetste kenmerken van de Indiase diaspora werpen licht op familiesystemen en genderspecifieke socialisatie met betrekking tot suïcide. Zo draagt de focus op gender bij aan het huidige suïcide-onderzoek naar niet-westerse groepen (in westerse landen) die zich voornamelijk richten op vrouwen en die mannen verwaarlozen.

Hoewel de bevindingen van dit onderzoek laten zien hoe cultuur gerelateerd is aan

suïcidaal gedrag, moet worden opgemerkt dat culturele factoren specifiek zijn en dus niet van toepassing op andere culturele groepen of op de hele Indiase diaspora. Een tweede beperking is dat de interne diversiteit van de onderzochte groep onderbelicht is gebleven. Dit is een algemeen probleem in kwalitatief sociaal onderzoek, maar alleen relevant wanneer de resultaten gericht zijn op generalisatie. Ten derde, de casestudies zijn moeilijk te repliceren gezien de specifieke kenmerken van tijd en plaats. Tenslotte, vergelijkbare studies in andere etnische groepen kunnen een andere operationalisering van concepten vereisen. Ondanks verschillen tussen etnische groepen, kan een toename van kwalitatieve studies over suïcide eerdere argumenten bevestigen, verfijnen, aanvullen of tegenspreken. Deze dissertatie is een uitnodiging voor dat soort onderzoek.