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Report on Parasuicide in Palestinian Society of the West Bank

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The views expressed in the document are solely the responsibility of the author.

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Preface

This report is based on extracts from the PhD thesis ‘Parasuicide in Arab Palestinian Society of the West Bank’ which was submitted to the department of psychiatry at University College, London in the year 2000.

In the main, this report is based on Chapter Four ‘Palestinian Suicide Statistics and their Social Construction’ and the final chapter ‘Conclusions and Recommendations’ as these two chapters were thought to be of the most immediate relevance and interest to (public) health workers in the region.

A copy of the thesis is held in the library of the Institute of Community and Public Health.

Acknowledgements

Completing a thesis needs guidance and encouragement for which I would like to thank my supervisors Professor Murray Last - who also supervised my BSc thesis - and Professor Roland Littlewood, at University College London, and Dr Sylvie Mansour and Dr Rita Giacaman, at Birzeit University on the West Bank.

Without contacting cases and finding data there would be no study, so I would like to thank everyone who helped me with this: all the staff of the Institute of Community and Public Health. Many people on the West Bank assisted me, directly and indirectly, in numerous ways ranging from the provision of background information, practical help and hospitality to linguistic or moral support. I can name only a few: Hala and Areej and all the girls from the dormitory at Inaash Al-Uusra; Anwar Hamam, Shaher Bedawi and Ghassan Khader from the Yaffa Cultural Center in Balata refugee camp; the family of Dalal Howeiti in Jenin refugee camp; and my relatives Dr Ahmed and Mrs Erika Muhtadie.

The core material from which this thesis has been developed was, ultimately, provided by the interviewees and I am especially grateful for their patience. All names and identifying details have been changed to ensure confidentiality.

Above all, I would like to say thank you to my ever-supportive parents, sisters and friends.

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Introduction

Background

As the daughter of a Palestinian refugee, the tremendous political and historical upheavals which the Palestinian people have endured over the last century have always been of great interest for me. I first visited the region that prior to 1948 was known as Palestine and is now split into Israel, the West Bank and Gaza, in 1993. At the age of 19, as a UK citizen, I was granted a one-week visa by the Israeli authorities to enter the country in which my father was born and of which I had heard endless nostalgic tales of sweet smelling orange groves and idyllic houses by the sea in Jaffa. I revisited several times spending one summer in the Palestinian Red Crescent Hospital in Ramallah and another summer in Birzeit University about ten kilometres outside Ramallah.

From my first visit I was impressed by the strength of character of many of the Palestinians I met. However, with every visit I became more disturbed by the enormity of the suffering endured by Palestinians living in the West Bank as it was slowly unveiled to me. It seemed that every household had stories to tell about house raids, imprisonments, beatings, torture and dispossession. But perhaps more insidious, and initially less apparent, was the daily humiliation of life under military occupation. I constantly wondered how people managed to cope with their difficult situation. Although Palestinian Arab society is close-knit and often supportive, it can also be quite conservative and repressive. The thesis is about those people who at some point have not been able to cope with the situation they have found themselves in due to social, economic or political forces or, more often, a mixture of them all.

I had become fascinated by the social and cultural aspects of health as a junior medical student and this lead me to study for an intercalated BSc in

medical anthropology at University College London. During the year I learnt more about the links between health, medicine, society and culture. After completing the BSc, I entered the intercalated MB-PhD programme which is offered at UCL. This PhD thesis, supervised by Professors Murray Last and Roland Littlewood, is the first one to be submitted to the Psychiatry Department as part of this programme.

I arranged to carry out my fieldwork in Palestine and for eighteen months, from the summer of 1997, I was based in the West Bank town of Ramallah at the Institute of Community and Public Health of Birzeit University, which is headed by Dr Rita Giacaman. I was helped in my research by the department as a whole, but mainly by clinical psychologist Dr Sylvie Mansour. I also participated in the organisation and teaching of some public health courses.

Contents of the PhD thesis

The particular focus of my study was the ‘suicide phenomenon’ (zahirat al-intihar) in Palestinian society. At the time I arrived in Ramallah there was increasing public discourse and concern about reports of suicide which was seen as something new and alien. This was highlighted as a topic of public health concern by the university department and my fieldwork consisted of examining and analysing this ‘suicide phenomenon’ and placing it in the context of the Western literature on suicide in which research is predominantly centred on the individual (Chapter One¹).

For the first year I lived in a recently opened girls’ dormitory of ‘The Society for the Revitalisation of the Family’ (Jameeyat Inaash Al-Usra), which also runs an orphanage for girls. This society was founded by a formidable lady, Samiha Khalil, who aimed to give girls and women occupational skills such as hairdressing, sewing, embroidery, cooking and nursing. The young women in the dormitory had come to Ramallah from the towns, villages and camps of the West Bank and Gaza to study or work. Away from their families, such dormitories were considered the most respectable places to stay. For myself, other than dramatically improving my Arabic and enabling

¹ Refers to chapters of the PhD thesis.

me to make friends, living in the dormitory gave me an insight into life in Palestinian society, particularly from the female perspective, since I visited many of the women's houses and families in different parts of the West Bank and Gaza. In addition, I also spent time in hospitals in Ramallah, Jerusalem and Jenin which not only gave me the opportunity to talk to people who had attempted suicide but also allowed me to retain my nascent clinical skills and to learn something about health care in the West Bank.

Although self-harming behaviour, such as parasuicide, is common throughout the world, there seem to be strong cultural variations in its epidemiology. Now that we live in a world which appears to be more 'globalised' and interconnected than ever before there is increasing interest in the effects of 'modernisation' or 'westernisation' on people's mental health, including suicide. However, so far there has not been any in-depth study of suicidal behaviour in the Arab world. Owing to the limited time and resources available, the study can only be labelled 'exploratory'. Nevertheless, I hope it can give an idea as to why some people in the Arab society of the West Bank are turning to self-harming behaviour. The material gathered also raises general questions about the widespread effects of modernisation and the secondary trauma resulting from 'the ripple effect of war', as well more specific questions about why and how some individuals cope with their socio-cultural environments while others do not.

There are two main dimensions to the 'suicide phenomenon': one relates to public discourse on suicide, especially in the media, and the other to private acts of suicide. The thesis begins by concentrating on the public dimension and looks at past and present attitudes to death and self-killing in, largely Islamic, Arab thought. Two predominant cultural categories are identified for self-killing: suicide and martyrdom. These are opposing concepts. Suicide is seen as a private act condemned by society and religion, whereas martyrdom is seen as a public act which is exalted as being for the sake of the greater good. The concept of the self (*an-nafs*) in Islamic thought is compared to western concepts of self, and it is argued that the Muslim concept is more collective and less individualistic (Chapter Two).

Cultural attitudes apart, an understanding of the historical and political

context in which Ramallah exists as a part of the West Bank is offered in an attempt to explain why public discourse on suicide in Ramallah in the 1990's reached almost panic levels (Chapter Three). It is suggested that the very act of suicide, particularly as a result of depression or despair, is regarded as contrary to the popular concept of Palestinian identity. Furthermore, an attempt is made to quantify suicidal behaviour in Ramallah. Methodological issues are discussed together with the difficulties encountered in obtaining data. The extent to which suicide statistics are socially constructed is examined (Chapter Four). The 'suicide phenomenon' in Ramallah could be regarded as a 'moral panic', but it could also, be regarded as a result of the substantial transformations which have occurred in the Palestinian society of the West Bank since the end of the mass popular uprising against the Israeli occupation, the Intifada, followed by the establishment of the Palestinian National Authority and the accelerated 'modernisation' of the society.

The private dimension of Palestinian suicide is examined in the second part of the thesis. Narratives taken from 31 cases of attempted suicide are examined closely within their social contexts (Chapters Six, Seven and Eight. Men and women are considered separately because, in spite of similarities, there are important differences in the way each group seeks to deal with the expectations and restrictions of the social context in which they live. Of the people interviewed, the women were found to be fundamentally affected by marital status, their position within the family and the ensuing demands made upon them, whereas the men were found to be affected by their ability to find steady work, marry and provide for and protect their families.

The importance of the supporting roles of the traditional social institutions of family and religion are discussed, both how they can fail and how they can help individuals to cope with problems. Suicide levels in Palestinian society still appear to be low compared with Western levels in spite of the existence of a large number of those stressors which have been shown to play important roles in contributing to suicidal behaviour in the West. Finally, the recommendations and implications of the findings of this study with respect to social policies are discussed (Chapter Nine).

The thesis is an interdisciplinary one. It made use of some of the ideas, terms and theories from psychiatry and set out some quantitative data. It also drew on anthropology when considering the social context within which the individual acts. The actual evidence presented by this study has been gathered by anthropological methods of field data collection, such as participant observation, in-depth interviews and narrative collection. This is not the only possible approach, but the aim was to explore the extent to which significant and useful inputs can be achieved by using anthropological techniques.

On Parasuicide: definition, characteristics, rates and trends

Definition

The distinction between suicide and parasuicide is based on whether the outcome is fatal or not. The term 'parasuicide' was defined by Kreitman as 'any individual who deliberately initiates an act of non-fatal self-injury or who ingests a substance in excess of any prescribed or generally recognised dose.'² The term parasuicide is frequently used interchangeably with 'attempted suicide.'

It should be noted that the separation of 'attempted', 'non-fatal', or 'para-' suicide from 'successful', 'fatal', or 'actual' suicide has been sharply contested. It is argued that there is an element of chance in much suicidal behaviour, that is to say there are those who may intend to die, but who do not, and those who do not want to die, but who do. In fact, rather than distinguishing between suicide and parasuicide, it may be more appropriate to describe a range of self-destructive behaviour, as 'the suicide spectrum' described by Kate Hill.³ Nevertheless, the distinction can be a useful one as long as the overlap between the two groups is borne in mind.

Characteristics

Characteristic features of parasuicide in the West were highlighted by a

2 N.Kreitman & M.Schreiber, 'Parasuicide in Young Edinburgh women:1968-75' in R.Farmer & S.Hirsch *The Suicide Syndrome*, Cambridge University Press, Croom Helm Ltd, London, 1979/80, p.55.

3 K.Hill *The Long Sleep: Young People and Suicide*, Virago Press, 1995, p.125.

recent WHO study on parasuicide in Europe.⁴ Compared with the general population, 'suicide attempters more often belong to the social categories associated with social destabilisation and poverty.'⁵ Hence, they tend to be female rather than male, mainly young, and often from disadvantaged or poorer social groups such as the unemployed. The methods used by parasuicides are primarily 'soft,' such as poisoning or cutting.⁶

Rates

Looking at the global situation regarding suicide and parasuicide at the beginning of the 90's, Diekstra wrote, 'Suicide behaviours constitute a serious public and mental health problem. In many countries fatal suicide attempts rank among the top ten causes of death for individuals of all ages and among the 3 leading causes of death for those aged 15 to 34 years. In 1980, around the world, an estimated 300,000 to 440,000 persons committed suicide. In addition at least ten times as many persons made non-fatal suicide attempts or deliberately harmed themselves seriously enough to require some kind of medical assistance.'⁷

Trends

Parasuicide is a major health problem. Although some decline in rates between 1989 and 1992 is recorded by the WHO study in Europe, in the United Kingdom deliberate self-poisoning has become the most common reason for acute medical admission of women to hospital, and second only to heart attacks as the most common medical reason for admission of men.⁸ The rise in the overall suicide rates in many countries is to a large extent due to the increase in suicides in the younger age groups. Even countries

4 A.Schmidte et al., 'Attempted suicide in Europe: rates, trends and sociodemographic characteristics of suicide attempters during the period 1989-92. Results of the WHO/EURO Multicentre Study on Parasuicide', *Acta Psychiatr. Scand.* vol 93, 1996, pp.327-338. Based on results from 16 centres in 13 European countries.

5 *ibid.* p.327.

6 This is in some contrast to fatal suicide which generally increases with age, is more common among men than women and methods used are often violent such as shooting or hanging.

7 R.Diekstra 'Suicide and Parasuicide: A Global Perspective' in *Current Approaches: Suicide and Attempted Suicide. Risk Factors, Management and Prevention.* Duphar medical relations, Southampton, 1991, pp.1-22. He goes on to say, 'The real number of persons engaging in any form of deliberate self-harm is unknown, but probably is much greater than the figures that are presently available.' This, Diekstra writes, is due to a number of difficulties with accurate and reliable recording of suicide statistics.

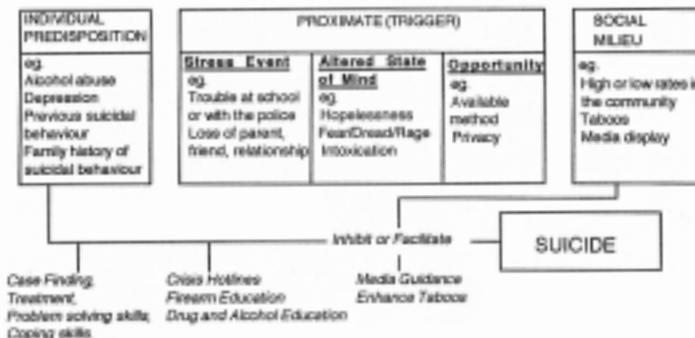
8 K.Hawton & J.Catalan, *Attempted suicide: A Practical Guide to its Nature and Management* Oxford University Press, (2nd edition), 1987. p.3.

with a stable or decreasing overall rate often still witness increasing rates in the young.⁹ Diekstra predicts that ‘the most dramatic increase in suicide mortality in the next decades will be observed in the Third World countries.’ He argues that this is because ‘the socioeconomic and behavioural factors of suicide risk ... are already present in a degree considerably higher than in most developed countries and this discrepancy will, in all probability, only continue to grow. The accompanying toll in human suffering, the decrease in quality of life of those left behind, the loss in years of productive life and related economic and social costs will be beyond the imagination.¹⁰’

Approaches to studying suicidal behaviour

Research into suicidal behaviour has taken three broad approaches: psychological, biological and social.¹¹ A summary of the conclusions from the extensive multidisciplinary research that has been carried out into suicide in general, and parasuicide in particular, has been attempted by the American sociologist David Shaffer.¹² He has drawn together in a single model the current knowledge about the risk factors for suicide, as understood by psychological, biological and social theories (Figure 1.1).

Figure 1.1: Shaffer’s Model of Suicidal behaviour



9 R.Diekstra, op.cit. (1991), pp.9-10.

10 ibid. , p.20.

11 These summaries are based mainly on: ‘Risk Factors for Youth Suicide’ Module Three from The ‘Response...Ability’ Curriculum Resources developed (for use in the university training of professionals in Australia) by the Hunter Institute of Mental Health with the collaboration of academics from the University of Newcastle [from the internet]. Updated November 1998. The main references used in this module were: A.Berman & D.Jobes Adolescent Suicide Assessment and Intervention, American Psychological Association, Washington DC, 1991; D.Shaffer ‘Preventing suicide in young people’ Innovations and Research, 2 (4), 3-9; J.Stillion & E.McDowell Suicide Across the Life Span, (2nd edition) Taylor and Francis, Washington DC, 1996.

12 Shaffer,D. Preventing suicide in young people, Innovations and Research, vol.2, no.4, 1993, pp.3-9.

Although it has been suggested that Shaffer's Model of Suicidal Behaviour could serve as a framework for suicide prevention, the prediction of suicide still remains practically impossible.¹³ This single fact exposes the enormous complexity of suicidal behaviour and the limitations of research into suicide. The cultural variations in suicidal behaviour shown by studies from cross-cultural psychiatry and medical anthropology indicate the importance of placing suicidal behaviour in its cultural as well as its social context.

Palestinian Suicide Statistics (and their social construction)

Aims and background

In the first chapters of the thesis Arab Islamic cultural attitudes were reviewed and the modern Palestinian socioeconomic and historical context of the West Bank was examined. It was suggested that the Palestinian public discourse on the phenomenon of suicide (*zahirat al-intihar*) could be the result of a 'moral panic.' A moral panic is defined as 'A condition, episode, person or group of persons [which] emerges to become defined as a threat to societal values and interests.'¹⁴ These panics serve to reassert the dominance of an established value system at a time of perceived anxiety and crisis.

It should be noted that suggesting that the 'phenomenon of suicide' in the West Bank and Gaza was in part due to a moral panic, is not to suggest that as such it can be ignored. Rather, that it can be regarded as symptomatic of the very real and serious transformations that the Palestinians of the West Bank and Gaza are going through at this time.

In order to investigate the forementioned suggestion that the phenomenon of suicide was in part due to a moral panic, efforts were made to try to quantify suicidal behaviour in the case study area of Ramallah. Evidence was sought to determine whether the numbers of suicides had increased and were increasing, and whether they were higher than in other societies.

13 Wilkinson, G. 'Can suicide be prevented? Better treatment of mental illness more appropriate aim', B.M.J. vol.309, October 1994, p.860.

14 S.Cohen *Folk Devils and Moral Panics: The Creation of the Mods and Rockers*, Blackwell, Oxford, 1973.

Trends and Record Keeping

When trying to understand suicidal behaviour, particularly its social impact, it is often useful to look at trends over time. In Ramallah there is no one reliable recording system for suicides or attempted suicides. Indeed, records of anything seem to be patchy and disorganised. In part this can be explained by 30 years of military occupation and the instability of the political and economic situation. Since the arrival of the Palestinian National Authority (PNA) in the West Bank there have been official suicide statistics for less than three years, whereas 16 European countries have records of suicides going back at least a century.¹⁵ Basically, the sophisticated infrastructure required for the detailed record keeping on which Western studies rely has not existed over the last century. Nevertheless, such records as were available in Palestine were examined and, in addition, efforts were made to try to set up a reliable recording system for a year, but this too had its problems.

No previous study into suicidal behaviour has been conducted in the West Bank, and only a handful have been carried out in the Arab Middle East.¹⁶ The aim of this study was to collect and examine all the information on suicidal behaviour from all possible sources and see if some kind of basic epidemiological picture could be pieced together. The intention was not only to estimate the incidence of suicide and attempted suicide in Ramallah, but also to see whether there was any correlation between suicide and such factors as age, sex or marital status.

The Social Construction of Statistics

The lack of records mean that the statistics obtained fall short of the levels of accuracy and reliability found in many studies in Western countries, but they illustrate how such social knowledge is produced. The social construction of suicide statistics is relevant to suicide studies everywhere.

15 R.Diekstra 'The epidemiology of suicide and parasuicide' *Acta Psychiatr. Scand. Supp.*, 371, 1993.

16 From the Arab Middle East: T.Daradkeh & N.Al-Zayer 'Parasuicide in an Arab industrial community: The Arabian-American Oil Company experience, Saudi Arabia', *Acta Psychiatr. Scand.* vol.77, 1988, pp.707-711; T.Daradkeh 'Parasuicide during Ramadan in Jordan', *Acta Psychiatr. Scand.* vol.86, 1992, pp.253-254 and Belkhenchir, D et al. 'Tentatives de Suicide et Suicides chez l'enfant et l'adolescent dans le Grand Alger', in *Tentatives de suicide a l'adolescence, Colloque de Centre International de l'Enfance sur la sante des adolescents*, 12-14 December 1988, pp.197-216. From Muslim countries: M.Khan, S.Islam & A.Kundi 'Parasuicide in Pakistan: experience at a university hospital', *Acta. Psychiatr. Scand.* vol.93, 1996. pp.264-267.

The suspect nature of official suicide statistics has been shown by many studies. Commenting on Durkheim's *Suicide*, Jack Douglas was critical of how sociologists have been so unquestioning about the production of the statistics upon which they rely, 'Most sociologists seem to have felt that these published, official figures are the 'facts' or 'things' called for by Durkheim and that, as things, they do not require probing criticism or justification, but only explanation.'¹⁷ These basic assumptions by sociologists about the nature of official suicide statistics as an objective, highly reliable measure of suicidogenetic forces that could be likened to a thermometer as an instrument to measure temperature are unjustified, Douglas argues. 'The difficulty ... is that one is still relying upon human judgment for the data, not simply upon sensory experience, which one used to observe the memory expansion and contraction against a calibrated scale, but actually upon the complex faculties of human judgments in interaction with each other.'¹⁸ [his emphasis] As such, however, they are informative about the nature of the official statistics-keeping organisations and the social meanings of suicide in Western societies.¹⁹

Statistics are socially constructed by the 'complex faculties of human judgments in interaction with each other' according to Douglas, and these are dependent on the social meanings attached to suicide. This needs to be borne in mind when considering suicide statistics in the Palestinian setting in general, and the governorate of Ramallah in particular.

Suicide Statistics in the United Kingdom

The inaccuracy of suicide statistics is not unique to Palestine. Indeed, it is an important issue in the United Kingdom, as Kate Hill pointed out in her 1997 study on youth suicide. 'The problem with statistics [is that] official suicides are far rarer than people who kill themselves.' The shrinkage is due to the way in which deaths are classified. 'Whilst the inaccuracy of

¹⁷ Douglas, *op.cit.*, 1967, p.166.

¹⁸ *ibid.*, p.170. For example with the definition of 'suicide.' Douglas argues that the most important error involved in the use of the official statistics has been the same error as that made in the theories themselves: the assumption that 'suicidal actions' have a necessary and sufficient, unidimensional meaning throughout the Western world. The assumption is that the categorisation of a death as 'suicide' means the same thing to all social groups, strata, and individuals. It fails to see that an official categorisation of the cause of death is as much the end result of an argument as such a categorisation by any other member of society. *ibid.*, p.229.

¹⁹ *ibid.*, p.167.

official suicide figures is widely recognised by suicide researchers, it is impossible to correct these distortions completely. But most suicides are traceable, and to provide more realistic estimates of lives lost, researchers now identify “probable” suicides... Most of these are disguised as ‘undetermined deaths’. The details of all deaths in the UK are registered according to a standard international system for classifying causes of mortality. In 1968 this system introduced a new category which became instantly popular in dealing with less clear-cut suicides: ‘Injuries undetermined whether accidentally or purposefully inflicted’. The ‘undetermined’ death, designated by an ‘open verdict’ in the English inquest system, provided the perfect pseudonym for unproven suicides.’²⁰

This situation exists in England²¹ partly because suicide and attempted suicide remained crimes in England and Wales until 1961, and the suicide verdict still reflects its innocent-until-proven-guilty criminal heritage. A suicide verdict requires an intention to die, and the law requires that this is proven to be beyond doubt, but ‘Since a dead person’s intentions are not easy to prove, doubt is inevitable.’²² Finding out the person’s intentions is an old problem with suicide and the burden of legal proof within the English system makes the under-reporting of suicide common practice. Hill found that youth suicide figures are also being eroded by tactful coroners. Inquests can be choked by considerations of stigma and private grief. A coroner can seek to minimise the impact of the drama on those implicated by sparing families a suicide verdict. In the view of one London coroner, ‘the reluctance of relations of the deceased to accept a verdict of suicide is well known.’²³ Insurance implications may have been taken into account by the coroner. If a man with wife and children is ruled as having committed suicide, the family may not be entitled to life insurance. Not wanting to add to the hardship of the family, a coroner may thus be disinclined to come to a verdict of suicide.

Some suicide simply cannot be detected concludes Kate Hill as she points

20 Hill, *op.cit.*, 1990, p.19.

21 As described briefly in the Chapter Two, the English historico-religious tradition regarded suicide as a sin and a crime. See Neeleman, J. ‘Suicide as a crime in the UK: legal history, international comparisons and present implications’, *Acta Psychiat. Scand.*, vol.94, 1996.

22 Hill, *op.cit.*, 1990, p.17.

23 *ibid.*, p.17.

to the unknown numbers who die each year in accidents which are neither classified as suicides nor undetermined deaths.²⁴ Numerous self-inflicted deaths each year in the UK are classified as accidental, in particular medical drug overdoses, which may have been cries for help that back-fired. ‘Ultimately there is no clean division between suicides and other deaths resulting from risk-taking behaviour. The complexity of self-destructive impulses and their myriad interpretations mean that innumerable young deaths might be judged to have a ‘suicidal component.’²⁵

Thus, even in a country with a long record of keeping suicide statistics, such as the UK, there are reasons why the statistics can be inaccurate. To understand why requires a knowledge, not only of the dominant historico-religious traditions of the past, but also of the socio-economic situation of the present, and the procedure by which a suicide statistic is ‘produced.’

Suicide Statistics in Palestine

The possible ways in which cases of actual or attempted suicide in Ramallah may or may not be counted and ‘become a statistic’ are shown in Figure 4.1. The right hand side of the diagram shows those cases which go to the local government hospital and which may be reported to the police. These reports may reach the DA’s office, be reported in the press and later be discussed in public debate. Essentially they are in the public sphere. The left hand side of the diagram shows those cases that seek private medical care and are essentially in the private sphere. This side also includes the ‘invisible’ cases, that do not seek any medical care and for one reason or another remain hidden from any outside gaze and are not included in any suicide statistics.

Consideration of each source of suicides on this diagram raises several important issues: how the sources differ, why some cases move up to the next level while others drop off, why the records are kept in a particular way, and the extent to which the statistics are socially constructed.

24 *ibid.*, p.19.

25 *ibid.*, p.20.

PART ONE: THE PUBLIC SPHERE

Newspapers

The most public and widely available sources of suicide statistics are local newspapers. They are important in that they do go back in time consistently. The changing nature of the content of local Palestinian newspapers through from the early 1980's to the late 1990's has already been discussed (Chapter Three).

Reports of suicide and parasuicide, first published by these papers at the end of 1996, are of particular interest for several reasons. First, because I believe it is basically these numbers that caused the public panic and moral debate and, secondly, because the statistics can be used to illustrate certain characteristics of these very public suicidal cases. They are, for example, mostly young people who have taken non-fatal drug overdoses. Also of interest is the way in which the characteristics of the fatal cases differ from those of the non-fatal cases.

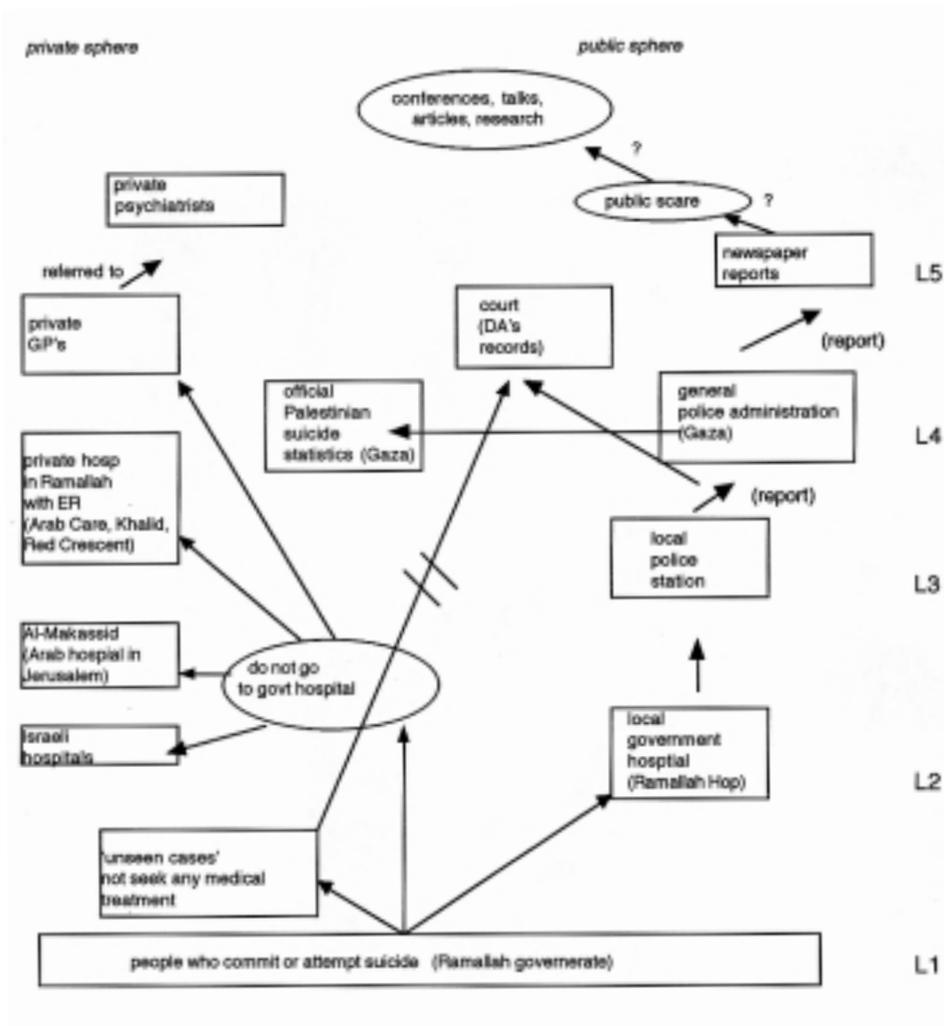
How reliable are these suicide statistics?

Cases in newspaper suicide statistics must have reached at least Level 5 of the diagram (Figure 4.1) since the person must have gone or been taken to a government hospital, the doctors there must have informed the police, the police must have come and made a report, which would have then been incorporated into a daily (except Friday) report in the public relations office in Gaza, faxed to a newspaper and printed the next day.

However, this sequence only happened to a small minority of the cases, at least in Ramallah. Many cases were not reported to the newspapers, nor to the police, and some did not go to a government hospital, so it could be argued that the statistics are inaccurate and unrepresentative. Certainly, they miss a large number of cases. For the period November 1997 to November 1998, I recorded 52 cases of fatal suicide, attempted suicide and suspected

suicide that came to Ramallah government hospital. Yet, for that same period the police recorded only 13 cases and the newspapers only 2. Thus only about 4% of the cases recorded in the government hospital appeared in the newspaper reports.²⁶

Figure 4.1: Palestinian suicide: how the statistics are constructed



²⁶ However, it must be taken into account that newspapers stopped reporting cases of suicide from June 1998. For the period November 1997 to June 1998 hospital entries of possible suicide cases 26, newspapers 2, that is to say almost 8%. Still, the point is that only a small fraction of government hospital cases reach the newspapers.

Findings from newspapers

Diagrams were prepared from the 'selection' of suicide cases in the newspaper reports and the following points were noticed (Figure 4.2).

- 1) The numbers of cases appear to be split almost equally between Gaza and the West Bank. The population of Gaza is about 1 million and that of the West Bank 1.5 million. This could suggest either a higher incidence or a higher level of newspaper reporting from Gaza. (Diagram 1)
- 2) The vast majority (92%) are attempted suicides. Of 168 cases, 154 are suicide attempts, and only ten of them are fatal, that is there are 17 times more attempted than actual suicides. (Diagram 2)
- 3) By far the most common method used is taking drugs, followed by other 'soft' methods such as taking poison, drinking household products, such as bleach or kerosene, and even, in one case, drinking shampoo! (Diagram 3)
- 4) The age distribution shows that the suicide attempts (muhawalaat al-intihar) are mainly amongst young people and the 18-24 group is the largest. In contrast, the oldest age group (>45) has most cases of fatal suicide. (compare Diagrams 4b and 4c)
- 5) Female cases slightly outnumber males for attempted suicide, but the great majority of fatal suicides are male. (Diagram 5)

It is interesting that in spite of the unsatisfactory nature of the records, they generally accord with the main findings in the Western literature on suicide: men die from suicide more often than women; attempted suicides are much more frequent than fatal suicides and are more common among women; the most common method for a suicide attempt involves drugs or medicines; young people attempt suicide more often, whereas old people die of suicide more often. The main difference is that there is not such a sharp difference between the sexes as far as choice of method is concerned; both use 'soft' or non-violent methods, such as drugs and poisons.

One trend (Figure 4.3) of particular interest is the dramatic drop in the number of suicide cases in January 1997, during the month of Ramadan when people fast, pray, and are generally more social and religious so that there is a great sense of community and ‘togetherness.’ Cases of suicide were also noticed to drop dramatically in Jordan during the month of Ramadan, according to Daradkeh, suggesting a protective effect.²⁷ An alternative and more skeptical view is that, in general, the reporting system is likely to be more inefficient during Ramadan since the health care professionals and police are fasting. The number of cases seemed to rise in October and November 1997 which, retrospectively, could be regarded as the peak of the public debate on suicide. The reasons for this are obscure. Perhaps the doctors or the police themselves had become more diligent about the reporting of suicide cases, or perhaps more people were attempting ‘copy-cat’ suicide.²⁸

27 Daradkeh, *op.cit.*, 1992. pp.253-4.

28 There is some debate about ‘copy-cat’ suicide. Although some research suggests that films about suicide, media interest in suicide or even ironically suicide prevention programmes have at times been shown to increase levels of suicidal behaviour through ‘copy-cat’ suicide, other research shows that over a longer period - such as a year - the level of suicidal behaviour stays the same.

Figure 4.2: Diagrams showing findings from newspaper reports

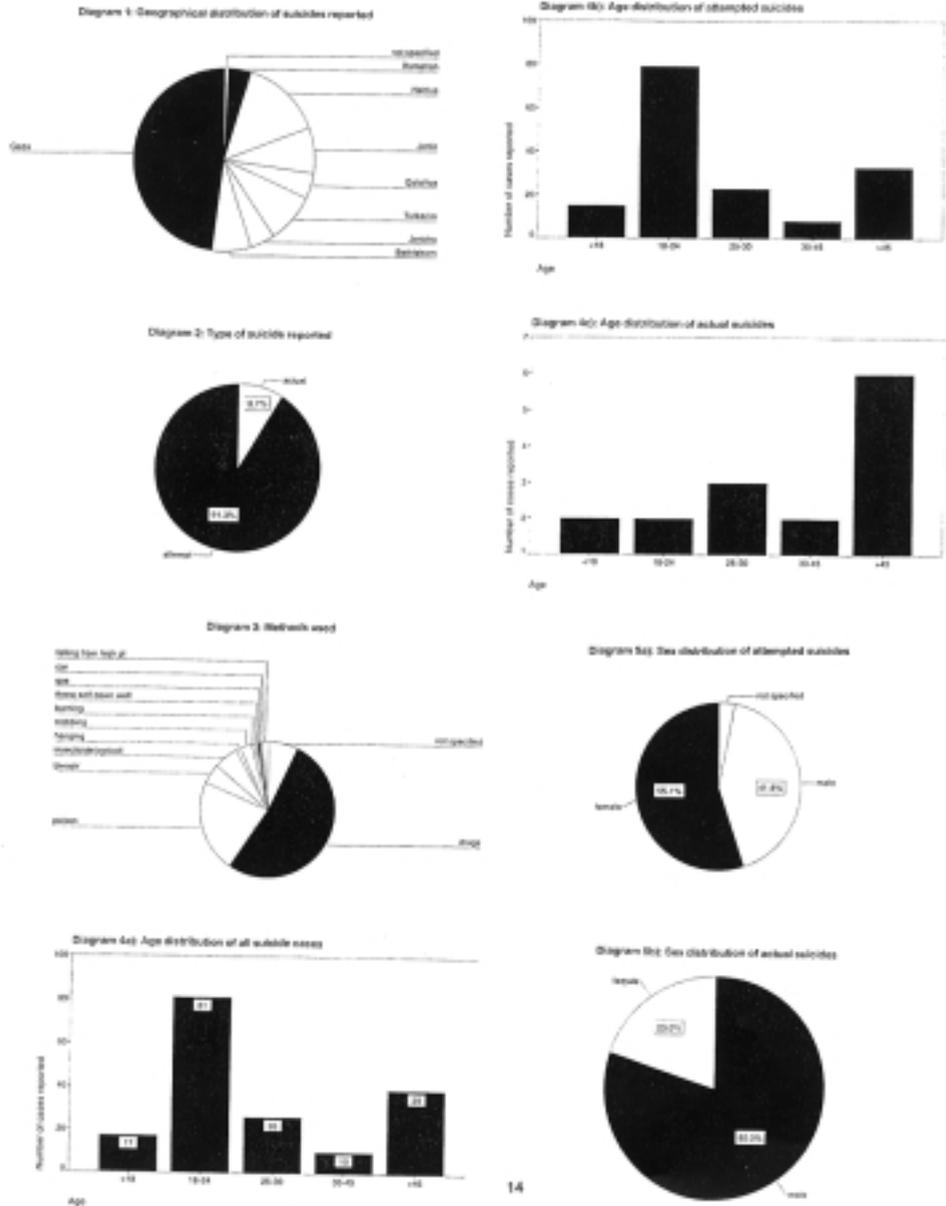
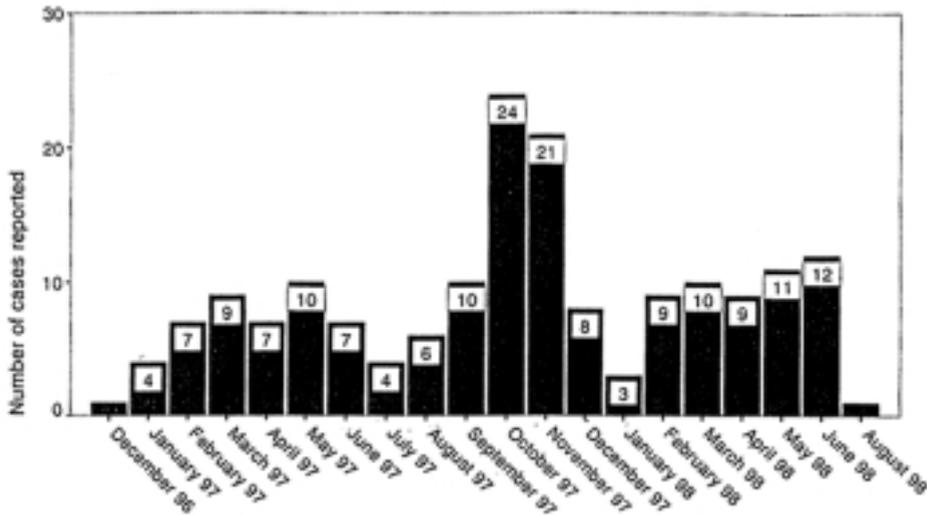


Figure 4.3 : Number of suicide cases reported in newspapers by date



What happened to these reports?

The last suicide case was reported by Al-Ayaam newspaper on 17th December 1997. Al-Hayat started reporting in November 1997 and stopped in June 1998. The last case was reported in August 1998. Since then Al-Hayat has continued to publish the police reports, but any cases that could have seemed to be suicide cases have been headed with something like ‘Woman poisoned’ without specifying whether it was accidental or intentional and without using the word suicide (intihar). When I asked at Al-Ayaam why they had stopped publishing these reports, I did not get a clear answer. One employee suggested that there were doubts about their accuracy. At a time when the police statistics were going up, the newspaper reports went down and then stopped. This suggests that a political decision was made not to report suicide cases any more in the national press.

P **Police sources**

The police sources consisted of the local Ramallah police station and official reports from the Gaza Police Headquarters which both came into existence in 1996. I obtained two reports from the Gaza headquarters one headed

‘The Palestinian National Authority Police - The General Directorate of General Intelligence’ [which I refer to as Report A] and the other ‘The Police General Directorate - Assistant Director of Police for operations and training.’ [which I will refer to as Report B]. Some information was also obtained from a magazine entitled ‘Ash-Shurta’ (the police) which published tables of the incidence of crimes. I initially assumed that there would be continuity between these three different sources of in, but in fact they contained a considerable amount of contradictory information.

1) Ramallah police station

I managed to go through the files at Ramallah police station with various members of staff. Some police personnel were around when I was there, so I was able to ask them about some details of cases that some had attended to. There was a general air of disorganisation in the police station which had previously been the Israeli army’s headquarters in Ramallah. A few years ago a huge blue Star of David had flown above the old stone building, with barbed wires on the walls, military jeeps all around and Israeli soldiers looking out from the roof. Now it was covered with Palestinian flags, Palestinian police in dark blue uniform hung around the building, and some rather sleek looking Mercedes were parked outside.

The Criminal Investigation Office was chaotic and dirty. The paint on the walls was peeling off and an assortment of things lay around gathering dust, including a clothes hanger. Files and records were stuffed onto some shelves. The main office’s furniture was dominated by a large desk covered with papers, ashtrays filled with cigarette butts, coffee glasses with the remnants of coffee grains, and dust - a depressing scene. It felt like how I imagined the PLO to have been in Lebanon or Jordan, as fugitive freedom fighters, with a feeling of temporariness. Much of how the PNA runs operations makes you think that the same ‘revolutionary’ mentality is still being used, rather than one more suitable to the building of a national government.

In a side office there was a new computer where statistics were being compiled. A young head-scarved (muhajabe) girl, a returnee from Lebanon, was working. She helped me gather the information. Most of it was not yet

computerised and of that which was computerised there seemed to have been several data entry errors when it was checked with the files. I was told that files are made for fatal suicides, but not for attempted suicides, for which only a report is made and no one knew what happened to these.

Findings from Ramallah police station statistics (Figure 4.4, Table 1 and Table 2)

- 1) The numbers are small, with a total for 1996 to 1998 of 10 fatal suicides and 24 attempted suicides.
- 2) As in the newspaper reports, suicide attempts outnumber fatal suicides, but not to such a great extent. Suicide attempts represented 70% of all cases, whereas they represented over 90% in the newspaper.
- 3) There is no clear difference between the sexes. Of the 10 fatal suicides, five are male and five are female. Of the 24 suicide attempts, 10 are male, 13 are female, and in one case the sex is unknown. Thus female suicide attempts are slightly higher in police station records, while in the newspaper reports they clearly outnumbered male attempts.

Figure 4.4 Tables showing findings from police sources for RAMALLAH Governorate

Ramallah police station suicide reports 1996-98

Table 1. Fatal suicides

Fatal Suicide	Male	Female	Total
1996	1	2	3
1997	4	1	5
1998	0	2	2
Total	5	5	10

Table 2. Attempted suicides

Attempted suicide	Male	Female	Unknown	Total
1996	1	4	0	5
1997	4	8	0	12
1998	5	1	1	7
Total	10	13	1	24

Police Report A (Gaza)

Table 3. Fatal suicides 1997

No.	Date	Place of Crime	Method of Crime	Name	Age	Reasons
1	13/8	town	falling from a high place	(male)	27	psychological state
2	25/12	town	taking pills	(male)	46	family problems
3	8/9	town	falling from a high place	(female)	28	mental illness

Table 4. Attempted suicides 1997

No.	Date	Place of Crime	Method of Crime	Name	Age	Reasons
1	10/7	town	iron instrument	(male)	17	family problems
2	13/7	village	taking pills	(female)	25	family problems
3	17/9	town	taking pills	(male)	23	family problems
4	4/12	village	taking pills	(female)	22	failure in studies
5	15/12	town	taking pills	(male)	20	family problems

Table 5. Attempted suicides 1998 (no fatal suicides for 1998)

No.	Date	Place of Crime	Method of Crime	Name	Age	Reasons
1	25/3	village	poisonous substance	(female)	30	family problems
2	17/7	town	taking pills	(male)	27	family problems
3	8/9	village	taking pills	(female)	23	family problems
4	1/11	camp	poisonous substance	(male)	20	family problems
5	5/11	town	falling from a high place	(female)	20	family problems
6	15/11	village	taking pills	(male)	21	family problems

Police Report B (Gaza)

Table 6. 'Cases where there is suspicion' for 1998 (no Report B for 1997)

Cases Where There is Suspicion	Type of incident	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
	SUCIDE				1				1					2
	ATTEMPTED SUICIDE				1						1	1	1	4
	POISONING													0
	DROWNING													0
FALLING FROM A HEIGHT	1												1	

- 4) In many cases the age is missing from the records. However, for those cases where it is recorded, the 18-24 year old group is the largest and about 80% are under the age of 30.
- 5) By far the most common methods used, as in the newspaper reports, are drugs and poisons. The only violent method mentioned is falling, or rather throwing oneself, from a height. This was the method chosen by five cases, causing four fatalities. Interestingly, all of these cases were female.

A similar overall picture is presented by both the police and the newspaper reports, with suicide attempts apparently made mainly by young people using drugs and poisons. However, in the newspaper statistics the sex differences are much less clear cut.

2) Official reports from Gaza

The two police reports from Gaza, on suicide in the Palestinian Authority areas of the West Bank and Gaza, Report A and Report B, contradict each other, as well as the local Ramallah police station list with regard to the numbers of cases. Report A has the names listed so some can be traced, but Report B has only summarised numbers of cases, so it is much more difficult to understand what their origins are.

The categorisation of suicide in police reports needs to be explained.²⁹ The first tables of police statistics that I could find were from the back of the police magazine, 'The Police' (Ash-Shurta). These dated from 1996 and were listed under a category 'Honour crimes and suicide' (qadaaya sharaf wa al-intihar). In Report B of 1998 suicide and attempted suicide were under the category 'Cases where there is suspicion' (qadaaya mushtabih fee). Also included in this category were incidents of poisoning, drowning and falling from a height.³⁰

²⁹ For the full list of crimes in Report B see Appendix A.

³⁰ Honour crimes (qadaaya sharaf) no longer formed a specific category. Presumably they are now classified in the 'murder section' which includes premeditated murder, attempted murder, unintentional murder and manslaughter. 'hatak'ard' literally means 'dishonour' - but in this case it refers to rape rather than honour crimes which refer to when a brother, father or other family member kills a woman who is suspected of having had extramarital sexual relations.

Report A

Report A turned out to have the years 1997 and 1998 mixed up! I am sure this is so because the names are there and I saw the cases of suicide that came into Ramallah Hospital between November 1997 and November 1998. If it had not been possible to match up the names and dates, then these statistics would be nonsensical for the two years for which they were issued. Report A records for 1997 (corrected year) three suicides and five suicide attempts and for 1998, six suicide attempts. (Tables 3, 4 and 5)

Report B

Report B is for 1998 only and reports that in the Ramallah area there were two fatal suicides and four suicide attempts. (Table 6)

The most noticeable aspect of these two reports is how the suicide statistics have generally shrunk during transfer from the previous police source (the local police station) to the police headquarters in Gaza:

Table 4.1: Comparison of suicide statistics from police sources

	Police Station	Report A	Report B
1997			
Suicides	5	3	n/a
Attempts	12	5	n/a
1998			
Suicides	2	0	2
Attempts	7	6	4

As with the other reports, the cases seem to be young for all of them being under the age of 30, except for one fatal case. There is no clear majority for attempted suicide as far as sex is concerned: in 1997, three were male and two female, and in 1998 three were male and three female. These figures will be referred to again when comparing the different statistics obtained.

District Attorney's Records

The District Attorney (DA) records all criminal incidents, including cases of suicide and attempted suicide. Up until the arrival of the PA and the introduction of computers in 1997, the records were maintained by an assistant to the DA who entered by hand each week the criminal incidents that had been brought to the DA's offices in Ramallah court in the West Bank.

The search for records at the DA's offices in Ramallah court lasted for a few months. Periodic visits were made and each time the records were requested, official papers from the university were shown, cups of tea were drunk and general chit chat was centred on research and the 'situation'. At first an assistant to the DA told me that the old records had been lost, and that no one knew where they were. Later, he said that he had been told they were in the basement and under so much dust and dirt that they were irretrievable. When he realised from my frequent visits how much I wanted to see the records, he said that he sympathised with me as he too had been a student, and the next time I went he was delighted to tell me that they had found the records in a metal cupboard down the corridor.

We arranged the large and very dusty books into years. The earliest records dated from 1985. The handwriting was so unclear it appeared to bear little resemblance to Arabic! I was told that there had been an extremely old clerk working in the court who had been there for so long that no one wanted to fire him. After his death, the handwriting improved somewhat but it was still illegible at times. To help me, a friend from the dormitory where I was living kindly spent a few afternoons going through the records with me in a very hot and dusty side room.

Each entry consisted of the date, the name of the defendants, and where they were from, the nature of the crime and additional details. It was sometimes unclear whether the date was that of the incident or the court hearing. Indeed, sometimes both were written down, but it appeared that in most cases the date was that on which it was brought to court or to the DA's office.

An assistant DA told me that these records are more accurate than the police

records because they have been investigated and bogus suicide cases, such as cases of suspected suicide that were found to have been murdered, had been omitted.

These records are the only ones to go back as far as 1985 in some kind of continuous order. The hospital records, for instance, turned out to be in complete disarray with missing records, inexplicable gaps, and sudden changes in procedure. With the DA's records there is one book for each year and all books are available. There are, however, a number of reasons to be concerned about their reliability:

- 1) Same bias as police records. Since the only source for the DA's records is the police, the figures suffer from the same bias related to police sources in that there are a large number of missed cases which have not been reported to the police, or for which the police have not made a report after being informed.
- 2) Avoidance of Israeli judicial system. Up until 1996 the DA was under the Israeli military authority so it is possible that people were less willing to report cases. Several doctors mentioned that even though they knew that the law required suicides to be reported, they tended not to do so. This behaviour formed part of a general reluctance to turn to the Israeli judicial system. Indeed, since the early 1980's many Palestinians have actively tried to avoid the Israeli system as a form of civil disobedience. Although this movement was particularly strong in the camps, it was also broad-based. Conciliation committees (lajan as-sulh) were set up as an alternative as a means of resisting Israeli occupation.³¹
- 3) Suicides weighted more than attempted suicides. It is possible that the DA's office, particularly prior to the establishment of the PA, would be more likely to investigate cases of fatal suicide than attempted suicide, so they would be more likely to be recorded.
- 4) Human error reading the records. Cases could have been missed because of the poor handwriting and the fact that it was only possible to go through the records once.

³¹ The conciliation committees (lajan as-sulh) formed as alternatives to the Israeli courts have been mentioned in Chapter Three (footnote 14).

Findings from District Attorney's records

The data collected from the DA's records was represented diagrammatically and three important points can be made. (Figure 4.5)

- 1) There has been a huge increase in the overall number of suicide cases recorded since the arrival of the Palestinian Authority. In 1996, there are 23 cases recorded representing a 44% increase from the highest pre-sulta recorded level. In 1997, there are 61 cases recorded, representing a 281% increase from the highest pre-sulta recorded level. (Diagram 1a)

Figure 4.5: Diagrams showing findings from District Attorney's office records

Diagram 1: TRENDS. Suicide cases recorded by DA's office each year

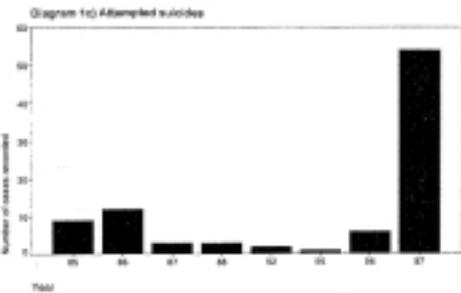
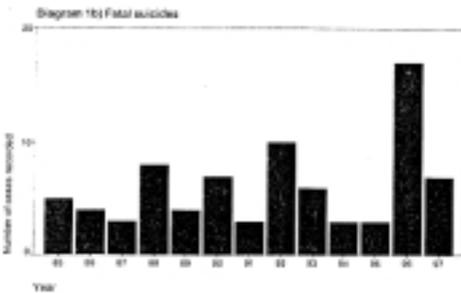
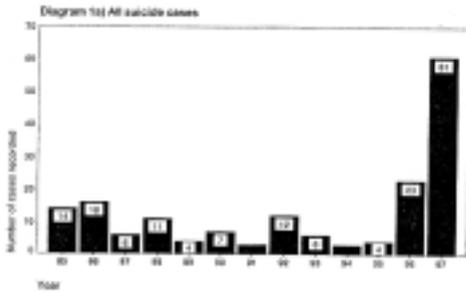
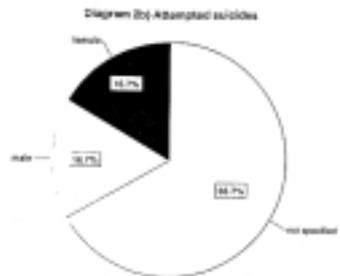
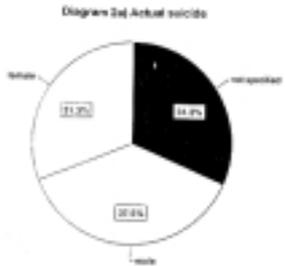


Diagram 2: SEX DISTRIBUTION of all suicide cases recorded by DA's office



- 2) Attempted suicide cases show a more noticeable increase than fatal suicides. Fatal suicides seem to stay at the same, rather low level throughout, whereas the level of attempted suicides seems to be more variable. During the years of the Intifada, the number of attempted suicides goes right down and for several years there are no reported suicide attempts, until after the arrival of the Authority when they shoot up. (Compare Diagrams 1b and 1c)
- 3) Male suicide cases, both fatal and attempted, are in the same proportion (31.3% and 16.7% respectively) as female cases (Diagrams 2a and 2b). It is only in this source of statistics that male suicide attempts are equal to female; usually the female suicide attempts outnumber the male. It may be that people are less willing to take women into the public law court than men and that women are somehow being guarded against entering the public domain which is generally the reserve of men.

Although the reliability of the numbers should be regarded with some suspicion, they do not contradict the hypothesis that fatal suicides remain at low and relatively constant levels,³² whereas attempted suicides are more susceptible to politico-economic changes. During the Intifada the rate dropped to only two or three cases per year and then shot up to 54 in 1997. It is interesting that all the reports show that fatal suicides and attempted suicides seem to have somewhat different characteristics, as is suggested by most Western literature on the subject.

However, these statistics have to be considered in context. Public interest provoked by the newspaper reports may have increased the reporting of suicide cases. With the arrival of the PNA annual records of criminal incidents had to be compiled, and by the beginning of 1997 there was a requirement for suicide attempts (*muhawalaat al-intihar*) to be reported to the DA. These factors led to more people reporting suicide attempts. Changes in reporting rather than in actual incidence are likely to have played a role in the increase.

³² If this was taken as accurate it would give a suicide level of the last 12 years of roughly 0.44 fatal suicides per 100,000 per annum.

Hospital Records: 1981 to 1997

The next line of investigation was to look for cases of suicide in Ramallah Hospital, which is the government hospital. It was built in the 1960's and, until recently, its emergency room (ER) was the only one in Ramallah. This hospital is shown in Figure 4.1 as one of the first places where a suicide would be recorded.

The procedure for recording cases of suicide that come to Ramallah Hospital is shown in Figure 4.6. When a person is admitted after a suicidal action there are four places this should be recorded: the ER record book, the patient's file, the department records, and the admission records.

If someone dies in the ER, arrives there dead, is discharged or not admitted after treatment, this should be recorded in two places: the ER records' book and the ER sheets file. All of the above documents provide a space for entering a diagnosis, apart from recording the patient's name, age, sex and address. So, theoretically, it should be possible to go through the records of Ramallah Hospital and gain an idea as to how many cases of suicide or attempted suicide have come there and also to obtain some basic demographic data about them. However, this was not possible for two main reasons, the first related to the storage and upkeep of these records and the second to the recording method itself.

1) Record storage (Figure 4.6)

Records are stored in two large mobile containers, the size of two average-sized caravans, which are called 'The New Archive' and 'The Old Archive.' The New Archive is meant to contain the department records, admission records and patients' files from the previous five years. After that period the department records and admission books are put into the Old Archive and the patients' files are thrown out. After a year or so, the ER sheets files are thrown out. This is what is said to happen, but in reality the system was in a state of disarray.

The New Archive, with the patients' files, had some sense of order, and people come and use it to get files for insurance purposes, or the police

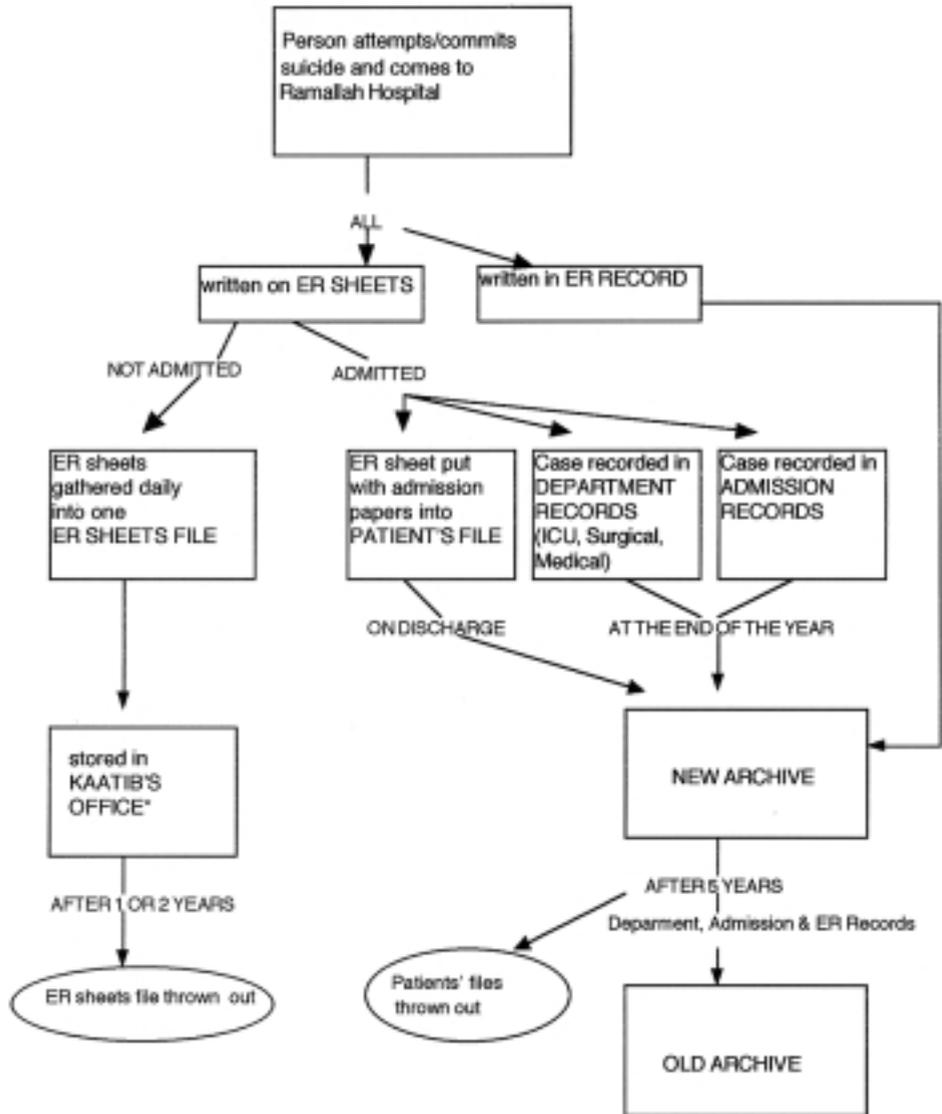
may use it for criminal cases. However, many of the department records and admissions records seem to have disappeared. The head nurse of the Internal Medicine department, who has been there for well over 20 years, swore that he had handed in the department record book to the New Archive at the end of 1998. I had seen the book in June 1998 and had the data from January to June, but before leaving wanted to check the data for July to December. He came with me to the New Archive, but the department book was nowhere to be found: in the space of three months the book had been lost. This was fairly typical; the admission books were found for only part of 1995, and huge gaps existed throughout the sequence of department records and admission books.

Patients' records for the previous five years appeared to be in some kind of order although many were certainly missing. However, it would have been extremely impractical to use these as a means of looking back over that period as there were at least 5,000 sheets for each year.

Eventually, I went through all the ER, Department and Admission Records that could be found by going through the Old Archive for as far back as possible. The records were patchy as they were not well maintained and huge numbers of books and records were missing, especially for the Intifada years (1987 to 1992).

When I asked to go to the OldArchive everyone laughed and said that no one goes there. I was even told that there were rats! When I finally got the key and went in it was a complete shambles. You could hardly get in. From floor to ceiling was a jumble of papers, files and books. Stifling heat and choking dust. Tape, receipts, old chairs, x-rays. It was an incredible sight. With a friend, I offered to tidy up. We cleared the way so as to get into the container and separated records from random, jumbled-up papers, but the separated rubbish was still there nine months later when I visited the hospital just before I left Ramallah. I was told that it was illegal to burn any of the records without authority from the PNA, but neglecting them does not appear to be! So, although a system of recording existed, most documents had been either thrown out or lost.

Figure 4.6: Recording system for suicidal cases in Ramallah Hospital



2) The method of recording

All the documents indicated in Figure 4.6 - the ER sheets, the ER record, the patients file, the department and admissions records - have a space for entering the diagnosis. Unfortunately, this is filled in very rarely and haphazardly; often the form was either blank or indecipherable. So obtaining data from these records was hampered by the following problems:

- i) Missing entries. No entry had been made.
- ii) Indecipherable entries. Apart from poor handwriting, indecipherable records could be attributed to the records being kept in English. Doctors are expected to be able to read English which is the language of medicine in all Arab countries except Syria, which uses Arabic since it is argued that this saves Arab countries from having to translate medical and scientific journals. In Egypt and Jordan, where most students train within that country in English, this requirement is fair enough, but the problem in Palestine is that until three years ago there was no medical training there.³³ Many students travelled to Eastern European countries, since they were cheaper than Western Europe and some other Arab countries, and studied in the language of that country, be it Russian, Hungarian or Rumanian. On returning to Palestine, many of these doctors then had enormous difficulties adapting to practising in English. This has clearly had an effect on the standard of note taking. The inability to spell basic English words and medical terms means that many doctors hide behind squiggles.³⁴ In Ramallah Hospital, notes written by nurses were clearer than those written by doctors. The nurses train locally in Palestine, in English using English text books.
- ii) No clear diagnosis of suicide. A legible diagnosis may have been entered, but it is not clear if it is related to a suicidal act or not. For example, 'drug poisoning' is entered but no indication is given as to whether it was self-induced or accidental.

³³ It is presently still limited to a handful of medical students who can train in Palestine. The constraints are the high cost of the course and the limited facilities in Palestine.

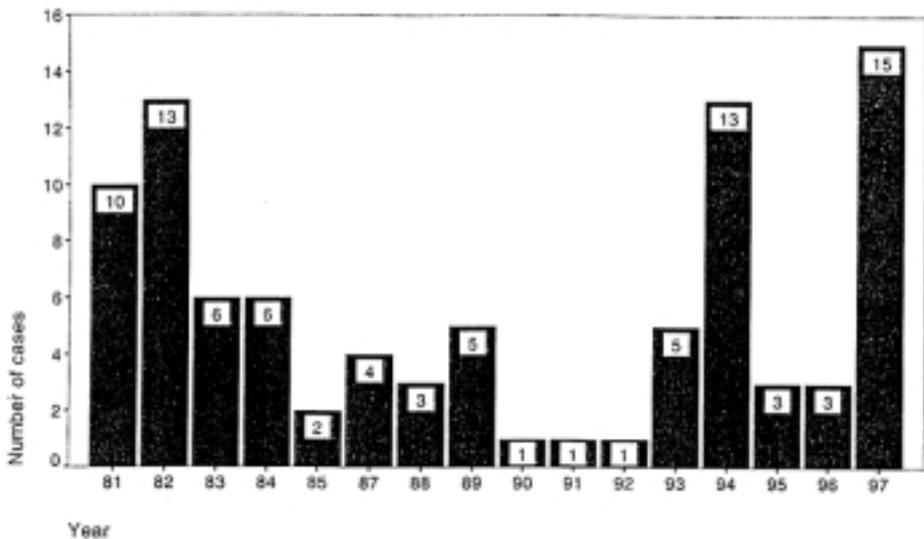
³⁴ Perhaps not just in Palestine!

Findings from hospital records prior to 1997

Although the system had virtually collapsed, and record taking was inconsistent and inaccurate, a few points can be made about those records that were seen:

- i) The word suicide is not mentioned in any records before 1997.
- ii) Cases with the diagnosis ‘drug poisoning’ and aged between 17 and 30 were found. It is possible that at least some of these were suicide attempts. In 1998, when I was able to see patients entering the hospital, the medical label ‘drug poisoning’ and an age between 17 and 30 often indicated a suicide attempt. This is evidence that the ‘suicide phenomenon’ is not an entirely new phenomenon.
- iii) The most noticeable trend was the apparent drop during the Intifada. This may have been because the records were less well kept and the hospital staff were having more problems with time and resources, but records were made of many cases of gunshot wounds and tear gas-related casualties. (Figure 4.7)

Figure 4.7: Ramallah hospital records of suicide prior to 1997



Thus, although the numbers produced by searching the hospital records were extremely inaccurate, the exercise did produce some information.

Cases of suicide coming to Ramallah Hospital November 1997 to November 1998

Having soon realised the patchiness and unreliability of hospital records, I decided to set up a recording system of sorts for a one-year period while in Palestine. The hospital director agreed to ask nurses and/or doctors to phone me whenever a case of suicide or attempted suicide came to the ER. They were all informed by letter.

I spent the month of November 1997 mainly in the emergency department of Ramallah Hospital helping doctors and nurses in my capacity as a medical student. This meant that everyone knew who I was and that I was doing research on suicide. During the year I would phone up periodically and ask if any cases had come in, or I would come in and see the doctors and nurses and ask them about cases. I would also come in every few weeks to go through the ER sheets and record any cases that could possibly have been suicide attempts.

When the hospital informed me of a case, I would go immediately and see if it was possible to talk to the patient, even if this meant going at night, although occasionally, I would be told that a patient would certainly be admitted that night, so I would go early in the morning and try to see him or her then.

On meeting the patient, I would either talk to him or her then and there, using a questionnaire as a guide for the interview,³⁵ or ask if it was possible for me to visit them at home. If they agreed, I would arrange a time to go and try and record an interview with them on tape. It was impossible to record the interview in the hospital itself. The emergency room consisted of a row of five beds with flimsy curtains in between and there was a constant stream of people wandering in and out, such as friends, relatives, people seeking quick medical advice and policemen.

³⁵ A questionnaire for patients was developed asking for details such as age, sex, marital status, educational level, employment, residence, reasons for the suicidal behaviour, economic and social situation. Basically the questionnaire asked about risk factors which have been previously shown to be associated with suicidal behaviour.

If I missed an attempted suicide case in the ER, for reasons explained later, I would get their name and address from the ER sheet and try and go to tape an interview with them. The ease with which this could be done varied considerably from case to case.

Methodological Problems

Missed cases

The aim was to see all ‘cases’ in the relative neutrality of the hospital setting. As a medical student my presence was not unusual, which meant that I could talk to patients quite easily on their own and explain why I was there, why I wanted to talk to them, and assure them of confidentiality. It was thought that in this setting the ‘patient’ would be more able to talk freely without the worry of explaining to his or her family what we were talking about. Generally, this was the case for the people that I managed to see in the ER. Seeing patients in the hospital also enabled me to gain their trust on home visits, since I did not just appear to them as a random stranger. In spite of the arrangements I had made, some cases were missed for the following reasons:

- i) Notification not received. On a few occasions, the mobile phone which I had acquired to enable me to be informed by the hospital when cases were admitted, did not receive the message. Unfortunately, as there was no phone in the dormitory where I lived at the time, this was the only way I could be contacted directly.
- ii) Notification not given by the hospital. Sometimes nurses were too busy to phone me, since the emergency department of Ramallah Hospital is very busy, with people constantly coming in hoping to receive free or cheap treatment, especially in the evening or at night when other health centres are closed. A few of the doctors and nurses were not particularly keen on informing me. From their comments it appeared that some did not regard suicide as a serious or an important topic. Suicide attempts were thought of as ‘hysterical’ and attention seeking and not worth wasting my energy on. Others thought the topic unsuitable for a Palestinian girl coming from ‘outside’ and did not understand why should she come and see these people whom they viewed with some disdain. Others would tell me a week afterwards, ‘Oh yes, there was a case... but

in the middle of the night... how would you get here?’ Sometimes the implicatiwas that a respectable Arab girl shouldn’t be going around in the middle of the night. Others knew that I was in a dormitory with a curfew so, thinking one step ahead, said they had assumed I would not be able to get out.³⁶ The nurses, however, were generally very helpful, more so than the doctors. A few became good friends and were very reliable and would always phone if there was a case during their shift.³⁷

- iii) Notification received, but patient not contacted. On a few occasions the hospital informed me of a case, but by the time I got there, which might have been less than an hour later, the patient had been discharged, either by him/herself or his/her family. Sometimes it was difficult to get to the hospital quickly as I often travelled around to other parts of the West Bank, in particular Jerusalem, Nablus and Jenin. It takes about two hours to get to Ramallah from Jenin. A couple of times I was told that a patient would be admitted and yet when I arrived the next morning he or she would have been discharged in the middle of the night.
- iv) Absence. I was abroad for two three-week periods during the year (December 97 to January 1998 and June to July 1998) and although I had tried to set up an alternative system to take over in my absence, it did not work very well, and several cases were missed during these two periods.

Overall, the system of recording, although rather basic, improved as the year went on. Particularly important was the fact that the doctors and nurses saw that I always came in whenever anyone from the hospital spoke to me about a case. My improved relations with the nurses proved crucial.

In the hospital

Almost always I managed to chat with the ‘patient’ though this would

36 Indeed, the first time I was called I was unable to get out! I was locked into the dormitory and unable to get out until 5a.m. the next day. I eventually got special permission to get a key ONLY to be used to go to the hospital for research purposes. This was done in secret, no one else was to know that I had the key.

37 Indeed, a couple of times they were overly-enthusiastic and I would find a case was highly unlikely to be suicide, but be told that anyway it was an excuse to drink coffee with them!

depend to some extent on his or her medical status. Only on one occasion was it completely impossible when access was blocked by the woman's father who refused to allow me anywhere near her. I arranged with a nurse that he should slip a note into her hand as he took her blood pressure. It had my phone number on it but she never called. Her father appeared to have complete control over her and this was not relinquished in any way in the hospital, although in general, such power might be expected to be diminished in the hospital setting, faced with the medical authority and its trappings. In this particular case, the reason for the overdose was the father's authority: he had banned her from going out to work as a computer teacher, and said that she was to stay at home from then on.

Going through the records

I went through every ER sheet to check that no cases had been missed completely. Often a nurse would tell me, when I came in, that he had heard of a case coming in the previous week, so I would know where to check. However, for the sake of thoroughness I went through every sheet and any case that could possibly have been a suicidal case was noted down with the intention of then going to check it. However, there were a number of problems with these sheets:

- 1) Unclear diagnosis. Frequently doctors did not write more than a couple of words and those words were often illegible.
- 2) Vague address. Even if a diagnosis was decipherable and said, for example, 'drug poisoning' there might be a problem with the address. Usually only one word entries were made on the ER sheet of the name of the town, village or camp, such as Ramallah, Kobr or Al-Amari. By far the easiest people to find were those from the villages. With the family name and the village name, it was highly probable I would find the person in question. This is largely due to the system of knowledge used in the Ramallah area and the way in which communities have developed. Most villages are based on a few different clans (hamoola). So in a village, I could ask for someone from a particular family and ask them for the person that I wanted to talk to. When I was looking for someone from a camp I could go to the camp's UNRWA office and ask there. They would either know immediately, or occasionally they would check

electricity bills (which went through the office) for the name I was looking for. If the address was simply that of a town, such as 'Ramallah' or 'Al-Bireh,' it was almost impossible to trace a person after their departure from the hospital. I tried asking in the municipalities, post offices and the new telephone company and did find a couple of people this way. However, a number were untraceable, and I have entered them in the category of "?SA" or "??SA" on the list that I compiled of cases of suicide that came to Ramallah hospital during the year that I recorded cases.

"?SA" means a case that was very probably a suicide attempt according to the doctor's diagnosis on the sheet, such as 'suicidal case' or 'voluntary drug ingestion' or according to reports from nurses.

"??SA" represents a possible suicide attempt as when the diagnosis was, for example, 'drug poisoning' or 'drug ingestion' which could also have been accidental. The question mark indicates that I was unable to trace the 'patient' and therefore check up on what had happened.

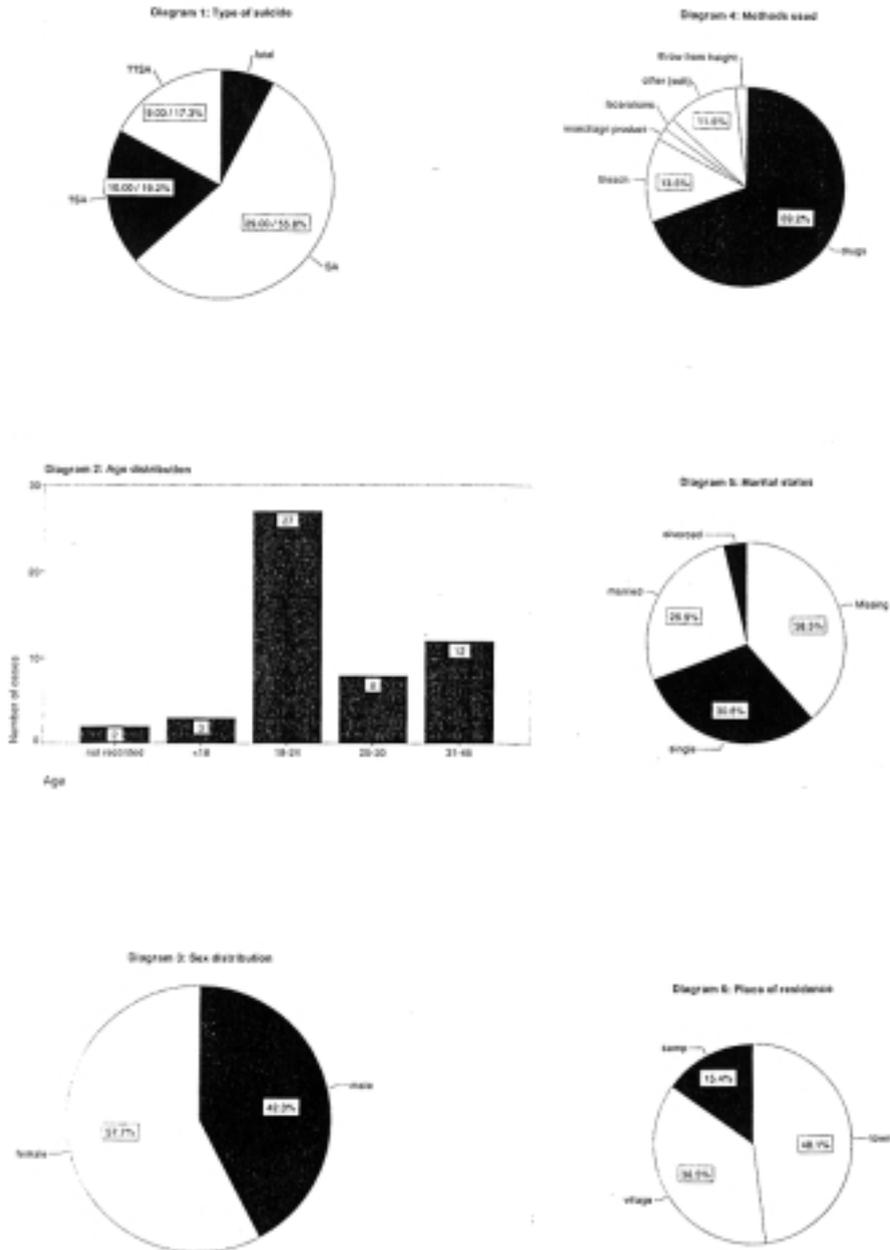
"SA" represents a definite case of attempted suicide, I had seen and spoken to the individual concerned or doctors, nurses and police had assured me that that particular case was a suicide attempt.

- 3) Lack of basic demographic data for the missed cases. For those cases that I did not see, I was unable to find out basic data such as marital status, level of education, or employment. The ER sheets only record name, age, sex, address and medical notes.

Findings from emergency department of Ramallah Hospital November 1997 to November 1998 (Figure 4.8)

- 1) During the year 52 suicide cases were recorded. Non-fatal suicide attempts were much more frequent than fatal suicides. There were up to 48 cases of attempted suicide (approximately 92%) compared with only four cases of fatal suicide (approximately 8%). (Diagram 1)
- 2) The cases were generally young. By far the largest age group was the 18-24 group which included over 50% of all suicide cases. Almost 75% of all suicide cases were under the age 30. (Diagram 2)

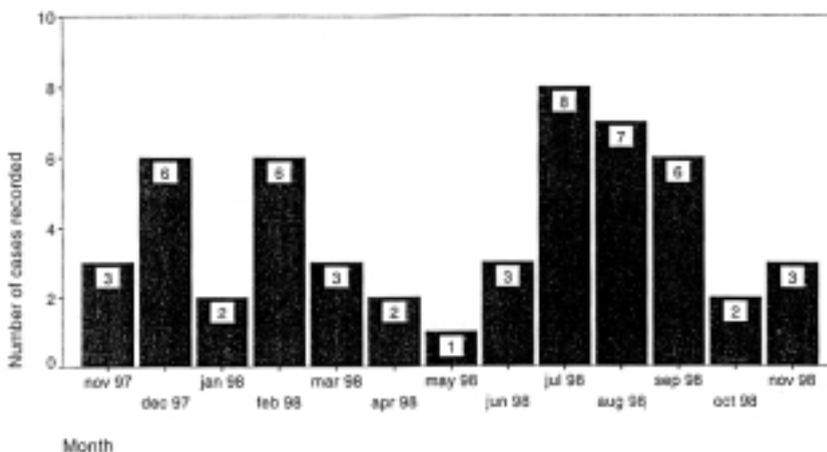
Figure 4.8: Diagrams showing findings from Emergency Room of Ramallah Hospital from November 1997 to November 1998



- 3) The majority of the cases, almost 60%, were female. (Diagram 3)
- 4) By far the most common method used was drugs of various types which accounted for almost 70% of all methods used. The next most common method was bleach, followed by other 'soft' methods including poisons, vinegar concentrate (rouh khal), kerosene and even, in one case, of cologne! Other methods were falling from a height (fatal), lacerations, and insecticide with one case in each category. (Diagram 4)
- 5) The data on marital status is missing in more than a quarter of cases (38.5%) as it is not entered in the records. Of the remainder approximately 31% were single, 27% married and 4% divorced. (Diagram 5)
- 6) Most cases (48%) came from urban or residential areas, while approximately 37% were from villages and, the smallest group came from camps (15%). (Diagram 6)

No clear trends are evident over the year, apart from the low level during the month of Ramadan which occurred in January and a considerable increase in the month after. There seems to be more cases in the summer/early autumn months which happens to be the wedding season, I think an important factor was the improvement in my relations with the nurses over the year with a consequent improvement in the recording system.

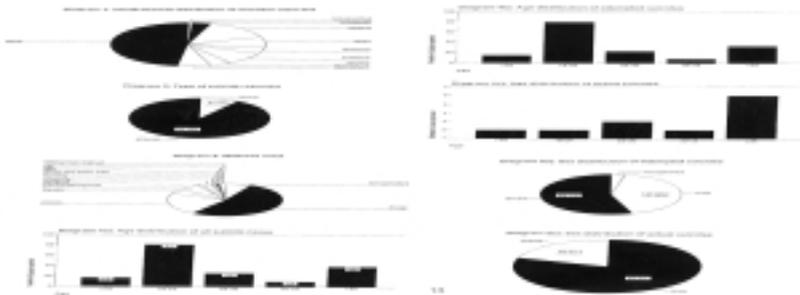
Figure 4.9: Suicide cases recorded in Ramallah Hospital between November 1997 and November 1998



Discussion of data from all public sources

Having gathered as much information as possible from the various public sources described above, the information was compared. From Table 4.2 below two important conclusions can be drawn. Firstly, the extent to which cases move up the reporting ladder, and secondly, the inadequacies of the official statistics.

Table 4.2 Summary of statistics obtained from public sources November 1997 to November 1998



The main observation to be made from the table is the decrease in the number of suicides reported, and thus included in the statistics, as the records move up to the next level. Very few of the cases entering hospital are recorded in official police statistics and eventually published in a newspaper. From 52 cases of possible suicide recorded in Ramallah hospital, over the year, 13 were recorded in Ramallah police station statistics. Ten in the official suicide statistics Report A, six in Report C and only two in the national newspapers.

Since only about 4% of possible suicide cases reach the newspapers, there is some justification in people saying that the reports are only the ‘tip of the iceberg.’ Certainly, the vast majority of suicide cases, at least in Ramallah, were not reported in the newspapers.

Reasons for under-reporting

Various reasons can be suggested for the number of cases ‘dropping off’ at different levels.

Reports from hospital to the police Ramallah Hospital does not invariably report cases to the police. There may be pressures from the family who want to keep the incident quiet and do not want it to move further into the

public sphere. Doctors in the emergency room may be simply far too busy to inform the police. Although the doctors are legally required to report all suicide cases, this is apparently to enable police to investigate a possible crime, such as an attempted murder, rather than to investigate suicide as a crime. Doctors may feel that in a clear case of self-harm there is little point in bringing in the police. Obviously, the patient usually prefers that the police are not informed.

There are proportionately fewer female cases in the police statistics compared with the number of cases entering Ramallah Hospital. It appears that doctors are less likely to report female cases. This might be because female patients are usually brought into hospital by male family members who would be seen as the people to deal with a woman's problems, almost as 'protectors,' so that doctors are less willing to interfere. Possibly doctors are aware of the potential problems caused by the police getting involved and more people finding out about a shameful incident which, particularly in the case of women, could damage their reputation. An additional factor is that doctors may be less likely to take female patients seriously. When a woman comes into hospital and is labelled 'drug poisoning' the staff's response is often to refer to the case as 'lovelitis' or 'dala'-itis.³⁸ The underlying assumption is that the reason for the attempt is emotional and therefore not serious. It could be that when a man attempts suicide there is greater suspicion that he has more serious problems, such as being mad, bad, immoral, or on drugs. Maybe women are simply better at persuading the hospital staff not to inform the police.

There are proportionately fewer suicide attempts compared with fatal suicides in the police statistics than there are in the Ramallah hospital statistics. This may be because less female cases are reported and female cases are more likely to be attempted suicides. Alternatively, doctors deem only potentially life-threatening cases as worthy of being reported to the police. I tended to find that the sex difference was a more important factor in the doctors' decision as to whether or not to report cases to the police.

Police recording of statistics

Once a case is reported to the police it may not be included in the statistics.

³⁸ dala's means to be spoilt/overly-pampered

In the local police station I was told that a file is only made for fatal suicides. While a report is written for attempted suicides, a file is not made. This procedure makes it much more likely that attempted suicides are not included in statistics. At the time of my visit, various members of the police were entering crime records onto computers by going through the files but not the reports.

The data on suicide cases was not entering a well worn system of information gathering. The PNA police organisations in 1997 to 1998 were only a few years old and the offices appeared to be in a somewhat chaotic state. The large number of missed cases may be just one symptom of the time of change and readjustment that new PNA organisations are going through.

Who decides when a suicidal action becomes a statistic?

The reporting of a few cases was followed up from entry into hospital to see why some were recorded by the police and others were not. It seems to be important who the patient is accompanied by, particularly in the case of women, and the gender of the patient. It is not always the patient who decides whether their action was suicidal or not.

Amal's case

Amal came into Ramallah Hospital in December 1997 having taken a packet of paracetamol. She was brought in by her husband who was very concerned. She had taken the pills after an argument with him. Her stomach was pumped and she went home. The doctors were going to inform the police but decided not to after the husband convinced them of no wrong doing. Thus the police have no record of this suicide attempt.

Areej's case

Areej, a 24-year-old single woman was brought into hospital by her elder brother in August 1998 having taken an overdose after an argument with her sister's fiance. She was clearly very emotional and exhausted. She said she had taken the pills with the intention of killing herself but said it was a mistake. She left after having her stomach pumped. The police were not informed and her brother took her home.

Dana's case

Dana also came into Ramallah Hospital in December 1997 having taken an overdose of painkillers. She was a 22-year old final year English literature university student from Gaza studying in a West Bank university. She was brought in by a girlfriend from the student dormitory. She told the nurses that she wanted to die. The doctors both informed the police and called me. [It might have been that because they called in 'the researcher from outside' that they also called the police.] She told me that she was distressed because of a relationship with a male student and wanted to die. She told the police that she had been studying for an exam and had had a headache and so, by mistake, kept on taking pills until she realised that she had taken too many. She said she did not want to die and laughed when they suggested she had tried to commit suicide. She begged and pleaded with the two police officers not to tell her family. In the end, the police recorded her case as a case of attempted suicide with the reason recorded as 'study problems'.

Bassam and Ghassan

Both Bassam and Ghassan, 28 and 20 respectively, came to Ramallah Hospital during 1998 having taken overdoses. Neither had taken a large overdose and both denied having taken the pills with the intention of committing suicide. However, in both cases the police were informed and their cases were recorded as suicide attempts (muhawalaat al-intihar).

Kareem

Kareem, a 40-year old unemployed labourer from a village, was brought into Ramallah Hospital by his friends in August 1998 having taken an overdose. He said that he was fine and refused treatment. The police were informed and his case was recorded as a suicide attempt.

The above examples show the lack of a clear policy regarding informing the police but some of the reasons mentioned above do seem to apply. In general, doctors and police, rather than the patient, decide whether a case is suicidal, and doctors seem to be more likely to inform the police about male cases than female cases brought in by male family members.

Police headquarters recording of statistics

The reason for the discrepancy between the police station statistics and the ‘official statistics,’ is difficult to pinpoint clearly, but could be due to a number of factors: a disorganised system, poor communication between Ramallah police station and the Gaza office, or even the geographical separation from the local police station. I was told that Gaza health statistics in general, and the suicide statistics in particular were more accurate than those from Ramallah. This might be attributed to the proximity of central headquarters in Gaza to the local Gaza police station, which could possibly promote better communication.

Deficiencies of newspaper statistics

The observed discrepancy between the ‘official statistics’ and the newspaper reports is difficult to explain. It is curious that, in the middle of 1998, while the number of suicide cases were increasing in Ramallah Hospital and police reports showed rising numbers of suicides, the newspaper reports stop completely after June 1998. As suggested elsewhere, this may have been due to a public moral panic that led to a political decision not to publicise these cases.³⁹

Peculiarities of official Ramallah statistics

In comparison with most other governorates, Ramallah appears to have a very low number of suicide cases recorded in the official statistics. This may be because there are various alternatives available for residents of Ramallah who do not want to go to the government hospital: new private hospitals, numerous private doctors, and Jerusalem hospitals and Israeli hospitals less than an hour away. The official police statistics were much higher for Nablus than Ramallah. However, not only is Nablus more populous, in Nablus police station there was a female police officer who had formerly been a social counsellor and who had a special interest in cases of suicide. It is possible that this made the hospital staff there more

³⁹ I am not sure about Al-Hayat but Al-Ayam newspaper is certainly pro-Fatah. That the Palestinian press has become controlled by the PNA in general, and by Arafat in particular has been widely documented. This period is sometimes referred to as the ‘Age of Arafat’, such is his domination of nearly all Palestinian affairs.

willing to contact the police and that the police were more ready to respond, or it might be that Nablus really did have higher suicide levels.

In sum, the situation described above shows the dangers of taking police statistics at their face value owing to the complexity of the factors underlying their compilation.

PART TWO: THE PRIVATE SPHERE

Having considered the situation in the private sector with regard to the production of official statistics, the relationship of the private sphere can be considered. The various organisations and individuals that may become involved are shown in Figure 4.1.

The doctors' questionnaire

Although it was generally believed by those health professionals I consulted, particularly those in government hospitals, that the majority of suicide cases would be taken to Ramallah government hospital, a few suggested that in some cases private help might be sought. It was important to discover where these patients were taken in order to find out how representative my figures were for the year November 1997 to November 1998. To elucidate the situation, I developed and administered a simple questionnaire to as many "private" doctors⁴⁰ as possible in Ramallah governorate. This aimed to find out three things:

- 1) Where 'patients' went besides Ramallah Government hospital, and whether private doctors were referring suicide cases to the government hospital, or to private hospitals, or were they simply treating them and sending them home. Also whether the death of such a patient would be recorded as a suicide.
- 2) The characteristics of the patients that went to private doctors, such as whether they showed an age and sex distribution similar to those who went to government hospitals.
- 3) Whether the doctors themselves noticed any trends such as a recent increase in the number of cases of suicide.

⁴⁰ It was often difficult to categorise a doctor as 'private' as many may have a job in the main government hospital (Ramallah Hospital), or work in government clinics in villages in the morning but have a private practice in Ramallah in the afternoon.

The format of the questionnaire was simple. It asked three main questions:

- 1) Have you ever seen a case of suicide or attempted suicide?
- 2) If yes, when did you see the most cases: before, during or after the Intifada?
- 3) In your opinion as a doctor practising in Ramallah has there been an increase in suicide over the last few years?

If the doctor had seen any cases, he or she was asked to fill in a simple form for each case:

Of the act itself: date, age, sex, type of residence (town, village or camp), educational level, employment and type of suicide.

How did you come to see the patient?

How did you treat the patient?

In the event of going to a hospital what type of hospital did the patient go to?

From the replies given to the questionnaire, it was hoped to form some idea as to where cases went other than the local government hospital.

Methodological problems and biases of the data

A number of serious problems associated with this method of data collection need to be taken into account, and although interesting, the statistical results should not be taken too seriously! The neat diagrams make it dangerously easy to forget the small size of the sample as well as the biases behind that sample.

1) Lack of an efficient mailing system

Using a questionnaire to gather information from over a hundred doctors would be much simpler if there was an efficient mailing system, which there is not. A letter from the Arab Bank in the centre of Ramallah can take four months to reach a house in Ramallah, if it arrives at all. However, even with an efficient mailing system, I doubt whether the response from doctors would have been very high. There is no 'mailing culture' as such which, in view of the lack of an efficient mailing system, is hardly surprising.

2) Time consuming nature of delivering and collecting questionnaires by hand

Thus, the only way to administer this questionnaire was to go to each and every doctor with the questionnaire and ask him or her to fill it out. However, doctors often have a number of practices. Some may work in a hospital during the day and a private practice in the evening; others may work both in a village practice and a town practice; and most private GP's rent a couple of rooms in different parts of the town where they see patients during office hours. The office hours vary from doctor to doctor and may sometimes vary from the time announced on the door. Although most doctors had practices in the town, these were not necessarily close to each other, although they were nearly all within half-an-hour's walking distance of the town centre. After finding a doctor and waiting to see him, sometimes up to an hour, he would often be too busy to fill in the questionnaire immediately which necessitated a return visit. The next time, the doctor might again be busy or might not have filled in the questionnaire. Visiting each doctor twice involves at least 200 visits, and if three times, 300 visits etc. If an hour is spent getting information from each doctor, a total of over 100 hours is involved. This outline gives an idea as to how time-consuming this exercise was. There were only two or three group practices or small clinics where I could leave a few questionnaires and come back and collect them all together. My own limited time meant that some doctors were missed from the sample.

3) Missed doctors

Some doctors did not fill in a questionnaire as I could not find them. I obtained a list of the doctors who were in the doctors union (naqaba), but I soon found out that this did not include all the doctors practising in Ramallah. Some, for political or personal reasons, had left the union or never joined. One doctor whose name was on the union list, I was specifically told not to go and see as he was a collaborator and an "x" had been put next to his name.

4) Low response rate

Overall, I think I managed to get a response rate of around 50%, that is about a hundred out of the almost 200 registered doctors. However, many of the missed doctors were specialists in areas unrelated to suicide, for

instance, dermatologists, ophthalmologists, and paediatricians. Out of the general practitioners the response rate was higher, perhaps 60% or 70%. These are only estimates owing to the difficulty of determining how many practising GPs there are. The health system in Palestine is somewhat confusing, particularly in the private sector. It appears that just about anyone can put up a sign saying that he is a doctor and then start practising.⁴¹

5) Memory and Motivation: Under-reporting and Inaccurate reporting of cases

Doctors were often busy and not very motivated to fill in the questionnaire at all, let alone enter as many suicidal cases as they could remember. Some did not see the point of the questionnaire and so had to be persuaded and cajoled to answer the questions. None of the private doctors appeared to keep systematic records of the cases they had seen, so they had to rely on memory. Hence, I am sure that many cases, particularly those that occurred some years ago would have been forgotten. Assuming that people remember more of the recent past than the distant past, more cases would be expected to be reported recently than in the past. The reporting of the cases themselves is also quite inaccurate. Many doctors could not remember the date of the suicide case nor the patient's details, such as age and marital status at that time, as they had since seen so many different medical cases and the suicidal case was one which had occurred a long time ago. However, for 1998, the year I was particularly interested in, memory would be expected to be more accurate and the figures to be more reliable than for other years.

6) Repeated cases

Besides under-reporting, there was also some 'over'-reporting in that a few of the cases appeared to have been repeated. For example, there was a suicidal attempt by a 19-year-old boy from a refugee camp in November 1998. I saw him in the government hospital and spoke with his family and some friends. They reported that he had spent the year retaking the school leaving certificate (tawjihi), which he had failed again that summer. He was helping his father in a workshop. After an argument between them, the

⁴¹ In my opinion, the lack of regulation of medical practice is one of the most serious and worrying aspects of Palestinian medical care. Of course, as occurred in England, it is very difficult to regulate private doctors as they often have considerable financial and social power.

boy went off and drank half a bottle of an organophosphate ('feledol'). He remained in Ramallah hospital for several weeks. He did not die, but was left permanently brain damaged. This incident was reported on the questionnaires by four doctors in four different ways:

i) The camp doctor:

24-year-old single male, camp, reached preparatory school, labourer suicide attempt, poison, half bottle of feledol, went to government hospital

He wrote that he had visited the man in hospital.

ii) Private endocrinologist:

22-year-old married male, camp, reached preparatory school, labourer actual suicide (reported died after 2 days in hospital), drug - organophosphate went to government hospital

Not clear how he saw him, reported that he had transferred him to hospital (?).

iii) Hospital doctor with private practice:

19 year old single male, camp, secondary school, labourer suicide attempt, poison, feledol (organophosphate compound) seen in hospital

iv) Private GP:

18-year old single male, camp, secondary school, ?work suicide attempt, poison - organophosphate transferred to the hospital

These four versions of the same case show how the details can vary and thus that the data from the questionnaires contains some considerable inaccuracies. Allowance was made for such obviously repeated cases when preparing the charts, but there may be repeated cases I am unaware of as the details vary too much for them to be recognised as the same case.

7) Doctor's length of practice

Some of the older doctors who had practised in Ramallah prior to the Intifada

were now dead, and many of the younger doctors had only started to practise after the end of the Intifada, so they could only talk of cases since the Intifada, and were not able to comment on trends.

Findings from doctors' questionnaire

Positive outcome

By visiting all the doctors, I could discuss the issue of suicide with some of them and some made interesting comments. The main aim of the questionnaire had been to find out more about where suicide cases were going for treatment and, in that sense, it was useful.

A) Destination of the suicide cases

According to the questionnaire, and this was confirmed by talking to other health professionals, suicide cases that did not go to Ramallah government hospital might go to a number of places: GP's or other private doctors, one of three private hospitals in Ramallah with an emergency room, that is Khalid Hospital, the Arab Care Hospital, the Red Crescent Hospital, Al-Makassid Hospital - a private charitable hospital in Jerusalem - or Israeli hospitals. (Figure 4.1, left hand side)

Private hospitals

These hospitals have only started to have ER in the past few years, that is since the signing of the Oslo agreement. Khalid and Arab Care are fairly new hospitals.

Khalid Hospital. On talking to doctors in Khalid Hospital (and administering a questionnaire), I was told about four cases of suicide: three attempts and one actual.

Arab Care. Staff here reported two cases of attempted suicide, neither of which was reported to the police.

Red Crescent Hospital. The staff in the emergency room said that they had not seen any cases, but I felt perhaps they could not be bothered to fill in a form.

Al-Makassid Hospital (Jerusalem). During the year, I spent some time training in the Al-Makassid hospital, which is a Charitable Islamic Hospital situated on the Mount of Olives in Jerusalem. Recently, a psychologist and a counsellor have been added to the social services department. The psychologist reported that some cases of suicide had come from Ramallah, and she believed they had chosen to come to Jerusalem as the family knew that it was highly unlikely that the Palestinian staff or administration would inform the Israeli police which govern Jerusalem. However, since 1994, one year after the Oslo agreement, the Israelis have tried to close off the rest of the West Bank from Jerusalem and there is a military checkpoint on the road from Ramallah. To get past it you need either a foreign passport, a Jerusalem ID card that shows you are a resident of Jerusalem, or a permit to enter the city. This rules out most West Bankers. Although there are ways of getting around the checkpoint, it still prevents people from using Al-Makassid as frequently as they did previously.

Israeli Hospitals. A psychiatrist in Ramallah suggested that a few cases may go to Israeli hospitals as they would be assured of secrecy. However, it is often difficult for Palestinians in the West Bank to obtain treatment from these hospitals since the cost of treatment is very high, they do not have medical insurance and they have relatively low salaries, in comparison with Israelis.

The majority of cases of suicide that the doctors saw just after the patient had taken the suicidal action⁴² were reported to have been transferred to hospital (68.8%). In 8.6% of the cases the patient was already dead, and in 22.6% of the cases the patient was treated and sent home.

In the 106 cases the doctor specified what kind of hospital the patient went to: 76 (71.7%) went to the government hospital and 30 (28.3%) went to a private hospital. During 1998, the year that I was recording and seeing cases in Ramallah government hospital, the doctors reported 18 cases of

⁴² Some doctors saw suicide cases after they had received the emergency treatment, that is, they were treating them for the later effects of the suicidal act. For example, a private ENT surgeon saw a woman who had broken her jaw after throwing herself from the top of a building. Other doctors saw the patients for other reasons such as for endocrinology problems or psychiatric treatment but, as their doctors, they knew about their suicide or attempted suicide.

suicide, seven went to the government hospital (38.9%), five to private hospitals (27.8%) and six did not go to hospital (33.3%).

B) The characteristics of the patients seeing private doctors (Figure 4.10)

- 1) Most cases overall were young, and fell into the age group 18 to 24 years. As in the public sphere, however, when the cases were split into fatal and attempted suicide, the two groups showed different age distributions. For attempted suicides by far the largest age group was 18 to 24, with only two attempted suicides over the age of 45 years, whereas fatal suicides were more evenly distributed among the age groups, the greatest number being in the group 31-45 years. Whereas 77.6% of the attempted suicides were under the age of 30 years, only 41.1% of the fatal suicides were. (Diagrams 1a to 1d)
- 2) The majority (64%) of all suicide cases were female. Again, however, when attempted and actual suicide were separated the characteristics were somewhat different. For the fatal suicide the majority were male (60%) and for attempted suicides the majority, by far, were female (75%). (Diagrams 2a and 2b)
- 3) The most common method used overall was medicinal drugs (53.7%), with poisoning⁴³ coming next (17.6%). When the fatal were separated from the attempted suicides, again they showed different characteristics. The fatal cases used drugs proportionately less (only 22.9%) and employed more violent methods such as burning, hanging and lacerations, besides poison. The attempted suicide cases mainly used drugs (64.5%) (Diagrams 3a and 3b). There were sex differences: the use of drugs is much more common in women (65.5%) than in men (31.9%). Male cases used proportionately more poison than women and more male caused violent methods such as burning, hanging and lacerations (36.1%) in comparison to women (11.4%).⁴⁴ Interestingly however, only women were reported as having thrown themselves from a height,

43 This group includes harmful fluid substances consumed other than medicine eg. insecticide.

44 This is not including 'throwing oneself from a height' as a violent method. If it is included, then the percentage rises to 20.6%.

representing 9.2% of the methods used by women. This is interesting as the police station statistics for 1998 included four cases of fatal suicide and all were female, all threw themselves from a height. No men were reported as having thrown themselves from a height.

- 4) The cases overall were quite evenly split according to marital status: 44.1% were single and 49.3% were married, while 2.9% were divorced. In this sample, the fatal cases of suicide were more likely to be married: 62.9% were married and 31.4% single. In the attempted suicide cases there was also a difference but the other way round: more attempted cases were single (48.7%) than female (44.7%), but the difference was much less. (Diagrams 4a and 4b)
- 5) No particular place of residence predominated: overall 37.5% were from the town, 43.4% from a village, and 13.2% from a camp. However, whereas fatal suicides were mainly from the villages (62.9%), the majority of attempted suicides were from the town. However, the number of attempted cases from the villages (34.2%) was similar to that from the towns (39.5%). Only 18.4% were from the camps. (Diagrams 5a and 5b) However, if the normal distribution of the population in Ramallah between towns, villages and camps is taken into account, the percentages of the suicide attempts from the towns and camps appears significantly higher than normal.⁴⁵

C) Trends

The methodological problems of collecting this data have been described and must be borne in mind. Often the doctors were relying on memory so the cases they report should not be taken in the same way as those recorded in writing. Nevertheless, the findings are still interesting.

If the fatal suicide trends reported by the questionnaire are compared with those for attempted suicide, the levels of the former seem to remain more stable and at a low level, whereas the attempted suicide levels do seem to

⁴⁵ The normal distribution of the population between town, village and camp in Ramallah is approximately: town 22% (44,738), village 72% (145,853) and camp 6% (13,162). Figures from Final 1997 census results, Population, Housing Units, Buildings and Establishments, Ramallah/Al-Bireh, published 1999.

rise considerably after the end of the Intifada. (Diagrams 6a and 6b) This parallels the situation in the public sphere. There are a number of possible reasons for these figures other than this being the actual situation. It could be that doctors reporting cases from previous years are more likely to remember fatal suicides than the suicide attempts. Also, some of the doctors had only started to practice in Ramallah recently and 23% had been practising for less than five years, so a rise in the number of cases reported recently would be expected.

Figure 4.10: Diagrams showing findings from doctors questionnaire

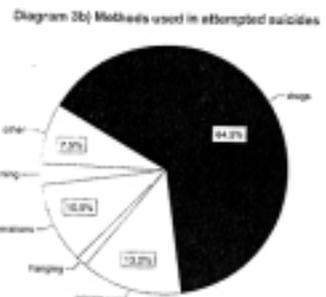
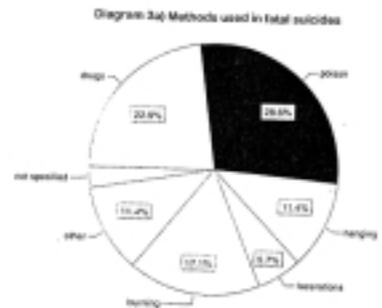
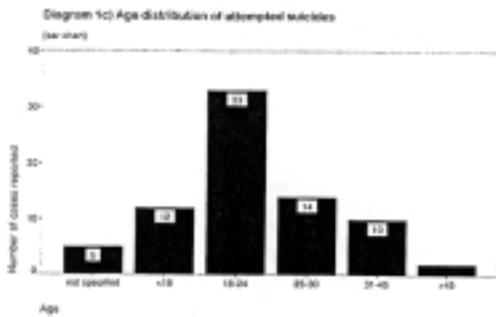
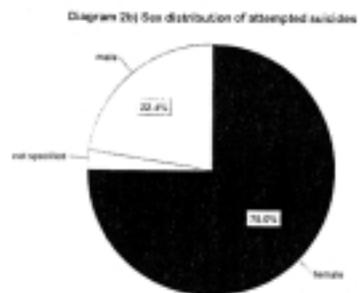
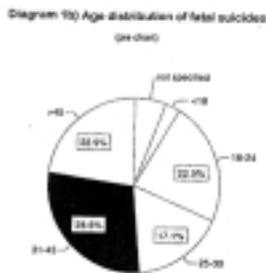
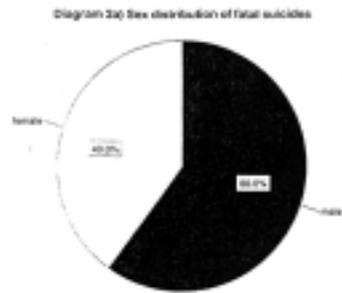
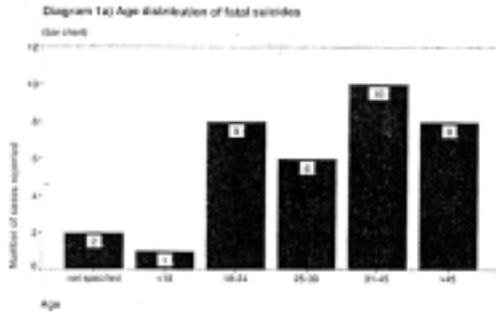


Diagram 4a) Marital status of total suicides

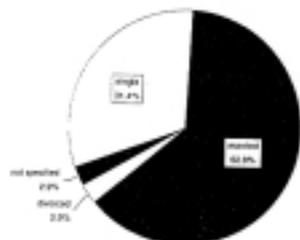


Diagram 4b) Marital status of attempted suicides

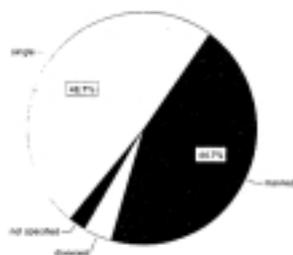


Diagram 5a) Place of residence of total suicides



Diagram 5b) Place of residence of attempted suicides

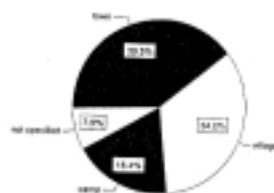


Diagram 6a) Date of total suicides

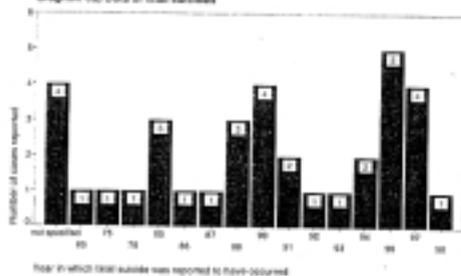
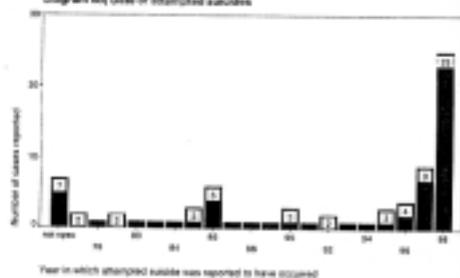


Diagram 6b) Date of attempted suicides



Of all the doctors questioned, 46.8% said they had seen at least one case of suicide and 53.2% said they had never seen a case of suicide. However, if just the GP's replies were considered, since some of the specialists would not necessarily see suicide cases, then 67.4% of GP's said that they had seen at least one case of suicide.

The period after the Intifada was given by 43.2% of the doctors as the period when they had seen most cases of suicide. In contrast, 15.9% said they saw the greatest number during the Intifada and 18.2% before the Intifada. The remaining 22.7% did not answer this question. When only GP's were considered, the distributions were similar although a slightly higher proportion reported seeing the greatest number of cases during the Intifada (24.1%) and fewer reported seeing the most cases before the Intifada (10.3%).

When asked, 'In your opinion has suicide increased over the past few years?' 45.7% of all doctors said, 'Yes', 31.9% said, 'No' and 19.1% said they did not know, while 3.3% did not respond. Of the GP's, as many as 62.8% said they thought it had increased and 23.3% did not; 9.3% said they didn't know and 4.6% did not respond. Of course, these figures only reflect their opinions which have been subject to a variety of influences, including the often cited newspaper reports of suicide.

Significance of the results of the questionnaire

The results of the questionnaire produced information which enabled the situation in the private sphere to be more fully understood, as shown diagrammatically in Figure 4.1. Cases not referred to the government hospital, go to private hospitals in Ramallah, Jerusalem and Israel, while others are only seen by a private doctor.

The characteristics of the cases described by the doctors are generally similar to those found in the public sphere as well as to those found in studies in the West. Females attempt suicide more than males; males succeed in suicide more than females; attempted suicides are mainly young; fatal suicides generally older. Women are more likely to use drugs and other 'soft' methods, whereas men are more likely to use relatively violent methods.

In spite of the imprecise nature of this data, it is interesting that the trends reported show a greater rise in attempted suicides rather than fatal suicides, which seem to have stayed at a low and more or less constant level. A further important finding is that 'suicide' is definitely not a new and foreign entity in the West Bank; doctors reported seeing cases of suicide as far back as 1965.

Invisible Cases (see Figure 4.1)

Some instances of suicide never appear in the statistics. From hearsay, it seems that women in villages may try to commit suicide by burning themselves or throwing themselves down a well which may be recorded as an accident. Stories of this kind emanated from the villages of the north of the West Bank, in particular, and corresponded with tales from the northern villages of neighbouring Jordan.

A nurse told me that she had recently found out that a woman who had burned herself severely some 15 years earlier had done so in order to kill herself. All attempts to talk to her were turned down by her husband who was worried about confidentiality and, understandably, wanted to put the whole incident into the past. Cases such as these are truly private, they are usually not heard of and go unrecorded.

When medical treatment is not sought, deaths are attributed to accidents, and some non-fatal suicidal acts are treated at home. The possibility of this last option is borne out by the results of a study on bullying in schools which included a question on suicide.⁴⁶ The confidential questionnaire was completed by about a thousand school girls in Ramallah governorate and found out that 25% had thought of committing suicide and almost 7% had attempted suicide. Of these, 34.8% did not get any medical treatment, that is they were invisible cases. Also, 22% of the school girls knew someone who had attempted suicide.

Presumably such cases are only a small minority of the actual suicide cases but this cannot be substantiated in the absence of hard evidence. They should,

46 Hala Salim was carrying out PhD research on bullying in schools. As part of her research she administered a questionnaire to school girls in the Ramallah area. A question on suicide was included. Institute of Community and Public Health, Birzeit University, 1997.

however, be borne in mind when trying to estimate suicide rates.

Estimating the annual incidence of suicide in Ramallah.

Having assessed all the sources and considered the biases and other factors involved, I think that an estimate can be made for rates of actual and attempted suicide in the Ramallah area for the one-year period during which I was collecting data there, from November 1997 to November 1998, but estimates before that are problematic. See Table 4.3. where the findings from the public and private sphere are summarised and minimum and maximum estimates for rates of suicide are made.

When compared with other countries these rates of suicide and attempted suicide are very low. Globally, some of the highest fatal suicide rates per 100,000 are recorded for Hungary at 38.6, and Sri Lanka at 33.2. The lowest rates are in Venezuela at 4.8, and Mexico at 2.3. The UK and Israel rates are 7.9 and 7.8, respectively. In Europe, the highest attempted suicide rates are among women in France, at 462, and the lowest among men in Spain at 45. Of course, the rates of fatal and attempted suicide estimated for Ramallah are the absolute minimum rates. As already mentioned there are many cases which could have been missed from this calculation. However, these estimated Palestinian rates are still far higher than those calculated from the official Palestinian statistics.

Table 4.3 Estimating the annual incidence of suicide in Ramallah, November 1997 to 1998

PUBLIC SPHERE						
	Ramallah Hospital	Ramallah Police Station	Official Statistics		Newspaper Reports	
			A	C (98)		
Suicide attempts (SA)	28	10	8	4	2	
'Probable' Suicide Attempts (?SA)	12	-	-	-	-	
'Possible' Suicide Attempts (??SA)	4	-	-	-	-	
Suicides (S)	4	3	2	2	0	
PRIVATE SPHERE						
	GP'S	PRIVATE HOSPITALS				
		Khalid	Arab Care	Red Crescent	Al-Makassid	Israeli
SA	6	4	2	0	72	-
S	0	1	0	0	0	-
OTHER (INVISIBLE) CASES*						
No statistics available						

*Refers to cases that are not included in any statistics as they are not brought to medical attention

ESTIMATE OF THE RATE PER 100,000

	Suicide Attempts	Suicides
Ramallah Hospital	28	4
GP's only	6	0
Private Hospitals	6	1
Al-Makassid Hospital	2	0
Israeli hospitals	-	-
TOTAL	42	5

Minimum rate:

Since the population of Ramallah is about 200,000, rate per 100,000 is obtained by dividing 42 by 2

Therefore, minimum number of suicide attempts per annum is	21
Minimum number of fatal suicides per annum is	2.5

Maximum rate:

Including cases of 'probable SA' and 'possible SA' who entered Ramallah hospital =

42 suicide attempts + 12 'probable' + 4 'possible' equals **58**

Dividing by 2, as above, gives the rate per 100,000 as **29**

i.e. the maximum number of possible suicide attempts that received some medical care apart from the invisible cases.

SUMMARY AND CONCLUSIONS

After tracing the history of our 20th century Western obsession with using numbers to understand nearly every aspect of life, it is conceded that numbers can be useful in building up an epidemiological picture, looking for trends, and quantifying the magnitude of an issue, such as parasuicide. However, it is emphasised that the numbers themselves are not always the product of 'objective knowledge'.

The process of gathering suicide statistics has been described and used to highlight the many factors, including social forces, which lie behind the numbers and mould and influence the construction of the statistics. Overall the data analysed enables some conclusions to be drawn about suicidal behaviour in Palestine:

- 1) Suicide is not a totally 'new' phenomenon or 'foreign' mode of behaviour. It was popularly thought that it did not occur in Palestine, nor in the Arab world, but evidence has been found to show that suicide and attempted suicide have been taking place for at least the last 30 years.
- 2) The epidemiological picture built up from public sources appears to be very similar to that found in the West, with different characteristics for attempted suicide and actual suicide. Attempted suicide is much more common, being largely carried out by young people, mainly women, often using 'soft' methods such as drugs. Fatal suicide appears to be generally committed by older age groups, more often by men, using more violent methods. A particular feature of the Palestinian setting is the use of insecticides, which provide a readily available method of suicide for those who work on the land, and probably reflects the high proportion of people living in villages and the dominant 'peasant' background of many Palestinians. Throwing oneself from a height seems, at least in the case of Ramallah, to be a method almost exclusively chosen by women.
- 3) The picture built up from 'private' medical sources seems largely to concur with the picture built up from public sources.

- 4) It is almost impossible to comment on the truly private cases of suicides, such as those of women in villages who were reported verbally as having burned themselves, or other self-caused deaths or injuries classified as accidents. My attempts to talk to people who had attempted suicide in this way were unsuccessful.⁴⁷
- 5) Looking back into the past to find trends was also found to be difficult. However, it did gradually appear that fatal suicide levels may have remained at much the same low levels for the last 30 years, whereas there does seem to have been some increase in the number of cases of attempted suicide, particularly those who overdosed on medicinal drugs.

As West Bank Palestinian society becomes increasingly 'modern', it may be that distressed people are increasingly turning to 'modern' types of self-harm or suicidal behaviour, such as taking drug overdoses. Verbal reports from older doctors do seem to suggest that fewer women are now attempting suicide by burning themselves, which may be regarded as a more 'traditional' method.

At the start of the chapter the issue was raised whether the 'suicide phenomenon' of the late 1990's, which was the subject of much public discourse, was the result of a moral panic or due to a real 'phenomenal' increase in the incidence of suicide. There is no conclusive answer, but I suggest that two main changes have been taking place in parallel. First, there has been a slight increase in the number of suicide attempts, which may be attributed to the historical, social and political context of the period (described in Chapter Three) and, second, there has been an increase in the public recording and reporting of cases of suicide. Both factors have together helped to trigger a moral panic.

47 A psychiatric nurse Najah Munasra who teaches psychiatry in a nurses training college in Ramallah also wanted to investigate these suicide cases of women burning themselves, particularly in the village of the North of the West Bank, after getting reports of such cases from her students from those areas. She found it too difficult and abandoned the study.

Conclusions and Recommendations

Conclusions

Several conclusions can be drawn from this thesis which has tried to put suicidal behaviour, in all its complexity, into a social, economic, political and historical context.

The statistical material (Chapter Four) indicates that even when ‘invisible,’ undocumented cases are taken into account, levels of suicide and attempted suicide in Arab Palestinian society are low when compared with other regions of the world, although suicide attempts by overdosing may be on the increase.

It appears that cultural rules about suicidal behaviour as seen in the thoughts, ideas and attitudes discussed (mainly in Chapters Two and Three) still hold. Ultimately the act of killing oneself is that of an individual, but Kral argues that ‘it is less a solo venture than a product of a collectivity of ideas.’⁴⁸ And, I would add, circumstances.

The public response to the ‘phenomenon’ of suicide in the West Bank, or ‘moral panic’, was found to be strongly influenced by the ideas about self-killing and self-harm in Arab (mainly Islamic) thought, that formed part of the local context. The panic in Palestinian society appeared to serve to reinforce cultural rules on suicide and, indeed, Cohen, argued that moral panics serve to reaffirm cultural attitudes.

Although the levels are low, the existence of suicidal behaviour the Arab Palestinian society of the West Bank is graphically borne out by the biographical material in the interviews from the cases of parasuicide seen. The suicidal actions of these particular men and women have been seen to be a means of communication when words fail, an act of protest or rebellion, a cry for help and attention⁴⁹, or an act of desperation when an individual’s

48 Kral, M. ‘Suicide and the Internalization of Culture: Three Questions’ *Transcultural psychiatry* 35 (2), June 1998.

49 See also Littlewood’s paper ‘Agency, opposition and resistance: a systemic approach to psychological illness in sub-dominant groups’, in T. Pollard & S. Hyatt (eds), *Sex, Gender and Health*, Cambridge University Press, Cambridge, 1999, pp.137-161, which discusses the instrumentality of overdoses: ‘Whilst the reasons given by-

will to go on living in particular circumstances in society has been lost.

In some cases the difficult circumstances of those who attempted suicide appeared to have been exacerbated by prominent social institutions, such as marriage and the family, in that the individuals found themselves to be in a powerless or anomalous position within them.

Parasuicide, gender and the concept of honour

For women in the West Bank social status has been seen to be largely determined by marital status. Each state, unmarried, married or divorced, results in certain strains. Society has high expectations for the unmarried woman to be chaste, the daughter to be dutiful, and the wife and mother to be obedient. Some of the women interviewed felt unable to cope or simply unappreciated. Since for the majority of women life revolves around the family, and there are limited alternatives or outlets available, they can experience a marked sense of entrapment being confined to house and family.

Men are also subject to high expectations. They can feel pressurised to find work, to make money, and to provide for, support and protect their family, all of which can make them also feel trapped and confined by their situation.

Although the worlds of men and women, shown by the narratives, are very different, there is a danger in creating monolithic stereotypes in any society, including those of the Mediterranean and Middle East. 'The category of "women" is no more monolithic than that of "men"', according to Nancy Lindisfarne, 'Anthropological descriptions have often emphasised idealised, hegemonic versions of gendered identities and ignored the shifting reality of people's experience as gendered beings.' She finds this emphasis is particularly evident in the literature of honour and shame. The categorical images of dominant competitive men and passive women presented in summary accounts are often contradicted in more extended ethnographic descriptions. She says that 'When attention is paid to everyday negotiations

-the individual for 'taking overdoses' are often expressive... they may be instrumental - that is they are explained in terms of the desired consequences of the act, such as the desire for support or understanding.' He adds, 'While overdoses can be seen as strategies designed to avoid or change specific situations, the experience of the principal is one of distress, social dislocation and extrusion.' p.141.

involving men and women a range of variant masculinities and femininities emerges.⁵⁰

Two interviewees in this study, Samira and Diab, illustrate this by showing some behaviour that could be labelled as more typical of the opposite gender. Samira is educated and works to support and provide for her husband and children. Although she complained about her low social status due to her ineffective and wayward husband, she also said that she preferred it when he reverted to his drug addiction because 'I would feel bigger than him, and than him', which is a sentiment more typical of a male. When Diab is threatened with desertion by his more educated fiancée, because she thinks she can find a better man, he resorts to an apparently impulsive overdose, which is soon regretted and seems to be a plea for attention more typical of the behaviour of a female parasuicide.

Over-enthusiastic use of the concept of honour can result in unfortunate stereotyping and is criticised by Herzfield who believes that the notion of a pan-Mediterranean honour code contributes to a sort of 'exoticism' in a potentially damaging way⁵¹. Separating out Mediterranean cultures by focussing on honour, leads to such a strong sense of 'otherness' that it discourages comparisons with other cultures. It may be used to indiscriminately separate them from their neighbours and suggest that whole populations are incapable of concerted industrial and economic development.⁵²

Nevertheless, there are ideas in the anthropological literature on Mediterranean concepts of honour and shame appear to fit well with the data I collected and help to explain many aspects of Palestinian society, particularly with regard to the position of men. It is, however, impossible for such concepts to cover the messy complexities of social life, and divisions between the sexes can be less clear cut and more ambiguous than they initially appear.

50 N.Lindisfarne 'Variant Masculinities, Variant Virginites', in A.Cornwall & N.Lindisfarne (eds), *Dislocating Masculinity: Comparative ethnographies*, Routledge, London, 1994, pp.82-3.

51 Herzfield, M. "'As in your house": Hospitality, Ethnography and the Stereotype of Mediterranean Society' in D.Gilmore, *Honour, Shame and Unity of the Mediterranean*, *American Anthropological Association*, no.22, 1987, pp.75-6.

52 *ibid.*, p.87.

If a society is considered from only one gender perspective, only half the picture is seen and experiences common to both men and women may be missed. A study of suicide in Palestine which looked only at women would surely conclude that many women feel confined and long to escape. This would add fuel to the belief that Arab women are trapped and suppressed, which is certainly true in many ways, but it would miss the fact that men in Palestine also feel trapped and long to escape. However, whereas women want to break free from the house, men want to break free from the society altogether.

Parasuicide and powerlessness

The interviews I made and the epidemiological data I gathered in Ramallah between 1997 and 1998, show that not only are certain aspects of suicidal behaviour in Palestinian society similar to Western suicidal behaviour, but the incidence also accords with Hodes' conclusions when he reviewed the epidemiology of overdosing in the West, that 'the highest rates occur among the least powerful in society: the young, women, the unemployed and those in lower socioeconomic groups⁵³'. However, it needs to be borne in mind that my data may be subject to bias due to methodological problems, the small size of the sample, and unavoidably missed cases.

According to Hodes, the groups with the highest suicide rates are 'the least powerful in society'. Detailed epidemiological studies carried out in the UK support a link between powerlessness and overdosing and Hodes explains that 'this may be because they [the relatively powerless in society] are ineffective communicators as they lack the language skills, or because their verbal communications do not maintain the attention of the intended receiver or produce the desired effects⁵⁴'. His ideas are also applied to the ways in which young people and women deal with the power of the dominant group in other parts of the world on the basis of reports from social anthropologists. Most famously, in what appears to be a cry for changes in parental behaviour towards them, young men and women in Tikopia attempt

53 M.Hodes, 'Overdosing as communication: A cultural perspective', *British Journal of Medical Psychology*, Vol.63, 1990, pp.327-8. Referring to the work of Hawton & Catalan 1987, Hawton et al. 1988, Krietman 1977, Morgan et al. 1975, Platt 1986 & Revoize et al. 1989.

54 *ibid.*, p.329

suicide by swimming or canoeing out to sea. Other behaviour which appears to be a way for the relatively powerless to gain some power from the dominant groups, include zar. The zar sick role tends to be adopted by urban Sudanese women when they fail to live up to an expected female role, do not find a suitable spouse, have unsatisfactory marriages, fail to produce children, or are married with children yet find life unsatisfactory.⁵⁵

In Palestinian society, the cases of parasuicide in this study, which were largely overdoses, certainly seemed to come from the least powerful groups. Notable was the substantial proportion of newly married women who are in the least powerful position within the household.

Life without work is devastating for men and some of the narratives build a picture of the realities underlying high unemployment figures, and the damaging effects of the high unemployment and poor economic situation. The situation in the West Bank has deteriorated dramatically since the Oslo agreement and in Gaza the unemployment situation is even worse with access to Israel even more tightly controlled with Arab workers having to obtain security passes and walk each day through a long tunnel to get into Israel.

Also illustrated by the narratives are the damaging effects of occupation, political violence and war. Suffering can be long-term and wide reaching for the pain does not stop when the killing stops, the imprisonment is over, or a peace treaty is signed. Indeed, the Oslo Agreement and ensuing peace treaties have not even managed to stop the killings, injuries, house demolitions and land confiscations. The tales of these men and women show the 'ripple effects of war', the repercussions of an occupation which has sought to strip the population of their land, culture, identity, and traditional ways of life. There is no 'Peace in the Middle East'. The suffering continues. The levels of anxiety after the Intifada in 1994, were shown by psychiatrist Samir Quota's study to be higher than the levels in 1984.

⁵⁵ According to Constantinides in the introduction to 'Zar in Context: The past, the present and future of an African healing cult', Lewis, Al-Safi, Hureiz (eds), *Women's medicine: The Zar-Bori Cult in Africa and Beyond*, Edinburgh, 1991, pp.1-16.

When society comes under stress, the greatest strain falls on the 'weakest' members of the society. In fact, they need enormous strength in order to deal with their situation, particularly Muslim women who, given the tremendous stresses described, have more reason than ever for resorting to such measures as overdosing. Perhaps ultimately this thesis is a testament to the strength women and other powerless groups in Arab Palestinian society need to have, rather than the weakness of the particular women who attempted suicide.

Modernisation and Westernisation

Are the so-called 'modernisation' and 'Westernisation' of Palestinian society leading to patterns of suicidal behaviour increasingly similar to those in the West? There does appear to have been an increase in overdosing in the 90's in comparison with the 80's, although it is not possible to estimate its magnitude. Could this be the result of an increase in the degree of Western-type individualism? If so, it may be that other aspect of mental illness, previously thought of as more 'Western', such as depression and eating disorders, will also become increasingly common in non-Western settings such as Palestine.

It is interesting to note that Littlewood writes, "'Overdoses" appear to be a relatively discrete reaction which appears, historically and geographically, culturally specific to industrialised societies, especially to the United States and Britain.' Such biosocial patterns of behaviour', he writes, 'frequently articulate personal predicament but they also represent public concerns, usually what we may take as core structural oppositions between age groups or the sexes. They have a shared meaning as public and dramatic representations in an individual whose personal situation demonstrates these oppositions... At the same time they have a personal expressive meaning for the particular individual for whom they may be regarded as individually functional ('instrumental').⁵⁶ Basically he argues that these patterns of behaviour, such as overdosing, 'appear to occur where major points of

56 See R.Littlewood, op.cit., 1999, pp.143-144. He adds, 'How "conscious" the principal is of pragmatically employing the mechanism as a personal strategy is debatable but it may be noted that medical observers have frequently described these reactions as "dissociative."'

political and cultural oppositions are represented in a particular subdominant individual's rather drastic situation and thus, not surprisingly, where the everyday resolution or affirmation of power relationships are inadequate as perceived solutions to the problem.⁵⁷

Coping and Coping Systems

Indeed, it must be not be forgotten that the interviewees in this study were selected on the basis that something had 'gone wrong' with their lives in that they had reached a level of distress that had led them to harm themselves to the extent that the act was considered suicidal. There are, of course, men and women Palestinian West Bank Society who have managed to cope by adjusting and adapting to difficult and changing circumstances and, in comparison with most Western countries, the estimated level of suicide and attempted suicide is still low. It can be postulated that this is related to the strength of the family, religion and the community which give many people a sense of belonging.

When young people in Gaza who had actively participated in the Intifada were studied by Brian Barber, a surprising resilience was revealed and he commented 'how remarkably competent adolescents can be'.⁵⁸ From in depth interviews with 23 young men he remarked 'Perhaps most impressive... was the degree to which these young people saw beyond themselves to the concerns and needs of the broader society. Adopting their society's agenda of redressing historical oppression and inequity was clearly the driving motive behind adolescent involvement in the Intifada. Stereotypic adolescent thrill at risk and danger was evident only occasionally.' Barber regarded the commitment which was maintained during years of sustained violence and trauma as extraordinary.⁵⁹

A surprising resilience was also shown in his study of 7,000 high school students who had participated in the Intifada. Barber attributed this resilience

⁵⁷ *ibid.*, p.147.

⁵⁸ B.Barber, 'Youth Experience in the Palestinian Intifada: A Case Study in Intensity, Complexity, Paradox and Competence', *Bringam Youth University*, p.31, 1997. To appear as a chapter in M.Yates and J.Youniss (eds) *Community Service and Civic Engagement in Youth: International Perspectives*, New York, Cambridge University Press.

⁵⁹ *ibid.*, p.31.

to the power of cultural norms and values and the psychological meaning that the conflict had for the child participants and their level of ideological commitment to the underlying cause. 'Although Arab cultures in general place high value on family, education, and religion, the rather unique history of Palestinian tension with or isolation from other Arab cultures, and the decades of occupation by Britain and Israel, appear to have accentuated the importance of these values for the survival of the culture.⁶⁰' He proposed that the limited impact of involvement in the Intifada on parenting revealed the institutional resilience of the Palestinian family in the face of politically based conflict. Indeed, he concluded elsewhere that, 'Now, some years after the formal end of the struggle, negative consequences can still be observed, mostly in heightened participation in some forms of deviant behaviour. For those who are well integrated into the value-rich social institutions of family, education and religion, this effect was not apparent.⁶¹'

This conclusion of Barber's fits in well with my own observations, particularly for the men. The individuals whom I interviewed had shown 'deviant' behaviour, such as by attempting suicide, and appeared to be poorly integrated into the social institutions of the family, education and religion. Indeed, they sometimes seemed to be in an 'anomalous' position, particularly with regard to the family. Even so, the generally low level of suicide and attempted suicide suggests the value of the social institutions in helping people to cope with life's stresses.

Implications and Recommendations for Social Policy

There are a few measures which could be taken to reduce stress levels, although some of the sources of the difficulties faced by the men and women who attempted suicide are difficult to change, in particular the political and economic situation. Continued Israeli hegemony over the region is restrictive and often punitive, including closures of the West Bank, control of vital resources such as water, restrictions on trade and industry, and continued

60 B.Barber 'Political Violence, Family Violence and Palestinian Child Functioning', Brigham Young University. Paper presented at the Gaza Community Mental Health Programme conference on 'Health and Human Rights', October 1997, p.21.

61 B.Barber, 'Palestinian Children and Adolescents during and after the Intifada', Palestine-Israel Journal of Politics, Economics and Culture, Vol.IV, No.1, 1997, p.31. Deviant behaviour included smoking, drinking, stealing, running away from home.

human rights violations in the form of imprisonment, land confiscation and house demolitions.

1) Provision of employment for men

Strategies to provide means of employment for men should be at the top of the PNA's agenda. There are surely some measures that could be taken even though they are working within such a difficult framework of restrictions.

2) Reduction of wealth differentials

The PNA should certainly take steps to curb the dramatic increases in wealth differentials between the rich and poor which only add to many people's sense of frustration and resentment which is often directed towards the PNA.

3) Bolstering social institutions: the family, education and religion.

The social institutions of the family, education and religion have been seen to be fundamental support systems that help people cope with difficult circumstances. Indeed they, and their social and cultural values, are considered the main reason why Palestinians have shown such resilience in the face of very adverse conditions, so any measures which bolster the family are helpful. Poor economic circumstances put a strain on families, a further reason for needing an improvement in for the economic situation. Education was severely disrupted during the Intifada and needs to be strengthened.

a) Reducing domestic violence

A number of the women interviewed had taken overdoses while or after having been beaten up and abused by their husbands, so campaigns to reduce levels of domestic violence, such as the 'Violence Against Women' campaign, could be helpful. Family response seems to be very important in affecting the outcome of a case of parasuicide. When the family listened and took action, for instance by criticising the husband for his behaviour towards his wife, the situation appeared to improve. An interesting finding was the role of the mother-in-law in restricting her son's behaviour towards his wife. The family's role could be reinforced by religious leaders if they discouraged men from abusing their wives. The aya which condones beating

one's wife is often quoted to justify beating, but there are many other ayas and hadith which commend the husband who looks after his wife well. As with family cohesion, poor economic circumstances can be an important factor in domestic violence.

b) Discouraging early marriage

Several women's groups are trying to tackle the issue of early marriage, although this can be a sensitive matter in a society which often encourages it. Frequently this is for economic reasons, so it is another stress factor that should be reduced by an improvement in the economic situation. Early marriages can be happy and successful, but they are a problem when they are not and the woman is unhappy, divorced, or has lost her opportunity to become educated. This study has shown that girls often marry in an attempt to escape from an unhappy family home or to increase their freedom. Educational institutions, such as schools, could highlight the potential difficulties of marrying young, while at the same time they could provide activities for adolescent girls so that their lives are not solely filled with often mundane schoolwork and housework. They should be strongly encouraged to finish high school before marrying and legislation to this effect could be beneficial. Some of the more enlightened religious leaders and institutions could also play a role in encouraging families to allow girls to finish their education before marrying.

4) Provision of help in the public domain - the stigma of mental health

a) Psychologists and psychiatrists

Like many societies, Palestinian society is divided between public and private domains. Mental illness is often stigmatised, psychiatrists are seen as being for 'mad' people only, and most suicidal behaviour is generally kept in the very private domain of the home and family. It is therefore difficult to intervene. Similar problems were faced in the UK when trying to deal with domestic violence. The police were very uneasy about entering people's homes to deal with domestic violence which was considered to be in the private domain and outside their public remit. This distinction of the two domains and the stigma attached to mental illness is very important. After I had interviewed each of the men and women, I gave them Dr Mansour's number and told them that they could go and see her, free of

charge, if they ever wanted someone to talk to. They only needed to phone her to make an appointment to go and see her in Birzeit University, yet during the year of this study, only two people responded and went to see her. Not only would it have seemed strange to go to a psychologist, but it would also be difficult, particularly for women, to leave the house, go to Birzeit and talk to a ‘stranger’, thereby entering the public domain.

b) Women’s groups.

The attitudes above form part of the dilemma faced by some of the new women’s groups in Ramallah town. Some have smart reception rooms, but I feel that they must seem a very alien environment to many women and make them feel extremely uncomfortable. The well meaning ‘modern’ women with tight jeans, big hair and make up who run the groups are full of energy and ideas, but must appear to be from another world to the women whom I interviewed, who had lead very sheltered lives at home, surrounded almost continuously by relatives. This heavy reliance on family means that if it fails to provide support, and the women’s groups are intimidating, there are few places to turn to. Efforts should be made to provide more accessible alternatives.

c) Provision of health professionals with relevant training in hospitals

One way to ‘gain access’ to suicidal cases is in hospital, as I did in this study. The patient is already in the public sphere, which is less alien to them than the women’s centres or other public places. While in hospital, cases of suicide could be referred to a social worker, counsellor, psychologist or a nurse with some psychiatric training. A suitable member of staff would need to be available in the hospital 24-hours a day and would also need to develop a good relationship with the other health professionals, especially the doctors and nurses.

If each attempted suicide case could be listened to and interviewed about their situation then perhaps they could be helped. In some of the cases that I saw, small things could have been done to improve their situation. For example, with Diab, an improvement in the control of his epilepsy through more careful medication could potentially have been very useful. Mustapha could have been assisted more directly by helping him to get free health insurance for his wife.

I was anxious when I started this study in case nobody would want to talk to me, a stranger, about their very private problems. However, I found that nearly all of the people I interviewed appeared to appreciate being listened to and genuinely enjoyed being able to talk freely to someone who was not related to them or part of their immediate social circle and who was also not judgmental. Confidentiality is crucial and this would have to be assured and maintained. Very serious cases, who might need medication, could be referred to local psychiatrists. There seem to be two main ways help might be made available in hospitals: small health centres or specially trained nurses

- i) Small health centres. The head of the mental health services in the West Bank, the psychiatrist Bassam Al-Ashab has suggested the idea of having a mental health department within each of the government hospitals and I think this is a commendable idea in theory. A social centre was established in Jerusalem hospital a couple of years ago with a psychologist and sociologist working there. They tried to see cases of suicide and other people with psychological problems, but unfortunately the programme appeared to be fraught with problems. Crucially, the staff of the centre had failed to develop a good understanding relationship with the doctors and nurses who saw them as peripheral. In addition, the social centre was only open from 8am to 2pm and many of the attempted suicide cases came in during the afternoon or at night. These hours only added to the sense of distance between the overworked and often exhausted doctors and nurses and the staff of the centre. Even so, the presence of the centre does seem to have been beneficial in some cases, and it did hold a workshop for nursing staff to talk with a clinical psychologist about how to deal with suicide cases.
- ii) Specially trained nurses. From my experience in Ramallah Hospital, I think that the best option would be for nurses to be trained to deal with cases which seem to have psychological or social problems, such as attempted suicide cases. These nurses should have already worked in the hospital, be well liked and respected by the other health professionals, and have a genuine interest in mental health. The advantage of arranging for a nurse to deal with such cases is that he or she understands the hospital system, is aware of the stresses faced by the health professionals, and is able to integrate into the existing health care team. If there was such a

nurse always on duty, then he or she could listen to and talk to the patients and, if possible, their families so as to assess the situation and see what measures could be taken to help. When there are no cases to be seen, then he or she could work as a regular nurse.

I can think of a number of nurses who could fill such a position and would genuinely enjoy feeling that they had a special role to play. They should be paid substantially more for this responsibility and this should encourage them to want to stay. However, the extra cost of training and paying a higher salary to, say, three nurses in each of the five government hospitals could be a cheaper option than employing on duty psychiatrists.

5) Public health campaigns and improving mental health services

The evidence in support of conducting suicide prevention programmes is not clear cut. Some studies have even shown them to be followed by increased levels of suicide, since they break down protective social taboos. So rather than running such prevention programmes, it may be more effective to focus on more general ways of improving mental and social health and by providing places for people to turn to when they feel very distressed. As yet, however, mental health services are still very limited in the West Bank.

6) Curbing the medicine culture

Palestinians take far too much medicine. One newspaper article said that they they take eight times more medicine per person than in Denmark. They think that there is an appropriate medicine for every bodily ill and are addicted to medicine. Just about every Palestinian house has a so-called ‘pharmacy’ (saydaleeya) or cupboard full of medicines. Medicines are very readily prescribed and there is a lack of regulation of private doctors and pharmacies. Enforced restrictions on prescribing medication are needed. Such a move will face much resistance from these doctors and pharmacists, but numerous studies have shown that restricting access to the means of suicide can reduce both suicide fatalities and attempts.

Final note

Although the statistics indicate that the incidence of suicide and parasuicide in the Arab Palestinian Society of the West Bank is low when compared to other regions of the world, it cannot be ignored and regarded as ‘inevitable.’

The biographical material in this thesis cannot be used to predict who will choose to attempt suicide but, perhaps, by reading it carefully and looking at the expressions of distress used by the men and women who had attempted suicide, we can help to identify those people 'at risk' and it is these men and women whom we should seek to support. Here are a few extracts from the narratives of men and women who attempted suicide between 1997 and 1999.⁶²

Women

Getting married

A recurring theme amongst the women was the difficulty of adjusting to getting married. Some women found it particularly difficult to have to adjust to a new environment as well as the way of life can differ between towns, villages and refugee camps. Rasha, for instance, after growing up in a refugee camp in Jerusalem married into a family in a fairly isolated village. She discovered that village life was quite different to what she was accustomed to with regard to the food, the cooking, and the way of dressing.

Well, everything was new to me. I mean, their food is different; their drink is different; their cooking is different. I mean, I see their cooking as being different, not like my family's. You see, even their clothes are different. I mean, I used to wear a short coat, but here they say, 'no, it's shameful (eeb)', because here it is a village.

(RASHA)

Life in the camp had felt freer to Rasha than in the village where she found herself observed and monmuch more.

The atmosphere (aj-jow), the people, are different, their dealings (maamalithum) perhaps are different, it's not like with us in the camp. Here, they have 'It's forbidden, not like this, let's not let people talk.' (andhum haram, mish hayk, balaash an-naas biseeru yihku). With us (andna), no. In the camp there is freedom. In the camp, I would go out to my paternal uncles's house, I come and go. It's true they ask [what I am doing] but this was for my own good.

Here, no, they say, 'Your husband is responsible for you' (zawjik massool anik). And my husband even starts to ask where am I going...

⁶² All names and identifying details have been changed to ensure confidentiality. For fuller versions of their narratives see the complete thesis available in Birzeit University.

But people start to talk, yaani, it's because it's like this, because the people talk, their gossiping (takharufaathum), I mean.

(RASHA)

The religious attitudes in the village seemed more conservative to Rasha. There was more monitoring of the piety of women especially with regard to the head scarf. Rasha does not wear a head scarf (mandeel). In the camp people had had more relaxed attitudes and if a girl put on a mandeel then they would congratulate her and that was all. Not so in the village.

Yaani, [in the camp] they don't say for example - about the head scarf - 'This one wore it. This one took it off.' But rather - it's normal (aadi) - they just say, 'Congratulations on the head scarf' (mabrook' al-mandeel).

(RASHA)

Rasha would often think back nostalgically to her school days prior to getting married.

But, I don't know how, I mean, I think about how I was living as a girl. I start to think back.. I mean, like [at times like] now, presently, I would be sitting in the room on my own and I would think what I would like to do as a girl, me and my sisters, and I would start to cry by myself. When we went to school, when we met each other, me and my sisters, I see it as being the loveliest period [of my life] that I have had.

So I start to cry. So my husband asks me, 'Why are you crying?' I tell him, 'This period, if only I could return for a week to those days!' So he tells me, 'It will never return, we go forward, we don't go backwards to the past.' So these are the things that perhaps made me drink the medicine.

(RASHA)

Abla married a man much older than herself from a small and isolated village who had been married several times previously. She said there was no one for her to talk to as a woman in a strange balad.

If a woman is in a strange balad, who can she talk to? My family is far away. If I have an upset between me and him and I want to go to my family's house - I'm unable to sit me and her [the other wife of the husband] not a minute - I stay sitting in the house here. I neither go nor come. Here there are no neighbours, nor houses, there is no place, we are here in the open - in emptiness (al-khilaa').

(ABLA)

Physical abuse

Dalal said that her husband would frequently get angry and hit her. She showed me the marks on her arms where he had burnt her with a cigarette.

From the beginning, when I married he was always very wound up, and he would 'put his hand on me' [hit me]. He would scream at me a lot.

(DALAL)

It was after he started to hit her that she threatened to commit suicide. He responded by telling her that she has the medicine so she should do go ahead. She took the overdose in front of him.

I threatened him. But what did he tell me? 'OK. Speak!' I told him, 'If you stay doing this, I want to drink medicine.' He told me, 'You've got the medicine, drink it!' I went and drank it all.

(DALAL)

Aisha was very distressed and angry with her brother who had been sexually abusing her.

I was twelve years old. I was still young. He destroyed me. I couldn't stand it. I committed suicide. I drank pills like a mad person (shiribt haboob zay wahid majnoon).

(AISHA)

Amna also tried to commit suicide after being abused, in her case physically, by her husband's family. They were beating her up so fiercely that she swallowed nails.

From the amount that they beat me, my husband's family. I saw the nails on the window and I swallowed them.

(AMNA)

Other women

Anxiety about their husband's behaviour with regard to other women, was a common complaint. Khaloud's major concern and anxiety was that she suspected that her husband was having an affair with his brother's wife. This distressed her for many reasons. She thought that people were talking about her and her husband, and went on at length about 'what people say' (*kilaam an-naas*). She said that she felt they were all watching her and her husband and she was distressed by the possible damage caused by this gossip.

I am unable to doubt my husband. For me to say to him, for example, 'You do this and you do that.' I mean, it's difficult. For him as well, it is difficult. I mean his reputation between people is that he is respected and good and a merchant. What do you do if people say that his wife said this, and his wife said that? No! No! He worries about his reputation and I don't want anyone to talk about him... for he is my cousin [son of paternal uncle - ibn ammha]. A woman should look after her house and her husband. Does she want to ruin her life all because of people?! So, it's difficult. People want something to talk about. Between you and me, people here in our society just want to chatter about each other... and then from one to the other and then to the other and to the other. Someone says to the whole balad that the son of whoever did this to the son of whoever... We, of course, in the balad, our reputation is like gold (like a sword - seeritna zay as-sayf). But people say, 'That woman did this' and 'That woman made this' and 'Look at her husband'... What they say! They stay chattering with this talk. They have the 'transport of talk' (naqal al-haki) in our society.

(KHALOUD)

Khaloud was also worried that her husband was no longer interested in her and that she had grown old and lost her looks as well as his attention. Indeed, a few women were scared that their husbands were losing interest in them to the extent that they were planning to remarry.

A woman's status in society was often perceived to be determined by the status of her husband. Samira has had to deal with more than most wives; her husband has become addicted to drugs, is rarely employed, has stolen and, more recently, been unfaithful. Samira found his behaviour was humiliating for her.

Here, a woman's husband raises her and lowers her... My husband lowered me... and let all of them stamp over me.

(SAMIRA)

Divorce and the fear of divorce

For one of the interviewees, Liyana, the fact that she was divorced weighed heavily on her mind and she saw it as one of the main reasons for her feelings of misery. As a divorced woman in Palestinian society Liyana often felt shunned or exploited.

Our society is no good at all ... if you are divorced they put a red 'x' sign on you.

(LIYANA)

Indeed, Samira prefers to put up with her 'bitter tragedy' rather than face the stigma of being divorced.

I am scared to get divorced. I can get divorced. But I'm scared of being displaced (mitshared). Because of this, I get scared. I have a husband, in front of people. I come and go. But if I get divorced, our Arab society doesn't forgive. It doesn't know what's inside me.. Because of this, I live a bitter tragedy, but it's better than getting divorced.

(SAMIRA)

Entrapment and confinement

Throughout the interviews women used words for being suppressed, subdued, suffocated, pressurised and oppressed (makbout, kaatim, makhooa, madghut, mazloom). Most of the women had feelings of confinement and of being entrapped. They spoke of wanting to escape (biddi ahrub). When Samira drank the bleach she wanted to escape from the difficult position she was in.

.. At that moment I wanted to escape from the position that I was in. A difficult position, it put pressure on me. I want to finish with/ be done with this position. I want something strong. So I found the glass of bleach....Because I am upset, and I want to relieve the suppression (kabt) that's inside me, and I want it all to be finished.

(SAMIRA)

Aisha, feeling trapped at home repeated many times that she would either die oremigrate (la amout aw ahaajir). Liyana wanted to escape but she had nowhere to escape to. Before Liyana took the medicine she was thinking:

Either I die or I escape from the house.

(LIYANA)

Men

Many of the men who tried to kill themselves felt unable to fulfil their socially expected roles as men; to find employment and so have a steady income, to get married and have children and to provide for and protect their family.

Saeed felt life without money was humiliating, indeed, that death would be more honourable.

Finish (khalas). It's the material (al-medde), I mean money, that talks about us. Someone who has money, you find that everyone goes with him, and comes with him. Someone who doesn't have money, there's no one that looks at him in the village. Wherever you go, in reality (al-haqeeqa)...

(SAEED)

When I asked him if he thought about death, if he wanted to die, he said that he wished for it.

I wish!... In honesty, if the life is like this, and work is like this, death is more honourable.(al-mawt ashraf)

(SAEED)

Abid cannot work as he suffers from uncontrolled post-traumatic epilepsy as a result of beatings by the Israeli army and nearby settlers when he was a teenager. He not only lives in fear of the next attack, he also feels despairing and useless as a young man who cannot work.

Of course, I always get irritated (tidayi). A man without work, who is a youth (shab), and who can't work, and who takes money from his brother and isn't able to get a house. He isn't able to live, him and his wife. Well, it's not a small thing - and so my psyche is tired (nafseeyati taabana) and I complain about this life and this world. I was in a state of despair (haalit ya'as). From this world, I am tired. This life has no flavour (taam).

(ABID)

Many of the men thought of dying when they assessed the political and economic situation around them.

Yes, [I think of death]. For example, I sit and think why it was that God created us, the Palestinian people in particular (bithat). God created us from the beginning and we woke up in the world and we are under the occupation. I mean, it's true we're living in the world... but it feels like a jail.

(DIAB)

The problem was that I saw the world - That's it, finish (khalas). May God curse this world.

...I was angry from the world, the work, the economy. The social situation is difficult, That's it. I see that the world is not right (mazboota). When I drank the medicine, I thought, 'That's it, finish. That's it. May God curse this life. Sometimes... How does a person think when he sees such difficulties? [He

thinks] if only God would rest me from the life! We are not living in relation to other countries... Every day [I think this]. The shabab say, if only God rested us from this life. Not just me. If only there was death. I mean, that we all die. It would be better. It's not just me. There are many like me.

(KAREEM)

Indeed, many of the men expressed the belief that dying was better than going on in the world around them which they saw as miserable, frustrating and without hope.

Sometimes, I think with this life, if I died, it's better.

(KAREEM)

References

- Abou Zeid 'Honour and shame among the bedouins of Egypt' in Peristiany, J.G. *The Nature of Human Society Honour & Shame: The Values of Mediterranean Society*, Weidenfield & Nicolson, London, 1965, pp.245-257.
- Ahmed,A. *Discovering Islam: Making Sense of Muslim History and Society*, Routledge, London, 1988.
- Ajarma, Y. 'The phenomenon of suicide in Palestinian Society - a debate' (zahirat al-intihar fi al-mujtamaia al-filistaniya), BSc presentation, Bethlehem University, June 1998. (Unpublished)
- Al-Hayat article: 'The phenomenon of suicide: another aspect of frustration' published in Al-Hayat newspaper in March and June 1998
- Ali, A. *The Meaning of the Holy Quran*, Amana publications, Maryland, U.S.A.,1997, (English and Arabic) (Ali died 1953, published posthumously)
- Al-Issa,I. (ed) *Al-Janun: Mental Illness in the Islamic World*, International Universities Press, Madison, 1999.
- Al-Rais,N. 'Suicide in The Time of Ashes' (al-intihar fi zaman ar-ramada), Al-Hayat, Ramallah, 5th March 1998.
- Al-Ashab,B. 'The Mental Health Service in the West Bank: Its Current Dilemma and Future Prospects', paper presented to Palestinian Ministry of Health, June 1995.
- Alvarez,A. *The Savage God: A Study of Suicide*, Penguin Books, 1974.
- Anani,R. & Qablan,M. 'Suicide: a scary, new situation', *The Jerusalem Times*, June 20 1997.
- Arouri,A. 'Is suicide a phenomenon in our society', *People's rights, LAW*, Jerusalem, October 1998.
- Ashour,H. 'Suicide' (al-intihar), paper presented for a workshop on suicide held at The Working Woman Organisation, October 1997.
- Ash-Sheikh,J. *Suicide in Arab Literature (Al-intihar fi al-adab al-arabi)*, The Arab Institute for Studies and Publications, Beirut, 1997.
- Baker, A 'The Impact of the Intifada on the Mental Health of Palestinian Children Living in the Occupied Territories', paper presented to 67th annual meeting of the American Orthopsychiatric Association, Miami, Florida, Dec 1989.
- Baker,A. 'The psychological impact of the Intifada on Palestinian children in the Occupied West Bank and Gaza: An Exploratory Study', *American Journal of Orthopsychiatric Association*, vol.60, no.4, Oct 1990, pp.496-505.
- Barber,B. 'Palestinian Children and Adolescents during and after the Intifada', *Palestine-Israel Journal of Politics, Economics and Culture*, vol.4, no.1, 1997, pp.23-33.
- Barber,B. 'Political Violence, Family Violence and Palestinian Child Functioning', Brigham Young University,. Paper presented at the Gaza Community Mental Health Programme conference on 'Health and Human Rights', October 1997, pp.1-37.
- Barber,B. 'Youth Experience in the Palestinian Intifada: A Case Study in Intensity, Complexity, Paradox, and Competence', to appear in M.Yates & J.Youniss (eds)

- Community Service and Civic Engagement in Youth: International Perspectives, New York, Cambridge University Press. (Forthcoming 1997/8)
- Belkhenchir, D. et al. 'Tentatives de Suicide et Suicides chez l'enfant et l'adolescent dans le Grand Alger', in *Tentatives de suicide a l'adolescence*, Colloque de Centre International de l'Enfance sur la sante des adolescents, 12-14 December 1988, pp.197-216.
- Berman, A. & Jobes, D. *Adolescent Suicide Assessment and Intervention*, American Psychological Association, Washington DC, 1991.
- Bille-Brahe, U. 'The role of sex and age in suicidal behaviour', *Acta. Psychiatr. Scand.*, 1993, suppl. 371, pp. 21-27.
- Birleson, P. 'Depression and suicide in adolescence', *Australian Family Physician*, vol.17 no.5, 1988, pp.331-2.
- Bouhdiba, A. *Sexuality in Islam*, Routledge & Keegan Paul, London, 1985 (translated from French).
- Bowen, D. & Early, E. *Everyday Life in the Muslim Middle East*, Indiana University Press, Bloomington and Indianapolis, 1993.
- Braam, A. et al. 'Religiosity as a protective or prognostic factor of depression in later life; results from a community survey in the Netherlands', *Acta. Psychiat. Scand.*, vol.96, 1997, pp.199-205.
- Buckley, N. et al. 'An analysis of age and gender influences on the relative risk for suicide and psychotropic drug self-poisoning', *Acta. Psychiat. Scand.*, vol.93, 1996, pp.168-171.
- Cairns, E. & Wilson 'Coping with Political Violence in Northern Ireland', *Soc.Sci.Med.*, vol.28, no.6, 1989, pp.621-24.
- Canetto, S. & Lester, D. 'Gender, Culture and Suicidal Behaviour', *Transcultural psychiatry*, vol.35, no.2, June 1998, pp.163-190.
- Caracciolo, S. et al. 'Circadian rhythm of parasuicide in relation to violence of method and concomitant mental disorder', *Acta. Psychiatr. Scand.*, vol.93, 1996, pp. 252-256.
- Carstairs, G. Discussion on suicide, *Proceedings of the Royal Society of Medicine Meeting*, November 1960, pp.262-268.
- Choquet, M. & Davidson, F. 'Famille et suicide: Quelle famille pour les suicidants?', *Psychologie Medicale*, vol.16, no.12, 1984, pp.2035-2037.
- Choquet, M. 'Le suicide des adolescents: approches psychosociale du phenomene suicide', *Les conduites suicidaires*, bulletin no.24, 1990, pp.62-66.
- Cobban, H. *The Palestinian Liberation Organisation: People, Power and Politics*, Cambridge University Press, Cambridge, 1984.
- Coggan, C., Patterson, P. & Fill, J. 'Suicide: Qualitative Data from Focus Group Interviews with Youth', *Soc.Sci.Med.*, vol.45, no.10, pp.1563-70, 1997.
- Cohen, S. *Folk Devils and Moral Panics: The Creation of the Mods and Rockers*, Blackwell, Oxford, 1973.
- Conrad, L. 'Epidemic disease in formal and popular thought in early Islamic society' in Ranger, T. & Slack, P. (eds) *Epidemics and ideas: essays on the historical perception of pestilence*, Cambridge University Press, Oxford, 1992, pp.77-99.

- Counts, Dorothy Agnes 'Fighting back is not the way: suicide and women of Kaliai', *American ethnologist*, 1980, pp.332-351.
- Daradkeh,T & Al-Zayer,N. 'Parasuicide in an Arab industrial community: The Arabian-American Oil Company experience, Saudi Arabia', *Acta Psychiat. Scand.*, vol.77, 1988, pp.707-711.
- Daradkeh,T. 'Parasuicide during Ramadan in Jordan', *Acta Psychiatr. Scand.*, vol.86, 1992, pp.253-254.
- Davis, J. 'Family and State in the Mediterranean' Gilmore,D. Honour, Shame & the Unity of the Mediterranean, *American Anthropological Association*, no.22, 1987,pp.22-33.
- Dawes,A. 'Political and Moral Learning in Contexts of Political Conflict', paper prepared for the meeting on 'The mental health of refugee children exposed to violent environments, Refugee Studies Programme, Oxford University, Jan 1992.
- Desjarlais,R. Eisenberg,E. Good,B. Kleinman,A. *World Mental Health: Problems and Priorities in Low-Income Countries*, Oxford University Press, Oxford, 1995.
- Diekstra,R. 'Suicide and Parasuicide: A Global Perspective', in *Current Approaches: Suicide and Attempted Suicide: Risk Factors, Management and Prevention*, Duphar medical relations, Southampton, 1991, pp.1-22.
- Diekstra,R. 'The epidemiology of suicide and parasuicide' *Acta Psychiat. Scand.*, Supp 371, 1993,pp.9-20.
- Douglas,J. *The social meanings of suicide*, Princeton University Press, New Jersey, 1967.
- Durkheim,E.*Suicide: a Sociological Study*, New York:Free Press; London: Routledge & Keegan Paul, 1963. (Original work written in French in 1897.)
- Eickelman,D. 'Islam and the "religions of the book"' in D.Eickelman *The Middle East:An Anthropological Approach*, Prentice Hall, New Jersey, 1989, pp.255-315.
- Elbedour,S. Bensel,R. & Bastien,D. 'Ecological Integrated Model of Children of War:Individual and Social Psychology', *Child Abuse & Neglect*, vol.17, 1993, pp.805-819.
- El-Otmani,S. and Moussaoui,D. 'Systeme nerveux et neuropsychiatrie chez Ibn Rochd (Averroes) et Ibn Zohr (Avenzoar)', *Histoire des sciences medicales*, 1992, vol.26, pp.1-6.
- Etzersdorfer et al 'Sex differential for suicide among Austrian age cohorts', *Psychiatr. Scand.* vol.93, 1996, pp.240-245.
- Farmer,R. 'The Relationship Between Suicide and Parasuicide' in Farmer,R. *The Suicide Syndrome*, Cambridge University Press, 1979/80, pp.19-37.
- Farmer,R. 'Assessing the Epidemiology of Suicide and Parasuicide', *British Journal of Psychiatry*, vol.153, 1988, pp.16-20.
- M.Feghali *Proverbes et dictons syro-libanais*, Université de Paris, Travaux et Mémoires de l'Institut d'Ethnologie, vol 31, Paris, 1938.
- Firth,R. 'Suicide and Risk-Taking in Tikopia Society', *Psychiatry*, vol.2, 1960, pp.1-17.
- Fombonne, E. 'Increased rates of depression: update of epidemiological findings and

- analytical problems', *Acta Psych. Scand.*, vol.90, 1994, pp.145-156.
- Fridell,E. et al. 'A 5-year follow-up study of suicide attempts', *Acta Psychiat. Scand.*, vol.93, 1996.
- Garbarino,J. 'Challenges we face in understanding Children and War: A personal essay', *Child Abuse & Neglect* vol.17, 1993, pp.787-793.
- Garland,A. & Zigler,E. 'Adolescent Suicide Prevention:Current Research & Social Policy Implications', *American Psychologist*, Feb 1993.
- Gastel,A. et al. 'The prediction of suicidal intent in depressed patients', *Acta Psychi. Scand.*, vol.96, 1997, pp.254-259.
- Giacaman,R. & Johnson,P. 'Palestinian Women: Building Barricades and Breaking Barriers' in Lockman,Z.& Beinini,J.(eds) *Intifada: The Palestinian Uprising Against Israeli Occupation*, A MERIP Book, South End Press, Boston, 1989, pp.155-170.
- Gibson,K. 'Children in Political Violence', *Soc.Sci.Med.*, vol.28, no.7, 1989, pp.659-667.
- Gilmore,D. *Honour, Shame & the Unity of the Mediterranean*, American Anthropological Association, no.22, 1987.
- Gilmore, D. *Manhood in the Making: Cultural Concepts of Masculinity* Yale University Press, New Haven & London, 1990.
- Giovanni, M. 'Female Chastity codes in the Circum-Mediterranean: Comparative Perspectives', in Gilmore,D. *Honour, Shame & the Unity of the Mediterranean*, American Anthropological Association, no.22, 1987.
- Glover et al. 'Parasuicide in Young Asian Women', *B.J. of Psychi.*, 1988 (letter).
- Good,B. 'Culture and psychopathology: directions for psychiatric anthropology' Schwartz,T. White,G. & Lutz,C. *New directions in psychological anthropology*, Cambridge University Press, 1994.
- Green,L. 'Lived Lives and Social Suffering:Problems and Concerns in Medical Anthropology', *Medical Anthropology Quarterly*, vol.12 n.1, 1998, pp.3-7.
- Grotanelli,C. 'Archaic Forms of Rebellion and their Religious Background', in B.Lincoln (ed) *Religion, Rebellion, Revolution: An interdisciplinary and cross-cultural collection of essays*, Macmillan, London, 1985, pp.15-46.
- Hacking,I. *The Taming of Chance*, Cambridge University Press, Cambridge, 1990.
- Hajjar,L. Rabbani,M. & Beinini,J. 'Palestine and the Arab-Israeli Conflict for Beginners' in Lockman,Z. & Beinini,J. *Intifada: The Palestinian uprising against Israeli occupation*, A MERIP book, South End Press, Boston, 1989, pp.101-112.
- Hamam,A. Masters thesis, *The social and demographic situations of the Palestinian refugees in the camps of the West Bank (al-awdaa al-ijtimaiya wa demoghrafiya fi mukhayamaat al-laajeen fi ad-daffa al-gharbiya)*, Tunis University,1998. (Unpublished)
- Hamzeh-Muhaisen,M. 'Suicides on the rise in PA areas', *Palestine report*, November 14 1997, p.1.
- Hans-Wehr *A dictionary of Modern Written Arabic*, Librairie du Liban, Beirut, 1974.
- Hassan,R. & Carr,J. 'Changing Patterns of Suicide in Australia', *Aus. & N.Z. Journal of Psychiatry* vol.23, 1989, pp.226-234.
- Hawton,K. & Catalan,J. *Attempted Suicide: A Practical Guide to its Nature and*

- Management, Oxford University Press, 1987 (2nd edition).
- Hawton et al. 'Deliberate self harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition', *B.M.J.*, vol.317, Aug 1998, pp.441-7.
- Herzfield, M. "'As in your house'": Hospitality, Ethnography and the Stereotype of Mediterranean Society' in D. Gilmore Honour, Shame & Unity of the Mediterranean American Anthropological Association, no.22, 1987, pp.76-89.
- Hicklin, M. 'War Damaged Children: Some aspects of recovery', Association of Psychiatric Social Workers, 1946, pp.2-28.
- Hill, K. *The Long Sleep: Young People and Suicide*, Virago Press, 1995.
- Hodes, M. 'Overdosing as communication: A cultural perspective' *British Journal of Medical Psychology* vol 63, 1990, pp.319-333.
- Hourani, A. *A History of the Arab Peoples*, Faber and Faber, London, 1991.
- Jamous, R. 'From the death of men to the peace of God: violence & peace-making in the Rif', in Peristany & Pitt-Rivers Honour and Grace in Anthropology, Cambridge University Press, Cambridge, 1992.
- Jawad, M. 'People who committed suicide in pre-Islamic times and Islamic times' (al-muntahoon fi aj-jahaliya wa al-islam), *Halal magazine*, Cairo, 1934, pp.475-479.
- Jenkins, P. *Intimate Enemies: Moral Panics in Contemporary Great Britain*, Aldine de Gruyter, New York, 1992.
- Jenkins, J. 'The Medical Anthropology of Political Violence: A Cultural and Feminist Agenda' *Med. Anth. Quart.* vol.12 no.1, 1998, pp.122-131.
- Johnson, P. and O'Brien, L. with Joost Hiltermann 'The West Bank Rises Up' in Lockman, Z. & Beinun, J. (eds) *Intifada: The Palestinian Uprising Against Israeli Occupation*, A MERIP Book, South End Press, Boston, 1989, pp.29-42.
- Kassab, A. 'Study on depression in the Palestinian personality', Research Centre, Gaza, 1995.
- Khan, M., Islam, S. & Kundi, A. 'Parasuicide in Pakistan: experience at a university hospital', *Acta Psychiatr. Scand.* vol.93, 1996, pp.264-267.
- Kienhorst, C. et al. 'Two subtypes of adolescent suicide attempters', *Acta Psychiatr. Scand.*, vol.87, 1993, pp.18-22.
- Kral, M. 'Suicide and the Internalisation of Culture: Three Questions' *Transcultural* vol.35, no.2, June 1998, pp.221-233.
- Kreitman, N. & Casey, P. 'Repetition of Parasuicide: An Epidemiological & Clinical Study', *British Journal of Psychiatry*, 153, 1988, pp.792-800.
- Kreitman, N. & Schreiber, M. 'Parasuicide in Young Edinburgh women: 1968-75', in R. Farmer & S. Hirsch *The Suicide Syndrome*, Cambridge University Press, Croom Helm Ltd, London, 1979/80, pp.54-72.
- Lester, D. 'Domestic Social Integration and Suicide in Israel', *Israeli Journal of Psychiatry Related Science* vol.34, no.2, 1997, pp.157-161.
- Levav, I. & Aisenberg, E. 'Suicide in Israel: crossnational comparisons' *Acta Psychiatr. Scand.*, vol.79, 1989, pp.468-473.
- Levin, J. 'Religion and Health: Is there an association, is it valid, and is it causal?',

Soc.Sci.Med. vol.38, no.11, 1994, pp.1475-1482.

Lewis et al. 'Zar in Context: The Past, the Present and Future of an African healing cult' in Lewis, Al-Safi & Hureiz (eds) *Women's Medicine: The Zar-Bori Cult in Africa and Beyond*, Edinburgh, 1991.

Lindisfarne, N. 'Variant Masculinities, Variant Virginites' in A. Cornwall & N. Lindisfarne (eds) *Dislocating Masculinity: Comparative ethnographies*, Routledge, London, 1994.

Lipsedge, M. & Littlewood, R. 'Psychopathology and its public sources: from a provisional typology to a dramaturgy of domestic sieges', *Anthropology & Medicine*, vol.4, no.1, 1997, pp.25-33.

Littlewood, R. & Lipsedge, M. 'The "Culture-Bound Syndromes" of the dominant culture: culture, psychopathology and biomedicine', in J. Cox (ed) *Transcultural Psychiatry*, Croom Helm, London, 1986, pp.253-273.

Littlewood, R. & Lipsedge, M. 'The Butterfly and the Serpent: Culture, Psychopathology and Biomedicine', *Culture, Medicine and Psychiatry*, vol.11, 1987, pp.289-335.

Littlewood, R. 'Psychopathology and personal agency: Modernity, culture change and eating disorders in South Asian societies', *British Journal of Medical Psychology*, vol.68, 1995, pp.45-63.

Littlewood, R. 'Agency, opposition and resistance: a systemic approach to psychological illness in sub-dominant groups', in T. Pollard & S. Hyatt (eds) *Sex, Gender and Health*, Cambridge University Press, 1999, pp.137-160.

Lockman, Z. & Beinun, J. *Intifada: The Palestinian uprising against Israeli occupation*, A MERIP book, South End Press, Boston, 1989.

Magwaza, A. Killian, B. Petersen, I. & Pillay, Y. 'The Effects of Chronic Violence on Preschool Children Living in South African Townships', *Child Abuse & Neglect*, vol.17, 1993, pp.795-803.

Mahon, N. Yarcheski, A. Yarcheski, T. 'Health Consequences of Loneliness of Adolescents' *Research in Nursing and Health*, vol.16, 1993, pp.23-31.

Mann, L. 'Youth Suicide', *Australian Nursing Journal*, vol.4, no.7, Feb 1997.

Mansour, S. 'The Intifada Generation in the Schoolroom', *Prospects*, vol.26, no.2, June 1996, pp.293-310.

Mansour, S. *Going through Adolescence in Palestine*, Birzeit University. (Currently under publication.)

Marsella, A. & White, G. (eds) *Cultural Conceptions of Mental Health and Therapy*, Reidal Publishing Company, 1982.

Mendonica, J & Holden, R. 'Are all suicidal ideas closely linked to hopelessness?', *Acta Psychiatr. Scand.*, vol.93, 1996, pp.246-251.

Merrill, J. & Owens, J. 'Ethnic Differences in Self-Poisoning: A Comparison of Asian and White Groups', *B.J. of Psychiatry*, 148, 1986, pp.708-712.

Myntti, C. 'Hegemony and healing in Rural and North Yemen', *Soc.Sci.Med.*, vol.27, no.5, 1988, pp.515-520.

Nahid Muneer Al-Rais 'Suicide in the Time of the Ashes', *Al-Hayat newspaper*, 5/3/98.

- Ndosi,N. & Waziri,M. 'The Nature of Parasuicide in Dar Es Salaam, Tanzania', *Soc.Sci.Med.*, vol.44, no.1, 1997, pp. 55-61.
- Neeleman,J. 'Suicide as a crime in the UK:legal history, international comparisons and present implications', *Acta Psychiat. Scand.*, vol.4, 1996, pp.252-257.
- Noldeke,T. *Sketches of Eastern History*, London-Edinburgh, 1892 quoted by Rosenthal,F. 'On Suicide and Islam', *Journal of Arab and Oriental Studies*, vol.66, 1955.
- O'Brien & Farmer, R. 'The Role of Life Event in the Aetiology of Persons of Self-Poisoning' from Farmer,R. *The Suicide Syndrome*, Cambridge University Press, Croom Helm Ltd, London, 1979/80, pp.124-130.
- Olujic,M. 'Embodiment of Terror:Gendered Violence in Peacetime and Wartime in Croatia and Bosnia-Herzegovina', *Med Anth Quart* vol.12, no.1, 1998, pp.31-50.
- PASSIA directory, Jerusalem, 1999.
- Patton,G. et al. 'Adolescent suicidal behaviours:a population-based study of risk', *Psychological Medicine*, 27, 1997, pp.715-724.
- Pelto & Pelto 'Studying Knowledge, Culture, and Behaviour in Applied Medical Anthropology', *Med. Anth. Quart.*, vol.3, issue 2, 1997, pp.147-163.
- Peristiany, J.G. *The Nature of Human Society Honour & Shame: The Values of Mediterranean Society*, Weidenfield & Nicolson, London 1965.
- Peristiany, J.G & Pitt-Rivers, J. *Honour and Grace in Anthropology*, Cambridge University Press, Cambridge, 1992.
- Petersen et al. 'Depression in Adolescence', *American Psychologist* vol.48, issue 2, Feb 1993, pp.155-168.
- Pina-Cabraol,J. 'The Mediterranean as a category of regional comparison: A critical review', *Current Anthropology*, 30, pp.399-406.
- Pitcher,L. 'The Divine Impatience:Ritual, Narrative and Symbolization in the Practice of Martyrdom in Palestine', *Med. Anth. Quart.*, vol.12, no.1, pp.8-30, 1998.
- Pitt-Rivers,J. 'Honour and Social Status' in J.Peristiany *The Nature of Human Society: Honour and Shame: The Values of Mediterranean Society*, Weidenfield & Nicolson, London, 1965, pp.21-77.
- Poland,S. *Suicide Intervention in the Schools*, Guildford Press, London, 1989.
- Ponizovsky,A. et al. 'Suicide Ideation Among Recent Immigrants:An Epidemiological Study', *Israeli Journal of Psychiatry Related Science*, vol.34, 1997, pp.139-148.
- Pitcher,L. 'The Divine Impatience: Ritual, Narrative and Symbolisation in the Practice of Martyrdom in Palestine', *Medical Anthropology Quarterly*, vol.2, no.1, 1998, pp.8-30.
- Population Census carried out by the Palestinian Central Bureau for Statistics (PCBS), Ramallah,1997.
- Punamaki,R. 'Content of and Factors affecting Coping Modes Among Palestinian Children', *Scandinavian Journal of Develop.*, vol.6, no.1, March 1987, pp.86-97.
- Punamaki,R. Qouta,S. & Sarraj,E. 'Relationships between Traumatic Events, Children, Gender, and Political Activity, and Perceptions of Parenting Styles', *Inter. Journal of Behavioural Development*, vol.21, no.1, 1997.

- Qalaeeli, Abdul-Fatah 'Early Marriage' (az-zawaaj al-mubakir) in A directory of social awareness campaign: calling towards parents towards a better family, the PNA, Ministry of Social affairs, October 1998, pp.208-221.
- Qouta,S. 'Collective Punishment and the Mental Health of Children', GCMHP, Sept.1993.
- Qouta,S. & Sarraj,E. 'Level of Anxiety in Gaza Before and After the Intifada (1984-1991)', GCMHP, Nov 1992.
- Qouta,S., Punamaki,R. & Sarraj,E. 'The Impact of the Peace Treaty on Psychological Well-Being: A Follow-Up Study of Palestinian Children', Child Abuse & Neglect, January 1995, pp.1197-1208.
- Qouta,S. Punamaki,R. & Sarraj,E. 'The Relations Between Traumatic Experience, Activity, and Cognitive and Emotional Response Among Palestinian Children', International Journal of Psychology, vol.30, no.3, 1995, pp.289-303.
- Qouta,S., Punamaki,R. & Sarraj,E. 'Prison Experiences and Coping Styles Among Palestinian Men', Peace & Conflict:J. of Peace Psycho. 3, 1997,pp.19-36.
- Quesada,J. 'Suffering Child:An Embodiment of War and Its Aftermath in Post-Sandinista Nicaragua', Med. Anth. Quart., vol.12, no.1, 1998, pp.51-73.
- Rajab, A, Violence Against Women: a case study from Egyptian society (al-unf did al-mara': darasat haalat min al-mujtamia al-masri), Paper presented to The Arab Forum for Social and Health Science, Sept. 1997.
- Resnick,G. & Burt 'Youth at Risk:Definitions and Implications for Service Delivery', American J of Orthopsychiatry, vol.66, no.2, 1996, pp.172-188.
- Response...Ability', Curriculum Resources developed for use in the university training of professionals in Australia by the Hunter Institute of Mental Health with the collaboration of academics from the University of Newcastle, Updated November 1998. (From the internet)
- Robins,I. & Kulbrook,P. 'Methodological Strategies in Suicide ' in J.Mann & M.Stanley Psychobiology of Suicidal Behaviour, New York Academy of Sciences, New , 1986.
- Rosenthal,F. 'On Suicide in Islam', Journal of Arab and Oriental Studies, vol.66, 1955.
- Rubinstein, D. 'Epidemic suicide among Micronesian Adolescents', Soc. Sci. Med. vol.17, no.10, 1983, pp.657-665.
- Sakinofsky,I. et al. 'Problem Resolution and Repetition of Parasuicide:A Prospective Study' BJ of Psychiatry 156, 1990, pp.395-399.
- Salem,H. 'A study on the phenomenon of violence and dropping-out of school students in Ramallah, Palestine', Institute of Community and Public Health, Birzeit University, 1997. (On-going research.)
- Sarraj,E. 'Mental Health of the Palestinians Under Occupation', GCMHP, August 1992.
- Sarraj,E. 'Peace and the Children of the Stone', GCMHP, 1992.
- Sarraj, E & Abu-Hein,F. 'Trauma, Violence & Children:The Palestinian Experience', Gaza Community Mental Health Programme, May 1993.
- Sarraj,E., Punamaki,R., Salmi,S. & Summerfield,D. 'Experiences of Torture and Ill-Treatment and Posttraumatic Stress Disorder symptoms among Palestinian Political Prisoners', J. of Traumatic Stress, vol.9, no.3, 1996, pp.595-606.

- Saunders, L. 'Variants in Zar Experience in an Egyptian Village', in Crapanzano & Garrison, *Case Studies in Spirit Possession*, 1977, pp.177-191.
- Schacter, D. *Searching for memory: The brain, the mind and the past*, Basic, New York, 1996.
- Shaffer, D. 'Preventing suicide in young people', *Innovations and Research*, vol.2, no.4, pp.3-9.
- Shehada, R. *I am Samid*, Ramallah, 1992.
- Schmidtke, A. et al., 'Attempted suicide in Europe: rates, trends and sociodemographic characteristics of suicide attempters during the period 1989-92, Results of the WHO/EURO Multicentre Study on Parasuicide', *Acta Psychiatr. Scand.*, vol.93, 1996, pp.327-338.
- Schnyder, U. & Ladislav, V. 'Suicide Attempters in a Psychiatric Emergency Room Population', *Gen. Hosp. Psych.* vol.19, 1997, pp.119-129.
- Schreiber, G. 'A unique monthly distribution of suicide and parasuicide through firearms among Israeli soldiers', *Acta Psychiatr. Scand.*, vol.87, 1993, pp.110-113.
- Schwartz, T. White, G. & Lutz, C. *New directions in psychological anthropology*, Cambridge University Press, Cambridge, 1994.
- Shehadeh, R. *Samed: Journal of a West Bank Palestinian*, Adama Books, New York, 1984
- Stack, S. 'The Relationship Between Culture & Suicide: An Analysis of African Americans', *Transcultural Psychiatry*, vol.35, no.2, June 1998, pp.253-269.
- Steffan, V. 'Life Stories and Shared Experience', *Soc.Sci.Med.*, vol.45, no.1, 1997.
- Stengel, E. et al. *Patterns of death among suicide attempters, a psychiatric population and a general population*, *Archives of General Psychiatry*, vol.34, 1958.
- Stengel, E., Cook, N. & Kreeger, I. *Attempted suicide: Its social significance & effects*, Institute of Psychiatry, Chapman & Hall, London, 1958.
- Stillion, J. & McDowell, E. *Suicide Across the Life Span*, (2nd edition) Taylor and Francis, Washington DC, 1996.
- Stork, J. 'The Significance of Stones: Notes from the Seventh Month', in Lockman, Z. & Bein, J. *Intifada: The Palestinian uprising against Israeli occupation*, A MERIP book, South End Press, Boston, 1989, pp.67-81.
- Strauss, C. 'Motives and models' in R.D'Andrade & C.Strauss (eds) *Human motives and cultural models*, Cambridge University Press, New York, 1992.
- Summerfield, D. 'The Social, Cultural and Political Dimensions of Contemporary War' *Medicine, Conflict & Survival*, vol.13, 1997, pp.3-25.
- Suominen et al. 'Mental disorders and comorbidity in attempted suicide' *Acta Psychiatr. Scand.*, vol.94, 1996, pp.234-240.
- Suominen, K et al. 'Hopelessness, impulsiveness and intent among suicide attempters with major depression, alcohol dependence or both', *Acta Psych. Scand.*, vol.96, 1997, pp.142-149.
- Taylor, S. *Durkheim and the Study of Suicide*, MacMillan Press Ltd, London, 1982.
- Tulloch, A. et al. 'Adolescent-Parent Communication in Self-Harm', *Journal of Adolescent Health*, vol.21, 1997, pp.267-275.

On Palestinian women, Union of Palestinian Medical Relief Committees, Newsletter no.29, June 1998.

White,G. 'The Ethnographic Study of cultural knowledge of "Mental Disorder"', in A. Marsella & G.White (eds) Cultural Conceptions of Mental Health and Therapy, Holland, 1982, pp.69-95.

WHO Regional Office for Europe, 'Changing Patterns in Suicide Behaviour', EURO reports and studies, 74, Copenhagen, Denmark, 1982.

Williams,D. et al. 'Religion and Psychological Distress in a Community Sample', Soc.Sci.Med., vol.32, No.11, 1991.

Wilkinson,G. 'Can suicide be prevented? Better treatment of mental illness more appropriate aim', B.M.J., vol.309, October 1994, p.860.

Appendix: Tables on 31 Cases of Parasuicide Seen

Table A: Details of the cases of parasuicide

No.	Name	Age	Sex	Marital Status	Residence	Origin*	Occupation	Source
1	Heba	28	f	m	v	v	housewife	RH
2	Najwa	19	f	m	v		housewife	RH
3	Lina	22	f	d	t	US	none	RH
4	Dana	22	f	s	v	c	student	RH
5	Amal	22	f	m	t		housewife	RH
6	Ranya	30	f	a	v		none	KH
7	Saeed	21	m	s	v		unemployed	RH
8	Khaloud	42	f	m	t		housewife	RH
9	Samira	27	f	m	v	v	teacher	RH
10	Fareeda	21	f	s	t		secretary	RH
11	Dalal	18	f	m	c	t (48)	housewife	RH
12	Bassam	28	m	s	t		waiter	RH
13	Mariam	29	f	s	t		teacher	RH
14	Kareem	40	m	m	v		unemployed	RH
15	Abid	24	m	s	c	v	unemployed	RH
16	Areej	24	f	s	t		secretary	RH
17	Rasha	17	f	m	v	c	housewife	RH
18	Reem	18	f	m	c	c(Gaza)	housewife	RH
19	Nisreen	23	f	m	v		housewife	KH
20	Watan	35	f	m	c	t	housewife	RH
21	Abla	20	f	m	v	v	housewife	RH
22	Liyana	20	f	d	t		unemployed	RH
23	Ghassan	20	m	s	v		unemployed	RH
24	Jamil	19	m	s	c		unemployed	RH
25	Suha	20	f	s	c		none	RH
26	Diab	21	m	s	v		unemployed	RH
27	Aisha	28	f	d	c		none	RH
28	Amna	18	f	d	c		none	RH
29	Muhammed	25	m	s	c (Jenin)		prisoner	JH
30	Mustapha	30	m	m	v (Jenin)		unemployed	JH
31	Mona	17	f	s	c(Gaza)		none	Gaza

Sex:	Marital Status:	Residence/Origin:	Source:
f = female	m = married	v = village	RH = Ramallah Hospital
m = male	s = single	t = town	KH = Khalid Hospital
	d = divorced	c = camp	JH = Jihan Hospital

*Origin, if different, e.g. if went from one village to another on marriage

Table B: Timing of suicide attempts and interviews

No.	Name	Date of Suicide Attempt*	Time of Day	Day of Week	Month	Date of Long Interview
1	Haba	11/1997	afternoon	Friday	November	8/1998
2	Najwa	11/1997	night	Saturday	November	11/1997
3	Lina	11/1997	afternoon	Wednesday	November	hospital only
4	Dana	12/1997	evening	Wednesday	December	12/97 & 1/98***
5	Amal	12/1997	night	Sunday	December	8/1998
6	Ranya	3/1998	afternoon	Wednesday	March	6/1999
7	Saeed	4/1998	afternoon	Tuesday	April	2/1999
8	Khaloud	4/1998	afternoon	Sunday	April	7/1998
9	Samira	5/1998	evening	Sunday	May	11/98
10	Fareeda	6/1998	night	Thursday	June	6/1998
11	Dalal	6/1998	night	Tuesday	June	8/1998
12	Bassam	7/1998	night	Friday	July	8/98
13	Mariam	7/1998	night	Monday	July	hospital only
14	Kareem	8/1998	evening	Sunday	August	2/1999
15	Abid	8/1998	afternoon	Sunday	August	1/1999
16	Areej	8/1998	evening	Sunday	August	short interview only
17	Rasha	8/1998	evening	Saturday	August	1/1999
18	Reem	8/1999	evening	Wednesday	August	short interview only
19	Nisreen	9/1998	afternoon	Wednesday	September	6/1999
20	Watan	9/1998	morning	Wednesday	September	12/1998
21	Abla	9/1998	evening	Friday	September	2/1999
22	Liyana	9/1998	evening	Tuesday	September	1/1999
23	Ghassan	10/1998	night	Tuesday	October	3/1999
24	Jamil	11/98	morning	Sunday	November	family interviewed**
25	Suha	11/1998	evening	Monday	November	hospital only
26	Diab	11/1998	evening	Sunday	November	1/98
27	Aisha	2/99	-	-	February	3/1999
28	Amna	summer 94	?afternoon	-	July	2/1999
29	Muhammed	2/1998	night	Wednesday	February	hospital only
30	Mustapha	2/1998	evening	Friday	February	interview 2/98 & 3/98
31	Mona	1990	-	-	-	10/97

***Interviewed by Dr Mansour

** Patient in a coma

*Exact dates not given for reasons of confidentiality

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Table C: Methods used and ostensible cause(s) of parasuicide

No.	Name	Method	Ostensible cause(s)
1	Heba	overdose	argument with husband, unwanted pregnancy
2	Najwa	overdose	newly married & pregnant, argument with husband, lack of attention
3	Lina	overdose	divorce, beaten by husband, loss of children
4	Dana	overdose	break-up of relationship
5	Amal	overdose	recently married, argument with husband, lack of attention
6:	Ranya	vinegar concentrate	argument with sister in law
7	Saeed	overdose	miserable, wants to marry
8	Khaloud	overdose	unhappy, fears husband is unfaithful
9	Samira	bleach	unfaithful husband
10	Fareeda	overdose	problems with men
11	Dalal	overdose	newly married, abuse from husband
12	Bassam	overdose	unhappy with work and general life situation
13	Mariam	overdose	father's prohibition on working
14	Kareem	overdose	unemployment and family conflicts
15	Abid	overdose	epilepsy, unemployment
16	Areej	overdose	argument with brother's fiancée
17	Rasha	overdose	newly married, unhappy, unable to talk to husband
18	Reem	overdose	newly married, suppressed in new house
19	Nisreen	overdose	fears husband wants to remarry
20	Watan	overdose	badly behaved son tormenting her
21	Abla	bleach	third wife to difficult husband, unable to cope
22	Liyana	overdose	divorced, recent break up of relationship with man
23	Ghassan	overdose	?unemployed and unhappy
24	Jamil	insecticide	failure at school and argument with father
25	Suha	overdose	argument with brother
26	Diab	overdose	fiancée's threat of break-up
27	Aisha	overdose	divorced, feeling trapped at home
28	Amna	nails	unable to cope with abuse from husband and his family
29	Muhammed	razor	imprisoned
30	Mustapha	overdose	unemployed, penniless, wife recently miscarried
31	Mona	overdose	feeling trapped in Gaza

