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Attempted suicide in west London, II. Inter-group comparisons

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ABSTRACT

Background. Previous studies of attempted suicide have suggested that cultural and social factors play a significant role in the causation of deliberate self-harm.

Method. In order to measure elements of culture conflict two inter-group comparisons were undertaken. In the first, 27 Asian women who had presented to hospital services following attempted suicide (Asian group) were matched with a group of similar age Asian women attending GP surgeries for other reasons (Asian GP attenders group). The second comparison was between the Asian and 46 White attempters.

Results. On comparing Asian attempters with Asian GP attenders group the former were more likely to have a history of previous suicidal behaviour, to have a psychiatric diagnosis, and be unemployed. Their parents were more likely to have arrived in the United Kingdom at an older age. In addition, those who attempted suicide were more likely to have been in an inter-racial relationship and to have changed religions. In the second inter-group comparison, the characteristics of Asian and White suicide attempt patients were examined. White attempters were more likely to have mental illness, and were more likely to use alcohol as part of the method of attempted suicide. By contrast, Asian attempters had experienced life events pertaining to relationships, took fewer tablets and yet expressed greater regret at not succeeding in the attempt.

Conclusions. Although numbers are small, social stress and other cultural factors play an important role in the act of deliberate self-harm.

INTRODUCTION

Previous studies have suggested that culture conflict plays an important role in the genesis of suicidal behaviour (Merrill & Owens, 1986). Changes in the family set-up, and problems with family expectations and arranged marriages were reported to be contributory factors. Changes in cultural identity can be measured on a number of parameters and these have been tried by Merrill & Owens (1986) as well as by Stopes-Roe & Cochrane (1990). In a separate study, Bhugra *et al*. (1999) developed a Culture-Identity Schedule that measures the degree of comfort within one's own culture and also the degree of comfort within the broader majority culture. However, such crude measurements are fraught with difficulties and have to be understood in a specific context. As rates of attempted suicide and completed suicide are high among females in the Indian subcontinent as well as in the Indian diaspora, it is important to study culture conflict which may play some role in the latter setting, but is unlikely to affect the rates in the countries of origin.

In American Blacks ethnic and racial identity combined with other social factors plays an important role in determining patterns of committing and attempting suicide (Bush, 1976). These pressures have been described as intra-group and extra-group. According to Bush (1976) the former include self-construct, role expectations and language, child-rearing and the latter will include dogma, racism, prejudice resulting from neocolonialism and resultant

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family ties and kinship bonds. Kirk & Zucher (1979) have argued that Black suicide attempters will be characterized by a lesser degree of Black consciousness and lesser degree of group cohesiveness. They showed that the intergenerational differences in education and economic status were greater in attempters. Acculturation (contact between two groups, degree of conflict between them and eventual style of adaptation of the non-dominant group that determines the group's use of suicide) and subculture of violence have been suggested to be key factors in attempting and completing suicide (Committee on Cultural Psychiatry of the Group for the Advancement of Psychiatry, 1989). Social alienation is not a key factor for suicide in small societies (Tousignant, 1998). Economic deprivation and racism (Frierson & Lippmann, 1990) at the extra-group level and family conflict (Bush, 1978; Kingsbury, 1993), living alone (Johansson *et al*. 1997), religion (Bush, 1976) and religiosity (Stack, 1998) at an intragroup level been shown to be important factors in the causation of attempted suicide among Blacks in the USA and UK.

Studies from the Indian subcontinent suggest that alcohol abuse, unemployment, interpersonal relationship difficulties and stress are important factors (Ponnudurai *et al*. 1986; Kumar *et al*. 1995). Younger males were the most likely group to attempt suicide. In one study (Kumar *et al*. 1995), two-thirds of the sample had a positive family history of alcohol abuse, suicide or depression.

From India, Adityanjee (1986) argues that rates of attempted suicide are higher in married females and they are related to prevalent problems related to dowries and consequent maltreatment of brides in the extended families. Thus, family arguments, disappointment and rejection, marital infidelity, rape, unwanted pregnancy or childlessness, and alcoholism in husbands were important factors. Hinduism as a religion has been very tolerant of suicide with joy of sacrifice and certain kinds of suicide seen as justifiable and acceptable. From Pakistan, Khan & Reza (1998) reported that more younger women presented following conflict with spouse, or family and they suggested that key cultural factors – arranged marriage and religion, psychological factors like self-esteem and social factors like changing gender roles played an important role in the influencing rates of attempted suicide. Where a strong emphasis is placed on marriage and discouragement from having careers, in addition to pressures from in-laws to confirm, can lead to 'escape for a while from an impossible situation' (Bancroft *et al*. 1979). As the likelihood of divorce is low, the repetition of attempts can be high. Using case-vignettes of a suicidal individual, Marecek (1998) found in a Sri Lankan population that two-thirds did not see this as a mental illness and the management recommended using emotion-focused responses (e.g. love and kindness) or expert healing systems but not mental health systems. Self-injury may also be a form of protest (especially in some situations such as prisons, Haycock, 1989) rather than suicidal.

Lockhart & Baron (1987) reported that rates of attempted suicide in west London presenting to hospital had dropped, but within this fall there was a dramatic increase in the rates for minority ethnic groups that they attributed to assimilation of European attitudes and values.

In our previous paper (Bhugra *et al*. 1999*b*) we have demonstrated the rates of attempted suicide among various ethnic groups. Asian women may be especially prone to experience cultural conflict, which includes dealing with changes in family expectations regarding social behaviour. This paper describes possible links between cultural identity conflicts and attempted suicide, first, by comparing Asian suicide attempt patients with patients of similar origin attending a GP surgery, and secondly, by comparing the characteristics of Asian and White patients who had recently attempted suicide.

METHOD

First control group

The first control group consisted of 27 Asian women attending one GP surgery (GP Asian group) on different days. On varying days of the week the researcher approached Asian females attending one GP surgery (with 98% of registered patients being of Asian origin) and women in the age range between 16 and 64 were asked to take part in the interview. The GP receptionist (well known to the patients and the local community) was instrumental in helping to recruit patients. No controls refused to take part. The controls were age-matched with

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attempters (to within 1 year). During an extensive interview they were asked about details of any suicide attempts, and were further assessed using GHQ-28 (Goldberg, 1972), CIS-R (Goldberg, 1972) and a modified version of the LEI (Cochrane & Robertson, 1973; Bhugra *et al.* 1997). In addition, they were interviewed using the Cultural-Identity Schedule (Bhugra *et al.* 1999*a*), which measures cultural identity in areas of religion, education, family decisions and behaviour, social expectations and behaviour, entertainment, links with relatives here and abroad, dietary and shopping habits. Only those subjects who were able to complete the Cultural-Identity Schedule are described in this report.

Second control group

As part of the second inter-group comparison, interviews were conducted in a group of 54 White women who had presented to the team following suicidal attempt within the same week. For case–control purposes we had wanted to recruit two White women for every Asian woman who had attempted suicide, but we were only able to obtain complete data in 46 White attempters. After recruiting one Asian attempter two sequential White attempters were approached for recruitment. The refusal rates were acceptably low (eight individuals out of 54 refused or did not persist with the interview). Complete data were collected on 46 White attempters. These will be presented here. The data were analysed using the Mantel–Haenszel test and Fisher's exact text was employed if indicated. Where χ^2 values have not been given Fisher's exact two-tailed test was carried out.

Refusers from both White and Asian groups were brutally frank in their reasons for refusing to take part in the study. Even with a female Asian interviewer fluent in three regional languages reasons for refusal included distrust of the investigator and of the system and establishment in general. More specifically, either the attempters or key family members were keen not to be reminded of their act, which was often reported as sinful or shameful and as the family had come together to support the individual or the couple any oustide 'interference' was resented. On comparing the refusers and completers no differences emerged on religion or social class.

Three attempts at direct personal contact were made after two letters or telephone calls. On several occasions husbands or parents refused access to the individual. Home visits were made (following a contact by letter) on at least three different days at different times of the day.

RESULTS

Comparison of Asian attempters with Asian GP attenders

A total of 65 South Asian women attempted suicide and presented to medical services. Due to a range of problems and family concerns, 30 women agreed to be interviewed, and only 27 completed all the sections of the interviews. There were no age or social class differences between those agreeing to the interview and those refusing it. Of the refusers on which information was available, 12 had presented with an attempt following a family argument, and did not want to be reminded of this further, in three cases the reasons were not clear and four were said to be 'depressed'. Others had left the catchment area and were either abroad or could not be traced. Two women refused because the researcher was unable to offer financial incentives. Among those who were contacted repeatedly, most responded by saying that they wished to forget the incident and did not wish to speak to the researcher.

General practice sample

The age range was 16–64 years, the mean age being 29 years (S.D. 13). Nearly half (44%) were married, there being no significant difference in marital status between the attempter and GP groups. Nearly half (48%) of the GP sample were employed, compared with 26% in the suicide attempt group, this difference not being statistically significant. Table 1 gives details of the employment status of the two groups.

When social class was defined according to employment, more patients in the control group were from classes II and III, but again this difference was not statistically significant. Most of the GP sample were either in employment or studying, although no statistically significant differences emerged.

Accommodation

In both Asian groups a majority were (76%) reported to be living in owned accommodation.

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Table 1. *Employment status and social class*

Social class/employment status	Self-harm patients ($N = 27$) N (%)	Control ($N = 27$) N (%)
Employed	7 (26)	10 (37)
I	0	0
II	1 (4)	2 (7)
III	1 (4)	5 (18)
IV	5 (19)	2 (7)
V	0	1 (4)
Students	4 (15)	8 (30)
Retired	2 (7)	2 (7)
Unemployed	14 (52)	7 (26)

Unemployment *v.* the rest χ^2 3·75 $P = 0{\cdot}05$.

None of the patients in the two samples lived on their own. One-third (32%) lived with their partners and 39% lived in the parental household. Of the women, 15% lived in an extended family household. There were no differences in either the type of accommodation or the household structures of the two groups.

Psychiatric history

The two groups differed significantly with respect to psychiatric history. Only one patient (3%) from the GP group had previous psychiatric history compared with 16 (59%) in the attempter group ($\chi^2 = 9{\cdot}247$, $P = 0{\cdot}0023$). Only one subject from the GP group gave a history of attempted suicide (compared to a history of previous deliberate self-harm in 44% of the attempter group). Twelve (44%) of the attempters had a history of physical disorder in the past (compared with 2·7% of GP sample $P = 0{\cdot}001$).

The mean GHQ-28 score for the attempter group was 15·5 (9·9), compared with 6·4 (1·7) for the GP group (independent samples t test: $t = 3{\cdot}31$, df 36·80, two-tailed $P = 0{\cdot}002$). The mean CIS-R score was 23·2 (10·8) for the attempters and 7·2 (7·6) for GP group ($t = 0{\cdot}22$, df 51, two-tailed $P = 0{\cdot}000$). There was no relationship between GHQ or CIS-R scores and place of birth. Those who had attempted suicide were more likely to have a past psychiatric history (37%) and a history of previous self-harm (48%) whereas among GP group only one patient each had past psychiatric history and past self-harm.

Place of birth

A third of the attempters and 48% of the control group were born in the UK. In the attempters group 52% were born in Asia and 15% in East Africa, compared with 44% and 7% respectively in the GP group. Of those born outside the UK, the majority were born in India. The average age of arrival in this country was 18·7 years (ranging from 6 months to 47 years), there being no significant differences between the two groups.

Parental origin

Parental origins were checked in both groups; one patient did not know her parents' origin. More than three-quarters of fathers came from India, 13% from East Africa and 4% from Pakistan. More parents arrived at a younger age (below 30 years) in the GP group than in the self-harm group.

Cultural factors

Various factors in the Cultural-identity Schedule showed a significant difference. We shall present only significant differences in detail below.

Arranged marriage

When asked to define 'arranged marriage', it was defined by virtually everyone as when parents, family or someone in the community arranges a match. Twenty-four (88%) of the GP groups considered arranged marriage to be a good idea, compared with only nine (30%) from the attempters – a further 18 (70%) in the latter group were either against the concept, or ambivalent about it ($\chi^2 = 17{\cdot}207$ df = 1, $P = 0{\cdot}00003$).

Age of marriage

Both samples believed that women should be married in their early 20s, and men only a few years later. In the attempter sample nearly half (43%) felt cohabitation to be acceptable compared with only eight (30%) in the GP group, this difference just failed to reach significance. The vast majority did not believe in having children before marriage, for practical reasons, reporting fears that the man may leave, or the family environment may not be stable.

Inter-racial relationships

Whereas six of the attempters (22%) group described a relationship (romantic/sexual) with a White person, none of the control group did (two-tailed test $P = 0{\cdot}022$). However, among both groups, more subjects were agreeable to

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Table 2. *Racial life events*

	Asian attempters *N* (%)	Asian GP attenders *N* (%)
Racial	5 (23)	3 (19)
Cultural	1 (4·5)	1 (4·8)
None	16 (72)	16 (76)

the idea of their children or siblings having such relationships. As one respondent in the attempter sample put it 'I cannot even consider marrying a White man because it would hurt my parents deeply, but my children can do so because I will be able to accept it'.

Religious affiliations and practice

In the attempter sample 12 (44%) were Sikh, 11 (41%) Hindus and three (11%) Muslim; one women described herself as having no religion. In the GP group the numbers were 16 (59%), eight (29%), two (7%) and one (4%) respectively. Two patients from the self-harm group had changed their religions – one because of marrying into a different religion. A further two women in this group were thinking of changing religion, whereas no one from the GP group had done so; again, because of a small number differences did not reach statistical significance.

Gender roles

All but three respondents (88%) in the attempter sample believed that all tasks should be shared between a couple but actually these were shared in only one-quarter. The attempters were less likely to keep in contact with relatives abroad (only 20 did so) compared with all the GP attenders (two-tailed $P = 0{\cdot}010$).

Life events

There were no differences between the two groups in the number of life events experienced over the previous year. However, a significantly higher number of miscellaneous events (e.g. loss of valuable object, family arguments, separation) were experienced by the self-harm group ($t = 2{\cdot}92$, df 41, two-tailed $P = 0{\cdot}006$). Among those born in the UK, legal events ($t = 2{\cdot}17$, df 41, two-tailed $P = 0{\cdot}036$) and events related to education ($t = 2{\cdot}87$, df 41, two-tailed $P = 0{\cdot}006$) were more likely to have occurred, and the number of events related to relationships with the opposite sex (non-marital) was significantly higher in those born in the UK ($t = 2{\cdot}40$, df 41, two-tailed $P = 0{\cdot}021$) (see Table 2).

Problems

The vast majority (80%) in both samples believed that people of Asian background faced difficulties in the UK although there were no intergroup differences. The problems highlighted concerned housing, financial difficulties, language problems and differences with children who are growing up here.

Nearly three-quarters of the total sample acknowledged that racism had played no role in the life events they had experienced. In the attempters only 17% felt they had been affected by racism. Two subjects in the attempter sample, believed that their experiences occurred because of the conflict in cultures they faced, such as differing expectations between their family and community and that of the dominant Western society.

Comparison of Asian and White suicide attempters

Apart from religious differences and place of birth the demographic characteristics of the two groups were broadly similar. Out of 27 Asians, 10 were born in the UK, 16 in the Indian subcontinent and one in East Africa. Of the White sample, 37 were born in the UK, five in Ireland and four elsewhere. Among the White women, 16 (35%) were single, divorced or separated, compared with 16 (55%) of Asian women.

Attempt

When asked whether they regretted that the suicide attempt had not succeeded, 17 (36%) White women and 18 (62%) Asian women

Table 3. *Method of attempted suicide*

	White women *N* (%)	Asian women *N* (%)
Overdose	39 (85)	25 (86)
Self-laceration	2 (4)	1 (3)
Other	2 (4)	1 (3)
More than one	1 (2)	1 (3)
Non-ingestible	2 (4)	1 (3)
Total	46 (100)	29 (100)

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expressed regret. Among the group of 47 White women, 29 had wanted to die (62%) compared with 86% of the Asian attempters ($N = 29$) ($P < 0{\cdot}010$).

The methods of attempted suicide are presented in Table 3. Approximately one-quarter of both groups (White women 23·9%; Asian women 27·6%) had taken an overdose of paracetamol, and another quarter (23·9% and 13·8% respectively) had taken a mixture of tablets. White women generally took more tablets than Asian women (mean 37·9 compared with 21·7, two-tailed $P = 0{\cdot}016$).

Eight White women (17%) and four Asian women (13%) had written their wills while preparing for the attempt, and 10 White women (23%) and nine Asian women (31%) had written a suicide note. Twenty-five White attempters out of 46 who had been interviewed (55%) and 14 (52%) Asian attempters had a past history of attempted suicide. When asked whether the respondent thought that the number of tablets taken would be fatal, 58% of the total sample believed so, there being no significant differences between the two groups. Asian women were more likely to live in owner-occupied accommodation (68%) than White women (38%) ($P = 0{\cdot}00893$). All Asian women lived with someone.

White women were more likely to have used alcohol in their attempt (33 out of 46 (72%)) than Asian women (four out of 29 (13%)) (Pearson's $r = 23.89346$; $P < 0{\cdot}00001$).

Psychiatric disorder

Twenty-four White attempters (52%) were depressed, compared with eight (27·6%) Asian attempters. Four White women (9%) and four Asian women (14%) had an adjustment reaction. Nearly one-fifth of the White women had a drug or alcohol problem, compared to only one Asian woman (3%). Six White women (11%) and 14 Asian women (48%) had no psychiatric disorder. Overall, psychiatric disorder was significantly more common in White women ($P = 0{\cdot}001$). At clinical interview (CIS-R), 17 out of 47 White women (36%) and seven out of 29 Asian women (24%) had depression, another six (20%) and 14 (58%) having other psychiatric disorders. Twenty-four (51%) White women and eight (27%) Asian women had no psychiatric disorder ($P < 0{\cdot}00029$).

Life events

When presence of life events prior to the attempt were compared across two groups – significant differences emerged in two categories only. Asians were more likely to have had health-related life events (43%) compared with 17% Whites ($\chi^2 = 11{\cdot}089$, $P = 0{\cdot}0008$). Asian attempters were also more likely to have experienced life events related to opposite sex (22% compared with 4% White attempters – two-tailed t test = 0·036).

DISCUSSION

Two caveats need to be emphasized before we interpret our findings. First, for the Asian attempters the attrition rates are very high. Although the refusers gave a variety of reasons for refusing further contact or interview there is a theoretical possibility that their circumstances or family ties may well be such that the degree of conflict and resulting chronic difficulties are high thereby affecting the rates. It is possible that financial inducements might have made some difference. As the basic demographic details between refusers and completers are not dissimilar it is likely that some generalizations can be made. The data from the case-notes were not always reliable enough to get details of life events, type of marriage (mixed or not) or previous psychiatric history. This remains a key weakness of the study. Secondly, the heterogeneity of the three groups – Asian attempters, Asian attenders and Whites must be borne in mind while interpreting these comparisons, even though we have used these as if they were homogenous groups with similar experiences.

Previous history

More of the patients in the Asian attempters suicide group had made a previous suicide attempt and had previous medical or psychiatric illness. Despite the small numbers (as these are the ones who completed the interview) this observation is striking and supports findings from the Indian subcontinent suggesting that repeat attempts are linked with various kinds of psychosocial distress (Venkoba Rao & Chinnian, 1972). Our findings are in marked contrast to previous work in Birmingham, which found that previous psychiatric history, psychiatric illness,

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personality disorder or previous suicide attempts were less likely in a sample of suicide attempt patients (Merrill & Owens, 1986). In our Asian GP group, only one person had taken an overdose, because of conflict within the family (parental unwillingness to accept her choice of husband). The conflict with the family as a precipitant and life event in Asian females is a remarkable and important finding and deserves to be studied further. These repetitions suggest that continuing conflict within the family needs to be understood and managed within the gender and cultural boundaries so that repetitions can be reduced. Steele (1977) had argued that White attempters were more likely to modify behaviour or induce guilt in others, which may explain some of the reasoning for differential rates of repetition. However, as we did not set out to study repeaters it is difficult to make any general observations here. When we presented the findings to Asian females in the community their overwhelming recommendation was that families needed to be educated.

Religious difference

Most attempters were involved in religious activity on a regular basis. Sikhs formed the largest religious group. This probably reflects the local population, although it has been argued that the attitude of the Hindu religion towards suicide (where some kinds of suicide are acknowledged and not others) may account for some of the increased rates of self-harm (Maniam, 1988). Another interesting finding in our attempters sample was either a recent change in religion (two cases) or current thoughts of doing so (two further cases). This may stem from a need for acceptance in the new relationship, but at the same time could increase alienation from the family and previous support systems. It may also be an attempt to increase social support in those under extreme psychological pressure.

Arranged marriage

Although one-fifth felt arranged marriage was not a beneficial institution, the attempter group appeared somewhat ambivalent, and one-third would like their relatives to have arranged marriage. These mixed feelings may reflect changing mores or indicate an uncertainty about an institution supported by the culture against which they might wish to rebel. The description of arranged marriage as outlined by our respondents is not a static one – an element of choice by the partners has become an important component. Furthermore, some of the women acknowledged that the couple should be allowed to get to know each other for some time before marriage. The reported differences between the two groups could reflect the greater turmoil the self-harm group had experienced. As Khan & Reza (1998) had reported from Pakistan, arranged marriages have stresses of their own. Newly married couples even in the UK may share the house with the groom's family having little or no space of their own and under such conditions the cultural expectation is that the bride will make all the compromises thereby contributing to the stress. In our interview we did not ask about the duration of marriage which may well affect the social functioning. Inability to have children, or comfortable sexual life, in situations where privacy is at a premium it is likely that the individual will feel even more alienated especially if family expects the newlyweds to have children as soon as possible. These systematic social, economic and cultural pressures are more likely to affect the females than their male counterparts.

Inter-racial relationship

Although there were no statistically significant differences between the two Asian groups on their relationships (romantic or sexual) with White men, more patients in the self-harm group had experienced such relationships. This may reflect personality traits of extroversion and curiosity, or the subjects may have generally experienced pressure on themselves and distress as a consequence. Because there were no educational or socio-economic differences between the two groups it seems possible that the reasons are more likely to be intrapersonal. Similar findings in the Indian diaspora in Trinidad have led to suggestions that inter-racial relationships, love affairs and marriages play an important role in precipitating suicide attempts (Mahy, 1993).

In spite of small numbers, social support or lack of support appears to play an important role in the development of psychosocial distress, which can lead to acts of self-harm. Changing religion may be a possible warning sign of stress which may lead to future suicidal behaviour. In

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addition, a past medical or psychiatric history indicates an increased likelihood of repetition of self-harm.

Asian and White attempters

Although numbers are small, comparison of the Asian group with the sample of White women produces some interesting differences. For example, in comparison to the Asians, White attempters were more likely to have used alcohol and Asian attempters had lower rates of alcohol dependence. Rates of alcohol dependence are low in Asian women (Cochrane, 1999). Although Sikhism as a religion is not entirely anti-alcohol, it does not encourage women to drink. As we did not include a measure of assessment of alcohol abuse we are unable to comment on the levels of problem drinking or alcohol dependence in the two Asian groups.

The sociodemographic characteristics of the attempter groups were broadly similar, although clinical characteristics varied significantly. Suicide intent and a regret that an attempt did not succeed was more common in the Asian sample. Asian women were more likely to regret that they had failed because they did not know how many tablets to take. White women took more tablets in overdose, and although there were no differences between the groups in preparing for the attempt (i.e. writing a will or suicide note) ingestion of fewer tablets was a feature within the Asian sample. Unlike previous reports, both samples showed a significant proportion of major or minor psychiatric disorder, and Asian attempters were also more likely to have had health related life events which suggests the possibility of arranging preventive strategies through early diagnosis, use of telephones help lines, and early and assertive psychiatric management.

Unlike previous reports from the UK but confirming some American observations a significant proportion of our sample had previously attempted suicide. Longitudinal studies in this group of patients may give a clue to the contributing factors and suicidal intent. Two possible factors to emerge from interview of the respondents were a sense of a desperate need for something to be done, with simultaneous reluctance to give information about a private and deliberate act. Those who agreed to the interview process were more likely to be in-patients – once they had been discharged from hospital, repeated contacts with a female Asian researcher who spoke their language and understood their culture were usually unsuccessful. We suggest that future researchers in this field give much thought to the method of recruiting subjects.

Perceptions of racial harassment and reporting of racial life events suggest that in the Asian group racial harassment though present was not a markedly significant factor. Significant life events in Asian attempters were to do with relationship difficulties, suggesting that pressures because of family and relationships and resulting conflict are important precipitants in deliberate self-harm in this group.

We believe that even though we have used the term 'White' and 'Asian', these terms are sometimes ambiguous. Within the 'White' category we have included British and Irish for the sake of simplicity, but the uniqueness of these cultures should not be under-emphasized.

Conclusions

It is evident that rates of attempted suicide are much higher in the Asian females when compared with Asian males as well as White women. Some of the possible reasons for these elevated rates include social and cultural stress. Interestingly, racial pressures and harassment were not increased in the two Asian groups but interracial relationships and a level of less traditional views were common in the Asian attempters. More attention must be paid to better recruitment and future research must be multicentred and include numbers of Asians who belong to different religions in order to ascertain the role of religion.

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