

Suicidality In Young Asian Women: The Role Of Shame

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Overview

Part 1, the literature review, covers the main areas of definitions, prevalence and models of suicidal behaviour as well as current literature on shame, introducing the Asian cultural concepts of *sharam* (shame) and *izzat* (honour). It concludes that these concepts are central to understanding the experiences of South Asian women, that Western models of suicide do not provide adequate explanations of a higher risk in Asian women and that current hypotheses that cite 'culture conflict' as a causal mechanism may be too simplistic. Part 2, the empirical paper, reports on a study of suicidality and experiences of shame in 159 female, Asian Hindu, Asian Muslim and White British university students aged between 18-24, using structured questionnaires in addition to a measure designed for this study to assess *sharam*. Cultural values conflict was also assessed in both Asian groups. The main findings gave support to the hypothesis that suicidality would be higher in Asian women and to the proposed model suggesting that conflict between culturally prescribed values and an Asian woman's own values may lead to greater suicidality via the mechanism of a *sharam* experience. Part 3, the critical appraisal, discusses the strengths, weaknesses and limitations of the present study, with reference to community vs. clinical studies, self-report vs. interview measures and problems associated with defining suicidal behaviour and *sharam*, leading to difficulties in interpreting results. Finally, this part concludes with a discussion of issues of political correctness and anxiety in researching ethnicity and suicide.

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Part 1:

Suicidal Behaviour in Young South Asian

Women: A Review

ABSTRACT

The literature addressing suicidal behaviour in young South Asian women is reviewed. Most published literature cites 'culture conflict' as a causal mechanism for the high rates of suicidal behaviour found in this group. Whilst this concept is undoubtedly of relevance, it is ill defined and does not propose a mechanism through which conflicting cultural roles may lead to suicidal ideation and behaviour. Recent research suggests a role for shame in the suicidal behaviour of young Asian women. A specific pathway is for the first time proposed in this study, by hypothesising that experiencing conflict between Western and South Asian cultures in terms of acceptable moral and social behaviour for women may lead to or at least contribute to suicidal behaviour through the cultural concepts of 'sharam' (shame) and 'izzat' (honour). The shame experienced is thought to relate more to a fear of shaming one's family and/or community, and thereby affecting family honour rather than to Western concepts of shame. Religion is examined as a moderating variable, as research suggests that Muslim women may be at lower risk of suicidality than South Asian women from other religious backgrounds; in particular Hindu women. A hypothetical model is proposed linking culture conflict, shame and suicidal behaviour with religion moderating the effect of shame on suicidal behaviour.

INTRODUCTION

In this paper, I review the literature on suicidal behaviour in young South Asian women. Firstly, I define suicidal behaviour, before considering its prevalence; beginning with general prevalence of suicide in the UK, then specifically in young Asian women in the UK and end this section with a comparison of suicide prevalence rates in young Asian women in Asia. I then examine current models of suicide in the literature, considering the value of these (Eurocentric) models for understanding suicide in a South Asian cultural context. This is followed by a discussion of the literature available on the meaning of suicidal behaviour in young Asian women, introducing the concepts of *sharam* and *izzat* (shame and honour). Finally, I review the (limited) literature on shame and suicide, beginning with definitions of shame and relevant psychological issues associated with an experience of shame. I then briefly explore affective and behavioural components of the experience of shame before discussing links between shame, honour and suicide. I highlight the gap in the literature addressing shame as a possible cause of suicidal behaviour rather than just as a result of the (failed) act.

The terms 'South Asian' or 'Asian' in this literature review are used to describe the ethnicity of people originating from Sri Lanka, India, Pakistan and Bangladesh, regardless of country of birth. Geographically, the terms 'Indian subcontinent' and 'South Asia' also include Afghanistan, Nepal, Bhutan and the Maldives. However, despite using these geographical terms, the literature reviewed is clearly only pertaining to people originating from the countries first mentioned, and are collectively recognised in the UK as 'Asian'.

DEFINITIONS

Suicide, which may be defined as the intentional killing of oneself, is by definition, extremely difficult to study. Although causal hypotheses may be examined via informant testimonies, it is more likely that the probable complex and multiple reasons behind the suicidal act are tragically lost with the person who committed it. Suicide research therefore must include survivors of non-fatal suicidal behaviours in order to further our understanding of the mechanisms through which a person comes to take their own life, or attempt to do so.

Suicidal ideation refers to cognitions that can vary from fleeting thoughts that life is not worth living, concrete, well-thought-out plans for killing oneself, to an intense delusional preoccupation with self-destruction (Goldney, Winefield, Tiggemann, Winefield, & Smith, 1989) and comprises an important part of risk assessment of a potentially suicidal person. However, suicidal ideation is far more frequent than suicide attempts, and suicide attempts are more frequent than acts of completed suicide (Thompson & Bhugra, 2000).

Defining 'non-fatal suicidal behaviours' is problematic, as this term may include 'attempted suicide', 'deliberate self-harm' and 'parasuicide' – with no universal consensus on what these describe. Broadly speaking, 'attempted suicide' is usually taken to mean an act of failed suicide and may be defined as an act 'used to intentionally inflict harm upon oneself with non-fatal outcome' (Kerkhof, 2000). Kreitman, Philip, Greer, and Bagley (1969) proposed the term 'parasuicide' instead of attempted suicide, to describe an act that seemed like suicide, but where intention and motivation may be less clear. This term received criticism (Hawton & Catalan,

1987) as it still implied suicidal intention when there may be none. The term 'deliberate self-harm' (DSH) may be divided into two broad categories - 'deliberate self-poisoning' and 'self-injury'. Hawton et al. (2003) defined self-poisoning as 'the intentional self-administration of more than the prescribed dose of any drug, whether or not there is evidence that the act was intended to cause harm' and self-injury as 'an injury recognised by hospital staff as having been deliberately self-inflicted.' They considered attempted suicide as part of DSH, but with an additional clear intention to die.

The argument for which term to use is hinged on whether the behaviour represents intent to die (failed suicide) or a distinct act with a different set of meanings in which the primary aim is not to destroy the self. Non-fatal suicidal behaviours may differ enormously in the individual's intent. Some attempts are aimed at dying, others at mobilising help, and some may be a combination of both (Kerkhof, 2000). A definition is given below which seeks to include all the terms above but differentiates between non-fatal suicidal behaviours and repeated DSH.

In the WHO/Euro Multi-Centre Study on Parasuicide, the terms 'parasuicide' and 'attempted suicide' are used as equivalents, defined as:

'An act with nonfatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences' (Platt et al., 1992, p.99).

This definition therefore includes acts of self-poisoning and self-injury (which may be termed DSH) but excludes acts of self-cutting which are part of a repetitive pattern of self-mutilation (which may also be termed DSH). Although DSH is associated with significant risk of suicide (e.g. Hawton & Fagg, 1988), studies of DSH in repeating self-cutters have discussed the difference in meaning between these acts and those aimed at ending life.

The meaning of acts of DSH or attempted suicide may be fairly difficult to establish based on overt characteristics of the behaviour or on the person's self-report (Kerkhof, 2000). In contemporary research, parasuicide and attempted suicide are used as synonyms, with many researchers also classing these amongst the broader range of behaviours that constitute DSH. Burless & De Leo (2001, p.108) conclude that 'suicidal behaviour exists on a continuum ranging from ideation to actual attempt'.

Since (i) many of the terms discussed above are used interchangeably in research, (ii) suicidal intentionality is often difficult to establish conclusively, (iii) solid evidence exists to link previous self-harming behaviour and later suicide (Brent et al., 1993) and (iv) the National Suicide Prevention Strategy for England (Department of Health [DoH] 2002) states as one of its goals; 'to reduce the number of suicides in the year following DSH' this review will consider literature on suicide *and* related behaviours.

PREVALENCE OF SUICIDE

General Prevalence of Suicide in the UK

Approximately 5000 people in England die each year from suicide (DoH, 2002). Suicide rates are consistently higher in males across all Western countries (World Health Organisation [WHO] 1996), in contrast with hospital admission rates for suicide attempts, where females are the majority (Kerkhof, 2000). In 1994 across England and Wales, the rate of suicide in men was 11.1 per 100,000 and in women, 3.0 per 100,000, giving a male to female ratio of 3.7:1 (WHO, 1996). Brent and Moritz (1996) suggest possible explanations for the higher rate of suicide amongst men; they use more lethal methods (such as firearms and hanging) than women, who are more likely to cut or take drug overdoses, both of which provide more opportunity for rescue. Men also have a greater propensity for impulsive violence and are more likely to abuse substances - a risk factor for suicide.

In most countries, suicide rates in men increase with age (Lester, 1982). However, suicide rates in young men (aged 15-24) have been steadily rising, mostly evident in the English-speaking nations (Cantor, 2000). In the last 20 years in England, suicide rates have fallen in older men and women, but risen in young men, such that the majority of suicides are now occurring in young adult males aged 19-34 and suicide is the most common cause of death in men under thirty-five (DoH, 2002). For this reason, most UK studies investigating high-risk groups for suicide have historically focussed on young males. Young females in the same age bracket have consistently been found to have the lowest rates of suicide (Cantor, 2000).

Internationally, for females, the picture seems somewhat different, with suicide rates

generally varying with the level of economic development of the nation. Generally, for the wealthiest nations, female suicide rates peak in middle age. Elderly women are at greater risk than other women in the poorer nations, with younger adult women being most at risk of suicide in the poorest nations (Cheng & Lee, 2000). A cultural group that do not conform to this general trend are young Asian women in the UK.

Prevalence of Suicide in Young Asian Women in the UK

For many years, a vast array of literature was available on many aspects of suicide and attempted suicide. What had been lacking in the research were investigations of ethnic differences. Recent research shows that in the UK, attempted suicide rates among young South Asian women are higher than in older South Asian women, 2.5 times the rate in age-matched White women and seven times higher than in Asian men (Bhugra, Desai & Baldwin, 1999a). Rates of completed suicide also show an excess of young Asian women compared to these other groups (Raleigh, 1996; Raleigh & Balarajan, 1992; Raleigh, Bulusu & Balarajan, 1990). Increasingly, epidemiological studies also show that young Asian women have higher rates of suicide than other ethnic groups (e.g., Bannerjee, Nandi & Nandi, 1990; Raleigh, 1996). The literature examining the prevalence of suicide in young Asian women in the UK is reviewed below.

The earliest published study found marked differences between Asian, Irish, West Indian and White groups. Burke (1976a, b and c) retrospectively studied case notes of Asian, Irish and West Indian people admitted to a Birmingham hospital following attempted suicide between 1969 and 1972. He found that Asians were *under-represented*, and were young, less likely to abuse drugs or alcohol and less likely to

repeat the attempt. However, there are a number of reasons why these results may not be accurate. Firstly, as a retrospective study, based on case notes of individuals admitted to hospital following self-harm, it may have missed many Asian people who refused admission to hospital and therefore for whom no data was available. Studies certainly give evidence for a greater stigma attached to emotional difficulties in Asian communities, and Asians may be less likely as a group to agree to admission (Rao, 1965). Secondly, country of birth, *not* ethnicity of patient was recorded. Only the case notes of patients for whom this information was *initially* known were reviewed. The researchers randomly selected a sample of case notes that were not used because country of birth had not initially been recorded, and it was found that 2.5% of these were South Asian patients. Also, it was not reported whether any deaths by suicide were included. This may be important because the literature suggests that South Asian women may use more lethal means, such as self-immolation than White women (Raleigh, Bulusu and Balarajan, 1990).

Wright, Trethowan & Owens (1981), as cited in Merrill and Owens (1986), conducted a pilot study at a Birmingham hospital and found that the mean annual rate of increase in self-poisoning between 1975 and 1979 was higher for Asians than White people. Merrill & Owens (1986) followed this pilot with a study comparing demographic, social and psychiatric characteristics of Asian and White individuals admitted to a Birmingham hospital following deliberate self-poisoning over 2 years. The Asian group consisted of people born in India, Pakistan, Bangladesh, the UK and East Africa (almost 60% were Indian Sikhs). The White group included people born in England, Scotland and Wales; excluding Irish-born individuals due to research suggesting this group is over-represented in attempted suicide rates (Burke,

1976b). The two groups were compared using data collected on age, gender, marital problems, alcoholism and psychiatric diagnosis. Only the findings on rates will be reported here as other findings are reported later in this review. The rate of self-poisoning was found to be higher for Asian females than for White females and the rate for Asian males was lower than for White males. These rates of self-poisoning were considered inaccurate due to the investigators comparing UK-born with Asian-born groups (for census comparison purposes). Therefore, the UK- and East African-born Asian people were included with the White group for analysis, which suggests that the rate of self poisoning found in Asian females compared to White females could be even higher than reported.

Merrill, Owens, Wynne and Whittington (1990) administered various validated questionnaires to fifth-form students at two Birmingham schools and found that suicidal ideation was highest in Asian females, followed by Asian males, then White females, with White males scoring the least 'definitely have' answers to questions such as 'have you recently found yourself wishing you were dead and away from it all?' Asian females also scored highest on hopelessness.

Glover, Marks and Nowers (1989) analysed the attendances of patients aged 10-24, to two casualty departments, following self-poisoning. These casualty departments served a community that had a very high proportion of Bangladeshi residents and Census figures were used to estimate proportions of the population that were of Asian origin in the age groups being studied. Comparing Asian with non-Asian attendees, they found a significant excess of Asian women aged 15-19 in their sample. Whilst this age group constituted only 7% of the female population, they

represented 16% of the total number of females in the sample. No significant differences were found in the proportion of Asian and non-Asian males attempting suicide, nor were differences found for women aged 10-14 and 20-24. The authors also noted that there were no actual deaths from suicide in their area of London in Asians aged between 10-24, in the years 1980 to 1984.

Glover et al.'s (1989) study added to the growing evidence base on suicidal behaviour in the Asian population, and looked specifically at age groups. However, none of the studies cited distinguished between different Asian groups, although this may be highly significant, given that Asian groups settled in different geographical areas of the UK after migration. As will be discussed later, Islam explicitly forbids suicide. Consequently, although experiencing high rates of parasuicide, an area with (e.g.) a high proportion of Muslim Bangladeshi people may have low rates of actual suicide in this group – either because people would be likely to use less lethal means and not have a wish to die, or because family members may present a suicide as accidental where there might have been evidence to the contrary, for example, a suicide note. Inconclusive evidence may then lead to a verdict other than suicide.

Raleigh et al. (1990) analysed suicide statistics available on immigrants who had been living in England and Wales, born in India, Pakistan, Bangladesh and Sri Lanka from death certificates supplied by the Office of Population Censuses and Surveys (OPCS). Certificates were included in the study only when the individuals were born in the countries specified and an actual verdict of suicide was declared as cause of death. The names of the deceased were used to determine ethnic origin and any certificates with non-South Asian names were omitted from analysis.

Since data was not available on age-specific rates of death by suicide amongst South Asians, the data Raleigh et al. (1990) gathered was compared to data on the general population, calculating 'proportional mortality ratios' (PMRs); the ratio of the proportion of actual deaths by suicide to the proportion of expected deaths by suicide. For the period 1970 to 1978, they found that 86 South Asian women died from suicide, and 145 South Asian men died. This represented 2.7% of South Asian female deaths and 1.8% of South Asian male deaths. This was compared with 0.8% and 0.6% respectively, of male and female deaths by suicide in the general population in the same time period. When PMRs were calculated, South Asian men were found to have significantly low ratios and South Asian women had slightly higher ratios, but not statistically significantly so. Most startling was their data on age-specific PMRs. There was a significant excess of suicide mortality in young Asian women, aged 15-24, compared with women of this age in the general population. Older South Asians had low PMRs, significantly so in older males. When comparing female and male South Asians, females were found to have significantly higher proportional suicide mortality. The sex difference in the general population was small.

Significant differences were also found in methods used. In males in the general population and in South Asian males, poisoning and hanging were the most common methods. In the general population in women, poisoning was used in approximately two thirds of female deaths. However, in South Asian female deaths, poisoning was used in only 20% of cases. A significantly higher proportion of South Asian women used hanging (28%) and burning (31%) as methods; the latter being non-existent in the general population data for that time period and accounting for only 3% of South

Asian male deaths.

Raleigh et al. (1990) found marital status to be an important factor; 1971 Census figures showed that 57% of young Asian women (15-24) were married, whilst in the sample of suicide mortalities in young Asian women of the same age group, 83% were married. In the general population, suicide mortality is more likely in men, the elderly and people who are widowed or divorced. In South Asians, deaths from suicide are more likely to occur in young, married females. In the 15-24 age group, the death rate was 80% higher in young Asian women than in the general population.

Religion was determined on the basis of the names of the deceased. Although not a wholly reliable exercise (e.g. surnames such as Patel can be either Muslim or Hindu), this gave some indication of differences. Of the death certificates used in the sample, 83% of the women and 69% of men were Hindu. Muslims made up only 15% of the women and 26% of men. This was consistent with data presented by Maniam (1988) as cited in De Leo (2002).

Raleigh et al.'s (1990) study was important in determining actual death rates and comparing them to expectancies from the general population. However, since the study only looked at deaths officially classed as suicide and did not include those classed as 'undetermined', it may have missed even more South Asian deaths by suicide. In the National Suicide Prevention Strategy for England (DoH, 2002), the figures quoted for numbers of suicides include both suicide verdicts and 'undetermined injury', since 'undetermined' deaths are known to be mainly suicides and the authors argue that it is conventional to include them in suicide statistics.

Since burning was such a common method used in young Asian women, there may also have been a case for including deaths as a result of 'accidental fires'.

Raleigh (1996) later conducted similar research using the latest mortality data available, for suicides between 1988 and 1992 in the UK. Women aged 15-64, born in East Africa, Sri Lanka and India were approximately 50% more likely to commit suicide than women in the population as a whole (DoH, 1998). Women born in Pakistan, the Caribbean and Bangladesh had considerably lower standardised mortality ratios (SMRs). At present, country of birth, *not* ethnicity is recorded at death by coroners, which prevents accurate rates of suicide in different ethnic groups being studied. However, the increasing evidence of the vulnerability of certain ethnic groups to suicide has prompted the National Institute for Mental Health in England (NIMHE) to call for action to be taken to ask the Coroners Review Group to consider routinely recording ethnicity to allow monitoring (DoH, 2002).

More recently, Bhugra and colleagues (Bhugra, 2002; Bhugra, Baldwin, Desai & Jacob, 1996b; Bhugra et al. 1996a) reported from studies conducted in West London, in which all patients (aged 18-64) presenting to Accident and Emergency services, psychiatric or medical wards were screened. Rates of attempted suicide were highest in South Asian women, when compared with those of men and women in all other ethnic groups (Black, White and Other). When rates were broken down into age-specific categories, South Asian women aged 18-24 were nearly three times more likely to attempt suicide than White, female, age-matched controls and nearly seven times more likely than Asian males in the same age group. In an earlier study, Bhugra, Thompson, Singh and Fellow-Smith (2003) demonstrated that inception

rates for attempted suicide amongst White and Asian teenagers were similar, as were adjustment reactions, rates of alcohol and drug use and peer and relationship problems. Bhugra (2002) concludes that since rates are similar among adolescents, and that over the age of 24 differences also disappear, there seem to be certain factors that trigger vulnerability to self-harm particularly for Asian women in the 18-24 age-range. When comparing the Asian experimental group with age-matched Asian controls, he found that the suicidal group were less 'traditional' as measured by the Cultural Identity Schedule (Bhugra et al., 1999b) and more likely to have mixed race relationships.

People from South Asia have been migrating to Britain since the 1950's and 1960's. Poor economic climates, politics and war have led hundreds of thousands of South Asian men and women to leave their families and homelands to settle in Britain. Certainly these issues, coupled with being met with racism and hostility in Britain and beginning a life in a country where both language and culture are unfamiliar may have led to significant and long-term distress. However, consistently higher rates of suicidal behaviour in South Asian women have been found when compared with both White women *and* South Asian men. The life experiences of South Asian immigrants then, cannot in themselves account for why suicidal behaviour is higher in *women* and as much as 2 to 3 times higher than the national average in younger women. When looking at which cohorts may be most at risk, recent studies show that second generation young Asian women are also at risk, without the same language and cultural barriers their parents would have been confronted with. Amongst South Asian women, religion seems to play an important part in that Hindus seem to be most at risk of suicidality.

Prevalence of Suicide in Young Asian Women in Asia

Research is relatively scarce on suicide prevalence rates in the Indian subcontinent, due to legal and cultural barriers affecting the reporting of suicides. In Pakistan (Khan, 2002), India (Murthy, 2000) and Sri Lanka (Marecek, 1998) suicide is a criminal offence punishable with a jail term and a heavy fine, although most cases are not prosecuted in Sri Lanka (Marecek, 1998).

Khan (2002) states that in Pakistan, to avoid harassment by the authorities, many people who have committed suicide are taken to private hospitals where they are recorded as 'accidental' deaths. In both India and Pakistan, attempted suicide carries considerable social stigma for the family, sometimes resulting in the family being ostracised and marriage prospects for the survivor, if female, being considerably reduced, adding to family shame. Condemnation of completed suicide is also common; women who have killed themselves are suspected of sexual misconduct, except when the cause is clear, such as following a rape or dowry dispute (Lester, Agarwal & Natarajan, 1999). For all these reasons, it is generally accepted that suicide attempts and completed suicides in the Indian subcontinent are significantly underreported and that the figures available for these countries are well below actual prevalence rates. At present, only Sri Lanka reports its suicide statistics to the World Health Organisation.

The following studies give an estimate of prevalence rates of suicide and attempted suicide for women in Asian countries. They are not all directly comparable to the data presented for UK rates, since UK rates mostly give comparisons to the general population. The limited UK studies looking at completed suicide in Asian women do

not give comparable rates per 100,000 population as is presented in Asian studies.

Raleigh et al. (1990) discuss their findings in terms of their similarity to the *pattern* found in India (i.e. higher rates in young, married women) but actual rates are not compared. Merrill & Owens (1988) make comparisons of the rates of self-poisoning found in their study with those in country of origin and conclude that they are much higher in immigrant groups in the UK. However, as will be demonstrated by the following studies, rates of actual death by suicide are hard enough to come by; rates of self-poisoning are certainly fairly unreliable. One striking difference in suicide rates for Asian women in the UK is when male to female ratios are calculated. In almost all cases in country of origin, males outnumber females slightly in both attempted and completed suicide data. As noted previously, in the UK, Asian females have significantly higher rates than Asian males (Raleigh et al., 1990; Bhugra, 2002).

Suicides in the Indian subcontinent are high; 10% of the total world's suicides take place in India, Pakistan and Sri Lanka (Khan, 2002). Generally, the picture of suicides in India suggests that more males commit suicide than females, except data from Bannerjee, Nandi and Nandi (1990), which suggests that the rate in females is higher. The difference however, is not great and the relative similarity in rates for males and females in India is in stark contrast to ratios in Western countries where males outnumber females 3:1 or 4:1.

Suicide rates in India have been gradually increasing from approximately 6 per 100,000 population in the 1980's to 11 per 100,000 in 1998 (WHO, 2004). There are considerable regional variations; for example, the state of Kerala has a rate of 29 per

100,000 and when these figures are corrected for underreporting, they are even higher (Lester, 1998). Girdhar, Dogra and Leenaars (2003) collected data from the National Crime Record Bureau (NCRB) in India and found similar rates of suicide from 9.7 per 100,000 in 1995, generally increasing each year to 11.2 per 100,000 in 1999. The male to female ratio confirmed findings in the literature of an approximate 60% to 40% (1.45:1) ratio. This ratio has been generally stable since 1988 (Mayer & Ziaian, 2002) and is remarkably different to the picture in the Western world where men outnumber females from 3:1 in Scotland to 5.1:1 in Ireland with other Western countries such as Australia, Canada and the U.S. falling somewhere in between (WHO, 1996).

Most completed suicides of South Asian females in the Indian subcontinent have been committed by those less than 30 years of age. Narang, Mishra and Mohan (2000) studied 100 people presenting to a hospital in Ludhiana, India, from August 1996 to October 1997 and found that although males outnumbered females overall, there was a greater proportion of female attempted suicides in the 21-29 age group. Married females outnumbered married males and significantly fewer females had a diagnosable mental illness. Mayer and Ziaian (2002) looked at data from the NCRB and found that between 1995 and 1997, the rate of suicide in under 14's and 15 to 29 year-olds was higher in females than males. The picture in India, therefore, bears similarities to that in the UK concerning young Asian women.

Data from Pakistan is much more scarce. As stated earlier, due to religious and legal barriers, suicide remains under-researched in this country. Pakistan does not report its mortality statistics to the World Health Organisation, nor are national suicide

statistics compiled. Javed (1996), cited in Murthy (2000), studied depressed patients in a hospital in Pakistan and found that 45% of those studied showed suicidal psychopathology. Suicidal ideation was greatest in females.

Khan and Reza (1998) performed a retrospective case-note analysis of people referred to a psychiatric department of a (private) university hospital in Karachi, Pakistan, following a suicide attempt between January 1989 and July 1995. Under law, cases of attempted suicide must be taken to a government hospital designated as a 'medicolegal centre' in order for the police to conduct an inquiry (due to the legal status of suicide in Pakistan). In practice, many people are taken to private hospitals to escape recrimination. Data was collected only for nonfatal suicide attempts. In keeping with other suicide literature, suicidal behaviour was most common in young people (67.1% of the females and 61% of the males were 16-29 years old) and women outnumbered men. Gender differences were significant with regard to marital status; females were more likely to be married (53%), and males, to be single (57.2%). Another striking finding was level of education. In a country where overall literacy is approximately 30% (43% for males and just 18% for females), 64% of the male participants and 62% of the females had at least 6 years of education. It was noted, though, that this might be reflective of the particular sample rather than reflective of the general population of those attempting suicide. Khan and Reza (1998) discussed the gender differences noted in terms of Pakistan's social, economic and legal discrimination against women. It is unsurprising in an atmosphere of little freedom and independence that the women in the sample gave conflict with family, spouse or in-laws as the major reasons for their suicidal acts.

Khan and Reza (2000) later performed a 2-year analysis of newspaper reports of completed suicide in Pakistan. Despite the social and legal difficulties in reporting suicide described earlier, incidents of suicide are regularly reported in newspapers in Pakistan, and the authors argue that in the absence of other means, they serve as useful information on suicide mortality. They found that over a two year period (1996 and 1997), 306 suicides were reported; 68% male and 32% female. The women were younger than the men (mean age of 23.4 years and 26.8 years, respectively) and 82% of the sample were younger than 30 years of age.

Khan and Reza (2000) confirmed previous findings of gender difference in marital status with more women being married and more men being single. Although the validity and source of the data were not satisfactory, this study confirmed previous findings of suicide being more prevalent in young people and in married rather than single women. The authors also argue that the relatively small numbers of suicides reported in comparison to the country's population is probably due to difficulties mentioned elsewhere rather than being reflective of the actual number of suicides occurring. Certainly this country warrants further robust research into suicide and attempted suicide.

The data available from Bangladesh is extremely limited. For the whole country, there is only one 400-bed psychiatric hospital, and only approximately 40 psychiatrists (Murthy, 2000). There is no crisis centre in Bangladesh, and suicide statistics take a back seat in a country where infectious diseases, sanitation and housing are the priority. An overall estimate by WHO (2004) suggests that between 1992 and 1993, the rate of suicide in Bangladesh was approximately 10 per 100,000.

Anecdotal evidence in addition to media reports suggests that the majority are young, illiterate urban residents, and that more women (58%) are committing suicide than men (42%) (WHO, 2004).

Sri Lanka has the highest suicide rate in Asia and one of the highest in the world (Marecek, 1998). Suicide and attempted suicide have become a public health priority in this country (Cheng & Lee, 2000). The suicide rate has risen from 18.2 per 100,000 in 1971, to 40 per 100,000 in 1996 (Murthy, 2000). Acute pesticide poisoning is a major public health problem; a readily available means to commit suicide in a country where 78% of the population are rural farmers (Marecek, 1998). Sri Lanka has the highest rate of attempted suicide in young people, especially in females since 1990 and there is evidence to suggest that these figures may be subject to substantial under-reporting, so that actual figures may be more like 44-50 per 100,000 (WHO, 2004). Ratnayake (1996), cited in Marecek (1998), suggests that death by suicide in some regions of Sri Lanka has risen to 118 per 100,000. In the 1970s and 1980s, the ratio of male to female deaths by suicide was similar to Western countries (3:1). However, during the 1990s, female suicide mortality increased at a faster rate than for males such that by 1995 the ratio was 2.76:1 (Marecek 1998).

Higher suicide rates in Asians have been found in other countries. In Saudi Arabia, Elfawal (1999) examined cases of suicide at a medicolegal centre and found that immigrants formed 77% of the cases, despite only constituting 25% to 30% of the population. Of these, Asians accounted for 70% of cases and Indians in particular showed the highest suicide rates (43%), although the total rate of suicide was found

to be low, at 1.1 per 100,000. Males outnumbered females in all the racial groups except for Indonesians and Sri Lankans, where there were more female deaths. Asians employed more violent methods than any other group.

Maniam (1988), as cited in De Leo (2002), found higher rates of suicide in young Hindu Asian women in Malaysia compared with the rest of the population and discussed this in terms of 'the ambivalent attitudes of Hindu religion towards suicide', in contrast with Islam, which strictly forbids it.

Wassenaar, van der Veen and Pillay (1998) presented case studies of nonfatal suicidal behaviour by Indian women in South Africa. Although rates of suicide in this group (3.4 per 100,000) are lower than that for South African White women (5 per 100,000) they argue that young Indian females are over-represented in suicide attempts at the general hospital in South Africa where they work. The highest suicide mortality within South African Indian females is in the 15-24 age group, in line with findings in other countries. In the literature the authors reviewed, other previous findings were also confirmed in terms of more Asian females being married than single.

Singapore is multi-racial, with the main racial groups being of Chinese, Malay and Indian origin (Ho Kong Wai & Heok, 1998). These authors studied case notes of people presenting to a university hospital following attempted suicide in Singapore, and compared the racial groups above, between 1991 and 1995. Indians were found to have a higher risk of parasuicide than the other two groups, with Indians accounting for 17.2% of all cases despite comprising only 6.5% of the population. Females outnumbered males across each year studied, with the overall male to

female ratio being 1:2.6; young females being most at risk (60.5% of all cases). Gender differences were not given as a function of racial group.

In summary, young Asian women seem to be at greater risk of suicide than older Asian females and Asian males of the same age in most studies in other countries of origin, similar to findings in the UK. Consistently, women under 30 and those who are married are at greatest risk. Islamic nations seem to have lower rates than other nations, with Sri Lanka having the highest suicide rates in Asia.

MODELS OF SUICIDE

The prevailing models of suicide have been constructed from Eurocentric perspectives and may be of limited use in explaining high rates of suicide in young Asian women. The editors of the *International Handbook of Suicide and Attempted Suicide* (Hawton & van Heeringen, 2000) acknowledge that most of their contributors are from the Western World, reflecting perhaps the particular attention that is paid to the topic in these countries, in turn reflected in the research and explanatory models available.

Within Western perspectives, there are mainly two broad schools of thought in regard to suicide causation: (i) the medical model, with a view of suicide as an expression of an underlying mental disorder (which may be tautological as suicide is often taken as proof of an underlying disorder) and (ii) the diathesis-stress model, concentrating on the importance of the social framework in which suicide occurs. Other models seek to combine all known risk- and protective-factors in order to understand and assess suicide risk (e.g. Sanchez, 2001). Western perspectives do also

acknowledge the possibility of ‘rational suicide’ – with a presumption of reasonable choice by a terminally ill person; although, in the West, suicide in the absence of a mental illness is considered a rare occurrence.

Current knowledge on risk and protective factors for suicide is based on research conducted on White Western populations. As some of these models are reviewed below, it can be seen that they may provide an understanding of suicide in young Asian women, for *individual* cases. None of the empirical research, however, includes the cultural factors necessary to understand an elevated risk in a whole group.

The Medical Model

The medical model suggests an increased risk of suicide in people suffering from an underlying mental disorder. The problem is conceptualised as within the individual and as such, pharmacological treatment of the underlying disorder is typically used to decrease suicidality. Suicide risk is apparently elevated in all mental disorders, but particularly so in depression (Lönqvist, 2000). Suicidality is also greater in people with bipolar-affective disorder (BPAD) (e.g. Harris & Barraclough, 1997) and a major risk in psychotic patients (e.g. Haddock & Tarrier, 1998). This leads authors (e.g. Lönqvist, 2000) to suggest that for effective suicide prevention we must look at the best possible treatments for the underlying disorder.

More than half of clinically depressed people have suicidal thoughts, with suicidal ideation significantly related to severity of depression. Suicide is the main cause for increased mortality in depressed people and research suggests that depression is

found in 29-88% of all suicides (Lönqvist, 2000, in a review of 12 studies of suicide). Harris & Barraclough (1997) reviewed literature on psychiatric diagnoses and suicide between 1966 and 1995, finding that the mortality risk for suicide was 20 times the expected rate in all affective disorders. Other studies similarly find an elevated rate of completed suicide in people with depressive disorders (e.g. Wulsin, Vallant & Wells, 1999). However, most of these studies, where specified, were conducted in the Western world and most likely with White participants; no specific literature looked at psychiatric diagnosis and suicidality in different ethnic populations. The very high range in percentages of suicide linked to depression found in the review by Lönqvist (2000) suggests that many other different mechanisms may be implicated.

When investigating cause of completed suicide, the 'psychological autopsy method' is used. This is a retrospective reconstruction of the life, personality, and state of mind of the deceased person from records and interviews with others. None of the studies examining suicide in young Asian women used this method. Evidence for the presence or absence of depression and other affective disorders therefore comes from studies on young Asian women having presented at hospital with some form of suicidal behaviour. These studies consistently show an absence of psychiatric disorders amongst young Asian women attempting suicide, although a more comprehensive analysis of people already deceased via psychological autopsy may provide a clearer picture.

A similar wealth of evidence is available for the link between schizophrenia and suicide risk (e.g. De Hert & Peuskens, 2000). Approximately 10% of patients

suffering from schizophrenia kill themselves – the risk of suicide being 40 times higher in this population than in the general population. Alcoholism, along with other substance abuse has been recognised as a major contributing factor in suicide (Murphy, 2000). Substance abuse has been shown to be significantly lower in South Asian people than White people attempting suicide. Merrill and Owens (1986) found that the incidence of alcoholism was similar in Asian and White males attempting suicide, but that no Asian females had alcoholism diagnosed. Significantly fewer Asians (both males and females) had previously self-poisoned or received previous psychiatric treatment in their study. It should be noted, however, that previous psychiatric history may not be an accurate indicator of mental disorder because members of ethnic minorities are less likely to access mental health services (DoH, 1999). Asian people may also be less likely to disclose previous difficulties than their White counterparts, due to the particular shame and stigma surrounding mental disorder in Asian communities. However, significantly fewer Asians received a psychiatric diagnosis by the assessing psychiatrist in Merrill and Owens' (1986) study and personality disorder was also diagnosed in significantly less Asians than White patients. The medical model suggesting increased risk in those suffering from a diagnosable mental disorder or substance abuse does not seem appropriate for most young Asian women, with findings for this group consistently showing an absence of such disorders.

Diathesis-Stress Models

The diathesis-stress-hopelessness model of suicidal behaviour (Schotte & Clum, 1987) proposes that predisposed cognitive rigidity (reflected in an inability to identify problems and their solutions) mediates the relation between life stress and

suicidal behaviour. Specifically, this model predicts that when under naturally occurring conditions of high life stress, certain individuals are cognitively unprepared for adaptive coping. This in turn leads to hopelessness and more risk of suicidal behaviour. The model focuses on four factors: life stress, cognitive rigidity, interpersonal problem-solving deficits and hopelessness, which the authors note have all separately received empirical support in studies of suicidal behaviour. A model including a predisposition, significant stress and resulting hopelessness about a situation does seem compelling. However, it would not appear to explain why suicide risk should be higher in young Asian women.

Little research has addressed the question of what hopelessness actually is – we do not fully understand the characteristics or predictors of it. Intuitively, hopelessness may contribute to suicidality in young Asian women, and may fit in a model including appropriate cultural issues such as restricted life choices leading to a feeling of hopelessness. However, this has never been examined specifically for young Asian women.

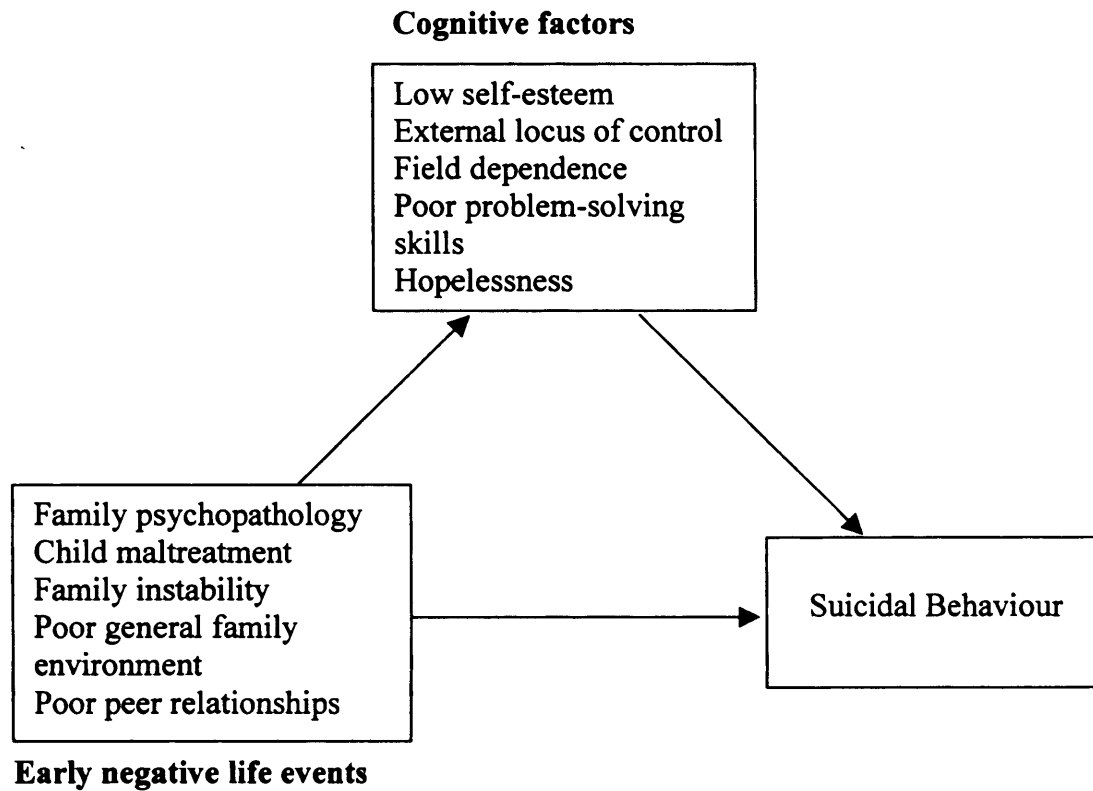
Schotte & Clum (1987) state that suicide ideators report four times as many negative life events in the 6 months preceding their attempt than do nonsuicidal people. However, what little research there is on young Asian women reveals that events leading to distress are not confined to specific negative life events such as abuse or bereavement, but include more chronic life issues such as lack of freedom and independence. Problem solving ability has not been specifically studied in Asian suicide attempters but a general deficit in this ability seems unlikely in young Asian women and as such does not add to an understanding why they might be a

particularly vulnerable group.

In a review of the literature addressing the aetiology of suicidal behaviour, Yang and Clum (1996) cited empirical evidence linking early (negative) life events with suicidal behaviour, early life events and cognitive variables, and cognitive variables with suicidal behaviour. Using the evidence gathered, they proposed a hypothetical model (see Figure 1.)

The early negative experiences they reviewed centred around family psychopathology (e.g. alcoholism, depression), child maltreatment, family instability (e.g. parental death or divorce) and family environment (e.g. extremes of permissiveness or control). Varying degrees of these early negative life experiences are all, sadly, realities in both Western and South Asian cultures, although there may be less alcoholism and divorce in Asian families due to cultural traditions inhibiting them. Certainly the studies Yang and Clum (1996) cited were based on White Western populations. Extremes of parental control certainly seem to have been implicated in the psychological distress of young Asian women from their accounts (e.g. Yazdani, 1998) but this alone is too simplistic an account for greater suicide risk in young Asian women. Again, although this model may fit for some young Asian individuals, it does not add to an understanding of why a cultural group as a whole has a greater vulnerability to suicide.

Figure 1. Proposed Etiological Model of Suicidal Behaviour (Yang & Clum, 1996)



Studies looking at specific risk factors and protective factors have been based on White Western populations, as this is where most of this research takes place (van Heeringen, 2001). Sanchez (2001) reviewed the literature and combined all known risk and protective factors to provide a comprehensive model for suicide assessment and intervention. Risk factors were categorised as historical, personal, psychosocial-environmental and clinical. Among historical factors, Sanchez (2001) included any demographic data that statistically places an individual at higher risk than others, with mental illness as the strongest risk factor. Other historical factors include prior suicidal behaviour and childhood abuse. As has been argued previously, mental illness is not a common risk factor in young Asian women.

Personal risk factors pertain to the characteristics that define an individual's personality, including cognitive style and personality traits. Amongst these, Sanchez (2001) lists personality disorders, distorted cognitions and inadequate impulse control. Psychosocial-environmental factors are events that may create stress or contribute to a breakdown of a person's support systems such as recent relationship problems and sexual identity issues. Finally, clinical factors are the specific behaviours that are suggestive of suicide planning and changes in mental state. Some of the protective factors reported that lower suicide risk, are support systems, satisfying social life, marriage, employment and religion, culture and ethnicity (Sanchez, 2001).

Sanchez' (2001) model does not seem adequate in assessing, understanding or intervening in suicide risk for young Asian women. The research on risk and protective factors on which his model is based, was conducted in Western contexts

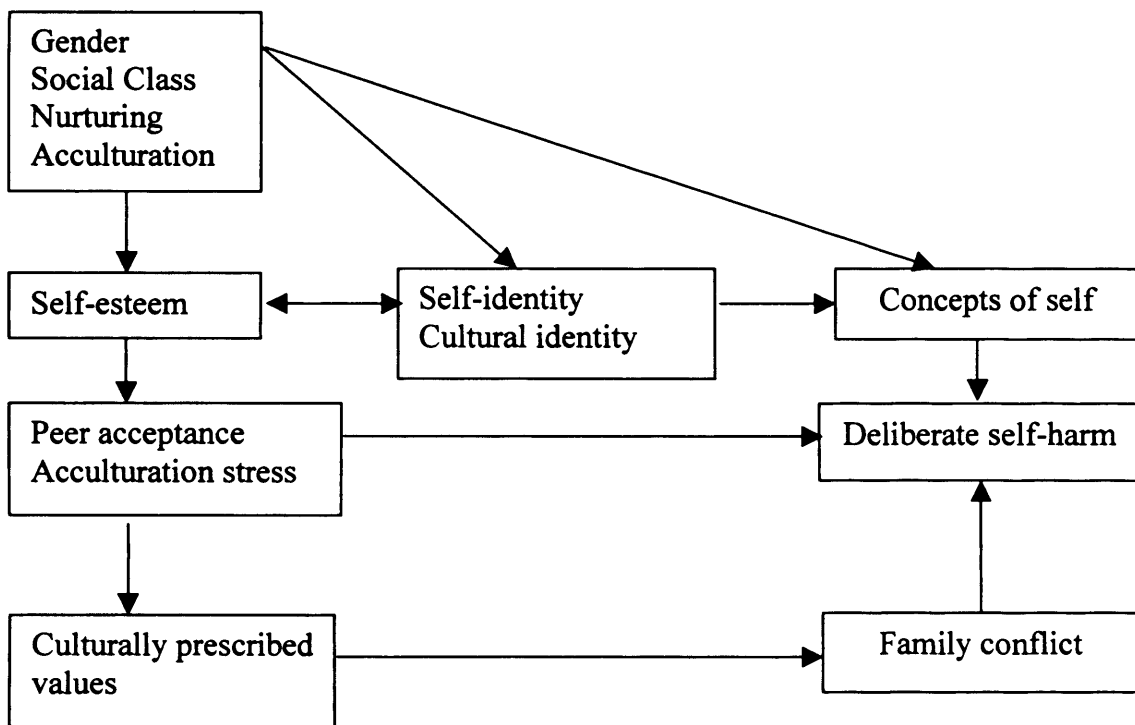
on mainly White Western individuals. Asian and White individuals may share some risk factors; e.g. based on the limited data available, difficulties in significant relationships may be common precipitants for suicidal behaviour in young Asian women (e.g. Yazdani, 1998) as well as in White populations (e.g. Sanchez, 2001). However, others are clearly not relevant to young Asian women such as marriage as a protective factor. Suicidality in young Asian women may be more impulsive, less planned, include specific factors pertinent to their lives and cannot be directly mapped onto models based on Eurocentric perspectives. Thus, there is a need for a model incorporating specific cultural issues relevant to young Asian women's experiences.

Marecek (1998) discusses cultural meanings of suicide in Sri Lanka. She argues that in this country, suicide is rarely conceptualised in terms of a mental illness or psychological disorder. If attending hospital, suicidal individuals are admitted to medical wards, not psychiatric ones and then discharged. Psychiatric facilities are not regarded as necessary or useful, reflecting the prevailing attitude in Sri Lanka, which seems to be that suicide is a likely impulsive reaction to a discrete crisis.

Thomson & Bhugra (2000) proposed a conceptual model of aetiological factors for suicidal behaviour in young Asian women based on a review of the literature available. They suggest that in addition to the pressures exerted on all young people regardless of ethnicity, a different set of pressures, which are culturally unique to Asian females, may increase the risk of suicide. They argue that it is neither sufficient nor adequate to ascribe the cause of suicidal behaviour to 'culture conflict'. More research is needed to understand what is meant by this term and why Asian

females are affected more than Asian males. Their proposed model is shown in Figure 2.

Figure 2. Interrelations of factors in deliberate self-harm in young Asian females (Thompson & Bhugra, 2000).



Thomson & Bhugra's (2000) model includes concepts of self-identity and self-esteem important in an individual's development. They relate these concepts to a higher risk of suicidal behaviour in young Asian women who may have left home to study independently at college or university, but do not explain *how* self-identity is affected. Similarly, culturally prescribed values and conflict with family is taken into account, without an explanation of the mechanism by which these issues may lead to self-harm. What may be lacking in this model are the cultural concepts of *sharam* and *izzat* – shame and family honour, which Bhugra (2002) agrees are extremely important in the Asian community and warrant further research. These concepts are discussed in more detail later.

In summary, risk and protective factors may vary remarkably in different cultures (De Leo, 2002). Psychiatric diagnoses are associated with elevated risk of suicide in Western populations, (e.g. Lönnqvist, 2000) whilst South Asians attempting suicide have been shown to be significantly less likely to be suffering from a mental disorder than their White counterparts (e.g. Merrill & Owens, 1986). Marriage is considered a protective factor in Western models of suicide (e.g. Sanchez, 2001), but conversely a risk factor for young Asian women (e.g. Raleigh et al., 1990). Western perspectives have regarded suicidal behaviour as an expression of mental illness, as resulting from negative early life events and/or specific natural life stressors and as combinations of these. They have failed to take into account the cultural relativity of norms and concepts of mental health. Suicide, as discussed later, has been regarded in some cultures as normal and even obligatory. It is clear that current models do not provide an adequate account of higher risk in young Asian women.

RELIGION, RESTRICTION AND ROLE CONFLICTS:

THE MEANING OF SUICIDE

Epidemiological studies have been useful for establishing the relatively high rates of suicide and attempted suicide in young Asian women, but very few studies have explicitly set out to explore the *reasons* and *meaning* behind these acts. Some epidemiological studies discussed below, have included information in their results about what respondents said regarding their suicide attempts to the researchers. However, researchers' conclusions about causal mechanisms and precipitants to distress may not explain the whole picture for a number of reasons, which are discussed below.

The epidemiological studies described below were not designed to further our understanding of the suicidal act *per se*; they were primarily designed to discover rates of suicidal behaviour. Respondents may not have been fully honest about possible precipitants of their suicidal behaviour for various reasons. Timing may also have been a significant factor; respondents were interviewed in hospital following their suicidal behaviour, thus at a time when distress levels were probably very high and they may not have been able to frankly discuss factors leading to personal distress and suicidal behaviour.

Many studies report that a percentage of individuals seen at hospitals following a suicide attempt went home before researchers could interview them and were not contactable thereafter. Significant findings on suicide precipitants may have been missed in those least likely to want to be interviewed. Later, I discuss conceptualisations of shame in Asian women. If the women in the studies above

were fearing shaming their family, or feeling that they had brought shame upon themselves, they would be unlikely to disclose this to researchers.

There are a number of interesting differences found between Asian and White groups presenting with suicidal behaviour. Asians who self-poison are more likely to be young, married and female than White controls (Wright et al., 1981; Merrill and Owens, 1986). Amongst completed suicides in Asian females, there has also been a consistent finding that the women are more likely to be young and married, both in the UK (e.g. Raleigh et al., 1990) and in other Asian countries (e.g. Narang et al., 2000). In addition to these findings, Merrill and Owens (1986) found that Asians were less likely to have previously self-poisoned, received previous psychiatric treatment or to have been diagnosed with any psychiatric illness. This conflicts with the medical model account of risk factors for suicide discussed earlier. Asian females in their study also reported marital problems significantly more than White females. This was reported in the paper as due to 'culture conflict'. In a discussion of their findings, Wright et al. (1981) cited 'transcultural' problems as common in the female Asian group in their study. Glover et al. (1989) suggested that unmarried adolescent girls might face 'culture conflict' around family discord over differing Asian and Western lifestyles and Maniam (1988), as cited in De Leo (2002), discussed parental disapproval in marriage as one area that led to conflict in his sample.

The term 'culture conflict' employed in the studies above was a term coined by the authors to describe the range of difficulties that participants were reporting; it was not used by the study participants themselves. The data collected on cultural and marital difficulties, previous attempts and psychiatric treatment were dependent on

information supplied by the patient. It is highly possible, perhaps even probable that many individuals did not feel able to discuss highly sensitive and emotive reasons behind their suicide attempt and were unwilling to disclose certain information (e.g. under-reporting racial prejudice when interviewed by a White psychiatrist). Therefore, as will be argued later, using the term 'culture conflict' without an operational definition of what this means may not account well for the distress that leads to suicidal behaviour in young Asian women.

It is useful at this point to discuss the ideas of *individualism* and *collectivism* in relation to how traditional Asian and Western cultures differ. Attempts have been made by researchers (e.g. Triandis, 1995) to classify cultures according to whether they are group-orientated (collectivist) or individual-orientated (individualist). Generally speaking, Western cultures are considered individualist; namely individuals are relatively autonomous and independent from their in-groups. Personal goals in individualist cultures are given priority over the goals of the in-group and people behave primarily on the basis of their own attitudes rather than the norms of their in-groups (Triandis, 1995). In practical terms, this generally means for the individual growing up, that he or she is encouraged to follow his/her own path, make his/her own decisions and to generally live his/her own life.

In contrast, collectivist cultures such as Asian cultures give priority to the goals of the community rather than the individual. The self and family are integral concepts and each member of the community is expected to make personal sacrifices such that an individual may suffer for the good of the group as a whole. For Asian people, this means being brought up to be obedient and to behave in a way so as to bring honour

to the family by personal behaviour, maintaining high academic standards and by contributing to the well-being of the family (Farver, Narang & Bhadha, 2002). The individualist-collectivist distinction is particularly important when discussing concepts of shame in Asian culture later.

In one of the few studies specifically exploring the meaning of suicidal behaviour in young Asian women, Yazdani (1998) conducted focus groups with Asian women aged between 14 and 30 years, with discussions guided by various vignettes. In addition, in-depth interviews were conducted with the young Asian women who had a history of DSH. Yazdani (1998) also looked at the views of service purchasers and providers and professionals directly working with Asian women who had self-harmed.

Yazdani (1998) found that issues leading to distress in young Asian women were: conflicting roles, living dual lives, transitions to different life stages, domestic violence, lack of freedom at home, absence of avenues in the family to tell someone about their distress, racism, bullying at school, sexual abuse, poor relationships in the family, and physical and emotional abuse in marital or other significant relationships. Professionals upheld the stereotypical view of 'culture conflict', which Yazdani (1998) suggests may lead to a perception that the problem is beyond the influence of health and social care. The young Asian women interviewed did not themselves feel that *culture* conflict adequately described what had led to distress. This mismatch may be due, in part, to differing understandings of what 'culture conflict' actually means. The term may suggest to some, a preference for living in the Western culture rather than the Asian one. Many women in Yazdani's (1998) study felt that they did

identify positively as bicultural women; respecting Asian values as well as integrating into Western society. What was difficult was negotiating their differing roles within Asian and Western contexts and being able to access sources of support. Some aspects of Asian culture were certainly implicated; restrictive parenting being one such aspect, but the Asian women in the study did not feel that the term 'culture conflict' *per se* accounted well for their experiences.

Marshall and Yazdani (1999) reviewed the literature on suicidality in young Asian women and similarly found that the prevailing explanations for the increase in suicidality in this group were mainly around the term 'culture clash'. They argued that this term has not been precisely defined in the literature and is generally taken to relate to the mismatch between traditional Asian cultural values and British ones. However, the evidence reviewed below does not support a simple 'culture clash' model of suicidality in young Asian women.

In Marshall and Yazdani's (1999) discursive analysis of the accounts of the women interviewed in the Yazdani (1998) study, constructs of DSH included release from distress, effecting change, taking control and ending it all – similar to those found in White British women who have self-harmed. However, in addition to these, they also found that certain elements of Asian culture were reported. These included pressure to get married by a certain age and failure to fulfil gendered family expectations (where concepts of *izzat* and *sharam*, defined later, were central). The adherence or not to these expectations were not simply an issue for the individual concerned or her family, but related widely to the family's standing in the community. The authors concluded that the term culture clash does not fully account for, or seem concordant

with women's own accounts of the reasons behind their self-harm and suicide attempts. As they argue, the studies using the term 'culture clash' have rarely examined self-accounts of the women and rely on the (often White) researcher's assessment of 'culture' as causative of self-harm.

Notwithstanding the limitations of the term 'culture conflict', Marshall and Yazdani's (1999) assertion that the term implies that Asian culture is pathogenic in itself seems exaggerated. Indeed, it is clear from the literature discussed in this section, that many Asian women do feel trapped in patriarchal and oppressive practices. It is also clear that the same women value other parts of Asian culture such as family cohesion. The problem lies in a misunderstanding of the term 'culture conflict' and in not specifying what it is about certain cultural practices that may lead women to intense distress.

Ghuman (2001) discusses differing roles within Western contexts and Asian (usually home) contexts in relation to Asian girls' experiences in school. He reviewed literature that discusses teachers' views of Asian girls' experiences, putting forward a viewpoint that simply applying the norms of the indigenous (White) society and concluding that Asian girls who lack the autonomy of their White peers must be miserable and need help, is not useful in alleviating the difficulties of young Asian women. It is clear that a better-informed view, including Asian women's experiences of cultural difficulties as well as strengths is needed.

Young Asian women's personal accounts seem to implicate Asian culture in diverse ways, including lack of access to pathways of support and care (Yazdani, 1998). A

common theme seems to be Asian ideals of honour and shame; that it is better not to speak about abuse or mental distress, that failure in education or career path is unacceptable, and that women's prescribed roles cannot be argued against.

Restrictive parenting in Asian families has been implicated in the distress of young Asian women. In a retrospective study, Pillay (1987) searched clinical records of 55 Indians aged 15-23 years who had been admitted to a general hospital in South Africa over a six-month period, following parasuicide. The sample was made up of 42 females and 13 males. Primary problems precipitating suicidal acts were extracted from files and categorised into 8 areas: boyfriends/ girlfriends, parents, school, siblings, marriage, work situation, medical/ psychiatric illness and other. No one had reported more than one problem area. The two main difficulties found were with parents (67.3%) and boyfriends/ girlfriends (16.4%). The difficulties arising with parents related to not being allowed to socialise or engage in relationships. The authors cited attempts at freedom being thwarted by parents as another difficulty - a conflict between a Western lifestyle and the relative freedom of peers that young Asian people were exposed to, and the restrictions placed on them by parents.

Handy, Chithiramohan, Ballard and Silveira (1991) compared 25 Asian adolescents with 25 White adolescents (average age 14-15 years) who had been referred to a child guidance clinic following DSH over a 5-year period. Participants were matched for social class and compared via case notes. The authors found that disciplinary crises were the most common precipitant for DSH in *both* groups. Since discordance between peer groups and parental views were expected in both groups, they only termed factors as cultural conflicts when the disagreements were about specific

issues such as religion, or moral and traditional expectations. With this in mind, 'cultural conflicts' (arguments about Western dress, relationships and friendships with White peers) were found to be the most important factor in the suicidal behaviour of Asian adolescents, whereas a wide variety of factors accounted for the suicidal behaviour of Caucasians. Disrupted family background was the predominant precipitant in White adolescents. The authors discussed limitations of their findings in terms of a difficulty in applying a tight operational definition of cultural conflicts.

Despite the heterogeneity and diversity in Asian culture, it can be argued that there is a consciousness that is experienced collectively – the concepts of shame (*sharam*) and honour (*izzat*). It is interesting that in Urdu, Hindi, Gujarati, Bengali and Punjabi, the words *izzat* and *sharam* are understood to describe the same cultural concepts despite the diversity in these South Asian languages, some of which do not bear any resemblance to each other. *Sharam* in Asian cultures is used to describe a sense of modesty and decency. Asian people talk of *having* shame; a moral value, a sense of decency according to prescribed traditional Asian values. When used in the context of describing a person who 'has no shame', the accompanying mood is of disgust. It is also described as a behaviour; an act which you *do* to yourself or inflict on your family; "I have shamed myself" or "I have brought shame on my family". In another context, *sharam* can mean 'shyness'. It is a quality valued in Asian women; to be too confident and brash may be considered akin to not having any shame or morals.

Izzat translated directly means 'honour' in English. It is a concept closely related to shame for Asian people, as *izzat* relates to family honour. To shame one's family is

to affect the family *izzat*. Maintaining a standing in the community as a family that is 'decent' and moral is of utmost importance in collectivist cultures. These concepts are explored later in the work of Gilbert and others (Gilbert, Gilbert & Sanghera, 2003).

The concepts of *sharam* and *izzat* link to issues of morality, social standing and respect in Asian societies and, critically, *are expressed through the actions of women more than men*. As is evident in the writings of various young Asian women in 'Telling It Like It Is' (Kassam, 1997) discussed later, in Asian society, although all members are expected to behave in a manner that upholds honour, males are often given much more freedom than females. Issues of dishonour are often connected to a woman's sexuality, although the ramifications affect the whole family and its social standing within the community. This may have evolved from the fact that a woman's sexuality may be more visible than a man's, for example through pregnancy before marriage.

Shame and honour featured strongly in the focus group discussions in Yazdani's (1998) study. These concepts were implicated in the following: performance and succeeding in conflicting roles (e.g. maintaining high academic achievement at school and university whilst also learning to cook at home); a sense of feeling pressure to be 'perfect' at everything male members of the family (fathers and husbands) wanted; difficulty in maintaining a healthy concept of self identity – living in very different cultures, leading a 'double life' (e.g. freedom at university versus going home for holidays) and in transitions to different life stages such as marriage and a difficulty in breaking out of violent marriages for fear of shaming the family.

Ghuman (2001) also discusses traditional gender roles in Asian families; young women being brought up to 'be obedient and uphold the *izzat* of the family', with schooling and education planned in such a way so as to make them faithful and conforming wives.

Gilbert et al. (2003) looked at the concepts of *izzat*, shame, subordination and entrapment and their effects on mental health in South Asian women. Their study examined South Asian women's views on these processes by way of three focus groups discussing a series of vignettes, designed to tap into each of the four concepts described above. The women were grouped according to their age; 16-25 years, 26-40 years and 41 and over.

The key themes that emerged during the focus groups were as follows. Gilbert (2002) coined the term *reflected shame* to describe the concepts of *sharam* and *izzat* discussed earlier; related to family honour, reputation and personal reputation. The women described feelings of subordination, with subordination and control by (usually male) members of the family as ways of maintaining *izzat*. This links with the idea that *izzat* is upheld primarily through the behaviour of women, and that male members maintain *izzat* by restricting female members of the family in order to prevent them doing anything that would compromise family honour.

Entrapment was linked to fears of being disowned by family and the community due to a loss of *izzat*. Crucially, the women in this study felt that it would be better to commit suicide than to leave an abusive or unhappy marriage (which would damage family honour). This suggests that many Asian women may feel trapped; perceived

choices in such a situation were limited to either putting up with it, or escaping via suicide. Pressure to maintain *izzat* also prevented women from talking about their difficulties, which could then result in bottling things up to the point of trying to commit suicide. This is the only study to date, which demonstrates the enormous value placed on maintaining *izzat* in Asian families, particularly for the females in the family and directly implicates loss of *izzat* with suicidality.

Individual cases of suicide following a perceived loss of *izzat* or to prevent loss of *izzat* (e.g. instead of leaving an unhappy marriage) have been reported in the media (Astill, 2004; BBC News, 2004a; BBC News, 2004b). In an environment where an Asian woman has to *visibly* uphold family *izzat*, issues of personal space and privacy may also be more pertinent. In the studies by Yazdani (1998) and Gilbert et al. (2003), women spoke about personal feelings of intrusion and having no sense of personal space or privacy. Many women spoke about ‘moral’ situations being catastrophised by family members in a way that would be alien in Western culture; “they sentence you before you’ve even done it...” (Gilbert et al., 2003, p.11).

Evidence so far suggests a strong link between the particular constructs of shame and honour encountered in Asian communities and psychological distress in young Asian women. In Gilbert et al.’s (2003) study, women discussing the vignettes literally reported that suicide would be the best (least shaming) option in certain circumstances.

Similar themes leading to distress were discussed in ‘Telling It Like It Is’ (Kassam, 1997) – a collection of scripts in which British young Asian women aged 14-22

wrote about their lives. In these accounts, women discussed their communities not allowing them to speak freely, the stress of having to juggle many identities throughout the day and the fact that so many women face the same dilemmas but do not talk about them through fear of shame. *Sharam* permeated every part of these women's lives – acting one way with Asian peers so as not to sound too 'Western' but feeling trapped and wanting change. Women stayed silent for fear of judgement from others.

Restriction emerged as one theme from this book, pertaining to: educational level, speaking out against things they did not believe in and dating. Women discussed the extreme taboo of dating Black men, which was viewed as completely unacceptable and hidden even at college amongst peers. One woman discussed her life as a lesbian Muslim woman in hiding due to her very real fear of being killed by her father. Family pride and the woman's role as passive, subordinate and obedient emerged as another theme. In relation to the extreme importance of *izzat*, one woman was prohibited from seeking counselling for distress related to sexual abuse because of the shame of 'everyone knowing what's wrong with you'. One woman talked about her fear of failing at university and causing shame to her parents. Another important theme was the difficulty in forming a coherent sense of identity. Women discussed being accused of not 'knowing' their culture and language and this being shameful. There were difficulties in negotiating independent roles as something other than wife or mother. Women also reported feeling torn between their two cultures; wanting to be loyal and maintain the positive ideals of the culture they were brought up in, such as family security and respect for elders, but also wanting the 'good parts' of British culture such as respect for women and independence. From these qualitative

accounts, it seems that young Asian women are expected to reflect the morals and ideals of their family and community; the worth of a woman being defined by how she conducts herself. It was the fear of fathers' *izzat* being lost that led to a dual life in most cases, as women knew others whose families were treated as outcasts when their daughters had committed a social taboo such as running away from home.

'Emerging Voices' (Gupta, 1999) is a collection of articles written by South Asian women living in the United States. These accounts reflect similar themes regarding dating, marriage, self-identity and independence. One difference between these experiences and those from the British perspective (Kassam, 1997) appears to be that some Asian women in America felt able to run their family lives more independently than they would have been able to, had they been in closer proximity to an Asian community as is usually the case in the UK. It was the physical distance that seemed to free the women to live more independent lives with their husbands and children.

A simple model of culture 'clash' or 'conflict' therefore does not seem to adequately explain what leads young Asian women to distress. What may be more useful is to understand further how the concept of *izzat* affects how young Asian women feel about themselves and what it means to attempt to form a bicultural identity in terms of maintaining *izzat*. The distress that leads to suicide may have more to do with feeling *sharam* and fearing the loss of *izzat* (and the consequences of these) than simply clashing with family cultural traditions.

As has been mentioned previously, although most studies have looked at South Asian women as a whole; a heterogeneous group of Sri Lankans, Indians, Pakistanis and

Bangladeshis, with differing religions and beliefs influencing suicidal behaviour, there does seem to be a marked difference in the prevalence of suicide between women of different religions. Raleigh's (1996) study seems to show a greater vulnerability for suicide in Indian-, East African- and Sri Lankan-born women compared to Pakistani- and Bangladeshi-born women living in England and Wales. Many Asians originating from India were born in East African countries, and it seems reasonable from this study to infer a difference based on religion. Data seems to suggest that the overwhelming majority religion amongst people born in Bangladesh and Pakistan is Islam, while Indians are predominantly Hindu (Office for National Statistics [ONS], 2003).

De Leo (2002) reviewed literature on suicide and concluded that Muslims were less likely to commit suicide than Hindus, Sikhs or Buddhists. Islam explicitly forbids the taking of one's life. Suicide in Islam is considered a sin and consequently a crime, and beliefs are strongly held that it is '*haraam*' – a serious religious offence that would deny the person entry to heaven.

Cultural norms surrounding suicide exist in certain Asian societies, usually based on ideals of honour. It has been reported that the Japanese regard suicide as an honourable way to take responsibility (Cheng & Lee, 2000). For example, *hara-kiri* (self-disembowelment) was the traditional form of suicide committed by Japanese warriors in the feudal era, as an alternative to falling into enemy hands. Voluntary *hara-kiri* in the face of having committed an offence that affected family honour was an act that would serve to completely erase all dishonour. *Shinju* (literally meaning oneness of mind) was the practice of double suicide; usually when lovers, unable to

live a life together because of social restriction, would kill themselves. Now this term is used to describe the act of a young mother killing her small children before killing herself. Japanese society is largely sympathetic to a mother who commits *shinju*, unable to find another way of solving her problems.

Amongst South Asian communities, there are also ‘honourable’ suicides. Although Islam condemns self-killing, amongst the Islamic Moros of the Philippines, death at the hands of a Christian qualifies as a martyr’s death and thus a pathway into paradise. A man who wished to end his life because he had been shamed, would go to a place frequented by Christians and kill as many as possible in the realistic hope that he would be killed – this type of suicide known as *juramentado*. Some of these suicides would be self-punishments, due to some religious crime. This ritual suicide is no longer practiced but the basic beliefs are still accepted (Cheng & Lee, 2000).

Suttee (in Sanskrit meaning ‘faithful wife’) is the former Indian funeral practice of the self-immolation of a widow on her husband’s funeral pyre. Its stated purpose was to make amends for the sins of both husband and wife and to ensure the couple’s reunion beyond the grave, but it was, and some argue still is (Sen, 2001) encouraged by the low regard in which widows are held. Note that there is no equivalent ritual required of a husband in the event of his wife’s death. In addition to ensuring the husband and wife would be reborn together again, *suttee* also gave prestige to both the husband’s and the wife’s families as well as to all those who witnessed the cremation. It was widely accepted as a compulsory sacred practice and although outlawed by the British in 1829, still apparently continues now in certain rural parts of India (e.g. BBC News 2002; Sen, 2001). Even after being outlawed, *suttee* may

have been seen as the only option for an Indian woman, in a society where widows were treated as outcasts and as people without identity. For women, to be unmarried was dishonourable and shameful, but widows were not permitted to remarry. The unusually high numbers of South Asian women found to have used self-immolation as a method of suicide by Raleigh et al. (1990) bears an uncomfortable resemblance to the practice of *suttee*.

As a final point linking death to shame and honour, it is of note that so called 'honour killings' have been prevalent in the media. Cases have been reported in the British media of male members of families murdering daughters, sisters and nieces as a way of maintaining family honour in Muslim communities. Although a relatively rare occurrence in England, apparently hundreds of women are killed in this way every year in Pakistan (BBC News 2004c). The importance of family dishonour and shame in Asian culture and what they can tragically lead to cannot be minimised.

SHAME

Definitions

Shame has been conceptualised as a personal experience (e.g. Tangney & Dearing, 2002) as well as an interpersonal process via acts of stigmatising and shaming (e.g. Crisp, 2001). The experience of shame seems to focus on either the social world (beliefs about how others perceive you), the internal world (how you see yourself) or both (how you see yourself as a consequence of how you perceive others see you). Within the personal experience of shame, Gilbert (1997) differentiates between internal or internalised shame (relating to the self as devalued in one's own eyes in a way that is damaging to the self-identity) and external shame (relating to one's self

presentation as devalued and unattractive, as the person thinks others perceive them). This view of externalised shame may relate somewhat to the experience of shame in South Asian cultures, namely feelings of being disgraced in some way in the eyes of others.

Shame can be defined as (Concise Oxford Dictionary, [COD] 1995):

1. A feeling of distress or humiliation caused by consciousness of the guilt or folly of oneself or an associate.
2. A capacity for experiencing this feeling, especially as imposing a restraint on behaviour (*has no sense of shame*).
3. A state of disgrace, discredit, or intense regret.

This definition therefore makes some link between shame and guilt, it implies that the feeling of shame has a role in directly modifying behaviour and relates to the affective state of shame. These issues will be discussed briefly below. As other authors (e.g. Gilbert & Andrews, 1998; Tangney & Dearing, 2002) have exhaustively reviewed shame literature, including differences between shame and guilt, psychological aspects of shame and the effect of shame on behaviour, these issues will only be briefly mentioned here. The purpose of this section is to demonstrate the gap in the literature linking shame to suicidal behaviour and to highlight the difference in shame conceptualisations across individualist and collectivist cultures.

Tangney and Dearing (2002, p.1) describe the feeling of shame as an ‘intense, painful, grinding, self-scrutiny and denouncement of the self’. It has been shown to be a distinct concept from guilt, although shame and guilt are often discussed

interchangeably. Guilt may be defined as ‘the fact of having committed a specified or implied offence; culpability; the feeling of this (COD, 1995).

Lewis (1971) was central in providing a cognitive framework within which to understand the distinction between guilt and shame. The focus of evaluation in shame is the self (e.g. “*I did that awful thing*”); in guilt the focus of evaluation is the specific thing that was done, or undone (e.g. “*I did that awful thing*”). Although the self is somewhat negatively evaluated in guilt, this is only in connection with something, not itself the focus of the experience.

In shame, the person is said to feel the experience of shrinking, of being small and having a sense of worthlessness and powerlessness. To feel ashamed is to feel exposed, and the accompanying desire is to escape, hide or disappear. Shame responses are submissive. In guilt, the person becomes concerned with the particular transgression and the desire is to undo the damage – to confess, repair, apologise. Shame reparations are narcissistic; trying to make things better for the self, whilst guilt reparations are about making things better for others affected.

According to attribution theory (Weiner, 1974), people perceive events along dimensions of globality, controllability, locus and stability. Further, to attribute negative outcomes as global, stable and internal is associated with more negative psychological outcome (e.g. Furnham & Brewin, 1988). In a review of the literature, Tangney and Dearing (2002) conclude that the experience of shame leads the individual to make more global, stable and internal attributions, whilst in guilt, only the specific behaviour is condemned. In simple terms, shame is much worse a feeling

than guilt.

Affective and Behavioural Components of Shame

The experience of shame is linked to various negative affective states. Gilbert (1998) argues that anxiety is central to the shame experience. Shame is associated with an intense fear of being exposed and judged by others. Tangney and Miller (1996) further suggest that shame is not only about public disapproval, but disapproval of the self in that the defective self is exposed to an internalised observing 'other' with shame leading to a desire to escape and hide.

Cognitions during shame leading to a feeling that the entire self is negatively evaluated can lead to a sense of injustice and eventually a defensive reaction of blame and anger. Lewis (1971) suggested that a shamed individual's anger is initially directed inward toward the self, but that this experience is so aversive that the person may shift the hostility and blame outward. A focus on what others are thinking may contribute to this shift from shame to outwardly directed anger (Tangney & Dearing, 2002). Tangney, Wagner, Barlow, Marschall & Gramzow (1996) found an association between shame-proneness and anger held in (a ruminative, unexpressed anger), self-directed hostility and a tendency to withdraw. They conducted a cross-sectional study of children, college students and adults, finding that shame-proneness was correlated to anger arousal across all age groups. They found that this anger led people to do more unconstructive things than less shame-prone individuals to 'let off steam'.

Disgust is an affect that warns an individual of contamination and triggers movement

away and has been linked to shame. Gilbert (1992) suggested that anxiety and disgust might give rise to different forms of shame. For example, sexual behaviour judged as 'immoral' or deviant may give rise to disgust in others, and shame in the person engaging in the behaviour, whilst shame associated with breaking loyalties would be associated with anxiety, not disgust. Disgust is an affect that people fear triggering in others and is an important consideration in understanding the shame experience of young Asian women. Since traditional Asian values for women so often pertain to decency, morality and chastity, a fear of eliciting disgust in family members may be related to reflected shame.

The behaviours associated with shame may be divided into four aspects (Gilbert, 1998): (i) behaviours as part of the shame response; (ii) behaviours that are triggered to deal with shame in some way; (iii) behaviours instigated to avoid being shamed; (iv) reparative behaviours. Behaviours that seem to be part of the shame response are those such as hiding and eye gaze avoidance. Coping behaviours may include efforts to conceal the feelings of shame; one such way is by using anger. Avoidance behaviours may include avoidance of shaming situations, although here evidence is mixed. Tangney and Dearing (2002) argue that intensely painful feelings of shame do not appear to lead people to less shaming behaviour. Little is known about reparative behaviours in shame, but Gilbert (1998) suggests that they may include behaviours that repair self-image. As has been discussed in a previous section, suicide may be perceived as the only 'reparative' option for members of Asian societies where a significant shaming experience has occurred.

Shame, Honour and Suicide

In the Western world, there are numerous accounts of people killing other people over matters that to outsiders seem trivial, such as sexual jealousy. Social status concerns people the world over. Honour is not purely an Asian phenomenon, nor is its opposite, shame. However, there seem to be fundamental differences in what members of different cultures find shaming, and as Gilbert et al. (2003) suggest, in how they conceptualise the experience of shame. Honour and honour-related violence may be strongest in those cultures in which society exerts most control over its members (Cohen, Vandello & Rantilla, 1998). Anger and aggression have been linked to the experience of shame, conceptualised as 'shame-rage' by Lewis (1987). In Asian cultures, where the role of women may be to be passive, submissive and obedient, with men as 'protectors of shame' by controlling female behaviour, it may be impossible for young women to express their shame-rage outward. It would not be a major leap to consider that shame and dishonour in Asian societies may result in rage turned outward in men ('honour killings') and rage turned inward in women, resulting in more suicidal behaviour.

There is little empirical research linking shame and suicide, although studies have been conducted giving evidence for the pathogenic nature of shame. Shame has been implicated in depression (Gilbert, 1992) and other negative emotional states such as anxiety, low self-esteem, impaired empathy and depressogenic attributional style (Tangney & Dearing, 2002) and so to a theorised link to later self-destructive behaviour. However, few studies have examined shame as a precipitant for suicide; most studies looking at shame and suicide specifically have examined the experience of shame having attempted suicide; as a *result* of this act rather than as a possible

cause.

Authors have reported findings in clinical work where suicidal patients have been largely motivated by shame (e.g. Kalafat & Lester, 2000; Cottle, 2000). Mokros (1995) conducted an informal interpretive analysis of two audiotaped suicide notes of two teenage boys in order to further understand the role of shame. Despite the obvious lack of scientific rigour in this method, he concluded that analysis of the notes show a deeply humiliated state (indicating an intense feeling of shame), a failure to acknowledge this humiliation and an absence of someone to turn to, in both cases, leading to the act of suicide.

Motto and Bostrom (1997) studied gender differences in completed suicide in a prospective study of 2,756 depressed and/or suicidal inpatients over four years (1969 to 1974). Clinical interviews were used to examine demographic, social and psychological characteristics of each inpatient. Of those that died, information from death certificates, family members, coroner's reports and clinical sources were used to determine which deaths resulted from suicide, and only suicides that occurred within 4 years of discharge were considered. They found a higher risk for completed suicide associated with feelings of guilt or shame in females than was evident for males.

Tangney and Dearing (2002) cite their Longitudinal Family Study as one study that provides direct evidence for a shame-suicide link. They studied 380 children at age 10, with their parents and grandparents and then again 8 years later. In preliminary analyses, they found that the emotional style of the 10-year-olds predicted 'bottom

line' behaviours at 18-19 years. These behaviours included substance use, risky sexual behaviour, involvement with the criminal justice system and most importantly to this review, suicide attempts. More specifically, shame-proneness at age 10 predicted suicide attempts. This study has not yet been published so details are unavailable, but these initial findings provide some support for a hypothesis linking an experience of shame to suicidal behaviour.

Lester (1997) discussed the role of shame as a motive for suicidal behaviour, illustrating his argument with examples from China and Japan as two 'shame-oriented societies'. He uses the term 'Asian' to mean cultures such as Japanese and Chinese rather than South Asian. However, with regards to the concept of shame in collectivist societies, his comments are relevant here. He notes that although an over-generalisation, Asian cultures have been viewed as shame cultures, and Western cultures as guilt-cultures – with shame-motivated suicide cited in 'Asian' (e.g. Japanese) historical accounts and myths.

The only other study providing direct evidence for a causal link of shame to suicide was conducted by Lester (1998). He administered various guilt and shame scales and the Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) to 116 undergraduate students in the US. In addition to one item in the BDI that measures current suicidality, Lester (1998) asked whether the students had ever considered, threatened or attempted suicide. He found that men had lower scores on both guilt and shame scales compared to women, and that shame scores were significantly associated with both current suicidality and a history of ideation and threats, but not attempts. However, the association between current suicidality and

shame was present for the men and not the women. No figures (other than correlation coefficients) were reported in this study and details were not given about the shame and guilt measures used, how the sample was obtained, or whether the male and female groups were found to differ in any significant way, such as in an excess of suicidality in one group. Thus it was not possible to critically examine the reliability of the findings. However, in view of the lack of other concrete studies linking shame and suicide, this provides some evidence for a propensity for shame correlating to suicidality. At present, there is no quantitative research evidence directly linking shame and suicide in Asian women. The papers discussed earlier by Yazdani (1998) and Gilbert et al. (2003) give qualitative accounts of women's experiences of self-harm linked to shame in the first instance and women's opinions of solutions to certain dilemmas in the second, both giving some evidence for a relationship between suicidality and shame.

There are many media reports of Asian female suicides from South Asia that hypothesise shame as the cause of suicide. For example, Siddiqi (2002) argues that the number of women and girls in Bangladesh who have felt compelled to commit suicide following rape may well be the result of cultural constructions of shame and honour which do not allow 'tarnished' women to be accepted in society. It is clear that there is a great need for more empirical research in the area of suicide and shame, particularly in the Asian community.

CONCLUSIONS

The principal argument guiding the present review is that suicidality in young Asian women may be a result of a wish to repair or avoid shame and dishonour brought about by some aspect of their behaviour. The avoidance and reparation of shame has been linked to practices such as honour killings (BBC News, 2004c) and suicide in Japan, the Philippines and India in the practices of *hara-kiri*, *shinju*, *juramentado* and *suttee*. The suicide rituals and practices mentioned above are all outlawed and certainly members of these cultures prefer them to be discontinued (e.g. Tousignant, Seshadri & Raj, 1998). However, what is also clear is that, as a reflection of the prevailing societal attitude, people in India still flock to areas where a woman has made herself *suttee* and this practice is still held in some esteem (e.g. Sen, 2001).

Despite the diversity of language and culture across South Asia, it has been argued that South Asians share a collective consciousness of shame and honour, with these being particularly pertinent in respect to the (moral) conduct of women. The cultural concepts of *sharam* and *izzat* have been discussed with respect to the difference between them and Western concepts of shame. Although Western and South Asian cultures may share some ideas on what is considered shaming, there are some marked differences in this also, based on varying social values and discourses, which are culturally defined. Triandis (2001) defined cultures as either collectivist or individualist. According to this account, people from collectivist cultures, such as those found across Asia, are more likely to define themselves in terms of their group, to give priority to in-group goals and to pay more attention to external processes as determinants of social behaviour than internal ones. Some collectivist cultures such as those in South Asia have been described as 'honour cultures' (Fischer, Manstead

& Mosquera, 1999). In honour cultures the dishonourable conduct of one person reflects on the honour of all. Gilbert (2003) coined the term 'reflected shame' to describe how the concept of honour affects how shame is conceptualised in Asian culture. Peristiany (1965) suggests that the most significant in-group in honour cultures is the nuclear or extended family, and that family members are obliged to defend the honour or social reputation of the family.

Finally, by suggesting a conceptualisation of shame in young Asian women that may go some way in accounting for increased psychological distress leading to suicidal behaviour in this group, I do not seek to pathologise them. Suicidal behaviour is often complex and there may be multiple reasons behind it. In arguing a case for understanding the role of shame, I am not suggesting that 'shame-prone' is a dispositional trait in young Asian women, or that the associated pathology with shame fits for this group. In line with Leeming and Boyle's (2004) conceptualisation of shame, I argue that shame may be more problematic in young Asian women's lives due to the values expressed by their cultural context. Further, Leeming and Boyle (2004) argue that shame is a reflection of the perceived power or status of the shamed person relative to those around them. From the discourses in the qualitative studies reviewed (Gilbert et al. 2003; Yazdani, 1998), it is clear that many young Asian women feel disempowered within their cultural contexts. Further research is greatly needed in this area.

REFERENCES

- Astill, J. (2004). *Women Choose Death Over Marriage*. Persian Journal 02.04.04.
www.iranian.ws/iran_news/publisharticle-1895.shtml, Retrieved on 11.12.04.
- Bannerjee, G., Nandi, D. N. & Nandi, S. (1990). The vulnerability of Indian Women to Suicide – A Field Study. *Indian Journal of Psychiatry*, 32, 305-308.
- BBC News (2002). *The Ultimate Sacrifice*. www.bbc.co.uk, Retrieved on 17.11.04.
- BBC News (2004a). *Police Probing 'Honour' Suicides*. www.newsvote.bbc.co.uk,
Retrieved on 09.12.04.
- BBC News (2004b). *School hope for rape victim*. www.newsvote.bbc.co.uk,
Retrieved on 09.12.04.
- BBC News (2004c). *Honour-killings bill too weak*. www.newsvote.bbc.co.uk,
Retrieved on 09.12.04.
- Beck, A.T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4, 561-571.
- Bhugra, D. (2002). Suicidal Behaviour in South Asians in the UK. *Crisis*, 23, 108-113.
- Bhugra, D., Baldwin, D. S., Desai, M. & Jacob, K. S. (1999b). Attempted suicide in west London II. Inter-group comparisons. *Psychological Medicine*, 29, 1131-1139.
- Bhugra, D., Desai, M. & Baldwin, D. S. (1999a). Attempted suicide in west London I. Rates across ethnic communities. *Psychological Medicine*, 29, 1125-1130.
- Bhugra, D., Thompson, N., Singh, J. & Fellow-Smith, E. (2003). Inception rates of deliberate self-harm among adolescents in West London. *International Journal of Social Psychiatry*, 49, 247-250.

- Brent, D. A. & Moritz, G. (1996). Developmental pathways to adolescent suicide. In: D. Cichetti & S. Toth (Eds.), *Adolescents: Opportunities and Challenges*. Rochester, NY: University of Rochester Press.
- Brent, D. A., Perper, J., Moritz, G., Allman, C., Friend, A., Roth, C., Schweers, J., Balach, L. & Baugher, M. (1993). Psychiatric risk factors for adolescent suicide: A case control study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32, 521-529.
- Burke, A. W. (1976a). Attempted suicide among Asian immigrants in Birmingham. *British Journal of Psychiatry*, 128, 528-533.
- Burke, A. W. (1976b). Attempted suicide among the Irish-born population in Birmingham. *British Journal of Psychiatry*, 128, 534-537.
- Burke, A. W. (1976c). Socio-cultural determinants of attempted suicide among West Indians in Birmingham: Ethnic origin and immigrant status. *British Journal of Psychiatry*, 129, 261-266.
- Burless, C. & De Leo, D. (2001). Methodological Issues in Community Surveys of Suicide Ideators and Attempters. *Crisis*, 22, 108-123.
- Cantor, C. H. (2000). Suicide in the Western World. In: K. Hawton & K. van Heeringen (Eds.), *The International Handbook of Suicide and Attempted Suicide* (pp. 9-28). Chichester: Wiley.
- Cheng, A. T. A. & Lee, C. S. (2000). Suicide in Asia and the Far East. In: K. Hawton & K. van Heeringen (Eds.), *The International Handbook of Suicide and Attempted Suicide* (pp. 29-48). Chichester: Wiley.
- Cohen, D., Vandello, J. & Rantilla, A. K. (1998). The Sacred and the Social Cultures of Honour and Violence. In: P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal Behaviour, Psychopathology and Culture* (pp. 261-282). New

York: OUP.

The Concise Oxford Dictionary (9th ed.). (1995). New York: OUP.

Cottle, T. J. (2000). Mind Shadows: A Suicide in the Family. *Journal of Contemporary Ethnography*, 29, 222-255.

Crisp, A. (2001). The tendency to stigmatise. *British Journal of Psychiatry*, 178, 197-199.

De Hert, M. & Peuskens, J. (2000). Psychiatric Aspects of Suicidal Behaviour: Schizophrenia. In: K. Hawton & K. van Heeringen (Eds.), *The International Handbook of Suicide and Attempted Suicide* (pp. 121-134). Chichester: Wiley.

De Leo, D. (2002). Struggling Against Suicide. The Need for an Integrative Approach. *Crisis*, 23, 23-31.

Department of Health (1998). *Our Healthier Nation: A Contract for Health*. Department of Health, London.

Department of Health (1999). *National Service Framework for Mental Health: Modern Standards and Service Models*. Department of Health, London.

Department of Health (2002). *National Suicide Prevention Strategy for England*. Department of Health, London.

Elfawal, M. A. (1999). Cultural Influence on the Incidence and Choice of Method of Suicide in Saudi Arabia. *The American Journal of Forensic Medicine and Pathology*, 20, 163-168.

Farver, J. A. M., Narang, S. K. & Bhadha, B. R. (2002). East Meets West: Ethnic Identity, Acculturation and conflict in Asian Indian Families. *Journal of Family Psychology*, 16, 338-350.

- Fischer, A. H., Manstead, A. S. R. & Mosquera, P. M. R. (1999). The Role of Honour-Related vs. Individualistic Values in Conceptualising Pride, Shame and Anger: Spanish and Dutch Cultural Prototypes. *Cognition and Emotion*, 13, 149-179.
- Furnham, A. & Brewin, C. R. (1988). Social comparison and depression. *Journal of Genetic Psychology*, 149, 191-198.
- Ghuman, P. A. S. (2001). South Asian Girls in Secondary Schools: A British Perspective. *Intercultural Education*, 12, 198-207.
- Gilbert, P. (1992). *Depression: The evolution of powerlessness*. New York: Guildford Press.
- Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology*, 70, 113-147.
- Gilbert, P. (1998). What is Shame? Some Core Issues and Controversies. In: P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal Behaviour, Psychopathology and Culture* (pp. 3-38). New York: OUP.
- Gilbert, P. (2002). Body shame: A biopsychosocial conceptualisation and overview, with treatment implications. In P. Gilbert & J. N. M. Miles (Eds.), *Body Shame: Conceptualisation, assessment and intervention* (pp. 3-54). London: Routledge.
- Gilbert, P. & Andrews, B. (1998). *Shame: Interpersonal Behaviour, Psychopathology and Culture*. New York: OUP.
- Gilbert, P., Gilbert, J. & Sanghera, J. (2003). A focus group exploration of the impact of *izzat*, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby. *Mental Health, Religion and*

Culture, 6, 1-22.

Girdhar, S., Dogra, T. D. & Leenaars, A. A. (2003). Suicide in India, 1995-1999.

Archives of Suicide Research, 7, 389-393.

Glover, G., Marks, F. & Nowers, M. (1989). Parasuicide in young Asian women.

British Journal of Psychiatry, 154, 271-272.

Goldney, R. D., Winefield, A. H., Tiggemann, M., Winefield, H. R. & Smith, S.

(1989). Suicidal ideation in a young adult population. *Acta Psychiatrica Scandinavica*, 79, 481-489.

Gupta, S. R. (1999). *Emerging Voices – South Asian American Women Redefine Self,*

Family and Community. New Delhi: Sage.

Haddock, G. & Tarrier, N. (1998). Assessment and Formulation in the Cognitive

Behavioural Treatment of Psychosis. In N. Tarrier, A. Wells & G. Haddock (Eds.) (1998). *Treating Complex Cases*. Chichester: Wiley.

Handy, S., Chithiramohan, R. N., Ballard, C. G. & Silveira, W. R. (1991). Ethnic

differences in Self –Poisoning : A Comparison of Asian and Caucasian Groups. *Journal of Adolescence*, 14, 157-162.

Harris, C. E. & Barraclough, B. M. (1997). Suicide as an outcome for mental

disorders. *British Journal of Psychiatry*, 170, 205-228.

Hawton, K. & Catalan, J. (1987). *Attempted Suicide. A Practical Guide to its Nature*

and Management, 2nd Edn. Oxford: OUP.

Hawton, K. & Fagg, J. (1988). Suicide, and other causes of death, following

attempted suicide. *British Journal of Psychiatry*, 152, 359-366.

Hawton, K. & van Heeringen, K. (2000). *The International Handbook of Suicide and*

Attempted Suicide. Chichester: Wiley.

Hawton, K., Hall, S., Simkin, S., Bale, L., Bond, A., Codd, S. & Stewart, A. (2003).

- Deliberate self-harm in adolescents: a study of characteristics and trends in Oxford, 1990-2000. *Journal of Child Psychology and Psychiatry*, 44, 1191-1198.
- Ho Kong Wai, B. & Heok, K. E. (1998). Parasuicide: a Singapore perspective. *Ethnicity and Health*, 3, 255-263.
- Javed, M. A. (1996). Suicidal symptoms in depressed Pakistani patients. *Journal of the Pakistan Medical Association*, 46, 69-70.
- Kalafat, J. & Lester, D. (2000). Shame and Suicide: A Case Study. *Death Studies*, 24, 157-162.
- Kassam, N. (1997). *Telling It Like It Is – Young Asian women Talk*. London: The Women's Press.
- Kerkhof, A. J. F. M. (2000). Attempted Suicide: Patterns and Trends. In: K. Hawton & K. van Heeringen (Eds.), *The International Handbook of Suicide and Attempted Suicide* (pp. 49-64). Chichester: Wiley.
- Khan, M. M. (2002). Suicide on the Indian Subcontinent. *Crisis*, 23, 104-107.
- Khan, M. M. & Reza, H. (1998). Gender Differences in Nonfatal Suicidal Behaviour in Pakistan: Significance of Sociocultural Factors. *Suicide and Life-Threatening Behavior*, 28, 62-68.
- Khan, M. M. & Reza, H. (2000). The Pattern of Suicide in Pakistan. *Crisis*, 21, 31-35.
- Kreitman, N., Philip, A. E., Greer, S. and Bagley, C. R. (1969). Parasuicide. *British Journal of Psychiatry*, 115, 746-747.
- Leeming, D. & Boyle, M. (2004). Shame as a social phenomenon: A critical analysis of the concept of dispositional shame. *Psychology and Psychotherapy: Theory, Research and Practice*, 77, 375-396.

- Lester, D. (1982). The distribution of sex and age among completed suicides. *International Journal of Social Psychiatry*, 28, 256-260.
- Lester, D. (1997). The Role of Shame in Suicide. *Suicide and Life-Threatening Behaviour*, 27, 352-361.
- Lester, D. (1998). The Association of Shame and Guilt with Suicidality. *Journal of Social Psychology*, 138, 535-536.
- Lester, D., Agarwal, K. & Natarajan, M. (1999). Suicide in India. *Archives of Suicide Research*, 5, 91-96.
- Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York: IUP.
- Lewis, H. B. (1987). Shame and the narcissistic personality. In: D. L. Nathanson (Ed.), *The Many Faces of Shame* (pp. 93-132). New York: Guildford Press.
- Lönnqvist, J., K. (2000). Psychiatric Aspects of Suicidal Behaviour: Depression. In: K. Hawton & K. van Heeringen (Eds.), *The International Handbook of Suicide and Attempted Suicide* (pp. 107-120). Chichester: Wiley.
- Marecek, J. (1998). Culture, Gender and Suicidal Behavior in Sri Lanka. *Suicide and Life-Threatening Behavior*, 28, 69-81.
- Marshall, H. & Yazdani, A. (1999). Locating Culture in Accounting for Self-Harm amongst Asian Young Women. *Journal of Community Applied Social Psychology*, 9, 413-433.
- Mayer, P. & Ziaian, T. (2002). Suicide, Gender and Age Variations in India. *Crisis*, 23, 98-103.
- Merrill, J. & Owens, J. (1986). Ethnic differences in self-poisoning: A comparison of Asian and White groups. *British Journal of Psychiatry*, 148, 708-712.
- Merrill, J. & Owens, J. (1988). Self-poisoning among four immigrant groups. *Acta Psychiatrica Scandinavica*, 77, 77-80.

- Merrill, J., Owens, J., Wynne, S. & Whittington, R. (1990). Asian suicides (letter).
British Journal of Psychiatry, 156, 748-749.
- Mokros, H. B. (1995). Suicide and Shame. *American Behavioural Scientist*, 38,
1091-1103.
- Motto, J. A., Bostrom, A. (1997). Gender Differences in Completed Suicide.
Archives of Suicide Research, 3, 235-252.
- Murphy, G. E. (2000). Psychiatric Aspects of Suicidal Behaviour: Substance Abuse.
In: K. Hawton & K. van Heeringen (Eds.), *The International Handbook of
Suicide and Attempted Suicide* (pp. 135-146). Chichester: Wiley.
- Murthy, A. S. (2000). Approaches to Suicide Prevention in Asia and the Far East. In:
K. Hawton & K. van Heeringen (Eds.), *The International Handbook of
Suicide and Attempted Suicide* (pp. 631-643). Chichester: Wiley.
- Narang, R. L., Mishra, B. P. & Mohan, N. (2000). Attempted Suicide in Ludhiana.
Indian Journal of Psychiatry, 42, 83-87.
- Office for National Statistics (2003). National Census 2001.
- Peristiany, J. G. (1965). *Honour and Shame: The values of Mediterranean Society*.
London: Weidenfeld & Nicholson.
- Pillay, A. L. (1987). Factors Precipitating Parasuicide Among Young South African
Indians. *Psychological Reports*, 61, 545-546.
- Platt, S., Bille-Brahe, U. & Kerkhof, A., Schmidtke, A., Bjerke, T., Crepet, P., De
Leo, D., Haring, C., Lönnqvist, J., Michel, K., Philippe, A., Pommereau, X.,
Querejeta, I., Salander-Renberg, E., Temesvary, B., Wasserman, D. &
Sampaio F. J. (1992). Parasuicide in Europe: the WHO/ EURO Multicentre
Study on Parasuicide. 1. Introduction and preliminary analysis for 1989. *Acta
Psychiatrica Scandinavica*, 85, 97-104.

- Raleigh, V. S. (1996). Suicide Patterns and Trends in People of Indian Subcontinent and Caribbean Origin in England and Wales. *Ethnicity and Health, 1*, 55-63.
- Raleigh, V. S. & Balarajan, R. (1992). Suicide and self-burning among Indians and West Indians in England and Wales. *British Journal of Psychiatry, 161*, 365-368.
- Raleigh, V. S., Bulusu, L. & Balarajan, R. (1990). Suicides Among Immigrants from the Indian Subcontinent. *British Journal of Psychiatry, 156*, 46-50.
- Ratnayake, L. (1996). Suicide and crisis intervention in rural communities in Sri Lanka. *Crisis, 17*, 149-151.
- Rao, A. V. (1965). Attempted Suicide. *Indian Journal of Psychiatry, 7*, 253-259.
- Sanchez, H. G. (2001). Risk Factor Model for Suicide Assessment and Intervention. *Professional Psychology: Research and Practice, 32*, 351-358.
- Schotte, D. E. & Clum, G. A. (1982). Suicide ideation in a college population: A test of a model. *Journal of Consulting and Clinical Psychology, 50*, 690-696.
- Schotte, D. E. & Clum, G. A. (1987). Problem-Solving Skills in Suicidal Psychiatric Patients. *Journal of Consulting and Clinical Psychology, 55*, 49-54.
- Sen, M. (2001). *Death by Fire: Sati, Dowry Death and Female Infanticide in Modern India*. Guernsey: The Guernsey Press.
- Siddiqi, D. M. (2002). *Bangladesh: Sexual Harassment and the Public Woman*.
www.himalmag.com/2002/may/analysis.htm. Retrieved on 05.12.04.
- Tangney, J. P. & Dearing, R. L. (2002). *Shame and Guilt*. New York: Guildford Press.
- Tangney, J. P. & Miller, R. S. (1996). Are shame, guilt and embarrassment distinct emotions? *Journal of Personality and Social Psychology, 70*, 1256-1269.
- Tangney, J. P., Wagner, P. E., Barlow, D. H., Marschall, D. E. & Gramzow, R.

- (1996). The relation of shame and guilt to constructive vs. destructive responses to anger across the lifespan. *Journal of Personality and Social Psychology*, 70, 797-809.
- Thompson, N. & Bhugra, D. (2000). Rates of deliberate self-harm in Asians: findings and models. *International Review of Psychiatry*, 12, 37-43.
- Tousignant, M., Seshadri, S. & Raj, A. (1998). Gender and Suicide in India: A Multiperspective Approach. *Suicide and Life-Threatening Behavior*, 28, 50-61.
- Triandis, H. C. (1995). *Individualism and Collectivism*. Boulder, CO: Westview Press.
- Triandis, H. C. (2001). Individualism-Collectivism and Personality. *Journal of Personality*, 69, 907-924.
- van Heeringen, K. (2001). *Understanding Suicidal Behaviour. The Suicidal Process Approach to Research, Treatment and Prevention*. Chichester: Wiley.
- Wassenaar, D. R., van der Veen, M. B. W. & Pillay, A. L. (1998). Women In Cultural Transition: Suicidal Behavior in South African Indian Women. *Suicide and Life-Threatening Behavior*, 28, 82-93.
- Weiner, B. (1974). *Achievement motivation and attribution theory*. Morristown, N.J: General Learning Press.
- World Health Organisation (1996). *World Health Statistics Annual, 1995*. Geneva: WHO.
- World Health Organisation (2004). *Suicide Prevention: Emerging from Darkness*. W3.whosea.org. Retrieved on 08.04.05.
- Wright, N., Trethowan, W. N. & Owens, J. (1981). Ethnic differences in self-poisoning. *Postgraduate Medical Journal*, 57, 792-793.

- Wulsin, L. R., Vaillant, G. E. & Wells, V. E. (1999). A systematic review of the mortality of depression. *Psychosomatic Medicine*, 61, 6-17.
- Yang, B. & Clum, G. A. (1996). Effects of Early Negative Life Experiences on Cognitive Functioning and Risk for Suicide: A Review. *Clinical Psychology Review*, 16, 177-195.
- Yazdani, A. (1998). Young Asian women and Self-Harm. A mental health needs assessment of young Asian women in Newham, East London. London: Newham Inner-city Multi fund/ Newham Asian Women's Project.

Part 2:

Suicidality in Young Asian Women: The Role of Shame

ABSTRACT

A group of 159 female, South Asian¹ Hindu, South Asian Muslim and White British university students aged between 18-24 years were compared on measures of suicidality and shame, including a measure designed to assess a culturally bound concept of shame (sharam) related to a loss of honour (izzat). Asian groups were also compared on the Cultural Values Conflict Scale (Inman, Ladany, Constantine & Morano, 2001) to test the proposed model suggesting that conflict between culturally prescribed values and an Asian woman's own values may lead to greater suicidality, mediated by an experience of shame particular to Asian culture. The model further proposes that religion may moderate this effect, such that suicidality would be greater in Hindus. The percentage of Asian Hindus reporting having attempted suicide was 1.3 times the percentage found in Asian Muslims and twice that in White British women. Sharam emerged as a significant mediating variable, but support was not found for religion as a moderating variable at the point suggested. 'Cultural conflict' suggested by previous authors as a possible cause of suicidality in Asian women is too simplistic; this study provides evidence for a possible mediator in the relationship between cultural values conflict and suicidality.

¹ The terms 'South Asian' or 'Asian' in this paper are used to describe the ethnicity of people originating from Sri Lanka, India, Pakistan and Bangladesh, regardless of country of birth. Geographically, the terms 'Indian subcontinent' and 'South Asia' also include Afghanistan, Nepal, Bhutan and the Maldives. However, despite using these geographical terms, all the studies reviewed clearly only pertain to people originating from the countries first mentioned, and are collectively recognised in the UK as 'Asian'.

INTRODUCTION

One of the British government's targets in the National Service Framework (DoH, 1999) is to reduce suicide by a fifth by 2010. The framework recognises the specific vulnerability of women born in India and East Africa (living in England and Wales) since research shows that these women have a 40% higher rate of suicide than those born in England and Wales (DoH, 1999). However, certain barriers exist that prevent accurate and reliable studies of suicide, particularly when looking at ethnicity as a variable. Firstly, completed suicide is a relatively rare occurrence. Secondly, the most reliable source of information concerning precipitants to suicide and circumstances surrounding the event is tragically lost with the person who committed the act. Thirdly, country of birth, but *not* ethnicity is routinely recorded at death by coroners, which prevents accurate study of rates of suicide in different ethnic groups.

In a review of the research on suicide, van Heeringen, Hawton and Williams (2000) have suggested that previous attempts are the strongest clinical predictor of suicide, and that suicide is preceded by a process that may begin with suicidal thoughts, evolving to more concrete plans and attempt(s) to completed suicide. Solid evidence exists which links deliberate self-harm (DSH) to later suicide (DoH, 2002), although it should be noted that several authors have argued that DSH is a distinct act with a different set of meanings in which the primary aim is not to destroy the self (*see* Kerkhof, 2000 for a review). Some individuals who perform potentially lethal self-destructive acts may not have any wish to die, whilst others presenting with very minor self-injury may have strong intentions to die. For these reasons, therefore, it is useful to study deliberate self-harm, suicide ideation and previous (unsuccessful) attempts together as more frequently occurring phenomena that are all associated

with higher risk of suicide. The term 'suicidality' in this paper, therefore, encompasses all the phenomena discussed above.

National mortality data for England and Wales spanning three decades consistently shows that young South Asian women born in India, Sri Lanka and East Africa are at higher risk of dying by suicide than national averages of women of the same age group (Raleigh, 1996; Raleigh & Balarajan, 1992; Raleigh, Bulusu & Balarajan, 1990). Hanging and burning are common methods used amongst South Asian women, accounting for 28% and 31% of deaths, respectively, between 1970 and 1978 (Raleigh et al., 1990). In the same study, burning accounted for only 3% of South Asian male deaths by suicide and was non-existent in completed suicide in other groups in the general population. In direct contrast to data on Western individuals (this volume, p.9), it seems that it is the women in South Asian communities who use more lethal means.

A significant excess of young Asian women in studies of *attempted* suicide has also been reported, when compared to Asian men (Burke, 1976); White women (Merrill & Owens, 1986); non-Asian age-matched women (Glover, Marks & Nowers, 1989); Asian men and both White men and women (Merrill, Owens, Wynne & Whittington, 1990) and men and women in all ethnic groups (Bhugra, Desai & Baldwin, 1999a). Since research into suicidality in this group is relatively new, there is a paucity of studies examining specific vulnerabilities for suicidality in young Asian women. Several authors have found that the majority of deaths by suicide (Raleigh et al., 1990) and suicide attempts (Merrill & Owens, 1986; Wright, Trethowan & Owens, 1981) in young Asian women occur in those who are married. This is in direct

contrast to data on Western individuals, where marriage is a known protective factor (e.g. Sanchez, 2001). In White Western populations, alcoholism (Murphy, 2000) and a history of mental disorder (Lönnqvist, 2000) have both been recognised as major contributing factors in suicide. This is not true for young Asian women, in whom an absence of alcohol use and psychiatric history has been found (e.g. Merrill & Owens, 1986).

Most studies on suicidality have looked at South Asian women as a whole, despite dealing with a heterogeneous group of Sri Lankans, Indians, Pakistanis and Bangladeshis with differing religions and beliefs influencing suicidal behaviour. However, there does seem to be a marked difference in the prevalence of suicide between women of different religions. Raleigh (1996) demonstrated a greater vulnerability for suicide in Indian-, East African- and Sri Lankan-born women compared to Pakistani- and Bangladeshi-born women living in England. Many Asians originating from India were born in East African countries. It seems reasonable from this study to infer a difference based on religion, since data shows that the majority religion amongst people born in Bangladesh and Pakistan is Islam, while Indians are predominantly Hindu (Office for National Statistics [ONS], 2003). Other authors have also suggested that amongst Asian women, Hindus may be at greater risk and Muslims at lesser risk of suicidality (Bhugra, 2002; De Leo, 2002; Maniam, 1988 as cited in De Leo, 2002). Suicide in Islam is considered a sin and a crime. Beliefs are strongly held that suicide is '*haram*' – a serious religious offence that would deny the person entry into heaven. In contrast, Hindu religion and culture may have more ambivalent attitudes to suicide; one example being the honourable practice of *suttee* - the self-immolation of a widow on her husband's funeral pyre.

Although outlawed, this practice still continues in certain rural parts of India (Sen, 2001).

Other studies have cited a causal link between 'culture conflict' in young Asian women and suicidality (Handy, Chithiamohan, Ballard & Silveira, 1991; Merrill & Owens, 1986; Glover, et al., 1989) but this term has been criticised, in part due to the lack of a precise operational definition of what it means (Marshall & Yazdani, 1999). In general, 'culture conflict' has been used to describe the mismatch between traditional Asian cultural values and British ones, particularly in relation to discordant views with parents. However, family conflict, and in particular discordance between peer groups and parental views are also expected in young White people who self-harm (Handy et al., 1991). A major difference may be the age at which most Western young people have autonomy from their families of origin.

Issues of autonomy and independence may be considered under the influence of cultural norms. The terms *individualist* and *collectivist* have been used to classify cultures according to whether they are group-orientated (collectivist) or individual-orientated (individualist) (e.g. Triandis, 1995). Generally speaking, most Western cultures are considered individualist; members give priority to personal goals over the goals of the in-group and behave primarily on the basis of their own attitudes rather than the norms of their in-groups. In contrast, collectivist cultures such as Asian cultures give priority to the goals of the community rather than the individual. The self and family are integral concepts and each member of the community is expected to make personal sacrifices such that an individual may suffer for the good

of the group as a whole. A young Asian woman is, generally speaking, expected to follow the wishes of her parents with whom she would usually live until marriage and then follow the wishes of her husband. It follows that conflict between a young Asian woman's wishes and those of her parents may continue to an age at which most White Western individuals would be making autonomous choices. However, intergenerational or cultural conflict *per se* is too simplistic an explanation for the excess of young Asian women in suicidality studies. The studies discussed thus far do not provide a mechanism by which conflict between culturally prescribed values and an individual's values lead to greater suicidality in young Asian women. Three more recent studies implicate a culturally bound concept of shame in greater suicidality in young Asian women.

Bhugra, Baldwin, Desai and Jacob (1999b) reported from studies conducted in West London, in which all patients (aged 18-64) presenting to Accident and Emergency services, psychiatric or medical wards were screened. South Asian women who had attempted suicide were compared with White women who had attempted suicide and female Asian age-matched controls from a GP surgery in the same area. Their findings revealed that Asian attempters had experienced more life-events pertaining to relationships than White attempters. Asians attempting suicide were more likely to have been in an inter-racial relationship than Asian controls. The authors noted that conflict with the family, as a precipitant to suicidality, was an important finding in Asian females – one such example being conflict over parents not accepting the woman's choice of husband. Asian female suicide attempters had less traditional views than Asian controls. In a later paper commenting on these results, Bhugra (2002) discussed the importance of family honour and shame in relation to an Asian

woman's desire to make autonomous decisions such as choice of husband and suggested that these concepts need further exploration in relation to suicidality in young Asian women. Bhugra et al. (1999b) also suggest that further research seeks to ascertain the role of religion in suicidality in this group.

In a qualitative study of young Asian women aged between 14 and 30 years, Yazdani (1998) found issues leading to distress in young Asian women to be varied and numerous. Conflicting roles, living dual lives, transitions to different life stages, lack of freedom at home, absence of avenues in the family to tell someone about their distress, sexual abuse, poor relationships in the family and physical and emotional abuse in marital or other significant relationships all featured. Some aspects of Asian culture were certainly implicated, restrictive parenting being one example, but the women interviewed in the study did not themselves feel that *culture conflict* adequately described what had led to their distress. This mismatch may be due, in part, to differing understandings of what 'culture conflict' actually means. To some, the term may suggest some preference for living in the Western culture rather than the Asian one. Many women felt that they identified positively as bicultural women; valuing Asian principles as well as integrating into Western society. In Yazdani's (1998) study, constructs of DSH included release from distress, effecting change, taking control and ending it all – similar to those found in White British women who have self-harmed. However, in addition to these, they also found that certain elements of Asian culture were implicated. In particular, the cultural concepts of *izzat* (family honour) and *sharam* (shame) were important determinants of distress. They related to the adherence, or non-adherence to certain expectations that were not simply an issue for the individual concerned or her family, but related widely to the

family's standing in the community.

In Urdu, Hindi, Gujarati, Bengali and Punjabi the words *izzat* and *sharam* are understood to describe the same cultural concepts. *Sharam* in Asian cultures is used to describe a sense of modesty and decency. Asian people talk of *having sharam*; a moral value, a sense of decency according to prescribed traditional values. It is also described as a behaviour; an act which one *does* to oneself or inflicts on one's family; "I have shamed myself" or "I have brought shame on my family". *Izzat* translated directly means 'honour' in English. It is a concept closely related to shame for Asian people, as *izzat* relates to family honour. To shame one's family is to affect the family *izzat*. Maintaining a standing in the community as a family that is 'decent' and moral is of utmost importance in collectivist cultures.

Gilbert, Gilbert & Sanghera (2003) conducted focus groups to examine the concepts of *izzat*, shame, subordination and entrapment and their effects on mental health in South Asian women. Gilbert (2002) coined the term *reflected shame* to describe the concepts of *sharam* and *izzat*, related to family honour, reputation and personal reputation. The women in the study described feelings of subordination, with subordination and control by (usually male) members of the family as ways of maintaining *izzat*. Primary maintenance of *izzat* was expressed through the behaviour of women, whilst male members maintained *izzat* by restricting female members of the family in order to prevent them doing anything that would compromise family honour. Entrapment was linked to fears of being disowned by family and the community due to a loss of *izzat*. Crucially, the women in this study felt that it would be better to commit suicide than to leave an abusive or unhappy marriage (which

would damage family honour). This is the only study to date, which demonstrates the enormous value placed on maintaining *izzat* in Asian families, particularly for the females in the family and directly implicates loss of *izzat* in suicidality.

Thomson & Bhugra (2000) proposed a conceptual model of aetiological factors for suicidal behaviour in young Asian women based on a review of the literature available (figure 2, this volume, p. 35). They suggest that in addition to the pressures exerted on all young people regardless of ethnicity, a different set of pressures, which are culturally unique to Asian females, may increase the risk of suicide. They argue that it is neither sufficient nor adequate to ascribe the cause of suicidal behaviour to 'culture conflict'. Conflict between personal values and those prescribed by Asian culture does seem to be linked to significant distress in young Asian women, but what seems to be missing is a mediating variable. I propose that this mediating variable is a culturally bound concept of shame.

Experiences in terms of life events and conflicts with family may be occurring at relatively similar rates in both young Asian and White women, although conflicts with family may continue to a later age in Asian women due to cultural norms surrounding independence from family. What may further differentiate between these groups is the experience of culturally bound concepts of shame in Asian communities (*sharam*). These are related to values of honour (*izzat*) that the women in Asian society are expected to uphold. In terms of the most vulnerable age group, most studies examining suicidality in young Asian women have considered the age group 15-24 years. Bhugra, Thompson, Singh and Fellow-Smith (2003) demonstrated that inception rates for attempted suicide amongst White and Asian

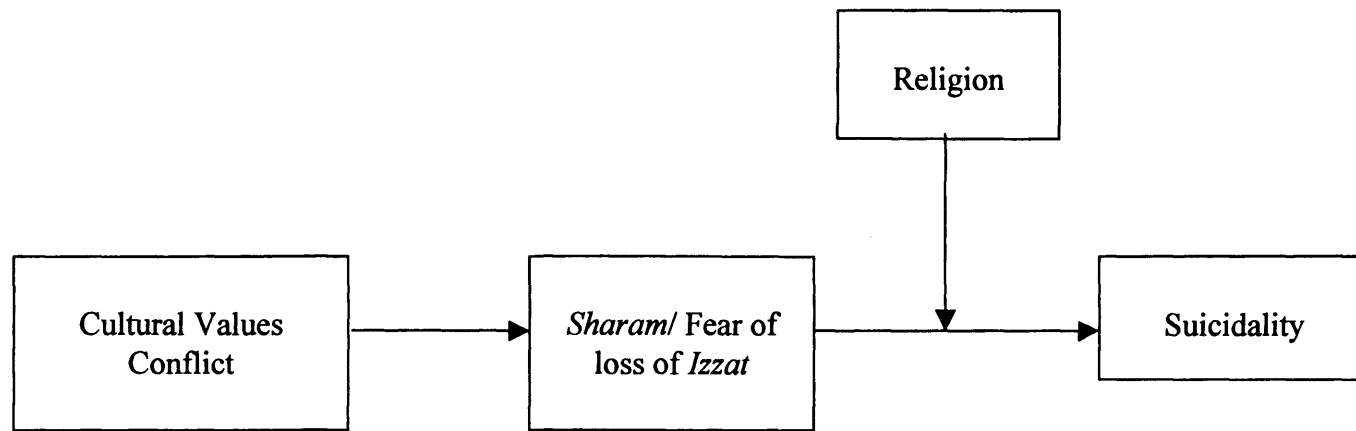
teenagers were similar. White and Asian 16- and 17-year-olds had similar adjustment reactions, rates of alcohol and drug use and peer and relationship problems. Bhugra (2002) concludes that since rates are similar among adolescents, and that over the age of 24 differences also disappear, there seem to be certain factors that trigger vulnerability to self-harm particularly for Asian women in the 18-24 age-range. Religion has been implicated in that Hindu women may be at higher risk of suicidality than Muslim women (e.g. Raleigh, 1996).

This community study aims to find out whether amongst 18-24 year olds, there is a higher incidence of suicidality in Asian women in the general population, compared with White women in the general population, and whether this is particularly true in Asian Hindus. The study predicts that greater conflict between the cultural values the Asian women have been brought up with and the values they hold themselves will be associated with higher levels of shame being experienced in both Asian groups. Shame is proposed as a mediating variable in a causal link between cultural value conflict and suicidality, with religion acting as a moderating variable. The specific model proposed is shown in figure 3.

Hypotheses:

1. Asian women experience higher levels of shame than White women, particularly when culturally bound concepts of shame are taken into account.
2. Asian women experience higher levels of suicidality than White women, with the highest level amongst Asian Hindus.
3. Higher levels of culture conflict will correlate with higher levels of suicidality in Asian women, mediated by shame and moderated by religion.

Figure 3. Proposed Model of Suicidality in Young Asian Women



METHOD

This research project was approved by University College London's Committee on the Ethics of Non-NHS Human Research (Appendix I).

Participants

One hundred and fifty-nine female students attending three universities in London participated in the study. Their mean age was 20.09 years (SD = 1.44; range 18-24). Three groups of participants were recruited; Asian-Hindu (N=50), Asian-Muslim (N = 60) and White British (N = 49). An opportunity sampling method was used, in that all students who were female and appeared to be from a South Asian or White British background were approached. As ethnicity, age and religion in the Asian groups were central to this study, participants were excluded if these details were omitted on their questionnaires, or if age or ethnicity were different from the inclusion criteria specified.

Procedure

Six hundred questionnaires were given out to students fitting the inclusion criteria of age and ethnicity in cafeterias, bars and the student unions on campus. Their participation was requested in a study looking at cultural differences in the mental health experiences of White and Asian women, in particular considering when women from these backgrounds may consider suicide and self-harm. It was emphasised that the researcher was not affiliated with their course in any way and that contribution was entirely voluntary and confidential. Information sheets (Appendix II) were included in the questionnaire pack and participants were encouraged to read these before deciding whether or not to take part. Consent forms (Appendix III) were given to participants and they were told that they could sign

them with any (false) name. To ensure anonymity, questionnaires were returned in sealed, unmarked envelopes by post to the researcher, or could be put in a sealed box that was stationed in a designated place in the student union. Each questionnaire pack and consent form was numbered so that these could be matched for ethics, if required. An information and resources sheet was included at the end of the questionnaire, to provide respondents with appropriate avenues for seeking help for any distressing feelings that may have arisen upon completion of the questionnaire (Appendix XI).

Design

The study employed a mixed between-group and within-group questionnaire design. Multiple regression was used for final analysis of the model, testing *sharam* as a mediating variable and religion as a moderating variable in suicidality for Asian women.

Measures

Participants completed a brief demographic information questionnaire (age, country of birth, ethnicity, age of entry to the UK, religion, level of religiosity, languages spoken, marital status and country of birth of their parents) (Appendix IV) and the following self-report instruments. Internal consistency is reported as the Chronbach α statistic (Chronbach, 1951).

Suicidal Behaviors Questionnaire-Revised (SBQ-R)

The SBQ-R (Osman et al., 2001; Appendix IV) is a 4-item measure of suicidal behaviour and past attempts, condensed from the original 34-item SBQ (Linehan &

Nielson, 1981). Item 1 is designed to assess past suicide ideation and suicide attempts, item 2 measures the frequency of past suicidal ideation, item 3 evaluates the threat of suicidal behaviour and item 4 assesses self-reported likelihood of future suicide. It has been used in research with both clinical and non-clinical populations (e.g. Osman et al., 1996) and has adequate internal consistency in an undergraduate sample ($\alpha = 0.76$; Osman et al., 2001).

Self-Harm Inventory (SHI)

The SHI (Sansone, Wiederman & Sansone, 1998) is a 22-item questionnaire, asking respondents to indicate (yes or no) whether they have ever intentionally engaged in a list of self-destructive behaviours to harm themselves (Appendix V). Although originally developed as a screening tool to distinguish between individuals with and without Borderline Personality Disorder, it has been suggested by the authors as a useful measure of self-destructive potential. The total score on the measure is simply the number of 'yes' responses.

Positive and Negative Suicide Ideation Inventory (PANSI)

The PANSI (Osman, Gutierrez, Kopper, Barrios & Chiro, 1998) is a 14-item measure for assessing the frequency of both protective and negative risk dimensions of suicidal ideation (Appendix VI). Participants respond according to how they have felt in the past year and each item is rated on a 5-point scale (ranging from '1 = never' to '5 = most of the time'). Good internal consistency has been shown on the separate positive ($\alpha = 0.80$) and negative ($\alpha = 0.91$) subscales.

Experience of Shame Scale (ESS)

The ESS was developed from an earlier interview measure (Andrews & Hunter, 1997) by Andrews, Qian & Valentine (2002) and consists of a 25-item questionnaire assessing characterological shame, behavioural shame and bodily shame (Appendix VII). Participants respond according to how they have felt in the past year and each item is rated on a 4-point scale (ranging from '1 = not at all' to '4 = very much'). This scale has shown high internal consistency ($\alpha = 0.92$) and test-retest reliability of $r(88) = 0.83$ (Andrews et al., 2002).

Other As Shamer Scale (OAS)

The OAS (Goss, Gilbert & Allan, 1994) is a measure of 'external shame'; the experience of shame as a factor of how others see or judge the self (Appendix VIII). The scale is a modification of the Internalised Shame Scale (ISS) (Cook, 1993) and looks at global judgements of how people think others see them. The scale consists of 18 descriptions of feelings or experiences and participants respond on a 5-point scale indicating how often they feel this way (ranging from 0 = never to 4 = almost always). The scale has good internal consistency ($\alpha = 0.92$, Goss et al., 1994).

South Asian Shame Scale (SASS)

I adapted this scale from a measure developed by Professor Paul Gilbert and colleagues (Gilbert et al., submitted) to assess cultural differences in attitudes towards mental health and experiences of shame in Asian and non-Asian women (Appendix XII). In Gilbert et al.'s (submitted) measure, the subscale measuring reflected family shame began with a hypothetical scenario (*imagine that you suffered from a mental health problem such as depression and anxiety*) and participants were

asked to consider how concerned they would be that these problems would impact on their family. Six statements followed, to which participants were required to respond on a 4-point scale (ranging from '0 = do not agree at all' to '3 = completely agree'). P. Gilbert (personal communication, March 1, 2004) found that the scores for Asians on this subscale were significantly higher than those for non-Asians and the subscale had good internal consistency ($\alpha = 0.92$) (Appendix XIII). This format was used for 6 hypothetical situations to form the SASS. In addition to the hypothetical scenario about mental health that was used in Gilbert's scale, I added five others, chosen for their pertinence to shame experiences in young Asian women (e.g. Kassam, 1997; Yazdani, 1998; Gilbert et al., 2003). These were: being in a relationship with a Black man, failing final exams at university, deciding not to get married or have children, being in a relationship with another woman and becoming pregnant whilst unmarried (Appendix IX).

Cultural Values Conflict Scale (CVCS)

The CVCS (Inman et al., 2001) was developed as a measure to assess the degree to which South Asian women living in the US experience cultural value conflicts, but was readily adaptable for a British audience (Appendix X). It is a 24-item scale, consisting of various beliefs, feelings and experiences related to conflicts of cultural values and participants respond on a 6-point scale (ranging from '1 = strongly disagree' to '5 = strongly agree' and '6 = not applicable'). The scale has been found to have good internal consistency ($\alpha = 0.84$) and test-retest reliability (pair-wise correlation of 0.81) (Inman et al., 2001).

RESULTS

All statistics were performed using the SPSS package for PCs, except for the final regression analysis examining shame as a mediating variable. Since SPSS is unable to perform this function, I used the Sobel test (Preacher & Leonardelli, 2001).

Distributions were examined for normality and all were skewed except the distribution for the Cultural Values Conflict Scale (CVCS). Appropriate transformations were carried out on the others, after which normality was achieved. Thus parametric analyses were conducted on the original CVCS variable and transformed variables for all other measures.

Age and Marital Status

The three groups were similar in age. The mean age of the Asian-Hindu (AH) group (N = 50) was 20.00 years (S.D. = 1.44; range 18 - 23), the Asian-Muslim (AM) group (N = 60) was 20.17 years (S.D. = 1.39; range 18 - 24) and the White-British (WB) group (N = 49) was 20.08 (S.D. = 1.53; range 18 - 24). In the AH group, one participant was divorced and in the White British group, one participant was married. All other participants were single.

Country of Birth

Most participants across all three groups were born in the UK (78% of AHs; 87% of AMs and 94% of the WB group). The remaining Asian Hindus were born in India, Sri Lanka and Kenya whilst other Asian Muslims were born in Pakistan, Bangladesh, Kenya and other countries. The remaining White British people were born in other countries in Europe. Of the few participants born in other countries, most came to the

UK before the age of 10 (70% in AH group, 63% in the AM group and all of the WB group).

Ethnicity

In the Asian Hindu group, 86% described their ethnicity as Indian and 14% as Sri Lankan. Just over 43% of the Asian Muslim group described their ethnicity as Pakistani, followed by Bangladeshi (31.7%) and Indian (20%).

Religion

The Asian groups were obviously assigned according to whether they were Hindu or Muslim. In the White British group, 47% reported having no religion; 47% were Christian and 6% had other religions (but were not Hindu or Muslim). The level of religiosity was similar amongst Hindus and Muslims. Seventy-six percent of Asian Hindus described themselves as 'somewhat religious'; 16% as very religious and only 3 participants (6%) stated that they were not religious at all. In the Asian Muslim group, 73% described themselves as 'somewhat religious', 18% as 'very religious' and only 7% as not religious at all. In contrast, most of the White British group described themselves as not religious at all (59%); 37% as 'somewhat religious' and only 4% described themselves as very religious.

Asian languages spoken

Ninety percent of the Asian Hindu group could speak at least one Asian language, with 18% speaking more than one. In the Asian Muslim group, 80% could speak at least one Asian language and 25% could speak more than one.

Parental Country of Birth

The majority of the parents of the Asian Hindus were born in India (42% of mothers and 40% of fathers), Kenya (24% and 20% respectively) and Sri Lanka (16% and 18%, respectively). Parents of the Asian Muslim group were born mainly in Pakistan (38% mothers; 33% fathers), Bangladesh (31% for both) and India (12% and 20%, respectively). As expected, the parents of the White British group were mainly born in the UK (88% and 94%, respectively).

Qualitative Differences

Although no qualitative questions were asked, some interesting findings emerged worth commenting upon. None of the Asian Hindus or the White British group missed out any questions from the SASS. In the Asian Muslim group, one person missed out question 2, one missed out question 3, two did not complete question 4, seven did not answer question 5 and five individuals did not answer question 6. Next to these missing responses, individuals from the Asian Muslim group had written various comments suggesting that the situations in the questions were not even imaginable. Examples of some of the comments written next to questions 5 and 6 (questions pertaining to being in a relationship with another woman and becoming pregnant whilst unmarried) are "...it's against my Islamic beliefs to consider it", "no way", and "I'm sorry but I cannot imagine such a disgraceful situation". One woman had written next to SBQ-R item 4 (*How likely is it that you will attempt suicide someday?*) "It's haraam. You'll go to hell if you do." None of the Asian Hindu group or the White British group made any comments on the questionnaire.

Examining measures for constructs of shame and suicidality

Pearson's product-moment correlations were performed on each of the three shame measures (ESS, OAS and SASS) and each of the three suicidality measures (SBQ-R, SHI and PANSI). ESS and OAS scores were found to correlate moderately ($r = 0.657, p < 0.01$), so these two variables were summed under the singular construct of shame. Significant, but very small, negative correlations were found between SASS and OAS scores ($r = -0.291, p = 0.01$) and SASS and ESS scores ($r = -0.200, p = 0.01$) suggesting that the SASS should not be summed together with other shame measures. The three measures of suicidality correlated positively and significantly to allow these measures to be summed together under the singular construct of suicidality. Tables 1 and 2 show the product-moment correlations for these variables. Thus the variable 'shame' is made up of the ESS and OAS and the variable 'suicidality' consists of the SBQ-R, SHI and PANSI. The variable of cultural shame (*sharam*) refers to that measured by the SASS.

Group differences on all variables

Table 3 shows the means, medians, standard deviations (SD), significance between groups and Cronbach's alpha coefficients (Cronbach, 1951) for all variables. The Asian Hindu group seemed to score higher on all measures apart from the SHI and the ESS, although most differences were found to be not significant. There was no significant effect of ethnic group on shame ($F_{(2,152)} = 0.248, p = 0.781$) or suicidality ($F_{(2,148)} = 5.132, p = 0.424$). However, there was a highly significant effect of ethnicity on *sharam* ($F_{(2,155)} = 61.918, p < 0.0005$). Bonferroni post-hoc comparisons revealed significant differences between Asians Hindus and Asian Muslims ($p = 0.002$), between Asian Hindus and White British women ($p < 0.0005$) and Asian

Muslims and White British women ($p < 0.0005$) on *sharam*. Asian Hindus experienced significantly more cultural conflict than Asian Muslims ($t_{(106)} = 2.482, p < 0.05$).

Table 1. Correlation matrix for all shame variables

Variable	1	2
1. ESS		
2. OAS	.657**	
3. SASS	-.200*	-.291**

**p<0.01; *p<0.05

Table 2. Correlation matrix for all suicidality variables

Variable	1	2
1. SBQ-R		
2. SHI	.572**	
3. PANSI	.720**	.542**

**p<0.01; *p<0.05

Table 3. Means, medians, standard deviations, significance between groups and Cronbach's alpha levels

Variable*	Mean**	Median	SD	<i>p</i>	Alpha
SBQ-R	3.08 (AH)	2.00	3.79	0.091	0.83
	1.98 (AM)	1.00	2.74		0.58
	2.55 (WB)	1.00	3.76		0.89
	2.50 (Tot)	1.00	3.43		0.79
SHI	2.66 (AH)	2.00	3.18	0.599	0.82
	2.72 (AM)	2.00	2.86		0.78
	3.06 (WB)	2.00	3.42		0.84
	2.81 (Tot)	2.00	3.13		0.80
PANSI	28.16 (AH)	25.50	11.21	0.083	0.93
	26.62 (AM)	23.50	10.07		0.92
	23.82 (WB)	21.00	8.07		0.92
	26.24 (Tot)	23.00	9.98		0.93
ESS	50.84 (AH)	49.00	14.12	0.672	0.93
	51.07 (AM)	48.50	14.90		0.93
	52.57 (WB)	50.00	16.41		0.96
	51.46 (Tot)	49.00	15.07		0.94
OAS	20.24 (AH)	18.00	14.52	0.463	0.95
	18.25 (AM)	15.00	14.97		0.95
	17.78 (WB)	16.00	13.20		0.96
	18.73 (Tot)	16.00	14.25		0.95
SASS	82.06 (AH)	83.00	27.38	0.000	0.96
	65.08 (AM)	65.00	31.29		0.96
	17.71 (WB)	11.00	15.14		0.93
	55.43 (Tot)	55.50	37.01		0.98
CVCS	75.96 (AH)	75.50	14.85	0.015	0.87
	67.07 (AM)	67.50	21.25		0.85
	--- (WB)	---	---		---
	71.19 (Tot)	71.50	19.01		0.86

*SBQ-R, Suicidal Behaviours Questionnaire – Revised; SHI, Self-Harm Inventory; PANSI, Positive And Negative Suicide Ideation inventory; ESS, Experience of Shame Scale; OAS, Other As Shamer scale; SASS, South Asian Shame Scale; CVCS, Cultural Values Conflict Scale

**AH, Asian Hindu; AM, Asian Muslim; WB, White British.

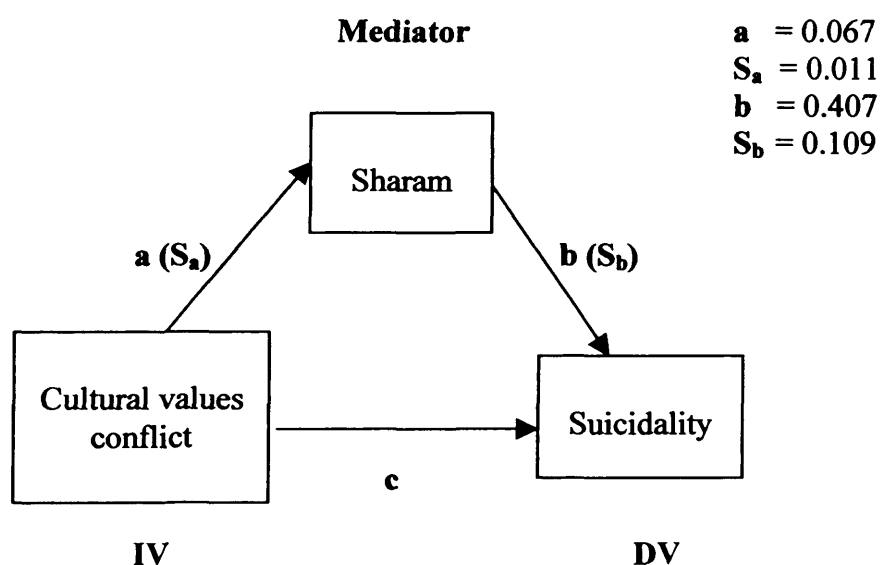
Suicidal Behaviour

Groups were compared on singular items of the SBQ-R and the SHI. Item 1 on the SBQ-R (*'have you ever thought about or attempted to kill yourself?'*) has been recommended as useful in correctly identifying suicidal individuals in non-clinical populations (Osman et al., 2001) with a cut-off score of 2 indicating the respondent has either had a plan to kill themselves or had attempted suicide at some time in their lives. Twenty-eight percent of the Asian Hindu group (N = 14), 15% of the Asian Muslim group (N = 9) and 18% of the White British group (N = 9) were identified as suicidal, although, these differences were not significant ($\chi^2_{(2)} = 3.232, p = 0.199$). For item 2 on the SBQ-R (*'how often have you thought about killing yourself in the past year?'*), 14% of the Asian Hindu group (N=7), 5% of the Asian Muslim group (N=3) and 6% of the White British group (N=4) had thought of killing themselves more than twice in the past year. On item 18 on the SHI (*'have you ever attempted suicide?'*), 16% of the Asian Hindu group (N = 8), 12% of the Asian Muslim group (N = 7) and 8% of the White British group (N = 4) answered 'yes'. Since burning has been shown to be a common method of self-destructive behaviour amongst Asian women (Raleigh et al., 1990), item 3 (*'have you ever burned yourself on purpose?'*) on the SHI was examined, revealing that 10% of the Asian Hindu group (N = 5), 5% of the Asian Muslim group (N = 3) and 6% of the WB group (N = 3) had burned themselves on purpose. An absence of alcoholism has been found in Asian women attempting suicide (Merrill & Owens, 1986). Item 6 on the SHI assessing whether respondents had ever abused alcohol revealed a much higher incidence in White British women (55%) compared with Asian Hindus (24%) and Asian Muslims (5%).

Testing the model I – Does cultural-values-conflict correlate with shame; does shame correlate with suicidality?

Pearson’s product-moment correlations were performed and showed that there was a small, significant correlation between cultural values conflict and the Western concept of shame for Asian Muslims ($r = 0.320, p = 0.016$) but not for Asian Hindus ($r = 0.265, p = 0.065$). For both Asian groups, there was a moderate correlation between cultural values conflict and *sharam* (Hindus: $r = 0.639, p < 0.0005$; Muslims: $r = 0.417, p < 0.001$). For the Asian groups, suicidality correlated significantly with shame (Hindus: $r = 0.451, p = 0.002$; Muslims: $r = 0.477, p < 0.0005$) and *sharam* (Hindus: $r = 0.400, p = 0.005$; Muslims: $r = 0.350, p = 0.008$). For the White British group, however, suicidality correlated significantly with shame ($r = 0.636, p < 0.0005$) but not with *sharam* ($r = 0.148, p = 0.326$).

Testing the model II – Does sharam mediate the effect of cultural values conflict on suicidality?



The Enter method in SPSS was used to calculate the raw (unstandardised) regression coefficient (**a**) and to obtain the standard error of **a** (**S_a**) for the association between

the IV and mediator. The same was done for the raw coefficient (**b**) and its standard error (**S_b**) for the association between the mediator and the DV (when the IV is also a predictor of the DV). These numbers were entered into the calculation tool for the Sobel test (Preacher & Leonardelli, 2001). Using this analysis, *sharam* was found to significantly carry the influence of cultural values conflict to suicidality (Sobel test, $Z = 3.183, p = 0.001$).

Testing the model III – Does religion moderate the effect of sharam on suicidality?

Using the Enter method, a significant model emerged ($F_{(3,100)} = 5.935, p = 0.001$). Adjusted R square = 0.126. However, no interaction was found between religion and shame ($Beta = -0.037, p = 0.692$).

DISCUSSION

Both statistically significant and non-significant results are discussed as important findings, bearing in mind the small sample size of each group and the fact that this study was examining a non-clinical sample. On isolated items on the SBQ-R and the SHI, consistently higher percentages of Asian Hindu women were found to have a history of suicidal ideation or suicide attempt when compared with the other two groups. On item 1 of the SBQ-R, suicidality in the Asian Hindu group was 1.5 times that of the White British group and almost twice that for the Asian Muslim group. On item 2 of the SBQ-R pertaining to suicidal ideation, 14% of Asian Hindus had thought about killing themselves more than twice that year. This is contrasted with 5% of Asian Muslims and 6% of White British women. Sixteen percent of Asian Hindu women had attempted suicide, compared to 12% of Asian Muslims and 8% of White British women. When suicidality measures were summed as a whole, there

were no significant differences in suicidality between the groups, although Asian Hindus scored highest on the SBQ-R and the PANSI, whilst the White British group scored highest on the SHI.

The SHI is a measure developed by Sansone et al. (1998), originally for use as a screening tool to distinguish between individuals with and without Borderline Personality Disorder. As with all the measures used, the SHI was developed using data from White Western populations and as such, certain items on this measure may not have been appropriate for use with Asian populations. Individual items on the SHI were compared across groups (not reported) and a much higher percentage of White British women responded 'yes' to items pertaining to abuse of alcohol and to promiscuity (items 6 and 11). Alcohol use is not permitted in Islam and prohibited in females in Hindu culture. One Muslim woman had written next to item 6, 'no access!' - suggesting that the restrictions placed on Asian women may not give opportunities for alcohol abuse or promiscuity. This fits with studies of attempted suicide showing lower levels of alcoholism in Asians compared to White women (e.g. Merrill & Owens, 1986).

A much higher percentage of Muslims responded 'yes' to item 21 on the SHI (pertaining to starving the self). The Islamic religious holiday of Ramadan requires that all Muslims who are physically able to do so, fast. Although fasting has different meanings for different Muslims, one central notion is that of feeling extreme hunger (i.e. hurting the self on purpose) in order to develop more appreciation of what one has and to be able to understand the feelings of those who do not have. If responding in this context, the higher percentage of Muslims answering 'yes' to item 21 would

not indicate a higher risk of suicidality. A more appropriate measure (not yet developed) would be one that uses items known to be most associated with suicide and accounts for cultural differences such as those described.

Previous studies examining suicidality in non-clinical (student) samples have found much lower levels than were found in this study. Brenner, Hassan and Barrios (1999) found that 10% of their college sample had seriously considered killing themselves in the past year – almost three times this level was found in Asian Hindus in the present study. In their sample, Brenner et al. (1999) found that 7% had a plan to kill themselves in the past year and 2% had attempted suicide in the same year. The current results are not directly comparable to this since the SBQ-R asks ‘*have you ever...*’ as opposed to Brenner et al.’s study, which looked at suicidality in the past year. However, the data collected here indicates generally higher levels of suicidality in the present sample. The levels of suicidal ideation found in Asian Hindus in this study were comparable to those in the National Comorbidity Survey in the US (Kessler, Borges & Walters, 1999), where a lifetime suicidal ideation level of 13% was found in the general population. Levels of suicidal ideation in the other two groups in this study were considerably lower than this.

No significant differences were found between the three groups on Western measures of shame. As expected, there were significant differences between the three groups on the SASS, which attempted to tap into culturally bound shame (*sharam*) - Asian Hindus scored highest and the White British group scored the lowest. One consideration in using the ESS for Muslim populations may be to leave out or modify the items assessing body shame. Item 25 on the ESS asks about wanting to

hide or conceal the body. Covering up for modesty is generally encouraged in Asian females, but is even more pertinent for Muslim women. Female Muslims may wear *hijab* (scarf covering the head, neck and chest, with the face uncovered), *chador* (a black sheet covering the head and entire body, with face uncovered) or *burqa* (similar to the *chador* but also covers the face, with a small slit or mesh to see out of). Some Muslim respondents in the present study commented that they were proud to cover, next to item 25 on the ESS (a high score on this item, then, not indicating shame, but pride in their religious beliefs). It is of note that a number of Muslim women recruited to the present study wore a *burqa*, indicating fervent religious beliefs.

The OAS scale measures the experience of shame as a factor of how others judge the self; similar to the concept of *sharam* that I was attempting to measure in the SASS, although the ‘other’ was named in the SASS as family and community. Interestingly however, the OAS and SASS did not correlate well, so could not be said to be measuring the same construct. Since the SASS was developed for the first time in this study, it has certain limitations, one being whether it is actually the cultural concept of shame that is being measured. Further research may use an adapted version of the OAS to measure *sharam* and substitute ‘other people’ for ‘family/community’. In Asian culture, having *sharam* and *izzat* means being brought up to be obedient and to behave in a way so as to bring honour to the family by personal behaviour, maintaining high academic standards and by contributing to the well-being of the family (Farver, Narang & Bhadha, 2002). In an Asian context, describing a person who ‘has no shame’ is accompanied by a conveyance of disgust. These issues could be explored further in developing a robust scale for measuring

shame in Asian women. Understanding an Asian woman's experience of shame requires a more in-depth understanding of *sharam* and *izzat*; what the shaming experience was, who may have born witness to it and who the woman fears shaming – including what consequences may occur as a result – rather than the more personalised, dispositional shame assessed in Western models.

Asian Hindus experienced significantly more conflict in cultural values than the Asian Muslim group. This could be due to slight differences found in the percentages of Hindus and Muslims who were born here (Muslims were slightly in excess), but this seems unlikely, as differences were small. Another hypothesis may be that cultural values conflict (CVC) is related to identification with the group 'Muslim' or 'Hindu'. Anecdotally, Muslim people seem to have a greater sense of in-group membership related to religion, evidenced in a small way by the existence of prayer rooms and Muslim societies in universities, that meet more regularly for actual Islamic events. Hindu societies also exist at universities, but they are generally used to organise social events unrelated to Hinduism as a culture or religion – more as a way of meeting other Hindus, regardless of religious affiliation. In both Asian groups, there was a small correlation between CVC and Western measures of shame and a moderate correlation between CVC and *sharam*. Moderate correlations were found between shame and suicidality ($r = 0.47$) and *sharam* and suicidality ($r = 0.39$) in the Asian groups. In the White group, shame correlated significantly with suicidality ($r = 0.64$) but *sharam* did not. As predicted, in the Asian groups, *sharam* significantly mediated the relationship between CVC and suicidality. Religion did not emerge as a moderating variable in that there was no difference between Hindus and Muslims in the relationship between *sharam* and suicidality. Since CVC was

also lower in Muslims, it may be that religion moderates earlier, for example affecting the extent to which life experiences lead to CVC, perhaps relating to Muslims identifying more strongly as Muslim and having more fervent religious beliefs. With this hypothesis in mind, a better fitting model is proposed in figure 4.

One major way to improve this study would be to have a much larger sample. Using a clinical population (e.g. attendances at Accident & Emergency following suicidal behaviour) would have provided a bigger sample of suicidal individuals to test the proposed model. However, with much more time, resources and funding, Bhugra et al. (1999b) were only able to recruit 27 Asian women who had attempted suicide to compare with control groups in their study. Indeed, the women who refused contact in their study did so because of “distrust of the investigator, of the system and of the establishment in general” (Bhugra et al., 1999b, p. 1133). These authors added that the suicidal act had been reported as sinful and *shameful* and that the individuals concerned, along with their families, were therefore unwilling to discuss it with a researcher. Since shame was central to the present investigation, finding a way women would feel able to disclose personal information was an important consideration in designing the study. Non-clinical populations for whom no personally identifying details are known, therefore, may be the best way to access large samples of Asian women.

The measures used could also have been improved to some degree. Apart from the SHI, there are as yet, no inventories for DSH. Using a measure developed to assess only those self-harming behaviours known to have a link to suicidality (e.g. ‘overdose’ – item 1 on SHI as opposed to ‘distancing from God’ – item 14) and

which is also culturally sensitive would have allowed better comparisons with other suicidality measures. More research on issues of shame in Asian women will hopefully lead to better measures to assess this construct.

Notwithstanding the limitations of this study and the need for replication, as the first study to examine *sharam* and *izzat* as mediators of the effect of CVC on suicidality, this study has significant implications for future research and clinical practice. Firstly, rates of suicidality in non-clinical populations of Asian women warrants further investigation, especially when considering that members of ethnic minorities are less likely to access mental health services (DoH, 1999) and suicidality in young Asian women has generally been characterised by an absence of mental disorder (e.g. Merrill & Owens, 1986). Secondly, constructs of shame and their importance in Asian culture also warrant further study. The importance given to *izzat* in Asian culture has also been demonstrated by Gilbert et al. (2003) and in recent media reports relating to ‘honour killings’ (BBC News, 2004).

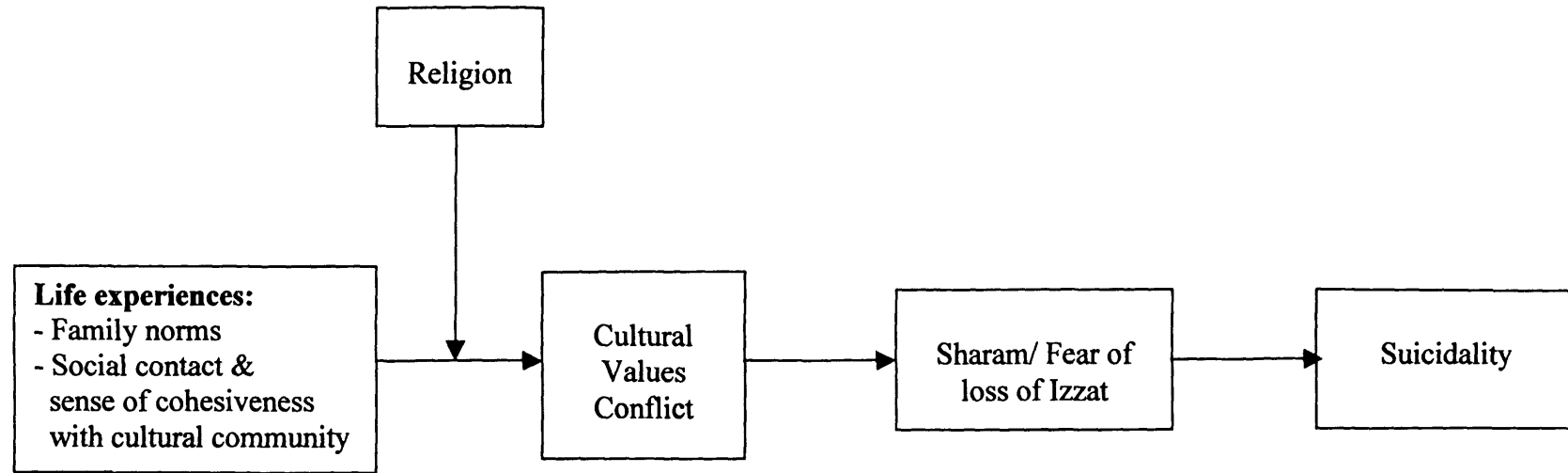
Clinically, results from this study imply that in assessment of young Asian women, sensitive exploration of the woman’s experiences of *sharam* and fear of loss of *izzat* are important considerations in both suicide risk assessment and in tailoring treatment interventions. Current measures of shame may be of limited use in understanding and measuring shame experienced by young Asian women. In attempting to understand the experience of shame in Asian women, most current literature regarding dispositional shame appears to have only indirect relevance. In line with Leeming and Boyle’s (2004) recent critical analysis of the concept of shame, conceptualisation of shame in Asian women may be better considered in

relation to their cultural context and as a product of certain social encounters. For clinical psychology, this indicates a need for a contextual approach to case conceptualisation and intervention for shame problems in Asian women. Previous studies examining completed (Raleigh et al., 1990) and attempted suicide (Merrill & Owens, 1986) in young Asian women have found an excess of married women. In the present study, 99% of the participants were single. Bhugra et al. (1999a) found that 66% of the Asian women attempting suicide in his sample were single, separated or divorced. Considering that the mean age of the present sample was 20 years, perhaps they were less likely to be married since they were younger. Another hypothesis may be that in 2005, marriage is not a very significant risk factor for young Asian women. Depending on the sample, Asian women aged 18-24 years, may have more opportunity to remain single for longer, for example through academia, but still experience *sharam* and fear of loss of *izzat* in other situations, unrelated to difficulties or conflicts relating to marriage.

Behaviours that young Asian women engage in, that are perfectly acceptable and possibly even expected in Western culture (such as dating, premarital sex and other social-sexual behaviours) conflict with traditional Asian values and may lead to an intense feeling of *sharam*, especially if the woman's family discover any of these behaviours. This is true not only for moral behaviour, but also for issues of social standing and success, such as academic achievement. In Western cultures, although going against family wishes (or failing in an academic situation) may induce some psychological distress, as a member of an individualist culture a White woman may feel more able to stand up for her own decisions and behaviours. The resultant feeling may be sadness, regret or guilt, but not the intense and more pathological

(e.g. Tangney & Dearing, 2002) feeling of intense shame. In shame, the person is said to feel the experience of being small and having a sense of worthlessness and powerlessness. To feel ashamed is to feel exposed, and the accompanying desire is to escape, hide or disappear. The ultimate escape from *sharam* for young Asian women may be death.

Figure 4: Revised Model of Suicidality in Young Asian Women



REFERENCES

- Andrews, B. & Hunter, E. (1997). Shame, early abuse and course of depression in a clinical sample: A preliminary study. *Cognition and Emotion*, *11*, 373-381.
- Andrews, B., Qian, M. & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The Experience of Shame Scale. *British Journal of Clinical Psychology*, *41*, 29-42.
- BBC News (2004). Police Probing 'Honour' Suicides. www.newsvote.bbc.co.uk, Retrieved on 09.12.04.
- Bhugra, D. (2002). Suicidal Behaviour in South Asians in the UK. *Crisis*, *23*, 108-113.
- Bhugra, D., Baldwin, D. S., Desai, M. & Jacob, K. S. (1999b). Attempted suicide in west London II. Inter-group comparisons. *Psychological Medicine*, *29*, 1131-1139.
- Bhugra, D., Desai, M. & Baldwin, D. S. (1999a). Attempted suicide in west London I. Rates across ethnic communities. *Psychological Medicine*, *29*, 1125-1130.
- Bhugra, D., Thompson, N., Singh, J. & Fellow-Smith, E. (2003). Inception rates of deliberate self-harm among adolescents in West London. *International Journal of Social Psychiatry*, *49*, 247-250.
- Brener, N. D., Hassan, S. S. & Barrios, L. C. (1999). Suicidal Ideation Among College Students in the United States. *Journal of Consulting and Clinical Psychology*, *67*, 1004-1008.
- Burke, A. W. (1976). Attempted suicide among Asian immigrants in Birmingham. *British Journal of Psychiatry*, *128*, 528-533.
- Chronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika*, *16*, 297-334.

- Cook, D. R. (1993). *The Internalised Shame Scale Manual*. Menomonie, WI: Channel Press. (Available from author, Rt. 7, Box 270a, Menomonie, WI 54751, USA).
- De Leo, D. (2002). Struggling Against Suicide. The Need for an Integrative Approach. *Crisis*, 23, 23-31.
- DoH (1999). *National Service Framework for Mental Health: Modern Standards and Service Models*. Department of Health, London.
- DoH (2002). *National Suicide Prevention Strategy for England*. Department of Health, London.
- Farver, J. A. M., Narang, S. K. & Bhadha, B. R. (2002). East Meets West: Ethnic Identity, Acculturation and conflict in Asian Indian Families. *Journal of Family Psychology*, 16, 338-350.
- Gilbert, P. (2002). Body shame: A biopsychosocial conceptualisation and overview, with treatment implications. In P. Gilbert and J. N. M. Miles (Eds.), *Body Shame: Conceptualisation, assessment and intervention* (pp. 3-54). London: Routledge.
- Gilbert, P., Bhundia, R., Mitra, R., McEwan, K., Irons, C. & Sanghera, J. (submitted). Cultural differences in attitudes towards mental health and experiences of shame in Asian and Non-Asian women.
- Gilbert, P., Gilbert, J. & Sanghera, J. (2003). A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby. *Mental Health, Religion and Culture*, 6, 1-22.
- Glover, G., Marks, F. & Nowers, M. (1989). Parasuicide in young Asian women. *British Journal of Psychiatry*, 154, 271-272.

- Goss, K., Gilbert, P. & Allan, S. (1994). An exploration of shame measures – I: The Other As Shamer Scale. *Personality and Individual Differences, 17*, 713-717.
- Handy, S., Chithiramohan, R. N., Ballard, C. G. & Silveira, W. R. (1991). Ethnic differences in Self-Poisoning : A Comparison of Asian and Caucasian Groups. *Journal of Adolescence, 14*, 157-162.
- Inman, A. G., Ladany, N., Constantine, M. G. & Morano, C. K. (2001). Development and preliminary validation of the Cultural Values Conflict Scale for South Asian women. *Journal of Counselling Psychology, 48*, 17-27.
- Kassam, N. (1997). *Telling It Like It Is – Young Asian women Talk*. London: The Women's Press.
- Kerkhof, A. J. F. M. (2000). Attempted Suicide: Patterns and Trends. In: K. Hawton & K. van Heeringen (Eds.), *The International Handbook of Suicide and Attempted Suicide* (pp. 49-64). Chichester: Wiley.
- Kessler, R. C., Borges, G., Walters, E. E. (1999). Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. *Archives of General Psychiatry, 56*, 617-626.
- Leeming, D. & Boyle, M. (2004). Shame as a social phenomenon: A critical analysis of the concept of dispositional shame. *Psychology and Psychotherapy: Theory, Research and Practice, 77*, 375-396.
- Linehan, M. M. & Nielson, S. L. (1981). Suicidal Behaviors Questionnaire (SBQ). Unpublished manuscript. (Available from Marsha M. Linehan, University of Washington, Seattle).
- Lönnqvist, J., K. (2000). Psychiatric Aspects of Suicidal Behaviour: Depression. In: K. Hawton & K. van Heeringen (Eds.), *The International Handbook of Suicide and Attempted Suicide* (pp. 107-120). Chichester: Wiley

- Marshall, H. & Yazdani, A. (1999). Locating Culture in Accounting for Self-Harm amongst Asian Young Women. *Journal of Community Applied Social Psychology*, 9, 413-433.
- Merrill, J. & Owens, J. (1986). Ethnic differences in self-poisoning: A comparison of Asian and White groups. *British Journal of Psychiatry*, 148, 708-712.
- Merrill, J., Owens, J., Wynne, S. & Whittington, R. (1990). Asian suicides (letter). *British Journal of Psychiatry*, 156, 748-749.
- Murphy, G. E. (2000). Psychiatric Aspects of Suicidal Behaviour: Substance Abuse. In: K. Hawton & K. van Heeringen (Eds.), *The International Handbook of Suicide and Attempted Suicide* (pp. 135-146). Chichester: Wiley.
- Office for National Statistics (2003). National Census 2001.
- Osman, A., Bagge, C. L., Gutierrez, P. M., Konick, L. C., Kopper, B. A. & Barrios, F. X. (2001). Suicidal Behaviors Questionnaire – Revised (SBQ-R): Validation with clinical and non-clinical samples. *Assessment*, 8, 445-455.
- Osman, A., Gutierrez, P. M., Kopper, B. A., Barrios, F. X. & Chiros (1998). The Positive and Negative Suicide Ideation Inventory: Development and Validation. *Psychological Reports*, 82, 783-793.
- Osman, A., Kopper, B. A., Barrios, F. X., Osman, J. R., Besett, T. & Linehan, M. M. (1996). The Brief Reasons for Living Inventory for Adolescents (BRFL-A). *Journal of Abnormal Child Psychology*, 24, 433-443.
- Preacher, K. J. & Leonardelli, G. J. (2001). Calculation for the Sobel test: An interactive calculation tool for mediation tests [Computer software]. Available from <http://www.unc.edu/~preacher/sobel/sobel.htm>.

- Raleigh, V. S. (1996). Suicide Patterns and Trends in People of Indian Subcontinent and Caribbean Origin in England and Wales. *Ethnicity and Health, 1*, 55-63.
- Raleigh, V. S. & Balarajan, R. (1992). Suicide and self-burning among Indians and West Indians in England and Wales. *British Journal of Psychiatry, 161*, 365-368.
- Raleigh, V. S., Bulusu, L. & Balarajan, R. (1990). Suicides Among Immigrants from the Indian Subcontinent. *British Journal of Psychiatry, 156*, 46-50.
- Sanchez, H. G. (2001). Risk Factor Model for Suicide Assessment and Intervention. *Professional Psychology: Research and Practice, 32*, 351-358.
- Sansone, R. A., Wiederman, M. W. & Sansone, L. A. (1998). The Self-Harm Inventory (SHI): Development of a Scale for Identifying Self-Destructive Behaviors and Borderline Personality Disorder. *Journal of Clinical Psychology, 54*, 973-983.
- Sen, M. (2001). *Death by Fire: Sati, Dowry Death and Female Infanticide in Modern India*. Guernsey: The Guernsey Press.
- Tangney, J. P. & Dearing, R. L. (2002). *Shame and Guilt*. New York: Guildford Press.
- Thompson, N. & Bhugra, D. (2000). Rates of deliberate self-harm in Asians: findings and models. *International Review of Psychiatry, 12*, 37-43.
- Triandis, H. C. (1995). *Individualism and Collectivism*. Boulder, CO: Westview Press.
- van Heeringen, K., Hawton, K. & Williams, J. M. G. (2000). In: K. Hawton & K. van Heeringen (Eds.), *The International Handbook of Suicide and Attempted Suicide* (pp. 223-234). Chichester: Wiley.

Wright, N., Trethowan, W. N. & Owens, J. (1981). Ethnic differences in self-poisoning. *Postgraduate Medical Journal*, 57, 792-793.

Yazdani, A. (1998). *Young Asian women and Self-Harm. A mental health needs assessment of young Asian women in Newham, East London*. London: Newham Inner-city Multi fund/ Newham Asian Women's Project.

Part 3:

Researching Shame and Suicidality in Young Asian Women: A Critical Appraisal

Why Study Suicidality in Young Asian Women?

In the present research I intended to further add to the mounting evidence of a greater vulnerability to suicidality amongst young South Asian women, as well as to aid the understanding of why this may be so. A sound national context in terms of the British Government's concerns with improving mental health provided me with an initial rationale behind the importance of understanding suicidality in this group. Standard 7 in the National Service Framework (DoH, 1999) relates to preventing suicide, with a target set to reduce suicide by a fifth by 2010. The framework recognises that certain groups of people are at higher risk; amongst women living in England, those born in India and East Africa have a 40% higher suicide rate than those born in England and Wales (DoH, 1999).

The national suicide prevention strategy for England (DoH, 2002) includes goals to reduce risk in high-risk groups and to promote research on suicide and suicide prevention. Young Asian women do not meet the criteria of a high-risk group as defined in the document because actual suicide numbers are not known (coroners are not expected to routinely record ethnicity) and there is a lack of appropriate research in this group, resulting in little evidence on which to base preventative measures. The document states that vulnerable groups that do not meet criteria for high-risk groups are included instead in Goal 2 (promoting well being as opposed to specifically reducing risk) – one objective specified being to promote mental health among people from black and ethnic minority groups, “*including Asian women*”. These documents, therefore, demonstrate a need for further research in this area.

Strengths, Weaknesses and Limitations of the Present Study

Burless and De Leo (2001) reviewed community surveys of suicide ideation and attempts and highlighted important methodological issues. Since there is evidence that suicidal behaviour exists on a continuum from ideation to actual attempt (e.g. Beck, Schuyler & Herman, 1974; Brent, et al., 1988) and because evidence exists for an intensification of suicidal manifestation (ideation, plans and attempts) being highest in the year following the first suicidal manifestation (Kessler, Borges & Walters, 1999), Burless and De Leo (2001) note the importance of early detection to prevent later suicide. This demonstrates a strength of the present study; community studies are important areas of research in the early detection of suicidality alongside research with clinical populations.

Several points are worth noting related to the representativeness of my sample. I used a sampling method that allowed a fairly equal probability of recruitment to the study, in that I personally approached almost every female student I saw on three university campuses who appeared to be White or Asian, and this was done in different areas of the university campuses, on different days over four months. One might expect this method to produce a fairly representative sample of university students with little bias in results. A personal reflection on this process, however, reminds me that this was sometimes a nerve-racking undertaking and so there could have been a bias due to some individuals seeming more approachable to me than others, and also a bias of personality characteristics of those agreeing to take a questionnaire. I purposefully decided not to recruit groups of Psychology students, although access to Psychology undergraduates would have been much easier in terms of gaining permission to talk to year groups as a whole, which would have taken less time than my method of

individually approaching students on campus. As Burless and De Leo (2001) point out, using Psychology undergraduates in community studies of suicidality compromises generalisability of results. I also note that the extent to how representative the present sample was may be compromised by the fact that all participants were undergraduate university students; who may not be very representative of the general population of young White and Asian women, not least because of educational and socio-economic differences. Amongst Asian women, those who may be brought up more traditionally and who may not be encouraged or allowed to attend university may also be those who are married at a younger age. This may be significant since marriage has been shown to be a risk factor in young Asian women (e.g. Merrill & Owens, 1986) and so future research in this area may usefully investigate non-student community samples. Much of the literature concerning community studies of suicidality in young people utilise university student samples. Gutierrez, Osman, Kopper, Barrios & Bagge (2000) review current literature and conclude that suicidality is a major area of concern for the university student population. In considering representativeness, one also has to take into account funding constraints, ease of accessibility to samples and also methods of data collection. In general, the results from the present study may be considered to be more representative of the communities I am seeking to research than results from clinical studies.

One weakness of the present study is the relatively small sample size. For a medium effect size at power = 0.80, for $\alpha = 0.05$, I needed at least 52 participants in each group (Cohen, 2003), which was more or less achieved (50 participants in the Asian Hindu group, 60 in the Asian Muslim group and 49 in the White British group).

However, the effect size may have been much smaller than estimated. Also, having given 600 questionnaires out, only 159 were returned, giving a response rate of 26.5%. Burless and De Leo (2001) comment that poor response rates may impact on the generalisability of results. Ensuring an adequate sample size for statistical power and ensuring good response rates could improve this study. However, since this research was asking about shame and suicidality, I believe one of its strengths was in the anonymity of participation. Offering small financial incentives to respondents may improve response rates but may also compromise what is gained by anonymity. Intuitively, I question the use of any other method in gaining honest and frank prevalence rates of attempted suicide. It is not clear how face-to-face interviewing affects the reporting of suicidal behaviour in community studies, but evidence suggests that patients in clinical research feel more comfortable in disclosing suicide attempts on anonymous surveys (Kaplan et al., 1994). As a relatively cost- and time-effective method, which also allows for full and frank responses, anonymous surveys are a good method of data collection.

A final point of weaknesses in the present study is that of definition and measurement of suicidality. Burless and De Leo (2001) argue that most community studies of suicidality do not allow for comparability across studies due to the varying definitions and measures used. For example, two of the studies they reviewed, assessing suicidality in young people, specifically examined self-reported prevalence of attempted suicide in university students, and so seemed comparable to the present study. Rudd (1989) found a 5.5% prevalence of attempted suicide and Schweitzer, Klayich and McLean (1995) found a 6.6% prevalence rate in their sample of Australian university students. In the present study; I found a prevalence of

attempted suicide of 16% in Asian Hindus, 12% in Asian Muslims and 8% in White British women. Notwithstanding the limitations of small sample size already discussed, these prevalence rates in the Asian women do seem much higher than those found in the general student populations in the studies described above. However, Burless and De Leo (2001) point out that differences in the wording and interpretation of questions may have a marked impact on results, even when asking about the seemingly set event of attempted suicide (as opposed to the various ways of framing questions about suicide ideation). They suggest, for example, that some individuals might consider it a suicide attempt when “one attempts an attempt (such as pointing a loaded gun at oneself but does not fire)” (Burless & De Leo, 2001, p. 122). If a study specifically asked questions about the method of attempt, consequences of it (e.g. medical) and how serious an intention the person had to die, conclusions about prevalence rates of attempted suicide would not necessarily then be comparable to, say, the present study where prevalence rates were gained from simply the frequency of ‘yes’ responses to the question ‘have you ever attempted suicide?’ Conclusions about whether or not my results represented elevated rates of attempted suicide should therefore be tentative. Burless and De Leo (2001) argue that future studies of suicidality should all use the same operationalised definitions, measures and core questions concerning suicidal behaviour in order to allow adequate comparisons between studies.

The main methodological difficulty in researching shame in an Asian cultural context is the inadequacy of current validated shame scales, which led me to develop a measure for use in this study. This puts limits on the validity of conclusions related to shame assessed by this measure. These issues are discussed below.

Researching Shame in an Asian Cultural Context

Shame has been subject to much research interest over the past 10 to 15 years. It has been referred to as the “gold to be mined psychotherapeutically” (Miller, 1996, p. 151) and although many researchers believe that there is a growing consensus about what shame is and how it feels, others suggest that we do not yet have methodologies to explore the differing points of view with regards to the experience of shame (Andrews, 1998). Variants in the experience and conceptualisation of shame in different cultures remains an area that has not as yet received much research interest.

Andrews (1998) discussed how researchers have conceptualised the characteristics of high-shame in their measures and whether shame scales actually measure shame or some other related concept. She examined the construction of existing scales, finding that they were designed to assess individuals who were ‘shame-prone’, those who felt generalised shame and those who were chronically ashamed of their behaviour or personal characteristics. This embodies one of the major difficulties I had in designing the present study. In examining published and validated shame scales, I found that none of them seemed to capture the type of shame I was trying to assess in Asian women. I was not looking for a measure that assessed ‘shame-proneness’ in individuals. The underlying notion in dispositional measures of shame is that certain individuals are more prone to experiencing shame across a range of situations. The hypotheses I had in mind certainly led me to believe that Asian women as a group are perhaps more prone to feeling shame in situations that transgress cultural norms than White women would be in the same situations (because the situations do not necessarily transgress White British cultural norms) but I was not hypothesising about individual personality dispositions. I recognised that Asian women from

differing backgrounds and religions and indeed family values may not be 'shame-prone' when measured by existing (Western) scales. Similarly, reviewing background literature and thinking about this research did not lead me to hypothesise that Asian women may experience generalised shame, or a chronic shame relating to behaviour or personal characteristics that existing measures assess. Indeed, as an Asian woman myself, I intrinsically knew what it was I wanted to measure, but found it very difficult to express in words.

Fortunately, Professor Paul Gilbert had already begun looking at shame experienced in South Asian culture and kindly sent me a scale he was using in on-going research assessing cultural differences in attitudes towards mental health and experiences of shame in Asian and non-Asian women (Gilbert et al., submitted) (Appendix XII). Highly significant differences were found in the study by Gilbert and colleagues, between Asian and non-Asian groups of women on the reflected family shame subscale (see Appendix XIII), which I used to form the basis of my questionnaire, the South Asian Shame Scale (SASS). Having had more time to reflect on the items in this scale, I can now see how the wording may be further improved to capture the essence of *sharam*, related to *izzat* (see this volume, p. 44-45 for definitions). For example, in traditional Asian society, values are still widely held that the father is the head of the household and has ultimate say over decisions affecting a member of the family. In such a patriarchal context, the concept of family *izzat* is probably more usefully understood as father's *izzat*. In other words, a young Asian woman may fear shaming her *father* the most, and items on the SASS, if worded as such, may have captured the concept of *sharam* better. Indeed, many of the young Asian women quoted in Kassam (1997) wrote about living a 'dual life' for fear of fathers' *izzat*

being lost if certain aspects of their lives were discovered. A comparison of different versions of the SASS along the lines suggested would certainly be useful to identify the most valid way of assessing *sharam*.

The concept of living a 'dual life' is one that warrants further research. Evidenced by the experiences of women recorded by Yazdani (1998) and Kassam (1997), but also anecdotally from conversations with Asian clients, friends and colleagues, many young Asian women seem to be coping with living in two cultures by literally living out two separate existences; one at 'home', amongst Asian relatives and another when outside the home, with peers. In effect, many young Asian women may be living a 'secret' life – one that may have serious consequences, if discovered by their families. Tragic reports in the media tell of 'honour killings' of daughters and nieces upon the discovery of a break of cultural rules such as an illicit relationship (BBC News, 2004). Of course, this brings us back to shame. The experience of *sharam* in Asian women may be conceptualised as having 'secrets' about the self that, if discovered, would result in others' disapproval, disgust, and loss of *izzat*.

Tangney & Dearing (2002) argue that although certain situations may be more likely to elicit shame than others, shame comes from self-relevant meanings given to an event rather than the type of event itself; a principle central to cognitive formulations of emotions. This may be true also for Asian individuals; however, I argue that in an Asian cultural context, *sharam* is culturally constructed in that *sharam* comes from *culturally-relevant* meanings rather than *self-relevant* ones. This has implications for cognitive formulations and therapy with Asian individuals if the type of shame experienced is *sharam*.

Why Might a Sharam Experience Lead to Suicide?

Nathanson (1994) argued that a sudden decrement in positive affect is central to shame. This may fit with a model of suicidal behaviour in young Asian women that recognises the absence of mental disorder, and conceptualises a suicide attempt as a drastic, impulsive act. A sudden decrement in positive affect, the desire to hide, escape or disappear and the possible feelings of being trapped in a situation (e.g. Gilbert, Gilbert & Sanghera, 2003) may lead to increased risk of suicidality in Asian women. This leads me to wonder how likely it would be that in studies of suicide attempts in young Asian women, the women themselves would describe feeling *sharam* as a precipitant to suicidal behaviour. Certainly, in such studies, previous authors have cited 'culture conflict' as a precipitant (Glover, Marks & Nowers, 1989; Handy, Chithiamohan, Ballard & Silveira, 1991; Merrill & Owens, 1986) since the women interviewed in these studies cited difficulties such as unwanted arranged marriages as precipitants to distress. However, some theorists suggest that shame may be bypassed (i.e. the individual does not become fully conscious of feeling shame) and instead the individual just experiences a shame-defensive emotion such as the desire to escape (e.g. Retzinger, 1991).

Izzat has been implicated in distress leading to self-harm and suicide in South Asian women in a number of studies and theoretical papers (Bolz, 2002; Bhardwaj, 2001; Chew-Graham, Bashir, Chantler, Burman & Batsleer, 2002; Gilbert et al., 2003; Yazdani, 1998). Bolz (2002) discussed the high suicide rate in Sri Lanka with reference to *izzat* controlling individuals' freedom to express rage and anger, especially in females in the population - leading to directing aggression inwards and resulting in suicidality.

In a focus group study of Asian women's experiences, Chew-Graham et al. (2002) found that all four groups in their study referred to the concept of *izzat* as a major influence in their lives. They proposed that *izzat* was given precedence over the care and happiness of children in some families and that it could be misused to reinforce women's traditional roles and to coerce women into remaining silent about their problems. The women also thought that the burden of *izzat* was unequally placed on the females in a family, resulting in hard-to-achieve expectations for women. This, coupled with a 'very efficient community grapevine' (Chew-Graham et al., 2002, p. 342) resulted in an extreme lack of personal space and privacy, and a feeling that any behaviour deemed to be inappropriate would very quickly get back to family members and result in some catastrophe for the woman concerned. Seeking help was similarly governed by *izzat* and lack of privacy, in that women worried about who would see her, for example, going to a doctor's surgery unaccompanied. Real mistrust of other Asian individuals working in health care is evident from these accounts and unfortunately represents a legitimate fear. In Yazdani's (1998) study, women spoke about (Asian) male GPs overriding professional guidelines on confidentiality and telling their parents when they had gone to the GP in confidence over a personal matter. In a study by Dwyer (2000), young Muslim women also reported feeling under the scrutiny of a wider extended community and perceived or actual losses of *izzat* being catastrophised.

Experiences of *sharam* related to loss of a father's *izzat* may result in impulsive suicidal behaviour in Asian women through the fear of what might happen to them if their '*sharam* secret' is discovered and through feelings of disempowerment, entrapment and subordination (Gilbert et al., 2003) with little or no freedom or

privacy to escape in any other way. Under high socio-cultural pressure to conform, Asian women may see no other way out of a crisis situation than to turn to suicide.

Personal Reflections on the Research Process

I would like to raise a number of issues, which are pertinent to my own position in planning and conducting this research. In considering why there is so little research on understanding suicidality in what appears to be a high-risk group, I was struck by two factors which may be responsible for the scarcity of research. Firstly, I wondered whether (White) people might feel so ‘paralysed by political correctness’ that research such as this is mainly left for Asian researchers to conduct. In qualifying this view, I would like to note that as an Asian woman brought up in England, I inherently understand both cultures. The idea of studying *sharam* and *izzat* came about from my own experiences of these concepts and I recognise that this would not be the experience of a White researcher. I also note that it may have been easier for me to recruit Asian women participants to the study, as an Asian woman myself. Since I was approaching potential respondents individually, I had to ‘guess’ ethnicity before I approached and then ask directly once I had introduced myself. I wondered how comfortable a White researcher would be in this situation and whether Asian participants might react with possible hostility at being asked about their ethnicity by a non-Asian. I note Marshall and Yazdani’s (1999) assertion that the term ‘culture clash’ used by researchers in an attempt to explain high rates of suicidal behaviour in Asian women implies that Asian culture is pathogenic. They point out that this term has often been used by White researchers, perhaps implying that Asian culture has been misunderstood by those not part of it. In my view, this may further add to the ‘uneasiness’ of researchers from the cultural majority when considering ethnic

minority cultural differences and contribute to opinions that only Asian people should research Asian issues. The present research implicates Asian culture in the suicidality of Asian women. Would my research similarly be taken to be pathologising Asian culture or fostering negative stereotypes, or perhaps are such conclusions better digested when coming from a fellow Asian woman? I believe that it was an easier exercise for me to dissect and discuss Asian culture and not feel that I was being racist or stereotyping, than it may have been for a non-Asian.

Secondly, in my clinical experience I have come across colleagues who openly expressed their view that 'ethnicity is irrelevant in the NHS'. Such attitudes left me with some sense of apprehension while planning this study, not least wondering whether this type of research would be valued and supported by my (predominantly White) training course. I am pleased to say that my experiences in conducting the present research have been very positive. My research ideas were supported, validated and encouraged by all the potential supervisors I spoke to, and I also had the fortune to be supervised by two individuals with whom I could speak openly, and both of who were never once 'paralysed by political correctness'. In understanding cultural difference, one may still be respecting that difference whilst attempting to understand negative aspects of it. I appreciated being able to discuss various ideas with my supervisors without feeling censored. Since both my supervisors are non-Asian, I found it a useful challenge in the initial stages of my research, to try and convey what I understood by *sharam* and *izzat*. Had my supervisors been Asian, we may have all intrinsically understood these concepts without being able to explicitly verbalise their meaning as clearly as was required. Conducting this study under the supervision of two White supervisors made me recognise, from a non-Asian clinician's point of view, the complexity of the concepts of *sharam* and *izzat*, which

need careful explanation and discussion. Non-Asian clinicians working with high numbers of Asian individuals may require specific training on these issues in order for them to feel confident to raise them in a sensitive manner during the assessment and treatment process.

Finally, I wanted to reflect on studying suicidality. From my clinical experience working in a 24 hour crisis team, often with acutely suicidal individuals, to experience just simply telling people what I am studying for my thesis, I have become acutely aware of how frightened we are of mentioning suicide. Indeed, my initial attempts at contacting universities to gain access to students for this research were met with considerable mistrust and fear. It was often difficult to step back from the frustration of this to understand why people reacted in this way. One head of department I approached at a university told me that she felt many of her female Asian students were 'very vulnerable' and suicide and self-harm were certainly relevant issues for them, and therefore it would *not* be a good idea for me to access them. Reflecting on the fear of members of the public, institutions and even health care professionals of asking about suicidal ideation, I believe the most pertinent issues are to do with risk and responsibility. The prevailing expert opinion is that asking about suicidal ideation does NOT increase the likelihood of suicide attempts (Hall, 2002). However, this conclusion does not seem to have filtered through to non-experts and I felt that pervasive opinions existed amongst the people I contacted at universities, that by coming to speak to their female students about my research, I would in some way be 'opening the flood gates' and that they would be left to contain the fear and increased risk of their students' suicidal urges.

In conclusion, the present study, keeping in mind the limitations highlighted, goes some way to demonstrate an elevated risk of suicidality in Asian women, compared to White women, and also gives some support to *sharam* as a mediating factor between cultural values conflict and later suicidality. I recognise that stereotypes concerning Asian women are unhelpful, and hope that I have been able to conduct this research honestly and without defence, without adding further to the stereotyping of Asian women. In recognising and naming the anxiety that pervades any discussion of race and culture, I hope that I have been able to examine these issues in a context of inclusion and not exclusion, and with a sincere desire for learning.

REFERENCES

- Andrews, B. (1998). Methodological and Definitional Issues in Shame Research. In: P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal Behaviour, Psychopathology, and Culture* (pp. 39-54). Oxford: OUP.
- BBC News (2004). *Police Probing 'Honour' Suicides*. www.newsvote.bbc.co.uk, Retrieved on 09.12.04.
- Beck, A. T., Schuyler, D. & Herman, J. (1974). Development of Suicide Intent Scales. In: A. T. Beck, H. P. L. Resnick & D. J. Lettieri (Eds.), *The Prediction of Suicide* (pp. 54-56). Philadelphia, PA: Charles Press.
- Bhardwaj, A. (2001). Growing Up Young, Asian and Female in Britain: A Report on Self-Harm and Suicide. *Feminist Review*, 68, 52-67.
- Bolz, W. (2002). Psychological Analysis of the Sri Lankan Conflict Culture with Special Reference to the High Suicide Rate. *Crisis*, 23, 167-170.
- Brent, D. A., Perper, J. A., Goldstein, C. E., Kolko, D.J., Allan, M. J., Allman, C. J. & Zellnak, J. P. (1988). Risk factors for adolescent suicide: A comparison of adolescent suicide victims with suicidal in-patients. *Archives of General Psychiatry*, 45, 581-588.
- Burless, C. & De Leo, D. (2001). Methodological Issues in Community Surveys of Suicide Ideators and Attempters. *Crisis*, 22, 108-123.
- Chew-Graham, C., Bashir, C., Chantler, K., Burman, E. & Batsleer, J. (2002). South Asian women, psychological distress and self-harm: lessons for primary care trusts. *Health and Social Care in the Community*, 10, 339-347.
- Cohen, J. (2003). A power primer. In A. E. Kazdin (Ed), *Methodological issues & strategies in clinical research* (3rd ed.) (pp. 427-436). Washington, DC, US: American Psychological Association.

- DoH (1999). *National Service Framework for Mental Health: Modern Standards and Service Models*. Department of Health, London.
- DoH (2002). *National Suicide Prevention Strategy for England*. Department of Health, London.
- Dwyer, C. (2000). Negotiating Diasporic Identities: Young British South Asian Muslim Women. *Women's Studies International Forum*, 23, 475-486.
- Gilbert, P., Gilbert, J. & Sanghera, J. (2003). A focus group exploration of the impact of *izzat*, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby. *Mental Health, Religion and Culture*, 6, 1-22.
- Gilbert, P., Bhundia, R., Mitra, R., McEwan, K., Irons, C. & Sanghera, J. (submitted). Cultural differences in attitudes towards mental health and experiences of shame in Asian and Non-Asian women.
- Glover, G., Marks, F. & Nowers, M. (1989). Parasuicide in young Asian women. *British Journal of Psychiatry*, 154, 271-272.
- Gutierrez, P. M., Osman, A., Kopper, B. A., Barrios, F. X. & Bagge, C. L. (2000). Suicide Risk Assessment in a College Student Population. *Journal of Counselling Psychology*, 47, 403-413.
- Hall, K. (2002). Suicide prevention topic 7: Does asking about suicidal ideation increase the likelihood of suicide attempts? *NZHTA Report*.
- Handy, S., Chithiramohan, R. N., Ballard, C. G. & Silveira, W. R. (1991). Ethnic differences in Self-Poisoning : A Comparison of Asian and Caucasian Groups. *Journal of Adolescence*, 14, 157-162.
- Kaplan, M. L., Asnis, G. M., Sanderson, W. C., Keswani, L., De Lecuona, J. M. & Joseph, S. (1994). Suicide assessment: Clinical interview vs. self-report.

- Journal of Clinical Psychology*, 50, 294-298.
- Kassam, N. (1997). *Telling It Like It Is – Young Asian women Talk*. London: The Women's Press.
- Kessler, R. C., Borges, G., Walters, E. E. (1999). Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. *Archives of General Psychiatry*, 56, 617-626.
- Marshall, H. & Yazdani, A. (1999). Locating Culture in Accounting for Self-Harm Amongst Asian Young Women. *Journal of Community Applied Social Psychology*, 9, 413-433.
- Merrill, J. & Owens, J. (1986). Ethnic differences in self-poisoning: A comparison of Asian and White groups. *British Journal of Psychiatry*, 148, 708-712.
- Miller, S. B. (1996). *Shame in context*. Hillsdale, NJ: Analytic Press.
- Nathanson, D. L. (1994). *Shame and Pride: Affect Sex and the Birth of the Self*. New York: Norton Paperbacks.
- Retzinger, S. (1991). *Violent Emotions: Shame and Rage in Marital Quarrels*. New York: Sage.
- Rudd, M. D. (1989). The prevalence of suicidal ideation among college students. *Suicide and Life-Threatening Behaviour*, 19, 173-183.
- Schweitzer, R., Klayich, M. & McLean, J. (1995). Suicidal ideation and behaviours among university students in Australia. *Australian and New Zealand Journal of Psychiatry*, 29, 473-479.
- Tangney, J. P. & Dearing, R. L. (2002). *Shame and Guilt*. NY: Guildford Press.
- Yazdani, A. (1998). Young Asian women and Self-Harm. A mental health needs assessment of young Asian women in Newham, East London. London: Newham Inner-city Multi fund/ Newham Asian Women's Project.

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The Graduate School
University College London
Gower Street London WC1E 6BT

Professor Leslie C Aiello
Head of the Graduate School

6 July 2004

Dr Katrina Scior
Lecturer
Sub-Department of Clinical Health Psychology
University College London
Gower Street Campus

Dear Dr Scior

Re: Notification of Ethical Approval

Suicidality in Young Asian Women: The Role of Shame

Further to the meeting of the UCL Committee for the Ethics of Non-NHS Human Research, I am pleased to inform you that your application has been approved. The Committee agreed that this was an extremely valuable, well-written and intelligible piece of research and that despite the fact that participants might find some of the questions in the questionnaire distressing, particularly those pertaining to suicidal ideation and self-harm, you had sought to effectively minimise the risks.

Ethical approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The form identified above can be accessed by logging on to the ethics website homepage: <http://zzz.grad.ucl.ac.uk/ethics/> and clicking on the button marked 'Key Responsibilities of the Researcher Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

Reporting Non-Serious Adverse Events.

For non-serious adverse events you will need to inform Ms Helen Dougal, Ethics Committee Administrator, within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics

Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Reporting Serious Adverse Events

The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

3. On completion of the research you MUST submit a brief report (maximum of two sides of A4) of your findings to the Committee. Please comment in particular on any ethical issues you might wish to draw to the attention of the Committee. We are particularly interested in comments that may help to inform the ethics of future similar research.

Yours sincerely

- -

1

Sir John Birch

Chair of the UCL Committee for the Ethics of Non-NHS Human Research

Cc: Ms Sejal Patel, Trainee Clinical Psychologist, Sub-Department of Clinical Health Psychology

APPENDIX II

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT



Participant Information Sheet

Research Study: Suicidality in White and Asian Women.
Researcher: Ms Sejal N. Patel, Trainee Clinical Psychologist.
Supervised by: Dr. Peter Scragg & Dr. Katrina Scior.

You are invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please read the following information. Please ask me if there is anything that is unclear or if you would like more information.

What is the purpose of the research project?

To understand differences in the experiences of White and Asian women. Specifically, we are looking at times when women from these groups may contemplate self-harm or suicide.

Why have I been chosen?

We are asking White, Asian Hindu and Asian Muslim women, aged 18-24 years, to take part in this study. Participants are mainly drawn from the student bodies at different London universities, where there are diverse ethnic student populations.

Do I have to take part?

You do not have to take part in this study if you do not wish to. The decision is up to you, and completely independent of the University. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form, which you will also have a copy of. If you do decide to take part, you can withdraw at any time without having to give a reason.

What will happen if I take part?

I will give you a questionnaire to complete in your own time. It will probably take you 15-20 minutes to complete and can be handed back to me in a sealed envelope, or I will arrange another time for collection. All information collected about you during the study is strictly confidential and will be coded by number only. Your name will not appear on any forms. All questionnaires will be collected and stored in accordance with the Data Protection Act.

What are the advantages and disadvantages of taking part?

The questionnaire includes questions about difficult feelings that you may have had, which some participants may find distressing. For this reason, you will find at the end of the questionnaire pack, a list of telephone numbers of organisations that you can contact if necessary. We hope that the information we collect from this study will improve our understanding of women's experiences and have implications for improving services to female clients.

What will happen to the results of the study?

The results will be written up as part of a thesis, which we hope will be published in a scientific journal. No individual responses will be identifiable in the writing up of this work. A summary of the findings will be available to all who take part.

Who is organising and funding the study?

The study is organised and funded by the Sub-Department of Clinical Health Psychology, University College London.

Contact for further information:

If you would like further information, please contact me on 07905 943654, or my supervisors, Peter Scragg and Katrina Scior on the numbers at the top of this page.

Thank you for taking time to read this.

Approved by University College London's Committee on the Ethics of Non-NHS Human Research

APPENDIX III

Informed Consent Form

CONFIDENTIAL

Research Study: Suicidal Ideation in White and Asian Women
Researcher: Ms Sejal N. Patel
Supervised by: Dr. Peter Scragg & Dr. Katrina Scior

Have you read the Participant Information Sheet?	YES	NO
Has the project been explained to you verbally?	YES	NO
Have you had the opportunity to ask questions and discuss the study?	YES	NO
Have you received satisfactory answers to all your questions?	YES	NO
Have you received enough information about the study?	YES	NO
Do you understand that you are free to withdraw from the study at any stage, without penalty?	YES	NO
Do you agree with the publication of the results of this study in an appropriate outlet/s?	YES	NO

Comments or Concerns During the Study

If you have any comments or concerns you should discuss these with the Principal Researcher. If you wish to go further and complain about any aspect of the way you have been approached or treated during the course of the study, you should email the Chair of the UCL Committee for the Ethics of Non-NHS Human Research (gradschoolhead@ucl.ac.uk) or send a letter to: The Graduate School, North Cloisters, Wilkins Building, UCL, Gower Street, London WC1E 6BT, who will take the complaint forward as necessary.

Signed (participant): **Date:**.....

Full name in capitals:

Signed (researcher): **Date:**

Full name in capitals:

APPENDIX IV

DEMOGRAPHICS

Today's date: _____ Age: _____ Country of Birth: _____

Ethnicity: (please tick *one*) Indian/ British Indian Sri Lankan/ British Sri Lankan

Pakistani/ British Pakistani Bangladeshi/ British Bangladeshi White British

Age of entry to UK: (if born elsewhere) _____ Religion: _____

Level of religiosity: (please circle *one*) Not at all religious Somewhat religious Very religious

Language(s) spoken: _____ Marital status: _____

Parents' country of birth: Mother: _____ Father: _____

SBQ-R

Please circle the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (Circle only one):

- 1 = Never
- 2 = It was just a brief passing thought
- 3a = I have had a plan at least once to kill myself but did not try to do it
- 3b = I have had a plan at least once to kill myself and really wanted to die
- 4a = I have attempted to kill myself but did not want to die
- 4b = I have attempted to kill myself and really hoped to die

2. How often have you thought about killing yourself in the past year? (Circle only one):

- 1 = Never
- 2 = Once
- 3 = Twice
- 4 = Three or four times
- 5 = Five or more times

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (Circle only one):

- 1 = No
- 2a = Yes, at one time, but did not really want to die
- 2b = Yes, at one time, and really wanted to do it
- 3a = Yes, more than once, but did not really want to die
- 3b = Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (Circle only one):

- 1 = No chance at all
- 2 = Rather unlikely
- 3 = Unlikely
- 4 = Likely
- 5 = Rather likely
- 6 = Very likely

APPENDIX V

SHI

Please answer the following questions by circling either 'Yes' or 'No'.

Circle 'Yes' *only* for those items that you have done intentionally, or *on purpose*, to hurt yourself.

Have you ever intentionally, or on purpose:

1. Overdosed?	YES	NO
2. Cut yourself on purpose?	YES	NO
3. Burned yourself on purpose?	YES	NO
4. Hit yourself?	YES	NO
5. Banged your head on purpose?	YES	NO
6. Abused alcohol?	YES	NO
7. Driven recklessly on purpose?	YES	NO
8. Scratched yourself on purpose?	YES	NO
9. Prevented wounds from healing?	YES	NO
10. Made medical situations worse on purpose (e.g. skipped medication)?	YES	NO
11. Been promiscuous (i.e. had many sexual partners)?	YES	NO
12. Set yourself up in a relationship to be rejected?	YES	NO
13. Abused prescription medication?	YES	NO
14. Distanced yourself from God as punishment?	YES	NO
15. Engaged in emotionally abusive relationships?	YES	NO
16. Engaged in sexually abusive relationships?	YES	NO
17. Lost a job on purpose?	YES	NO
18. Attempted suicide?	YES	NO
19. Exercised an injury on purpose?	YES	NO
20. Tortured yourself with self-defeating thoughts?	YES	NO
21. Starved yourself to hurt yourself?	YES	NO
22. Abused laxatives to hurt yourself?	YES	NO

Have you engaged in any other self-destructive behaviours not asked about in this inventory? If so, please describe below.

APPENDIX VI

PANSI

Below is a list of statements that may or may not apply to you. Please read each statement carefully and circle the appropriate number in the space to the right of each statement.

1 = Never

2 = Very rarely

3 = Sometimes

4 = A good part of the time

5 = Most of the time

During the past year, how often have you:

- | | | | | | |
|-------------------------------------------------------------------------------------------------------------|---|---|---|---|---|
| 1. Seriously considered killing yourself because you could not live up to the expectations of other people? | 1 | 2 | 3 | 4 | 5 |
| 2. Felt that you were in control of most situations in your life? | 1 | 2 | 3 | 4 | 5 |
| 3. Felt hopeless about the future and you wondered if you should kill yourself? | 1 | 2 | 3 | 4 | 5 |
| 4. Felt so unhappy about your relationship with someone you wished you were dead? | 1 | 2 | 3 | 4 | 5 |
| 5. Thought about killing yourself because you could not accomplish something important in your life? | 1 | 2 | 3 | 4 | 5 |
| 6. Felt hopeful about the future because things were working out well for you? | 1 | 2 | 3 | 4 | 5 |
| 7. Thought about killing yourself because you could not find a solution to a personal problem? | 1 | 2 | 3 | 4 | 5 |
| 8. Felt excited because you were doing well at college or at work? | 1 | 2 | 3 | 4 | 5 |
| 9. Thought about killing yourself because you felt like a failure in life? | 1 | 2 | 3 | 4 | 5 |
| 10. Thought that your problems were so overwhelming that suicide was seen as the only option for you? | 1 | 2 | 3 | 4 | 5 |
| 11. Felt so lonely or sad you wanted to kill yourself so that you could end your pain? | 1 | 2 | 3 | 4 | 5 |
| 12. Felt confident about your ability to cope with most of the problems in your life? | 1 | 2 | 3 | 4 | 5 |
| 13. Felt that life was worth living? | 1 | 2 | 3 | 4 | 5 |
| 14. Felt confident about your plans for the future? | 1 | 2 | 3 | 4 | 5 |

APPENDIX VII

ESS

Everybody at times can feel embarrassed, self-conscious or ashamed. These questions are about such feelings if they have occurred **at any time in the past year**. There are no 'right' or 'wrong' answers. Please indicate the response that applies to you with a tick.

	Not at all	A little	Moderately	Very much
1. Have you felt ashamed of any of your personal habits?	()	()	()	()
2. Have you worried about what other people think of any of your personal habits?	()	()	()	()
3. Have you ever tried to cover up or conceal any of your personal habits?	()	()	()	()
4. Have you felt ashamed of your manner with others?	()	()	()	()
5. Have you worried about what other people think of your manner with others?	()	()	()	()
6. Have you avoided people because of your manner?	()	()	()	()
7. Have you felt ashamed of the sort of person you are?	()	()	()	()
8. Have you worried about what other people think of the sort of person you are?	()	()	()	()
9. Have you tried to conceal from others the sort of person you are?	()	()	()	()
10. Have you felt ashamed of your ability to do things?	()	()	()	()
11. Have you worried about what other people think of your ability to do things?	()	()	()	()
12. Have you avoided people because of your inability to do things?	()	()	()	()
13. Do you feel ashamed when you do something wrong?	()	()	()	()

APPENDIX VII

	Not at all	A little	Moderately	Very much
14. Have you worried about what other people think of you when you do something wrong?	()	()	()	()
15. Have you tried to cover up or conceal things you felt ashamed of having done?	()	()	()	()
16. Have you felt ashamed when you said something stupid?	()	()	()	()
17. Have you worried about what other people think of you when you said something stupid?	()	()	()	()
18. Have you avoided contact with anyone who knew you said something stupid?	()	()	()	()
19. Have you felt ashamed when you failed in a competitive situation?	()	()	()	()
20. Have you worried about what other people think of you when you failed in a competitive situation?	()	()	()	()
21. Have you avoided people who have seen you fail?	()	()	()	()
22. Have you felt ashamed of your body or any part of it?	()	()	()	()
23. Have you worried about what other people think of your appearance?	()	()	()	()
24. Have you avoided looking at yourself in the mirror?	()	()	()	()
25. Have you wanted to hide or conceal your body or any part of it?	()	()	()	()

APPENDIX VIII

OAS

Below is a list of statements that may or may not apply to you. Please read each statement carefully and tick one of the appropriate spaces to the right of each statement.

	Never	Seldom	Sometimes	Often	Almost always
1. I feel other people see me as not good enough	()	()	()	()	()
2. I think that other people look down on me	()	()	()	()	()
3. Other people put me down a lot	()	()	()	()	()
4. I feel insecure about others opinion of me	()	()	()	()	()
5. Other people see me as not measuring up to them	()	()	()	()	()
6. Other people see me as small and insignificant	()	()	()	()	()
7. Other people see me as defective as a person	()	()	()	()	()
8. People see me as unimportant compared to others	()	()	()	()	()
9. Other people look for my faults	()	()	()	()	()
10. People see me as striving for perfection but being unable to reach my own standards	()	()	()	()	()
11. I think others are able to see my defects	()	()	()	()	()
12. Others are critical or punishing when I make a mistake	()	()	()	()	()
13. People distance themselves from me when I make mistakes	()	()	()	()	()
14. Other people always remember my mistakes	()	()	()	()	()
15. Others see me as fragile	()	()	()	()	()
16. Others see me as empty and unfulfilled	()	()	()	()	()
17. Others think there is something missing in me	()	()	()	()	()
18. Other people think I have lost control over my body and feelings.	()	()	()	()	()

APPENDIX IX

SASS

Below is a list of *hypothetical* situations. Some of them may apply to you now, and some may not. Please really try to imagine yourself **as if you are in the situation now**, and answer accordingly. Circle the number that best describes how much you agree with each statement, using the following scale:

Do not agree at all	Agree a little	Mostly agree	Completely agree
0	1	2	3

1. Imagine that you suffered from a mental health problem such as depression or anxiety. Please consider how worried or concerned you would be that these problems would impact on your family.

- | | | | | |
|-------------------------------------------------------------------------------------|---|---|---|---|
| a) My family would be seen as inferior | 0 | 1 | 2 | 3 |
| b) My family would be seen as inadequate | 0 | 1 | 2 | 3 |
| c) My family would be blamed for my situation | 0 | 1 | 2 | 3 |
| d) My family would lose status in the community | 0 | 1 | 2 | 3 |
| e) I would worry about the effect on my family | 0 | 1 | 2 | 3 |
| f) I would worry that I would be letting my family's honour down | 0 | 1 | 2 | 3 |
| g) I would worry that my mental health problems could damage my family's reputation | 0 | 1 | 2 | 3 |

2. Imagine that you were in a loving, committed, sexual relationship with a Black man. Please consider how worried or concerned you would be that this relationship would impact on your family.

- | | | | | |
|---------------------------------------------------------------------------|---|---|---|---|
| a) My family would be seen as inferior | 0 | 1 | 2 | 3 |
| b) My family would be seen as inadequate | 0 | 1 | 2 | 3 |
| c) My family would be blamed for my situation | 0 | 1 | 2 | 3 |
| d) My family would lose status in the community | 0 | 1 | 2 | 3 |
| e) I would worry about the effect on my family | 0 | 1 | 2 | 3 |
| f) I would worry that I would be letting my family's honour down | 0 | 1 | 2 | 3 |
| g) I would worry that my relationship could damage my family's reputation | 0 | 1 | 2 | 3 |

3. Imagine that you had failed your final exams at university and were unable to gain entry into the career you were working towards. Please consider how worried or concerned you would be that these problems would impact on your family.

- | | | | | |
|----------------------------------------------------------------------------|---|---|---|---|
| a) My family would be seen as inferior | 0 | 1 | 2 | 3 |
| b) My family would be seen as inadequate | 0 | 1 | 2 | 3 |
| c) My family would be blamed for my situation | 0 | 1 | 2 | 3 |
| d) My family would lose status in the community | 0 | 1 | 2 | 3 |
| e) I would worry about the effect on my family | 0 | 1 | 2 | 3 |
| f) I would worry that I would be letting my family's honour down | 0 | 1 | 2 | 3 |
| g) I would worry that failing my exams could damage my family's reputation | 0 | 1 | 2 | 3 |

APPENDIX IX

Do not agree at all	Agree a little	Mostly agree	Completely agree
0	1	2	3

4. Imagine that you were highly ambitious towards a particular career and had decided that you did not want to get married or have children. Please consider how worried or concerned you would be that this decision would impact on your family.

- | | | | | |
|-----------------------------------------------------------------------|---|---|---|---|
| a) My family would be seen as inferior | 0 | 1 | 2 | 3 |
| b) My family would be seen as inadequate | 0 | 1 | 2 | 3 |
| c) My family would be blamed for my situation | 0 | 1 | 2 | 3 |
| d) My family would lose status in the community | 0 | 1 | 2 | 3 |
| e) I would worry about the effect on my family | 0 | 1 | 2 | 3 |
| f) I would worry that I would be letting my family's honour down | 0 | 1 | 2 | 3 |
| g) I would worry that my decision could damage my family's reputation | 0 | 1 | 2 | 3 |

5. Imagine that you were in a loving, committed, sexual relationship with another woman. Please consider how worried or concerned you would be that this relationship would impact on your family.

- | | | | | |
|---------------------------------------------------------------------------|---|---|---|---|
| a) My family would be seen as inferior | 0 | 1 | 2 | 3 |
| b) My family would be seen as inadequate | 0 | 1 | 2 | 3 |
| c) My family would be blamed for my situation | 0 | 1 | 2 | 3 |
| d) My family would lose status in the community | 0 | 1 | 2 | 3 |
| e) I would worry about the effect on my family | 0 | 1 | 2 | 3 |
| f) I would worry that I would be letting my family's honour down | 0 | 1 | 2 | 3 |
| g) I would worry that my relationship could damage my family's reputation | 0 | 1 | 2 | 3 |

6. Imagine that you discovered that you had become pregnant, but you were not married. Please consider how worried or concerned you would be that this situation would impact on your family.

- | | | | | |
|----------------------------------------------------------------------------------------|---|---|---|---|
| a) My family would be seen as inferior | 0 | 1 | 2 | 3 |
| b) My family would be seen as inadequate | 0 | 1 | 2 | 3 |
| c) My family would be blamed for my situation | 0 | 1 | 2 | 3 |
| d) My family would lose status in the community | 0 | 1 | 2 | 3 |
| e) I would worry about the effect on my family | 0 | 1 | 2 | 3 |
| f) I would worry that I would be letting my family's honour down | 0 | 1 | 2 | 3 |
| g) I would worry that my pregnancy out of marriage could damage my family's reputation | 0 | 1 | 2 | 3 |

APPENDIX XI

Dear participant,

THANK YOU very much for taking the time to fill in this questionnaire. Your contribution is invaluable to this important research. Hopefully it will go towards improving services for women in distress.

When you have finished, please make sure you have answered all the questions, as it is difficult to analyse particular questionnaires with data missing.

Place your **completed questionnaire only** back into the envelope, seal it and place it in the sealed box at the information point, ground floor of the Students Union.

If I did not take a **signed consent form** from you when you got the questionnaire, please do sign it, (it **does not** have to be your real name) fold it in half and post it into the box separately.

Questionnaires can also be handed back to me. I will be around on Mondays and Fridays in the cafeteria and also around campus on other days. I do not open any questionnaires on campus, and have no way of knowing who gave me which questionnaire.

Your contribution is **completely confidential**. I have no personally identifying details for any participants, and I am giving out 600 questionnaires, so will not remember individuals who have taken part. For this reason, if anyone would like me to send her a summary of my main findings (I cannot comment on any individual questionnaires), please email me at s.n.patel@ucl.ac.uk.

Some participants may find themselves with some uncomfortable feelings upon completion of the questionnaire. If you would like to speak to someone for support and advice in **complete confidence**, you can contact:

Nightline:

Student Advice & Counselling at University:

Samaritans:

Newham Asian Women's Project:

Finally, please make sure to hand in the sealed envelope back to me or to deposit it carefully in the box provided in the Students Union. My research depends on high numbers of responses; I cannot use your questionnaires unless I get them back!

THANK YOU!

APPENDIX XII

ATTITUDES TOWARDS MENTAL HEALTH PROBLEMS

We are interested in people's thoughts and feelings about mental health problems. As you may know, some people suffer from mental health problems such as depression and anxiety. These can make it difficult to cope with everyday life. Depressed people can feel tired, not enjoy life and want to hide away. Below are a series of statements about how you, your community and your family may think about such problems. Read each statement carefully and circle the number that best describes how much you agree with each statement. Please use the following scale:

0 = Do not agree at all; 1 = Agree a little; 2 = Mostly agree; 3 = Completely agree

Please think about how your community and family view people with mental health problems such as depression and anxiety

- | | | |
|----|-----------------------------------------------------------------------------------------|---------|
| 1. | My community views mental health problems as something to keep secret | 0 1 2 3 |
| 2. | My community views mental health problems as a personal weakness | 0 1 2 3 |
| 3. | My community would tend to look down on somebody with mental health problems | 0 1 2 3 |
| 4. | My community would want to keep their distance from someone with mental health problems | 0 1 2 3 |
| 5. | My family view mental health problems as something to keep secret | 0 1 2 3 |
| 6. | My family view mental health problems as a personal weakness | 0 1 2 3 |
| 7. | My family would tend to look down on somebody with mental health problems | 0 1 2 3 |
| 8. | My family would want to keep their distance from someone with mental health problems | 0 1 2 3 |

Now please think about how *you* might feel if you suffered from mental health problems such as depression and anxiety

- | | | |
|-----|--------------------------------------------------------------------------|---------|
| 9. | I think my community would look down on me | 0 1 2 3 |
| 10. | I think my community would see me as inferior | 0 1 2 3 |
| 11. | I think my community would see me as inadequate | 0 1 2 3 |
| 12. | I think my community would see me as weak | 0 1 2 3 |
| 13. | I think my community would see me as not measuring up to their standards | 0 1 2 3 |
| 14. | I think my family would look down on me | 0 1 2 3 |
| 15. | I think my family would see me as inferior | 0 1 2 3 |
| 16. | I think my family would see me as inadequate | 0 1 2 3 |
| 17. | I think my family would see me as weak | 0 1 2 3 |
| 18. | I think my family would see me as not measuring up to their standards | 0 1 2 3 |

APPENDIX XII

Now please think about how *you* would see yourself if you suffered from mental health problems such as depression and anxiety

- | | |
|------------------------------------------|---------|
| 19. I would see myself as inferior | 0 1 2 3 |
| 20. I would see myself as inadequate | 0 1 2 3 |
| 21. I would blame myself for my problems | 0 1 2 3 |
| 22. I would see myself as a weak person | 0 1 2 3 |
| 23. I would see myself as a failure | 0 1 2 3 |

Imagine that you suffered from a mental health problem such as depression and anxiety, please consider how worried or concerned you would be that these problems would impact on your family

- | | |
|--------------------------------------------------------------------------------------|---------|
| 24. My family would be seen as inferior | 0 1 2 3 |
| 25. My family would be seen as inadequate | 0 1 2 3 |
| 26. My family would be blamed for my problems | 0 1 2 3 |
| 27. My family would lose status in the community | 0 1 2 3 |
| 28. I would worry about the effect on my family | 0 1 2 3 |
| 29. I would worry that I would be letting my family's honour down | 0 1 2 3 |
| 30. I would worry that my mental health problems could damage my family's reputation | 0 1 2 3 |

For the last set of questions we would like you to think about how you might feel if *one of your close relatives* suffers from mental health problems such as depression and anxiety. This time consider how worried or concerned you would be on the impact on you.

- | | |
|-------------------------------------------------------------------------------------|---------|
| 31. I would worry that others would look down on me | 0 1 2 3 |
| 32. I would worry that others would not wish to be associated with me | 0 1 2 3 |
| 33. I would worry that my own reputation and honour might be harmed | 0 1 2 3 |
| 34. I would worry that if this were known I would lose status in the community | 0 1 2 3 |
| 35. I would worry that others might think I would also have a mental health problem | 0 1 2 3 |