Chapter 8

Summary, Conclusion and Discussion

Introduction
The suicidal behavior of ethnic minority women raised our interest when health care professionals in The Hague, The Netherlands, published a report in 1999. The report showed that Moroccan, South Asian and Turkish young females in the age band 15-24 years were seen disproportionately compared to other ethnicities after a suicide attempt at hospitals and emergency services in The Hague, during the years 1987-1993. These findings prompted us to widen the knowledge on prevalence of suicidal behavior across ethnicities and to investigate the origins of this manifestation in young females of Moroccan, South Asian and Turkish descent.

In the study, we abided by the WHO definition of suicidal behavior: ‘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). Suicidal ideation refers to serious contemplation about suicide or ending one's own life. For brevity reasons, non-fatal suicidal behavior is referred to as ‘suicidal behavior’.

According to Emile Durkheim (1897, 1852), certain populations are more at risk for suicidal behavior than others due to variation in the socio-cultural structures across social or ethnic groups. Our first aim was to establish whether young women of South Asian, Turkish and Moroccan origin demonstrate suicidal behavior and suicidal ideation more often than majority Dutch young women in The Netherlands. The subsequent aim of our project was to unravel the apparent relation between suicidal behavior and ethnicity in young females of South Asian, Turkish and Moroccan origin. Considering that socio-cultural structures consist of norms, values, beliefs and practices, it seemed plausible that these structures are primarily (re)produced in the family context. The family and upbringing of young females hence became an important focus in our project. In addition, it was striking that all minority females who appeared to be at risk for suicidal behavior belonged to immigrant families with a non-western background. This underscored the possible relevance of a family history of (non-western) migration.
In short, our research questions were as follows:

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?

While our first question was concerned with rates of suicidal behavior and could be dealt with empirically through quantitative measures, our second question was interwoven with theoretical underpinnings of cross-cultural socialization and gender in relation to suicidal behavior. Faced with stress and adversity, females are more likely to develop internalizing behavior and disorders, e.g. anxiety, worrying or depressive illness than males (Nolen-Hoeksema, 1990). Internalizing behavior shows a strong relationship to suicidal behavior. The propensity in females to internalize is commonly explained by their socialization that permits female adolescents fewer externalizing ways of dealing with frustration and aggression than males. From this perspective, attempted suicide could be a response by people who lack the power to influence their situation in a more viable way (Edwards & Holden, 2001). This proposition provided a frame of reference when we addressed the second question.

In addition, Durkheim’s writings on social and cultural change and suicide also inspired the examination of the second question. Durkheim’s proposition was that suicide is intertwined with a distorted equilibrium between social integration and regulation levels in society. When individuals are either overly constrained by rules or when they experience a strong lack of moral guidelines, suicide could occur. In addition, when individuals were over-embedded in their social groups, or vice versa when they have only minimal connectedness with their group, suicidal behavior may occur (Durkheim, 1952).

In this chapter, we summarize the results of the prevalence of suicidal behavior and suicidal ideation across ethnicities. Then we discuss the findings of the origins of attempted suicide in young minority women. We first outline to what extent the quantitative enquiry elucidated these origins. Next we move on to insights that qualitative approaches have provided. We discuss theoretical implications within a Durkheimian perspective as well as a cultural frame. We propose directions of future studies into suicidal behavior of young immigrant females by underpinning the benefits of our research as well as pointing out limitations in our studies. We conclude with general conclusion and offer some thoughts for discussion.
Prevalence of suicidal behavior and suicidal ideation

We conducted a statistical analysis of the self-reported scores of the lifetime prevalence of suicidal behavior (Rotterdam) and suicidal ideation (Utrecht) of youth of ethnic minority and majority background. In Utrecht, the sample included 252 Turkish, Moroccan and Dutch male and female youngsters aged 12-18. In Rotterdam we selected females only. Altogether more than 4,000 female students aged 14-16 of Turkish, Moroccan, South Asian and Dutch origin were selected.

The results emphasized the vulnerability to suicidal behavior of Turkish and South Asian young females compared to majority females aged 14-16 years old in the city of Rotterdam and the risk of suicidal ideation of Turkish youngsters of 12 to 18 years old in the city of Utrecht. Fourteen percent of young females of Turkish origin in Rotterdam demonstrated rates of suicidal behavior. Thirty-eight percent of the Turkish youth in Utrecht had thought about suicide. South Asian females in Rotterdam demonstrated rates of 19.2 percent, while no information was available on South Asians in Utrecht. In Utrecht, although girls scored higher than boys, we did not observe significant gender differences in prevalence of suicidal ideation. Due to the small sample size, the lack of statistical power may be accountable for this.

These findings reflect the registration of female suicidal behavior by health care professionals in The Hague and Amsterdam in the late 1980s, 1990s and in the early twentyfirst century (Burger et al., 2005; Janssen & Buster, 2008). Turkish women attempt suicide 2 to 3 times more often (5.5 per 1,000 per year, 2002-2003) compared to Dutch women (2.4 per 1,000 per year, 2002-2003). South Asian women (4.2 per 1,000 per year, 2002-2003) demonstrated suicidal behavior almost two times more often compared to Dutch women. Since these findings, including the results we found, altogether cover a time interval from 1988 to 2006, the propensity of Turkish and South Asian young females to suicidal behavior is a long-standing susceptibility that has not yet started declining. By contrast, the self-reported prevalence of Dutch young women of suicidal behavior in Rotterdam of 8.8 percent and suicidal ideation of 20.3 percent (Utrecht) are lower; and have shown minor increases over time.

Compared to the country of origin (of the parents), a complex picture emerges. A hospital registration for the World Health Organization in the Mamak district of Ankara, showed that young Turkish women in The Hague attempt suicide at least twice as often as young women in Mamak; 2.3 versus 5.5 per 1,000 per year between 1998-2001 (Devrimci-Ozguven, 2003). In addition, Turkish young females in Rotterdam (self) reported 4.5 times as
often to have ever attempted suicide compared to female high school students in Aydin, Turkey; 14.3 percent versus 3.0 (Eskin et al., 2007). On the other hand, the southeast region of Batman in Turkey has registered rates of suicidal behavior as high as 20 percent, and in particular young women are prone to this behavior in this area (Oto et al., 2005; Bağlı & Sev’er, 2003). In addition, a study of high school students in Adana showed self-reported rates of a twelve month incidences of attempted suicide of 9.5 percent for females, which possibly reflects an estimated 11-14 percent for life time prevalence (Payci et al., 2005). Moreover, two Turkish studies into suicidal ideation report percentages of 23 and 50 percent in Aydin and Ankara respectively, versus 38.1 of Turks in Utrecht (Ulusoy & Demir, 2005; Eskin et al., 2007).

The comparison of rates of South Asian females with India and Surinam is difficult. South Asian women in The Hague reported to attempt suicide (19.2 percent) about 1.5 times as often compared to female adolescents in New Delhi (11 percent), yet when the term ‘self-harm’ is used, the figure for females in New Delhi was almost similar to Rotterdam (18 percent) (Sidharta & Jena, 2006). Prevalence based on registration at Indian hospitals could not be found. Extremely high prevalence of suicide in young males and females in rural southern India has been reported during the last decades, and this would probably be reflected in the rates of attempts, had they been available (Aaron et al., 2004). In the province of Nickerie in Surinam (which has a large South Asian population), hospital registration has shown an attempted suicide rate of 5.3 per 1,000 for South Asian females (Graafsm, 2008), which is comparable to the registered high rates of South Asian females in The Hague (4.2 per 1,000, Burger et al., 2005).

By contrast, Moroccan youngsters report slightly lower rates of suicidal ideation and suicidal behavior compared to majority youth. Moroccan females in Rotterdam report suicidal behavior of 6.2 percent and Moroccan youth suicidal ideation of 12.8 percent. The only study available from Morocco shows a rate of 2.7 percent of women of all ages in Casablanca (Moussoui & Kadri, 2006), which is a poor comparison. The self-reported rates in Rotterdam contradict findings of registration by health care during the late 1980s and 1990s (Schudel, Struben & Vroom-Jongerden, 1998). However, the most recent registration by health care professionals in 2002-2003 did not find any significant differences between Dutch and Moroccan young women either (Burger et al., 2005). We return to this matter further below.
Quantitative inquiries into the vulnerability to suicidal behavior

To answer the second research question, we first employed quantitative strategies e.g. an analysis of risk factors. Three levels contribute to suicidal behavior: social structures, the ecology (the family environment and intrapersonal relationships) and the individual (psychological, psychiatric and intrapersonal malfunctioning) (Beautrais, 1999). We studied associations between risk factors to ethnicity and suicidal behavior at these three levels. Two types of samples were used. Epidemiological samples that consisted of (female) youth allowed us to compare characteristics of those who previously conducted suicidal behavior (in Rotterdam) and suicidal ideation (in Utrecht) to those individuals who reported to have never done so. In addition, through clinical samples, we wanted to examine the scope of these risk factors in females who had demonstrated suicidal behavior. We approached this through a compound sample of 115 medical case files and 47 interviewees who previously displayed suicidal behavior or demonstrated suicidal ideation.

Social economic class and educational level

It seemed plausible that a lower socio economic status could contribute to suicidal behavior of female minority youngsters in Rotterdam and Utrecht (Schmidtke & Lohr, 2004). It is well-established that non-western immigrant families in The Netherlands, in particular Turkish and Moroccan families, predominantly belong to lower social-economic strata (Dagevos & Gijsberts, 2007). In addition, a South Asian family that consists of one-parent is vulnerable to economical deprivation, while registration shows that these single parent families are increasing in number in South Asian communities (Sociaal en Cultureel Planbureau & Centraal Bureau voor de Statistiek, 1999). Increased susceptibility to suicidal behavior could also result from additional difficulties immigrant parents face compared to Dutch lower class families. Turkish and Moroccan immigrant parents more often have no formal qualifications and are sometimes confronted with a number of disadvantages due to discrimination or language difficulties, resulting in high unemployment rates (Dagevos & Gijsberts, 2007).

Despite these indicators, in the data from Rotterdam, social and economic status was not significantly related to suicidal behavior of South Asian young women. The fact that we used aggregated data drawn from the postal codes rather than individual data may have influenced our results in this respect. However, social economic deprivation was found to heighten the propensity to attempted suicide in Turkish females compared to other
ethnicities. Also our study in Utrecht suggested the relevance of economic deprivation in Turkish families to suicidal ideation.

We assumed that since minority youngsters are disproportionately enrolled in lower levels of education, this could contribute to ethnic variation in their suicidal behavior (Van Ours & Veenman, 2003). Yet South Asian and Turkish females remained at increased risk for suicidal behavior, even when we controlled for the level of education. Thus, the findings suggest that ethnic minority status is independently associated with suicidal behavior.

**Ecological context: risk factors in the family environment**
The family environment has been identified as a crucial influence to suicidal behavior in adolescence (Pfeffer, 1987; Beautrais, 1999). The survey data we analyzed, addressed the family environment through items such as feeling isolated at home, whether there was frequent arguments at home or if adolescents had considered running away from home. We could not detect ethnic differences in the family environment. However, in the data from Utrecht, we did observe possible ethnic differences. Turks reported high scores on loneliness, yet different from the Dutch youngsters; this did not reflect feelings that no one cared about them. Feeling lonely and simultaneously not enjoying being at home, yet reporting to be cared for, suggests a family situation where there is a caring yet unsatisfactory relationship between children and parents.

In addition, research showed that mental health problems exist disproportionately in immigrants of Surinamese, Moroccan and Turkish origin, depression in particular (De Graaf et al., 2005; Van der Lucht & Foets et al., 2008). Children of immigrant parents hence are more likely to grow up with a parent with mental health difficulties. According to our Rotterdam data, parental psychopathology played a more pronounced role in Turkish and South Asian females in comparison with majority females. Why this has a stronger impact on these minorities remains unclear. It may be that due to the taboo nature of the issue and unfamiliarity with mental illness that access to a suitable treatment is even more difficult for non-western immigrants. Remarkably, the high relevance of psychiatric disorders and substance abuse of Turkish parents in our epidemiological sample contradicts with low frequencies of these aspects in our clinical sample of case files and interviews. Perhaps there is reluctance to reveal these issues in mental health care context as well as interview settings because of stigma and unfamiliarity, while they are admitted more readily when asked directly after in a survey through self-report. The findings of
South Asian females on the other hand, regarding the relevance of psychiatric disorders and substance abuse of their parents, showed congruency across the different samples.

In the epidemiological sample of Rotterdam, the relationship with the parents was examined through checking whether youngsters felt they could discuss problems with one of their parents. Adolescents who could discuss problems with at least one of their parents reported less suicidal behavior. We did not observe that a minority background could be held responsible for a worsened parental relationship in its association to suicidal behavior. The findings in the clinical samples point at the same direction. We established in our clinical compound sample that an impaired relationship with the parents was equally frequently reported by young women irrespective of ethnicity. However, the constructs in the survey data did not allow us to further disentangle the origins of strains in the parent-child relation.

**Individual aspects in suicidal behavior and suicidal ideation**

We paid special attention to physical and sexual abuse, which are well-known important factors for suicidal behavior and suicidal ideation (Coll et al., 2001; Salander-Renberg, Lindgren & Osterberg, 2004). We found strong support in our study of females in Rotterdam for the detrimental effect of sexual and physical abuse to suicidal behavior regardless of ethnicity. The examination of clinical samples also showed that women often mentioned physical and sexual abuse. It is suggested that the relationship between abuse and suicidal behavior may occur through an impaired self-concept, shame, self-blame and low self-esteem (Brodsky & Stanley, 2008). For minority females, we hypothesized that these feelings would be worsened as a result of increased shame related to being a disappointment to herself and her family by losing (family) honor. However, this was not supported in the epidemiological data; sexual abuse was less reported in Turkish and Moroccan young females. Sexual abuse may be underreported in minority women due to the feelings of shame and repercussions that could occur when the abuse becomes known. Considering the fact that the questionnaires used in Rotterdam have not been filled out anonymously, this remains a possibility.

The data of Utrecht suggested that those Turkish youngsters who ideated suicide had a lower self-image compared to majority females who ideated suicide, mostly accounted for by their feelings of not being proud of oneself. We also examined the contribution of psychiatric disorders that are known in western population to compose a risk for suicidal behavior. The data on youngsters in Utrecht showed that being clinically diagnosed as
depressed seemed to have a stronger impact for suicidal ideation in minority youngsters compared to Dutch youngsters. This suggests that Turkish and Moroccan youngsters are perhaps introduced to professional mental health care relatively late, or it could also mean that minority youth are faced with more detrimental conditions. Alternatively, minority youngsters may be less equipped at coping with adverse circumstances. In general, the outcomes confirm previous research that identified significantly more internalizing problem behaviors and emotional problems in Turkish immigrant children and adolescents in The Netherlands compared to majority youth (Murad et al., 2003; Van Oort et al., 2007).

Remarkably, the scope of psychiatric disorders in the clinical samples showed that these disorders were less relevant for Turkish and Moroccan young women compared to majority women. Psychiatric disorders were equally relevant for South Asian women in comparison to Dutch women. In contrast to the findings of Utrecht, this would suggest that social cultural stressors would perhaps be more applicable to Turkish and Moroccan women as opposed to the impact of disorders. However, an alternative explanation for these contradictory findings is that our clinical samples also included immigrants of the first generation, while the data from Utrecht and Rotterdam mostly consists of youngsters of the second or in-between generation. Those youngsters belonging to the second or in-between generation possibly more easily refer to their psychological complaints in line with western discourses of ‘disorders’ or ‘mental illness’ (Kamperman, 2005).

In sum, we undertook the quantitative studies to see how relevant well-established western risk factors would be in females of non-western origin. If these factors would be aggrandized in non-western groups, this could explain their increased rates of suicidal ideation and suicidal behavior. The quantitative examinations transpired that many similarities exist in risk factors among ethnicities; social, ecological and individual in nature. We also identified some differences in the impact of these factors. The differences mostly consist of the more substantial contribution of psychiatric illness and substance abuse in South Asian and Turkish parents of suicide attempters compared to Dutch females, as well as a heavier impact of socio economic deprivation on Turkish young females who demonstrated suicidal behavior. We realized however that suicidal behavior and suicidal ideation of non-western groups may (also) be the results of different risk factors compared to majority groups (Colucci & Martin, 2007). To investigate this we opted for qualitative research strategies.
Qualitative methods to understand attempted suicide: five patterns that characterize the lives of women who turn to suicidal behavior

We interviewed 47 women aged 18 to 40, of South Asian, Turkish, Moroccan and Dutch ethnicity. Forty-three women had conducted suicidal behavior, while four had ideated suicide. We analyzed them with a grounded theory approach. The medical case files were available from the archives of a public mental healthcare centre in Amsterdam. We selected 115 case files of females aged between 12 and 41 years old of the same four ethnic groups. We initially analyzed these files according to risk factors, and later used a Durkheimian frame when this appeared relevant (see ‘theoretical implications’).

Processes toward autonomy, and a clash over strategic life choices

The lack of autonomy emerged as an important contributor to suicidal behavior of women belonging to the first or in-between generation of Turkish, Moroccan and South Asian immigrants. Women's lives featured coping with the daily hardships of the care of others while being denied to have a life of their own. Their family (in-law) and husbands created restrictive conditions (e.g. being locked up, or expected to never leave the house, denied to go to school, forced into a marriage), often upheld by abuse or maltreatment. As a result of these oppressive practices starting at young age, many minority women were initially unaware of what they needed in life; they often did not envision their own needs and had a limited sense of 'self'. However, we also found one example of a Dutch woman with a lack of autonomy skills. Her parents planned her entire activity calendar, they as well emphasized from their orthodox faith that life consisted of sins and stressed the need to be reflective and apologetic about these. This led this woman to feel incapable of steering her life and continuously doubting whether her actions were pure and worthy enough.

We observed how not only conditions were important to suicidal behavior, but also the specific narrative and perspective of women proved to be crucial. The social and cultural nature of the self that featured in the narrative was fundamental to this (Chanfrault-Duchet, 1991). The social influences of their sacrifice were demonstrated by the impact of cultural images prevailing in women's families and communities. These images consisted of embodying the enduring wife, which resulted in incorporating the faith of suffering and accepting women's position as subordinate to those of husband and family. Simultaneously they aimed to avoid being a woman who has gone astray, relating to a lost sense of (family) honor for instance because of choosing a partner of other than the own ethnic and religious
background, having premarital (sexual) relationships or opting for a divorce. These images were the key to understanding why women would endure their situation and simultaneously hampered self-transformation. For South Asian women, the cultural memory appeared important as well. This was transpired through Indian traditions where women are expected to make themselves disappear by self-immolation in order to avoid shame or being a burden to the family (Kumar, 2003; Vijayakumar, 2006). To elucidate this, suicide was suggested by the mother of one of the interviewees as the appropriate reaction for females after loss of honor. This suggests a lower threshold and cultural predisposition for female suicidal behavior embedded in the South Asian cultural repertoire, which is underscored by the high rates of suicidal behavior of South Asian women worldwide (Patel & Gaw, 1996).

Another meta narrative that was related to autonomy found in Turkish and Moroccan women of the second generation, was a clash over strategic life choices (Kabeer, 2001). Different from the narratives of women of the first pattern, young women of this category clearly had developed autonomy skills and aimed to be in control of their direction in life. They wanted to decide over strategic life choices, in particular choices regarding freedom of movement, education, career wishes and spouse choice. Their choices conflicted with those of their family (and husband). Both the daughters and their families experienced their will as irreconcilable. The hopelessness, frustration and pain that young women felt over these conflicts led them to feel torn apart between affection and loyalty towards the parents (and/or husband) versus their own quest for goal fulfillment. This led them to enter a deadlock. It is often in this stage that suicidal behavior emerges.

Research by Williams (2001) underscored that the sense of (long-term) entrapment, in which an individual has little or no control over his/her environment, is central to suicidal behavior. When a person has grown up in an environment where she could exercise very little control, she learned over a long period of time to submit and is prone to long-term demobilisation. In that sense, attempted suicide is a response belonging to those who lack power. However, fortunately in many cases eventually a process of self-transformation occurred. Women developed a critical consciousness of the taken for granted praxis and a shift towards recognizing own needs. Suicidal behavior emerged during the prolonged sense of entrapment and often symbolized a transition stage. During this development toward autonomy women often became aware of non-congruency in their sense of self and the inaccessibility of goals in life. These
aspects were difficult to accept since women regretted what happened in the past and frustrated over the lack of autonomy (Townsend-Carlson, 2001). Suicidal behavior can hence be seen as a protest or regret that emerged when a woman realized the unfavorable outcome of her life, yet alternatives have either not been envisioned or cannot be translated (yet) into other ways of being and doing.

We observed how Moroccan young women seem less at risk for suicidal behavior and ideation today than previously. The reasons for this decline are unclear. Possibly, autonomy restrictions have become less frequent in Moroccan community at large, for example because of processes of emancipation. Arguably, fatalistic suicide may be associated with a period of transition towards more autonomy, which may signal that Moroccan women are slowly moving out of this transition phase. It is also possible that autonomy restrictions are still as frequent as before, yet more Moroccan women increasingly leave their family home before the situation escalates and suicidal behavior is prevented in this way. Alternatively, it may also be that Moroccan women are less affected by cultural images of self-sacrifice, endurance and female subordination than they did previously.

**The contraposition of autonomy: lack of connectedness**

Many Dutch majority women and South Asian women with a history of suicidal behavior experienced a lack of connection and affection from their parents and family. The lack of meaningful family ties transpired as the core of their unhappiness. The relationship with the parent(s) had been severely disturbed over the years as a result of an upbringing where care was not (sufficiently) shown and they felt parents had failed to provide them with a safe and loving environment. Although in some accounts (minor) conflicts over strategic life choices were found, these aspects were not central. Young women who belonged to this category also reported psychological maltreatment (e.g. denigration and manipulation) or (sexual) abuse that was sometimes conducted by the parent(s). Physical abuse and denigrating statements by their parents were mentioned by South Asian women in particular. This is striking since South Asian families used to be characterized by strong and warm family bonding, despite the hierarchy and obedience to parents (authoritarian parenting) that is still common in many South Asian families (Choenni & Adhin, 2003; Saharroso, 2000). When strict control and harsh parenting methods are employed, yet affection is not in place, it is understandable that many South Asian women struggle with family relations. The timing of their suicide attempt often coincided with the
moment when isolation is felt intensely and young women feel misunderstood and unloved.

From the above, we gather that (lack of) autonomy and lack of connectedness are two sides of the same coin which contribute to suicidal behavior when extreme positions are taken up in these dimensions. Too little autonomy in a family that is over-involved in strategic life choices was found detrimental, yet a lack of involvement and affection in family context was harmful as well in relation to suicidal behavior.

A sense of self that lacked worthiness as a result of upbringing
A fourth meta narrative consisted of the sense of self that is small and without value, which mediated the turn to the suicidal behavior. This narrative concerned young women whose self image was shattered and who spoke about their feelings of self-hatred, worthlessness and inadequacy. There was hardly any control in the family context as opposed to the first or second pattern; the key element was that women did not consider themselves as valuable. The key factor contributing to young women's suicidal behavior was that they perceived themselves as without value and hence felt they had no reason for living. Young women had experienced a socialization that did not strengthen their self worth. The mechanisms leading to a denigrated sense of self were somewhat different for minority and majority women. For majority women, a low self image was mediated through negative stressful life events e.g. bullying, school anxiety, sometimes denigration and physical abuse by family members, contextualized in a family where parents had rejected their children. These aspects also were relevant for minority women. Yet for minority women, honor related issues also played an important role. Their stress sometimes originated from (the fear of) their ambiguous position in their family ethnic community because it was speculated that they had squandered their honor. For example, in the case of a Turkish woman, family relations were warm until her brother-in-law raped her. Her family doubted her story and she then went to a women's shelter, and gossiping started in her extended family and ethnic community. Her family behaved cold blooded towards her, which had serious effects on her psychological well-being and diminished her ability to cope with the aftermath of the abuse.
Psychiatric illness leading to unbearable suffering

The last meta narrative concerned women for whom living with a psychiatric illness e.g. psychotic episodes, anxiety, depression, had become unbearable. Mental suffering resulting from for instance (acoustic) hallucinations, as well as social stress (e.g. financial loss), contributed to women's suicidal behavior. For minority women, diagnosis of schizophrenia and psychosis resulting from migration, as previously identified in cross-cultural psychiatry, seems to play a role (Bhugra, 2000). A biological vulnerability is likely to contribute to this. The process of migration appeared to be too demanding a task for these women and precipitated psychosis, acculturative stress and a sense of isolation. It concerned women of the first generation who spent (most of) their childhood in their country of origin and narrated with a sense of yearning about their youth and family. Problems in the parent-child relationship and family environment during upbringing of the woman could hardly be identified. As opposed to aforementioned narratives; there was no or little oppression of women's autonomy.

The role of migration and economic deprivation

Through the interviews, we were able to understand more precisely the role of a (family) history of migration. For some women, migration was a factor in the discomforting life conditions they faced. For instance, a number of minority women were used as a caretaker for the entire family. Often, this was influenced by the poor health, acculturative stress and marital difficulties of their parents partly resulting from migration. For example, after living apart for so many years when the father was in The Netherlands as a ‘guest laborer’, the relationship of many parents had often became troublesome after reunification. The acculturative stress of the mother who had come from rural and traditional areas seemed to cause physical complaints. All these aspects led to an increased demand for the support that was demanded of young women. The (extended) family system had often become disrupted after migration. Family members who would have been able to help out in the country of origin with household tasks and upbringing, were unavailable in The Netherlands. For some minority women belonging to the second or in-between generation, control and restricted freedom of movement were intertwined with the migration of their parents, who struggled with their upbringing amidst a liberal host society.

Migration, poverty and oppression were sometimes interwoven. For example, a young woman of a poor family from Turkey tolerated being
suicidal behavior in hospitals in Ankara, Turkey compared to The Hague, hint at a detrimental effect of migration. However, the majority of Turks in The Netherlands do not have their roots in urban Turkey, rather they come from rural areas (Den Exter, 1993). A more appropriate comparison is perhaps with the traditional and rural region in South East of Turkey (Batman), that has worrisome rates of female suicidal behavior. Oppressive conditions, poverty, and denial of strategic life choices for women are mentioned as causes (Bağlı & Sev’er, 2003). This underpins the explanatory power of autonomy restriction for the suicidal behavior of Turkish women independent from processes of migration. Moreover, Moroccans in The Netherlands have a similar disadvantaged position economically as the Turks (Dagevos & Gijsberts, 2007), yet do not share vulnerability for suicidal behavior. Hence, it seems likely that the influence of economical factors occurs in interaction with ethno cultural factors.

In addition, rates for suicidal behavior in South Asian women are high also in India and Surinam (Nickerie), as well as throughout the Indian Diaspora. Moreover, an examination by Steen and Mayer (2004) failed to identify a decline in high rates of female suicidal behavior in India when modernization increased, even when time effects were controlled for. This undermines the idea that migration would lead to struggles for more modern values as the explanation for the suicidal behavior of South Asian women in The Netherlands.

Theoretical implications: the relevance of Durkheim's archetypes of suicide

Emile Durkheim's work was based on an investigation of rates of suicide in the late nineteenth century. Durkheim, focused on the influences of social and cultural structures on suicide. He suggested a relation between suicide
to cultural and social change, modernisation, and social integration and regulation. He associated the prevalence of suicide in western societies with anomie and egoism; a state of moral disintegration and lack of social integration respectively. According to Durkheim, anomie emerged due to individualisation, whereby traditional moral regulations eroded and no longer functioned as a guide for crafting the life of an individual. As a result, the control that a social group has over its members also decreases.

Durkheim observed mainly negative consequences i.e. that without a moral compass, an individual entered a moral vacuum and becomes confused about the directions in life. A discrepancy emerged between aspirations and actuality since modernization made goals in life and their scope endless in theory, but then a reality check symbolizes a disappointment for many individuals who never accomplish those goals.

In addition, Durkheim (1952) argued how society became increasingly prone to egoism. Beliefs, values and sentiments ceased to be shared collectively since traditions were declining in modern and urban times. Social interaction between groups decreased and collective life diminished, leading to individualization and the assertion of individual interests. As a result, without being socially embedded, people struggle to find meaning in life and this may result in an egoistic suicide (Pope, 1978).

Based on the above, our hypothesis was that anomie would be a relevant concept for minority women. We expected that tensions accompanying cultural transformation after migration would be played out in the form of family conflicts and on the individual level in feelings of moral insecurity and personal inadequacy, leading to suicidal behavior with elements of anomie. At first glance, few empirical findings pointed at the erosion of moral frameworks and lack of bonding in Turkish and Moroccan young women of the second generation and their families. On the contrary, moral frameworks regarding strategic life choices were often firmly in place in the families they belonged to. However, in favor of Durkheim's theory on anomie we observed that cultural change towards modernity over generations had taken place. For example, had Moroccan and Turkish young women grown up in the rural villages in their country of origin, they would perhaps not have developed the will to opt for a college degree, a career or choose their spouse. As opposed to the archetype of anomic suicide, minority women were not necessarily confused over their morality; the second generation was aware of their own wishes. Instead of confusion about which values to hold on to, or disappointment over having indefinite goals at their disposal, these young women felt they only had two options. The first one was to abide by their parental demands, and the second one
was to make their own strategic life choices, yet lose the family connections. In contradiction to Durkheim, their distress was not born out being adrift, but a result of the impossibility of reconciliation of two different moralities. From the fact that many women found it unbearable to be outcast from their family and community, it can be derived that the social control over members that Durkheim argued to be disappearing was still in place. One reason why Durkheimian theory on anomic suicide may fail to be fully supported in young Moroccan and Turkish women in our studies is the development of highly heterogeneous societies. Due to processes of migration that were unknown in Durkheim's age, distances between traditional and modern cultures, moralities of the urban and the rural, have become closer in space and time.

The findings of Gibbs and Martin (1964) who supplemented Durkheim's theory on anomic suicide by studying the conditions where a cultural change in traditional norms would lead to suicide, are explanatory. Gibbs and Martin introduced the status integration theory, in which they posited that every social identity that is infrequently taken up by an individual in society produces intra- and interpersonal conflicts that may lead to suicide. Crucial is the extent of norm congruency toward the perception of social identities among social groups. To illustrate this, Gibbs and Martin pointed at the increase in female suicide rates in the USA in the 1950s and 1960s when women entered the labor market, which they attributed to the great changes in values concerning gender relations and subsequent changes in female roles. The increased rates existed only up to the point where these changes had become socially normative after which reduced rates of female suicide followed (Stack, 2000). We mentioned that Moroccan young women might be approaching this point. The status integration theory is highly relevant to young minority women. The resistance of a number of parents of young minority women of the second generation who opted for a career, college degree or partner of their own choice is indicative of the fact that these roles and identities are not yet accepted by their entire ethnic communities.

South Asian women, as well as Dutch young women, narrated about different origins of distress compared to Turkish and Moroccan young women, e.g. a lack of connectedness and bonding with their family. These findings point in the direction of egoistic suicide, i.e. a lack of meaningful ties in their families since an individual is not sufficiently socially embedded and connected.

When studying Durkheim's paradigms on causes of suicide, at some point we came across another archetype of his that has remained rather
obscure. It concerns the *fatalistic suicide*, resulting from overregulation. The suicide of slaves is mentioned by Durkheim as illustrative of this. The key feature of fatalistic suicide is a lack of control and a sense of powerlessness and dehumanization. Those individuals who faced with harsh moral demands that are upheld through force are prone to fatalistic suicide. The moralities individuals have to abide by come from others; hence these rules are experienced as external, demanding and obtrusive and fail to be internalized. Fatalistic suicide is hence highly relevant. Many minority women of all ethnic groups lacked autonomy. The pressure by the parents and family members to ensure a woman abided by cultural norms led to an absence or struggle over crafting one's own life course that is characteristic for fatalistic suicide. The relevance of fatalistic suicide for minority women also undermines the idea that strong community bonds are protective against suicidal behavior, as Trovato argued (1986).

Is fatalistic suicide crucial only to ethnic minority women? This may seem so, since family honor being intertwined with a woman's reputation was hardly observed in Dutch women. However, we did find a few medical case files that showed how overregulation has some relevance for Dutch women. Overregulation for a few Dutch women originated for example in being stalked by an (ex) partner or being forced into prostitution.

The conclusion we draw from applying Durkheim's study to our empirical work, is that Durkheimian suicide types are still relevant today. However, our analysis transpired that Durkheim's classification of suicides are ideal types rather than distinct concepts and should be used accordingly. Some elements of anomie, in particular those related to the status integration theory, seemed relevant for young minority women. In addition, many minority women shared features of fatalistic suicide, while South Asian women as well as Dutch women's situation displayed aspects of egoistic suicide. South Asian women's high rates of suicidal behavior in areas where patriarchal oppression exists (including Nickerie, Surinam and Southern India), provides support for the occurrence of fatalistic suicide. The culture in rural areas in Turkey (i.e. Batman) have much in common with the traditions of many Turks in The Netherlands. The suicidal behavior of both Turkish groups is often fatalistic.

**Directions for further research and limitations**

The results showed that the scope for autonomy, cultural images of women, strategic life choices, generational differences in migration history, and honor related practices of overregulation and family connectedness need to be the primary focus of further research. Currently, questionnaires for
large-scale surveys are insensitive to intersections of culture and gender. In addition, the formulation of items at a general level e.g. ‘impaired relationship with parents’, which is common across disciplines, needs further operationalization to detect cultural variation. The findings of the research provide knowledge to include pivotal contributors to suicidal behavior of ethnic minority women as well as for the operationalization of general constructs. Our research design combined qualitative research strategies with a quantitative approach. Such a combination is beneficial for widen the scope and depth of findings and increases validity through triangulation. We hence recommend a combination of different methods.

The research was inspired by the variation in rates of suicidal behavior that exist among ethnicities. During the course of our project, we had to acknowledge that we could not answer this question, since the cross-sectional surveys that we investigated did not provide us with such an answer. The quantitative enquiries confirmed the relevance of well-established risk factors, yet could not exhaustively explain the variation in prevalence among ethnic groups. In addition, qualitative inquiries do not provide a quantitative answer to the variation in epidemiological sense. Nonetheless, we succeeded in interviewing 10 to 14 women per group, and had a large number (N=115) of medical case files available. We also succeeded in establishing richness and depth in our life story interviews. Considering these elements, we feel that the qualitative work succeeded in understanding variations in the vulnerability to suicidal behavior across cultures.

Throughout our project, we were confronted with a number of practical difficulties. It proved to be difficult to obtain an epidemiological dataset that included a topic of suicidal behavior, as well as young women from minority groups in the right age band (i.e. 15-24 years old). We propose that future epidemiological surveys on health will include suicidal behavior as a topic and will ensure that ethnic minorities are included. Another dilemma we faced was that very few datasets distinguish South Asian-Surinamese from Creole and other Surinamese. While health differences as well as cultural differences among several ethnic Surinamese groups has been widely acknowledged (Van Niekerk, 2001), this is unfortunately not reflected in current research and data collection and hopefully will be incorporated in the future.

Regarding terminology, concepts and vocabulary used to inquire after suicidal behavior and suicidal ideation varies across studies, which may influence the rates. A review of Dutch studies into suicidal behavior of high school students found that when the question is posed: “Have you ever made
a suicide attempt?" the incidences are somewhat lower than when the expression reads as: “Have you ever made an attempt to end your life?” (Kienhorst & De Wilde, 1995). The latter expression was used in our study. Fortunately, we could compare these self-reported rates with rates of registration by health care professionals, which improved the validity of these findings. However, if questionnaires would include the method and intent of suicidal behavior, validity would increase. This would enable a distinction between medically serious or less serious forms of suicidal behavior as well as providing more insight into the lethal intent. Next, in the qualitative studies, we could not systematically compare serious attempts versus less serious attempts since we used a very broad inclusion regarding suicidal behavior.

In addition, it is recommended to use a validated scale on suicidal ideation (for example the Beck Depression Inventory, Beck, 1961). However, cross-culturally testing is needed prior to application. In addition, we came across issues of reliability when collecting our medical case file data, since they had not been filled out systematically. Moreover, these files rarely included information on the social and economic status of the parents. For research and intervention purposes, socio economic information is pivotal to enable accurate comparisons and control mechanisms that enhance the validity of research findings.

Since young females of specific ethnic minority groups were a primary focus of our study, males have only been included in our enquiry to a small extent. We recommend young males to be included in future research in order to have more insight into the peculiarities and similarities of suicidal behavior among women versus men.

The Ethics Committee did not allow for minors to be interviewed. Although we agree that the well-being of the (young) interviewee should always be of main concern, we do not recognize that interviewing a minor will involve a risk per se. From our experience with those young women who agreed to a meeting, we gathered they found it beneficial to tell their story. When an individual is enrolled in mental health care, reflection on what happened in her life is often already part of the trajectory. Hence, we feel that interviewing a minor in the presence of her therapist would be sufficiently cautious for their inclusion in research. Of course, informed consent and allowing time to contemplate about the decision to participate deserves even more attention in the case of minors compared to adults.
Conclusion

Our results emphasized the vulnerability to suicidal behavior of Turkish and South Asian young females compared to majority and Moroccan females. From the epidemiological studies and clinical samples, we derived that well-established risk factors are relevant to minority groups. Parental mental health and substance abuse, a low social economic status, an unsatisfactory family environment, psychiatric disorders, sexual and physical abuse and a low self image are all related to suicidal behavior. Some of these well-established risk factors were aggrandized in non-western groups. The differences consisted of a more substantial contribution of psychiatric illness and substance abuse in South Asian and Turkish parents of suicide attempters compared to Dutch females, as well as a heavier impact of socio economic deprivation for Turkish young females who demonstrated suicidal behavior. Despite the relevance of these factors to suicidal behavior, the effect of Turkish and South Asian ethnicity remained significant even when we controlled for these aspects. We realized that suicidal behavior and suicidal ideation of non-western groups may (also) be the result of different risk factors and aspects compared to majority group.

To examine this we turned to qualitative research methods. Through qualitative methods we derived that mechanisms that lead to suicidal behavior originate in social, cultural and personal factors, and how these are interconnected with gender and ethnicity. Decision over strategic life choices was more limited in minority women. This finding elucidated the puzzle coined by our quantitative results, i.e. why the relationship between Turkish and Moroccan females of the second generation and their parents is not necessarily un affectionate, yet still unsatisfactory. Cultural images of females that valued subordination to the family and husband, self-sacrifice and honor protection hampered self-transformation, and were detrimental to women's self image. Yet simultaneously, the internalization of these images of ‘enduring wife’ and avoiding the image of ‘the girl gone astray’ was the key to understanding why many minority women endured their hardship. We also found indicators that generational differences (i.e. belonging to second or first generation of immigrants) influenced the desire and capacity for autonomy, as well as the age from which females were confronted with oppressive practices. Migration seemed to worsen the scope for autonomy, in the sense that disruption of the extended family system, marital stress and acculturative stress of parents increased control and the demand of caretaking roles by young women.
The contraposition of a lack of autonomy, i.e. the absence of connectedness and caring bonds, was the core of many Dutch women and also South Asian women's life stories. This underscores the relevance of relational autonomy referring to importance of intersubjective dimensions of selfhood and identity. Self-realization never occurs in a social void but is constituted dependently of other agents (MacKenzie & Stoljar, 1999). The lack of bonding was striking in particular in South Asian families since they previously were characterized by strong family bonding and connectedness. Different from Dutch families, a hierarchical family structure was often in place e.g. South Asian parents used harsh and directive parenting methods, and physical abuse was often present, which made it even more difficult to cope with the lack of connectedness and care. Moreover, the cultural memory (e.g. ‘suttee’ and altruistic suicide for women in India, Kumar, 2003; Vijayakumar, 2006) renders suicidal behavior a suitable response for South Asian women and seems to lower the threshold for suicide (attempts). Other important narratives of majority and minority women referred to an impaired sense of self worth resulting from a socialization that did not foster self-value. Psychiatric illness was another theme we identified in women and appeared as relevant for both minority and majority women. However, migration was a factor contributing to these disorders (e.g. psychotic disorder) in minority women. To conclude, we suggest that the interplay of autonomy, cultural images of women, self-worth and connectedness to be the main focus for quality of life of young minority females.

Discussion
Some studies (e.g. Lamur, 1992; Bağlı & Sev'er, 2003) earlier suggested that (attempted) suicide is an outcome of living a life in a patriarchal culture that is oppressive toward women. Indeed we found that autonomy restrictions have an impact on the emergence of suicidal behavior. It is more plausible however, to think of oppression as a risk factor, a condition that aggrandizes the possibility of a suicide attempt. Suicidal behavior was influenced by a socialization that lacked autonomy development and simultaneously effectuated the internalization of self-sacrifice and subordination, in particular when combined with abuse. Notably, ethnic minority women could have gained from what Ewing (1991) identified as intrapsychic autonomy, i.e. the ability to maintain a strong mental representation of oneself in spite of limited space for ego development and amidst negative cultural images of women. Our data have shown that establishing intrapsychic autonomy is difficult to establish. Fortunately, we also observed that many minority women were not frozen in unrewarding
lives forever; shifts toward more autonomy and rejection of these notions did eventually happen.

Women would benefit from assistance in developing techniques how to cope with harmful practices of silencing their selves and the presence of an impaired self worth. It is important that images of women such as ‘enduring wife’ and ‘the girl gone astray’, which through (self) sacrifice contributes to the tolerance of living unrewarding lives, are counteracted. If our society successfully wants to engage in the prevention of suicidal behavior of young minority women, attention should be paid to questioning and improving the cultural images of women and reflecting upon how these images can be questioned at community level as well as in immigrant families.

In addition, we found cases where women with suicidal behavior who were seen at hospitals were not followed up by health care professionals. This needs to be improved, especially when realizing this may be one of the very few opportunities for action that exist in case it concerns women who are imprisoned at home and denied to go to school. The studies we conducted demonstrate that practices such as forced marriages, underage marriages, imprisonment and denial of enrolment in education still take place in The Netherlands. This asks for alertness by policymakers, civil servants and the police. In addition, practical help i.e. shelter and social housing facilities for those who seek a way out of oppression is crucial. However, for those women who belong to the second generation of immigrants and who have developed autonomy, yet who struggle with how to reconcile this with their parents' demands, mediation in the family would perhaps be helpful.
References

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