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Suicide in Immigrants: An Overview

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ABSTRACT

Globalization in the Internet era has rendered job mobility and migration frequent and important social phenomena, with implications at several different levels of societies. In addition, migration, either voluntary or forced, is accompanied by significant changes in suicide ideation, frequency of suicide attempts and rates of suicide of people that migrate compared to the host country. However, several different peculiarities render the interpretation of the interaction of migration-suicidality as quite complex. This article provides an overview of the most significant aspects that contribute to this complexity, in order to provide the reader with a road map for better orientation in a world of rapidly changing landscapes.

Keywords: Globalization; Migration; Acculturation Stress; Inter-Generational Conflicts; Asylum Seekers

1. Globalization and Suicide

Already in 1897, Durkheim [1] stated that the changes associated with modernization were related to higher rates of suicide in European countries. After the Second World War and the collapse of the Soviet empire, a phenomenon somewhat similar to what reported by Durkheim, defined as “globalization” has expanded. Globalization is a process of creating networks between individuals from different continents, through flows of people, information, ideas, capital and goods. It manifests itself in the increase of economic and political connections between countries, faster transportation, more efficient forms of instant communication, use of new technologies such as the Internet, and changes in jobs type and location [2]. Globalization is breaking down natural boundaries: it makes it possible to travel from one culture to another, either physically or through television, Internet, movies and books.

Global migration and rapid changes in the social fabric and context and in the labour market could contribute to further isolate people, increasing their risk of suicide. Globalization may also increase suicide probability through increased accessibility of alcohol and drugs, while decreasing protective factors specific to each culture through the process of homogenization or “cultural

hybridization” [2,3].

2. Emigration and Suicidal Behaviour

Emigration is defined as the process by which an individual moves from one cultural context to another, in order to settle for a long period of time or lifelong [4]. Emigration can occur en masse or individually. For example, people who emigrate for economic or academic reasons can move initially alone and then be followed by families. Instead, people who emigrate for political causes move more often in mass, with or without families [5].

The process of migration (human movement in general) has been divided into three phases: the pre-migration, which includes the decision to migrate and the preparation for it; the step of emigration, *i.e.*, the physical transfer of the person from one place to another, and the post-migration, defined as the process of integration of immigrants in the new social and cultural context of the hosting country, where new rules and roles have to be learned [5]. Quite clearly, this process might vary significantly from person to person [4].

Immigrants might have higher rates of psychopathology and suicidal behaviour than the host populations, due to exposure to the stress of the migrating process. The ending of the links with their country of origin, the

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loss of status and social network, a sense of inadequacy because of language barriers, unemployment, financial problems, a sense of not belonging, and feelings of exclusion can cause loss of interest in entering into a relationship with others, and cause a variety of psychiatric disorders such as depression, anxiety, post-traumatic stress disorder, addiction to alcohol and drugs, and lead to loneliness and hopelessness, and suicidal behaviours [4,6,7].

The person might live a condition similar to bereavement, caused by the loss of their previous social structure and culture. The most missed aspects are the language (especially colloquial language and dialect), attitudes, values and social support networks. The pain for these losses is a natural consequence of emigration. However, if the suffering causes significant distress or impairment and lasts for a long period of time, professional support may be necessary [5].

Migration poses a risk not only for immigrants but also for the families remained in the country of origin. For example, it has been observed that the next of kin of Mexican immigrants in the United States were at greater risk of suicidal ideation and suicide attempts than Mexicans without a family history of emigration [8]. Emigration could weaken family ties, lead to feelings of loneliness and insecurity, and thus increase the risk of suicide among family members who remained at home [8].

3. Acculturation and Acculturation Stress

“Acculturation” refers to the changes that groups and individuals undergo when they come into contact with a different culture. Acculturation stress is instead a more specific concept and refers to the psychological reactions that result directly from the process of acculturation. The latter can be a risk factor for suicidal behaviour [6].

Acculturation is a two-way process, where members of both cultures (the migrant and the host) do change. In order to witness a successful acculturation process, the person or the group of individuals should retain their own cultural identity but in the meantime establish a good relationship with the host society: there should be then integration between the two cultures or “biculturalism”. In some cases, however, the immigrant encounter with the dominant culture may produce different outcomes, such as assimilation, rejection or “deculturation”. “Assimilation” indicates the loss of the cultural identity of origin, replaced by identification with the dominant group. It is therefore a unidirectional adaptation process, where the migrants adopt the language, laws, religion, norms and behaviours of the dominant culture.

“Rejection” refers to the maintenance of the cultural identity of origin without establishing a positive attitude towards the host community. “Deculturation” is instead the loss of own cultural identity in the absence of a posi-

tive relationship with the dominant culture [5,9]. According to some researchers, the highest degree of social assimilation corresponds also to the highest risk of suicide; for acculturation, instead, there would be the opposed trend [10]. One possible explanation is that assimilation, in addition to leading to more probable improvements in own economic position, could reduce the protective factors, such as religion, cultural identity and integration among immigrants in the same area [11].

Acculturation stress may be composed of a mixture of emotions and behaviours, including anxiety and depression, and feelings of marginality and alienation, psychosomatic symptoms and identity confusion [10]. Some studies have reported the existence of a significant correlation with suicide ideation [9].

Individuals who migrate from predominantly collectivist societies to individualistic societies may face serious problems of adaptation. This could result in a real or perceived lack of adequate social support system, disparity between expectations and reality, and low self-esteem [5]. Many immigrants undergo radical changes in their social status and may also be subject to discrimination. This could be an additional risk factor for suicide, as evidenced by one of the US studies where immigrant’s suicide rates were positively correlated with the negative valence of the words used by the majority to describe their ethnic group [12].

The main variables that can reduce the stress of acculturation, and therefore lower the levels of depression and suicidal ideation, are social support within the family and the new community, a good socio-economic status, self-esteem, coping skills, knowledge of the new language and culture, the voluntary choice to emigrate, hope for the future, strong religious beliefs, and high degree of tolerance towards other cultures [5,6,10]. Immigrants who experience a sense of loss for their culture and feel a sense of guilt for having left their homeland may discover, with the progress of the acculturation process, to be able to feel more part of the new country. When the individual becomes more linguistically and socially expert in the dominant culture, the latter may appear less threatening and more inviting, and social support can come in the form of new friendships, job opportunities, and medical care, thus reducing the feelings of loss and grief related to the process of emigrating [5]. Usually, immigrants who perceive the changes embedded to the acculturation as an opportunity experience less stress and present less suicide ideation [6].

4. Cultural Differences and Suicide Rates among Immigrants

Often there is confusion in the definition of culture, ethnicity and race of the immigrant. “Culture” is the set of shared ideas, meanings and roles, in other words, the lens

through which each person perceives and understands the world. The ethnic group usually shares the same geographical origin, the same culture, language and religious traditions. The race involves instead the genetic homogeneity, and is characterized by physical appearance—especially skin colour—but provides in itself little information on the ethnic group to which the immigrant belongs [13].

Several studies show that suicide rates vary from country to country, and that the rates among immigrants tend to follow those of the country of origin, showing a significant and positive correlation (from moderate to strong) between the two values [14-18]. Most of the research originated in the United States, but the same type of evidence has been obtained in other host countries, such as Austria, Australia, Canada, Sweden and the United Kingdom. The similarity of the rates with those of the country of origin was also found among immigrants of second generation [19,20]. In a study conducted in Austria lowest rates were found among Turkish immigrants and the highest among the Japanese [20]. This result was in line with the rates of both countries of origin and with those observed in other host countries: lower for Turks in Germany, high for the Japanese in the United States [20]. A similar trend was found in a study involving ten European countries: Turkey, Switzerland, Belgium, Finland, Israel, the Netherlands, Italy, Sweden, Estonia and Germany [21]. In this survey, the highest rates of suicide attempts among immigrants generally corresponded to higher rates of suicide in the country of origin, and there was also an analogy between the rates of suicide attempts of the same ethnic group in different host countries [21]. Similarly, in 33 studies that reported rates of suicide among immigrants from almost 50 nationalities in seven host countries (Australia, Austria, Canada, England, the Netherlands, Sweden and the USA), the rates of suicide among immigrants and those of the countries of origin were strongly correlated [18].

In most studies conducted in Europe, America and Australia, the highest risk of suicide was found in immigrants from northern Europe (including the UK, Ireland and Finland), and Eastern Europe (especially from Russia and Hungary). The lowest risk was instead found in immigrants from southern Europe and the Middle East. With regard to immigrants from Asian countries, the risk of suicide seems generally low for men but appreciably higher for women. The rates vary, therefore, not only in relation to the country of origin but also for sex of the immigrant [5,19,21-24]. For example, in a study conducted in the United States, Asian, black and Hispanic men had the lowest risk of suicide, while non-Hispanic white and Asian women had higher risk than the host population [14]. The apparently difficult cultural transition of Asian women will be discussed in the next section.

tion.

The high suicide rates among immigrants from Northern and Eastern Europe might be partly explained by the high alcohol consumption typical of these countries. For example, there is a significant correlation between alcohol consumption and suicide in Finland; Finnish immigrants who died by undetermined causes of death in Sweden also tend to have high alcohol levels in their blood [26]. A similar trend was found in Russia, where suicide rates related to alcohol abuse are very high, and among Russian immigrants who died by suicide in Estonia [27].

The low rates of suicide among immigrants from southern Europe, the Middle East and Asia may be due to some protective factors, such as the strong influence of traditional values, family and religious beliefs. These countries are more collectivist, have strong family ties and a strong group identity outside their country of origin. Both in Catholic and Muslim countries religion may be a strong deterrent to suicide, which is considered as a sin in the Catholic religion and as *haram*, or forbidden, by the Islamic law (*sharia*) [14,28]. The protective role of religion could also depend on the ties with the religious community, which might represent a strong source of social support [6,10].

5. Suicide in South Asian Women

The stress of acculturation and intergenerational conflicts related to acculturation appear to contribute to suicidal behaviour in young South Asian immigrant women in various countries around the world. For example, in Great Britain, Asian women attempt suicide three times more than their white race peers, while young Asian males are less likely to die by suicide than their white race peers [29]. Even young Hindustani women immigrant in the Netherlands attempt suicide four times more often than young Dutch women [30]. The rates are highest among women aged 18 - 25 years, but not in adolescents. This seems to suggest that when women start to find their way in life, they may experience more cultural conflicts with parents and other family members [5].

In many cases, migrant women follow their primary provider, this being husband or father. They often have low level of education, do not know the language and culture of the host country, live isolated and without friends. Their experience of migration and response to stress can be so very different from that of men. Women can experience the cultural conflict and the transition from the traditional cultural identity in the West. In some cases, husbands and in-laws want the woman to reach good levels of education and establish a career, but at the same time remaining true to their traditional female role [31]. The changes and role expectations that women live cause them family conflicts that their male counterparts

do not experience [32]. For example, they may have family disputes on marriage (often combined), the style of life, and submission to husband or parents [31].

Suicidal ideation and behaviour in Asian women seem to be associated with poor communication with parents and the lack of affection from them, in the presence of high levels of control of cultural values [33]. According to Durkheim's "fatalistic suicide" hypothesis, in many cases these values are imposed by the family and are no longer seen as their own. The traditional rules concerning the most important situations in life, such as marriage, divorce and sexuality then begin to be experienced as oppressive, and suicide becomes the only possible way to influence the course of their lives. It is clear that, in this case, strong links with the community of origin bring more risk factors than protective factors [34].

6. Immigrants in Italy

In recent decades, Italy has undergone major socio-political changes that have profoundly influenced the life of the country and its inhabitants. Like Ireland, Spain and Portugal, Italy has transformed itself from a country of emigrants to a desirable destination for immigrants. These often come as refugees in poor health conditions, and with the hope of finding "heaven" [35,36].

The data published on March 12, 2012 by the Italian National Institute of Statistics show that there were over 4.5 million foreigners living legally in the country in 2011, an increase of 7.9% from 2010 to 2011. These data covered all foreigners in possession of a valid residence permit, which represent approximately 7.5% of the resident population. Almost half (46.3%) of the citizens legally residing in Italy obtained a residence permit for an indefinite period. In 2010, approximately 60% of the permits were issued for work, 30% for family reasons, and 10% for other causes. In addition, it has been estimated that there are about 700,000 illegal immigrants in Italy [4].

Following the increased flow of immigration, there has also been a significant increase in the number of foreigners who have attempted suicide. For example, in Padua, comparing the periods 1992-1996 and 2002-2006, in the first period only 2.1% of people who have attempted suicide were not of Italian origin, in the second period instead foreigners accounted for 18.2% of the examined sample [36]. In this study, migrants of Romanian origin, Moldova and North Africa were most at risk. This might depend on the poor socio-economic conditions of these immigrants. For example, with regard to the Romanian immigrants in Veneto Region, even though the majority of them arrive for business reasons, they often perform less qualified tasks, and in less favourable working conditions [36].

It is possible that there is a strong political and ideo-

logical bias towards immigrants [36]. Italians, in general, show two main attitudes: on the one hand they are convinced that immigrants are necessary for the economy; on the other, they have also developed the conviction that illegal immigration and crime are deeply correlated [4].

In a study involving only immigrants resident in Italy for at least 5 years, the risk of suicidal behaviours was similar between Italians and immigrants. This finding suggests the positive mediation of certain factors, such as acculturation, cultural proximity and improved socio-economic conditions [4].

7. Genetic and Environmental Factors

Immigrants bring with them both a specific genetic profile (containing predisposition to physical and mental illness and perhaps to certain conducts, such as tendency to dyscontrol and suicidal behaviour) and environmental factors, such as the culture of the country of origin and personal experiences.

According to some initial research on the role of genetics in suicidal behaviour in Slovenia, individuals with different surnames would also present different risk of suicide, regardless of the area of the country in which they live [37]. The correspondence between suicide rates of immigrants and their country of origin described in the section on cultural differences is consistent with the hypothesis of genetic risk factors. The genetic makeup remains largely intact despite the environmental changes, and also tends to be transmitted from one generation of immigrants to the other because of the tendency to endogamy, or marriage within the same ethnic group, that exists in many communities. In this way, suicide rates in various groups remain almost unchanged [20].

Unlike genetic factors, the influence of the culture of the country of origin may decrease over time. Many immigrants—to be possibly considered as less rooted in their culture of origin, given the decision to emigrate—are constantly exposed to the host culture, and this may influence their suicide rates, making them farer from those of the country of origin and converge with those of the native population. This hypothesis has been confirmed by many studies. For example, in research on immigrants of the former Soviet Union in Israel, a much higher rate of suicide than that of the local population was noted, although the rate was considerably lower than that characterizing Russia [38]. In the same research it was evident that suicide rates varied according to the time of permanence in Israel. Even suicidal ideation, presence of a suicide plan or previous suicide attempts were particularly frequent among recent immigrants, compared to those residing in the country for longer [36]. Over time, therefore, suicidal behaviours among immigrants tended to decrease in frequency and converge with those of the host country.

A tendency to converge was also observed among immigrants coming from countries with low rates of suicide, such as those from the Middle East, migrating to California. Among them, suicide rates tended to be positively associated with length of residence, and then gradually increase in frequency with the time, to converge with the rates of autochthonous population [39]. A trend towards convergence has also been found among immigrants in Slovenia: the suicide rate of Hungarian immigrants in Slovenia was in fact lower than that recorded in Hungary and more similar to the Slovene rate [19]. In contrast, Croatian immigrants in Slovenia had higher suicide rates than in the home country, while Croatian immigrants in Australia had rates lower than those detected in Croatia, presenting then in both cases rates very close to those of the two host countries [19]. It would seem plausible to conclude that rates tend to converge, and often express intermediate values between the country of origin and destination, contributing in some cases to a decrease in the overall rate of suicide in the host population [14,15,40,41].

The importance of both genetic and environmental factors is confirmed by the “paradigm of interaction”. According to this paradigm, health is the result of interacting processes, including genetic predisposition, life experiences, and stressors during the migration process, and the individual and social resources to cope with them [42].

8. Urbanization and Ethnic Density

There are two contextual factors of post-settlement that seem related to suicidal behaviour among immigrants: urbanization and ethno-racial density. The importance of these factors seems to depend mainly from the accessibility to social support.

Contrary to what suggested by Durkheim [1], to reside in urban areas does not seem to be a risk factor for suicidal behaviour and could, in fact, constitute a protective factor, especially for males. For example, in a study carried out in Australia, the risk of suicide in men from Europe, the Middle East and New Zealand was significantly higher in rural areas than in urban areas, while there was no difference in the risk between rural and urban areas for Australians [24]. Isolation, rigors of country life, easy access to means for suicide, lack of employment and recreational opportunities and mental health services could explain this result. The geographic isolation, even if offset by the cohesion typical of small communities (for the autochthonous population), could lead to real feelings of isolation among immigrants, as they are not considered part of those communities and then easily excluded [24].

Generally, since the immigrant population is concentrated in metropolitan areas, it may be that it is the largest

ethnic density and therefore greater social support availability to justify the lower rates of suicide in those areas [43]. This may be especially true for immigrants belonging to racial minorities. In Canada, for example, the prevalence of suicidal ideation was noted to be higher among immigrants of racial minorities living in rural areas than in urban areas compared to white immigrants and residents in both rural and urban. A possible explanation may lie in greater access to mental health services in urban areas, which could represent an opportunity for timely treatment and at the same time be a source of social support. Also, it may be that racism is more deeply rooted and difficult to control in rural communities [44].

The increase in density of hosted ethnicity can improve social support and adaptation of certain immigrants, but also increase the discomfort of others, especially if there is any conflict between the individual immigrant and his culture of origin. For some people, the culture of the host country may be more suited to their beliefs than the original one. In this case, an increase in density can cause an ethnic cultural conflict and become a risk factor, instead of a protective one [5].

9. The “Healthy Immigrant Effect”

Some North-American research evidenced lower rates of suicidal behaviour among immigrants relative to the population of the host countries. It was then proposed the hypothesis of the healthy immigrant (healthy immigrant effect), according to which immigrants should be less likely to commit suicide being generally above average in terms of mental and physical health [45]. According to some studies, poor health would prevent emigration; as a result, immigrants would in fact be represented by strongest individuals [23]. The exception to this rule is represented by countries with unrestricted emigration, as in the case of the Irish within the United Kingdom or the Finns in Sweden: they can all migrate regardless their health condition [23].

However, several researches done in the United States, England, Canada and Sweden showed overall higher suicide rates among immigrants, and this when compared to both the country of origin and the host one [22,27,46]. These observations suggest that the low suicide rates presented in other studies could be due to having considered immigrants as a large homogeneous group, without distinguishing between countries of origin. As we have seen, there are instead rather large differences [46].

10. Immigrants of First and Second Generation

Research has noticed the existence of remarkable differences in rates of suicide among first-generation immigrants, or born abroad, and second-generation immi-

grants, *i.e.*, children of first-generation immigrants, usually born in the host country. Second-generation immigrants generally show a higher risk of suicidal behaviour compared to those of the first generation [45,47,48]. For example, among Mexican adolescents in the United States, those born in Mexico showed lower rates of suicidal ideation and less use of illicit drugs than those born in the United States [10]. In the study by Pena and associates [49], the second-generation Hispanic immigrants in the United States were twice more likely to present higher frequency of suicide attempt and abuse of alcohol and drugs than the first generation of teenagers. The third generation had a three times higher probability of presenting these behaviours compared to first-generation immigrants [49]. Even in Sweden suicide rates of the second-generation immigrants were reported to be higher than those of the first generation [47]. Unfortunately, many studies have included second- and third-generation immigrants in the group of the host population, and therefore there are not many other available data to confirm this hypothesis [49].

To explain the better health of first-generation immigrants at least three main hypotheses have been proposed [49]. The first is known as the Protective Culture Model, which suggests the presence of some protective factors against suicide in the culture of origin, such as religious beliefs and good family and social support, able to reduce the stress of acculturation. The protective effect of these values would decrease with time of residence, and therefore suicide rates would become progressively higher [48,49]. The second model, the Intergenerational Acculturation Conflict Model, considers the role of intergenerational conflict due to acculturation. The latter, in fact, can progress with different speed between parents and children and lead to misunderstandings, conflicts or role reversal, and then to suicidal behaviours in young second generation individuals. The third model, the Resilient Immigrant Model, is in line with the healthy immigrant paradigm, and suggests a selective effect of migration, which would involve only individuals in good health and with high resilience. In the second generation, this selectivity would no longer be present [45,47,49].

The first-generation immigrants are often characterised by a low socio-economic level, which, however, could be offset by a sense of privilege rather than deprivation. The first-generation immigrants tend, in fact, to compare their situation with that of the country of origin rather than with that of the host country. In contrast, second-generation immigrants tend to compare with the host population, and therefore in them may prevail feelings of disadvantage and deprivation [11].

11. Adolescents

Adolescence is a period of life in which people may be

very vulnerable and likely to present self-harm behaviour and suicidal ideation. This risk appears to increase in the case of adolescent immigrants [10]. Along with the normal developmental challenges of construction of personal identity, young people are facing the stress of acculturation in the host country, and at the same time trying to remain faithful to their culture of origin. In addition, because adolescents and their parents go through the process of acculturation with different rhythms, family conflicts may arise, which represent an additional source of stress [26]. The most relevant aspects characteristic of suicidal behaviour in adolescent immigrants seem to be the low socio-economic status, substance abuse and family conflicts. With regard to the low socio-economic status, it could lead to discrimination and fatalism, thus increasing the risk of suicidal behaviour [33].

Alcohol abuse and drug use seem important in mediating suicidal behaviour in adolescent immigrants. For example, in a study of cases of suicide among young Hispanics in the United States, more than 40% of them had alcohol in their blood [50]. Canadian immigrant adolescents in the United States show suicide rates lower than their US peers, with appreciably lower consumption of drugs during the suicidal crisis in Canadian immigrants [51].

The risk of suicidal ideation appears to be higher among adolescents who have family problems, difficulties in relationships with parents or see their peers as hostile [52]. Children of immigrants often reach levels of acculturation and education much higher than those of their parents, contributing to intergenerational conflict and decreasing the understanding and closeness between parents and children [33]. In several studies related to suicide among young immigrants, intergenerational conflicts with parents were reported as particularly present. For example, a study of young people of Asian origin in the United States showed that intergenerational conflict did increase the risk of suicide even by thirty times, especially in less educated young people. More educated adolescents, even though they could experience higher levels of conflict with their parents, had anyway lower rates of suicide. It is possible that as a result of intergenerational conflicts and loss of family support, more educated young people rely on peer support to mitigate their stress [29]. Also separation from one or both parents could lead to suicidal behaviour. It has been seen, for example, that adolescent Korean immigrants in the United States without parents (both) reported almost double levels of suicidal ideation compared to other immigrants, high levels of depressive symptoms and risk of suicide. Living with both parents was instead a strong protective factor, probably because, in addition to providing family support, it gives a sense of stability and security [52].

12. Refugees and Asylum Seekers

According to the Geneva Convention (1951), a refugee is a person who has a “well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or a particular political opinion, is outside the country of his nationality and can not, or will not, because of such fear, benefit of the protection of that country”. The asylum seeker is someone who has left his/her country of origin, has applied for recognition as a refugee and is awaiting a decision by the new state [5].

In general, risk factors for suicide in this particular group of people are the young age, male gender, low income, past traumatic experiences and lack of social support. Refugees and asylum seekers often have several of these risk factors [53]. Refugees are perhaps the most vulnerable group of all immigrants: they are often fleeing war, torture and persecution, with Post-Traumatic Stress Disorder (PTSD), depressive and anxiety symptoms [42]. Lack of adequate preparation, the way in which they are received in the destination country, poor living conditions, and lack of social support and isolation usually add to these vulnerabilities [5]. Refugees may also feel guilty for leaving the loved ones at home or for their death. The sense of guilt, together with isolation and pathological symptoms consequent to trauma, may be a strong risk factor for suicide [54].

To investigate the influence of Post-Traumatic Stress Disorder and depression on suicidal ideation and behaviour, a study of 149 refugees from various countries was carried out in Sweden. Of the refugees, 79% had PTSD. The rate of suicide attempts was higher among refugees with diagnosis of PTSD but not of depression; suicidal ideation, however, was more frequent in the presence of PTSD co-morbid with depression [54]. A recent review of the literature has also shown a moderate association between PTSD and suicidal ideation but no evidence of correlation between PTSD and death by suicide [55].

Immigrants describe the asylum procedure as the most important source of stress; therefore this would also increase the risk of suicide. The pending of a decision by the authorities could mainly affect suicidal behaviour of men. For example, people seeking asylum in the Netherlands in the years 2002-2007 had higher rates of suicide than native Dutch; women instead had rates similar to the Dutch women. It may be that men are more likely to be affected by unpleasant consequences if forced to return to their homeland; in addition, they may see the return as a failure, and are more likely to use substances [55].

Some asylum seekers slip slowly into depression, while others act impulsively in the face of a negative decision by the authorities; someone else loses hope and decides to die by suicide even before knowing the out-

come of asylum request [53]. This is in line with the theory of entrapment, which states that suicide occurs when people perceive occurring events as a defeat or a humiliation from which they do not feel able to escape, or see no possible alternatives [56].

13. Prevention

Immigration not only affects suicide rates of the host country but also the effectiveness of its prevention strategies. For example, in one of the US studies it was found that immigrants residing in the United States for less than 15 years were more likely to call the emergency number 911 and less likely to call a helpline at the time of suicidal crisis [57]. Differences were also found between US citizens of different ethnic groups: 66% of those who called the helpline were Caucasian, whilst African-Americans and Hispanics more frequently sought help by calling 911 and going to the emergency room, but not using the helpline. Unfortunately, in this study it was not possible to distinguish between second- and third-generation immigrants and ethnic minorities [57].

The study of Goldston and associates [58] confirmed the hypothesis of a different way to handle crises of people of different racial and ethnic backgrounds. In this study, African-Americans were less likely to seek professional resources, and more likely to seek help in informal settings such as parishes. Hispanic Americans instead tended to ask for help from family members or primary care physician, rather than professionals of mental health [58]. Korean immigrants in the United States, despite high levels of depression, used very little local services and sought the support of parishes, friends and relatives [59].

In some cases, psychological problems can be seen as a punishment, as a thing to be ashamed of, or condition not serious enough to require the intervention of specialists. Immigrants may also be afraid of being stigmatised [60,61]. On the other hand, specialists might not always find easy to diagnose a mental disorder and determine the risk of suicide because immigrants may have symptoms other than those usually reported by patients of the dominant culture. For example, Chinese citizens do not report feeling depressed or sad, but rather describe aspects of boredom, discomfort, pain, dizziness and fatigue, and this may confound the diagnosis [61]. In young Asian immigrants, impulsive, antisocial and poorly controlled behaviours are negatively correlated to suicidal behaviour, and may actually constitute protective factors [29].

Education on mental health for immigrants, and education about cultural differences for specialists are therefore of fundamental importance for the advancement of suicide prevention [60].

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