

# Women and Suicide in Palestine: Victimization, Loss, Socio-Psychological Factors and Lack of Support - A Phenomenological Study

Mrs. Einas Abu Safa<sup>1</sup> MSN, Dr. Sabrina Russo<sup>2</sup> PhD, Dr. Aidah Alkaissi, PhD<sup>3</sup>

1. An-Najah National University, Faculty of Higher Studies- Nablus-Palestine

2. An-Najah National University-Faculty of Medicine and Health Sciences-Nursing & Midwifery Department- Nablus-Palestine

3. Aidah Alkaissi, An-Najah National University-Faculty of Medicine and Health Sciences-Nursing & Midwifery Department- Nablus-Palestine

This paper was presented in the 1st nursing international conference, at king Abdullah Medical City, Jeddah, Saudi Arabia, 2015.

## Abstract

**Background:** Despite the protective factors of Islam suicide, female suicide attempts exists in Palestine. However there is little information about the causes, risks or protective factors regarding suicide for women in Palestine. **Aims:** This study investigates the history and experiences of Palestinian women who have attempted suicide in order to better inform policy makers, service providers and the international community about steps need to reduce this disturbing trend. **Methods:** Guided interviews were completed with 20 female suicide attempt survivors in Palestine using a qualitative phenomenological method to analyze the data. **Results:** Five themes emerged: victimization related to violence; Loss (family members, cultural identity, relationships, and security); psychological factors ; socio-cultural factors; and lack of support systems. **Conclusion and Recommendation:** The findings of the study demonstrate the importance of understanding the experience of suicide in the female population in Palestine, looking at risks related to victimization, loss, and lack of personal control. The findings reflect the need for a holistic national strategy for prevention including support for mental health and advocacy programs for women, demanding basic human rights, prohibiting cultural practices such as child marriage, providing economic and social support and promoting Islamic values rather than traditional customs.

**Keywords:** Suicide, Women's Issues, Palestine, Victimization, Socio-cultural factors

## 1.Introduction

Despite the fact that suicide is viewed as a global public health issue, it has nonetheless remains unacknowledged and under-studied in Arab countries. In Palestine, only two relevant studies have been conducted and published in modern psychosocial journals (Dagbah, 2005).

Data from the Police Research Unit in Palestine shows an increase in suicide and suicide-attempt rates in the last five years. 60.6% of those who attempt suicide in Palestine (West Bank and Gaza Strip) are women. Suicide rates are said to be underestimated due to the social stigma behind the subject, with most recorded as accidents (Police Research Unit, 2013).

A statistical analysis of suicide in Palestine was presented by Dabbagh in 2005. Documentation was gathered from hospitals, clinics, individual doctors and legal records. The epidemiology was found to be very similar to western countries. Attempted suicide was more common than completed suicide, in a younger, mainly female population, and often using 'soft' methods such as prescription or illegal medications. Fatal suicide appeared to be generally committed by older individuals, primarily male, and using more violent methods.

In addition, Dabbagh (2005) discusses the manner in which suicide statistics are recorded in Palestine. As suicide is regarded as a crime, all incidents are subject to police report. It was noted that single men arriving without family members were much more likely to be reported than women who came in with a family member (generally male). The latter were almost never reported. These decisions, made by health care workers greatly influence the accuracy of the statistical data regarding suicide in Palestine.

It is well documented that more men than women actually commit suicide, while women make more suicide attempts. This indicates that women are at a significantly higher lifetime risk of attempting suicide than are men (Cooperman et al. 2005; Oquendo et al., 2007).

Suicide is the fourth leading cause of death for women between the ages of 15 and 44 years of age, exceeding the number of deaths due to homicide, HIV, cerebrovascular disease (CVD), and diabetes (CDC, 2009). Although women have lower rates of suicide mortality than men, the fatality rates have not decreased in recent years. In 1999, the suicide rate among women aged 15–44 was 4.8 deaths per 100,000 people; in 2006, it was 5.0 deaths per 100,000 people (CDC, 2009).

Stressful situations such as unemployment, poverty, familial death, and divorce can increase the risk of suicide (Werneck, et al. 2006). Suicide in women is more related to cultural and social contexts. Social norms and values are often stringently applied to women putting them at greater risk (Rudmin, et al.2003). Factors associated to psychiatric disorders and suicidal behavior in women of in low-income countries includes early marriage, lack of autonomy, coercion to have children, and economic dependence on men (Khan, 2005).

Durkheim (1952) argue that suicide should not be viewed only as individual biological, psychological, or psychiatric phenomena, but also as a social phenomenon.

Most research reports lower suicide rates in Islamic countries such as Kuwait, Bahrain, Jordan, and Egypt compared with the Western societies (Lester, 2006). There are multiple factors to be considered, one is that fact that suicide is considered a great sin in Islam, familial obligation, especially for women is very strong, and factors that reduce inhibition ( alcohol and drug use) are not easily available. However, it is also likely that due to taboo and criminalization the majority of cases are not reported. Islam stresses the sanctity of life as the highest priority. The Quran states:

“and taken no life which Allah made sacred, except by way of justice and law.”(al\_An’am: 151)

“and kills (or destroy) not yourselves; verily, Allah is most merciful to you.”(al\_Nisa’,29).

Palestinian society is patriarchal, tightly knit and conservative. Segregation of genders for most activities is common. Generally, women marry and dedicate their lives to building families early in life. In 2012 about five percent of women aged 15-49 were married before the age of 15 and had their first child (16%) before the age of 17 (Palestinian Central Bureau of Statistics, 2012).

Women in Palestine find their situation particularly challenging with obstacles placed the Israeli occupation, societal patriarchy, and legal inequality. Amnesty International describes the situation of Palestinian women as a triple challenge: (1) as Palestinians under Israeli military occupation which controls every aspect of their lives (2) as women in a society governed by patriarchal customs, (3) as unequal members of society subject to discriminatory laws.

The multiple effect of violence on Palestinian women constitutes a risk to the wellbeing of women. Women come to believe in their own inferiority, and inability to affect positive change for themselves, their families or their society leading to suicidal considerations.

If society places a low value on certain members, they, in turn, will perceive themselves as having a lesser worth in society. Due to being devalued by both the external society of the occupiers and the internal society consisting of their own culture, as well as by their nuclear family, women are silenced and experience the loss of self- actualization.

Suicide among women is an unspoken dilemma within Palestine. It is therefore important to know the factors, which lead women to a decision of suicide in order to identify risk factors, strengthen protective factors and advocate for societal and legal changes that support women in having positive opportunities to affect changes in their lives.

## **2. Significance of the Study**

In line with the recommendations of several suicidology scholars (Cutcliffe, 2005; Cutcliffe et al, 2004; Hawton, 2001), this study explores the phenomenological experience of those women who have attempted and survived suicide. As such, it can complement and enhance the voluminous quantitative research on the topic. Studying the topic in this way may also open new pathways toward understanding suicide attempts and clinical intervention. It will help to move the individual from a less empowered position to one in which their own experiences and words are the expert and generative force behind the practitioner's understanding of this phenomenon.

Suicide and suicidal attempt behavior have come to be seen as a major international public and mental health issue. According to WHO, suicide is a major preventable cause of premature death. To identify the risk of suicide is the first step in developing national prevention strategy for suicide. In Palestine the only study describes and discusses the issue of suicidal behaviors carried by Dabbagh (2005). So we lack the research evidence and the data to understand the phenomena of suicide in Palestinian community, and to what extent it affects health and life of Palestinians.

## **3. Methods and procedure**

### *3.1 Study design*

The method used is a descriptive phenomenology, which was found by Giorgi (1985). The aim of phenomenological psychology following Giorgi (1971) is to produce accurate descriptions of human experience. For this reason, phenomenologists operating within this tradition mainly utilise descriptions provided by others, usually obtained through interviews (Giorgi, 1985).

### *3.2 Study Participants*

The study included 20 Palestinian women who have survived a suicide attempt. Participants were recruited from

national and non-governmental organizations involved in mental health activities and human rights issues in the West Bank. Potential subjects were given information about the project and their rights as a volunteer research participant. Inclusion was based on the survival of at least one suicide attempt with no previous diagnosis on mental illness. Data collection was the home of some participants or the centers they attended for therapy to insure subject comfort.

### *3.3 Study period*

The study sample collected between September 2013 and finished at September 2014.

### *3.4 Inclusion Criteria*

Adult Palestinian women survive after suicide attempt once or more and never diagnosed with mental illness.

### *3.5 Exclusion Criteria*

Females that diagnosed with mental illness

### *3.6 Study Instruments*

Data was collected by a semi-structured interview addressing themes of risk and prevention created by the first author during a pilot study. It focused on the gathering of accurate and personal descriptions of the experience of each woman before, during and after the suicide attempt.

### *3.7 Data Collection*

After completing the consent process, the guided interview was initiated. Interviews lasted between 60-90 min. Questions were open-ended and designed to gather information from the participant's perspective. Follow-up questions were asked only to get a more detailed and in-depth description (Robinson & Englander, 2007). The interviews were transcribed verbatim and all identifying features were excluded to ensure anonymity. All interviews were first listened through, printed and then similarities were recorded in a meaningful merger operation. Some quotes were saved in their original form.

The semi-structured interviews with women reflected the experience of the women leading up to and for a period of time after the suicide attempts. The interview focused on information about the events taking place in the life of the participant directly before the attempt of suicide related to the attempt; previous history of stressful life events and the coping mechanisms used to decrease stress; history of other suicidal attempts, childhood experiences; support systems available (professional and nonprofessional). A debriefing session was conducted at completion to decrease the stress provoked from recalling the experience of the attempted suicide.

### *3.8 Data Analysis*

The entire transcript for each interview was read several times. The idea was to obtain a description of the experience from the subject's perspective, not to explain or construct (Giorgi, 1989). The second step (Giorgi, 1986) is to separate the responses into sections that reflect the meaning of the experience (Giorgi, 1985). Aggregate themes that were relevant to the phenomenon that is being studied were then identified.

These themes are then expressed in psychological terms that do not interfere with personal nature of the phenomenon. This is called the transformation of the subject's lived experience into direct psychology terminology.

### *3.9 Evaluating the quality of phenomenological research*

When presenting phenomenological research, its value is established through honoring concrete individual instances and demonstrating fidelity to the personal phenomenon (Wertz, 2005). Research reports may, for example, contain raw data such as participants' quotations providing an opportunity for readers to judge the soundness of the researcher's analysis.

### *3.10 Ethical considerations*

The study was reviewed and approved by An-Najah National University's Research Ethics Boards. Additional ethical review processes were necessary due to the nature and location of the study. As discussed before, suicide is a very sensitive and stigmatized issue in the Palestinian community and much more so for women, thus challenging to approach. Approval was received from the Ministry of Health, the Ministry of Social Affairs and the Police Center, as well as all the NGO's from where participants were recruited.

The informants who met the selection criteria, after their wish to be part of the study, approved either by telephone call from the researcher or by the referral person, or institution. Information about the study and its purpose briefly explained. Women signed consent and informed by the interviewer, both verbally and in writing for the purpose of the interview and study in details, at the same time, the agreement was made on the

time of the interview.

The interview conducted in a private room which just the informant and the interviewer present. The interview recorded by tape recorder and no individuals can be identified after text processing. Information on all bands and prints the text stored under the current rules in locked cabinets.

The data stored until the investigation is completed. After that all the material from the interviews will be destroyed. The voluntary nature of the study explained carefully, they informed that they are free to participate in the study or not and that at any time can withdrawn from the study, and that these will not affect them in any way. Also they are free not to say their real names.

Clients who expressed an interest in the study where then approached by the researcher who more fully explain the purpose of the study, potential risks, and benefits of participation, the way in which data gathered, and the ways in which privacy and confidentiality maintained. If they met the criteria and were interested in taking part of the study, they were invited to participate.

Debate elated to suicidal research arise in many countries around the world as many scientists suggest that research on suicidal behavior carry many benefits, risks, or harm to participant inside.

Benefits include increase understanding of suicide as experience which considered by many to be a means to improving recognition, screening, and treatment of illness and ultimately prevention of suicide. Also being involved in research could be beneficial to participants directly. As people identified as suicidal via the research would be assessed and referred for treatment or would gain self-understanding and seek counseling or other help.

There are different ways that the process of research could be directly therapeutic: by providing the opportunity for participants to exercise altruism (a sense of contributing to the greater good and helping others), by conveying hope (the researcher demonstrating caring and concern), by gaining personal insight (into own psychology and situation), by gaining a sense of universality (that they are not alone and others suffer similarly), and by being listened to (having the opportunity to talk and be heard).

Risk of harm for participant is dominant theme in ethical issues related to suicide. Scientists suggested that suicidality might be exacerbated or “reinforced” by bringing attention to suicidal thoughts and feelings, revisiting or bringing up distressing material, inadvertently confirming the insolubility of problems, normalizing and advertising methods of suicide, and raising hope for assistance but not being able to provide any. Not having access to the right kind of supports to assist participants was mentioned by many people as being potentially problematic (Lakeman and FitzGerald, 2009).

Others pointed out that this was a vulnerable population and could readily be coerced or manipulated into participating in research or treatment. Further kinds of potential for harm cited the potential stigma of been labeled mentally ill, and the intrusion that research might entail (Lakeman and FitzGerald, 2009).

These considerations are based on the Helsinki Agreement (World Medical Association Helsinki Declaration, 2008) on ethical guidelines for nursing research on volunteerism, to withdraw from the project, potential risks or discomfort, anonymity, confidentiality and contacts for any information needed.

Phenomenological studies are always retrospective (Hedelin, 2001). The women will tell their stories of adventures. To construct the stories seem to be a natural human process that assist individuals in understanding the experiences and themselves (Pennebaker, 2000). How can it be a health effect for informants to participate in the survey? There is a significant, positive, consistent and identifiable relationship between talking about emotional difficult experiences and health. To construct their own history is a type of knowledge that helps to organize the emotional effects of experience as well as experience in itself. Audio recording, for example, might be perceived as unpleasant for some people and therefore we are always asked for permission. Being able to tell their history can be experienced as healing in itself. At the same time it might give some benefits for other parents and teachers in the same situation as a whole.

By telephone calls the women were informed to obtain consent to conduct the interview. We were very clear to explain to informants that their participation in the study be kept confidential and that the information that we have served will not be disclosed to anyone else and that the material will only be used in this study and that when the investigation is completed, the interview material will be destroyed and sound recordings erased. We also announced that the informants will be made anonymous in the presentation of the results.

The informants' identities were protected fully. No names or other information that may reveal informants' identities were reported. Our intention has been to maintain a moral researcher behavior, which means not just ethical knowledge but also includes our personality, sensitivity and commitment to moral issues and actions.

Risk of harm for participants is a special consideration in research related to suicide. Access to ongoing support was addressed for all participants.

#### **4. Results and discussion**

In total, 20 interviews were conducted. Demographic information is included in Table 1.

**Table (1) demographic data of all women at the time they attempt suicide**

#	Age of the women	Marital status	Age of the husband	Education Of the women	Education Of the husband	Work of the women	Work of the husband	Number of children	Place of residency
1.	37	married	54	7 <sup>th</sup> class	4 <sup>th</sup> class	Not working	carpenter	5	city
2.	35	Married	38	Lawyer	Lawyer	Not working	Lawyer	4	village
3.	21	single	-	Failed Tawjihi	-	prostitution	-	-	camp
4.	44	married	48	Tawjihi	Diploma	Not working	Not working	6	village
5.	23	single	-	university student	-	Not working	-	-	city
6.	20	single	-	Diploma of nursing student	-	Not working	-	-	village
7.	22	engaged	26	university student	Bachelor in science	Not working	Teacher	non	village
8.	18	single	-	11 <sup>th</sup> class	-	Not working	-	-	village
9.	21	single	-	Tawjihi	-	Not working	-	-	village
10.	21	single	-	university student	-	Not working	-	-	city
11.	23	married	27	university student	10 <sup>th</sup> class	Not working	Not working	2	camp
12.	25	Divorced	40	10 <sup>th</sup> class	6 <sup>th</sup> class	Not working	Merchant	3	camp
13.	21	engaged	26	Diploma of nursing	Bachelor in engineering	Nurse in hospital	Engineer	non	city
14.	19	single	-	university student	-	Not working	-	-	city
15.	27	married	32	university student	Bachelor English language	Not working	Teacher	non	city
16.	26	single	-	Bachelor Arabic language	-	Not working	-	-	village
17.	27	married	45	Tawjihi	Tawjihi	Not working	Merchant	non	city
18.	18	single	-	Failed Tawjihi	-	Not working	-	-	city
19.	18	single	-	Failed Tawjihi	-	Not working	-	-	village
20.	42	divorced	-	10 <sup>th</sup> class	-	servant	-	9	village

The analysis of the data was based on the Giorgi method in phenomenological qualitative research. Five major themes (with 18 sub-themes) emerged after data analysis in Table 2

**Table (2) Themes and subthemes that emerged from women's interviews**

Subthemes	Themes
1. Sexual violence 2. Domestic violence 3. Collective violence 4. Witnessing abuse 5. Child maltreatment	<b>I. Victimization</b>
1. Loss of parents 2. Loss of cultural identity 3. loss of relation 4. Loss of security	<b>II. Loss</b>
5. Low self efficacy 6. Low self esteem 7. Negative self image 8. Maladaptive coping mechanism	<b>III. psychological factors</b>
1. Poverty 2. Stigma 3. Dysfunctional family	<b>IV. Socio cultural factors</b>
1. Non professional 2. Professional	<b>V. Lack of support</b>

#### 4.1 Victimization

Our findings confirm the important and consistent relationship between women's suicide attempts and victimization. All women in this study had at least one experience of violent victimization. These results were

compatible with the the results of similar research that discusses the reasons and risks lead to suicide (Rezaeian 2010, Ghaleiha 2012, Dabbagh 2005, Keyvanara and Haghshenas 2011).

In current study women had histories of rape, harassment and sexual abuse by intimate partners and strangers, they expressed that these traumatic experience lead to a feeling of helplessness and despair which was unbearable and subsequently the suicide attempts.

Women and girls make up the majority of victims of sexual abuse and intimate partner violence (Guggisberg, 2006). Experiences of sexual abuse and assault are linked to suicide and suicide attempts (Ansari et al., 2001, Curtis, 2006, Holmqvist et al., 2008). Victims of sexual abuse and intimate partner violence are more likely to report having depression, post-traumatic stress disorder, anxiety disorders, eating disorders, and excessive alcohol consumption (Curtis, 2006). The findings of these studies are compatible with the result of the current study.

Similarly, intimate partner violence is a risk factor for suicide (Stewart, 2005, Guggisberg, 2006, Guggisberg, 2008). Vic Health, 2004, showed that intimate partner violence is the leading contributor to death in women aged 15 to 44 years, accounting for ten percent of deaths, more than half of which were due to suicide. Other studies reveal that women who have experienced intimate partner violence are almost four times more likely to have suicidal ideation than non-abused women (Taft, 2003). In current study all the married women reported intimate partner violence.

Many studies in accordance with current findings support the positive relationship between childhood sexual abuse histories for a women and increased risk for suicidal thoughts and behaviors (Gladstone et al., 2004). This heightened risk cannot be ascribed solely to the elevated rates of depression found among sexually abused women (Andover, Zlotnick, & Miller, 2007; Joiner et al., 2007).

The majority of women in this study were not employed and expressed that economic factors forced them to stay in abusive situations. One participant states:

***“My husband hit me, and cursed me. He rapes me after all that many times. I have severe and intolerable emotional pain. I cannot think, I have nothing to do, I feel helpless and hopeless. It was like I lost all the things I ever had”.***

#### 4.2 Loss

Losses of varied types were a clear initiating factor for suicidal thoughts in this sample. The loss of father, broken relationships, and divorce were identified by participants to have influenced their suicidal thinking. In a previous study, incidence of parental loss was found to be significantly higher in suicidal than in non-suicidal subjects. (Greer. S, 1980)

The death of father is crucial in the Palestinian context as the father is the source of power and support both financially and socially. One subject who lost her father as an infant equated this event to losing her whole family.

Dabbagh, (2005), in her study about suicide in Palestine reveals the role of loss and despair leading to suicide in the majority of cases in her study including loss due to death, divorced, homes or land and employment.

Loss of someone who provides emotional, informational, and/or material support has been shown to leave adults seriously vulnerable to suicide (Conroy & Smith, 1983; Hart & Williams, 1987). Also, divorce, separation, and chronic family discord, have been related to suicide attempts in previous research (Crook & Raskin, 1975).

In the current study two subjects attempted suicide after divorce. The loss in divorce is multiple including financial support, children and shelter.

Most of the women interviewed had precipitating events characterized by loss or interpersonal conflict, especially linked to poorly developed coping or conflict resolution skills. This is in concordance with a recent study that found nearly 75 per cent of suicide attempts in females occurred within one month of the breakup of a significant relationship (Baume, Cantor & McTaggart, 1996).

Other research reported that nearly one third of a consecutive series of 31 female who attempted suicide had experienced loss of a close interpersonal relationship within six weeks or less of their death. In other study of 50 suicides, they found that 26% had experienced such loss within six weeks, Chapman et al. (2013). Similar results were noted in this study as 35% of the participants attempted suicide after the breakdown of a relationship. One stated:

***“We were in love, but our relationship had broken down. He didn’t want to stay with me, I preferred to die.”***

Another started to use drug and alcohol after the termination of a relationship where she adopted political and religious values of others, and lost her own. She said:

***“I changed my beliefs and my values just for him. I started to wear hijab when he asks me to do so. I want to be religious because he was a religious man (sheikh). Then he left me. I took off the hijab and start to drink alcohol and use drugs”.***

In the current study 65% of individuals expressed loss as a main theme in their suicidal behavior. One participant noted:

***“At the moment my father died my life stopped, in other words I am dead also.”***

#### **4.3 Psychological factors**

Negative body image was a primary precipitant in 30% of our sample. In 2009, and Eaton DK et al. 2005, reported that Body Mass Index was significantly associated with both body image dissatisfaction and suicidal ideation. Another study found that feelings of social exclusion and stigmatization have been associated with increased suicidality in dermatology patients of both genders (Gupta MA; Gupta AK, 2013).

In the current study body dysphonia related to weight, physical deformity, and perceived lack of beauty was a relevant factor.

Low self-esteem has also been linked to the development of emotional problems, anxiety disorders, suicidal behavior, behavior disorders and depression (BHAR et al, 2008). Our findings confirmed that women attempting suicide had low self-esteem.

Research has shown suicidality to be a process (Beskow et al. 2005, Williams JMG. and Pollock LR. 2001, Mehlum et al. 2005). Events and established attitudes from early phases in life such as loss, low self-esteem, identity issues and attitudes to feelings as a nonissue are seen as contributors to the commencement of the suicide process.

90% of the participants in the sample noted events and conditions in early stages, and throughout their lives, which have contributed to forming their attitudes to themselves and to life in general.

#### **4.4 Sociocultural Factors**

Suicide rates are higher in samples from divorced families. Studies by Goldney (1982), Trovato (1986), and Adams, Bouchoms and Steiner( 1982), show a statistically significant incidence of separation and divorce in the families of adolescents who attempt suicide as compared with control groups.

Further, research shows a very close link between suicidal behavior and parent-child relationships (Hughes, 1999). Perceptions of social and family support and connectedness have been shown to be significantly associated with lower rates of suicidal behaviour (O'Donnell et al,2004). Other findings suggest that feelings of loneliness are associated with an increased risk of suicide attempt (Hjelmeland and Groholt, 2001. Stravynski, and Boyer, 2001), and that family and social support are protective factors [Nock et al., 2008]. These finding were supported in our sample with 60% identifying family conflict either current or past.

In his study on the impact of parental status on the risk of completed suicide (Qin and, Mortensen, 2003) concluded that having children, especially young children, is protective against suicide, a finding not reflected in our study as 30% of the sample had children.

Schmidke, (1996) concluded from the WHO/EURO Study that “compared with the general population, suicide attempters more often belong to the social categories associated with social destabilization and poverty”. In our sample poverty, early marriage, low level of education, unemployment were all raised as major contributing factor in suicidal behavior among women in Palestine.

Cultural and social stigma were noted associated with honor and guilt. One lady said:

***“We are a family that consists of 12 persons. We didn't have food to eat, we were living in two rooms. Poverty pushed me to prostitution and shame; I have no place in my home or even in this life. I decided to leave this life and I will”.***

Research suggests that Child and family support programs, including employment assistance and legal guarantees of gender equality, could moderate problems of socio-economic disparity and poverty, which predict suicidal behaviors in both adult and children. One participant reported

***“I have 9 children, one is mentally retarded. I am divorced, not educated, with no job or profession. My husband abused me and my daughters before divorce. We had no family to support us. We need governmental support, and social support. We need laws to protect our rights as women”.***

#### **4.5 Lack of support**

While problems in interpersonal relationships may increase the risk of suicidal behavior, social isolation can also be a precipitating factor for suicidal behavior. A large body of literature suggests that individuals who experience isolation in their lives are more vulnerable to suicide than those who have strong social ties with others.

Most of the participants interviewed suffered from loneliness, isolation and lack of social support. The stigma associated with mental health services was noted as an obstacle for women to seek professional support.

Tandon et al (2013) used cluster analysis to explore how coping, stress, and social support align and intersect with each other and relate to levels of suicidal behaviors. They reported high levels of depressive symptoms, suicidal ideation and as intimate partner violence in groups with low social support.

In the Palestinian sample a lack of effective coping skills, high environmental stress and low social

support were related to suicidal behaviors.

In addition, professional support prior to the attempt was non-existent in the sample. A few individuals sought help after the suicide attempt and some percentage found it was helpful.

The lack of economic support proved a higher risk for younger women and those with minor children. The multivariate analysis showed that lack of emotional support was a better predictor of suicidal ideation in middle-aged women.

Research indicates that a disruption in family structure, due to migration, divorce, death or intense conflicts among family members—may trigger suicidal behavior (Gulbas et al., 2011). These factors were noted in our sample. The participants expressed their need for support as follows:

*“After my husband was arrested and entered prison, we needed someone to stand beside and support us. Someone to provide food and shelter for me and my children. Provide us with safety and peace of mind. We were threatened to be killed every moment. No one offered this support, nor my family or the family of my husband. Death was the best choice for me and for my children.”*

Another stated:

*“The police said that they will protect me. They sent me to the shelter; it is the same as prison. Then they sent me to the mental hospital. It was horrible. And now they want to send me back home. My father will kill me, you will see, for the honor of the family”.*

## 5. Conclusions

World Health Organization (2010), and US Department of Health and Human Services (2001), stressed the need for suicide prevention efforts all over the world including strengthening social support, promoting development of coping skills, changing policies and norms to encourage effective help-seeking behaviors, and enhancing the early detection and treatment of at-risk individuals were created, as well as addressing global justice issues.

In the case of Palestine the current investigation suggests the following steps to begin to address the risk and protective factors for women in regard to suicidality:

1. Acknowledging the presence of suicide and increase awareness of risk and protective factors for the general public
2. Decrease victimization of women and provide support services when violence against women has already occurred.
3. Strengthen the health and legal sectors in responding to suicide attempts.
4. Increase accurate data collection and research into the lives of women in Palestine.

The tragic loss of life by suicide in a population of women so critical to the wellbeing of their families and society must be regarded as a critical concern for Palestine and the global community. The steps recommended are related to basic human rights and human living conditions due to all people. It is hoped that this investigation can place a spotlight on this greatly underserved population.

## References

- Adam, K.S., Bouckoms, A., Streiner, D. (1982). *Parental loss and family stability in attempted suicide. Archives of General Psychiatry*, 39, 1081–1085.
- Andover, M.S., Zlotnick, C., Miller, I.W. (2007). Childhood physical and sexual abuse in depressed patients with single and multiple suicide attempts. *Suicide and Life-Threatening Behavior*, 37, 467–474.
- Ansari, G., Chippis, J., Stewart, G. (2001). Suicide in NSW: the NSW suicide data report. *NSW Public Health Bulletin*, 12(3), 80-4.
- Beskow, J., Palm Beskow, A., Ehnvall, A. (2005). *Suicidalitetens språk. (The Language of Suicide)*. Studentlitteratur, Lund, Sweden.
- Bhar, S., Ghahramanlou-Holloway, M., Brown, G. Beck, A. T., (2008). Self-esteem and suicide ideation in psychiatric outpatients. *Suicide Life-Threat*, 38, 511-516.
- Cantor-Christopher, H., Baume, P., Turrell, C. (1996) Australian Institute for Suicide Research and Prevention.
- Centers for Disease Control and Prevention (2009). Web-based Injury Statistics Query and Reporting System (WISQARS). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2009. Available at [www.cdc.gov/ncipc/](http://www.cdc.gov/ncipc/), accessed May 12, 2009.
- Chapman, A.L., Gratz, K.L., Turner, B.J. (2013). Risk-Related and Protective Correlates of Nonsuicidal Self-Injury and Co-Occurring Suicide Attempts among Incarcerated Women. *The American Association of Suicidology*.
- Conroy, R.W. & Smith, K. (1983). Family loss and hospital suicide. *Suicide and life-threatening Behavior*, 13, 179-194.
- Cooperman, N. A., & Simoni, J. M. (2005). Suicidal ideation and attempted suicide among women living with HIV/AIDS. *Journal of Behavioral Medicine*, 28, 149–156.
- Crook, T., & Raskin, A. (1975). Association of childhood loss with attempted suicide and depression. *Journal of*

- Consulting and Clinical Psychology, 43(2), 227.
- Curtis, C. (2006). Sexual abuse and subsequent suicidal behaviour: exacerbating factors and implications for recovery. *Journal of Child Sexual Abuse*, 15(2), 1-21.
- Cutcliffe, J.R. (2005). Toward an understanding of suicide in first-nation Canadians. *Crisis*, 26(3), 141-145.
- Cutcliffe, J.R., Joyce, A., & Cummins, M. (2004). Building a case for understanding the lived experiences of males who attempt suicide in Alberta, Canada. *Journal of Psychiatric*.
- Dabbagh, N. (2005). *Suicide in Palestine: Narratives of Despair*, London. C. Hurst & co.
- Douki, S., Ben Zineb, S., Nacef, F., & Halbreich, U. (2007). Women's mental health in the Muslim world: cultural, religious, and social issues. *Journal of Affective Disorders*, 102(1e3), 177-189
- Durkheim, E., *Suicide : A study in sociology / by Emile Durkheim ; translated by John A. Spaulding and George Simpson ; edited with an introduction by George Simpson*. London : Routledge & Kegan, 1952, 404 p. ; 22 cm. ISBN 0710033117
- Eaton, D.K., Lowry, R., Brener, N.D., Galuska, D.A., Crosby, A.E. (2005). Associations of body mass index and perceived weight with suicide ideation and suicide attempts among US high school students. *Arch Pediatr Adolesc. Med. National Center for Chronic Disease Prevention and Health Promotion*, 159(6), 513-9.
- Ghaleiha, A., Afzali, S., Bazayr, M., Khorsand, F., Torabian, S. (2012). Characteristics of Hospitalized Patients Following Suicide Attempt in Hamadan District, Iran. *Oman Medical Journal* 27(4), 304-309.
- Giorgi, A., Fischer, W.F., & von Eckartsberg, R. (Eds.) (1971). *Duquesne Studies in Phenomenological Psychology: Volume 1*. Pittsburgh, PA: Duquesne University Press and Humanities Press.
- Giorgi, A. (1985). Sketch of a psychological phenomenological method. In A. Giorgi (Ed.), *Phenomenology and psychological research* (pp. 8-22). Pittsburgh, PA: Duquesne University Press.
- Gladstone, G.L., Parker, G.B., Mitchell, P.B., Malhi, G.S., Wilhelm, K., & Austin, M.P. (2004). Implications of childhood trauma for depressed women: An analysis of pathways from childhood sexual abuse to deliberate self-harm and revictimization. *American Journal of Psychiatry*, 161, 1417-1425
- Greer, S. (1980). The Relationship between Parental Loss and Attempted Suicide: A Control Study. *The British Journal of Psychiatry*, 305-314.
- Guggisberg, M. (2006). The interconnectedness and causes of female suicidal ideation with domestic violence. *Australian e-Journal for the Advancement of Mental Health*, 5(1), 7
- Guggisberg, M. (2008). Intimate partner violence: a significant risk factor for female suicide. *Women against Violence: An Australian Feminist Journal*. (20), 9-17.
- Gulbas, L., Zayas, L., Nolle, A., Kuhlberg, J., Hausmann-Stable, C., Baumann, A., & Pen, B. (2011). Family relationships and Latina teen suicide attempts: Reciprocity, asymmetry, and detachment. *Families in Society*, 92, 317-323.
- Gupta, M.A., Gupta, A.K. (2013). Coetaneous body image dissatisfaction and suicidal ideation: mediation by interpersonal sensitivity. *J Psychosom Res. Department of Psychiatry, Schulich School of Medicine and Dentistry, University of Western Ontario, London*, 75(1), 55-9.
- Hawton, K. (2001). Studying survivors of nearly lethal suicide attempts: An important strategy in suicide research. *Suicide and Life-Threatening Behavior*, 52, 76-84.
- Hedelin, B., Strandmark, M. (2001). The meaning of mental health from elderly woman's perspectives: A basis for health promotion. *Perspectives in Psychiatric Care*, 37:7-14.
- Hjelmeland, H., Groholt, B., (2005). A comparative study of young and adult deliberate self-harm patients. *Crisis*. 26(2), 64-72.
- Holmqvist, R., Carlberg, M., Hellgren, L. (2008). Deliberate self-harm behaviour in Swedish adolescent girls reports from public assessment and treatment agencies. *Child and Youth Care Forum*, 37(1), 1-13.
- Hughes, P., (1999). Changes in the family linked to rise in teenage suicides, *The Age*. Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety, and Suicide. *Journal of Women's Health*. Volume 15, Mary Ann Liebert, Inc.
- Jahshan, P. (2001) *Henry Miller and the Surrealist Discourse of Excess: A Post-Structuralist Reading*. New York: Peter Lang.
- Joiner, T., Sachs-Ericsson, N. J., Wingate, L. R., Brown, J. S., Anestis, M. D., & Selby, E. A. (2007). Childhood physical and sexual abuse and lifetime number of suicide attempts: a persistent and theoretically important relationship. *Behavior Research and Therapy*, 45, 539-547.
- Keyvanara, M., Haghshenas, A. (2011). The Socio-cultural Contexts of Attempting Suicide among Women in Iran. *Health Care for Women International*, 31, 9, 771 -783.
- Khan, M. (2005). Suicide prevention and developing countries. *Journal of the Royal Society Medicine*. 9 8, 98:459-463.
- Mehlum, L. (2005). Om motiver og intensjoner ved selvmordshandlinger. About motives and interventions concerning suicidal acts. In *Utholdelige liv. Om selvmord, eutanasi og behandling av døende*.

- (Unbearable Lives. About Suicide, Euthanasia, and Treatment of the Dying) (Herrestad H, Mehlum L eds), Gyldendal Akademisk, Oslo, Norway, 29–4.
- Lakeman, R., Fitzgerald, M.(2009). Ethical suicide research: a survey of researchers. *Int J Ment Health Nurs*,18(1),10-
- O'Donnell, L., O'Donnell, C., Wardlaw, D.M., Stueve, A. (2004). Risk and resiliency factors influencing suicidality among urban African American and Latino youth. *AM J Community Psychol*. 33, 37-49.
- Oquendo, M. A., Bongiovi-Garcia, M. E., Galfalvy, H., Goldberg, P. H., Grunebaum, M. F., Burke, A. K., et al. (2007). Sex differences in clinical predictors of suicidal acts after major depression: A prospective study. *American Journal of Psychiatry*, 164, 134–141.
- Palestinian Central Bureau of Statistics, (2012). Annual Report. Palestine Children–Issues and Statistics. Child Statistics Series (No. 15). Ramallah–Palestine. [http://www.pcbs.gov.ps/Portals/\\_PCBS/Downloads/book1863.pdf](http://www.pcbs.gov.ps/Portals/_PCBS/Downloads/book1863.pdf)
- Pennebaker, J. W., & Graybeal, A. (2001). Patterns of natural language use: Disclosure, personality, and social integration. *Current Directions in Psychological Science*, 10, 90–93
- Qin, P., Mortensen, P.B.(2003).The impact of parental status on the risk of completed suicide. *Arch Gen Psychiatry*, 60,797-802.
- Rezaeian, M. (2010). Suicide Among Young Middle Eastern Muslim Females, The Perspective of an Iranian Epidemiologist. *Social Medicine Department, Rafsanjan Medical School, Rafsanjan, Iran*, 31(1), 36-42.
- Rudmin, F. W., Ferrada-Noli, M., & Skolbekken, J. A. (2003). Questions of culture, age and gender in the epidemiology of suicide. *Scandinavian Journal of Psychology*, 44, 373–381.
- Schmidtke, A., Bille-Brahe, U., De Leo, D., Kerkhof, A., Bjerke, T., Crepet, P., et al.(1996). Attempted suicide in Europe: rates, trends and socio-demographic characteristics of suicide attempters during the period 1989–1992. Results of the WHO/Euro Multicentre Study on Parasuicide. *Acta Psychiatr Scand*. 93, 327-3.
- Stravynski, A., Boyer R. (2001). Loneliness in relation to suicide ideation and parasuicide: a population-wide study. *Suicide Life Threat Behave*, 31(1), 32-40.
- Trovato, F. (1987). A longitudinal analysis of divorce and suicide in Canada. *Journal of Marriage and Family*, 49, No. 1.
- US Department of Health and Human Services. (2001). National strategy for suicide prevention: goals and objectives for action. Rockville, MD: Public Health Service.
- Vic Health. (2004).The health costs of violence: measuring the burden of disease caused by intimate partner violence. Melbourne: VicHealth; [cited 25 January 2011];
- Werneck, G. L., Hasselman, M. H., Phebo, L. B., Vieira, D. E., & Gomes, V. L. de O. (2006). Tentativas de suicídio em um hospital geral no Rio de Janeiro, Brasil. *Cadernos de Saude Publica*, Rio de Janeiro, 22, 2201–2206.
- Wertz, F.J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology*, 52(2), 167-177.
- Williams, J.M.G, Pollock, L.R. (2001). Psychological aspects of suicide process. In *Understanding Suicidal Behaviour*. John Wiley & Sons, Chichester, 76–93.
- World Health Organization. Suicide prevention (SUPRE). *Mental Health*, 2010, retrieved 2 February 2010, from [http://www.who.int/mental\\_health/prevention/suicide/suicideprevent/en/index.html](http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/index.html).

\*Dr. Aidah Alkaiisi. Dean of the College of Nursing at An-Najah National University, Nablus, Palestine, coordinator of the master's program of nurse anesthesia, former coordinator of the master's program of community mental health nursing, Faculty of Higher Studies-An-Najah National University. International health expert in the United Nations Development Programme (UNDP). Graduate of BSN, MSN, PhD Nursing in anesthesiology from Linköping University - Sweden. Has specialty in nurse anesthesia and intensive care nursing. Higher education specialty from Hadassah University and Linköping University. Has Bachelor of Law, Arabic University of Beirut, Lebanon.