

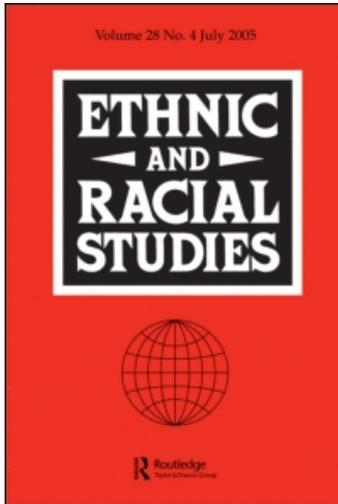
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# Suicidal behaviour of young immigrant women in the Netherlands. Can we use Durkheim's concept of 'fatalistic suicide' to explain their high incidence of attempted suicide?

Diana van Bergen, Johannes H. Smit, Anton J.L.M. van Balkom and Sawitri Saharso

## Abstract

Young immigrant women of South Asian, Turkish and Moroccan origin in the Netherlands demonstrate disproportionate rates of non-fatal suicidal behaviour. Suicidal behaviour is usually explained from a psychological or medical tradition. However, we would like to emphasize sociological correlates, by examining the relevance of Durkheim's *fatalistic suicide*, characterized by overregulation. We conducted a retrospective analysis of 115 case files of young women who demonstrated suicidal behaviour, to illuminate their living conditions. The analysis included a comparison of class factors as well as psychiatric and psychological risk factors. In at least half of the cases, South Asian, Turkish and Moroccan women experienced specific stressful life events related to their family honour. Women's lives were often characterized by a lack of self-autonomy. It is concluded that the archetype of *fatalistic suicide* should be re-evaluated when interpreting the suicidal behaviour of young immigrant women in the Netherlands, and incorporated into strategies of prevention.

**Keywords:** Gender and immigration; mental illness; children of immigrants; the Netherlands; behavioural autonomy; cultural factors.

## Introduction

Two epidemiological studies carried out in the city of The Hague showed that young women from certain ethnic minority groups more

often demonstrate non-fatal suicidal behaviour than Dutch young women (Schudel et al. 1998; Burger et al. 2005). This suggests that a substantial group of young immigrant women in the Netherlands suffer from severe difficulties and distress in life. In the late 1990s, the rates of suicidal behaviour of South Asian, Turkish and Moroccan women in the age range 15–24 years appeared to be two to four times higher than those of majority Dutch young women.<sup>1</sup> By 2005, the rates for South Asian and Turkish young females continued to be disproportionate, while those for Moroccan young women were still high compared to Dutch young women, but not statistically significant. The reports on the alarming rates of suicidal behaviour of young immigrant women occasioned research into the background of this phenomenon.<sup>2</sup>

Suicidal behaviour is defined by the World Health Organization (WHO) 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). It concerns behaviour including self-poisoning by taking an overdose of pills, or cutting the wrist(s). The desired change includes, but is often not limited to, the intent to die. In addition, desired changes may include a wish to escape from an unbearable situation or thoughts, the search for peace of mind, or the wish to communicate to others how much they are in mental pain (Hjelmelandt, Knizek and Nordvik 2002).

Research in suicidology usually explains suicidal behaviour almost exclusively by psychiatric and psychological risk factors, e.g. mental illness and dysfunction in personality. However, studies have pointed at the possible relevance of Durkheim's sociological theory of *fatalistic suicide*, by arguing that suicides of many young women world-wide originate in overregulated lives and their discontent with their social roles (see, for instance, Iga (1981) on suicidal behaviour of Japanese women, or Davies and Neal (2000) on the suicide of women in rural China). Two Dutch studies based on interviews with female South Asian students aged between 16 and 24 indicated that such women are often faced with high levels of control exercised by their parents (Krikke, Nijhuis and Weesenbeek 2000; Salverda 2004). This led us to analyse the relevance of Emile Durkheim's concept of *fatalistic suicide* for understanding the suicidal behaviour in young South Asian as well as Turkish and Moroccan women in the Netherlands (van Bergen et al. 2006).

Durkheim's work was based on an investigation of records of suicide in the late nineteenth century, when registration of non-fatal cases of suicidal behaviour did not yet occur. Across all ethnic groups in the Netherlands, men commit suicide twice as often as women, while more women than men attempt suicide.<sup>3</sup> This disparity is known as the

*gender paradox* in suicidology. This pattern of male to female ratio (ranging from 2:1 up to 3:1) can be observed world-wide (with the exception of rural China, where more women than men die by suicide) (Canetto and Lester 1995; Beautrais 2003).

Durkheim's focus on lethal cases, as well as the male to female ratio in suicide statistics, precipitates the question whether it is justified to use Durkheim's concepts for examining the non-fatal suicidal behaviour of young women. However, recent research indicates that those young individuals who die by suicide and those who attempt suicide are not two distinct populations but rather a similar group. Beautrais (2003) established by a case control study that those youngsters (aged 15–24 years) who die by suicide and those who attempt suicide share common sociological characteristics and psychiatric diagnostic and psychiatric history features. These features concern exposure to recent stressful life events, lack of formal educational qualifications, mood disorder and history of psychiatric care. Beautrais argues that the fact that men more often die by suicide than women could hence be attributed to their choice of more lethal methods. This proposition is supported by the fact that female youth suicides in New Zealand more than doubled from 1977 to 1996, notably due to the increased use of hanging and vehicle exhaust gas by women. These findings argue against a rigid separation of lethal versus non-lethal suicidal behaviour. Therefore, we believe it is justified to use Durkheim's theory for our focus on the non-fatal suicidal behaviour of immigrant women.

In this paper, our research procedures and research subjects will be described first. Subsequently we investigate the contribution of psychiatric and psychological risk factors and incidences of abuse, and compare the results. Durkheim's archetype of *fatalistic suicide* will be described next. Since the registration of suicidal behaviour indicates a relation between suicidal behaviour, gender and ethnicity we also verify how regulation can be understood in the light of these markers. Subsequently, we demonstrate the cultural context of South Asian, Turkish and Moroccan young women who demonstrated suicidal behaviour by providing a number of case file summaries. We conclude by discussing the relevance of Durkheim's theory for explaining and preventing the suicidal behaviour of young minority women.

### **Methodology and description of the sample**

Durkheim was criticized for the fact that he solely categorized on the basis of external and observable characteristics by using aggregated level data (for instance on divorce rate, income level or urbanization rate). By neglecting to study the individual dispositions, suicides are treated as occurring in a social void, without reference to the values and beliefs that constitute the cultural milieu of individuals (Hamlin

and Bryn 2006). By contrast, in our study we focused on collecting data that could illuminate the specific social environment and living conditions of young women. We thus chose to investigate medical case files consisting of accounts of mental health care workers of the lives of young women.

We selected case files ( $N = 115$ , mean age 23.5,  $SD = 6.6$ ) of females between 12 and 41 years old of South Asian ( $N = 24$ , mean age 25.3,  $SD = 5.9$ ),<sup>4</sup> Turkish ( $N = 32$ , mean age 23.7,  $SD = 6.7$ ), Moroccan ( $N = 30$ , mean age 23.7,  $SD = 6.4$ ) and Dutch ( $N = 29$ , mean age 21.7,  $SD = 6.7$ ) origin on the basis of the WHO definition of suicidal behaviour, non-native-Dutch last name, and age. Two researchers assessed which files belonged in the selection. The files were available from the archives of a public mental healthcare centre (95 per cent of the cases for the years 1995–2005) and an academic hospital in the city of Amsterdam (5 per cent of the cases for the years 2003–2005). Permission was granted from the Medical Ethical Committee. The case files were a collection of notes of the treatment provided by psychiatric nurses, psychologists or social workers and psychiatrists (in training). Although the files were not filled out systematically, since several professionals were involved with one patient and wrote the notes, this functioned as a cross-check and increased triangulation. Research indicated that immigrant females were most at risk in the 15 to 24 years age group, yet our research subjects were aged between 12 and 41 years. The rationale behind this is that suicidal behaviour is known for its repetitive character (Arensman and Kerkhof 2003).

To clarify the extent to which social and economic class could possibly be related to overregulation, we selected Dutch control cases where the parents had a low professional status, since it is known that non-western immigrant groups in the Netherlands often belong to the lower social-economic strata. We initially chose to investigate topics that are known in suicidology to be clear risk factors for suicidal behaviour (Beautrais 1998), e.g. demographics, childhood, relationship with parents, social support, relationship with partner, life events,

**Table 1.** *The marital status of female outpatients of four ethnic groups in Amsterdam*

	Turkish N = 32 N (%)	Moroccan N = 30 N (%)	South Asian N = 24 N (%)	Dutch N = 29 N (%)
Single	6 (19)	7 (23)	9 (38)	12 (41)
With a partner	9 (28)	9 (30)	6 (25)	10 (34)
Married	11 (34)	6 (20)	3 (13)	2 (7)
Divorced	4 (13)	6 (20)	6 (25)	5 (17)
Separating	2 (6)	2 (7)	0 (0)	0 (0)

**Table 2.** Method used in suicidal behaviour of female outpatients of four ethnic groups in Amsterdam

	Turkish N = 32 N (%)	Moroccan N = 30 N (%)	South Asian N = 24 N (%)	Dutch N = 29 N (%)
Auto-intoxication with medication and/or alcohol	24 (75)	22 (73)	15 (63)	20 (69)
Self-cutting	7 (22)	4 (13)	6 (25)	9 (31)
Self-poisoning with acid	0 (0)	0 (0)	4 (17)	1 (3)
Other method	3 (9)	7 (23)	7 (29)	5 (17)
Multiple methods	3 (9)	5 (17)	8 (33)	6 (21)

sexual and physical abuse, as well as psychiatric and psychological disorders. In addition, we also recorded the occasion and method used for suicidal behaviour. At a later stage, by shifting back and forth through the data on the life events of ethnic minority women, the principal researcher recognized elements of *fatalistic suicide* and subsequently included factors of overregulation in the analysis.

### The relevance of risk factors of psychiatric or psychological disorders and physical or sexual abuse

A plausible contribution to the suicidal behaviour of young immigrant women is the manifestation of psychiatric and psychological disorders. In addition, the rates of suicidal behaviour are elevated amongst those having multiple diagnoses of psychiatric disorders (co-morbidity). Some studies into psychiatric diagnoses among immigrants in the Netherlands hint at increased rates of certain psychiatric diagnoses, e.g. an elevated prevalence of anxiety disorder and depression for Turkish immigrants aged 12 to 65, while schizophrenia appears to be more often diagnosed in Surinamese and Moroccans, whether born in the country of origin or in the Netherlands (de Wit 2005; Van Oort et al. 2007). However, research from the United Kingdom indicated

**Table 3.** Extent of repetitive suicidal behaviour and lethal intent of suicidal behaviour of female outpatients of four ethnic groups in Amsterdam

	Turkish N = 32 N (%)	Moroccan N = 30 N (%)	South Asian N = 24 N (%)	Dutch N = 29 N (%)
Repetitive suicidal behaviour	18 (56)	14 (47)	16 (67)	16 (55)
Lethal intent	8 (25)	5 (17)	6 (25)	4 (14)

that psychiatric disorders were significantly more common among majority British women than among South Asian immigrant women who had demonstrated suicidal behaviour (Bhugra et al. 1999). These contradictory findings prompted us to examine the psychiatric and psychological risk factors of majority Dutch young women versus the ethnic minority women who displayed suicidal behaviour (see Table 4).

Overall, having a psychiatric or personality disorder appears more relevant as a risk factor for Dutch (79 per cent) in comparison to Turkish (59 per cent) and Moroccan women (60 per cent), while South Asian women differ less substantially from Dutch women (71 per cent). This difference in the Dutch majority as opposed to minority women originates in seemingly higher incidences of mood and anxiety disorder in Dutch majority women. Co-morbidity is notably more often found in Dutch women (59 per cent) compared to South Asian (33 per cent), Turkish (28 per cent) and Moroccan women (27 per cent).

Research into the role of sexual and physical abuse unanimously shows that these experiences are a serious risk factor for suicidal behaviour (McHolm, Macmillan and Jamieson 2003; Salander-Renberg, Lindren and Osterberg 2004). These findings motivated us to examine their contribution in the case of our research subjects and compare the results (see Table 5).

**Table 4.** Risk factors of psychiatric and personality disorders of female outpatients who displayed suicidal behaviour, in four ethnic groups

	Turkish N = 32 N (%)	Moroccan N = 30 N (%)	South Asian N = 24 N (%)	Dutch N = 29 N (%)
Mood disorders*	12 (38)	11 (37)	11 (46)	17 (59)
Anxiety disorders**	7 (22)	5 (17)	3 (13)	10 (34)
Psychotic disorders	2 (6)	2 (7)	3 (13)	4 (14)
Borderline personality disorder/traits	7 (22)	6 (20)	8 (33)	13 (45)
Substance abuse***	3 (9)	1 (3)	5 (21)	6 (21)
Other psychiatric disorders	4 (13)	7 (23)	5 (21)	5 (17)
No disorder	13 (41)	12 (40)	7 (29)	6 (21)
One or more disorders	19 (59)	18 (60)	17 (71)	23 (79)
Co-morbidity****	9 (28)	8 (27)	8 (33)	17 (59)

\*Mood disorders reported on include depression, depressive mood, dysthymia and bipolar disorder

\*\*Anxiety disorders reported on include generalized anxiety, panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder and posttraumatic stress disorder

\*\*\*Substance abuse include the abuse of alcohol, hard drugs or soft drugs

\*\*\*\*Co-morbidity refers to having two or more disorders

**Table 5.** Risk factors of sexual and physical abuse in female outpatients who displayed suicidal behaviour, in four ethnic groups in Amsterdam

	Turkish N = 32 N (%)	Moroccan N = 30 N (%)	South Asian N = 24 N (%)	Dutch N = 29 N (%)
Sexual abuse or sexual harassment	6 (19)	5 (17)	5 (21)	11 (38)
Physical abuse	10 (31)	11 (37)	10 (42)	6 (21)
No abuse	19 (59)	18 (60)	13 (54)	17 (59)
Either physical or sexual abuse	13 (41)	12 (40)	11 (46)	12 (41)
Both physical and sexual abuse	3 (9)	4 (13)	4 (17)	5 (17)

In correspondence with previous research findings, the frequency of sexual abuse and physical abuse in our sample is quite high. Sexual abuse is more often mentioned in the files of Dutch young women compared to ethnic minority women, whereas physical abuse is equally reported across ethnicities. This may reflect actual disparities, but it seems plausible that a taboo around sexual abuse in cultures that value chastity and virginity, such as the Turkish, Moroccan and South Asian cultures (Brouwer et al. 1992), has resulted in some underreporting.

In sum, previous research findings of immigrants being more vulnerable to psychiatric disorders were not confirmed in our study, and incidences of abuse were equally distributed as risk factors across ethnicities. These findings led us to suggest that psychiatric or psychological illnesses and abuse are not the key to explaining why minority women demonstrate suicidal behaviour more often than majority Dutch women. Hence, we turn to explore the relevance of *fatalistic suicide*.

### Durkheim's fatalistic suicide

A theoretical prism that continues to be beneficial in suicidology today is Durkheim's standard work *Suicide* (Kushner and Sterk 2005; Hamlin and Bryn 2006). Durkheim's goal was to account for the suicide rate by studying characteristics of individuals in their societal structure and social context. By emphasizing that suicide is a social manifestation and positing that individual motives could not explain the suicide rate, Durkheim went against previous beliefs that suicide resulted from entirely personal phenomena, such as the existence of mental illness (Durkheim 1952). Durkheim's work, which resulted in a typology of suicide, must be understood in terms of Weberian ideal types (Acevedo 2005). *Suicide* focuses on two core elements: the amount of social integration and the amount of social regulation.

Social integration refers to the degree to which people in society are connected to each other, through the possession of shared beliefs, sentiments and interest in one another, and a sense of devotion to common goals. Social regulation points to the extent to which society or a social group has control over the emotions, motivations and behaviours of its individual members through government by norms, rules and customs. According to Durkheim, the emergence of a severe lack or a very strong manifestation of either aspect could put individuals at risk for suicidal behaviour (Acevedo 2005).

*Fatalistic suicide* is characterized by a situation of extremely high levels of social regulation, while simultaneously social integration is low. Mutual ideas and shared feelings that should safeguard social bonding and connectedness no longer exist, yet strong regulation is present. It concerns suicide as a result of overregulated and thus unrewarding lives: 'futures are pitilessly blocked and passions violently choked by oppressive discipline' (Durkheim 1952, p. 276). Unfortunately, Durkheim himself wrote very little about *fatalistic suicides*; he mentioned only briefly that suicides of slaves were expected to fall into this category, as well as those of childless wives in the west (Durkheim 1952). Durkheim found *fatalistic suicide* hardly relevant for the west. His moral position led him to emphasize the social effects of underregulation or *anomic suicide* following from the decline of the importance of social norms due to processes of modernization.

Despite the underreporting in Durkheim's work on *fatalistic suicide*, we have indicators that its features of overregulation are highly relevant to the suicidal behaviour of young immigrant women in the Netherlands. For reflections on the mechanisms involved in *fatalistic suicide*, we turn to the arguments of scholars who have discussed the subject.

Pearce (1989) described the subservient situation of slaves, who were considered the property of their masters, as inferior and dehumanizing, and he described them as lacking control over the course of their life. *Fatalistic suicide* refers to environments where there is total coercion by an overwhelming force that has control over individual action (Acevedo 2005). For the accomplishment of human desires and to arrive at satisfaction, however, it is evident that individuals need to possess agency in determining their life course. When individuals experience serious oppressive forms of regulation, a consistent belief in human agency to realize social change becomes unimaginable (Acevedo 2005). Hopelessness arises: 'the individual's existence has been completely demystified and drained of possibility. [...] Excessively controlled by social-cultural prescriptions, individual freedom and improvement of life would become non-existing' (Douglas in Pearce 1989, p. 122). There is too little space for individuality because collective life is too intense to allow for individual development. The

individual counts for little or nothing and does not have control over his/her fate, which results in a sense of powerlessness and meaninglessness.

One of the few other examples of *fatalistic suicide* mentioned by Durkheim is the suicide of housewives who remain childless. Even though at first the example seems rather outdated in the twenty-first century, for the sake of the argument we investigate it. Durkheim (1952) argues that motherhood protects wives from suicide through its effect of social integration into family life. Durkheim thought that a childless wife could have no personal bonding with a role as merely a housewife and that she could not derive meaning from it: 'Fatalists do not derive protection from their role, for them it comes from the outside. Others that surround her reproduce the role, but not the individual who occupies it' (Bearman 1991, pp. 520–1). This touches upon a crucial aspect. The experience of constraint begins when the regulation is not (any more) based on accepted norms, and when these norms are not (any longer) internalized, but judged as external, and hence they can only be upheld through force. *Fatalistic suicide* is a reaction to a force coming from outside, which is perceived as unjust and which is not integrated in one's inner self. This results in feelings of individual isolation and alienation. Furthermore, an individual needs to have awareness of his/her own alienation in order to perceive it as problematic (Halbwachs in Travis 1990).

More recently, Davies and Neal (2000) investigated the suicides of young women in rural China and described these as a clear case of *fatalistic suicide*, mostly because of the restricted sex roles for women. Central to these restrictions is the practice of marrying off daughters by all-powerful families. These daughters subsequently live in unhappy marriages under the tyranny of their mother-in-law, who expects total compliance. Suicide rates for Chinese young women are much lower in the cities, which underscores that the risk for suicidal behaviour is associated with the rural family system, as well as demonstrating the pivotal role of the method commonly employed in rural China, i.e. pesticide poisoning.

In sum, the work of scholars who discussed Durkheim's *fatalistic suicide* defined it as involving overregulation originating from harsh moral demands, upheld through force. As a result, individuals are faced with a lack of agency and develop a sense of powerlessness and dehumanization. When norms are considered external, demanding and obtrusive and fail to be internalized by the individual, a sense of alienation is created. The individual does not experience having meaningful relations and lacks a sense of connectedness.

### **Overregulation in young immigrant women's lives: intersections of gender and culture**

Since we are concerned with females from specific ethnic minority immigrant groups in the Netherlands who display disproportionate rates of suicidal behaviour in comparison to majority Dutch women, gender and ethnicity seem important factors. Having established the make-up of a *fatalistic suicide*, the subsequent question that emerges is whether there is a relation between gender and ethnicity on the one hand, and overregulation on the other. Hierarchical and oppressive structures of gender and ethnicity intersect in different ways for different groups. Identities cannot be reduced to a single marker because they are interlocked. Because of this entanglement, it should be investigated how the gender system and its relation with other systems of inequality and oppression may function. Multilayered and routinized forms of domination that often converge in women's lives prompt analysis of multiple grounds of identity when considering how the social world is constructed (McCall 2005).

Ethnic minority groups deploy cultural practices that originate in distinct sets of behaviour and beliefs that often distinguish groups from a larger culture of which they are a part. As Geertz (1973) argued, cultural practices are symbolized and enacted by social actors and the context that gives such practices meaning and significance. Some cultural practices seem to have a much greater influence on the lives of (young) women than on the lives of men. In particular, in the domain of sexual and reproductive life that is central in many cultures, women's role is often pivotal (Yuval Davis 1997). The sphere of sexuality and reproduction is a crucial theme in cultural practices since it enables the continuity of the ethnic group. As a result, it is women in particular who are 'considered to be the guardians of the collectivity's identity and honor and who demarcate with their behaviour the moral boundaries of their group' (Yuval Davis 1997, p. 25). In addition, cultural traditions and sometimes the re-invention of traditions are often used as ways of legitimizing the control and oppression of women in situations in which individual men as well as the collectivity feel threatened by others.

### **Empirical findings on fatalistic suicide in the lives of young immigrant women**

After analysing the accounts of young immigrant women, eight factors of overregulation emerged that related to *fatalistic suicide*. These factors were not established a priori but emerged cross-culturally as a result of the analysis of the case files when we studied the circumstances that led these young women into suicidal behaviour.

Table 6 shows that factors of overregulation emerged in about 50 per cent of cases for Moroccan, Turkish and South Asian young women, as opposed to 28 per cent in the Dutch cases. Issues around demands of upholding chastity were found almost equally in all ethnic minority groups. (The fear of) being outcast appeared to be relevant to Turkish and Moroccan young women in particular. Incidences of forced marriages were observed mostly in Turkish young women, whereas the impossibility of opting for a divorce because of family pressure to stay in an unwanted marriage was observed in Turkish as well as Moroccan young women. Rejection of the partner by their families was found in particular in South Asian women. The threat of death could be found across ethnicities, but most notably among Moroccan women. Being stalked by an (ex-) partner emerged as a cross-cultural problem for women. Being forced into prostitution happened to two Dutch women and one Turkish woman. In sum, three factors were found that affected both minority and majority women, while five factors to do with family honour were observed in ethnic minority

**Table 6.** *Factors of overregulation in female outpatients who displayed suicidal behaviour, in four ethnic groups in Amsterdam*

	Turkish N = 32 N(%)	Moroccan N = 30 N(%)	South Asian N = 24 N(%)	Dutch N = 29 N(%)
Chastity jeopardized	8 (25)	9 (30)	4 (17)	0 (0)
(Fear of being) outcast by family	3 (9)	4 (13)	0 (0)	0 (0)
Pressure to maintain unwanted marriage	2 (6)	3 (10)	0 (0)	0 (0)
Threatened with death	2 (6)	4 (13)	2 (8)	1 (3)
(Threatened with a) forced marriage*	7 (22)	2 (7)	1 (4)	0 (0)
Rejection of partner/Being rejected as partner	3 (9)	3 (10)	6 (25)	1 (3)
Stalking by (ex-) partner	3 (9)	1 (3)	3 (13)	3 (10)
Forced prostitution	1 (3)	0 (0)	0 (0)	2 (7)
Forced abortion	0 (0)	1 (3)	0 (0)	1 (3)
Locked up at home/Forced housekeeping	0 (0)	1 (3)	0 (0)	0 (0)
Restrictions on activities outside the home	2 (6)	0 (0)	0 (0)	1 (3)
Forced by family to give up education	0 (0)	1 (3)	0 (0)	0 (0)
<i>No factors of regulation</i>	14 (44)	14 (47)	11 (46)	21 (72)
<i>One or more factors of regulation</i>	18 (56)	16 (53)	13 (54)	8 (28)
<i>Multiple factors of regulation</i>	7 (22)	8 (27)	3 (13)	1 (3)

\*In a forced marriage one or both partners do not have agency in the marriage arrangement and disagree with the marriage arrangement. This includes those partners who have cooperated under physical or psychic threat.

women only. To illustrate how overregulation originating in honour-related issues emerges and to illuminate the extent to which a lack of agency exists, case summaries of minority women are discussed below.

### **Chastity regulation: accusations, control and the threat of being outcast**

Accounts indicate how safeguarding the family honour through maintaining a chaste (decent) reputation is felt deeply by young minority women, who face serious consequences if they fail to live up to this prescription. The case files demonstrate how the status of a chaste woman was jeopardized, and how the women were subsequently faced with repercussions that appear to be associated with their suicidal behaviour. As a result, some women felt they had little choice but to run away from home.

Her mother migrated to the Netherlands just before giving birth to her. She used to be dad's favourite, although she knows that he would have preferred to have a son. Later there were severe conflicts between them. She used to be very angry with him, because he would not allow her all sorts of things, like going on school trips. Her father beat her up and she tried to hit him back. Her mother was isolated and sad, because her family was in Morocco and her husband did not give her any money. Her parents' marriage was bad. Her mother cried on her shoulder instead of the other way round. When her mother was pregnant with her sister, her mother had a fight with her father and left home, but returned later. In her mid-puberty one day her father hit her on the head. She then went to stay with friends in the city. She got introduced to drugs and criminals. At a party, she met a young man with whom she had sex for the first time. Her parents found out about this when they discovered a letter with the results of her pregnancy test. They were furious and never wanted to see her again. They pretended not to know her when they bumped into her, and thought of her as a whore. She then stayed with foster parents. At some point she contacted her family again, because she wanted to see how her younger sister was doing. Her father appeared to regret all the things that had happened between them, but her mother was jealous of this and therefore criticized her to her father. She concludes that her parents see her as a bad child.

(Moroccan student, aged 20, who took an overdose)

The account above shows how violent repercussions in the family follow from the loss of a woman's virginity, a cultural value of chastity, which is a woman's responsibility to bear.

**Marital regulation: rejection of the partner and (threats of) being forced into marriage**

Some parents and family members of young minority women who demonstrated suicidal behaviour rejected their partners. In South Asian families, this often concerns a rejection on the basis of caste, religion or ethnic background. When family members attempt to control a woman's spouse choice, they attempt to safeguard ethnic and cultural reproduction, and such efforts are often reinforced after migration. Rejection of the partner choice is also interlocked with agreements with family members, e.g. a match between cousins. This is often thought to guarantee a match between upbringing, religion or class and expected to result in the continuation of steady family relations (Sterkx and Bouw 2005). The following example illustrates the rejection of the daughter's partner by a South Asian family.

Her partner, of Surinamese Creole background, cheated on her and she then took many pills. They have now ended their relationship, which lasted three years. Her family have always been against her relationship, because of his ethnic background. They have forbidden her to ever meet him again. Asked about her family background, she describes how her father avoided the family and let her mother take care of everything. She had never got on well with her mother, since she felt her mother was more in favour of her brother than her. Also her mother always claimed that she resembled her father's family, which she understood as a criticism. She gets on really well with her brother. Except that when she had her first boyfriend he had remarked that this was something she could not do to her mother.

(22-year-old South Asian woman who took an overdose of pills on at least two occasions; employment status unknown)

An account of a Turkish young woman also demonstrates lack of individual choice in partner selection.

She arrived in the Netherlands when she was 12 years old and she lives with her mother. She introduced her boyfriend to her father two weeks ago. Her father is against her spouse choice because he already has a partner for her in mind, and he threatened to deport her mother from the Netherlands back to Turkey when she proceeded with her relationship and marriage. Her father has a Dutch partner now. Possibly, her father wants to save his honour by marrying his daughter off to his village friend. After consulting a counsellor she found out that she would need to wait two years before she could be married, otherwise her mother could indeed be expelled. During these two years, she feared she would be married

off to her father's choice of spouse from his village in Turkey. She subsequently took an overdose.

(17-year-old Turkish woman who took an overdose of pills; employment status unknown)

The effect of migration in the above account is that the young woman's mother is dependent on her husband for her residence permit. The father who wants to force a marriage upon the daughter exploits this dependency. In the next account of a Moroccan woman, it is shown that cultural value regarding what is considered to be respectable female behaviour does not end when a woman is divorced.

Her family is against her relationship with a Moroccan man who has been married twice before. Previously, her aunt supported her, but now her entire family is against the marriage. She has demonstrated serious life-threatening behaviour. She does not want her family to find out about this because she feels that they could blame her suicidal behaviour on her relationship. She also has serious worries about her infertility and she feels bad about the fact that her parents are divorced and her mother does not want contact any more. She used to be married herself but went through a divorce after six years of marriage, even though her husband did not agree; her family supported this, since the two of them had very different personalities. She herself is very outgoing and active, while her ex-husband was more timid and preferred to stay at home. She was married at a very young age to a Moroccan, since she felt this was the appropriate thing to do for a Moroccan woman. She is described as someone with big circle of multi-ethnic friends.

(28-year-old Moroccan woman, method unknown; employed and part-time student)

Interestingly, we observed that the woman featured above had internalized certain cultural demands around her spouse choice earlier in her life, i.e. that he should be a Moroccan and that she should marry young. Later in her life, her choice of partner clashes with the wishes of her family who want to control her partner selection in order for her to become respectable again.

### **Forced to maintain an unwanted marriage by threats of violence or death**

The following account illustrates how family members of a Turkish woman exercise control through threatening her with isolation, and how physical abuse intersects with gender and culture.

She reported the physical abuse she suffered from her husband at the police station. She lives with her husband at her mother's house. Three months ago, she underwent a forced marriage to her cousin, which was done in a sly way: her parents told her she needed to sign documents to report her missing passport, while in fact they were the papers for an Islamic marriage. Her family put her under great pressure to stay married and she withdrew her police report when she learnt about the consequences of her act for her family: social isolation and outcasting. Her parents threatened to kill her when she wanted to opt for a divorce. She then took an overdose. To the psychologist, her suicidal behaviour seems to be a way out of her powerless position.

(20-year-old Turkish woman who took an overdose of pills;  
employment status unknown)

In the following account of a Moroccan woman, it is highlighted how cultural negative attitudes towards divorced women precipitate a conflict between loyalty towards the family and a woman's personal wishes as an individual.

She grew up in Morocco with many siblings and was her father's favourite. Her father was sweet and kind, while her mother was very strict and punished her often. She hardly has a support system; all her family members live in Morocco. She married her first husband when she was 21 years old. She wanted to continue her education, but had to get married and then move to the Netherlands to be with her husband. Her husband had a job in education, yet he did not want her to continue her studies in the Netherlands. Her husband already had children from his previous marriage. He put pressure on her to take birth control pills and to have an abortion when she got pregnant. Her relationship with her husband has not turned out as she had hoped. Since she has given birth to a child, her husband has changed substantially. He has become a very religious man and this clashes with her own views. She struggles with what to do now. If she stays in her marriage, she will have to give up her own perspective on raising the children. If she follows her heart, she will lose her family and family honour.

(Moroccan woman, aged 34 who took an overdose  
on several occasions; employed in education)

## **Conclusion and discussion**

Our data show that well known risk factors in suicidology such as psychiatric and psychological illness as well as sexual and physical abuse do not appear to be sufficient to clarify the rationale of the

suicidal behaviour of young women of Turkish, Moroccan and South Asian origin. We observed that many minority women reported living conditions characterized by overregulation, which is a central feature of fatalistic suicide. Our aim was subsequently to illuminate the role and mechanisms of overregulation with regard to their suicidal behaviour. By studying individual cases (ranging in number from 24 to 32 per ethnic group) that provided details of the values and beliefs in their cultural milieu and family context, we wanted to overcome the pitfalls of studying aggregated level data that often place subjects in a social and cultural vacuum.

Elements of fatalistic suicide were shown to be important in at least half of the cases of suicidal behaviour among Turkish, Moroccan and South Asian young women. Honour-related life events were intertwined with excessive regulation and pressure by family members to ensure that a woman abided by cultural norms. This led to an absence of freedom to create one's own life course and an underdeveloped sense of autonomy, which is characteristic of fatalistic suicide. Highly demanding norms in crucial domains in life (e.g. marriage, divorce, partnership, sexuality) were experienced as oppressive. These cultural and moral practices had a huge influence on the lives of some minority young women. For instance this occurred when doubts around the reputation and virginity status of young women emerged. As a consequence of (being suspected of) violating cultural norms on appropriate female behaviour, violence and sometimes (threats of) a forced marriage took place. In addition, some minority women had to choose between continued abuse (e.g. by the husband) on the one hand and opting for divorce and involving the police. The latter, however, subsequently rendered some women an outcast in their own community, or led to them losing their residency permit.

Strict control by parents over their daughter's future spouse also emerged as central to the distress in a number of minority women. These regulatory measures originated in efforts to ensure continuation of the family and ethnic community. The honour-related rules prevented young women from achieving individuation and goal fulfilment. Their suicidal behaviour thus bears elements of fatalistic suicide. It seems plausible that suicidal behaviour of females in these ethnic groups can be understood as an expression of a deeper underlying need to influence their life course.

Since we matched a group of majority Dutch women with low social and economic status it seems safe to assume that the factors of overregulation are not a result of class background. Our data indicated that Dutch young women who displayed suicidal behaviour did not experience as much overregulation in their lives compared to minority women. On the occasions when they did face overregulation, it concerned forced prostitution and stalking by partners rather than

honour-related events. It appears that overregulation that originates in honour protection is culture-bound.

Durkheim (1952) asserted that the suicide rates found in various cultures were indicative of the level of social pathology. This precipitates the question why some immigrant families maintain such strict enforcement of rules and moral guidelines. It appears that many immigrant communities in the west are undergoing a process of cultural transition towards more individualism and greater freedom for women. Durkheim also argued that the suicide rate is a proxy for social solidarity (Bearman 1991). Hence, the alarming rates of suicidal behaviour and the fatalistic components we discovered hint at prevailing contestation in certain immigrant communities around cultural prescriptions, and imply gendered traditional power relations. Tensions develop when parents employ a traditional culture rationale for exercising honour-related regulations in spheres where young women wish to follow their own life. This process may also be influenced by 'a general frigidity of cultures which takes place in diasporic communities' (Yuval Davis 1997, p. 67), as a response to their localization in the dominant society at large which is characterized by modernization and individualization. The honour regulation exercised prevented young women from experiencing connectedness with their family and ethnic community and appeared to precipitate disintegration rather than the cultural stability desired by the family.

The information on the lives of the young women was not reported systematically and exhaustively. However, the fact that psychologists and psychiatrists wrote the notes in the files rather than sociologists renders underreporting plausible on social and cultural factors of overregulation. In addition, we focused on young women who were seen for treatment by mental health services. It may be expected that societal regulatory factors play an even larger role among ethnic minority women who are not in touch with mental health care.

Difficulties exist in translating the background and social meaning of suicidal behaviour across different cultures. Anthropological studies into attitudes on suicidal behaviour could help to illuminate if suicidal acts are recognized in an ethnic community as a response to certain kinds of distress. South Asian women are known to be vulnerable to suicidal behaviour world-wide, which may indicate a lower threshold and cultural rationale for suicidal behaviour since it is engrained in their cultural repertoire (Raleigh, Bulusu and Balarajan 1990; Patel and Gaw 1996). By contrast, since Islam fiercely forbids suicide, the threshold for suicidal behaviour seems higher in Moroccan and Turkish women.

On the basis of our data, we have shown that overregulation is central to the accounts of many young suicidal minority women in the Netherlands. In line with the work of Kushner and Sterk (2005,

p. 1141), who asserted that: 'Durkheim's definition of fatalism described the psychological and social condition of many women [...] who inhabit the globe today', we would like to emphasize how fatalistic suicide needs to be re-evaluated as a concept in suicidology. The reason why there has been a lack of attention to fatalistic suicide may be that, although women attempt suicide more often than men, since the suicidal behaviour of males is more often lethal, it is frequently taken as a yardstick for research on suicidal behaviour (Canetto and Lester 1995). In conclusion, factors of overregulation should be borne in mind for future directions in suicidology as well as for developing strategies for suicide prevention for Turkish, South Asian and Moroccan young immigrant women in the Netherlands.

## Notes

1. Turkish and Moroccan immigrants arrived as guest labourers in the 1970s and the majority stayed in the Netherlands. The South Asian migration history goes back to the late nineteenth century when contract labourers were shipped from India to the previous Dutch colony of Surinam to work in agriculture. Shortly before Surinam gained its independence in the 1970s, many Surinamese moved to the Netherlands. The South Asian-Surinamese mostly settled in The Hague. It is therefore expected that the ethnic group among the Surinamese that is at risk for suicidal behaviour is mostly South Asian. Approximately 85 per cent of the South Asian-Surinamese population are Hindu and 15 per cent are Muslim.
2. Incidences of suicidal behaviour as registered by hospitals and emergency agencies in the city of The Hague in 2002–2003: Turkish young women aged 15–19: 5.0 incidences per 1,000 per year, and aged 20–24: 7.0 per 1,000 per year. Surinamese young women aged 15–19: 4.5 per 1,000 per year, and aged 20–24: 4.0 per 1,000 per year. Moroccan young women aged 15–19: 2.3 per 1,000 per year, and aged 20–24: 2.0 per 1,000 per year. Majority Dutch women aged 15–19: 1.0 per 1,000 per year, and aged 20–24: 1.5 per 1,000 per year.
3. Statistics show that men commit two to three times more suicide than women in the Netherlands. South Asian men have increased rates compared to Dutch men, while rates for Moroccan and Turkish men are about 80 per cent of that for Dutch men. South Asian and Turkish men commit suicide three times as often as women in these groups. Moroccan and Dutch men commit suicide about twice as often as women in their ethnic groups (Garssen, Hoogeboezem and Kerkhof 2006).
4. Two women, from India and Bangladesh, were added to the sample of South Asians because of commonalities in their region of origin.

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