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PREDICTORS OF SUICIDAL BEHAVIOUR WITHIN SOUTH ASIAN FEMALES

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Contents

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Abstract

Suicide is seen to be the second leading cause of death worldwide, and the South Asians are seen to be a very high risk group due to the traditional cultural values they hold. The South Asian culture can be seen as a facilitator in suicidal behaviour due to its rigidly defined cultural values. The most dominant theory of suicide seem to be the interpersonal theory of suicide first proposed by Joiner (2005). The theory however can be seen to be limited as it does not take into account cultural factors which may affect its core structures. The present study thus looked at how South Asian cultural values would influence the Interpersonal Theory of Suicide. 215 South Asian females took part in a questionnaire to measure their suicidal behaviours and the proposed predictors of suicide. A logistic binary regression found that the significant predictors of suicide that made participants more likely to consider suicide within the last 12 months were a higher perceived burdensomeness, lower social support from friends and a higher association to South Asian cultural values. None of the variables were seen to significantly predict suicide attempts within the last 12 months. Results thus showed that South Asian cultural values do in fact have an influence on the Theory of Interpersonal Suicide as South Asian women could be more at risk for suicidal ideation. The present study thus supports research that culturally sensitive psychological interventions need to be put in place to help South Asian women who could be more at risk for suicidal behaviour, to seek help and treatment.

Introduction

In 2000, 800,000 suicides were reported worldwide, whilst the World Health Organization (2014) estimates that more people die every year from suicide than in the entire world's armed conflicts. In 2013, 6,233 suicides were recorded in the UK alone with a 4% increase from 2012 (Office for National Statistics, 2015), implying that suicide rates may slowly be on the rise after a 10-year decline. Ploskonka and Servaty-Seib (2015) further explain that suicide is the second leading cause of death for university and college students with research indicating that 18% of all undergraduates have at least once, seriously considered attempting suicide and approximately 40-50% of these students have reported numerous episodes of suicidal thoughts (Suicide Prevention Resource Center, 2004). Suicide can be seen as one of the first serious health problems that individuals commonly face in their lives as the World Health Organization (2014) tells us that in 2012 suicide was the second leading cause of death among 15–29-year-olds globally. What is important about such a serious public health concern is that with the right research and interventions, suicide can be prevented and controlled. The World Health Organization (2008) explain that only a small subsection of individuals that think about suicide actually go on to attempt it, and even fewer die by suicide. This therefore displays the importance of suicidal ideation in relation to suicide. It is estimated that each year approximately 3.3% of Americans seriously consider suicide, 1% develop a plan, 0.6% of people attempt suicide and only 0.01% of those die by suicide (American Association of Suicdology, 2006). Suicidal ideation is seen to be an early symptom of suicidal actions as it is from this which suicidal attempts can occur (Mustaffa, Aziz, Mahmood, & Shuib, 2014). The World Health Organization (2014) predicts that suicidal attempts occur every three seconds, whereas deaths due to suicide occur every forty seconds which again stresses the importance of suicidal ideation as this occurs much more frequently than a death due to a suicide itself.

The World Health Organisation (2006) also explains that males have a much higher suicide rate when compared to females with a 4:1 ratio. However, when it comes to non-lethal suicide attempts females outnumber males with a 3:1 ratio (American Association of Suicdology 2006). Suicidal ideation is therefore seen to be an important factor in relation to attempts and can be explored further by the use of psychological theories.

Interpersonal Theory of Suicide

The earliest theories of suicide came from sociologists such as Émile Durkheim (1897). In Le Suicide (1987) Durkheim conducted what was seen to be the first epidemiological studies investigating factors influencing suicide rates. Durkheim argued that whilst suicide is a very individualistic and solitary act, causes of suicide related back to a number of social factors and thus could be thought of as an individual decision that is made on social grounds. Durkheim (1897) found that suicide rates were seen to be highest in the summer and lower in the winter. He argued that this seasonal variation was due to the density of social interactions being higher in the summer when compared to winter and thus individuals felt more socially withdrawn in the summer. He then went on to categorise his findings into three different types of suicides being either Anomic suicide where collapsing forces in the society make one feel alone or lost; Altruistic suicide where excessive rules regulations of individuals by social forces are present; and Egoistic suicide when one feels completely detached from society (Jones, 1986). Thus, Durkheim concluded that whilst the act of suicide is a personal act, it is directly connected to the social life and social groups of the individual.

Research on suicide since Durkheim has greatly progressed with a number of theories having been developed surrounding suicidal behaviour. Theories of suicide now exist that span a whole host of diverse perspectives including biological, cognitive-behavioural,

psychodynamic and developmental viewpoints (Van Orden, Witte, Cukrowicz, Braithwaite, Selby & Joiner, 2010). Each of the theories is able to partially explain the mechanisms of suicidal behaviour but individuals who die by suicide are usually present with numerous risk factors, rather than isolated risk factors (Maris, Berman, Maltsberger & Yufit, 1992). Therefore, a comprehensive theory of suicide should be able to account for a diverse range of factors associated with those who either consider suicide, attempt suicide or both.

In relation to current literature Joiner's theory on Interpersonal Suicide remains to be the dominant theory. The interpersonal theory of suicide was first proposed by Joiner (2005) in order to explain an individual's reasoning behind suicidal ideation and attempts. He explained a person is most likely to commit suicide if they have both the ability to and desire to commit suicide. This theory was then developed through a set of hypotheses by Van Orden, Witte, Gordon, Bender and Joiner (2008). The theory proposes that the personal need to belong and contribute to surrounding close people is so fundamental that the prevention of these needs through perceived burdensomeness and thwarted belongingness is a proximal cause of suicidal desire (Van Orden et al., 2008). Therefore suicidal desire is influenced by the simultaneous presence of the two interpersonal constructs being thwarted belongingness and perceived burdensomeness (Van Orden et al., 2010). However, the theory continues to explain that suicidal desire alone is not sufficient to result in an attempt at suicide, as individuals must also attain the capability to engage in suicidal behaviour. This process begins through first exposure and the habituation to the fear and pain involved in lethal self-injury (Van Orden et al., 2008).

Van Orden et al. (2010) thus proposes three constructs that are central to suicidal behaviour. The first two being thwarted belongingness and perceived burdensomeness which are primarily related to suicidal desire, whereas the last is the acquired capability for suicide. An increased level of thwarted belongingness is stated to increase suicidal desire (Van Orden et

al. 2010). This concept of thwarted belongingness can be said to stem from the most reliable and strongest predictor of suicide being social isolation and social integration variables, for example loneliness. Van Orden et al. (2010) explain that these constructs are indicators of suicide because they are observable in a human's psychological need being unmet. Baumeister and Leary (1995) elucidate this to the 'need to belong' where Van Orden et al. (2010) explain that when the need to belong is not met, the state of thwarted belongingness develops, which in turn creates a desire for death. Durkheim (1897) supports this theory by stating that differing degrees of social integration result in suicide, thus a lack of social integration can make individuals lack a connection to something that excels and connects them, in turn leading to an increase in suicide.

Van Orden et al. (2010) build on the theory of the need to belong by proposing that thwarted belongingness is actually a multidimensional concept as individual factors also effects one's desire for suicide. They extend on previous research by explaining that thwarted belongingness also includes two secondary factors. These factors are loneliness and an absence of reciprocally caring relationships as it is thought that it is a necessity for individuals to have frequent positive interactions with the same individual in the framework of a long-term, stable and caring relationship (Van Orden et al. 2010). Loneliness is described as an individual having too few social connections (Van Orden et al. 2010). Chronic loneliness was seen to be the key state and thus Van Orden et al. (2010) suggest that when thwarted belongingness is prolonged, suicidal ideation is more likely. The second sub-factor is described as an individual having a lack of reciprocal relationships in which both individuals cared about each other, and also demonstrated care for the other. Thus, for relationships to meet the need to belong, they must occur in supportive contexts and include positive feelings.

Thwarted belongingness is therefore described by Van Orden et al. (2010) as a self-motivated cognitive-affective state influenced by both intrapersonal and interpersonal factors such as one's activated schema's, environments and emotional states, thus a person's degree of belongingness varies over time. However, to lead to suicidal desire, Van Orden et al. (2010) explain that high levels of perceived burdensomeness also have to exist within an individual. This is supported by Van Orden et al. (2008) study where an individual with a high level of thwarted belongingness did not exhibit an elevation in suicidal ideation unless high levels of perceived burdensomeness were also present.

Perceived burdensomeness in relation to this theory is described as when someone holds perception that they are a burden on others in their life, they then endorse a degree of self-hate regarding the said perceptions. For example, people may feel they are a financial or an emotional burden and make people around them feel miserable or cause pain to them. Individuals begin to believe that death is worth more than their life and endorse feelings of self-blame. Van Orden et al (2010) explain that perceived burdensomeness includes two dimensions of interpersonal functioning. The first is described as being a liability, a belief in which the self is so flawed that they become a liability on others. The second factor is self-hate, which is described as one's extreme hatred to the self, resulting in anger and prejudiced behaviour towards oneself.

Figure 1: **Causal pathway to suicidal desire according to the Interpersonal Theory of Suicide**

Perceived Burdensomeness

Liability
Belief that one is a burden on family
Family conflict
Expendability & Unwanted

Self Hate
Low Self-esteem
Shame
Self-blame
Agitation

Suicidal Desire

Thwarted Belongingness

Loneliness
Marriage
Number of Friends
Few social supports
Disconnected

Absence of reciprocal care
Social withdrawal
Loss
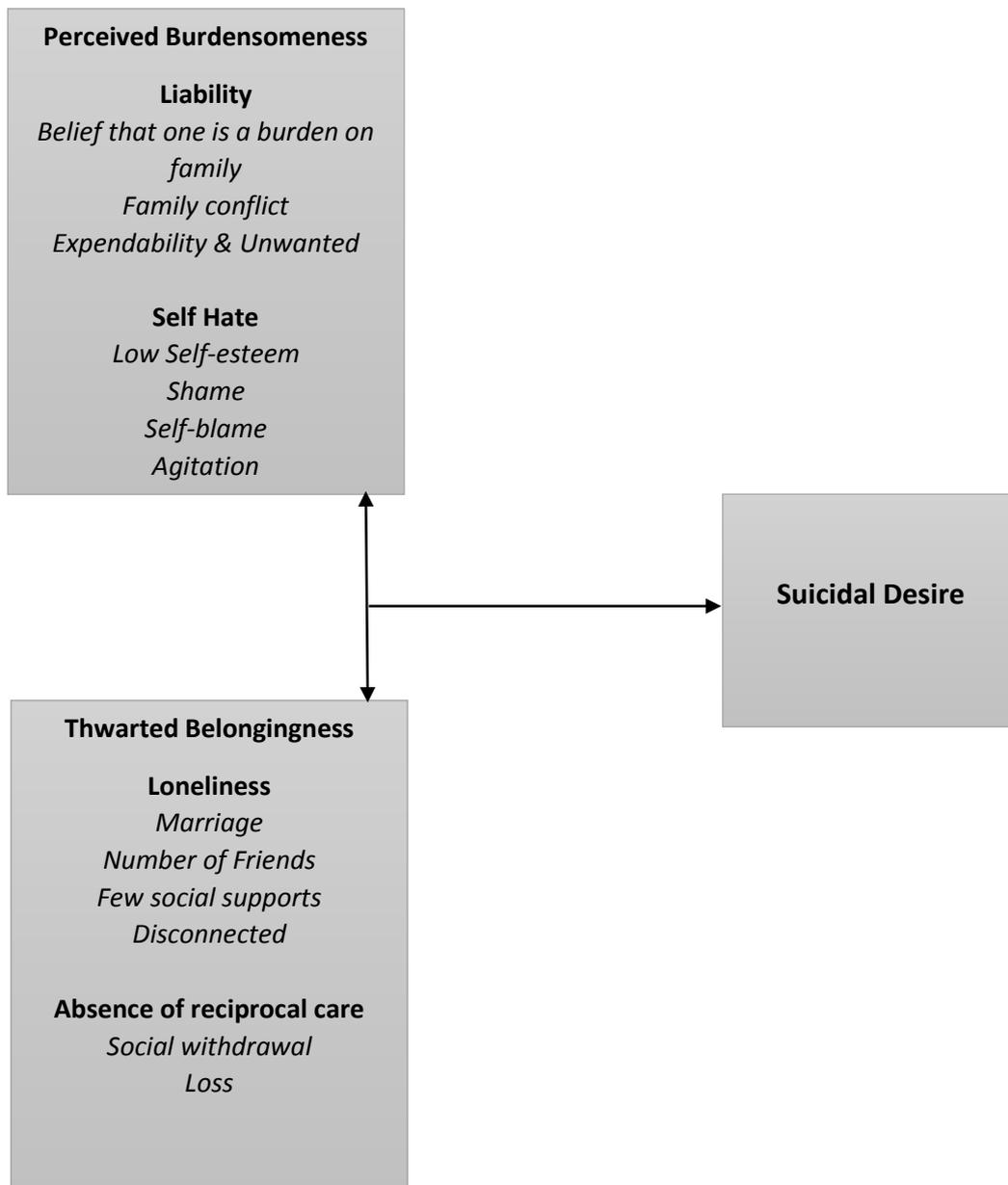
In the interpersonal theory of suicide, thwarted belongingness and perceived burdensomeness are assumed to be related but distinct constructs. Van Orden et al. (2010) explain that these constructs are a proximal cause of suicidal desire (Figure 1) but not sufficient to result in death through suicide, as individuals must also attain the capability to engage in suicidal behaviour. It is assumed that to die by suicide, individuals must lose a certain fear associated

with suicidal behaviours, as it is very rare for an individual to be born with a fear level low enough to engage in suicide (Van Orden et al. 2010). Van Orden et al. (2010) believe that people are biologically structured to fear suicide as suicidal behaviour includes exposure to stimuli that have been long associated to threats to survival. It is therefore suggested that it is possible for one to acquire the capability of suicide through habituation to repeated exposure to physically painful and fear inducing experiences (Van Orden et al. 2010). This in turn makes it possible for an individual to engage in increasingly physically damaging and painful lethal forms of self-harm.

Acquired capability is assumed to be a multidimensional variable that involves a range of factors, including elevated physical pain tolerance and painful and provocative experiences. Van Orden et al. (2010) further explain that another factor that contributes to an acquired capability of suicide is lowered fear of death as research from Linehan, Goodstein, Nielsen and Chiles (1983) tells us that fear of suicide is a reason that individuals give for not engaging in suicidal behaviour. Thus, fear has to be reduced so far to the point that one has a zero degree of fearlessness concerning suicidal actions (Van Orden et al. 2010). Another factor associated to an acquired capability is the habituation and opponent process. Van Orden et al. (2010) suggest the primary effect of self-harm (provocative and painful stimuli) is pain and fear, and the opponent processes are analgesia and relief. However, it is proposed that the primary processes weaken through repeated exposure and practice, and therefore what originally was a fear-inducing/painful experience such as self-injury, becomes less fear-provoking and also a source of emotional relief. This reduces an individual's capability of engaging in what was previously frightening and painful.

The theory concludes with four hypotheses based on the research conducted. (Van Orden et al. 2010).

- **Passive suicidal ideation (Hypothesis 1):** which is that perceived burdensomeness and thwarted belongingness are sufficient and proximal causes of suicidal ideation, thus an individual that possesses either complete perceived burdensomeness or thwarted belongingness will experience passive suicidal ideation.

- **Suicidal desire (Hypothesis 2):** which assumes that a mental state portrayed by the simultaneous presence of both thwarted belongingness and perceived burdensomeness, and also hopelessness about one's interpersonal networks is a proximal and sufficient cause of suicidal desire.

- **Suicide intent (Hypothesis 3):** which is described as the simultaneous presence of suicidal desire and also the first element of the acquired capability for suicide being a lowered fear of death. Therefore, in order to have suicidal intent, one must have habituated to the fear involved in suicide to such an extent that they are able to plan, imagine or decide to carry out suicidal actions.

- **Lethal and near lethal attempts (Hypothesis 4):** which addresses the outcome of serious suicidal behaviour. Van Orden et al (2010) explain that the outcome of a serious suicidal behaviour is most likely to occur within the context of suicidal intent, reduced fear of suicide and also an elevated pain tolerance.

Van Orden et al. (2010) propose a number of risk factors, which are seen to be the most robust and consistent predictors of suicide based on existing literature. The risk factors include those such as family conflict, mental disorders, social isolation, hopelessness and shame.

Van Orden et al. (2010) explain that there are also a number of observable indicators which are associated with an elevated risk for suicidal desire in relation to thwarted belongingness and perceived burdensomeness. Observable indicators for thwarted belongingness include

factors associated with loneliness such as number of friends, presence of marriage, living alone and few to no social supports. Observable indicators associated to reciprocally caring relationships include social withdrawal, domestic violence and familial disharmony. Van Orden et al. (2010) further explain that the risk factors for perceived burdensomeness include observable indicators associated with self-hate include such as agitation, self-blame, low self-esteem and shame. Observable factors associated with being a liability include variables such as distress from certain situation including unemployment and physical illness, feelings of being both unimportant, family conflict and unwanted and beliefs regarding being a burden on family.

The interpersonal theory of suicide explains that a major risk factor for predicting suicidal behaviour is a mental disorder. Mental disorders can make individuals feel hopeless about their situation and interpersonal networks and thus contribute towards suicidal desire. This is due to the fact that symptoms of mental disorders have been seen to be similar to the risk factors of both perceived burdensomeness and thwarted belongingness. Nock, Hwang. Sampson and Kessler (2010) also explain that mood disorders such as depression were found to be significant predictors for suicide and that depression was a major predictor for the onset of suicide ideation. Depression is thus likely to be associated with the development of the desire for suicide as it said to not increase the risk for suicide attempts beyond its association with ideation (Nock et al., 2010). Mustaffa et al. (2014) found a positive relationship between depression and suicide ideation which supported the research by Reeves (2010) suggesting that the factors that contribute to the risk of suicide is a psychopathological problem connected to a number of issues including depression.

Cavanagh, Carson, Sharpe and Lawrie (2003) describe that approximately 95% of people who die from suicide suffer from mental disorders. Nock et al. (2010) further explain that

mental disorders are the strongest predictors of suicide. Bostwick and Pankratz (2000) indicate that those individuals with a major depressive disorder have suicide rates between 2% and 6%. Verona, Sachs-Ericsson and Joiner (2004) further explain that among depressed individuals, around a quarter make a nonfatal suicide attempt throughout their lifetime and 25% report experiencing suicidal ideation (Goldney, Dal Grande, Fisher & Wilson, 2003). Nock et al. (2010) research on mental disorders and suicidal behaviour found that approximately 50% of those who seriously considered suicide and more than half of people who attempt suicide had a prior mental disorder. Thus previous research shows that mental disorders are also seen to be important risk factors in the intent for suicide, thus having an influence on both perceived burdensomeness and thwarted belongingness.

Figure 2: Causal pathway to lethal suicidal attempts according to the Interpersonal Theory of Suicide
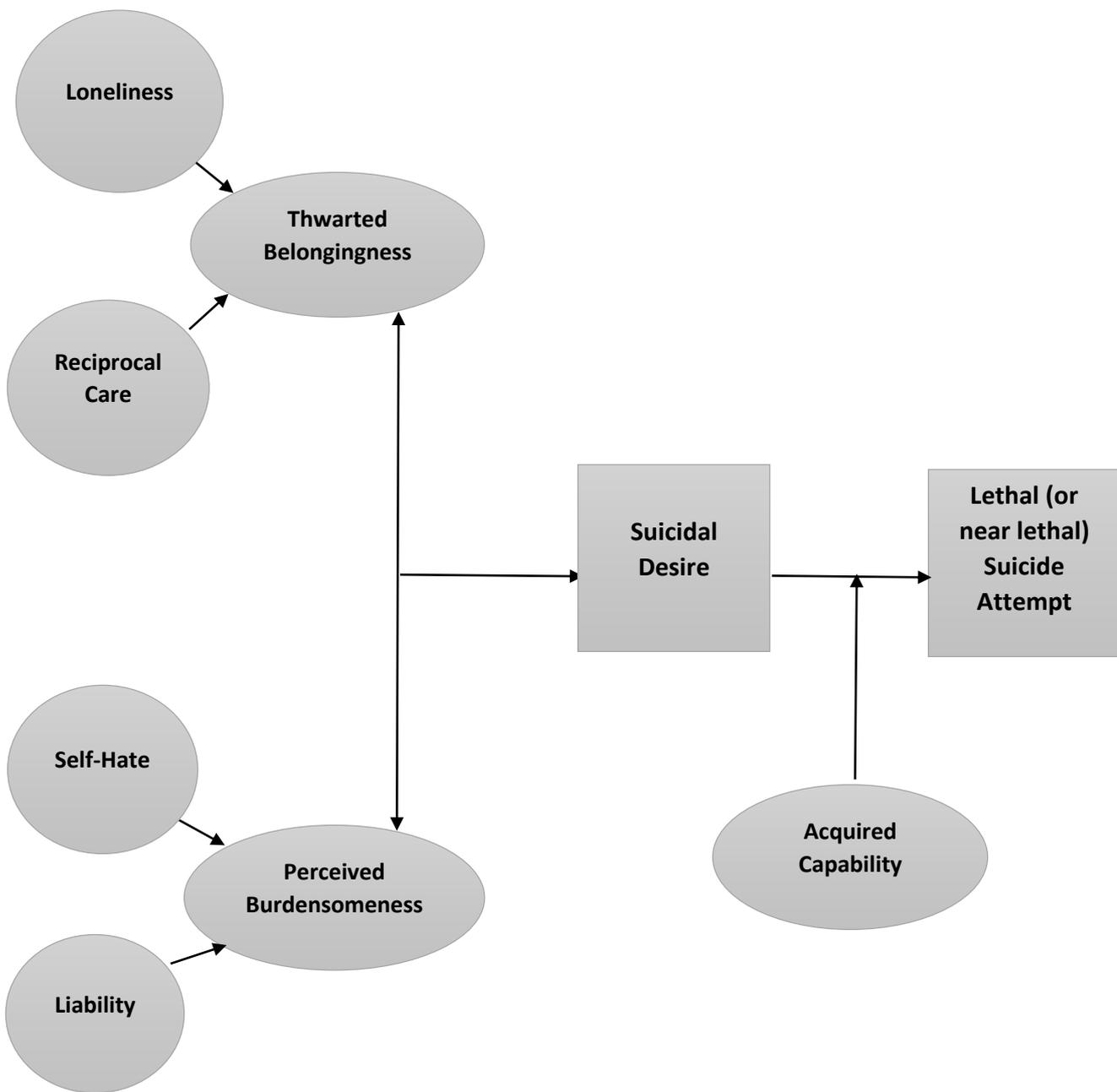
Empirical testing on suicidal desire and the capability for suicide in regards to the Interpersonal Theory of Suicidal has seen to be supportive of the theory. Van Orden (2008) carried out two studies the first of which aimed to assess the claim that simultaneous feelings of both thwarted belongingness and perceived burdensomeness leads to suicidal desire. Results supported the theory in that the interaction between thwarted belongingness and perceived burdensomeness predicted current suicidal ideation. The second study looked at the theory regarding habituation of fear and the acquired capability for suicide and found that greater levels of acquired capability were found among individuals with a greater numbers of past suicide attempts. Results also found that painful and provocative experiences significantly predicted acquired capability scores which provides support for the fact that acquired capability is needed for a suicide attempt. The last study looked at who was at greater risk for suicide for suicidal behaviour and found that the interaction of acquired capability and perceived burdensomeness predicted clinician-rated risk for suicidal behaviour which provided support for the observable risk factors outlined in Joiners theory.

Reasons why Joiner's theory is limited

The Theory of Interpersonal Suicide however, does not seem to fully account for suicidal behavior across all samples and cultures. Van Orden et al. (2010) explains that a complete theory of suicidal behaviour should account for demographic variables in suicide rates such as culture, age and gender. Recent research however, has found that in some samples only partial support for the theory was found. Bryan, Morrow, Anestis and Joiner (2010) tested the Interpersonal theory of Suicidal Behaviour in a military sample. Results found that the proposed three way interaction between burdensomeness, belongingness, and acquired capability did not significantly predict suicidal history in the sample. Bryan et al. (2010)

suggested that this could be because thwarted belongingness is less robustly related to suicidal desire when compared to perceived burdensomeness. It also highlights a fact that in certain populations, the theory may differ and other influences have an effect on one's suicidal behaviour. Cole, Wingate, Slish, Tucker, Hollingsworth and O'Keefe (2013) found similar results in their investigation in a sample of American Indians whether the relationship between suicidal ideation and symptoms of depression was indirectly affected by perceived burdensomeness and thwarted belongingness. Results showed a significant effect between suicide ideation and perceived burdensomeness but not for thwarted belongingness. They explain that thwarted belongingness may not have moderated the relationship between suicidal ideation and depressive symptoms because it may not have been as independently predictive of suicidal ideation as perceived burdensomeness is, thus supporting the findings of Bryan et al. (2010). Cole et al. (2013) however continued to argue that thwarted belongingness may not be relevant for the sample of American Indians because of possible cultural inadequacy, thus portraying the view that certain factors such as culture can have an effect on suicidal behaviours and so influence Joiner's theory.

There is no specific integration of culture into the Theory of Interpersonal Suicide and no explanation of how cultural norms may have an effect on the three focal points of the theory. Lincoln, Chatters and Taylor (2003) explain that social models and theories are not equivalent across cultures. This is because there are unique social and cultural conditions that constitute culture specific risks and protective factors which are essential in understanding the nature of social interaction and how they relate with other cultural factors to influence health outcome. The limited research that surrounds the South Asian culture points out major risk factors for suicide that may have a direct impact on the key components in the Interpersonal Theory of Suicide and show relations to the observable risk factors outlined in the theory.

Bhugra and Desai (2002) tell us that the reasons for committing suicide or harming oneself vary with cultures and societies. The South Asian culture displays a stronger emphasis on being a collective culture and encourages strong family ties which can have fundamental effects on both perceived burdensomeness and thwarted belongingness.

Previous research shows that unique factors associated to the South Asian culture have been seen to be similar to observable risk factors which Joiner (2005) explains are associated with both perceived burdensomeness and thwarted belongingness. Cultural influences on family relationships, mental illnesses, health seeking behaviour, mental health support, social support, religiosity, honour, marriage and acculturation have all been seen to lead to feelings of social isolation, burden on family, shame, self-blame, loneliness and negative relationships (Lai & Surood, 2008). The majority of the effects that have been an outcome of cultural values have shown to be observable risk factors for thwarted belongingness and perceived burdensomeness, further stressing the point that cultural factors can be seen to heavily influence components of the interpersonal theory of suicide. Bertolote et al. (2005) explored suicide ideation and attempts in culturally diverse sites and concluded that the indication of the suicidal process as a continuous progression from thoughts to plans and attempts of suicide needs to be further examined as it seems to be dependent on cultural settings and values. This further provides support for the view that cultural values may have an influence on suicidal ideation and activity.

How culture influences Joiner's theory

It has been said that the attempted suicide rate of South Asian women in the UK is 2.5 times that of South Asian men and 1.6 times that of White women (Bhugra, Desai, & Baldwin, 1999). The term 'South Asian' refers to individuals whose ethnicity originates from countries

of the Indian subcontinent including India, Bangladesh, Pakistan, Bhutan, Nepal and Sri Lanka and where the main religions consist of Islam, Hinduism and Sikhism (Hicks & Bhugra, 2003). Though there are different religious beliefs between the three major religions, there is somewhat of a shared culture usually termed as the South Asian culture. Husain, Waheed and Husain (2006) also tells us that there is a significantly raised risk of suicide and suicidal attempts among young South Asian women and thus is an area of particular concern. National data from Raleigh (1996) also highlighted the fact that women born in India and East Africa had a 40% higher suicide in comparison to women born in England and Wales. Raleigh and Balarajan (1992) collated data surrounding suicide rates for Indian and West Indian minorities in England and Wales and found that an increased rate of suicide was mostly confined to a younger age group of the ages between fifteen and thirty-four, being double of that recorded for native whites. Raleigh (2009) also tells us that high rates of suicide and attempts at suicide in young South Asian females have been a consistent and continuing finding in national and international research over past decades.

This therefore raises an area for concern regarding suicide within the South Asian community, and in particular South Asian females, as it could be religious and cultural values that are influencing an individual's suicidal thoughts and leading to the increasing amount of attempted suicide rates. Husain et al. (2006) reviewed several studies regarding rates and precipitants of self-harm in South Asian Women in the UK from the limited literature available surrounding the topic. The key themes that emerged from the literature review included interpersonal disputes, relationship issues with family, cultural conflict, marital problems, arranged marriages, rejection of arranged marriages, shame, gender expectations, pressure from family and individualisation. Many of these risk factors found can be seen to influence Van Orden's central constructs to suicidal behaviour.

Perceived Burdensomeness

Family conflict which is seen to be an indicator for liability and thus an increased perceived burdensomeness according to the Interpersonal Theory of Suicide can be seen to be very common in the South Asian community and can sometimes lead to the development of mental disorders and suicide ideation. Gilbert, Gilbert and Sanghera (2004) interviewed three different age groups of South Asian women living in Derby to evaluate their conceptions of shame, entrapment and inferiority in relation to mental health and using mental health services. The participants advocated that South Asian women can many a time, feel required to function within a set of norms of community and also family honour that can dominate personal concerns. Thus, South Asian women can sometimes view themselves as so called 'carriers' of their family honour, who feel obliged to control their actions so as not to bring shame and dishonour upon the family. Shame again being another observable risk factor associated with self-hate increasing one's perceived burdensomeness.

Chew-Graham, Bashir, Chantler and Burman (2002) also found that family honour could sometimes be used to maintain and strengthen a woman's inferior role in family life and to pressure them into remaining silent about all of their problems. Research therefore portrays women in the South Asian culture as seeing themselves in unequal relationships with their husbands and other men, and also feeling trapped in South Asian traditions and family values. Gilbert et al. (2004) further explain that entrapment within a certain set of cultural values also affects individual's perceptions of mental health problems and their willingness to engage with services. This can be detrimental to those who require help, as it could be an aspect that may be a risk factor in increasing one's perceived burdensomeness. Perceived burdensomeness could be increased because not being able to engage with health services further reduces someone's support system and thus makes the individual more dependent on their family for support. This could thus lead to an increase in family conflict due to women

not being able to talk about their problems and being told by their family to continue as they are (Gilbert et al. 2004). This could further lead to South Asian women feeling as if they are a burden on their family and again lead to an increase of perceived burdensomeness.

Gehlot and Nathawat (1983) explain that supposed performance failures could explain the large number of suicide cases in India. These performance failures are described as where an individual fails to achieve certain expectations enforced by both the society and family. This leads to the experience of shame as these women live with the fear of letting both the community and their family down. This shame can then lead to low self-esteem and self-blame as the family believe that the woman has dishonoured the faith by either having a mental illness or engaging with services to deal with mental illnesses. These feelings of shame and self-blame can be said to result from family conflict due to the disagreement within families regarding dishonour. These feelings are also described as observable risk factors for an increased perceived burdensomeness which has also been linked to individuals taking their own lives. Feelings of both low self-esteem and being a liability on others is described as being observable indicators for perceived burdensomeness by Van Orden et al. (2010) as those who hold perceptions of themselves as being so flawed to be a liability on others is a key factor in interpersonal functioning in regards to perceived burdensomeness.

Previous research suggests that family conflicts and marriage are seen to be potential high risk factors for suicide for South Asian females. Research has found that within the South Asian community several factors related to the areas of marriage, family and mental disorders contributed significantly towards suicide (Gururaj, Isaac, Subbakrishna & Ranjani, 2004; Bastia & Kar, 2009). This is also supported by the interpersonal theory of suicide as it is stated that family conflicts are risk factors for suicidal desire and can also increase perceived burdensomeness if an individual is felt to be a burden on the family. Previous literature

therefore proposes that family conflict in the South Asian community could be due to marital issues, and thus could be a risk factor for suicide in South Asian females.

Raleigh and Balarajan (1992, p. 5) explain that suicide in South Asian women in the UK is a result of "their rigidly defined roles in Indian Society. Submission and deference to males and elders, arranged marriages, the financial pressures imposed by dowries, and ensuing mental and family conflicts". Arranged marriage seems to be an important issue in research surrounding suicide in South Asian women (Raleigh and Balarajan 1992; Hicks & Bhugra, 2003; Cooper et al. 2006). Arranged marriage has been identified as a main causal factor for suicide in South Asian women because of it leading into mental health. A study by Cooper et al. (2006) found South Asian women were more likely to be married but less likely to live in circumstances usually associated with high risk or be unemployed. South Asian women in particular, reported higher rates of relationship problems with their families. Disputes between the wife and close in-laws have also been found to be common in many studies (Bhugra et al. 1999; Merrill & Owens, 1986).

One of the key reasons as to why arranged marriage can have catastrophic effects is because of the reasons that underlie the justification of arranged marriages. Many people from the South Asian community follow the potentially problematic cultural beliefs that lay behind arranged marriages as if they were their own religious beliefs. No major religion within the South Asian community encourages arranged marriage as a part of its beliefs as this phenomenon has been shaped by problematic cultural beliefs. These beliefs are seen to cause larger problems when applied in a western culture as the younger generation of the South Asian community often adopt more western views surrounding marriage (i.e love marriages). In the South Asian culture, marriage is often seen to be the key movement through which a family's status can be enhanced or expressed (Bhopal, 2011). Parents and families can begin to ignore their children's wishes and set up an arranged marriage as they see it best for their

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family, and to increase their status and thus become an unwanted marriage for the children. This in turn is a key factor in initiating family conflicts leading to feelings of perceived burdensomeness. If South Asian women feel as if they cannot live up to family statuses and higher expectations, they could develop feelings such as self-hate and shame and also see themselves as a burden on their family stopping their family form enhancing their reputation.

Social support within the South Asian community can also be seen to influence one's perceived burdensomeness in certain ways. Social support can differ in forms as Cohen and Syne (1985) explain that not only can social support contribute to the avoidance of stressful events but also be a factor in the generation of stressful events. They further explain that support can be helpful or harmful to individuals who appraise a situation to be stressful. Most research surrounding social support has been focused on the positive aspects which obscures the fact there are also costs related to such social relations. The central notion addressed in previous literature alludes to the point that supportive social relationships enhance coping with stressful events. However, non-supportive social relationships also could potentially cause stressful events and intensify one's mental health problems. The limited research point towards the view that negative social interactions can in fact have a more influential effect on psychological well-being than positive social interactions (Rook, 1984). This is particularly important if a person is seen to have fewer social links as the individual thus becomes more dependent on the support they have. This therefore makes such negative social support more potent in terms of its effect on an individual.

Negative social support can come in the form of actions by individuals in one's social network that cause distress such as shame, resentment and sadness (Lincoln, 2000), which again are seen to be observable factors for perceived burdensomeness. Negative interactions can include things such as inferring in another's affairs, making critical remarks, discouraging the expression of feelings and invading another's privacy (Lincoln, 2000).

These forms of negative social support can be related to the South Asian culture as such negative interactions have been seen to be common occurrences. Hicks and Bhugra (2003) explains that suicide attempts in South Asian women were due to too much interference by family and stress caused by partners.

The South Asian culture can be a facilitator when it comes to discouraging the expression of feelings as Husain, et al. (2006) explain that family honour also known as 'izzat' has a major influence on South Asian women. As explained previously, South Asian women are seen to carry the honour/dishonour of the family and thus are influenced to conceal their problems. Many South Asian women may talk to close family members regarding their mental health problems and be told to carry on and not get help to not bring shame and dishonour to the family, thus receiving negative social support and increasing their feelings of perceived burdensomeness.

Husain et al. (2006) found that proposed honour in South Asian families led to an increase in mental distress which in turn led to South Asian women in the study saw self-harm as a way of coping with such mental distress. Husain et al. (2006) further explain that many South Asian families are critical about the behaviour of women and that is imperative whether what they say or do is seen as good behaviour according to the community due to the critical point that gaining status is essential for the family. Thus, South Asian women can be at risk of being guided by their families in line with family honour rather than what is best for them. Husain et al. (2006) continue to explain that many women felt they had a lack of privacy and space due to the restrictions on their behaviour and interference from family members. Lincoln et al. (2003) explains that people whose social network members make critical remarks, show negative interaction or make them feel tense will experience a higher level of psychological distress. These are similar to observable indicators outlined by Van Orden et al. (2010) which are said to increase one's perceived burdensomeness. Critical remarks can

lead to some individuals feeling unimportant, agitated and distressed thus influencing their levels of perceived burdensomeness.

Lincoln et al. (2003) also supports the view that social support can differ between cultures and communities. The research examined the differential effects of social support between white and black Americans regarding psychological distress, and found that the two cultures were different from each other in terms of patterns and characteristics of their social and personal networks and network transactions that were seen to be significant for social interaction. Lincoln et al. (2003) explained that in some cases, negative social interactions with close relatives and family members may increase vulnerability to emotional distress and that relationships between psychological distress and social interactions were different between blacks and whites which again portrays the importance of cultural factors in regards to suicidal ideation. The further stressed the importance of non-kin members (such as friends and church members) on supportive relationships for African Americans. This can also be related to the South Asian culture as friends of South Asian women can be seen to be the only source of positive social support due to family members upholding cultural values such as honour. Therefore, friends of South Asian women exist outside of the close knit family circle. Lincoln et al. (2003) concluded that future research should explore the nature of social interactions with other social networks such as friends in regards to culture.

This notion is further supported by Kingsbury (1994) who reported that those who had attempted suicide were found to be in less contact with their friends and saw them less frequently for shorter periods. They further explained that parental and familial relationships did not compensate for this and parental relationships were a key cause in suicidal behaviour. Bhugra and Desai (2002) explain that this could be due to the South Asian community upholding the importance placed of academic and economic success, the overriding authority of elders and the stigma attached to failure. Research thus shows that traditional parental and

family concepts of honour in the South Asian community can lead to South Asian women having feelings of being a liability and self-hate, in turn increasing their perceived burdensomeness.

Previous research stresses the fact that mental disorders may have an effect on one's suicidal behaviour as symptoms are said to increase suicide ideation. Depression can lead to people having feelings of shame and self-blame and thus seen to increase one's perceived burdensomeness. Van Orden et al. (2010) explain that depression can also lead to being a burden on the family. Karasz (2005) tells us that among South Asian women, studies have found a strong connection between marital and family problems and a wide range of health problems. Depression can occur in any race or gender however, high rates of depression have been found in Punjabi primary care attenders in the UK, particularly in women. Likewise, a UK extensive population based study found greater rates of depression in Indian and Pakistani women. South Asian immigrants in the UK could be at a higher risk of psychiatric disorders due to the major psychological changes that are needed when living in a Western country. This could include totally different social values and cultural patterns, learning a new language and dealing with discrimination. This can also lead to the fact that the South Asian community are less likely to access health services compared to their White counterparts (Cooper et al. 2006). Research has found that South Asians can sometimes find it hard to sympathise with a depressed individual as the South Asian community can also be less understanding and sympathetic, suggesting that depressed individuals are not valued by society (Mallinson & Popay, 2007; McCllealnd et al. 2014).

The South Asian culture is more heavily inclined to conceal mental illness from the wider community because they believe that the family reputation is at stake (Furnham & Chan, 2004). In the South Asian culture, mental illness is not only limited to the one person that is affected but can also bring dishonour and shame to the entire family. This can be related to

the other risk factor proposed by Van Orden et al. (2010) being family conflict as it can be seen as an observable indicator for perceived burdensomeness. Feelings of being a burden on family have been heavily linked with a desire for suicide within previous research such as Rosenthal and Rosenthal (1984) who linked suicidal preschoolers to being a burden on their parents. Sabbath (1969) also explain in their family system's theory of adolescent suicidal behaviour that perceived burdensomeness on family is a key factor. According to the theory, factors for adolescent suicidal behaviour include parental attitudes about the family being better of is the adolescent was dead and that they are not essential or needed in the family. Woznica and Shapiro (1990) who experimented on the theory found that perceptions of being unwanted and expendable in the family were positively correlated to suicidal behaviour in adolescents.

The South Asian culture differs from that of the western culture as it is has limited resources for dealing with what would be classed as mental health problems. This is due to religions within the South Asian culture holding supernatural beliefs as reasons for mental illness as there is a predisposition to attribute supernatural forces such as possession by spirits and black magic as underlying causes for mental health (Lai & Surood 2008; Jorm, 2000). Rashid, et al. (2012) explains that a demonic possession can be seen to be due to the existence of a jinn (spirit) which are said to be a separate race in Islam which cause physical illness, sadness or anger and can cause harm by possessing a human (Hussain & Cochrane, 2002). Al Habeeb (2004) explains that these jinn's relate to bizarre behaviours and odd movements, which are usually considered as psychotic or non-psychotic disorders. Jinn possession however, is most likely to be seen among people from Pakistan and Bangladesh (Khalifa and Hardie, 2005) which means that these supernatural beliefs are more prevalent in certain Asian groups and not others. These beliefs on the supernatural are less prevalent but also found in other South Asian religions as Kuharik (2015) explains that in Hinduism,

Asuras are comparable to the concept of Jinn in Islam. Asuras are described in Hindu hymns as supernatural spirits that can take the form of either good or evil. Though there are no direct relation to supernatural forces within Sikhism, there is an influence from other religions from the South Asian culture regarding supernatural forces as Ferrari (2011) explains that Sikhs who have dispersed form the homeland of Punjab often come back to visit Punjabi pilgrimage sites used for healing and possession that are usually dedicated to Hindus and Muslims. Though the belief of supernatural forces is less prevalent in certain South Asian religious group, there still exists a shared common belief on the subject as Dein and Sembhi (2001) found in their research on the use of traditional healing for supernatural forces in South Asian psychiatric patients in the UK, the choices of healers among patients was not necessarily determined by a certain religious affiliation as both Hindus and Muslims were seen to consult both types of faith healers.

The problems lies when these supernatural beliefs are being used as reasons for mental health problems. This in turn leads to culture-specific approaches such as spiritual and religious healers as reputable and conventional forms of treatment within South Asian communities. These methods are preferred over using public health services as it is believed within the South Asian community that families will have shame for using them (Furnham & Chan, 2004). This restriction in available coping resources places a bigger emphasis on the family to help those suffering from a mental illness which can at times lead to family conflict and also self-blame, in turn increasing one's perceived burdensomeness. Meltzer et al. (2000) explain that within the South Asian community there is shame in discussing one's problems with health professionals, again potentially increasing one's suicidal desire as shame is seen to be an observable indicator of perceived burdensomeness.

Research therefore provides support for the viewpoint that culture has an effect upon the Interpersonal Theory of Suicide as cultural differences in social support can lead to risk

factors and observable indicators associated with perceived burdensomeness. Hofstede (1980) explains that cultures such as the South Asian culture which emphasise affiliation and communion may have a larger number of structural supports compared to other cultures; however these are not necessarily functional support systems. Thus, a social support can be seen to be in place regarding suicidal behaviour, but if they are not seen to functional, then social support can become a negative interaction, which in turn could lead to a higher level of psychological distress and risk factors for perceived burdensomeness thus increasing one's suicidal desire.

Thwarted Belongingness

Social isolation is an issue which Van Orden et al. (2010) explain is the strongest predictor of suicide as it can increase one's feelings of thwarted belongingness due to the loneliness one may feel. Van Orden et al. (2010) tells us that people who perceive others within their social networks to be those that rejected them or not available for interaction, are less likely to engage in affiliate behaviour and probably more likely to engage in self-defeating behaviours that accompany thwarted belongingness.

Chew-Graham, Bashir, Chantler and Burman (2002) carried out focus groups with South Asian women between the ages of 17-50 regarding suffering from psychological distress and found that the women based their weakened psychological and personal resources on lack of social support and other external pressures. Participants had also agreed to the fact that the inability to speak English had increased their sense of isolation and so used self-harm as a response to social isolation and what was viewed by them to be logical behaviour to reduce stress and ask for help. All participants mentioned that they would not be capable of accessing mainstream service provision in regards to mental health and suicide as they said they could not trust the service providers. Participants explained their behaviour to be

because of the fear from the community in seeking help from their General Practioners as they were worried it would go on their record and get out into the local community that they were accessing help. This is similar to research by Hussain and Cochrane (2002) on South Asian women's belief on depression. A participant in their research explained her social isolation in relation to shame from the community as she explained "I didn't tell anyone because at the end of the day it's private and if I tell someone, they'll tell someone else and they'll tell someone else" (Hussain & Cochrane, 2002, p. 296). This again shows how some South Asian women are scared to talk about their problems just to avoid breaches of confidentiality within the community. This is a detrimental factor for those in need of help not using help-seeking behaviours to access treatment as it shows that shame in accessing help adds further to their social isolation.

Social isolation in relation to thwarted belongingness can develop in various ways within the South Asian community. Research explains isolation can be a result of arranged marriage as women begin to feel isolated from their newfound family and thus develop mental disorders such as depression and also feel isolated after migrating due to lack of family and friends (Cooper et al. 2006; Mui & Kang, 2006). This is supported by Hussain and Cochrane (2002) as they suggest the strongest predictors of depression in South Asian women are unhappy marriages, living with extended families and social isolation. These factors can also be related to risk factors for thwarted belongingness outline by Van Orden et al. (2010) as they explain that observable indicators include familial disharmony, loneliness and social withdrawal. When the individual only interacts with those from similar cultural norms and values, they can then be reinforced making it harder for those with suicidal thoughts to talk to anyone about how they feel. These feelings of suicidal behaviour and loneliness can also be reinforced as in the South Asian culture, as mental illness is not only limited to the one person that is affected but can also bring shame to the entire family. This factor plays an

important role because of the structure of arranged marriage as family emphasis from a new family can lead to feelings of social isolation and familial disharmony.

Lin (1986) describes social support as actual or perceived expressive provisions supplied by partners, social networks and the community. Generally, social support is a positive interaction and beneficial to one's health and wellbeing as a strong support network is seen to be an essential coping resource. This is because it is seen as if having other people to disclose personal problems with or go to for help enhances one's subjective psychological wellbeing and also assists in coping with stress. However, literature has shown that this depends on the people that the individual goes to for help in times of need. Positive social support thus promotes belongingness and reduces the risk of suicidal desire but as mentioned before social support can also come in negative forms and in turn increases one's feelings of thwarted belongingness.

Obvious forms of social support such as family has been therefore seen to be a detrimental factor in one's feelings of thwarted belongingness within the South Asian community. Religion is another particularly important source for support in the South Asian community. Social support can also be related to an individual's religiosity as Gorsuch and McPherson (1989) explain that some individual can use religion as a means to make friends and provide social support.

Religiosity has been shown to have a varying effect on suicide intent and attempts with some research finding a positive association (Bergin, 1983; Clarke, Hayslip, Edmondson & Guarnaccia, 2003; Larson et al 1993) some finding a negative association (Huguelet, Borras, Gillieron, Brandt & Mohr, 2009; White, Joseph & Neil, 1995) and some research finding no association whatsoever (Pfeifer & Waelty, 1999). Much of the inconsistent results can be put down to a varying degree of religiosity. Thus, a distinction was made to separate different

aspects of religion being intrinsic and extrinsic religiosity (Allport and Ross 1967; Gorsuch and McPherson 1989). Allport and Ross (1967) explain that an individual who is intrinsically motivated lives his religion whereas the extrinsically motivated individual uses his religion. An example of an individual who is extrinsically motivated would go to their place of worship primarily because they believe it is the correct thing to and increases their social contacts, whereas an individual who is intrinsically motivated would go to their place of worship for themselves and to have a stronger relationship with their faith. Extrinsically motivated individuals thus use religion to fit more primary needs and is the means to an external end; whereas for an intrinsically motivated individual, religion is the end itself.

Rheeda and Shaughna (2005) examined the relationship between religiosity and suicidal ideation in a sample of African American and White college students. It was found that having a higher intrinsic religiosity was associated with less suicidal thoughts. This supports the point that intrinsic religiosity is linked with lower levels of suicide ideation when compared to extrinsic religiosity.

A reason for this could be that religion is a protective factor for suicide due to all major South Asian religions having explicit prohibitions against suicide. This could therefore be a barrier to one having the capability to suicide in relation to the Interpersonal Theory of Suicide. An individual that is seen to follow their religion in its entirety and have more involvement with their faith are usually seen as intrinsically orientated. Therefore, findings of lower rates of suicide ideation and attempts in intrinsically oriented individuals compared to extrinsically orientated individuals may be due to the fact that their faith does not allow them to carry out such thoughts and acts. Rheeda and Shaughna (2005) support this view as they explain that stronger church ties and religiosity act as protective factors that reduce one's risk for psychiatric problems and also suicidal behaviour

Stack (1983) theory on the effect of religious commitment on suicide explains that if one is sincerely committed to their religion, it helps to shape the individual to be more resilient in the face of adversity and reduces suicidal behaviour. The main reasons behind this view being that the religion believes in a life after death and encourages lifesaving values and beliefs. This relates to the religions within the South Asian culture, as this is what the common religions express.

Family conflicts within the South Asian culture can also lead to some of the observable risk factors outlined by Van Orden et al. (2010) in increasing thwarted belongingness such as loneliness and lack of reciprocal relationships. These types of feelings are supported by studies surrounding women who have attempted suicide as they suggest that sociocultural factors could be a significant factor in the suicide ideation of South Asian women (Cooper et al. 2006). Proposed sociocultural factors include unhappy arranged marriages, family problems over lifestyle and marriage, marital conflict, in-law problems, expectations of submission by women to men and elders, culture conflict and stigma (Hicks & Bhugra, 2003). Hicks and Bhugra (2003) carried out a study on the perceived causes of suicide attempts by UK South Asian women and found through interviews that Ninety percent of suicide attempts were because of unhappy marriages, too much interference by in-laws and the stress they caused and men. The South Asian culture can thus be seen to have an effect on individual's thwarted belongingness and exacerbate the risk factors and observable indicators attached to thwarted belongingness.

Research aims

Previous literature therefore suggests that cultural values may have an influence on suicidal ideation and activity, and so the present research will investigate whether South Asian cultural values has an influence on Joiner's Theory of Interpersonal Suicide. The primary aim of the present study is to examine the role of various suicide predictors in relation to the South Asian culture on suicide consideration and suicide attempts among South Asian females. Joiner's Theory on Interpersonal Suicide outlines the three components needed for suicide and provides support for the independent effects of each factor as predictors of suicidality as a whole. The present study however introduces cultural factors to Joiner's model (Figure 1), which have not previously been explicitly considered to effect each of the components within the interpersonal theory of suicide.

Figure 3: Proposed causal pathway to lethal suicidal behaviour.
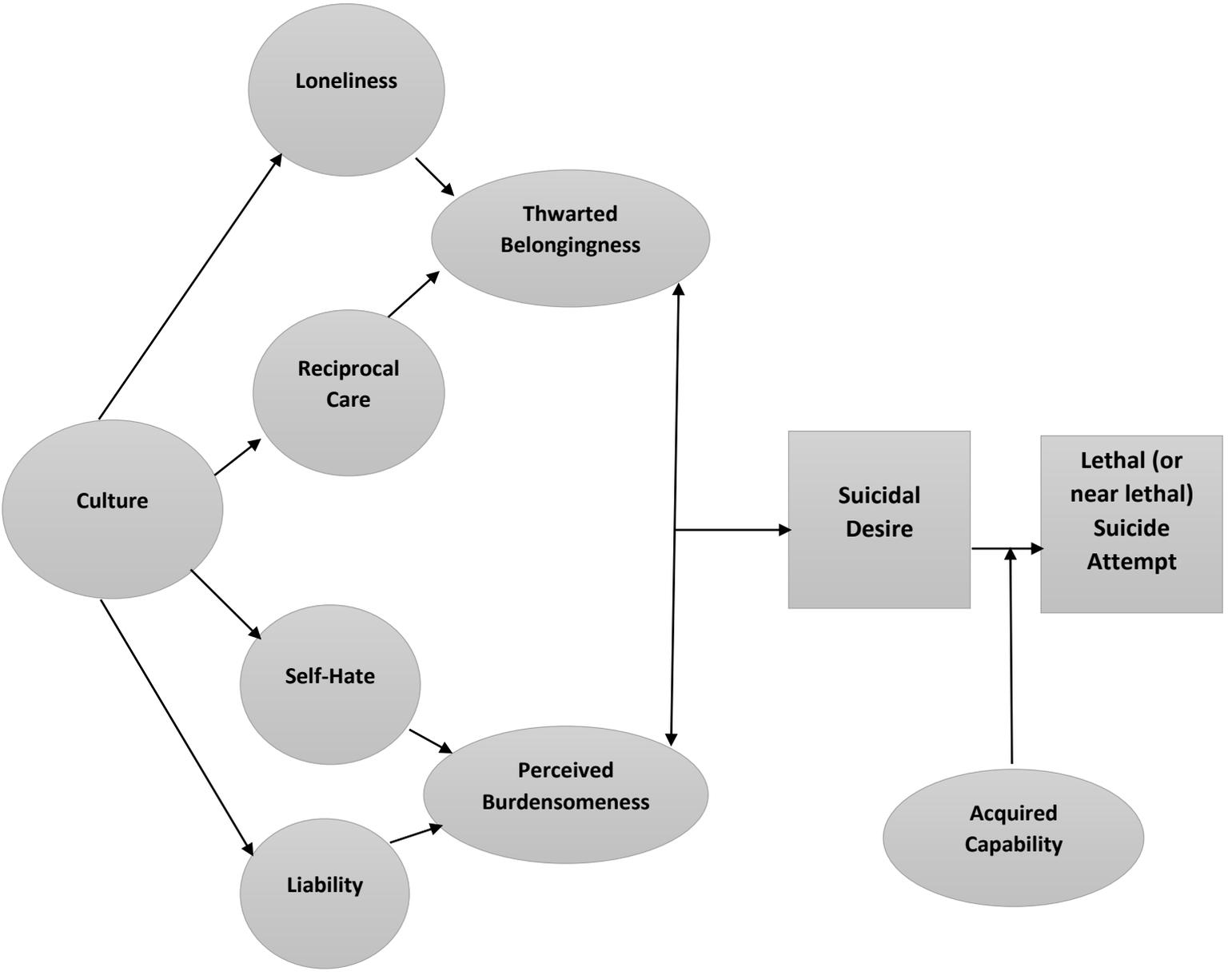
Method

Participants

A total of 215 participants completed the questionnaire. All participants were from a South Asian background and all were female. Participant's ages ranged between 18 and 85 (Mean age = 25.75, SD = 14.70, Range = 67). The participants were recruited both online and in person. A purposive sampling method was used to contact older participants from a Women's Activity Centre (WAC) based in Halifax. WAC offers social care to South Asian women over 50 years old by providing a wide range of services and also encouraging service users to maintain an independent and healthy living. A snowball sampling method was used to recruit younger participants through social media. The online questionnaire was distributed to certain groups and pages online and following this, existing participants would promote the study on their page to increase awareness. The pages included South Asian cultural groups, groups surrounding arranged marriage and university religious society groups.

Design

A Self-report survey design was utilised in the study as all participants carried out the same questionnaire with the same conditions. The two questions that were used, assessed whether an individual had attempted suicide within the previous 12 months and whether an individual had ever considered suicide within the previous 12 months. Thus, the two dependent variables were suicide attempts and suicide consideration. The study consisted of 3 predictor variables that were derived from 13 measures. These independent variables were then clustered into three groups for analysis. The first group investigated mental health status by measuring psychological well-being and psychological distress. The second group of independent variables investigated Joiner's theory of Interpersonal Suicide by measuring

social support, acquired capability for suicide, perceived burdensomeness and thwarted belongingness. The third group of independent variables investigated variables associated to the South Asian culture by measuring attitudes toward love and arranged marriages, cultural values and religious orientation.

Questionnaire

The questionnaire began with 8 demographic variables. The first was age and then followed with a series of questions.

1. 'Do you work or study outside of the home?'
2. 'Do you socialise with non South-Asians?'
3. 'What is your highest level of education?'
4. 'How any years have you been in the UK?'
5. 'What is your household income?'
6. 'Can you read English coherently?'
7. 'Can you speak English fluently?'

Alongside demographic variables the questionnaire consisted of a combination of scales which aimed to investigate effects on both suicide attempts and suicide consideration.

The questionnaire consisted of two response variables which were taken from the Youth Risk Behavior Surveillance System (Brener, Kann, Shanklin, Kinchen & Eaton, 2013), which is a large questionnaire that monitors six types of health-risk behaviours that contribute to the leading causes of death and disability among youth and adults. Questions were taken to investigate an individual's suicidality. These were simple closed questions with a response of

either yes or no. This assessed whether in the last 12 months, individuals ever seriously considered attempting suicide and whether individuals ever attempted suicide.

The Mental Health Inventory (Veit & Ware, 1983) includes 38 items in order to assess one's mental health index but also includes six subscales (anxiety, depression, loss of behavioural/emotional control, general positive affect, emotional ties & life satisfaction) and two subscales (psychological well-being & psychological distress). In the present study, the two global scales were utilised to measure individual's general levels of psychological well-being and distress. The items were scored on a 6-point Likert scale according to the frequency of the item's incidence over the past month; for example "During the past month, did you think about taking your own life?". The 38 items were then split into the two global subscales accordingly, to produce two sums where higher scores suggest greater psychological distress and greater psychological well-being. Internal reliability for psychological well-being and psychological distress in the current sample were $\alpha = .87$ and $\alpha = .90$ respectively.

The Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988) aims to investigate an individual's perception of social support from three different sources: friends, family and significant others. The scale contains 12 items, which are scored on a seven point Likert-scale ranging from 1 (very strongly agree) to 7 (very strongly disagree). Each subscale consisted of four items from which scores were averaged to produce a total perceived support score, where higher scores suggest a stronger perception of social support from the particular source. Internal reliability for friends, family and significant other in the current sample were $\alpha = .95$, $\alpha = .93$ and $\alpha = .90$ respectively.

The Acquired Capability for Suicide Scale (Ribeiro et al., 2014) was used to measure another key component of Joiner's 2005 psychological theory by assessing an individual's fearlessness of death, and fearlessness about engaging in potentially self-harming behaviours. The scale consists of 7 items where each item was rated on a 5-point Likert scale, ranging from 0 (not at all like me) to 4 (very much like me). All items are summed up to give a total score ranging from 0-28, with higher score indicating higher levels of fearlessness about death and higher fearlessness about engaging in self-harmful behaviours. Internal reliability for the Acquired Capability for Suicide Scale was $\alpha = .94$.

The Interpersonal Needs Questionnaire (Van Orden et al. 2008) was used to measure two of the main components of Joiner's interpersonal theory of suicide (2005), thwarted belongingness and perceived burdensomeness. The self-report questionnaire consisted of 12 items of which 5 items investigated individuals beliefs on feeling like a burden on people in their lives (perceived burdensomeness), and 7 items looked at individuals present beliefs about feeling connected to others (thwarted belongingness). Items were rated on a 7-point Likert scale ranging from 1 (not at all true for me) to 7 (very true for me). Scores were totalled for each subscale, from which a higher score indicated greater psychopathology for each scale. Internal reliability for thwarted belongingness and perceived burdensomeness in the current sample were $\alpha = .90$ and $\alpha = .96$ respectively.

The Attitude Towards Marriage Scale (Park & Rosén, 2013) aims to investigate an individual's overall positive and negative attitude towards marriage. The original scale was used twice in the present study, once to assess individual's attitude towards a love marriage and once again to assess individual's attitude towards an arranged marriage. This was carried

out by adding the word 'love' and 'arranged' to each question in the two scales. For example question one which was 'marriage is beneficial' was altered to both 'A love marriage is beneficial' and 'An arranged marriage is beneficial' in the corresponding scales. The scale consisted of 10 items which were rated on a 7-point Likert scale ranging from 0 (strongly disagree) to 6 (strongly agree). Scores ranged from 0-60 in which a higher score reflected a greater positive attitude to both love and arranged marriage. Internal reliability for both the attitude towards love marriage scale and the attitude towards an arranged marriage scale in the current sample was $\alpha = .97$ and $\alpha = .91$ respectively,

The Cultural Values Scale (Lai & Surood, 2008) was developed upon input and literature form the South Asian community to assess the amount of identification to traditional South Asian beliefs. The scale looked at various aspects of the culture including gender roles, parent relationships, use of language and interracial marriages. The scale consists of fifteen items on a scale of 1 (strongly disagree) to 5 (strongly agree) assessing the level of agreement to each South Asian value. The sum of all items was divided by fifteen so a final score would range between 1 to 5, with higher scores indicating a stronger level of identification to the South Asian culture. . Internal reliability for the Cultural Values Scale in the current sample was $\alpha = .86$.

The Religious Orientation Scale (Gorsuch & McPherson, 1989) was used to measure whether individual's viewed their religion as a genuine personal matter and belongingness to a religious identity (intrinsic religiosity) or a claim to a religious identity with minimal adherence to religious teachings and a means to maintain a social network (extrinsic religiosity). The scale consisted of 14 items where eight items assessed intrinsic religiosity

and six items assessed extrinsic religiosity. Items were assessed on a scale from 1 (strongly disagree) to 5 (strongly agree). Thus, a higher score out of forty for the extrinsic scale indicate higher extrinsic orientation and a higher score out of thirty for the intrinsic scale indicated a higher intrinsic orientation. Similar to other researchers interested in avoiding the potential Christian bias and confusion, the term 'Church' was replaced with 'Place of worship' (Steger et al. 2006). Gorsuch explains that a distinction in religious orientation is useful in the view of religious attitude and behaviour and has established its worth when investigating a relationship between religiosity and health. Internal reliability for intrinsic religiosity and extrinsic religiosity in the current sample were $\alpha = .77$ and $\alpha = .74$ respectively.

Procedure

Initially, the questionnaire was administered through an online program (Qualtrics) so that it could be circulated within the South Asian online community. This was done by giving a brief introduction of the questionnaire on social media and then sharing the link on social networking sites. Various types of social-networking sites were used to share the questionnaire such as Facebook, Twitter and Instagram. As this used a snowball sampling technique, specific South Asian groups were contacted online through social media. The questionnaire link was promoted through social media every few days for a period of six weeks.

The participant had to be of South Asian ethnicity, female and over 18 years of age and was given researcher details for any questions they may have had. Participants were informed of their unique participant ID that they would receive upon completion of the questionnaire, which could be used to withdraw their data by a certain date if they wished (19/04/2015). The

participants then completed the consent form (Appendix 2). Participants were also given the option to provide an email address if they wanted a copy of the results and study after the data had been analysed.

Participants were given separate instructions for each individual scale, with a reminder of the scoring details if a questionnaire continued over one page. Once all the questions were completed, participants were taken to a page that gave them a choice in submitting their answers. If they did not want to submit their answers for analysis they could quit the questionnaire by closing the page, otherwise they continued to submit and were shown the participant debrief sheet (Appendix 3) which revealed the project title and aims of the experiment. The debrief sheet also included contact details for a range of support services.

A paper-based questionnaire (Appendix 1) was also used to recruit an older age range of participants who were assumed to be unfamiliar with using computers and online surveys. These women were assessed individually at the Women's Activity Centre. They were asked if they had any questions and were told they could withdraw at any time they felt necessary. Following this, participants were handed the same questionnaire as used online but in a paper form. Once participants had completed their questionnaire they handed it back to the researcher and were then given the debrief sheet (Appendix 3). All women were also given a unique number on their debrief sheet, which was also written on top of their questionnaire, so if they wanted to withdraw their data at a later date, they could quote their number.

The present study was carried out in accordance with the British Psychological Society's ethical guidelines (BPS, 2009) and approved by the University of Huddersfield School Research Ethics Panel. Informed consent was obtained from all patients who took part in the study.

Statistical Analyses

A binary logistic regression was used to analyse the results due to the dependant variables being measured on a dichotomous scale, as the dependant variables consisted of mutually exclusive and exhaustive categories. This is because the answer to both questions regarding suicidal behaviour and attempts were answered by either a 'yes' or a 'no'. The study also consisted of 3 independent variables, which consisted of a range continuous and categorical variables. Thus, a binary logistic regression was used to analyse the relationship between both suicidal consideration and attempts with the 3 predictor variables being mental health status, the Theory of Interpersonal Suicide and South Asian cultural values.

Descriptive statistics

From the sample it was found that suicidal attempts existed in 5.1% of the sample as 11 participants out of the 210 recorded results reported that they had attempted suicide within the last 12 months. It was also found that suicidal ideation existed in 13.5% of the population as 29 participants out of the 210 recorded results reported that they considered suicide within the last 12 months. Demographic variables show that the mean age of participants was 25.75. Descriptive statistics also showed that the majority of participants worked or studied outside the home, socialised with non South Asians and could read and speak English fluently. Though 215 participants took part in the study only 210 were included in the analysis of suicidal ideation and attempts due to missing results in data collection as 5 participants did not record their results for suicidal ideation and attempts.

Table 1: Demographic and predictor variables of the sample group

Variable	N	%
Do you work or study outside of the home?		
Yes	173	80.5
No	41	19.1
Do you socialise with non South-Asians?		
Yes	189	87.9
No	23	10.7
What is your highest level of education?		
No education	8	3.7
School education	17	7.9
Further education	105	48.8
Higher education	85	39.5
How many years have you been in		

the UK?			
Born in UK	146	67.9	
< 5 Years	5	2.3	
6 – 10 Years	5	2.3	
11 – 20 Years	33	15.3	
20+ Years	25	11.6	
What is your household income?			
Under £10k	25	11.6	
£10 - £25k	77	35.8	
£25k +	110	51.2	
Can you read English coherently?			
Very well	199	92.6	
A little bit	4	1.9	
Not at all	11	5.1	
Can you speak English fluently?			
Very well	199	92.6	
A little bit	6	2.8	
Not at all	10	4.7	
Variable	**Mean**	**Standard Deviation**	**Range**
Age	25.75	14.69	18 - 85
Psychological Distress (MHI)	66.91	16.75	34 - 112
Psychological Wellbeing (MHI)	51.37	11.30	26- 79
Anxiety (MHI)	25.38	8.27	9 - 46
Depression (MHI)	10.79	4.08	4 - 22
Loss of Behavioural or Emotional Control (MHI)	23.19	7.84	9 - 46
General Positive Affect (MHI)	36.01	9.60	12 - 60
Emotional Ties (MHI)	7.74	2.61	2 - 12
Life Satisfaction (MHI)	4.00	1.18	1 - 6
Perceived Burdensomeness	14.73	11.98	7 - 45
Thwarted Belongingness	13.35	8.55	5 - 32
Acquired Capability for Suicide	12.33	10.16	0 - 28
Social support (Significant Other)	20.64	5.98	4 - 28
Social support (Family)	20.90	6.15	2 - 28
Social support (Friends)	15.49	3.56	4 - 20
Cultural Values	3.20	.64	1 - 5
General Attitudes to Arranged Marriage	28.91	13.95	1 - 60
General Attitudes to Love Marriage	38.19	17.46	0 - 60
Religious Orientation Scale - Intrinsic	21.87	5.66	8 - 35

Variable			
Religious Orientation Scale - Extrinsic	17.17	4.21	6- 30
Variable	**N**	**%**	
Suicide Attempts in Past 12 Months			
Yes	11	5.1	
No	199	92.6	
Suicide Consideration in Past 12 Months			
Yes	29	13.5	
No	181	84.2	

Binary Logistic Regression

Table 2: Results from Binary Logistic Regression on predictors of suicidal consideration

Variable	Model 1		Model 2		Model 3	
	B	Exp(B)	B	Exp(B)	B	Exp(B)
Psychological Wellbeing	0.000	1.000	-.025	.976	-.038	.963
Psychological Distress	.077*	1.080	.033	1.034	.042	1.043
Thwarted Belongingness			-.021	.979	-.007	.993
Perceived burdensomeness			0.110*	1.117	.108*	1.114
Social Support (Significant Other)			.059	1.060	.082	1.085
Social Support (Family)			.066	1.068	.074	1.077
Social Support (Friends)			-.118	.888	-.383**	.681
Acquired Capability for Suicide			-.049	.952	-.059	.943
Cultural Values					2.023***	7.561
Intrinsic Religiosity					.015	1.016
Extrinsic Religiosity					-.120	.887
Attitude towards Arranged Marriage					.006	1.006
Attitude towards Love Marriage					-.018	.982

A binary Logistic regression was performed to assess the impact of a number of factors on the likelihood of an individual considering committing suicide within the last 12 months (Table 2). The Hosmer-Lemeshow test results indicated that the goodness of fit was satisfactory for the model as the significance value greater than .05. The chi-square for the Hosmer and Lemeshow test was 11.336 with a significance level of .183.

The model contained three blocks of independent variables. The first block included predictors that focused on psychological well-being and psychological distress. Table 2 shows that the first step of the model containing two predictors was statistically significant, $\chi2$ (2, N = 215) = 32.8, p = .001, indicating that the model was able to distinguish between respondents who reported and did not report considering suicide within the previous 12 months. The Cox & Snell R Square and the Nagelkerke R Square values provide an indication about the amount of variation in the consideration of suicide explained by the

model. These are described as pseudo R square statistics. After controlling for mental health status, the first step of the model explained between 14% (Cox and Snell R square) and 26% (Nagelkerke R squared) of the variance in an individual considering committing suicide within the last 12 months, and correctly classified 86% of cases. Psychological distress was shown to have made a unique statistically significant contribution to the model ($p < 0.05$) with an odds ratio of 1.1. This indicated that respondents who had higher levels of psychological distress were 1.1 times more likely to consider committing suicide within the previous 12 months, than those who had lower levels of psychological distress.

Table 2 shows that the second step of the model containing an additional six predictors (social support – significant other, social support – family, social support – friends, acquired capability for suicide, perceived burdensomeness and thwarted belongingness) relating to Joiner's theory of interpersonal theory of suicide was also statistically significant, $\chi2$ (6, N = 215) = 50.62, p = 0.07, indicating that the model was able to distinguish between respondents who reported and did not report considering committing suicide within the previous 12 months. After entry of variables relating to Joiner's theory on Interpersonal Suicide at step 2, the total variance explained by the model was between 21% (Cox and Snell R square) and 39% (Nagelkerke R squared) of the variance in an individual considering committing suicide within the last 12 months, and correctly classified 90% of cases. The introduction of the second step of the model explained an additional 13% of variance in an individual considering committing suicide within the last 12 months. Perceived burdensomeness was shown to have made a unique statistically significant contribution to the model (p = 0.03) at step 2, with an odds ratio of 1.12. This indicated that respondents who had higher levels of perceived burdensomeness were 1.12 times more likely to consider committing suicide within the previous 12 months, than those who had lower levels of perceived burdensomeness.

Table 2 shows that the third step of the model containing an additional three predictors (attitudes toward love and arranged marriages, cultural values and religious orientation) relating to the South Asian culture was also statistically significant, $\chi 2$ (13, N = 215) = 57.07, p = .001, indicating that the model as a whole was able to distinguish between respondents who reported and did not report considering committing suicide within the last 12 months. After entry of the South Asian culture at step 3, the total variance explained by the model as a whole was between 24% (Cox and Snell R square) and 43% (Nagelkerke R squared) of the variance of an individual considering committing suicide within the last 12 months, and correctly classified 90% of cases. The introduction of the third step of the model explained an additional 4% of variance in an individual considering committing suicide within the last 12 months. Perceived burdensomeness was shown to have made a unique statistically significant contribution to the model as a whole (p = 0.05) with an odds ratio of 1.1. This indicated that respondents who had higher levels of perceived burdensomeness were 1.1 times more likely to consider committing suicide within the previous 12 months, than those who had lower levels of perceived burdensomeness. Social support from family was also shown to have made a unique statistically significant contribution to the model as a whole (p = 0.16) with an odds ratio of 0.7. This indicated that respondents who had lower levels of social support from friends were 0.7 times more likely to consider committing suicide within the previous 12 months, than those who had higher levels of Social support from friends. South Asian cultural values were shown to have made a unique statistically significant contribution to the model as a whole (p = 0.033) with an odds ratio of 7.56. This indicated that respondents who had a higher association to South Asian cultural values were 7.56 times more likely to consider committing suicide within the previous 12 months, than those who had lower levels of South Asian cultural values.

Table 3: Results from Binary Logistic Regression on predictors of Suicidal Attempts

Variable	Model 1		Model 2		Model 3	
	B	Exp(B)	B	Exp(B)	B	Exp(B)
Psychological Wellbeing	.042	1.043	.019	1.019	-.009	.991
Psychological Distress	.092*	1.096	.034	1.035	.029	1.029
Thwarted Belongingness			.134	1.144	.106	1.112
Perceived burdensomeness			.061	1.063	.100	1.105
Social Support (Significant Other)			.075	1.078	.074	1.076
Social Support (Family)			.082	1.086	.150	1.161
Social Support (Friends)			-.240*	.786	.055	1.057
Acquired Capability for Suicide			-.041	.960	-.077	.926
Cultural Values					-1.077	.341
Intrinsic Religiosity					-.031	.969
Extrinsic Religiosity					-.300	.741
Attitude towards Arranged Marriage					-.072	.930
Attitude towards Love Marriage					-.099	.906

A binary logistic regression was performed to assess the impact of a number of factors on the likelihood of an individual attempting to commit suicide within the last 12 months (Table 3). The Hosmer-Lemeshow test results indicated that the goodness of fit was satisfactory for the model as the significance value greater than .05. The chi-square for the Hosmer and Lemeshow test was 11.059 with a significance level of .198.

The model contained three blocks of independent variables. The first block included predictors that focused on one's psychological well-being and psychological distress. Table 3 shows that the first step of the model containing two predictors was statistically significant, χ^2 (2, N = 215) = 14.47, p = .001, indicating that the model was able to distinguish between respondents who reported and did not report attempting suicide within the previous 12 months. The first step of the model explained between 7% (Cox and Snell R square) and 20% (Nagelkerke R squared) of the variance in attempting suicide within the previous 12 months, and correctly classified 95% of cases. Psychological distress was shown to have made a

unique statistically significant contribution to the model (p = .002) with an odds ratio of 1.1. This indicated that respondents who had higher levels of psychological distress were 1.1 times more likely attempt suicide within the previous 12 months, than those who had lower levels of psychological distress.

Table 3 shows that the second step of the model containing an additional six predictors (social support – significant other, social support – family, social support – friends, acquired capability for suicide, perceived burdensomeness and thwarted belongingness) relating to Joiner's theory of interpersonal theory of suicide was also statistically significant, $\chi 2$ (8, N = 215) = 30.22, p = .001, indicating that the model was able to distinguish between respondents who reported and did not report attempting suicide within the previous 12 months. After entry of Joiner's theory on Interpersonal Suicide at step 2, the total variance explained by the model was between 14% (Cox and Snell R square) and 40% (Nagelkerke R squared) of the variance in attempting suicide within the previous 12 months, and correctly classified 95% of cases. The introduction of the second step of the model explained an additional 20% of variance in attempting suicide within the previous 12 months. Social support from friends was shown to have made a unique statistically significant contribution to the model (p = 0.007) at step 2, with an odds ratio of 0.79. This indicated that respondents who had a higher level of social support from friends were 0.79 times more likely attempt suicide within the previous 12 months, than those who had lower levels of social support from friends.

Table 3 shows that the third step of the model containing an additional three predictors (attitudes toward love and arranged marriages, cultural values and religious orientation) relating to the South Asian culture was also statistically significant, $\chi 2$ (13, N = 215) = 38.64, p = .001, indicating that the model as a whole was able to distinguish between respondents who reported and did not report attempting suicide within the previous 12 months. After entry of the South Asian culture at step 3, the total variance explained by the model as a

whole was between 17% (Cox and Snell R square) and 50% (Nagelkerke R squared) of the variance in attempting suicide within the previous 12 months, and correctly classified 96% of cases. The introduction of the third step of the model explained an additional 10% of variance in attempting suicide within the previous 12 months. None of the independent variables made a unique statistically significant contribution to the model as a whole.

Discussion

The results indicated that 13.8% of the sample population considered suicide and 5.2% actually attempted suicide. These findings are consistent with previous research on predominately non South Asians as results from the British Psychiatry Morbidity Survey in 2000 regarding suicidal ideation, self-harm and attempted suicide found that 4.4% (430/8571 participants) of the population actually attempted suicide and around 14.8% (1380/8572 participants) thought about suicide (Spiers et al. 2014). Findings were also similar to that of Crawford, Nur, McKenzie and Tyrer (2005) who examined suicidal ideation and suicide attempts among ethnic minority groups in England. The sample was drawn from the Health Survey for England of 1998-1999 and found that in the multi-ethnic sample of over 4000 adults living in England, 10% of the population had contemplated suicide at some stage in their life and 3% of the population had attempted suicide in their lifetime.

D'Alessio and Ghazi (1993) explain that in an unpublished study by the Health and Ethnicity Unit, funded by the North East and West Thames health authorities, 7.5% (13,333 out of 100,000 participants) of women of Asian origin between the ages of 16-24 committed suicide. This is similar to the present study's finding as it was found that 5.2% of participants attempted suicide. The mean age of the present study was slightly over that of the Health and Ethnicity study at 25.75, but however still displays alarming findings as only 2.5% (of the majority white British population were said to commit (D'Alessio & Ghazi, 1993). Bhogal, Baldwin, Hartland and Nair (2006) investigated the differences between ethnic groups in the demographic and clinical features of patients admitted after episodes of deliberate self-harm. It was found that 11.3% had considered and planned their own suicide which was thus seen to be an indicator of suicide intent. This is similar to the present study's research findings where 13.8 of the sample population were seen to have considered suicide.

Results from the binary logistic regression found the significant predictors of suicide consideration within the last 12 months were perceived burdensomeness, social support from friends and cultural values.

Results showed that those who were seen to have a higher level of perceived burdensomeness were more likely to consider suicide. These findings support the interpersonal theory of suicide by Joiner (2005) as perceived burdensomeness is explained to be one of the two constructs that are needed for suicidal desire. Findings also supports research by Jahn, Cukrowicz, Mitchell, Poindexter and Guidry (2015) and Zaroff, Wong, Ku and Van Schalkwyk (2014) who also found perceived burdensomeness to be the strongest and most significant predictor of suicide. As thwarted belongingness was not seen to be a significant predictor of suicide in the present study, the findings are thus inclined towards Van Orden's (2010) first hypothesis of passive suicide ideation as possessing only perceived burdensomeness or thwarted belongingness is sufficient for suicidal ideation. Monteith, Menefee, Pettit, Leopoulos and Vincent (2013) found similar findings to that of the present study as only partial support was found for the hypothesis that perceived burdensomeness and thwarted belongingness together would predict suicidal ideation. Recent studies by Cero, Zuromski, Witte, Ribeiro, and Joiner (2015), and Lamis and Lester (2012) also support the notion that perceived burdensomeness predicts suicide but thwarted belongingness did not..

Joiner (2005) explains that perceived burdensomeness is when someone perceives themselves to be a burden on all significant others in their life and then endorse a degree of self-hate which include observable risk factors such as feelings of shame, self-blame, low self-esteem, being unimportant, unwanted and feeling like a burden on the family. These observable risk factors for perceived burdensomeness can be seen to be heightened due to the South Asian culture as Gilbert, Gilbert and Sanghera (2004) found that South Asian women can feel required to function within a set of norms of community and carry the family honour. They

therefore feel that they have to control their actions to prevent bringing shame and dishonour upon the family. If a South Asian female is seen to have brought dishonour upon the family or herself then they may experience feelings of shame and self-blame thus increasing one's perceived burdensomeness and leading to suicidal ideation. Shame within the South Asian culture can be seen to be more intense than in individualistic cultures as shame is felt by not only the individual but also the family and so can have a greater effect on one's perceived burdensomeness. Gehlot and Nathawat (1983) tell us that failing to perform to certain expectations also increases feelings of shame within the South Asian community and women thus have to live with the anxiety of not letting their community down.

The current study shows that perceived burdensomeness is a significant factor in predicting suicide ideation. Van Orden et al. (2010) explain that family conflict is an observable indicator for perceived burdensomeness as Sabbath (1969) tell us that perceived burdensomeness on family is a key factor in suicide. The South Asian culture places a strong emphasis on family ties and thus conflict in the family can have severe effects on individuals. Izzard (1997) explains that where Western societies promote an instigation of change in a person's situation; Eastern societies tend to maintain the situation to keep peace in the family and the individual is therefore forced to adjust to the situation at hand. This can lead to a variety of problems as South Asian women can be seen to repress their feelings in order to not cause family conflicts and in turn endorse feelings such as shame and self-blame, increasing their perceived burdensomeness. Research portrays that South Asian women can sometimes begin feeling trapped in South Asian traditions and family values. This also supports findings in the current study as those with a higher association with South Asian cultural values were more likely to support traditional views such as men being the head of families and women following daily routines of looking after children and staying at home.

Feelings of shame and self-blame can be said to surface from family conflict due to the disagreement within families regarding dishonour and in turn lead to an increase in one's perceived burdensomeness. Karasz (2005) tells us that when conflicts in family do occur, a wide range of health problems can exist. Furthermore, repression of feelings and feelings burdensomeness and shame are all seen to lead to mental illnesses. Furnham and Chan (2004) explains that the South Asian culture is more likely to conceal mental illness from the wider community because it is believed that the family reputation is at stake (Furnham & Chan, 2004). This further supports the view that within the South Asian culture, mental illness is not only limited to the affected individual but instead brings dishonour and shame to the entire family, in turn increasing perceived burdensomeness.

This current study portrays the view that culture has an effect on one's perceived burdensomeness. The Interpersonal Theory of Suicide states that family conflicts are risk factors for suicide and can also increase perceived burdensomeness if an individual is felt to be a burden on the family. Marital issues within the South Asian culture can be seen to differ to that of the Western culture as there is a strong emphasis on gender expectations where women are usually encouraged to have arranged marriages and when married, to follow traditional rigid cultural roles. Women's roles within the South Asian culture are thus seen to be inferior to that of males and differ largely from the western culture. Thus, being a South Asian female can lead to a number of observable risk factors for perceived burdensomeness.

Perceived burdensomeness could also be said to be increased due to the South Asian culture as women not being able to engage with health services further reduces their support system and thus makes the individual more dependent on their family for support. This can lead to an increase in family conflict due to women not being able to talk about their problems and being told by their family to continue as they are (Gilbert et al. 2004).

Results also found that those who were seen to have a lower level of social support from their friends were more likely to consider suicide. This finding is supported by D'attilio, Campbell, Lubold, Jacobson and Richard (1992) who found that those that were at a greater risk of suicide appeared to have fewer social contacts and less in contact with their friends. Similar findings were seen in research by Kingsbury (1994) who found that South Asians who participated in suicidal behaviour were less likely to be in contact with their friends and saw them less frequently for shorter periods of time.

The current study also found that a lower level of social support from both family and significant others was not seen to be significant in increasing one's risk of suicidal ideation however, having a lower social support from friends was seen to increase one's risk of suicidal ideation. The results therefore suggest that the most important social network for South Asian females are there friends as social support from family and significant others are not seen to significantly reduce one's risk of suicidal ideation. These findings can be related to the South Asian culture as Lincoln et al. (2003) explains that social support can differ between cultures and communities. Thus within the current sample, friends are seen to be the helpful in the avoidance of suicidal ideation whereas family and significant others are not seen to make a significant difference. Within individualistic cultures, family and significant others would generally be the most important supports systems that individuals would turn to in times of need, however within the South Asian culture this is seen to be the opposite.

Explanations for such behaviour can be associated with cultural values that South Asian can believe in. Families and significant others in the South Asian community could be said to be providing negative social support due to them encouraging traditional views such as upholding family honour and not bringing shame on the family. Whereas lower social support from friends were seen to increase suicidal ideation. A study by Ahmad, Shik, Vanza, Cheung, George and Stewart (2005) found that many South Asian women discussed the

importance of making friends in integrating into the wider community. They explained that it was an important factor in maintaining a healthy body and mind and also for a better quality of life overall. Research thus suggests that within the South Asian community, having support friends can have a much stronger positive effect on an individual than support from their families or significant others. Participants in Ahmad et al. (2005) study further explained that going out with friends was important so they didn't feel like a burden on their family. This can be related to the results of the current study as perceived burdensomeness was seen to be a significant predictor of suicidal ideation and so a higher social support from friends may have decreased one's feelings of burdensomeness.

Participants in the study were therefore found to have a lower level of social support from friends which significantly increased their risk of suicidal ideation. The South Asian culture can be seen as a facilitator in this situation as family honour and feelings of shame can lead to a South Asian woman having only a limited social support network. At times it may only be limited to those who encourage a repression of feelings so if an individual was suffering from mental health or family problems and had lower social support network from friends they would thus be inclined to speak to their family or significant other. These people could tell them to conceal their problems due to the South Asian culture encouraging the repression of feelings. Due to a limited support network, these feelings can become even more important and influential on a person. Many South Asian women may try get help from friends regarding their problems but be told to carry on and not get help to not bring shame on their family, thus increasing their feelings of perceived burdensomeness. Husain et al. (2006) found that honour in South Asian families led to an increase in mental distress which in turn led to South Asian women viewing self-harm as a way of coping with such mental distress. Thus, a lower social support from friends can lead to suicidal behaviour due to an increase in perceived burdensomeness. Husain et al. (2006) further explain that many South Asian

families see it imperative that what South Asian women say or do is seen as good behaviour according to the community. Thus, South Asian women can be at risk of being guided by their families in line with family honour rather than what is best for them. Lincoln et al. (2003) explains that people whose social network members make critical remarks, show negative interaction or make them feel tense will experience a higher level of psychological distress. This in turn leads to South Asian females having feelings of shame, agitation, self-blame and believe that they are a burden on their family, thus increasing one's perceived burdensomeness.

The Interpersonal Theory of Suicide also tells us that a lower number of friends can be an observable risk factor for thwarted belongingness as it is said to decreases one's social support network in turn making them feel more lonely. Also as discussed above, having a smaller support network lead to South Asian women relying on their families for support. If negative social support is received through encouragement of cultural values, it could lead to feelings of isolation as they feel socially withdrawn. The interpersonal Theory of Suicide tells us that having few social supports and feeling withdrawn can be observable indicators of loneliness, thus increasing one's thwarted belongingness. Having a lower social support from friends can be seen as a lack of reciprocally caring relationship especially with the added fact that lower social support from families and significant others were not seen predict suicide consideration. An absence of reciprocally caring relationships is seen to increase one's levels of perceived burdensomeness therefore supporting the notion that culture has an influence on the Interpersonal Theory of Suicide.

Results from the study also found that those who were seen to have a higher association to South Asian cultural values were also more likely to consider suicide. Lai and Surood (2008) explain that the Cultural Values Scale was created from literature from the South Asian community to assess the amount of an individual's identification to traditional South Asian

beliefs. The scale looked at various aspects of the culture and stated that those with a stronger level of agreement with South Asian cultural values represented the fact that the participants continued to retain the traditional values, norms and beliefs of their own culture. These beliefs included values such as believing in arranged marriages, maintaining native languages, always following parent's decisions, caring about issues within one's own community, consulting religious priests before making important decisions, men being the head of families and women following daily routines of looking after children and staying at home.

Findings from the present study are supported by Hicks and Bhugra (2003) who explored perceived causes of suicide attempts by South Asian women in the UK. After examining perceived causes of suicide attempts in 180 ethnic South Asian women, the strongest and most frequent factors that were endorsed as causes of suicide attempts were being trapped in an unhappy family situation, violence by the husband, and depression. Ninety percent of suicide attempts were seen to be a result of unhappy marriages, too much interference by in-laws and the stress they caused and gender expectations. These factors can be categorised under cultural values as they are similar to what the cultural values scale measures. These factors could be seen as potentially playing a role in any family relationships however are particularly powerful in the South Asian community due to the traditional rigid roles it promotes.

Khan and Waheed (2009) also also support the findings from the present study as they looked at suicide and self-harm within South Asian immigrants in the UK. They explain a variety of cultural factors that can be seen to increase one's risk to consider or attempt suicide including female-gender role expectations, family conflict, cultural conflict and male dominance. Merrill and Owens (1986) found similar findings in their research on Ethnic differences in

self-poisoning. Culture conflict was seen to be one of the main issues among the Asian patients who had self-poisoned as well as marital problems, arranged marriages and rejection of arranged marriage proposals.

The three significant predictors for suicide ideation all point towards the view that culture has an effect on one's probability to consider suicide. Thus, culture can be seen to have an effect on the interpersonal theory of suicide supporting Lincoln's (2003) view that the failure to account for the social and cultural factors that characterise the life circumstances for different racial/ethnic groups promotes the view that social theories and models are equivalent across groups. Therefore, it is instead argued that unique social and cultural conditions apparent within different cultures may constitute specific risks and protective factors. Results from the present study found that a stronger identification to cultural values to be a predictor of suicide ideation, thus supporting the view that the South Asian culture has an effect upon the Theory of Interpersonal Suicide. Having a stronger identification to South Asian cultural values in the present study meant that the individuals were more likely to believe in arrange marriages, follow parent's decisions, and gender expectations on women, which can all be seen to effect the other predictors of suicide within in this study as these factors can be seen to have an influence on both perceived burdensomeness and social support from friends.

The way in which South Asian cultural values interacts with the other variables in the research that were seen to be significant predictors of suicidal consideration provides support for the view that cultural values have an influence on the Interpersonal Theory of Suicide. Support was however not found for any of the variables in the present study effecting one's attempts at suicide. This supports the notion all the major religions within the South Asian community prohibit suicide. This therefore suggests that religion can be seen as a protective

factor for suicide attempts for those in the South Asian culture that are intrinsically orientated towards their religion.

Another factor to why thwarted belongingness was not seen to be a significant factor in predicting suicidal ideation in the current study could be because South Asian females may feel that they belong to the South Asian community and so feel a sense of spiritual belongingness in relation to their religion. Results can thus be seen to support Stack's (1983) theory on the effect of religious commitment on suicide. Stack (1983) argued that commitment to a religion could be a powerful barrier against suicide. Stack (1983) continues to explain that religions often promote the belief that God is always watching and cares about those who suffer and so problems can be seen to be more tolerable if an individual believes that God is watching over them. This can be related to the South Asian culture as the common religions within the South Asian culture as they all promote the belief of God being a protector and looking out for them. Those that follow their religion may therefore be more likely to believe that God is always watching out for them and instead of engaging in suicidal behaviour, one instead puts their energy into pursuing spiritual success in regards to their faith.

The results from the study show that there is a low percentage of suicide attempts even though suicidal ideation is present within the participant sample. This could be put down to protective factors such as religious beliefs however gender also has to be taken into consideration as the sample only consisted of South Asian females. Statistics (Office for National Statistics, 2015) tell us that male suicide rates within the UK is three times higher than the female rate, and a possible explanation in relation to the South Asian community could be due to the displacement of burden onto males. Möller-Leimkühler (2003) explains that the traditional male gender role is defined by traits such as striving for power, courage and dominance and also taking control. This can be related to the South Asian community

due to South Asian cultural values that portray the idea of women being the housewife and males being the sole protector of the family and financially supporting the household (Raleigh and Balarajan, 1992). Möller-Leimkühler (2003) explains that women seek help and men die due to male gender roles. This is further promoted within the South Asian culture as males are taught to not admit to their anxieties, problems and burdens. Möller-Leimkühler (2003) tells us that these gender specific cultural beliefs lead to lower suicidal behaviour by males but higher suicide rates and attempts. This alludes to the point that males may experience suicidal thoughts however either overcome or oppress their suicidal ideation due to the pressure of providing for the family. Möller-Leimkühler (2003) explains that feelings such as perceived burdensomeness and thwarted belongingness could be overcome if their role takes precedence which is a common occurrence within the South Asian community. This however, could mean that females are more likely to consider suicide but less likely to commit suicide due to their gender role being characterised by the concepts of social relationships and a reduced emphasis on providing for the family. This therefore could be an explanation as to why females were seen to have higher suicidal ideation in comparison to attempts and thus highlights the importance of a South Asian female sample in regards to the Interpersonal Theory of Suicide.

Partial support was found for the Interpersonal Theory of Suicide as only perceived burdensomeness was seen to predict suicidal ideation, which is also consistent with past research and thus support the notion that the theory is influenced by cultural factors. None of the factors in the present study were found to be significant in predicting suicide attempts within South Asian females which therefore suggests that South Asian females are at a higher risk of suicidal ideation and that there may be other factors which cause them to attempt suicide. Results also did not find that acquired capability for suicide was necessary for a suicide attempt implying again that cultural factors can have an influence on the Interpersonal

Theory of Suicide.

Results from the study thus support the view that the South Asian culture has an influence upon the Theory of Interpersonal Suicide as cultural values was seen to be a significant predictor on suicidal ideation and the South Asian culture can also be seen to have an effect on the other significant predictors of suicidal ideation including perceived burdensomeness and social support. The results also support Bhugra and Desai's (2002) view that an individual's cultural group remains to be a useful starting point for understanding the motives behind both attempted suicide and suicide ideation. Results are also consistent with Lincoln et al. (2003) view that there are unique social and cultural conditions that constitute culture specific risks and protective factors, which are crucial in understanding the nature of social interaction and how they relate with other cultural factors to influence health outcome.

Limitations

One limitation of the present study is that there can be problems when comparing participants using broad ethnic categories such as 'South Asian' as this can include various nationalities, different religions and immigrations statuses that may all affect attitudes concerning suicidal behaviour (Borril, Fox & Roger, 2011). The current study did not differentiate between different religions and this may have influenced the results as one religion within the South Asian culture could be seen to have more influence on both the Interpersonal Theory of Suicide and suicidal behaviour. A review by Skegg (2005) identified numerous studies, which suggested that members of certain religious groups had stronger prohibitions against suicide. The present study thus did not differentiate between religious groups or acknowledge research which indicating different risk profiles for different religions within the South Asian culture.

Another limitation of the current research was that the mean sample age was 26 which portrays the view that the sample was relatively young. Though participants of an older age group took part there was a higher proportion of younger South Asian women within the sample. This could have had an effect on the results as previous research has found cultural differences in age groups (Bhugra, Desai & Baldwin, 1999). Bhugra, Desai and Baldwin (1999) found that adolescents within the South Asian culture were less traditional than their parents on topics such as language, leisure, decision making, and living with other ethnic groups. It was seen that there were less traditional attitudes to work and marriage held by adolescents who had attempted deliberate self-harm in comparison to their parents. It could be concluded that age within the South Asian culture could also have an influence on suicidal behaviour as younger South Asian could be seen to hold less traditional views in turn effecting their suicidal behaviour. Ineichen (2012) explains that younger generations may retain less of as 'Asian' identity due to UK education and have problems in finding a balance between both the South Asian and western culture. However, statistics tell us that in 2012 suicide was the second leading cause of death among 15–29-year-olds globally (WHO, 2014). Therefore, even though the mean age of the sample was relatively young it did indeed look into the most high risk group for suicidal behaviour and looked at the most distinguishing features of the South Asian culture and brought into focus how these can have an effect upon one's suicidal behaviour.

Clinical Implications

The present research thus alludes to the fact that the South Asian culture can create barriers to seeking help for suicidal thoughts and behaviours among South Asian women. Cultural factors have been seen to influence one's suicidal behaviour as the South Asian culture can be said to exacerbate the risk factors for suicide outline by the Interpersonal Theory of

Suicide. The present research thus supports Khan and Waheed (2009) in that culturally sensitive psychological interventions need to be put in place to help South Asian women who could be more at risk for suicidal behaviour, to seek help and treatment. The current research also outlines the fact that causes of suicidal ideation are different to causes of suicidal attempts. The research points to the view that the health service should be culturally aware of certain risk factors for suicidal behaviour for South Asian women and progress should be made towards helping those at risk to seek help. Thus, the key to developing effective prevention strategies for suicidal behaviour would be to make them culturally sensitive as the present research has shown how the South Asian culture can influence the Interpersonal Theory of Suicide. Further research would thus benefit in identifying strategies for culturally sensitive interventions of suicidal behaviour by further expanding on current research on what causes South Asian females to actually attempt suicide.

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Appendix 1 – Consent Form

Consent Form

1. I have read the information sheet and understand it clearly	Yes	
2. I have asked any questions about the study that I want to	Yes	
3. Any questions that I have asked have been understood and answered accordingly	Yes	
4. I understand that if at any point I want to withdraw from the study I may and is of my own free will, with no explanation needed	Yes	
5. I understand that I can withdraw my data before 19/04/2015 and it will not be used in the study	Yes	
6. I agree to the results of the questionnaires to be used by the researcher in data analysis	Yes	
7. I understand that all data will be kept anonymous and confidential, my identity will be protected and any personal details will be not be disclosed to anyone	Yes	
8. I would like a copy of the results of the study after the data has been analysed	Yes	

If you have answered 'Yes' to question 8, could you please provide an email address to which you will be emailed the data you require.

_____

Participant Signature: _____

Researcher Signature: _____

Date: _____

Appendix 2 – Debrief Sheet

Debriefing Report for Research Participants

Project title: Views on arranged marriage in relation to one's self perceived health and suicide ideation within the South Asian community.

Researchers: Sathpal Singh Panesar, University of Huddersfield

Dr Susanna Kola-Palmer, University of Huddersfield

Main aims and justification:

The study looks at whether views on arranged marriages have an effect on self-perceived health and suicide ideation. As a participant you were asked to complete a series of questionnaires which measured self-perceived health, religious orientation, suicide intent, cultural values, attitude towards arranged marriage and perceived social support. The questionnaire also took into account certain demographic variables such as income, age and English literacy, which have also been associative factors towards suicide ideation in South Asian women. The narrow existing literature indicates that within certain circumstances, factors associated to arranged marriage could lead to numerous mental health problems. The purpose of this study was therefore to explore the links between psychological and social variables and their effects on mental health.

The potential benefits of the study cannot be stressed enough as it could benefit future individuals who experience suicidal thoughts and behaviours associated with arranged marriages. It could show the importance of changing the system of arranged marriage and how it is viewed within the South Asia Culture. Indeed, this line of research has the potential to lead to better identification of those at risk for suicide, which would have a great impact on suicide prevention and treatment efforts. Virtually all previous efforts to identify those at highest risk for suicide within the South Asian culture have been very minimal, and so the importance potentially gained from this study is tremendous. The results of this research may provide researchers and healthcare professionals with much needed information to greatly improve clinical and research efforts in this area, with direct benefits to society.

If you need immediate help or if you are thinking about harming yourself or someone else, please tell someone who can help immediately:

- Call 999 for emergency services.
  Go to a hospital emergency room.
- Call the confidential HOPELineUK of PAPYRUS on 0800 0684141 or send a text message to 07786 209697 to be connected to professionally trained staff.
- Call the confidential Samaritans hotline on 08457 90 90 90 or email them on jo@samaritans.org to be connected to professionally trained staff.

If you do not need immediate help, but would like to talk to someone about the problems you might be having, you may contact the Student Counselling Service **Telephone:** 01484 472675,

E-mail: internalcounsel@hud.ac.uk

The Student Counselling Service also operates a Wellbeing drop-in clinic Monday-Friday at 11am at the Wellbeing and Disability Services, Level 4, Student Central.

You may also contact your GP for an appointment.

Thank you again for your participation. In the event you should wish to withdraw your responses to this study, please contact Sathpal Panesar (U1153918@hud.ac.uk) citing the participant number stated above.

If you would like to receive a summary of the results of this research or if you have any further questions or queries, please do contact me on U1153918@hud.ac.uk

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