



Suicidality, interpersonal trauma and cultural diversity: a review of the literature

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Abstract

There are substantial bodies of literature focusing on suicide and interpersonal trauma, and on suicide across cultures. There is also a growing body of knowledge relating to interpersonal trauma across cultures. However, there is a marked gap in the literature that brings these three areas together. Studies that specifically investigate the prevalence of suicidality in relation to experiences of domestic violence, sexual assault and childhood abuse in a cross-cultural context are indeed scant. Moreover, inconsistencies in data collection and reporting and considerable variability in results among the few existing studies highlight substantial methodological limitations and definitional differences in the research. The identification of at-risk groups is thus hampered, as is an examination of possible risk and protective factors. What is clear is that interpersonal trauma and suicide are linked in significant and complex ways. What is less evident is how culture mediates this inter-relationship. It is suggested that gender and cultural biases in suicide research may well account for our limited understandings in this area. Implications for practice include the need for alternative research perspectives and more inclusive frameworks that promote greater cross-discipline dialogue and intersectoral collaboration. There is thus ample scope for further research in this area so as to elucidate the implications for suicide prevention, intervention and postvention¹ work with culturally and linguistically diverse communities.

Keywords

suicide, suicidality, culture, interpersonal trauma, domestic violence, sexual assault, childhood abuse, mental health

Objective

To conduct a critical review of the literature published in Australia and overseas on suicide and parasuicide related to interpersonal trauma within culturally and linguistically diverse communities.

Method

CIAP was used to perform a literature search across four medical/ nursing databases (Medline, PsycINFO, Cinahl, Journals@OvidFullText). An additional search of two social science/ humanities databases (Sociological Abstracts, Academic Research Library) was performed using ProQuest. Fifteen search terms were used

in various combinations to search for all articles that appeared to be relevant, that is, those that related to suicidality and domestic violence (family violence/ intimate partner violence/ gender-based violence), sexual assault (rape/ child sexual abuse) and physical and emotional abuse and neglect of children (child abuse/ maltreatment) within culturally and linguistically diverse, immigrant and refugee communities. Initially, the search was limited to only those articles published between 1994 and 2004. Additional references from earlier dates that were deemed important were sourced through a manual identification process using the reference lists of the selected articles.

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An initial search combining the three areas of interest (suicide and interpersonal trauma and cultural diversity) yielded fewer than 20 citations. The search was then broadened to identify all those articles relating just to suicide in the context of interpersonal trauma. This yielded over 1,000 results. A second search combining the terms 'suicide' and variations of the term 'cross-cultural' yielded a similar number of results, as did a third search combining the terms 'interpersonal trauma' and 'cross-cultural' (and their variations). The abstracts were then scanned for relevance to the specific issue under investigation. Eventually, approximately 175 articles were identified as relevant to the project. The literature reviewed includes prevalence studies, cross-cultural and cross-national comparisons, theoretical analyses and international literature reviews.

Purpose and scope

The primary purpose of the literature review was to investigate the extent to which:

- the suicide and interpersonal trauma literature canvasses issues of culture in the assessment and management of suicidal clients who have histories of abuse
- the multicultural mental health/ cross-cultural suicide prevention literature considers the links between interpersonal trauma and risks for suicidality
- the cross-cultural literature on interpersonal trauma considers suicidality as a possible outcome of abuse.

It was anticipated that this process would expose the gaps in the literature, thereby pointing to directions for future research. A secondary purpose of the review was to highlight the implications of the findings for suicide prevention and intervention work in a culturally and linguistically diverse society such as Australia.

Limitations and exclusions

The review is not exhaustive; key studies were selected for review and analysis. In order to limit the parameters of the project, the review excludes the following:

Suicide within Aboriginal and Torres Strait Islander (ATSI) communities. The alarmingly high rate of suicides within ATSI communities, and indeed among other indigenous populations

that have a colonial history, is documented in a number of sources². The present review does not address itself in any detail to issues for Aboriginal communities. The rationale for this is that a separate project is required in order to do justice to the complexity of the issues.

Suicide in the context of non-domestic interpersonal violence. The prevalence and impact of trauma resulting from state-sanctioned violence (such as rape in war and the abuse of children within the context of armed conflict) is acknowledged, as are experiences of interpersonal violence between strangers (such as assault with robbery). The present review, however, focuses specifically on domestic/family violence, sexual assault and child abuse perpetrated within an intimate or family setting.³

Suicide of perpetrators of interpersonal violence. There is a growing body of literature that documents the occurrence of suicide by perpetrators of abuse, particularly Child Sexual Assault (CSA) offenders, usually after exposure and/or sentencing, and also in cases of domestic homicide/suicide. The focus of this investigation is on the experiences of victims.⁴

Terminology

A number of related terms are used in the literature. For the purposes of clarification, the following terms are defined as they are used in this review:

Interpersonal trauma is trauma that is sustained as a result of violence/abuse perpetrated within the context of an intimate or family setting; inclusive of the terms:

- Domestic violence
- Intimate partner violence
- Gender-based violence
- Family violence
- Sexual assault/abuse
- Rape
- Child sexual assault
- Physical abuse and neglect of children
- Childhood abuse/maltreatment (inclusive of emotional abuse).

Suicidality is used to include both deaths resulting from suicide (fatal suicide) and the range of non-fatal suicidal behaviours that do not result in death (also referred to as 'parasuicide'). These include verbalised threats and thoughts of suicide (ideation/cognition), without necessarily

the intention to die. Non-habitual self-harming acts are included in this definition, but repetitive self-mutilating behaviour is not, as a different intention motivates this sort of self-harm. While it is acknowledged that some habitual self-harmers may also become suicidal, self-injury *per se* is not generally considered to be on the continuum of suicidality.

Cultural diversity is used as an inclusive term that reflects the reality of a multicultural society such as Australia. It connotes the variety and richness of communities with diverse norms, beliefs, practices and values and may be based on culture, language, ethnicity or a combination of these, in addition to a range of other dimensions of difference (such as gender, class, age, sexual orientation etc.). The term 'cross-cultural' is used to mean dealing with or comparing two or more cultures, while the term 'transcultural' may be interpreted more broadly to mean extending across all human cultures.

Findings

Prevalence of suicide

Inconsistencies in data collection and reporting, definitional issues and methodological limitations and biases lead to some inconsistencies in findings, making it difficult to assess prevalence of suicide with any accuracy. Moreover, given the range of sample types and sizes and the variety of research methodologies (cross-sectional population-based, longitudinal prospective follow-up, retrospective self-reports, retrospective casenote analysis, 'psychological autopsy'⁵), cross-cultural comparisons of results is fraught with difficulty and complexity.

The global picture

The World Health Organisation (WHO) estimates that at least one death by suicide occurs every minute, representing an annual global mortality rate of about 14.5 per 100,000 people. These figures make suicide the thirteenth leading cause of death worldwide (Krug, Dahlberg, Mercy et al., 2002). In addition to those who die, many more people engage in non-fatal suicidal behaviour and still more people think about killing themselves. Evidence suggests that only about 25% of those who take suicidal action make contact with support services or health facilities, such as hospitals

(Diekstra & Garnefski, 1995; Kjolner & Helveg-Larsen, 2000; Sayer, Stewart & Chipps, 1996). Although suicidal ideation is undoubtedly more common than suicidal action, its extent is even less clear (Kessler, Borges & Walter, 1999). Data in relation to these categories of suicidal behaviour that do not have fatal outcomes are therefore likely to be even more limited than those regarding suicide deaths (which do not include 'accidental deaths', many of which may in reality be disguised/unsubstantiated suicides). It is therefore reasonable to assume that any estimates of the global prevalence of suicide and parasuicide are under-estimates.

National suicide rates vary substantially (possibly due as much to inconsistencies in data collection as to sociocultural differences in attitudes towards suicide), with the highest recorded rates being found in Eastern European countries and low rates generally in Latin America and some Asian countries (e.g. Philippines and Thailand). The suicide rates in other parts of Europe, North America and parts of Asia and the Pacific (including Australasia), fall somewhere between these extremes. There is little data available from African countries and from other developing nations (Krug et al., 2002).

Important demographic markers of suicide risk are known to be gender, age and ethnicity. Globally, suicide deaths are higher among men than women and parasuicide rates are consistently higher among women than men (Weissman, Bland, Canino et al., 1999). Exceptions to this suicide mortality trend are found in the People's Republic of China and in India where higher rates of suicide deaths are reported for young married women (Brockington, 2001; Khan, 2002; Pritchard, 1996). There is little explanation in the literature of the possible reasons for this anomaly. It is reasonable to speculate that it is a function of a number of compounding factors, including lethality of methods⁶ lack of access to health facilities and gendered meanings of suicide (an aspect that will be explored later in this paper).

Worldwide, suicide rates tend to increase with age, with rates among those over 75 years of age being approximately three times higher than those of young people aged 15-24 years (Krug et al., 2002). However, the absolute number of

cases recorded is actually higher among those under 45 years than among those over 45 years and many countries have indicated an alarming rise in youth suicide over the past few decades. However, Gould, Greenberg, Velting and Schaffer (2003) report that in the past decade there has been a marked decline in the youth suicide rate in Western developed nations. They posit the increase in the prescription of antidepressants for adolescents as one of the most plausible reasons for this recent decrease (Gould et al., 2003:386).

Epidemiological studies indicate that the prevalence of suicide among 'Caucasians' is approximately twice that observed in other 'races', with generally lower rates observed among African Americans, although rates are reportedly increasing among this group (Moscicki, 1999). A significant exception to this, however, is the disproportionately high suicide rates among indigenous peoples with histories of colonisation. This is documented among Australian Aboriginal people (Hunter & Harvey, 2002; Tatz, 1999), the Maori of Aotearoa / New Zealand (Langford Ritchie & Ritchie, 1998), the Canadian Inuit (MacMillan, MacMillan, Offord & Dingle, 1996), the native American Indian peoples (Robin, Chester & Rasmussen, 1998) and Hawaiian peoples (Yuen, Nahulu, Hishinuma & Miyamoto, 2000).

The Australian context

In Australia, suicide is ranked as the 7th leading cause of death (14.6 per 100,000 population – Australian Bureau of Statistics, 2002). Australia's rate of youth suicide is counted among the highest in the world with an estimated ten young people each week killing themselves and a further 1,000 acting on suicidal thoughts (Cantor, Neulinger, Roth & Spinks, 1998; Loff & Cordner, 1998). Young men and young people in rural and regional areas are considered to be most at risk, with Aboriginal youths 40% more likely to die by suicide than anyone else in the community (Hunter & Harvey, 2002). In the last fifty years, the male youth suicide rate has almost trebled and the rate among young women has doubled (Loff & Cordner, 1998), with young gays and lesbians experiencing heightened risk for suicidal behaviour (Fergusson, Horwood & Beautrais, 1999; Millard, 1995; Schaffer, Fisher, Parides & Gould, 1995).

Despite the fact that approximately 21% of deaths due to suicide occur in persons who were born overseas (Steenkamp & Harrison, 2000), most suicide research in Australia has omitted to address issues for people of non-English speaking backgrounds. The research that has been conducted amongst immigrant groups in Australia indicates great diversity in suicide rates among the various ethnic and cultural groups and that rates among some groups may be higher than native rates especially amongst women (McDonald & Steel, 1997).

A recent report by VicHealth on the health costs of intimate partner violence found that domestic violence was the single greatest risk factor associated with death for women aged 15-44 years, accounting for 10% of deaths, more than half of which were attributed to suicide (VicHealth, 2004).

As is the case elsewhere, non-fatal suicides are generally under-reported and therefore reliable data are lacking. It has been suggested, however, that in Australia the number of non-fatal suicides could be as high as 67% more than reported rates (Bevan in Bashir & Bennett, 2000). Consistent with global trends, the documented rate of attempted suicide among women in Australia is substantially higher than among men (Australian Bureau of Statistics, 2002). While hospitalised self-harm should not be seen as equivalent to 'attempted suicide', it is significant to note that rates for women in this category are markedly higher than among men for all age groups, with an overall ratio of male to female of 0.74 (Steenkamp & Harrison, 2000). In NSW in 1996-97, the ratio of 'attempted suicide' that resulted in hospitalisation to suicide death was 23.5:1 in females as compared to 4.4:1 in males. The rate of non-fatal suicide resulting in hospitalisation is even higher among young women, with approximately 40 attempts for every 'completed suicide', as compared to approximately 6 attempts for every death among young men (Ansari, Chipps & Stewart, 2001).

Suicide related to interpersonal trauma

Childhood abuse

The association between childhood trauma and suicidal behaviour has been well-documented over the last two decades. Physical abuse and neglect emerge as strong and independent risk

factors (Brent, Baugher, Bridge et al., 1999; Briere, 1992; Brown & Anderson, 1991; Browne & Finkelhor, 1986; Kaplan, Pelcovitz, Salzinger et al., 1997; Osvath, Voros & Fekete, 2004; Richie & Johnson, 1996; Santa Mina & Gallop, 1998; Silverman, Reinherz & Giaconia, 1996; Windle, Windle, Scheidt & Miller, 1995). Fewer studies have focused on emotional abuse as a possible precursor of suicidality (Nilsen & Conner, 2002). Researchers have typically focused on the assessment of risk among adolescents and adults (Fergusson, Woodward & Horwood, 2000; Gex, Narring, Ferron & Michaud, 1998; Gould et al., 2003), with relatively few studies looking at the risks among children (Hukkanen, Sourander & Bergroth, 2003; Kovacs, Goldston & Gatsonis, 1993). Some researchers have examined the links between growing up in a family characterised by domestic violence and later suicidal behaviour (Baldry & Winkel, 2003; Botsis, Plutchik, Kotler & van Praag, 1995). A Norwegian study by Ystgaard, Hestetun, Loeb & Mehlum (2004) concluded that both physical and sexual abuse in childhood are significantly and independently associated with chronic suicidal behaviour. Dube, Anda, Felitti et al.'s (2003) retrospective cohort study of over 17,000 adult primary care clinic attenders found a powerful graded relationship between multiple experiences of trauma (in any category) and lifespan risk of attempted suicide.

Sexual assault

A solid research base also exists correlating histories of sexual assault with suicidal behaviour. Much of this literature focuses on child sexual assault (CSA) (Bagley, Bolitho & Bertrand, 1997; Boudewyn & Liem, 1995; Bryant & Range, 1997; Dinwiddie, Heath, Dunne et al., 2000; Ernst, Angst & Foldenyi, 1993; Gladstone, Parker, Mitchell et al., 2004; Jarvis & Copeland, 1997; Mullen, Martin, Anderson et al., 1993; Neumann, Houskamp, Pollock et al., 1996; Peters & Range, 1995; Sullivan, Bulik, Carter & Joyce, 1995; Yellowlees & Kaushik, 1994). Longitudinal studies are believed to be the most methodologically rigorous design to examine the connection between CSA and subsequent suicidality 'due to the serious problems of retrospective recall in this area' (Gould et al.,

2003:395). Several such studies have found self-reported CSA to be significantly correlated with increased risk of suicidal behaviour (Fergusson, Horwood & Lynskey, 1996; Silverman et al., 1996; Kaslow, Thompson, Brooks & Twomey, 2000; Plunkett, O'Toole, Swanston & Oates, 2001). Plunkett et al. (2001) found that in a sample of 183 young people who had experienced CSA, 32% had attempted suicide and 43% had thought about suicide since they were sexually abused. In New Zealand, Lynskey and Fergusson (1997) found that in a sample of 1,025 young people, 22.2% of CSA survivors had made suicide attempts. Beckinsale, Martin and Clark's (1999) investigation of the relationship of CSA, depression and suicidal thinking from a cohort of 3,144 young Australians visiting GPs confirms these findings. In addition, they found that young men had a significantly higher suicide index than young women (40% had made serious suicide plans compared to 20% of young women). Another large Australian study by Martin, Bergen and Richardson (2004) found that 55% of sexually abused boys had attempted suicide as compared to 29% of girls. These findings are consistent with a study by Garnefski and Arends (1998) involving a large representative community sample of adolescents in the Netherlands. They found that 26.5% of abused boys reported a former suicide attempt, a rate that is thirteen times higher than that for non-abused boys. These gender differences clearly have implications for assessment of CSA in boys and young men.

A number of studies address suicidal behaviours as potential sequelae of adult sexual assault and rape (Bang, 1991; Davidson, Hughes, George & Blazer, 1996; Petrak & Campbell, 1999; Stepakoff, 1998). Some studies look at the impact of sexual assault in both childhood and adulthood (Cloitre, Scarvalone & Difede, 1997; Ullman & Brecklin, 2002; Van Egmond, Garnefski, Jonker & Kerkhof, 1993). Ullman and Brecklin (2002) examined demographic and psychosocial correlates of suicidal ideation and suicide attempts and found that in a national sample of American women those with histories of sexual assault in both childhood and adulthood reported significantly greater odds of lifetime suicide attempts. Another American study of 1,025 college students found that 15%

of adolescent women who had experienced frequent unwanted sexual touching had 'often' made suicidal gestures or attempts in the previous six months, compared with 2% of those who had no experience of sexual assault (Bagley et al., 1997). A number of researchers have studied populations of women prisoners and found significant correlations between previous experiences of sexual violence, harmful drinking and/or drug use and suicidal behaviour. Borrill, Burnett, Atkins et al. (2003) found that 46% of their sample reported making at least one lifetime suicide attempt. The high rate of attempted suicide in these samples prompts questions regarding the effects of incarceration as a variable in suicide risk assessments of sexual assault survivors.

Domestic violence

Almost a decade ago, Stark and Flitcraft (1995) identified domestic violence as possibly the single most important precipitant of female suicide, finding that in a sample of women who had attempted suicide and who attended the emergency department at Yale-New Haven hospital over a one-year period, 29.5% were 'battered'. They also note that 'studies with shelter, convenience, or volunteer samples of battered women have indicated that a substantial number, 35 to 40 percent, attempt suicide' (Stark & Flitcraft, 1995:44), a proportion far higher than in the general population. Taft notes that 'thirteen studies of suicidality demonstrated that abused women were three and a half times more likely to be suicidal than non-abused women' (Taft, 2003:7). Several other studies confirm this connection (Abbott, Johnson, Koziol-McLain & Lowenstein, 1995; Bergman & Brismar, 1991; Kaslow et al., 2000; McCauley, Kern & Kolodner, 1995; Olson, Huyler, Lynch et al., 1999; Wiederman, Sansone & Sansone, 1998). Two studies found that abused women and those who reported significant levels of 'marital discord' were three times more likely to report past suicide action than were non-abused women (Abbott et al., 1995; Kaslow et al., 2000). In homes where there is a firearm, the risk is up to five times greater (Wiebe, 2003). In a large population-based study of suicides among women in North Carolina two data sources were used, medical examiner files and interviews with law enforcement officials. Of the 882 women

who died by suicide between 1989-1993, 34.4% had taken previous action or had a known history of suicidal ideation. Significantly, while only 3.5% of the medical examiner files noted a history of domestic violence, 37.8% of the law enforcement officers noted 'interpersonal conflict' between the victim and her current or former intimate partner as a common precursor (Runyan, Moracco, Dulli & Butts, 2003). A hospital-based study of 500 women presenting to emergency rooms in Utah, the first in the US to link domestic abuse with suicidal ideation in adults, found that 40% of the women who disclosed that they were abuse victims had considered suicide (Allen, 2004). A cross-sectional self-report survey of 1,207 women attending thirteen doctors' surgeries in London showed domestic violence had strong associations with most measures of psychiatric morbidity including suicidality (Coid, Petruckevitch, Chung et al., 2003).

Most of the research confirms that co-morbid diagnoses of depression (Asgard, 1990; Coid et al., 2003; Gibb, Alloy, Abramson & Rose, 2001; Pacoe, 2001) and drug and alcohol abuse have been found to increase risk for suicidality (Borrill et al., 2003; Howard, Lennings & Copeland, 2003; Roy, 2004). Kaslow et al. (2000) applied a cumulative risk model and found that four or five risk factors increased the likelihood of making a suicide attempt threefold and six or more risk factors increase the risk tenfold.

The influence of 'culture'

Very little of the literature documenting the links between suicide and interpersonal trauma comments on sociocultural variables. Some studies compare national suicide rates, but such comparisons are fraught due to differences in data collection and reporting and the methodological limitations of studies, sample sizes and biases already noted.

The most significant finding seems to be the gender anomaly of higher rates of fatal suicides by women in rural China and on the Indian subcontinent (Brockington, 2001; Khan, 2002; Pritchard, 1996). While there is some suggestion that domestic violence plays a role in this finding, a close analysis of possible explanations is lacking.

Suicide across cultures

Many questions remain unanswered in relation to differences in suicide risk across ethnic and cultural groups and the information that is available concerning 'minorities' is particularly limited and often contradictory.

The cross cultural suicide literature that does exist tends to focus on the notion of different 'cultural idioms of distress', that result in differing manifestations of mental illness and different methods of suicide (Dusevic, Baume & Malak, 2002).

Most studies also emphasise the impact of sociocultural variables, with some researchers focusing on specific cultural groups (e.g. Kok & Tseng's 1992 study of suicidal behaviour in the Asia-Pacific region) or ethnic minorities (eg Eshun's 2003 comparison of suicidal behaviour in American and Ghanaian college students). In Australia, McDonald and Steel (1997) studied suicide prevalence rates among immigrant and refugee groups, identifying both cultural differences and similarities in risk factors.

The impact of migration and refugee experiences is also a dominant theme in this body of literature. Research among immigrant populations indicates that in general, patterns of suicide tend to be more like those in country of origin initially, becoming more like the host country over time and with 'acculturation' (Dusevic et al., 2002). A number of researchers also note that migration appears to have differential impacts on men and women, although the findings differ, adding to what Falicov calls 'the ambiguities of migration' (Falicov, 2003:382). McDonald and Steel (1997) and Kliewer and Ward (1988) note a marked increase in the relative rate of female suicides with immigration. They suggest that a possible explanation for more negative impacts on women is that the decision to migrate is often made by the man. Dusevic and her colleagues note that in this case, 'the woman is less aware of, and less prepared for, the difficulties that may be encountered in the country of resettlement' (Dusevic et al., 2002:10). Other research indicates a reversed gender dynamic, with many immigrant women gaining more personal freedoms with migration, which in turn makes them less vulnerable to depression and suicidality (Hondagneu-Sotelo, 1994). Falicov

makes the observation that the key issue here 'probably rests in whether immigrant women become part of the labour force or whether men maintain their privilege by continuing to be the sole family breadwinner' (Falicov, 2003: 382).

Bayard-Burfield and her colleagues also note that the effects of migration are likely to be mediated by a climate of xenophobia thereby heightening risk for suicidality among foreign-born nationals in countries of resettlement where racism and discrimination are rife (Bayard-Burfield, Sundquist, Johanssen et al., 1999).

The impact of 'cultural conflict' compounded by intergenerational differences is noted particularly for young people of immigrant parents. One study reported that 76% of a sample of Asian American youths indicated that conflict with parents was a contributor and a 'disciplinary crisis' was the most common precipitant of a suicide attempt (Lau, Jernewall, Zane & Myers, 2002).

A diagnosis of post-traumatic stress disorder (PTSD) in refugees who are torture and trauma survivors is also linked with suicidality in the literature (Ferrada-Noli, Asberg, Ormstad et al., 1998; Gong-Guy, Cravens & Patterson, 1991).

Childhood abuse, domestic violence and sexual assault as risk factors

Very few of the cross-cultural suicide studies make direct links with interpersonal trauma as a risk factor. Generally, there is some reference to 'negative/adverse life events' and/or 'spousal or family conflict', but these are not highlighted and 'cultural factors' tend to assume priority in importance.

Some of the transcultural suicide literature takes account of gender in discussion of sociocultural variables and begins to link this with a noting of interpersonal trauma among possible antecedents of suicidality (Andriolo, 1998; Canetto, 1992; Falicov, 2003; Khan, 2002; Marecek, 1998; Pritchard, 1996;).

There is a tendency in the cross-cultural suicide literature to frame particular variables such as 'collectivism' and 'religiosity' as potentially protective factors for suicide, an assumption that requires some interrogation in relation to experiences of interpersonal trauma. This will be explored in a later section of this paper.

Interpersonal trauma across cultures

The prevalence and manifestations of intimate gender-based violence is a growing field of cross-cultural research. An international review of the literature conducted by Krantz (2002) indicates that some forty population-based quantitative studies conducted in 24 countries on four continents revealed that between 20-50% of the women interviewed reported that they had experienced violence from their male partner (Heise, Pitanguy & Germain, 1994).

Some of these studies focus on specific cultural manifestations, such as 'bride-burning' (Jutla & Heimbach, 2004; Martin, Moracco, Garro et al., 2002) and 'honour killings' (Ahmad, 2000; Kandela, 2000; Pervizat, 2002). Other research has focused on the somatisation of emotional/mental distress that is more common among women where 'mental illness' is highly stigmatised (Lown & Vega, 2001; Weingourt, Maruyama, Sawada & Yoshino, 2001). A few articles make reference to issues specific to refugee women in abusive relationships (Burnett & Peel, 2001; Lamb, 1999; Friedman, 1992; Pittaway, 1999).

There is also a gradually expanding body of international literature regarding child abuse and protection issues from a cross cultural perspective (Baylis & Downie, 1997; Farmer & Owen, 1996; Korbin, 1991; Levinson, 1989; Phillips, 1995). Many studies highlight the role of cultural norms in relation to perceptions of child abuse and some studies have found notable cross-cultural differences in relation to both child sexual assault and physical and emotional abuse of children. Several Chinese studies, for example, found that the traditional concept of 'filial piety' (*xiao*) may be conducive to the acceptance of child abuse and certainly act as an inhibitor to disclosure (Rhind, Leung & Choi, 1999; Tang, 1996, 2002). However it must also be noted that cultural values in relation to familialism, for example, may also act as protective factors. A number of studies focus specifically on the experiences of refugee children (Berman 1999; McCloskey & Southwick, 1996; Savin, Sack, Clarke et al., 1996). A particularly valuable area of cross-cultural research looks at the experiences of abused children from non-dominant cultural groups, particularly black children, within the

context of societal racism (Bernard, 2002; Hill & Sprague, 1999; Jackson, 1996).

Cohen, Deblinger, Mannarino and de Areliano (2001) contend that the influence of cultural factors on mental health outcomes, help-seeking patterns, referral pathways and preferred service responses among abused and neglected children and their non-offending caregivers is generally poorly understood by clinicians.

Suicide as a possible outcome of childhood abuse, domestic violence or sexual assault

Given the extent of the research in relation to interpersonal trauma and suicide and the growing interest in cross-cultural suicide prevention, there are remarkably few cross-cultural studies that investigate the links between suicide and interpersonal trauma. However, those that do may provide the basis for a new field of cross-cultural research.

As previously noted, disproportionately high rates of fatal suicide have been found among women in rural China (Meng, 2002; Pritchard, 1996) and in Indian women (Banerjee, Nandi, Nandi et al., 1990; Patel & Gaw, 1996). Similarly high rates have also been found among ethnic South Asian women living in Pakistan (Khan & Reza, 2000), Sri Lanka (Miller & Kearney, 1988), South Africa (Wassenaar, Marchiene, Van der Veen & Pillay, 1998), Malaysia (Morris & Maniam, 2001), Singapore (Mehta, 1990) and in the UK (Chantler, Burneer, Batsleer & Bashir, 2002; Hicks & Bhugra, 2003; Patel & Gaw, 1996). Canetto and Lester (1995) found consistently higher rates for Asian women, arguing that the combination of the concurrent stressors of sociocultural transition and 'marital conflict' contribute to a higher than average mortality rate. Khan and Reza (1998) also studied gender differences in non-fatal suicidal behaviour and found that while 'domestic troubles' was a precipitating factor among both women and men, 'negligence by husband' was the reason most commonly given by women (35%).

Loue and Faust (1999) refer to one South African study that estimated that violence occurs in 50-60% of marriages and that approximately 25% of women in these marriages take suicidal action. Stark and Flitcraft (1995) report that studies in Greece and Denmark have reported

abuse as a factor in as many as 44% of non-fatal suicides among women (Arcel, Mantonakis, Petersson et al., 1992). Several studies of South Asian women in the UK note that the factors endorsed most frequently and strongly as probable precursors of suicidal behaviour are physical and sexual violence by the husband (Chantler et al., 2002; Hicks & Bhugra 2003). Chantler and her colleagues note the interlocking effect of uncertain immigration status, domestic violence and shame (Chantler et al., 2002). Similar findings are reflected in Australian research conducted by Echavarría and Johar (1996) by the Centre for Refugee Research at the University of NSW (2004).

Liu Meng (2002) raises the issue of women's (lack of) autonomy over their lives in a highly patriarchal society. She frames the meaning of suicide for Chinese women as an act of revenge and 'one of the ways for women to rebel against their oppressive status in the society and a real denouncement of the unequal relationship between genders in China' (Meng, 2002:308). Similarly, a study of sexual abuse trauma among Chinese survivors concluded that 'the patriarchal fetish for female chastity in the Chinese cultural construction of sexual victimization' (Tsun-Yin, Echo, Luo, 1998:1013) may increase the traumagenic effects of sexual assault. The extreme stigmatization experienced by survivors may, it is argued, increase the likelihood of suicide.

Case studies collected by Dorothy Counts from a range of Oceanic, African and South American societies similarly suggest that 'suicide may be a culturally constructed way in which a powerless person may avenge herself on her tormentor' (Counts, 1987: 198). She argues that, in the absence of support, 'an abused woman may, by following the rules that govern a meaningful suicide, require her survivors to demand compensation from or take revenge on her abusive husband' (Counts, 1987: 198)⁷.

Fischbach and Herbert's (1997) analysis of gender-based violence across cultures draws attention to reports of suicide in the aftermath of rape and other displays of violence against women, 'particularly in cultures where virginity is highly prized' (Fischbach & Herbert, 1997:1170). The dishonour and shame associated with sexual assault is also noted by

previous researchers (Fauveau & Blanchett, 1989; Heise, 1993). Indeed the claim is made that 'in some societies, female suicide is regarded as a socially sanctioned behaviour that enables the politically powerless or entrapped to avenge those who have made their lives intolerable' (Heise, 1993:1171).

The suggestion that suicide may be a 'culturally acceptable way out' of an abusive marriage for many women in India and indeed 'the only viable alternative to eventual murder by the husband or his family' is similarly made by Loue and Faust (1999:533). Despite the introduction of anti-dowry legislation, the occurrence of 'dowry suicides' is still relatively widespread (Banerjee et al., 1990; Patel & Gaw, 1996). Indeed, Banerjee et al. (1990) found that 'spousal conflict' was a factor in 46% of female suicides in West Bengal. Sitaraman (1999) however frames these deaths more as 'forced suicides' or 'disguised homicides'.

A high prevalence of non-fatal suicides is also noted in studies among women in Turkey (Baral, Kora, Yuksel & Sezgin, 1998; Tutken, 1996; Zoroglu, Tuzun, Sar et al., 2003). Baral and his colleagues note that in Turkey histories of domestic violence and/or childhood abuse are not often recorded, as these issues are 'rarely addressed directly by mental health professionals' (Baral et al., 1998:427). Nevertheless, Tutken (1996) reports that a suicide attempt rate of 64% was observed in those with a dissociative disorder and a recorded history of CSA. Zoroglu et al. (2003) surveyed 862 high school students and similarly found that those who had a history of abuse or neglect had a 7.6 fold higher rate of suicide attempts than those who did not.

Despite the paucity of suicide research from Africa and other developing countries, one large cross-sectional study of 10,468 adults in Ethiopia found that 63% of those who reported a lifetime suicide attempt were women between 15 and 24 years and that 'marital or family conflict' was the most frequently cited precipitant (Alem, Kebede, Jacobsson & Kullgren, 1999).

Research linking suicide with interpersonal trauma among immigrant communities in Australia is limited, but work by Dusevic et al. (2002) and Fry (2000) give some indication of

the prevalence of attempted suicide and suicidal ideation among women in abusive relationships and those with histories of childhood abuse. Dusevic et al. (2002) found that domestic violence was seen to be the dominant risk factor (14%) among the immigrant women they surveyed, followed by 'relationship problems' (14%) with sexual assault accounting for 5% of responses. Abuse was also noted as a suicide risk factor by 14% of the non-English speaking background young people surveyed.

Ann Fry's work with young migrant women in Blacktown (NSW) locates predisposing factors to suicidal behaviour within 'cultural and intergenerational conflicts embedded in gender roles' with sexual abuse and domestic violence perpetrated by males being precipitants for 17% (Fry, 2000:156).

Emerging questions

Interpersonal violence and suicide are two forms of violence that are clearly related in significant and complex ways. However, the gaps in our understandings of how culture mediates this inter-relationship begs the question of why there is still so little research in this area.

Gender and cultural biases in research?

While suicidologists have tended to focus on suicide mortality, which is typically male and epidemiologically quite rare, non-fatal suicidal behaviour, which is typically engaged in by more women, is actually more common. Indeed, Canetto and Lester (1995) suggest that when rates of fatal and non-fatal actions are combined, women are in fact found to be at greater risk of suicide-related events. Why then is there so little research in relation to women's suicidality?

Range and Leach (1998:24) note the 'inherent bias against women and non-majority cultures'. in suicide research. They assert that the relative lack of alternative worldviews is reflected in the methodologies adopted and that more feminist research is called for. They characterise feminist research as being based on a collaborative, egalitarian relationship between researcher and participant and addressing context and issues of power, rather than the detached, reductionist approach employed in the scientific empiricist tradition.

A tendency among mental health professionals to pathologise culture has been noted by Burr (2002). Her study of mental health professionals' explanations for the relatively high suicide rates (and low rates of treated depression) among women from South Asian communities living in the UK highlights how the construction of such cultural stereotypes forms the bedrock of a potentially racist mental health discourse. Falicov (2003) highlights the importance of recognising that our systems, process and diagnostic categories are culturally bound and that there is a need to 'start anew by incorporating unheard voices, untold worldviews, local knowledge and native psychologies' (Falicov, 2003:385).

Canetto (1992) also questions much of the epidemiological analysis and research methodology and highlights the role of language in directing research. For example, the terminology commonly used in the suicide literature refers to 'attempted' and 'completed' suicide, implying a 'failure' in the case of the former and 'success' in the latter. She argues that such language has constructed a continuum of suicidality, on which 'less serious' behaviour becomes conceptualised as 'more feminine' and 'more serious' behaviour logically is seen as 'more masculine'. Similarly, the term 'parasuicide' is open to critique as it has implications of 'pretence' or 'faking'. As non-fatal suicidal behaviour obviously signals intense distress and 'attempted suicide' is one of the strongest predictors of 'completed' suicide (Gunnell & Frankel, 1994; Moscicki, 1999), there is a strong case for seizing opportunities for effective intervention with identified sub-groups of 'attempters'.

There is generally less research in the area of parasuicide probably because of difficulties with reporting and data collection, but because non-fatal suicide is more characteristic of women's suicidal behaviour than of men's, this means that women are less 'visible' in the suicide research. This means that domestic violence (in which women are overwhelmingly the victims worldwide) also tends to be less visible as a risk factor for suicidality. Hicks and Bhugra (2003) note that the significance of marital violence as a specific factor in women's suicidality is often obscured within the general and often vague

categories of ‘family conflict’ and ‘marriage difficulties’. In this context, Canetto’s point that ‘what researchers ‘find’ depends on what researchers look for and are willing to see’ is especially salient (Canetto, 1992:13).

A need for new paradigms and frameworks for understanding?

The lingering influence of outmoded theories of suicide may also be partly responsible for the gaps in the research. For example, Durkheim’s (1897) theory that both marriage and religion act as protective factors for suicide still has considerable currency among suicidologists. While marriage may well act as a protective factor for men, the same cannot always be said in relation to women. Viewing risk from a ‘gender-neutral’ perspective in this context has the net effect of rendering domestic violence as invisible in suicide risk assessment, especially in cultural groups perceived to be particularly ‘religious’.

Lester and Abe’s (1998) study of suicide in Japan also questions the applicability of Durkheim’s theory to non-European nations, finding that the strong levels of social integration and regulation that characterise Japanese society do not necessarily protect against suicide. Analysis of suicide in Taiwan also found results in conflict with predictions from Durkheim’s theory (Lester, 1995).

While ‘religiosity’ and prohibitions against suicide are frequently referred to as protective factors (Kok, 1998; Neeleman, Wessley & Lewis, 1998; Stack & Wasserman, 1992), there is little attention paid to the influence of these on the prevalence of non-fatal suicidal behaviour. A study by Eskin (1999) comparing rates of suicidal thoughts and attempts in Swedish and Turkish adolescents found that despite strong sociocultural and religious prohibitions against suicide in Turkey, the Turkish students reported greater current suicidal ideation and significantly more suicide attempts than their Swedish peers. While living in a highly religious ‘culture of relatedness’, such as the Turkish culture, may have an effect on the rates of suicide deaths, it does not in and of itself ‘protect’ against suicidality.

In the context of higher rates of depression and non-fatal suicidal outcomes among women,

Stack’s (1998) argument that suicide is more ‘acceptable’ among men is worth interrogating. If women die by suicide less often than men because it is less ‘acceptable’ for them to kill themselves, does this mean that those women who do die from suicidal acts are transgressing gender roles in the only way they deem is possible? Stark and Flitcraft’s (1995) reframing of female suicidality as the exercising of ‘control in the context of no control’ shifts the theoretical framework to one that highlights social context. Liu Meng’s (2002) construction of rural Chinese women’s suicides as acts of ‘rebellion’ supports this reframing. By extension then, are women who have transgressed their gender-roles being omitted by researchers because they don’t ‘fit’ the expected gendered patterns of suicide?

Similarly, beliefs about the protective effects of ‘collectivist’/ sociocentric cultures may serve to hide the context of suicidal experiences of many people. Idealised images of extended family groups and ‘communal living’ may well have the effect of hiding the occurrence of child abuse and domestic violence, making it more difficult for victims to disclose and seek help. When the family is the source of the problem, or is unable to solve the problem and discourages the seeking of outside help, the negative effects of a ‘close community’ may be compounded. In this context, Anne Fry raises the possibility that ‘when taken to extremes, protective factors transmute into risk factors’ (Fry, 2000:158).

Accounting for such complex interactions between gender, culture, age, immigration and acculturation processes is thus bound to raise more questions than answers. The links between interpersonal trauma and suicidality become even more complex when regarded through a multi-focus lens.

Implications for policy and practice

Who is most at risk?

Given that the aetiology of suicidal behaviour is complex and multifaceted and that risk appears to accrue the greater the number of factors that interact, it is difficult to state categorically who is most at risk. The answer to this question depends on what sort of risk is being assessed and what data are being used. As noted, published suicide statistics indicate that young men and the elderly are the groups most likely to

die from suicide. Assessing risk for suicide attempts and suicidal ideation, however, results in a different picture as statistically more women, particularly young women, engage in non-fatal suicidal behaviour. If this risk is overlaid with other factors related to culturally-based gender roles and the effects of immigration, resettlement and pre-arrival experiences, then perhaps the answer to the question of who is most at risk may be a different one to that which is generally suggested.

What needs to be done?

Prevention

A range of prevention strategies is discussed in the literature, although rigorous evaluation of prevention efforts is sorely lacking (Krug et al., 2002) and very few have shown a significant effect on reducing suicidal behaviour or producing longterm sustainable results (Goldney, 2000). Prevention programs specifically targeting culturally and linguistically diverse communities are rare (Dusevic et al., 2002). While the suicide literature is replete with discussion of risk factors, much less is written about protective factors and potentially moderating co-variables (De Leo, 2002). Social support and connectedness, however, consistently emerge as key protectors (Nisbet, 1996; Wichstrom, 2000). It may well be that focusing on factors such as emotional wellbeing and support from family and friends may be as effective or more effective than trying to reduce risk in the prevention of suicide. In the context of reducing risk related to interpersonal trauma, it may be reasonable to assume that initiatives designed to raise awareness of domestic and family violence within diverse communities will contribute towards a reduction in suicidality in these communities.

Intervention

A number of pathways to care are suggested in the literature, the most common being appropriate risk assessment and management. Training initiatives targeting general practitioners and other allied health professionals are strongly advocated (Michel, Runeson, Valach & Wasserman, 1997; Rotheram-Borus & Bradley, 1991). The issue of cultural competence of service providers, however, does not appear to

be adequately addressed in the literature. Dusevic et al. (2002) note the potential for assessing the role and ability of bilingual general practitioners in immigrant suicide prevention. Most importantly, our cross-cultural suicide assessment frameworks need to incorporate a dimension that assesses for history of interpersonal trauma and abuse.

Postvention

Those bereaved by suicide may have limited opportunity to share their grief and hence there is clearly a need for support to surviving relatives and friends. Dusevic et al. (2002) note that the effectiveness of postvention initiatives however has not been demonstrated due to methodological limitations in studies exploring this issue (Patton & Burns, 2000). Young and Papadatou (1997) also note that the stigma related to suicide can act as a barrier to accessing bereavement services. This is likely to be an issue particularly for some immigrant and religious groups and thus has implications for cross-cultural practice also in the area of grief and loss counselling.

Policy considerations and concluding thoughts

Australia prides itself on being one of the first countries to develop a comprehensive national strategic approach to suicide prevention. But could it be more comprehensive?

Current policy, as articulated in the Commonwealth Department of Health and Aged Care's (2000) *LiFe (Living is For everyone)* framework, outlines a number of key areas for action, including progressing the evidence base for suicide prevention and good practice. Physical and sexual abuse, particularly in childhood, are noted in the document as risk factors for later suicidality, but little mention is made of domestic violence and its effects on women. Not surprisingly then, the framework omits to suggest that thorough suicide risk assessment ought to incorporate assessment of current risk of harm from others, as well as risk of harm to self (and to others). Much is made of the need to develop and foster partnerships across agencies, sectors and communities, but there is little acknowledgement that such collaborations may involve working with and

negotiating a way through the tensions created by sometimes clashing paradigms.

While people from culturally and linguistically diverse backgrounds are named as a specific population group in the *LiFe* framework, there is scant recognition of gendered differences in suicidal behaviour among immigrants and resettled refugees. The *Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia* (Commonwealth Department of Health and Ageing, 2004) is a timely document that presents a number of challenges to mainstream mental health service provision. It complements not only the National Mental Health Plan, but also suicide prevention policy.

There is thus ample scope within the existing policy context to act on some of the issues raised by this literature review. A thorough analysis of the policy landscape is beyond the scope of this paper, but it is likely that such an undertaking would reveal a number of policy vacuums and opportunities to cross-reference policies. Linking suicide risk assessment and management protocols to domestic violence routine screening and safety planning, for example, is one way of dovetailing policies and facilitating cross-discipline communication.

Based on what we know about the global prevalence of interpersonal violence perpetrated within intimate and family contexts, it seems reasonable to suggest that there is a need for further research into these experiences as they are lived within immigrant and refugee communities in Australia.

Focused research into the experiences of young people of diverse backgrounds, particularly second generation immigrant and refugee young people, will enable valuable exploration of the intersecting effects of intergenerational and intercultural conflict.

Perhaps the research light also needs to be shone more intensely on the role of protective factors in suicide prevention. It seems probable that efforts to reduce domestic and family violence must inevitably have a protective effect against suicidality for those sub-groups most affected by this kind of interpersonal trauma (i.e. women, children and young people).

However, in advocating for more culturally-inclusive research a *caveat* applies. Cross-cultural research is a delicate balancing act requiring careful avoidance of the pitfalls of an ‘all or nothing’ approach to cultural diversity. Too much focus on difference perpetuates an ‘us and them’ way of thinking; too little universalises individuals’ experiences, obscuring important culturally specific detail that can make a crucial difference to an intervention.

Finally, there is an urgent need to develop an inclusive framework for practice that reflects the diversity of our potential client base. An ‘intersectional’ approach, embedded within an ecological or integrative framework may emerge as a useful way for practitioners in a range of professional contexts to understand and respond to the issues in a cross-cultural setting. Indeed, such an enterprise opens up rich possibilities for the valuable cross-fertilisation of divergent discourses and perspectives.

Notes

1. ‘Postvention’ is a term used in some of the suicide literature to denote the provision of bereavement care and support to the surviving family and friends of the person who has died.
2. For an exploration of suicide within Aboriginal and Torres Strait Islander communities, see Bird (2002), Durie (2003), Hunter and Harvey (2002). For a discussion of suicide among Canada’s native people see MacMillan et al. (1996); for Maori people see Langford et al. (1998); for native American peoples, see Robin et al. (1998); for native Hawaiian people, see Yuen, et al. (2000).
3. For a discussion of suicide related to war experiences, see Bullman and Kang (1996), Farberow, Kang and Bullman (1990), Ferrada-Noli et al. (1998), Kramer, Lindy, Green et al. (1994).
4. For an exploration of issues relating to perpetrator suicide in the context of domestic violence, see Belfrage and Rying (2004), Conner, Duberstein and Conwell (2000), Eastal (1994), Lund and Smorodinsky (2001), Milroy, Dratsas and Ranson (1997), Morton, Runyan, Moracco and Butts (1998), Rosenbaum (1990).. For a discussion of incest perpetrator suicide see Morrison (1988).
5. ‘Psychological autopsy’ is a term used by some suicidologists to describe the process of determining the state of mind of the person and events occurring in the weeks and months before

death. This is generally done by interviewing surviving family members and close friends.

6. The ingestion of poisonous organophosphate insecticides is the most common method of suicide in China; self-immolation is still relatively common in India.
7. According to Counts, among the Kaliai women of Papua New Guinea the 'rules for a person who intends to kill herself' include warning others of her intent, dressing herself in her finest clothing, killing herself in the presence of others (or where they will be certain to find her body) and communicating to others the identity of the individual who is responsible for her death (Counts, 1987:195).

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