Research Trends

Gender and Cultural Patterns of Suicidal Behavior

Young Hindustani Immigrant Women in The Netherlands

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Abstract. Patterns of suicidal behavior vary among cultures and along gender. Young Hindustani immigrant women attempt suicide four times more often than young Dutch women. This article explores multi-disciplinary explanations for suicidal behavior in this group. The interconnection of Durkheimian concepts of social integration and regulation with ecological insights into family relations and psychological and psychiatric theories on individual distress are relevant. It is suggested that young Hindustani women who display suicidal behavior possess certain personality and cognitive constellations that are interlocked with specific parenting styles in stressful family environments. These families are embedded in a context of moral transformations resulting from migration to a Western culture and may be facing difficulties accompanying the transitional processes encountered in the West, particularly those regarding gender roles. Durkheimian *fatalistic* and *anomic* suicides elucidate this. The Hindustani women who appear most at risk are those facing contradictory norms and overregulation, which prevent them from developing autonomy.

Keywords: Hindustani (Indian) immigrant females, suicidal behavior, gender, ethnicity, research traditions

Introduction

Young Hindustani women in the city of The Hague, whose parents migrated from Surinam to The Netherlands in the 1960s and 1970s, have high rates of suicidal behavior. The history of Hindustani migration to Surinam and, subsequently, to The Netherlands goes back to the late 19th century. Indians were shipped from India to the former Dutch colony of Surinam to work as contract laborers. Shortly before Surinam gained its independence in the 1970s, a substantial number of Surinamese, including those of Indian origin as well as those of Creole background (i.e., of African and mixed background), emigrated to The Netherlands in search of economic and educational improvement. The Indian Surinamese are mostly referred to as *Hindustani*. The Hindustani population settled mostly in various neighborhoods of the city of The Hague.

In particular, Hindustani women in the age group 15–34 years are at increased risk of suicidal behavior (Burger, Hemert, van Bindraban, & Schudel, 2005). Incidences of suicidal behavior among Surinamese young women as registered by the hospitals and emergency agencies in the city of The Hague in 2002–2003 were as follows: 4.7 (15–19 years old), 4.5 (20–24 years old), and 1.8 (25–34 year old), all per 1000 per year. For young women of Dutch origin the comparable incidences were 2.0 (15–19 years old), 2.5 (20–24 years old), and 1.4 (25–34 years old) per 1000 per year. The statistics do not allow for analysis of ethnic subgroups within the Surinamese group (e.g., Hindustani and Creole). However, since almost the entire Surinamese population in The Hague consists of Hindustanis, it is safe to assume that these statistics point to an increased risk for suicidal behavior among Hindustani Surinamese females rather than other ethnicities among the Surinamese.

Disproportionate rates of suicide and suicidal behavior appear not to be specific for young Dutch-Hindustani women, but have been found for South Asian (immigrant) women living in South Africa, Surinam, Trinidad, Guyana, Singapore, and in the United Kingdom, as well as in certain regions of India and Pakistan (Bhugra, Desai, & Baldwin, 1999; Graafsma, Kerkhof, Gibson, Badloe, & van de Beek, in press; Hsiao-Rei Hicks & Bhugra, 2003; Patel & Gaw, 1996).

Suicidal behavior is usually explained from either a sociological, psychological, ecological, or medical tradition. Despite a clear interconnection, the relevance of all four traditions is rarely explored simultaneously. By contrast, this arti-

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cle departs from the position that risk factors for suicidal behavior intersect across these traditions and aims to explore their collective explanatory power for the suicidal behavior of young Hindustani women. In the first part, some methodological issues on researching this topic will be discussed, followed by an explanation of the sociological tradition that focuses on cultural change and Durkheimian theories of suicide. The second part will concentrate on the ecological tradition that focuses on the family environment, life events, as well as theories from migration studies. In addition, the relevance of the medical and psychological tradition will be discussed. Subsequently, the insights of these various traditions will be applied to the suicidal behavior of young Hindustani women by analyzing the empirical evidence from two studies, based on in-depth interviews with 10 young Hindustani women, aged 16–25 years old who made a suicide attempt (six informants) or experienced suicidal ideation (four informants) (Krikke, Nijhuis, & Wesenbeek, 2000; Salverda, 2004). The interviewees were single and between 16 and 20 years old, with the exception of two married women of 23 and 25 years old. Empirical studies in suicidology on South Asian women in the United Kingdom by Bhugra et al. (1999, 2002, 2003) and a UK study on health care professionals working with this group (van Bergen, 2006) are also used to interpret the Hindustani case.

Methodological and Conceptual Considerations

In correspondence with general patterns on gender ratios in suicide statistics, Hindustani women have high rates of nonfatal suicidal behavior, rather than fatal suicide. This brings into question the methodological aspects of differentiation between fatal and nonfatal acts (De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2006). Both suicidal behavior and suicide appear to be more about termination of suffering and relief from a terrible state of mind rather than the fulfillment of death. In addition, a clear overlap exists in risk factors for all types of suicidal behavior. Hence, it is hard to maintain that those involved in fatal suicidal behavior can be clearly distinguished from those who engage in nonfatal suicidal behavior with regard to motives or intentions. Therefore suicidal behavior, in this article, will be perceived in a continuum that includes serious self-harm, minor, and major suicide attempts, and previous research focusing on suicide as well as suicidal behavior will both be taken into account in discussing the case of Hindustani women.

Social and Cultural Change and Suicidal Behavior

Durkheim suggested that determinants of suicidal behavior can be found in aspects of social culture and vice versa; social structure would offer an explanation for variation in the suicide rate (Matthijs, 1983). The relation between individuals and the extent to which they were tied to society provided the key explanation for Durkheim in understanding how the structure in a certain society is linked to its suicide rates (Matthijs, 1983). The sociological tradition in suicidology following this theory focused on influences of social and cultural changes and their influences on suicidal behavior. Durkheim suggested that through transformational processes of modernization, manifestations of individualization emerged that evoked the breakdown of social integration in society, which ultimately precipitated suicide. The finding that higher suicide rates occurred in those countries with high rates of modernization (e.g., high levels of individualization, urbanization, industrialization and secularism) supported this thesis (Eckersley & Dear, 2002).

To understand why modernization and individualization can bring about self-destructive behavior, Durkheim introduced the concept of *anomie*, indicating a weakened state of social bonding and integration that results from the decline in importance of social norms on individuals. No longer do individuals experience previously embraced social or moral norms as adequate, or they experience these norms as confusing or unclear (Matthijs, 1983). Durkheim argued that weak or contradictory messages to the individual by the social group he belongs to can result in an *anomic suicide*, implying a lack in the individual's normative integration into the group's cultural standards (Gibbs & Martin, 1964). In addition, Durkheim identified a *fatalistic suicide*, resulting from being at the high extreme of the regulation continuum. Characteristic for fatalistic suicide is the existence of over-regulated yet unrewarding lives, with "pitilessly blocked futures and passions violently choked by oppressive discipline" (Durkheim, 1952, p. 276). Excessively controlled by social-cultural prescriptions, individual freedom and improvement of life would not exist. However, Durkheim found fatalistic suicide hardly relevant for the West. Only incidences of suicide of slaves and to some extent of young husbands and childless married women were expected to fall into this category (Durkheim 1952).

Gibbs and Martin (1964) developed an empirical conceptualization of Durkheim's thesis on social disintegration and anomie. In their status integration theory they suggested that a suicide attempt could imply a lack of the consensual nature of social norms. Any status configuration that is infrequently occupied by persons in a society is apt to be marked by role conflict, which increases distress and may eventually lead to higher suicide rates. This would explain how, after half a century of convergence, the female suicide rate in Western countries is falling back. The increase in suicide rates would be caused by the great changes in values concerning gender relations and subsequent changes in female roles in the 1950s and 1960s, but only up to a point where these changes would have become socially normative, after which reduced rates of female suicide followed (Stack, 2000).

Ecological Tradition: Family and Community Environments, Risk Versus Protection

Research in the ecological tradition in suicidology focuses on the influences of the family system and relational factors, life events and the role of the ethnic status, the migrant status, and the community. On family relations, Durkheim assumed that women were insulated from suicidal behavior to the extent that they were subsumed within the protective bounds of traditional family life. We know now, of course, that this is not necessarily so. In a more recent study, Pescosolido argued that the integrative function in Durkheim's work should, on the family level, be conceptualized as the level of emotional nurturance children receive from the parents, and the regulative function as the limits set by the parents around the kind of behavior they find acceptable (Pescosolido, 1994). Following Durkheim, the risk for suicide occurs when there is a lack of integration, e.g., when the level of emotional nurturance in the family is low. The effects of regulation are less clear. Durkheim suggested that regulation is protective for individuals. Yet, he also indicated that cases of overregulation could result in fatalistic suicide. Thus, overregulation at the family level could refer to oppressive restrictions, eventually leading to a fatalistic suicide. Hence, Pescosolido suggests that submission in the family does not necessarily always offer protection but could also predispose an individual to distress that may lead to suicidal behavior.

Psychological research reveals that particularly the combination of low levels of emotional affection in the family environment combined with high levels of parental control or overprotection – known as the parental bonding style *affectionless control* – constitutes a risk for suicidal behavior. Adolescents who classified their parental bonding style as such have double the relative risk for suicidal thoughts and a threefold increase in the relative risk for deliberate self-harm (Martin & Waite, 1994). McGarvey, Kryzhanovskaya, Koopman, Waite, and Canterbury (1999) added that affectionless control plays a role in suicidal behavior in particular through coexistence of low self-esteem and hopelessness. The risk of this bonding style was found to have a stronger impact for girls than for boys.

In terms of stressful life events, research points to a relationship between sexual and physical abuse and suicidal behavior (Egmond, Garnefski, Jonker, & Kerkhof, 1993). Sexually or physically abused suicide attempters are known to show more suicidal behavior and sexual and psychical traumatization during childhood appears to have an impact on the severity of mental disturbances in adulthood above and beyond the contribution of other variables (Egmond et al., 1993). On physical abuse, McHolm, MacMillan, and Jamieson (2003) found in a study of a community sample of women suffering from major depression that suicidal behavior was most strongly associated with physical abuse in childhood as well as the existence of comorbid psychiatric disorders.

Studies on ethnicity in relation to suicide hypothesize that being a member of a low-status ethnic minority group amidst a majority population may constitute a risk factor for suicidal behavior, possibly because of the low status ascribed to this position. Research on Mexican, Puerto Rican, and Dominican Americans and suicidal behavior confirms this position, but the low prevalence rates of suicides among African Americans contradict this view (Tortelero & Roberts, 2001). This indicates that the relationship between ethnic minority membership and suicidal behavior is a complex one.

In addition, a migration background has been shown to be a relevant factor in the psychological well-being of individuals, as a result of the acculturative stress that results from adapting to the host country. Migration is a social phenomenon that is stressful and complicated and may put parents and, thereby, their children at risk for experiencing a lower level of well-being and functioning (Berry, 1994). Acculturative stress appears to be related to poor expectations for the future and poor family functioning and is associated with several difficulties, e.g., prejudice and discrimination, disruption of support systems, stressors associated with living in high crime areas and poor housing, inadequate schools, as well as the stressors associated with living in dysfunctional family environments. Evidence has been found that suggests that greater acculturative stress may be an important factor for a higher suicide risk (Canino & Roberts, 2001).

In addition, a Canadian study suggested that those members of migrant groups who are prone to suicide are often those who have undergone high levels of assimilation (Trovato, 1986). It was hypothesized and validated that the higher the degree of social assimilation among immigrant-ethnic groups, the greater the suicide rate (Trovato, 1986). In a Durkheimian sense, the assimilation process that the individual goes through involves anomie, while simultaneously, erosion of social integration within the ethnic group occurs. An additional hypothesis scrutinized by Trovato (and supported) was that ethnic groups with strong degrees of community cohesiveness – considered as a buffer for stress– share reduced odds in their incidence of suicide. A similar mechanism is thought to operate in the religious domain, i.e., protection from suicide is thought to exist through participation in religious communities, at least when the cohesion in these communities is high and strongly felt by its members. Additional protection from the religious sphere has been found to correspond with the extent of orthodoxy present in the faith of an individual (Dervic et al., 2004; Greening, 2002).

Medical and Psychological Tradition in Suicidology

The medical tradition in suicidology focuses on the role of mental illness in general and depression in particular. Especially when it is associated with hopelessness and nega-

tive thinking about the future, depression is crucial as a risk factor for suicidal behavior. Studies with a gender focus in this tradition have emphasized the socialization factor and pointed at the internalization rather than the externalization of distress in females in terms of the development of psychological disturbance (Vanatta, 1997). In addition, mental disorders are known to have clear biological components. Studies in genetics indicate that the interplay of genetically determined biological factors, traumatic events, and stress leading to a dysregulation of the serotonergic system increases the vulnerability for the risk of suicidal behavior (Traskman-Bendz & Mann, 2000).

Research within the psychological tradition has looked into the relation between personality constitutions or patterns in thinking that have been found to function as risk factors for suicidal behavior. The prevalence of hopelessness coexisting with depression was found crucial in this; most importantly the impossibility of thinking of positive future events, as well as the overgeneralization of insolubility of difficulties (Williams, 2001).

On the relationship between cognitive styles and personality traits, Beautrais, Joyce, and Mulder (1996) identified high scores among suicide attempters of an external locus of control as well as neuroticism and impulsivity and high prevalence on measures of introversion or a style of emotional regulation turned against the self (Beautrais et al., 1996; Borst 1993). In addition, Hull-Blanks, Kerr, and Robinson Kurpius (2004) found that young women with histories of suicide attempts had significantly higher levels of impulsivity, aggression, and social recognition, defined as "concern" about reputation and approval and recognition of others.

Psychological theories also point to the importance of problem-solving capacities in adolescents in the development of suicidal behavior, since this leads to dichotomous thinking and hampers finding a solution to their distress. However, it has also been argued by Orbach, Mikulincer, Blumenson, Mester, and Stein (1999) that in suicidal adolescents problem-solving capacities may not necessarily be lacking, but they may simply be experiencing more stressful life events than others. A sense of insolubility leaves adolescents feeling trapped and they experience fatalism, which is significantly related to hopelessness and confused thinking. Hopelessness mediates the relationship between problem-solving deficits and suicidal behavior (Schooler cited in Orbach et al., 1999; Carris, Sheeber, & Howe, 1998). The family plays an important role in the ability of an adolescent to become a successful problem solver. Several studies have confirmed that a rigid family environment, defined as a family incapable of adaptability in response to problem situations and stress, promotes the development of an adolescent with a limited behavioral repertoire when confronted with major problems. The consequent absence of problem-solving skills increases the likelihood of suicidal ideation (Carris et al., 1998; Miller, King, Shain, & Naylor, 1992).

In light of the above, it can be said that the sociological, ecological, psychological, and medical traditions in suicidology are closely interrelated and often refer to similar problems from different angles. For instance, suicidal behavior that follows from depression (psychological and medical traditions) may have its origins in processes of migration outplayed on the family level (sociological and ecological traditions). Likewise, anomie may follow from sociological as well as ecological influences, e.g., migration may have disintegrated family coping strategies and parenting styles.

Social and Cultural Transitions for Young Hindustani Women

Durkheim's thesis on modernization and suicide leads to the suspicion of a relationship between the high prevalence of suicidal behavior among young Hindustani women and the shift from traditional Hindustani culture toward modernization, between the generations. The thesis then is that Hindustani female adolescents have more modern attitudes on topics of family, relationships and leisure than the parents, leading to conflict and a sense of alienation from parental cultural values. A self-administered survey among Hindustani youth indicated high levels of modern attitudes, nearly the same positions as autochthonous Dutch youngsters on modernization and more modern than other ethnic minority youth, e.g., Turks and Moroccans (Choenni, 2003). Research from the United Kingdom that compared a group of South Asian women who had made a suicide attempt with a control group also supports the modernity thesis (Bhugra et al., 1999). The group of attempters had higher levels of modernization than the control group, for example, in terms of being in or attitudes to interracial marriage, and being less in favor of arranged marriages.

In terms of anomie, i.e., moral insecurity, it can be hypothesized that the second generation of Hindustanis are undergoing a process of moral transition, where the norms and values that relate to gender roles that were previously well accepted in the community have ceased to be fully internalized and supported by those young Hindustani women at risk for suicidal behavior. Situated in a process of moral confusion, those young women lean toward internalization of alternative norms. It appears that young Hindustani women who display suicidal behavior are confronted with contradictory messages on the social norms they should abide by. The confusion is intensified since it concerns the period of adolescence, which is already a time of search for identity (Carr, 1999). Being confused, some young Hindustani women find themselves in a moral vacuum where they no longer support their traditional gender norms, yet still are without a replacement by new ones. It appeared that some of the suicide attempters had difficulties in developing an individual self and self-autonomy. Empirical evidence (Salverda, 2004) demonstrates how suicide attempters were frustrated about the aspects of Hindustani culture relating to its collective nature and lack of

self-expression. As one Hindustani suicide attempter remarked:

> *In Hindustani culture you don't have a life of your own. You have to bear everything and put yourself aside. Choosing to live your own life is inconceivable in Hindustani culture. I (. . .) learned not to demand anything for myself.* Geeta, 25 years old (quote from Krikke et al., 2000).

Another young female attempter explained on the same topic of self-autonomy:

> *As long as you live at home, you are expected to do as you are told. (. . .) The whole family was interfering with me, and I could not stand that.* Shakti, 18 years old (quote from Salverda, 2004).

It could also be hypothesized that these young women would like to embrace a different range of values, notably toward more freedom and self-expression, but are not enabled to do so. This thesis also finds support in Salverda's study (2004) since suicide attempters explained how they, for instance, would like to be able to go out rather than being coerced into staying at home in the evenings and weekends (Salverda, 2004). The proposition obtains additional empirical support through the finding that those two young women in the study by Krikke et al. (2000) who were married were motivated in this choice by the expectation of finding more space for self-expression after leaving the home. Marriage was, hence, used as a hindrance to gaining more independence.

The status integration theory, suggests that young Hindustani women would face contradicting social roles in the family environment as opposed to those roles located in the spheres of leisure and education, which are traditionally not ascribed to their sex roles. In the study by Salverda (2004) parents of suicide attempters were found to appreciate obedience and dutifulness, yet simultaneously pressure their daughters to be highly ambitious young women aspiring to careers, which clearly involves opposite skills, such as assertiveness. The study elucidated how polarization cannot only be found between Western and Hindustani culture, but also the parents of suicide attempters may employ contradicting ideals and goals for their daughters. The tensions between the norms and values met in educational spheres – focused on assertiveness, autonomy, and freedom – and more restricted norms at home, guided by Hindustani culture and notably reinforced after migration and located in a Western setting, lead to role conflict as proposed by the status integration theory.

Ecological Explanations: Hindustani Family and Community Environment

Salverda (2004) and Krikke et al. (2000) found that extreme levels of control, coercion, and restriction in all aspects of life were characteristic for those young Hindustani women who reported poor psychological well-being. Many accounts of the young Hindustani women in these two studies confirmed the assumption of affectionless control. They expressed how their parents' upbringing lacked care or interest for their feelings and experiences and how appreciation of their (nonacademic) achievements was absent, while simultaneously facing permanent restrictions to their behavior. This evoked feelings that nobody listened to or cared about them and resulted in their feelings of complete worthlessness. As one interviewee remarked:

> *Why does no one listen to me? Don't I have anything to say in this? Why do I always have to listen to what others tell me? I don't live my life like I want to, so my life is useless, really.* Mariska, 16 years old (quote from Salverda, 2004).

Such a family environment seems to confirm that the translation of Durkheim's thesis on integration to the family level is important for explaining the suicidal behavior of young Hindustani women and that conflict in the family appears to be indicative of poor social integration for individuals.

Abuse is also known to play a substantial role in suicidal behavior of women, in particular. It appears that abuse is also relevant in explaining the suicidal behavior of Hindustani women. The studies by Salverda (2004) and Krikke et al. (2000) both emphasize the incidence of, in particular, physical abuse for the Hindustani suicide attempters they interviewed. National reports on the large proportion of women from ethnic minority backgrounds (50%) in shelter because of domestic violence confirms the high incidences of physical abuse among ethnic minority groups (Kenzenkamp & Oudhof, 2000). Apart from rates, it should be emphasized that the way that abuse is (not) responded to in the Hindustani family and community also seems to have a substantial impact on suicidal behavior. A study of British healthcare professionals working with South Asian women confirmed the impossibility and taboo for Asian woman to discuss abuse, since the honor of family is at stake. This inability to discuss could lead women into expressing suicidal behavior (van Bergen, 2004).

As for Trovato's argument on community cohesion, the Hindustani group in the city of The Hague can be argued to be relatively close. For young females the close ties in the Hindustani community appear to be a risk factor rather than a protective factor, in particular because of the social control (gossip) involved. The risk seems closely related to the importance of family honor for Hindustanis, where the males of the family closely monitor the behavior of females in the community environment and violation of sexual and social codes can result in outcasting from the community. It seems that the community cohesion does not protect the Hindustani females from suicidal behavior and the gender dimension seems crucial in this.

The religious values of the suicide attempters were not systematically reported on in the studies by Krikke and Salverda, making it hard to draw conclusions about any protective factor for suicidal behavior through participation in religious communities. However, it was demonstrated that

two young women who made a suicide attempt prayed everyday and engaged in religious ceremonies, while another young female attempter declared not to be religious at all. This seems to suggest that there is no straightforward relation between the Hindu faith and practice of it and the display of suicidal behavior by Hindustani women in The Netherlands. The suggestion that Hinduism as a religion may be more lenient toward suicidal behavior than, for instance, Islam is also difficult to maintain since young Turkish women, who are Muslims, also have an increased risk for suicidal behavior in The Netherlands.

Medical and Psychological Views on Hindustani Women's Mental Health

Little is known of the prevalence of depression among young Hindustani women of the second generation and the paths into suicidal behavior. A preliminary report revealed increased risks of mood and anxiety disorders, in particular, for the second-generation migrants in The Netherlands, suggesting the relevance of possible mental disorders among young Hindustani women and their suicidal behavior. However, research in the United Kingdom has indicated that psychiatric illness in general was significantly more seen in White British suicide-attempters compared to South Asian female suicide-attempters. In addition, those incidences of depression observed were associated with social and cultural stress resulting from conflicting relationships (Bhugra & Desai, 2002).

Findings from cross-cultural psychiatry suggest vigilance is needed when applying Western understandings of depression and mental health to Hindustani women. Cultural meanings interact and the development from mental illness into suicidal behavior of young Hindustani women may not follow the same path as that of autochthonous Dutch females. For instance, some suicidal South Asian women of the first generation in the United Kingdom have been found not to display characteristics of hopelessness in depression since they viewed their miseries as part of life, not as things they controlled (Currer cited in Fenton & Sadiq-Sangster, 1996). A further complication is that the role of culture could be different for the first as opposed to the second generation Hindustanis.

On the relationship between cognitive styles and personality traits, it can be argued that if an external locus of control, high levels of neuroticism, and impulsivity were found among Hindustani suicide attempters, this would then contribute to the understanding of their suicidal behavior. These precipitators could, in turn, relate to acculturative stress in their family environment, and possibly their socioeconomic status or a marginalized position in society. Accounts of Hindustani suicide attempters confirm that some of their acts were characterized by impulsivity (Krikke et al., 2000; Salverda, 2004). For instance, in one case a young Hindustani woman drank a bottle of chlorine in front of her parents in order to stop their constant fighting. This suggests that to some extent suicidal behavior of young Hindustani women may be related to certain cognitive styles and levels of impulsivity; it also indicates possible communicative elements toward the (family) environment. In addition, research on the Hindustani population in Surinam revealed that suicide attempts were characterized as highly impulsive acts (Graafsma et al., 2006). The prevalence and similarity in expressions of such behavior of Hindustani worldwide, thus, suggests the possibility of (partially) culture-bound coping strategies.

The studies on problem-solving seem extremely relevant for suicidal female Hindustani adolescents. Orbachs' thesis seems plausible; not necessarily the number of events matter, but in particular the response to such events while both are intertwined with the cultural background. In particular, this applies to issues around loss of virginity, or being seen with a man. Such events are followed by sanctions, e.g., the outcasting of the woman by her parents, which may be followed by a suicide attempt. Krikke et al. (2000) found that the violation of gender norm(s) – e.g., having a (sexual) relationship before marriage or being suspected of it – had a large contribution to the development of suicidal behavior. As a response, some suicide attempters in Krikke's study were forced into a marriage, which in some cases also led to a suicide attempt. One of the most common precipitating life events in attempted suicide, among Western and non-Western adolescents alike, is the breaking up of romantic relations (Wichstrom, 2002). Considering the fact that virginity status is a major important issue in Hindustani culture for females, it seems plausible that the end of a romantic relationship, in particular one that has included sexual intercourse, is of crucial importance in the suicidal behavior of young Hindustani women. Even with sexual activity being absent, the honor of the girl and that of her family could be jeopardized. This was found to be characteristic of the Hindustani suicide attempters reported on (Krikke et al., 2000; Salverda, 2004). As one interviewee remarked:

> *Among Hindustanis it is like this; you are to remain a virgin until marriage (. . .) No one knew that I had a boyfriend. Among Hindustanis that is something shameful.* Shakti, 18 years old (quote in Salverda, 2004).

> *You are dependent on what others say about you. It is a kind of stranglehold that you cannot free yourself from.* Sanira, 19 years old (quote from Krikke et al., 2000).

It appears then that the enormous difficulties surrounding issues of honor for families of young Hindustani women may lead to problems seemingly beyond the individual's capacity to cope. It is hypothesized that rigidity in the family and a lack of problem-solving capacities in the family add to the problems and form a risk factor for suicidal behavior.

Conclusion

Cultural and gender transformational conflicts are central to the interpretation of suicidal behavior of young Hindustani women. The Hindustani community is undergoing a process of cultural transition toward more individualism and greater freedom for women. We hypothesized that a sense of anomie could result from conflicting Western versus traditional norms and values in the family environment and outside the home, yet also assumed that this can only be part of the explanation.

Empirical evidence on the psychological well-being of young Hindustani women revealed a high incidence of poor relationships with the parents (Salverda, 2004). With little or no interest, appreciation, or affection shown, this reflects a lack of family integration and can be understood as a case of anomie. The status integration theory is also highly relevant, since contradictory roles characterize the contrast within and between the paradoxical demands and expectations of the young women's professional and family lives, again leading to a sense of anomie.

The suicidal behavior of young Hindustani women, we believe, must be situated in a family environment that faces difficulties involved in the cultural transformation process they are in. Those young Hindustani women who attempt suicide are prone to over-guidance in their homes and subjected to strict control (often related to honor protection) that is imposed by their family in virtually all spheres of their lives. These restrictions lead in some to an underdeveloped sense of autonomy and put them at risk for a state of anomie in which they do not share the norms they are expected to obey. In addition, such demands are often linked to problems that for some are beyond their capacity to solve, such as having lost their virginity, being seen with a man, or being enforced into an unwanted marriage, all leading to seriously damaged and conflicting relationships in their rigid family environment. For many young women, such restrictions are also accompanied by physical or sexual abuse. In contrast to the suggested protective value of close community ties, for Hindustani females this rather seems to comprise a risk, because of the strict vigilance over the family honor. Contrary to Durkheim, we suspect that the fatalistic suicide is highly relevant for explaining suicidal behavior among young Hindustani women. Excessive regulation created by the parents leads to an absence of freedom. In an environment where self-autonomy is under-stimulated, yet combined with an affectionless parenting style, this may lead to a strong sense of living an unrewarding life with suicidal behavior as a consequence.

We want to conclude with a few words of caution. Contrary to the idea that it is (patriarchal) culture or authoritarian parenting *per se* that is to be held responsible, the combined insights from the four discussed traditions in suicidology suggest that culture and cultural transformation are important, but not in such a straightforward way. Suicidal behavior occurs in those families that somehow are not able to respond in a flexible way to the cultural transformational processes they are in. Many other equally patriarchal families that employ authoritarian parenting offer their daughters an affectionate and caring environment. We do recognize that a cultural socialization that does not value the development of individuality is probably not beneficial for developing autonomy competencies. Yet, growing up in a patriarchal family structure or being subjected to an authoritarian parenting style in a surrounding liberal culture clearly does not inevitably lead to suicidal behavior for all subjects. In some cases it does. We hope to have demonstrated that a perspective that combines the four discussed traditions in suicidology offers the most potential for gaining insight into why this is so.

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