Chapter 1

Introduction of the Research Project and its Background

Interview quote of Hanife, a Turkish woman aged 26 years old, born in The Netherlands, employed, interviewed at home. She reflects on the suicidal ideation that started in her late teens and continued until her early twenties:

‘Many people just told me I had to search for a happy medium. But when it comes down to men, relationships and sexuality, there is no such thing as a happy medium! These topics are huge obstacles, and I can’t make them disappear. And I was also upset with my parents. I resented many things they did. But it didn’t get me anywhere. What could I have done? Run away from home? I considered it for a while [...] but the idea that I would turn my back on them and would never return, was just too painful. I love my parents [...] I had a boyfriend for a while, but it was just too heavy [...] I saw him only once every three weeks, and had to come up with all sorts of excuses at home to see him [...] I wanted to fit in so desperately [...] I felt I had to meet all sorts of expectations [...] I tried to be the normal and nice girlfriend for him, yet I could never become a serious part of his life. And on the other hand I was lying bluntly in my parents face [...] In those days, I was staring at the ground a lot, my head bent down, searching for a solution for problems that were almost impossible to solve. It was as if two worlds existed independently from each other, and I was searching for the part to connect them: a way to make both my parents happy as well as living my own life the way I wanted it. But it was just impossible’.

Introduction and research questions

A report on the high rates of non-fatal suicidal behavior of young women of Turkish, Moroccan and South Asian-Surinamese origin in the city of The Hague occasioned this research (Schudel, Struben & Vroom-Jongerden, 1998).¹ Health care professionals noted that young women of these ethnic groups were disproportionately seen after suicide attempts at emergency services and hospitals in The Hague. In addition, research by Garssen and Van der Meulen (2008) showed that South Asian-Surinamese women in the age band 15-35 are also overrepresented among those who commit suicide. Moreover, research indicated that many individuals who conduct suicidal behavior are never attended by medical professionals, which underscores the possible magnitude of the problem. In The Netherlands, 16,000 people are seen each year after a suicide attempt in a hospital or by their general
practitioner (Kerkhof, Mulder & Draisma 2007). Self-reported scores in a large Dutch epidemiological study showed that 94,000 people make a suicide attempt each year in The Netherlands (Ten Have et al., 2006). In addition, an even larger number of people, about 3-4 times as many in comparison to those who demonstrate suicidal behavior, have thoughts about suicide (also referred to as ‘suicidal ideation’) (Kessler et al., 2005). In The Netherlands, this concerns 400,000 people each year (Ten Have et al., 2006).

According to these findings, we expected that a substantial number of young women of South Asian-Surinamese, Turkish and Moroccan immigrant families feel they live unrewarding lives compared to majority Dutch women. We supposed that these high rates of non-fatal suicidal behavior were reflective of the low well-being of young females in these immigrant groups. Sociologists have been concerned with the variation in the suicide rates across social groups or countries since the groundbreaking study of Emile Durkheim in 1897, who addressed the social foundations of suicide. In Durkheim’s view, social groups and societies have specific social features and patterns according to their moralities i.e. norms and values (Collins & Makowsky, 1997). International variation in the social infrastructure as well as social and cultural change were expected to be responsible for the differences in suicide rates across groups and countries. Durkheim’s paradigm continues to be an inspiration of sociologists who study suicide today. In the light of our study, important post-Durkheimian questions are whether processes of modernization will necessarily lead to increased suicide rates in non western groups, and how processes of ethnicity and migration influence the propensity to suicidal behavior. Since we felt the phenomenon of attempted suicide by minority women of immigrant families was alarming, a thorough investigation was needed in order to disentangle the underlying social conditions at stake in their suicidal behavior. In the research project, we first wanted to enhance the statistical evidence on the rates of young females' non-fatal suicidal behavior. Moreover, we wanted to underpin the problematics that are at the core of these young women's suicidal behavior. In short, the project addressed following the research questions:

1. Do young women of South Asian-Surinamese, Turkish and Moroccan origin demonstrate suicidal behavior and suicidal ideation more often than majority Dutch young women in The Netherlands?
2. How can we understand the relationship between suicidal behavior of young females, ethnicity and migration?
Moroccan, Turkish and South Asian immigration to The Netherlands

The first immigrants from Turkey and Morocco arrived in the beginning of the 1960s. They came as ‘guest laborers’ when The Netherlands, like many Northern European countries, were struggling with a shortage of (low-skilled) workers. The reasons for the migration of Turks and Moroccans were economic. Migration from Turkey happened from urban areas initially, but the majority came from rural areas in central Anatolia (Den Exter, 2003). Migration from Morocco occurred by people from rural areas who used to live in tribal societies (Vermeulen & Penninx, 2003). ‘Guest laborers’ continued to come over in large numbers until approximately 1974. However, the migration from Turkey and Morocco continued because of family reunification. The marriage of their children quite often happened with a spouse from Turkey or Morocco, which contributed to prolonged migration. As a result, a first, second and third generation exist, although it is hard to strictly separate these generations. In addition, those youngsters who came when they were aged between 12 and 18 are commonly referred to as the 1.5 or in-between generation. Most of the immigrants had a temporary stay in mind and part of them returned in the 1960s. However, during the 1970s it became clear that those who had not returned would extend their stay and perhaps stay for good. The former guest laborers and most of their children, now have Dutch citizenship, as well as Moroccan or Turkish citizenship (Penninx & Vermeulen, 2001). About 375,000 Turkish and 340,000 Moroccans reside in The Netherlands (Central Statistics Office, 2008).

South Asians migrated from India to Surinam to work as contract laborers in agriculture in the late nineteenth century. Surinam was a Dutch colony from the late seventeenth century until 1975. In the 1950s and 1960s, some migration took place by South Asian-Surinamese to The Netherlands as a result of colonial ties, for educational and economic purposes. Because of the colonial ties, South Asian-Surinamese got acquainted with the Dutch schooling system, culture and Dutch language. Just before Surinam gained its independence, a large number of South Asians migrated to The Netherlands because they were insecure about their position as a minority group in Surinam. Altogether, about 125,000 South Asian-Surinamese live in The Netherlands, the largest number (50,000) resides in The Hague (Choenni & Adhin, 2003). For brevity reasons, South Asian-Surinamese are referred to as ‘South Asians’ in this study.
Terminology and definitions: ‘parasuicide’, ‘attempted suicide’, ‘self-harm’ and ‘non-fatal suicidal behavior’

It seemed that young women of Turkish and Moroccan origin in The Netherlands have high rates of suicidal behavior with a non-fatal outcome, as opposed to completed suicide (Schudel et al., 1998; Jansen & Buster, 2008). South Asian young women are overrepresented on both fatal and non-fatal behavior (Jansen & Buster, 2008; Garssen & Van der Meulen, 2008). Hence, we focused the research on non-fatal suicidal behavior.

It should be noted that in general very few suicide attempts have a fatal outcome. In The Netherlands, for each suicide there are at least 65 suicide attempts calculated on the basis of registration by the health care (Ten Have et al., 2006). If the attempts that have not received medical attention are also taken into account, the ratio of suicide versus attempt is likely to be much larger. This is especially the case for adolescents and young adults, who are known to have the highest prevalence in non-fatal suicidal behavior of all age groups (Wichstrom, 2002). Methods in non-fatal suicidal behavior that are often used include: self-poisoning by taking an overdose of pills, self-cutting (of the wrist(s) or other body parts) with a knife or scissors or drinking poisonous substances e.g. acid or cleaning products.

Non-fatal suicidal behavior has been framed in various terms over the past decades (De Leo et al., 2006). The terms that have been in use previously and currently are for instance ‘parasuicide’, ‘attempted suicide’ and ‘self-harm’. Most of the definitions given to these terms have in common that they refer to the fact that the acts should have been carried out deliberately and intentionally, with the expectation of resulting in self-injury, and the acts should have been self-inflicted (not initiated by others) (De Leo et al., 2006).

However, a major ambiguity that was discussed by suicidologists was (and continues to be) whether a lethal intent should always have been the main of aim of the act. ‘Parasuicide’ and ‘attempted suicide’ suggest a lethal intent, while ‘self-harm’ as a concept has no direct connotation with suicide or death. However, De Leo et al. (2006) put forward a strong case when they argued that any kind of suicidal behavior, irrespective of motive, intent and outcome, is more about termination of suffering and relief from a terrible state of mind than the fulfillment of death. Moreover, repulsion by life and the wish to bring an end to suffering also seems appropriate for suicide. Obviously, death is a concept of which the contents and experience cannot be known empirically by anyone who is alive.
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In its important overview of the phenomenon of attempted suicide across Europe, the term non-fatal suicidal behavior was eventually chosen by the WHO steering group, and is defined as: ‘a non habitual act with a non-fatal outcome that the individual, expecting to, or taking the risk to die or inflict bodily harm, initiated and carried out with the purpose of bringing about wanted changes’ (De Leo et al., 2006). The desired change includes, but is often not limited to, the intent to die. Desired changes may also include a wish to escape from an unbearable situation, the search for peace of mind or to communicate mental pain (Hjelmeland, Knizek & Nordvik, 2002). In the research project, we abided by the WHO definition. In the dissertation, suicidal behavior will be perceived as a continuum of suicide attempts with a variation regarding the lethal intent and a varied outcome of medical seriousness. In addition, we assume that there are sufficient commonalities in the terms ‘attempted suicide’ and ‘non-fatal suicidal behavior’ regarding motive, intent and method to use them interchangeably. ‘Suicidal ideation’ refers to thoughts about suicide (Kessler et al., 1999).

Individuals who demonstrate non-fatal suicidal behavior and those who die by suicide. Is it a similar population?

Regarding motives and intent, we argued above that it seems inadequate to separate non-fatal suicidal behavior from suicide. Increasingly, research shows that those youngsters who commit suicide are not a distinct population from those who display non-fatal suicidal behavior. A clear overlap in risk factors for fatal and non-fatal suicidal behavior exists. Beautrais (2003) established, through a case control study, that those youngsters (15-24 years old) who die by suicide and those who attempt suicide share common sociological characteristics, psychiatric diagnostics and psychiatric history features. These features concern an exposure to recent stressful life events, lack of formal educational qualifications, a mood disorder and a history of psychiatric care. In addition, Beautrais showed that the fact that men more often die by suicide than women is likely to be attributed to their choice of more lethal methods. This is illustrated by statistics on the increase of female suicide in New Zealand over the past decades that has coincided with increase of females using the method of vehicle exhaust gas suffocation. These findings argue against a strict separation of lethal versus non-lethal suicidal behavior.

However, based on demographics, differences exist between suicide attempters and those who die by suicide. Those individuals who attempt are more often female and a younger population compared to those who die by suicide. According to registration by health care professionals in The
Netherlands as well as elsewhere in Europe, females attempt suicide about 1.5 to 2 times more often than males (see Schmidtke et al., 2004 for findings across Europe, Kerkhof & Arensman, 2004 for findings in Leiden, The Netherlands, and Jansen et al. 2008 for findings in Amsterdam, The Netherlands). A large epidemiological study from the United States based on self-reported rates showed similar findings (Kessler et al., 1999). However, a recent epidemiological study in The Netherlands based on self-reported scores did not find significant gender differences, we return to this matter further below (Ten Have et al., 2006). Over the last few decades, the Dutch population who die by suicide has been a relatively stable figure of 1,500 individuals each year, of which two thirds are males (Hoogenboezem & Van den Berg, 2004).

With respect to age, registrations by health care institutions as well as self-reported scores in The Netherlands and across Europe demonstrate that about 60-70 percent of suicide attempters are below the age of 44 (Schmidtke et al., 2004; Ten Have et al., 2006; Kerkhof & Arensman, 2004). By contrast, about 55 percent of people who die by suicide in The Netherlands are aged 45 and above (Garssen & Hoogeboezem, 2007; Schudel et al., 1998). However, the contribution of death due to suicide of youngsters is much larger compared to the elderly. In The Netherlands, suicide is the most important cause of death for females aged between 25 and 30, and males aged between 20 to 30, while it ranks much lower on the list of causes of death for the elderly. However, few youngsters die due to physical illness compared to the elderly (Hoogenboezem & Van den Berg, 2004; Garssen & Hoogeboezem, 2007).

**Four traditions in suicidology**

People who attempt suicide are not a homogenous group. Individuals demonstrate suicidal behavior for a variety of complex motives and reasons (O’Connor & Sheehy, 2001). In general, suicidal behavior occurs in interaction with a number of components that may vary within social forces and structures and cultures, socio economic conditions, individual and interpersonal stress and mental health (Sudak, Ford & Rushforth, 1984). Suicidal behavior is therefore best viewed as the result of a complex interconnection of many factors, taking place over a long span of time and leading, by a sequence of steps, to this behavior.

Four traditions can be distinguished in suicidology. The sociological tradition focuses on relationships between broad social factors and cultural changes and the prevalence of suicide (Durkheim, 1952; Gibbs & Martin, 1967; Stack, 2000a). Next, the ecological tradition focuses on stressors in the
environment of an individual, like the family system or stressful life events (e.g. Pfeffer, 1987; Johnson et al., 2003; Beautrais, 1999; Diekstra, 1987). The medical tradition examines psychiatric diagnosis such as depression, the role of genetics and the brain functioning in suicidal behavior (Mann & Brent, 2006; Van Heeringen, 2003). Lastly, the psychological tradition focuses on personality constellations and psychological traits in relation to attempted suicide (e.g. Williams, 2001; O'Connor & Sheehy, 2002; Kerkhof, 2008). In addition, gender and ethnicity are crucial factors for the epidemiology of suicidal behavior and their impact intersects across these four traditions.

**Sociological tradition: Durkheim and the study of suicide**

Durkheim's classic study on suicide (1897, 1952) examined the influences of social and cultural changes on suicidal behavior in order to reveal the nature of social reality. Durkheim argued that a seemingly individual act as suicide is constrained to a greater or lesser extent by the moral forces of social life (Durkheim, 1952). According to Durkheim, the variation in the suicide rate could be explained by the ways and extent to which individuals were tied to society and to their social group, i.e. through social bonding and morality or norms. The social groups according to Durkheim could exist for instance of families, religious communities or political communities. The key variables that influenced suicide were ‘social integration’ and ‘regulation’. Social integration refers to the degree, to which people are attached, bonded or connected to each other. This includes the degree to which members of society and a group possess shared beliefs, sentiments and interest in one another, and a common sense of devotion to common goals. The degree of commitment to these beliefs will be stronger when social cohesion is firmly in place (Durkheim, 1952). By regulation, Durkheim meant the extent to which society has control and guidance over the motivations and values of its individual members. In short, when extreme positions on these aspects developed, this would lead to suicide.

Altogether, depending on the extent of social integration and regulation, four archetypes of suicide were identified by Durkheim. **Anomic suicide**, was in Durkheim's view a result of the loss of importance of the group’s cultural standards (‘regulation’) in society, which occurred through processes of modernization. Through processes of modernization, individuals became increasingly prone to a lack of normative integration in their social context; social regulation ceased to function as a moral compass. This enhanced the likelihood of anomic suicide. Although much less frequent, Durkheim also mentioned incidences, for example slaves in ancient times,
where individuals experienced extremely high levels of regulation in their social world. This could result in being excessively controlled by social-cultural prescriptions and lead to a *fatalistic suicide*. In addition, Durkheim observed that the nineteenth century society became increasingly individualistic. Beliefs, values and sentiments ceased to be shared collectively since traditions were declining in modern and urban times. Without being socially integrated, Durkheim observed how the meaning of life is lost and this may result in *egoistic suicide*. By contrast, in exceptional occasions and settings e.g. for soldiers in the army, or members of a religious cult, Durkheim noted that individuals could also become overabsorbed in their social group. Such an extreme level of social integration could lead to an *altruistic suicide* that was undertaken as a duty and resulting from sacrifice for the group interest (Durkheim, 1952).

Durkheim’s argument was hence that the extent of social and normative integration into social groups revealed the underlying explanation of suicide. Support for this hypothesis was found for instance in the data on the suicide rates of Catholics versus Protestants. Protestants were more prone to suicide, since their social infrastructure and participation level was not as intense and collectively structured compared to Catholics. The social ties of the religious group an individual belonged to were considered more crucial for suicide than religious beliefs. This finding has been verified and elaborated by Pescosolido (1989) for the US who included geographical aspects i.e. density of religious group members in a certain area and historical regional strength of a specific faith in that area into her analysis of the suicide rate. Pescosolido (1989) confirmed that social factors are protective to suicide, rather than belonging to a specific faith (e.g. catholicism).

Many post-Durkheimian sociological studies on suicide have taken their inspiration from the concepts of anomie, egoism and integration and examined them in interaction with processes of increasing gender equality, urbanization or industrialization (Taylor, 1994). For instance a comparative study by Pampel (1998) found that processes towards gender equality could not be found to produce either divergence or convergence between male and female suicide rates in western countries (1998). A tendency for female rates of suicide to increase first when processes of gender equality started and subsequently decline was observed in anglo-saxon societies e.g. USA, UK, Canada and Australia, whereas other more social democratic countries e.g. The Netherlands, Scandinavia and Germany did not show such a patterns. A similar study conducted in India (Steen & Meyer, 2004) also failed to show an increase followed by a decline in the female suicide rate after
processes of gender equality occurred. The conclusion we draw from this is that the national and regional context is important to the consequences of changing gender roles, and effects on the suicide rates cannot be assumed a priori.

**Ecological tradition: family life and environment**

In a similar vein to the protective effects of social ties of religious networks that Durkheim (1952) reported against suicide, he also argued that integration into family life prevents suicide. He supported this argument by studying family structures in relation to suicide and demonstrated that across Europe, those persons who had never been married or who were divorced were more at risk for suicide than those who are married. However, protective effects were stronger for men than for women. He showed that in families in France, those families with more children were less at risk than persons in smaller families, because ‘in dense families as well as societies, social units are always in contact [...] have more interchange of feelings, ideas, cohesion; a mutual moral support’ (Durkheim, 1952, pp. 210). In general, when the number of social relationships that an individual has increases, the suicide risk decreases. These findings continue to be replicated today. A study by the World Health Organization (Schmidtke et al., 2004) showed that across Europe, suicide attempters were disproportionately divorced or single according to registration in the 1990s and early twentyfirst century. In addition, women who have children are less prone to suicide than those without children (Hoyer & Lund, 1993). These factors point at protective elements of family life.

Over the past decades suicidologists have more closely examined how an instable family context constitutes a risk for suicidal behavior. Beautrais et al. (1996) showed that low parental care and a poor parental relationship increase vulnerability to suicidal behavior. Parental care is affected by for instance the amount of parental interest in the children, a parental divorce, or psychiatric illness or substance abuse of the parents. Moreover, a range of childhood experiences and family adversities are known to influence the parental care and relation as well as family environment in relation to the propensity to suicidal behavior. These include a history of childhood sexual or physical abuse, and a family history of suicidal behavior (Beautrais, 1999). Sexual and physical abuse has the most weight among these risk factors for suicidal behavior and is known to happen more often to females (Fergusson & Mullen, 1999). In addition, family rigidity, defined as the incapability of adaptability in response to problem situations and stress,
may also hinder effective problem-solving skills and enhance the risk for suicidal behavior in youngsters (Carris, 1998).

**The medical tradition and psychological tradition in suicidology**

The medical tradition in suicidology has investigated psychiatric malfunctioning that constitutes a risk for suicidal behavior. More recently, there is also an increasing attention regarding the role of neurobiology and genetics in suicidology (Van Heeringen, 2000). Research on the contribution of psychiatric disorders acknowledged depression to be a crucial risk factor for suicidal behavior, as well as schizophrenia or bipolar disorder (Hawton, 2005; Pompili et al., 2007). An estimated two thirds of all suicide attempters in the west have a depressive illness (O'Connor & Sheehy, 2000). It is argued that an estimated 50 to 90 percent of all the suicide attempters may exhibit one of the high-risk psychiatric diagnoses. However, it can also be found in the literature that up to one third will not qualify for syndromal psychiatric diagnosis (Murphy, 1998). This confirms that depression is not a sufficient or necessary condition for suicidal behavior (Dieserud, 2001).

Research in non-western groups showed that depression may be less relevant as a risk factor. Cultural meanings are involved in the understanding and experience of depression across different ethnic groups. A study by Fenton and Sadiq (1996) in the United Kingdom indicated how symptoms such as a loss of meaning in life and loss of sense of personal worth, frequently associated with depression, were not easily found in the accounts of South Asian women of the first generation. This could be explained as a result of a difference in self-conception present in South Asian women, which does not match a similar emphasis placed on the individual as commonly seen in the west. These studies suggest vigilance is needed when applying western understandings of depression cross-culturally.

Personality disorders are also a factor of importance for being at risk for suicidal behavior, in particular a borderline personality. A low self image, a self-turned style of emotional regulation and high levels of impulsivity were also identified as playing a role in the development of attempted suicide (Borst, 1993; Beautrais, 1996). The latter aspects show high correlation with the diagnosis of borderline disorder, while females are overrepresented on this diagnosis (Linehan, 1993).

Research in the area of cognitive psychology examined the relation between personality constitutions or patterns in thinking that function as risk factors for suicidal behavior. The prevalence of hopelessness is found to be crucial as a risk factor for suicidal behavior, either within the context of a
depression or independently (O'Connor & Sheehy, 2001). Research also indicated that many suicide attempters engage excessively in rumination, worry frequently about past failures and are highly self-critical (Williams, 2001; Morrison & O'Connor, 2008; Kerkhof, 2008). In addition, individuals who lack adequate problem-solving capacities often engage in dichotomous thinking and passive coping (Pollock, 2004). These factors enhance vulnerability for suicidal behavior. However, it has also been argued that in those adolescents who display suicidal behavior problem-solving capacities may not necessarily be lacking, but they may be experiencing more stressful life events than others (Orbach, 1999).

The gender paradox in suicidal behavior

The demographics and statistics show that a gender paradox exists in suicidal behavior. It is men who more often die from suicide, yet women more often make suicide attempts. Young women in The Netherlands, as well as worldwide, more often attempt suicide compared to males. The gender ratio generally observed in suicidal behavior in western countries is at least 1.25 higher for female adolescents compared to males (Evans et al., 2005; McKeown et al., 1998; Beautrais, 2005; Evans et al., 2005; Madge et al., 2008). Countries that have reported gender differences include for instance the United Kingdom, France, US, Slovenia, Canada, New Zealand and Turkey (Ali & Maharajh, 2005; Beautrais et al., 2005). The gender gap seems to increase with adolescent age until youngsters are 16 to 20 years old and afterwards differences between males and females become smaller. There appears to be a peak of suicidal behavior in mid-adolescence for females, e.g. when they are 16 years old (Steinhausen, Bösiger & Metzke, 2006; Beautrais, 2005).

Unfortunately, suicidal behavior has often been framed as attention seeking and ‘unsuccessful’ (Beautrais, 2006). Research by Dahlen and Canetto (2002) showed that North American males evaluated suicidal behavior more negatively compared to suicide. Since women are overrepresented in suicide attempts, it is women in particular who are prone to these negative evaluations. Also, it is often assumed that women's suicidal behavior is non-medically serious and has a low suicidal intent. However, at this time numerous studies have shown that a lethal intent is present as often in females as in males and that the acts of women are medically serious as often as that of male attempters (Hjelmeland et al., 2002; Beautrais, 2006; Nordentoft & Branner, 2008).

One explanation for the gender paradox that has gathered much support, is that females in general choose less lethal methods, which is
likely to be responsible for the non-fatal outcome of their acts. Hence, if women would turn to more lethal methods, they would quickly exceed the number of suicides by men. The likelihood of this scenario is underscored by the picture that emerges outside Europe and the USA. Examples can be found in rural China and southern Indian states, where suicides by women are as frequent or higher compared to male suicides (Yip & Liu, 2006; Conner et al., 2005; Aaron et al., 2004). However, males are overrepresented in urban suicides in China. The methods for suicidal behavior used by women in the countryside are highly lethal (i.e. pesticides), notably more lethal than the methods commonly used by female suicide attempters in the west and in the urban areas of non-western countries.

The gender ratio of suicide attempts in the west has also been disputed regarding its validity. The representativeness of hospital data concerning suicide attempts has been questioned, since cultural assumptions may play a role in the registration of suicidal behavior (Wichstrom, 2002; Canetto, 1999). Canetto (1999) suggested that suicidal behavior by males may be subject to underreporting due to cultural attitudes about masculinity and suicide as well as the association of non-fatal suicidal behavior with femininity (Canetto & Lester, 1995). This would be less of a problem in self-reported suicidal behavior using community samples (Wichstrom, 2002). Yet, the fact that female deaths possibly due to suicide are perhaps more likely than male deaths to be classified as ‘not suicide’ indicates that the actual gender gap in suicide may be less skewed than documented in official statistics. However, it seems unlikely that underreporting would be of sufficient proportion to reduce the high gender suicide disparity (Canetto & Sakinofsky, 1999). Most researchers agree that the gender paradox of suicidal behavior is a real phenomenon and limited validity is unlikely to explain all of the gender difference.

Further explanations into the gender paradox have pointed at differential risk factors for females related to a differential socialization (Canetto & Sakinofski, 1999; Wichstrom, 2002). Regarding differential risk factors between the sexes, alcohol abuse is an important risk factor for suicidal behavior. Alcohol abuse is more frequently observed in males compared to females. Next, it has been suggested that specific life events that are risk factors for attempted suicide occur more often or only to girls compared to boys (e.g. sexual harassment and sexual abuse, abortion, teenage pregnancy, post birth depression) (Beautrais, 2006; Wichstrom, 2002).

From the theories on differential socialization, it follows that socialization might lead males and females to use different methods of
coping with life and responding differently to stress (Nolen-Hoeksema, 1990; Wichstrom, 2002). Socialization permits female adolescents fewer outlets for the release of aggression than males (Vanatta, 1997). One empirical foundation for this is the fact that adolescent girls are more often depressed than boys (Nolen-Hoeksema, 1990), whereas boys score much high on externalizing disorders e.g. conduct disorders. This propensity to internalize could be indicative of how suicidal behavior might be conceived of as more of an appropriate way for a female to respond to severe stress or difficulties, than for males (Canetto & Sakinofski, 1998). However, it is known that the elevated incidence rate of suicide attempts by adolescent girls is not maintained into young adulthood, whereas depression maintains to be gender skewed (Lewinsohn, 1994). Depression is therefore unlikely to be the crucial mediating factor. This is supported by research that showed how the gender differences in self-reported rates of suicidal behavior among adolescents was not eliminated even when depression was controlled for (Wichstrom, 2002).

**Ethnicity**

Research on ethnic minorities and immigrants has shown a number of examples of increased propensity for suicidal behavior. For instance this is the case for Latina subgroups in the United States (Canino & Roberts, 2001), native American youth in the United States (Olson & Wahab, 2006), South Asian women in United Kingdom, Malaysia and Fiji, (Patel & Gaw, 1996), and Asian Americans (Kisch, Leino & Silverman, 2005). In some studies, the increased propensity to suicidal behavior in minority groups in relation to majority groups demonstrated a disparity in comparison to the country of origin (Stack, 2000b).

The increased prevalence of suicidal behavior in immigrant groups has been suggested to be a result of several aspects. It could be that severe strains exist for immigrants and their children due to their low social, cultural and economic status in the host societies (Canino & Roberts, 1999; Trovato, 1986). A low social economic position is a well known risk factor for suicidal behavior (Schmidtke & Lohr, 2004). Additional difficulties and strains specific to (non-western) immigrants may aggravate their position and that of their children e.g. discrimination, lower or no educational qualifications, which can lead to unemployment. A study by Gutierrez et al. (2001) found that Hispanics as well as Blacks in the United States reported a greater repulsion by life compared to Whites, which suggested that they are less satisfied overall with their lives. In addition, social-economic status and a migration history from non-western countries are often
interconnected with a poorer mental health and the increased prevalence of psychiatric disorders (De Graaf et al., 2005; Van Oort et al., 2007; De Wit et al., 2005). This may also render immigrants and their children vulnerable to suicidal behavior.

The extent of acculturation and assimilation by immigrant groups into their host society could also influence their propensity to suicidal behavior (Trovato, 1986). Research from Canada shows that the higher the degree of social assimilation among immigrant groups, the greater the suicide rate (Trovato, 1986). This suggests that assimilation is a stressful event in which the individual is being ‘pulled’ by two opposing forces and values: the ethnic group and host society. As suggested earlier, in Durkheimian sense, this presupposes that the process that the individual goes through involves some extent of anomie during the assimilation transition. Simultaneously, it is expected that erosion of social integration within the ethnic group occurs. In addition, another preposition that showed to have merit was that of the degree of ethnic community integration in relation to suicide in Canada (Trovato, 1986). This thesis showed that: ‘ethnic groups with strong degrees of community cohesiveness share reduced odds in their incidence of suicide; this serves as buffer for psychological stresses associated with life in the new societies’ (ibid: 56). However, Durkheim put forward a strong case when he noted that only optimal levels of cohesion are protective, yet overly strong control may increase the suicide risk.

In addition, cultural anthropologists argued how mechanisms leading to suicidal behavior differ as a result of cultural models and perceptions. Local models of self and emotions can bring important insights to the understanding of suicidal behavior within a given culture (Brown, 1986; Giddens, 1964; Counts, 1980). This preposition refers to the social meaning and appropriateness or cultural fit of suicidal behavior across different cultures (Giddens, 1964). Culture influences the interpretation of the stress and the definition of the situation and also what is considered to be the most appropriate strategy to respond. In addition, there may be an element of imitation present that triggers the mechanism of suicidal behavior, which is passed on through the cultural memory.

Outline of the dissertation

We conducted five studies in order to understand the complexities of non-fatal suicidal behavior of young Turkish, South Asian and Moroccan women in The Netherlands. Our first study aimed, by exploring directions, theories and research findings from four traditions in suicidology, to scrutinize the
relevance of these disciplines for young South Asian women's suicidal behavior. We compared the insights from these traditions (sociological, ecological, medical and psychological) with the empirical evidence from two Dutch studies by Salverda (2004) and Krikke, Nijhuis and Wesenbeek (2000).

Subsequently, we studied and verified the rates of suicidal behavior in young females in The Netherlands. To establish the prevalence of attempted suicide, we examined two datasets of suicidal ideation of youth in Utrecht (chapter 3, N=249) and young females' suicidal behavior in Rotterdam (chapter 4, N=4562). The data in these two studies had been collected previously by Municipal Health Offices in these cities and included inquiries into the life time incidences of attempted suicide of youngsters cross-culturally. In addition, in both studies, we wanted to learn the relevance of risk factors for suicidal behavior. Research indicated that potential influences on suicidal behavior include social-economic factors, family factors and individual aspects, i.e. psychological well-being, self image and mental health. We examined whether the ethnic minority background would continue to increase vulnerability to suicidal behavior if these factors were controlled for in the analysis.

We felt that existing traditions in suicidology are arguably rather weak in the contextualization and motivation of suicidal behavior (Hamlin & Bryn, 2006). Moreover, current research has certain shortcomings regarding the inclusion of the perspectives of those it concerns. In order to overcome these pitfalls, and to provide an answer to the second research question, we used a two-fold approach. Through medical case files, we studied the living conditions of women who had attempted suicide in four ethnic groups, as outlined by their health care professionals. The medical case files were available from the archives of a public mental healthcare centre. We also addressed the relevance of their psychiatric diagnoses and stressful life events cross-culturally to verify whether this would be illustrative of ethnic variation in suicidal behavior. We selected case files (N=115) of females aged between 12 and 41 years old of South Asian, Turkish, Moroccan and Dutch origin. While examining women's living conditions, the archetype of Durkheim's 'fatalistic suicide' came into mind. We further theorized and tested the relevance of this theoretical concept throughout our data. In chapter 5 we discuss the outcome of the application of this Durkheimian paradigm to the medical case files.

In addition, we used the findings of the case files to guide the topics of the life story interviews, the final step we conducted for this project. We aimed to detect how women would explain their suicidal behavior, and to
examine the relevance of gender, ethnicity and migration to their behavior. We expected that the response of a suicide attempt would be related to the circumstances, but also perspectives, emotions and motivation of young women about what happened in their life, their life course, youth and upbringing. Thus we applied a format of interviewing where there was abundant space for women's viewpoints. We interviewed 47 women aged 18 to 40 of Turkish, Moroccan, South Asian and Dutch origin. Among the interviewees, 43 women had conducted suicidal behavior, while 4 had ideated suicide.

We analyzed the interviews with a grounded theory approach. In chapter 6 we describe in-depth through empirical data what we learnt from our interviews of females of four ethnic groups with a history of suicidal behavior. This chapter is followed by a methodological explication of the validity and reliability of the life story interview (chapter 7).

In our concluding chapter (8), we discuss the collective insights from our five studies in relation to our research questions. We discuss the theoretical implications of our project. We revisit Durkheim's typology of suicide and its appropriateness to the research subject. In addition, we outline the contribution of our studies to suicidology in the light of feminist debates on autonomy, as well as discussing the insights provided to migration and ethnic studies. We outline how these findings can be beneficial to (cross-cultural) suicidology and discuss their implications as well.

Notes
1. South Asian-Surinamese and Creole-Surinamese make up 90 percent of the Surinamese immigrant population (Choenni & Adhin, 2003). Surinamese migration to The Hague mostly consisted of South Asian-Surinamese, which lead us to assume that it concerns South Asian-Surinamese who have increased rates. Results of registration of suicidal behavior in the city of Amsterdam confirm that South Asian-Surinamese females are more at risk for suicidal behavior compared to Creole-Surinamese (Jansen & Buster, 2008).
References


Tatarelli, R. (2007) ‘Suicide risk in schizophrenia: Learning from the past to change the future’, *Annals of General Psychiatry*, 16, pp. 6-10


