

Guest editorial

Suicide and attempted suicide among South Asians in England: who is at risk?

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ABSTRACT

Evidence from both large-scale and small-scale studies suggests differences and similarities in patterns of suicide and attempted suicide between South Asians and the total population in England. Among South Asians, the excess of females among both suicides and attempted suicides is even more marked; the traditional view of a strong family structure among Asians is confirmed, although cultural conflict between generations is apparent. The technique of suicide by burning among Asians appears to be waning. Asians who attempt or complete suicide are more likely to be suffering

from stress, but less likely to have been diagnosed as mentally ill. Their psychological problems appear to have been frequently overlooked by general practitioners, or not presented to them. Differences in religion, with Hindus producing higher rates than Muslims, and demographic, geographical, financial and cultural differences, contribute to the need for disaggregation and up-to-date research.

Keywords: Asian, attempted suicide, suicide

Introduction

High rates of suicide among the world-wide diaspora of Indians has been noted by McKenzie *et al* (p.100).¹ The British Isles now contains a large number of ethnic minorities from India and South Asia who have arrived in the past century, and a second and third generation of their descendants. According to McKenzie *et al* (p.101), it remains unclear who among these British South Asians is at risk of suicide, and the reasons for this.¹ Evidence is coming forward from a number of studies which provides a partial answer to these questions.

The literature reviewed

Soni Raleigh and her colleagues have carried out large-scale studies of suicide in England and Wales,²⁻⁴ using national data between 1970 and 1992 (see also Bhugra p.60).⁵ Hunt *et al* studied a sample of 4790 suicides between 1996 and 2000 who had been in

touch with mental health services in the 12 months before their death.⁶ Two percent ($n = 95$) were South Asian. In 2005, Crawford *et al* conducted a secondary analysis of data from the EMPIRIC study, a cross-sectional survey of 4281 adults living in private households.⁷ They studied suicide ideation, the incidence of attempted suicide, and service utilisation following attempted suicide among different ethnic groups. Using ethnic identity based on names, McKenzie *et al* (2008) studied all suicides identified at coroners' inquests between 1993 and 2003;⁸ 1438 (2.6%) were South Asian.

Alongside this work, a number of local studies of suicide and attempted suicide were conducted in the 1980s and 1990s, notably by Merrill and Owens⁹ and Nasr *et al*¹⁰ in Birmingham, Glover *et al*,¹¹ Kingsbury,¹² Neeleman *et al*¹³ and Bhugra⁵ in London, and Handy *et al*¹⁴ and McGibben *et al*¹⁵ in Coventry.

The literature indicates the following trends: demographic features of South Asian suicides and suicide attempts suggest similarities with, and differences from, the majority population. Rates among

South Asian young women, especially the 15–19-year-old group, are particularly high. This appears from the national studies of Soni Raleigh,^{2–4} and is confirmed by several of the local studies.^{9,11,13} Bhugra's study of attempted suicide in West London found the rate of attempted suicide among Asian women aged 16–19 years was 17 times that of Asian men.⁵ This excess of females applies also to Caucasians: a national study in 2004 found rates for women were nine times those for men. It appears even among 12–15 year olds in one small study.¹⁵ Soni Raleigh found rates for South Asian males were low.^{2–4} A high female to male ratio has been noted from other studies.⁵ Dissenting findings come from Hunt *et al*,⁶ who found that compared to white suicides, Asians had a similar sex ratio, and McKenzie *et al* who reported only a small excess among South Asian females, concentrated among older women.⁸

The traditionally close Asian family structure is suggested by Hunt *et al*, who found that Asians who attempted suicide were a little younger than whites; fewer were unmarried, lived alone, or were homeless.⁶ Biswas found fewer Asians attempting suicide had been in social care.¹⁶

Historically, techniques have varied. Some reports found burning was a technique used almost exclusively among South Asians.^{3,17} This technique has also been widely reported from India and Fiji. Burning remained a commoner technique among South Asians (ten times that of the national figures for women) for suicides between 1988 and 1992 (Soni Raleigh, Table 3 p.60).⁴ In contrast, carbon monoxide poisoning was virtually absent among South Asians. In Hunt *et al*'s sample, only one South Asian used carbon monoxide poisoning against 8% of whites.⁶ But particularly in later work, it has been found that South Asians who attempt suicide overwhelmingly use overdose as their method. In this they have come to resemble the majority of the population.^{5,9–11}

Many writers describe suicide attempts among South Asians as involving culture conflict, particularly conflict between 'traditional' parents and more 'westernised' children. Conflicts often centre on the choice of boyfriend, or for young married women, disputes with parents-in-law. This subject will be discussed in more detail later.

Early studies have found repeated attempts at suicide to be rarer among Asians than whites (Bhugra, p.61).⁵ Kingsbury's small study found Asian adolescents who had overdosed were more likely to have made a previous attempt, but were less likely to display high suicidal intent the day after their attempt, and were more likely to exhibit depressive disorder, hopelessness and long premeditation time.¹² Kamal and Loewenthal found that although there were no differences between Hindus and Muslims in

suicidal thoughts, plans or attempts, Muslims endorsed moral and religious reasons for living more strongly than Hindus.¹⁸ Bangladeshis in Nazroo's national study (Table 3.5 p.40) were less likely than all other groups (including those of Pakistani origin) to consider life not worth living.¹⁹ There are likely differences between older and younger people in their interpretation of guidance gleaned from religion, especially among Muslims.²⁰

South Asian suicides and suicide attempters are less likely to be diagnosed as psychiatrically ill or personality disordered. Hunt *et al* found the commonest diagnosis for South Asians was affective disorder, then schizophrenia.⁶ Alcohol and drug dependence were rare. However, South Asians do experience a high level of stress, which, in one study of people of Pakistani origin in Manchester, has been implicated in depression,²¹ and similar conclusions may be drawn from other work.²² Powerlessness and deprivation influence how East London Bangladeshis respond to illness and misfortune, which often involves a belief in jinns (spirits) and recourse to folk and religious healers.²⁰ Cultural variations in the perception of depression and responses to it are widespread.^{22,23} In the subcontinent, distressed people may seek help by visiting the shrines of holy men.²⁴

Discussion

South Asian patients are widely reported to have psychological problems overlooked by general practitioners (GPs), and diagnosis and treatment are often restricted to accompanying somatic symptoms.

Husain *et al* found 44 depressed (level 5 or over on PAS) patients among women of Pakistani origin attending a GP surgery in North Manchester.²¹ All but five had symptoms lasting over a year, yet depression was noted by the GP in only one case.

Half of a sample of 100 Asian women, resident in the UK for at least a year, and who were rated as 'cases' by the General Health Questionnaire (GHQ), had withheld their psychological problems from their GP, and there was a general failure among them to recognise depression as an illness.²⁵ In East London, prescribing patterns for antidepressants varied hugely between practices, with low rates where the Asian population was greatest.²⁶ Asian patients received lower dosages.²⁷

A low rate of referral to child guidance services has been found among Bangladeshis in Tower Hamlets, East London,²⁸ and Gujeratis in Manchester,²⁹ although it is unclear whether this was due to an unwillingness of parents to reveal problems (due

either to inhibition or the belief that such matters were inappropriate to bring to a GP), or to a genuine absence of problems.

Certainly there can be differences in symptomatology. Rack points out that withdrawal from social contacts may be treated as suspiciously pathological for a white teenage girl, but treated as a mark of deference and praiseworthy docility for a Muslim.³⁰ Such differences may produce a different pattern of demand on services. Hackett *et al* found that phobias, which were common in their sample of Gujarati children, produced no concern among their parents.²⁹ The pattern of social problems families face may differ too. Husain *et al* found that among Muslim families, also in Manchester, more chronic difficulties were reported among families containing a depressed member, in areas of health, housing and marriage, but fewer around work, than a white control group.²¹ Asian families are also more likely generally than white families to face problems of racism.

Family relationships make up a large proportion of the problem areas for suicidal or depressed patients. Merrill and Owens found that three-quarters of their female sample of Asian deliberate self-harmers in Birmingham reported marital difficulties.⁹ Kingsbury's small study suggests that among Asian adolescents, sibling relationships may be as problematic as those between boyfriends and girlfriends.¹²

A further area of difficulty which has been widely discussed is that of culture conflict. For South Asians in England, this often manifests itself in disputes over the degree of freedom afforded to teenagers, and to the degree of influence exerted by parents over their child's choice of marriage partner. This topic features in much of the work quoted here, and has been summarised by Bhugra, who concludes from the research (including his own) that the parents of children attempting suicide held more 'traditional' views than their children (p.158).⁵ However, conflict may equally be present in a large proportion of the families of white young adult suicides.¹⁹

The need for better family contact has been stated,⁶ and the claim made that if it were provided for depressed patients the suicide rate could be cut.¹ Awareness of medical or psychiatric treatment for depression appears low among English South Asians (Bhugra, p.186).⁵ Bhugra found older women were more likely to confide in their GP (p.206), and that an educational pamphlet had a positive effect.⁵ Handy *et al* suggested a greater use might be made of multilingual professionals, but the time for this may have passed.¹⁴ There remain, however, the real needs of young brides who have arrived recently from the Indian subcontinent.

Religious differences may be a largely hidden influence. High rates of suicide for Hindus and low rates for Muslims have been reported from many countries, reflecting different attitudes towards suicide shown in the two religions.^{31,32} Higher rates among Hindus than Muslims have been reported from the UK.² Between 1988 and 1992, there were higher rates among people born in India than the UK, and lower rates among those born in Pakistan and Bangladesh (Soni Raleigh, Table 2 p.59).⁴ A small study of self-poisoning among 12–15 year olds in Coventry in the 1980s found a higher rate among Sikhs than both the other groups.¹⁵ Kamal and Loewenthal, as mentioned previously, found Hindus less likely than Muslims to endorse religious and moral reasons for living.¹⁸

The excess of young females among suicides and suicide attempters is the strongest finding of this research. It may be that reasons for this excess are not exactly similar to the reasons for the excess in the general population.

Growing up may be particularly hard for South Asian girls in England. Their parents (possibly to a greater extent than white parents) expect daughters to help with the housework while boys are given a freer rein. The emotional aspects of girls' lives may be emphasised more than those of boys (Bhugra, pp.74–6, 148).⁵ Asian women more generally may be seen as 'bearers of blame' (p.187).⁵

In the Indian subcontinent their position may be even weaker, where, especially in rural areas, their roles are rigidly defined, and the position of young brides in their husband's extended family household makes them especially vulnerable, isolated and subject to conflicts over dowry payments. Their deaths at home by burning may be dismissed as 'kitchen accidents'. Women generally may be perceived, according to one source, as martyrs.³³

There is a need for more research in this area to keep abreast of the changing circumstances of South Asians in Britain. Changes in levels of prosperity and of integration may be highly influential. Differences within this population due to religion have been mentioned. Demographic and geographical differences may be even more significant, between, say, populations in Lancashire mill-towns and in London and more prosperous Southern towns. Variation between subgroups is growing, and with it the need for disaggregation.^{4,8}

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