**transcultural psychiatry**

*Article*

# "*I felt so hurt and lonely*": Suicidal behavior in South Asian-Surinamese, Turkish, and Moroccan women in the Netherlands

**Diana D. van Bergen, Anton J. L. M. van Balkom, Johannes H. Smit and Sawitri Saharso**
VU University Amsterdam

## Abstract
Young immigrant women in the Netherlands demonstrate disproportionate rates of suicidal behavior. This study investigated the origins of suicidal behavior in South Asian-Surinamese, Turkish, and Moroccan immigrant young women in order to identify ethnic- and gender-specific patterns of suicidal behavior. Based on life story interviews of women who had been enrolled in mental health care, we constructed five typical patterns in which social, cultural, and personal factors were interconnected. Suicidal behavior was influenced by the ability and right to act autonomously with regard to strategic life choices, as well as by the questioning of cultural values of self-sacrifice and protection of honor.

Research from the 1990s showed that young women in the Netherlands of Turkish, Moroccan, and South Asian-Surinamese descent had disproportionate rates of nonfatal suicidal behavior (Schudel, Struben, & Vroom-Jongerden, 1998).[1] Several additional studies conducted over the last decade have shown that the rates of nonfatal suicidal behavior in women aged 15 to 24 years from these ethnic groups appeared to be two to four times higher than those of ethnic majority

**Corresponding author:**
Diana D. van Bergen, Department of Theory and Research in Education, Faculty of Psychology and Education, VU University Amsterdam, van der Boechorststraat 1; 1081 BT, Amsterdam, the Netherlands.
Email: d.d.van.bergen@vu.nl

(hereafter "majority") Dutch young women (Burger, van Hemert, Bindraban, & Schudel, 2005). Moreover, research in other western countries has also pointed at increased rates of attempted suicide among females of nonwestern origin (e.g., Bhugra & Desai, 2002).

Apparently, being female and belonging to specific ethnic minority (hereafter "minority") groups constitutes a risk for nonfatal suicidal behavior. This prompted us to examine the suicidal behavior of immigrant women in the Netherlands. The World Health Organization (WHO) defines suicidal behavior 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, Burgis, Bertolote, Bille Brahe, & Kerkhof, 2006). The desired change includes, but is often not limited to, the intent to die. Desired changes may also include a wish to escape from an unbearable situation, the search for peace of mind, or to communicate mental pain (Hjelmeland, Knizek, & Nordvik, 2002). For brevity, nonfatal suicidal behavior is referred to as "suicidal behavior" throughout this paper.

Turks, Moroccans, and Surinamese are the largest immigrant groups in the Netherlands and put together they make up about 7% of the Dutch population. Turkish and Moroccan immigrants from predominantly rural areas arrived as guest laborers in low-skilled factory jobs in the 1970s (Vermeulen & Penninx, 2000). Initially, Turkish and Moroccan male workers came to the Netherlands alone, with the expectation of saving money and then returning home. However a majority stayed in the Netherlands. Turks and Moroccans are mostly Muslim. Many Turks and Moroccans belonging to the first generation of immigrants (hereafter when referring to first, second, or "1.5/in-between" generations of immigrants, they will be mentioned as first, second, or 1.5/in-between generations) are economically and socially disadvantaged.

Immigration of South Asian-Surinamese from Surinam to the Netherlands occurred from the 1950s onward as a result of previous colonial ties. South Asian-Surinamese had migrated from India to Surinam to work as contract laborers in agriculture in the late 19th century. Predominantly, the South Asian-Surinamese are Hindus, but there is a Muslim minority among them. The South Asian-Surinamese belong to higher social and economic strata compared to the Turks and Moroccans.

Opinions on sex roles among these three minority groups are more traditional when compared to majority Dutch (Dagevos & Gijsberts, 2009). Only 30% of the Turkish and Moroccan women of the first generation are part of the labor force. All three minority cultural groups are characterized as collectivistic (Brouwer, Lalmahomed, & Josias, 1992). For example, studies of child-rearing practices indicated that conformity is a very important goal of parenting among Turkish, Moroccan, and South Asian-Surinamese parents, whereas Dutch parents focus much more on autonomy skills (Dekovic, Pels, & Model, 2006, Mungra, 1990).

The Turkish, Moroccan, and South-Asian Surinamese immigrant population in the Netherlands consists mostly of the first and second generation of immigrants.

The number of immigrants belonging to the first generation remains steady since marriages with women/men from the country of origin are still common (Dagevos & Gijsberts, 2009). There is also an in-between or "1.5 generation" that arrived when they were aged 9 to 15 years. The study we present here reflects these population characteristics by including these different generations of immigrants.

## Individual, social, and cultural correlates of suicidal behavior

The present study is part of a project that combines quantitative and qualitative methods to examine suicidal behavior among young immigrant women in the Netherlands. In the quantitative study (van Bergen, 2009) we analyzed whether certain confounding risk factors could be responsible for ethnic variation in the rates of suicidal behavior. We found that a lower social economic background, the manifestation of parental psychopathology, sexual and physical abuse, and an impaired relationship with the parents contributed to attempted suicide in Dutch, South Asian-Surinamese, Moroccan, and Turkish female high school students. However ethnic disparities in suicidal behavior still remained when controlling for the above-listed confounders. Similarly, other research indicated that the high rate of suicidal behavior in South Asian women in the United Kingdom could not be explained by increased rates of depression and suggested culture conflict as a possible explanation (Bhugra & Desai, 2002).

Across cultures, suicidal behavior without a fatal outcome is found more often in females (Canetto, 2008). In addition, research shows that female immigrants are overrepresented among those who present suicidal behavior (see for instance Baca-Garcia, Perez-Rodriguez, Mann, & Oquendo, 2008). Hence, the role of ethnocultural factors in relation to gender in suicidal behavior is in need of further investigation (Herrera, Dahlblom, Dahlgren, & Kullgren, 2006).

The meanings that minority women ascribe to their suicidal behavior can inform us about the relative role of culture, gender, and ethnicity. We therefore chose the life story approach. In the next section we outline the method and procedures of the study. We then present the main themes in the life perspectives narrated by women with a history of suicidal behavior, and report variations across ethnicity. Finally, we discuss how these life stories contribute to theory on culture, oppression, and autonomy and how our approach opens up hitherto unexamined mechanisms and new lines of inquiry for future research.

## Method

### Sample

Participants in our sample were female; belonged to one the four following ethnic groups: South Asian-Surinamese, Turkish, Moroccan, or Dutch; were aged between 18 and 40; had demonstrated suicidal behavior or serious suicidal ideation

(as indicated by health care staff and/or participants themselves); and were not experiencing a crisis at the time when they were invited for an interview (e.g., suicidal crisis, a psychotic or manic episode). Participants were contacted mostly through healthcare professionals and to a lesser degree via the Internet. These two methods of contact were chosen in order to avoid selection bias associated with a single sampling source. The participants we attracted through mental health care professionals had been diagnosed mostly with mood disorder, some of them with borderline personality traits or disorder, and two subjects had suffered psychoses. Health care professionals did not refer any patients for the study whose mental health was in a very poor condition at the time of the interview request. We advertised a link to the homepage for the research project on websites that target immigrants, as well as on mental health websites. We noted afterwards that nearly all participants that reached us through the Internet had also (recently) been enrolled in mental health care. In total, 47 women aged 18 to 40 participated in this study (see Table 1), including 14 Dutch majority women who were used as a control group against whom immigrant women could be compared.

## Procedure

Participants agreed to a meeting that lasted 1 to 3 hours. The interviews were recorded and transcribed. The interviews were conducted by the principal investigator (DvB), a Dutch majority young woman. All interviews were conducted in Dutch except for four interviews with Turkish participants, where a female interpreter assisted with translations. The life story interviews focused on the interpretations participants gave of their (family) history of migration, childhood, school environment, upbringing, family relations, culture and religion, sexual and physical abuse, suicidal behavior and emotions or motives behind this, as well as future plans. Examples of the questions are: "Could you tell me about your feelings at the time when you [took pills, cut yourself, etc.—hereafter using the words used by

**Table 1.** Demographic characteristics of participants

|  | Turkish | Moroccan | South Asian-Surinamese | Dutch | Total |
|---|---|---|---|---|---|
|  | $n = 10$ | $n = 10$ | $n = 13$ | $n = 14$ | $n = 47$ |
| Mean age (*SD*) | 26 (6.2) | 29 (4.8) | 29 (4.5) | 26 (6.4) | 27 (5.5) |
| Generation: |  |  |  |  |  |
| First | 3 | 1 | 2 | – | 6 |
| 1.5 | 4 | 2 | 2 | – | 8 |
| Second generation | 3 | 7 | 9 | – | 19 |
| Nonimmigrant |  |  |  | 14 | 14 |

participant]?''; and ''Looking back at the time when you [took pills, cut yourself, etc.], what made you so [sad, unhappy, angry, etc.]?'' Interviews were held at a place suggested by the participant, this was mostly the participant's home or the office of her health care professional, and in two cases interviews were held at the office of the principal investigator (first author).

In the analysis we aimed to detect overarching narrative themes. To identify these, we initially coded the themes, processes, and emotions directly derived from the transcriptions. From these codes, categories were constructed and linked. Through ongoing comparisons within and between the interviews the principal investigator searched for similarities and differences regarding women's viewpoints, contextualized in (family) relationships and circumstances. Furthermore, we observed the specific narrative in a story, referring to how a participant made sense of what happened, how she spoke about it and organized her story, what she left out or emphasized, and the value judgments she provided (Chanfrault-Duchet, 1991). Through integrating categories across interviews as well as extensive rereading of individual stories, saturation was reached when five overarching narratives were identified.

The Dutch participants were included to explore possible differences and similarities in western and nonwestern women. However, a preliminary categorization based on ethnicity or generation was avoided in order to work inductively, that is, the relevance of ethnicity would emerge from analysis of the transcripts. Two researchers read the transcriptions independently. The principal researcher initially disguised information that could directly reveal the ethnicity of interviewees in order to prevent bias by the second researcher. The overarching narratives were discussed with the second researcher until consensus was reached. A psychiatrist was consulted to verify psychiatric aspects, since these appeared to be the key in one of the patterns. A third researcher who had not been involved in the classification categorized a random subsample of 10 interviews and there was 90% agreement with the original coding.

## Results

About 60% of the participants reported a lethal intent, and half demonstrated suicidal behavior repetitively. Most had taken an overdose of medication or had cut themselves on the wrist as a method. Five had seriously contemplated suicide but had not attempted it; however, in four of these cases preparations for hanging, jumping, or stabbing had been made. For most of the participants their acts were preceded by suicidal ideation. In what follows, we present the five narrative themes underlying participants' suicidal behavior.

### Lack of autonomy

The first theme concerned carrying out social roles that involved caring for others while being denied a life of one's own. Central to this narrative were attempts to

cope with the suffering associated with the care work itself and the self-sacrifice it required. This is embodied in the remarks from Fadime,[2] a married housewife with a young child, who migrated from rural Turkey to the Netherlands when she was 9 years old. She had suicidal ideation and prepared to commit suicide as a teenager. She was interviewed at her therapist's office, (the therapist did the translation).

Interviewer: "What was it like to grow up in your family?"

Fadime: …"Because my father didn't know how to raise us, we weren't allowed to go outside and were imprisoned in our own house. He wanted to protect us…. My life consisted of having four walls around me, a TV and nothing else. I did not think for myself. I did not think about myself, but always of others. For example, instead of buying sandals for myself I bought pairs for my father and sisters."

Interviewer: "What made you so unhappy?"

Fadime: "I just had these four walls around me. But even between those four walls, I didn't have a life of my own. I had a father who was ill, who was constantly fighting with my mother. My mother was using me to take care of him and my younger sisters. I could hardly speak the language and didn't know how to go anywhere. I had no plans for the future whatsoever. This was the life that I had to live. And I didn't like it. My fantasies for the future did not come true… Everyday I felt as if I was slapped in the face. That's why I wanted to end my life…. Around you, you see people of your age who live normal lives, while I didn't get any step further. I felt time was standing still and I wasn't getting anywhere. On New Year's Eve, I was crying because another year had passed while I hadn't achieved anything."

The roles Fadime had to abide by included those of live-in maid, caretaker, nurse, and babysitter. Fadime felt she was used for all sorts of purposes according to the family needs and was expected neither to have nor express her own voice. Fadime and two other Turkish women in the study reported being denied to go anywhere outside the home and one reported being locked up. Altogether, seven women who participated in the study reported this pattern of a lack of autonomy, of which six were minority women of predominantly Turkish origin. Some participants reported that family (in-laws) and husbands sometimes enforced harsh conditions upheld by physical or psychological maltreatment in order to ensure obedience. The psychological threat included the threat of being sent back to the country of origin where they anticipated abuse or poverty.

Women described being denied strategic life choices including the choice of whom and when to marry, movement in and outside the house, and the right to education. Three participants stated that the family (in-law) or husband made these strategic life choices during the women's early adolescence. These women obeyed

their parents to prevent conflict over these issues. Three other women in the research who were slightly older when strategic life choices were made for them had developed more autonomy. The narrative of a lack of autonomy was found only among participants who belonged to the first or in-between generation, but not the second generation.

Variation in responses of the women in the study to the oppression they perceived was associated with age, but also with their ability to envision and act upon other ways of being and doing. Cultural norms of female endurance and self-sacrifice and the injunction to be loyal to family and husband played an important role in this. The minority women we interviewed had often lived up to images of *the enduring wife* or *the obedient daughter* in order to avoid family turmoil or loss of (family) honor. These cultural images of women seem to have enabled respondents to cope with their hardship as well as hampered women's own transformation. Latifah, a Moroccan woman (single, aged 26, second generation, born and grown up in a large Dutch city, employed) who recently made a suicide attempt, was interviewed at her therapist's office and explained these norms:

> Latifah: "…A woman would do whatever it takes to keep her family together. The husbands usually cheat on their wives immediately… but not women. Women are strong, have to endure anything and suffer, yet manage to survive. A woman never shows her sorrows to others. She holds up the image of a good woman, so that it looks as if everything is perfect. A Moroccan woman will never say anything bad about her husband to an outsider… She will go to great lengths, because she doesn't want to be seen as a fallen woman."
>
> Interviewer: "…And do you mean [honor is] beautiful because of a woman's strength?"
>
> Latifah: "Because of perseverance, in order to maintain his [husband's] honor and pride."

For a number of women in the study, it appears that a process of self-transformation began when they developed a critical consciousness of the taken-for-granted roles and shifted towards recognizing their own will and needs. For example, a Turkish woman who was abused by her in-laws and used as a maid, eventually improved her life by obtaining a residence permit and renting her own house. Suicidal behavior was also a way of protesting and emerged when women said they had become tired of being taken advantage of. Participants in this category reported that it took years before their autonomy and personal well-being became a focus of attention. When suffering had reached its height and was ultimately questioned, regret emerged over past self-sacrifice and suicidal ideation started. This is illustrated in the following account of a Turkish woman, Fetiye (aged 40, born in rural Turkey, arrived in the Netherlands when she was 10 years old, housewife, divorced, interviewed at her therapist's office).

I blame myself for many things... Why me? Why did I let it all just happen? Why was I never able to say no? Why why why? Why have I never opened my mouth and asked my parents-in-law for the government benefits for the children to be paid to us, so I would have been able to buy something for my children? When I wonder about these things, I think: Shall I open the window and jump?

It took many years before Fetiye, who was married off to her cousin at the age of 12 and then kept at home to take care of the family-in-law, began to focus on her personal well-being. Her quote shows how, even after decades of housework and care work, she was still more concerned about her children's happiness than her own mental wellness.

In the stories of Fetiye and Fadime, migration was a factor in the difficult life conditions they faced. For instance, Fadime's parents had been living apart for many years while the father was in the Netherlands as a guest worker. This type of separation is common among guest workers and often such relationships face difficulties after reunification. All these factors led to an increased demand for domestic work from Fadime. Family members who would have been able to help out in Fadime's family in Turkey were unavailable in the Netherlands.

A lack of autonomy was not central to the life stories of most of the Dutch women in our study. However, we identified one case of a Dutch participant, whose family belonged to an orthodox Protestant Christian Church in which a lack of autonomy was central. She reported that her parents strictly controlled her during adolescence, which resulted in daily arguments and made her feel unable to think for herself later in life.

## A clash over strategic life choices

The second narrative theme featured a clash over strategic life choices as illustrated in the following excerpt from the interview with Karima, a Moroccan woman aged 23 who is a housewife with a young child. She had attempted suicide twice over the preceding 3 years. She was interviewed at her therapist's office.

> Interviewer: "When you made a suicide attempt... what made you so angry or sad?"
>
> Karima: "I am upset with myself for not being able to make a choice between staying married or to divorce. I am angry that I feel I can't manage raising the child alone, without my family. I have run away from home a few times, but somehow... I feel so lonely and unhappy. I don't want that either and then I return home. It seems as if my mother has brainwashed me... In my mind... she hunts me all the time, so to speak... then I panic..."
>
> Interviewer: "So, the struggle over the choice to continue or being on your own..."

> Karima: "Yes, I can imagine what my life would be like, very easily... I want to finish my studies and achieve something, but to act upon it is so hard, because I want my parents. I cannot choose and it makes me crazy. I hate seeing them unhappy; that they have not succeeded to have the kind of daughter they wanted."

As shown in Karima's account, the clash usually originated in the family's attempt to influence various life domains including education and marriage. In contrast to the first pattern, young women with this type of narrative clearly had developed a sense of autonomy and aimed to be in control of their lives. This pattern was found exclusively in second-generation immigrant young women. Altogether, eight women fell into this category, all of whom were minority women, in particular of Moroccan background.

The childhood of Karima and several other participants of the second generation showed (ethnic) identity struggles due to what were felt to be irreconcilable demands in different domains. This was mainly between traditional culture at home (which includes obedience to parents, restriction of movement, having an arranged marriage, becoming a housewife) versus common values prevalent in Dutch society and at school (assertiveness, opting for a college degree, a career, choosing a spouse). Some of them explained they also felt different from majority youngsters, whose parents would hint that they, as immigrant children, were different or poor. The conflicts with their parents intensified during puberty when serious clashes emerged, especially over restriction of movement, romantic relationships, living independently, and educational choices. Subsequently, women critiqued the control they faced, which provoked fights or punishment. Sometimes secret strategies emerged that involved sisters or nieces providing alibis regarding the whereabouts of the young woman after school. Another strategy employed by two Moroccan women (Karima and one other woman) was to run away from home. As shown in Karima's story, such decisions were difficult to make and were followed by ambivalence or regret.

Women with narratives of this type felt that their realization of important needs in life was obstructed and wished that their family would be more supportive. The hopelessness that emerged originated in a split between loyalty towards parents versus their quest for goal fulfillment. This led them to a deadlock in which they felt intense frustration over seemingly insoluble issues and suicidal behavior emerged. A 26-year-old Turkish woman, Hanife, employed as a civil servant who had suffered from suicidal ideation in her late teens and early twenties explained the deadlock in the following interview quote:

> When it comes down to men, relationships and sexuality, there is no such thing as a happy medium! These topics are huge obstacles, and I can't make them disappear ... I had a boyfriend for a while, but it was just too heavy ... I saw him only once every three weeks, and had to come up with all sorts of excuses at home to see him ... I wanted to fit in so desperately... I felt I had to meet all sorts of expectations ... I tried

to be the normal and nice girlfriend for him, yet I could never become a serious part of his life. And on the other hand I was lying bluntly in my parents' face ... It was as if two worlds existed independently from each other, and I was searching for the part to connect them: a way to make both my parents happy as well as living my own life the way I wanted it. But it was just impossible.

As the cases of Hanife and Karima demonstrate, relations with their parents became complex and alienated. Hanife and Karima blamed their parents for not taking into account that their happiness is intertwined with self-realization. The tragic irony is that by exercising control over strategic life choices, their parents also wanted to safeguard the family ties. Both parties appeared unable to demonstrate adaptability; other ways of being and doing were not envisioned because modern and traditional values were perceived as irreconcilable. In the cases of Hanife and Karima, who belong to the second generation, their family history of migration had some relevance to their dilemmas. Their parents were traditional and struggled with their children's upbringing amidst a host society with different values. From Karima's account, it was evident that in the rural areas where her parents came from daughters did not opt for a college degree and a career. Negotiation between daughter and parents, as Karima had become familiarized with through her western socialization was not common in her parents' community of origin.

## Lack of connectedness and affection

The key feature constituting this pattern was uncertainty or negation of care and understanding by the parent(s). The relationship with the parent(s) became severely disturbed over the years as a result of an upbringing where participants reported that affection was not (sufficiently) shown and young women felt their parents did not care to understand their inner world. Moreover, psychological maltreatment (e.g., denigration and manipulation), physical or sexual abuse were occasionally reported as conducted by the parent(s). A strong sense of isolation and lack of connectedness emerged, which was often reinforced by bullying, for instance at school or by siblings. Substance abuse or psychiatric illness of the parent(s) also played an important role in some instances affecting ability to care. Nineteen participants fell into this category, who were mostly Dutch and South Asian-Surinamese. A lack of connection seems to be the contraposition of the issues over autonomy observed in the first two narrative themes. Being relationally over-absorbed characterized Pattern 1 and 2, while in Pattern 3 family ties lack meaning, affection, and connection.

Two subpatterns emerged within this theme: the first one refers to a context where parent(s) hardly communicate any affection or interest, sometimes combined with continuous arguments over what is remembered later as unimportant issues of household tasks or schoolwork. In the second subpattern there is ongoing instability in the affection that parent(s) demonstrate. The timing of the suicide attempt

coincides with women in the study feeling misunderstood or unloved, with consequent isolation being felt intensely. Although in some accounts, conflicts over strategic life choices or an impaired self-image were found in addition to a lack of affection, yet these aspects were not central to the life story.

These points are instantiated in the interview fragment with Manisha, a South Asian-Surinamese woman, aged 32. She immigrated to a large Dutch city when she was 7. She is a divorced housewife and made several suicide attempts in her twenties. She was interviewed at home:

> She [mother] was very mean to me and I felt so hurt and lonely [she speaks about revealing the incest committed by her father] I didn't get any support from anybody. First my mother supported me, but then she switched completely... My whole world collapsed... she started to accuse me instead. She said to my sister and brother: "She herself does this and she does not tell when her father touches her," while I didn't dare to tell because I was so afraid. And after a couple of months, she just left for a holiday, with my sister. While she knew what happened, she just left me for five months. And all that time my father just went along with touching me, he could do whatever he wanted; my mother wasn't even there.... She has never given me time, love or attention—everything I needed. She has never been there for me.

Cultural norms of gender seem to make a contribution to this pattern. In the case of a Turkish woman, family relationships were warm until her brother-in-law allegedly raped her. She then went to a women's shelter, and she reported that gossiping about her reputation started in her family and ethnic community. She reported that her family behaved coldly towards her, which had prolonged effects on her psychological well-being and diminished her ability to cope with the aftermath of the abuse. In addition, Manisha remarked that men are valued more in her culture. She observed how her brother was chosen over her, when her mother had to choose whom to bring first to the Netherlands. In addition, after she had disclosed the incest, her mother remarked: "In our culture, women are expected to commit suicide then."

An authoritative parenting style was frequently reported in South Asian-Surinamese families of participants. Some participants reported that this interacted with a lack of affection to produce difficulties. Difficulties also resulted from confusion over moral values. For instance, a South Asian-Surinamese mother initially wanted to give her daughter a modern upbringing and let her be introduced to dating. Later she regretted this and scolded her daughter for indecent behavior. Such confusion over morality may indicate social change among the South Asian-Surinamese in the Netherlands.

## A sense of self lacking in worthiness as a result of upbringing

Derya is a Turkish woman of the first generation, divorced, 30 years old, with a child, employed. She grew up in a Turkish city and came to the Netherlands when

she was 18 to live with her Turkish husband. She attempted suicide twice in her teens and twenties. She was interviewed at her therapist's office, who also did the translation:

> It seems as if the world has always been too much for me, or as if I have always been too much for this world. I cannot live, I do not want to live—I always have these feelings . . . I do not succeed in life, I cannot live like others do . . . If I would be able to love myself then I would be able to love others . . . When I grew up, I couldn't do anything without permission of my father and had no confidence in myself. The fact that I do not have self-esteem is because of that.

This pattern concerns an upbringing that did not strengthen self-worth nor emphasized dignity. Young women who fell into this category narrated their feelings of self-hatred, worthlessness and inadequacy, which were central to their suicide attempt. There was hardly any control in the family context as opposed to the narratives that focused on autonomy (1 and 2). In two cases, a lack of care was also observed, yet this was less strongly felt by women compared to a lack of affection. The mechanisms leading to a denigrated sense of self were somewhat different for minority and majority women in the study. For the majority women whom we interviewed, the path towards a low self-image was mediated through stressful life events for example, bullying, school anxiety, denigration and physical abuse by family members. These events often led to feelings of isolation. Women belonging in this category expressed self-hatred. Nurturing of self-value had been absent in their upbringing. Although some women in this category also reported a lack of affection from their parents as in the third pattern, their impaired self-worth was central in their narratives. Nine women belonged to this category, three of whom were Dutch, the rest included two of each cultural minority group.

The same factors that contributed to a lack of self-value found in majority women were also present in the minority women we interviewed, yet for minority women honor-related issues also played an important role. Stressful life events consisted of (the fear of) their ambiguous position in their ethnic community because of the stigma of *women who have gone astray* or who were suspected of this. For instance, one Moroccan woman, daughter of a single mother was ostracized because this was considered shameful in her ethnic community.

For two South Asian-Surinamese women and a Moroccan woman, the loss of their virginity (in two cases by untrustworthy boyfriends and in one case through rape) resulted in a seriously decreased sense of self-worth; they were very ashamed that they had lost their honor. Four minority women were very afraid to tell their families what had happened. When they did speak out, women experienced rejection by their family and community. Young women felt hurt and wished their parent(s) had been more supportive. Minority women in the study reported that the experience of sexual abuse or divorce decreased their chance of finding a partner or spouse substantially. This was not the case for majority women.

### Psychiatric illness leading to unbearable suffering

The last narrative theme concerns the domination of one's life by a psychiatric illness, for example, depression, panic attacks and (general) anxiety, and psychotic episodes. Mental pain and suffering influenced either by anxiety, hearing voices, or social stress (e.g., financial loss) triggered women's suicidal behavior. Four women belonged to this category, two Dutch, one Turkish and one Moroccan of the first generation of immigrants. Willemijn is a Dutch woman, aged 40, unemployed, interviewed at home. She made two suicide attempts in her thirties:

> I feel that I am using more energy than I can create, and that eventually, this will result in my death. It feels like I have a psychiatric ulcer that asks more and more of my energy … The anxiety I feel makes it impossible to function and work…. I cannot cope with life. I find life very beautiful, but I have not been equipped to live it.

Regarding the minority group, the migration process seems to have been too difficult a task for these Moroccan and Turkish women thus precipitating psychiatric problems, acculturative stress, and a sense of isolation. It concerned two women of the first generation who spent (most of) their childhood in their country of origin. Different from all the other minority women we interviewed, these two had immigrated to the Netherlands on their own for the purpose of marrying a Dutch man. In that sense, cultural alienation was more profound for them than for others. The two women narrated with a sense of nostalgia their youth when their life was still going well. Problems in the parent–child relationship and family environment during these women's upbringing, which prevail in other patterns, could hardly be identified. As opposed to Patterns 1 or 2, parents (in-law) or the husband had little influence on women's autonomy.

Although a majority of the women in the study had been diagnosed for example with depression or a borderline personality disorder, very few highlighted these disorders as the key explanation for the development of their suicidal behavior. There was variation in the extent to which participants included psychiatric causes as explanations for their suicidal behavior. Dutch majority women in the study were more inclined to mention psychiatric causes, perhaps because of their western culture and its familiarity with psychopathology. On the other hand, their explanatory frame seemed to have been influenced by education as well, that is, women with higher education were more inclined to name psychiatric disorder as a relevant factor. Table 2 summarizes the narrative themes that emerged and shows the variation across ethnicities and generations of immigrants.

## Discussion

This study was inspired by the variation in rates of suicidal behavior that exists among ethnicities and the vulnerability of minority women to suicidal behavior. Autonomy was an important theme in many of the life stories of immigrant women

in the study. The origins of suicidal behavior in young women in this research overall could perhaps be traced to inner pain caused by difficulties in directing their life course toward fulfillment, personal well-being, and meaningful relationships. The analysis of the life stories suggested that a framework that combines autonomy together with relatedness (Kağitçibaşi, 2005) is highly beneficial to understanding the suicidal behavior of young women. The narrative theme of (a) a lack of autonomy (b) and the one about a clash over autonomy appear to constitute a continuum; when the lack of autonomy is felt by a woman and ultimately questioned, a struggle over *strategic life choices* (Kabeer, 2001) may emerge. The step from Pattern 1 to 2 also seems to develop over generations; the first pattern featured women belonging to the first and in-between generations of immigrants, while the second pattern consisted of the second generation. Extreme ends of the scale influence suicidal behavior: Both a lack of connectedness with their family (Narrative Theme 3) as well as being overembedded by family demands and wishes of significant others (Narrative Themes 1 and 2) lead to decreased well-being that puts immigrant women at risk for suicidal behavior.

On a closer inspection, the narrative theme of low self-image could be incorporated within an autonomy-relatedness framework in the sense that a healthy self-image is hard to pursue in a cultural environment in which women are reportedly blamed for the loss of family honor. Lastly, the narrative theme about psychiatric illness as a key factor in suicidal behavior is linked with autonomy connectedness as well, in the sense that these young women felt they were overwhelmed by external factors (psychosis, anxiety) over which they could not exert any control.

The findings underscore the insights of feminist scholars that autonomy is not built on individualism or egoism but is relational in nature (MacKenzie & Stoljar, 1999). The social features of their ego development were also demonstrated by the impact of cultural norms prevailing in the women's families and communities. These images focused on embodying the *enduring wife*, which resulted in

**Table 2.** Narrative themes emerging from life stories of women with a history of suicidal behavior (N = 47)

| | Turkish | Moroccan | South Asian-Surinamese | Dutch | Total |
|---|---|---|---|---|---|
| | $n = 10$ | $n = 10$ | $n = 13$ | $n = 14$ | $n = 47$ |
| Narrative theme | n (%) | n (%) | n (%) | n (%) | n (%) |
| 1. Transformation to autonomy | 4 (40) | 1 (10) | 1 (8) | 1 (7) | 7 (15) |
| 2. Clash strategic life choices | 2 (20) | 5 (50) | 1 (8) | 0 (0) | 8 (17) |
| 3. Lack of connectedness | 1 (10) | 1 (10) | 9 (69) | 8 (57) | 19 (40) |
| 4. Lack of self-worth | 2 (20) | 2 (20) | 2 (15) | 3 (21) | 9 (19) |
| 5. Psychiatric illness | 1 (10) | 1 (10) | 0 (0) | 2 (14) | 4 (9) |

incorporating the fate of suffering, and avoiding being *a woman who has gone astray*, relating to a lost sense of (family) honor. An impaired sense of self-worth was linked to culture, since honor and shame are known to be important in Islamic as well South Asian-Surinamese culture (Brouwer et al., 1992). Notably, these gender norms enabled women in the study to cope with their suffering, while they simultaneously led to praxis that "silenced women's selves" (Jack, 1991).

The critical awareness of gender norms brings to mind the work of Bourdieu who argues that common sense propositions of culture need to begin to lose their "naturalized" character before alternative possibilities can be imagined (Bourdieu, 1977). This suggests that suicidal behavior is a product of a socialization that did not equip women with more viable directions to protest against oppressive conditions. This also underscores the work of Bordo (1997), who argued how the body could be read and translated as a text. Individuals invest the body with meaning to give voice to "dramas of social oppression" (Bordo, 1997, p. 8). Suicidal behavior can be related to a return to the "semiotic level, a self repudiating form of discourse in which the body signifies what social conditions make it impossible to state linguistically" (Bordo, 1997, p. 97). The positioning of women in the lower strata of power relations is an effect of cultural and gender divisions in their social world. This plays a crucial role in their response of internalizing their distress.

We also observed that the first generation of rural immigrants in the study had less awareness of autonomy compared to the second generation. This suggests that awareness of autonomy may increase over generations, and an upbringing amidst a different host society may foster the recognition of autonomy. However, in southeast Turkey (Batman) and rural Surinam (Nickerie), elevated rates of female suicidal behavior exist as well. Oppressive conditions, poverty, and denial of strategic life choices to women have been mentioned as causes for women's suicidal behavior in these areas (Bağlı & Sev'er, 2003, Spijker, van Graafsma, Dullaart, & Kerkhof, 2009). Autonomy restriction may help explain the suicidal behavior of women in these situations as well. The right to autonomy of strategic life choices is a minimum well-being condition for all human beings. A socialization that does not stimulate or actively denies autonomy, may put the desire for autonomy "on hold" for several years. The emergence of suicidal behavior among the women in this study stemming from oppressive conditions suggests that the urge for personal freedom may come to the fore regardless of nation, culture, and ethnicity. At the same time, it is clear that socialization that fosters autonomy skills will better equip individuals to deal with these situations, when later in life, they are confronted with circumstances in which their right to autonomy is restricted (Saharso, 2007).

## Conclusion

Suicidal behavior has been characterized as a "cry of pain" in a "stage of entrapment" (Williams, 2001). The narrative themes in the life stories of young immigrant women who attempted suicide were consistent with this perspective and revealed experiences of disempowerment in which pursuing a meaningful life is

unattainable. The disempowerment may refer to concrete oppressive situations or unaffectionate environment, as well as to states of mental distress and feelings of personal inadequacy. In all of the life stories there is an implicit or explicit longing for a life that moves toward relational fulfillment and goal attainment. The participants shared a perception of the impossibility to assert control over these crucial aspects. Fortunately, we also observed that women in the study were not frozen in unrewarding lives forever; shifts toward greater autonomy did eventually happen, sometimes after many years. This also underscores the relevance of the life story method for detecting such changes over time. These transformations indicate the potential benefits of autonomy awareness programs for immigrant women as a prevention strategy. In addition, immigrant women deserve assistance while coping with practices of silencing their selves, and they need support in order to contest cultural norms imposed upon women in their families and communities. Those women, for whom a lack of affection and care by their family was central in the pathway to a suicide attempt, may benefit from family counseling programs that enhance mutual relationship building between parents and their children.

## Funding

## Notes

1  In the 1990s, the rates of suicide increased twofold for young women in all three minority groups. By 2003, the rates for South Asian-Surinamese and Turkish women were still significantly higher, while those of Moroccan women had changed (incidences of suicidal behavior registered in the city of The Hague 2002–2003 (per 1,000 per year): Turkish women aged 15–19 years: 5.0 incidences. Turkish women aged 20–24 years: 7.0. Surinamese women aged 15–19 years: 4.5, and aged 20–24 years: 4.0. Moroccan women aged 15–19 years: 2.3, and aged 20–24 years: 2.0. Dutch women aged 15–19 years: 1.0, and aged 20–24 years: 1.5) (Burger et al., 2005).
2  Participant names are pseudonyms.

## References

Baca-Garcia, E., Perez-Rodriguez, M. M., Mann, J. J., & Oquendo, M. A. (2008). Suicidal behavior in young women. *Psychiatric Clinics of North America*, *31*(2), 317–331.
Bağlı, M., & Sev'er, A. (2003). Suicide, suicide theories, suicide rates, female suicides, Turkish women, gender and suicide, patriarchy and women's health, poverty and suicide. *Women's Health and Urban Life*, *2*(1), 60–84.
Bhugra, D., & Desai, M. (2002). Attempted suicide in South Asian women. *Advances in Psychiatric Treatment*, *8*(6), 418–423.
Bordo, S. (1997). The body and the reproduction of femininity. In K. Conboy, N. Medina, & S. Stanbury (Eds.), *Writing on the body: Female embodiment and feminist theory* (pp. 90–113). New York, NY: Columbia University Press.

Bourdieu, P. (1977). *Outline of a theory of practice*. Cambridge, UK: Cambridge University Press.

Brouwer, L., Lalmahomed, B., & Josias, H. (1992). *Andere Tijden, Andere Meiden. Een Onderzoek naar het Weglopen van Marokkaanse, Turkse, Hindostaanse en Creoolse Meisjes [Different times, different girls. A study of Moroccan, Turkish, Hindustani and Creole runaway girls]*. Utrecht, the Netherlands: Van Arkel.

Burger, I., van Hemert, A. M., Bindraban, C. A., & Schudel, W. J. (2005). Parasuïcide in Den Haag: Meldingen in de jaren 2000–2004 [Parasuicide in The Hague. Incidences in the years 2000–2004]. *Epidemiologisch Bulletin*, *40*(4), 2–8.

Canetto, S. S. (2008). Women and suicidal behavior: A cultural analysis. *American Journal of Orthopsychiatry*, *78*, 259–266.

Chanfrault-Duchet, M. F. (1991). Narrative structures, social models and symbolic representations in the life story. In S. Berger Gluck, & D. Patai (Eds.), *Women's words: The feminist practice of oral history* (pp. 77–93). New York, NY: Routledge.

Dagevos, J., & Gijsberts, M. (2009). Jaarrapport. *Integratie 2009 [Annual report on integration 2009]*. The Hague, the Netherlands: Sociaal en Cultureel Planbureau, Nederland.

Dekovic, M., Pels, T., & Model, S. (2006). *Child rearing in 6 ethnic families. The multicultural Dutch experience*. Lewiston, ME: Mellenpress.

De Leo, D., Burgis, S., Bertolote, J. M., Bille Brahe, U., & Kerkhof, A. J. F. M. (2006). Definitions of suicidal behavior: Lessons learned from the WHO/EURO Multicentre Study. *Crisis, The Journal of Crisis Intervention and Suicide Prevention*, *27*(1), 4–15.

Herrera, A., Dahlblom, K., Dahlgren, L., & Kullgren, G. (2006). Pathways to suicidal behavior among adolescent girls in Nicaragua. *Social Science and Medicine*, *62*(4), 805–814.

Hjelmeland, H., Knizek, B., & Nordvik, H. (2002). The communicative aspect of nonfatal suicidal behavior: Are there gender differences? *Crisis, The Journal of Crisis Intervention and Suicide Prevention*, *23*(4), 144–155.

Jack, D. C. (1991). *Silencing the self: Women and depression*. Cambridge, MA: Harvard University Press.

Kabeer, N. (2001). Resources, agency, achievements: Reflections on the measurement of women's empowerment. In *Discussing Women's Empowerment: Theory and Practice, 3*, 17–57. Stockholm: SIDA (Swedish International Development Cooperation Agency).

Kağitçibaşi, C. (2005). Autonomy and relatedness in cultural context. *Journal of Cross-Cultural Psychology*, *36*(4), 403–422.

Mackenzie, C., & Stoljar, N. (1999). *Relational autonomy. Feminist perspectives on autonomy, agency and the social self*. Oxford, UK: Oxford University Press.

Mungra, G. (1990). *Hindostaanse gezinnen in Nederland [Hindustani families in the Netherlands]*. (Unpublished doctoral thesis). University of Leiden, Leiden, the Netherlands.

Saharso, S. (2007). Is freedom of the will but a western illusion? Individual autonomy, gender and multicultural judgement. In B. Arneil, R. Dhamoon, & A. Eisenberg (Eds.), *Sexual justice/cultural justice* (pp. 122–138). London, UK: Routledge.

Schudel, J., Struben, H. W. A., & Vroom-Jongerden, J. M. (1998). Suïcidaal gedrag en etnisch-culturele afkomst 1987–1993 [Suicidal behavior and ethnic origin in the years 1987–1993]. *Epidemiologisch Bulletin*, *33*(4), 7–13.

Spijker, B. A. J., van Graafsma, T., Dullaart, H. I. A., & Kerkhof, A. J. F. M. (2009). Impulsive but fatal self-poisoning with pesticides among South Asians in Nickerie, Surinam. *Crisis, The Journal of Crisis Intervention and Suicide Prevention*, *30*(2), 102–105.

Van Bergen, D. D. (2009). Suicidal behavior of young migrant women in the Netherlands: A comparative study of minority and majority women. (Unpublished doctoral thesis). VU University Amsterdam, the Netherlands).

Vermeulen, H., & Penninx, R. (2000). *Immigrant integration: The Dutch case*. Amsterdam, the Netherlands: Het Spinhuis.

Williams, M. G. (2001). *Suicide and attempted suicide. Understanding the cry of pain*. London, UK: Penguin Books.

**Diana D. van Bergen** obtained her PhD in the Department of Sociology at VU University, Amsterdam in 2009. Her thesis focused on suicidal behavior in young migrant women in the Netherlands. Currently, she is a postdoctoral researcher in the Department of Theory and Research in Education at VU University, Amsterdam. [Email: d.d.van.bergen@vu.nl]

**Anton J. L. M. van Balkom** is a Professor in the Department of Psychiatry at VU University and works as a clinician at VU Medical Center in Amsterdam. Address: Department of Psychiatry, VU Medical Center, A.J. Ernststraat 887, 1081 HL, Amsterdam, the Netherlands. [Email: T.Balkom@ggzingeest.nl]

**Johannes H. Smit** is a Professor in Survey Methodology in the Department of Sociology at VU University Amsterdam and in the Department of Psychiatry at VU Medical Center in Amsterdam. Address: Department of Psychiatry at VU Medical Center, A.J. Ernststraat 887, 1081 HL, Amsterdam, the Netherlands. [Email: j.smit@ggzingeest.nl]

**Sawitri Saharso** is a Professor in Intercultural Management at the School of Governance at the University of Twente and in the Department of Sociology at VU University, the Netherlands. Address: School of Management and Governance at the University of Twente, PO Box 217, 7500 AE, Enschede, the Netherlands. [Email: s.saharso@utwente.nl]