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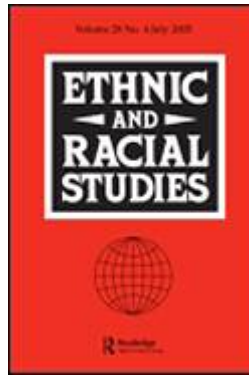
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Suicidal Behavior of Young Immigrant Women in The Netherlands.

Can we use Durkheim's concept of 'fatalistic suicide' to explain their high incidence of attempted suicide?

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Abstract

Young immigrant women of South Asian, Turkish and Moroccan origin in The Netherlands demonstrate disproportionate rates of non-fatal suicidal behavior. Suicidal behavior 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 behavior 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 honor. 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 behavior of young immigrant women in The Netherlands and incorporated in 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 behavior 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 nineties, the rates of suicidal behavior of South Asian, Turkish and Moroccan women in the age range of 15-24 years old appeared to be two to four times higher than that of majority Dutch young women.¹ By 2005, the rates for South Asian and Turkish young females continued to be disproportionate, while those of Moroccan young women were still increased compared to Dutch young women- yet not statistically

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3 significant. The reports on the alarming rates of suicidal behavior of young immigrant
4 women occasioned the research into the background of this phenomenon.²
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7 Suicidal behavior is defined by the World Health Organization (WHO) as: ‘a non
8 habitual act with a non-fatal outcome that the individual, expecting to, or taking the risk to-
9 die or inflict bodily harm, initiated and carried out with the purpose of bringing about wanted
10 changes’ (De Leo *et al*, 2005). It concerns behavior including self-poisoning by taking an
11 overdose of pills or cutting the wrist(s). The desired change includes, but is often not limited
12 to, the intent to die. In addition, desired changes may include a wish to escape from an
13 unbearable situation or thoughts, the search for peace of mind or the wish to communicate to
14 others how much they are in mental pain (Hjelmelandt *et al*, 2002).
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25 Research in suicidology usually explains suicidal behavior almost exclusively by
26 psychiatric and psychological risk factors e.g. mental illness and dysfunction in personality.
27 However, studies have pointed at the possible relevance of sociological theory of
28 Durkheim’s *fatalistic suicide* of young women worldwide originating in overregulated lives
29 and their discontent with their social roles (see for instance, Iga (1981) on suicidal behavior
30 of Japanese women or Davies and Neal (2000) on the suicide of women in rural China). Two
31 Dutch studies based on interviews with female South Asian students aged between 16 and 24
32 indicated that they are often faced with high levels of control exercised by their parents
33 (Salverda 2004, Krikke *et al* 1999). This led us to analyse the relevance of Emile
34 Durkheim’s concept of *fatalistic suicide* for understanding the suicidal behavior in young
35 South Asian as well as Turkish and Moroccan women in The Netherlands (van Bergen *et al*,
36 2006).
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51 Durkheim’s work was based on an investigation of records of suicide in the late
52 nineteenth century, when registration of non-fatal cases of suicidal behavior did not yet exist.
53 Across all ethnic groups in The Netherlands, men commit suicide twice as often as women,
54 while more women than men attempt suicide.³ This disparity is known as the *gender*
55 *paradox* in suicidology. This pattern of male to female ratio (2:1 up to 3:1) can be observed
56 world- wide (with exception of rural China, where more women than men die by suicide)
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3 (Beautrais, 2003; Canetto & Lester, 1995). Durkheim's focus on lethal cases, as well as the
4
5 male to female ratio in suicide statistics precipitates the question whether it is justified to use
6
7 Durkheim's concepts for examining the non-fatal suicidal behavior of young women.
8
9 However, recent research indicates that those young individuals who die by suicide and
10
11 those who attempt are not a distinct population but rather a similar group. Beautrais (2003)
12
13 established by a case control study that those youngsters (15-24 years old) who die by
14
15 suicide and those who attempt suicide share common sociological characteristics, psychiatric
16
17 diagnostic and psychiatric history features. These features concern an exposure to recent
18
19 stressful life events, lack of formal educational qualifications, a mood disorder and a history
20
21 of psychiatric care. Beautrais argues that the fact that men more often die by suicide than
22
23 women could hence be attributed to their choice of more lethal methods. This proposition is
24
25 supported by the fact that female youth suicides in New Zealand more than doubled from
26
27 1977 to 1996, notably due to the increased use of hanging and vehicle exhaust gas by
28
29 women. These findings argue against a rigid separation of lethal versus non-lethal suicidal
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31 behavior. Therefore, we believe it is justified to use Durkheim's theory for our focus on the
32
33 non-fatal suicidal behavior of immigrant women.
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38 In this paper, our research procedures and research subjects will be described first.
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40 Subsequently we investigate the contribution of psychiatric and psychological risk factors
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42 and incidences of abuse and then the results will be compared. Durkheim's archetype of
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44 *fatalistic suicide* will be described next. Since the registration of suicidal behavior indicate a
45
46 relation between suicidal behavior, gender and ethnicity we also verify how regulation can
47
48 be understood in the light of these markers. Subsequently, we demonstrate the cultural
49
50 context of South Asian, Turkish and Moroccan young women who demonstrated suicidal
51
52 behavior by providing a number of case file summaries. We conclude and discuss the
53
54 relevance of Durkheim's theory for explaining and preventing the suicidal behavior of young
55
56 minority women.
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Methodology and Description of the Sample

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3 Durkheim was criticized for the fact that he solely categorized on the basis of external and
4
5 observable characteristics by using aggregated level data (for instance on divorce rate,
6
7 income level or urbanization rate). By neglecting to study the individual dispositions,
8
9 suicides are treated as to occur in a social void, without reference to values and beliefs that
10
11 constitute the cultural milieus of individuals (Hamlin & Brym, 2006). By contrast, in our
12
13 study we focused on collecting data that could illuminate the specific social environment and
14
15 living conditions of young women. We thus chose to investigate medical case files
16
17 consisting of accounts of mental health care workers on the lives of young women.
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19

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21 We selected case files (N=115, mean age 23.5, SD=6.6) of females between 12 and
22
23 41 years old of South Asian (N=24, mean age 25.3, SD=5.9)⁴, Turkish (N=32, mean age
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25 23.7, SD=6.7), Moroccan (N=30, mean age 23.7, SD=6.4) and Dutch (N=29, mean age 21.7,
26
27 SD=6.7) origin on the basis of the WHO definition of suicidal behavior, non native-Dutch
28
29 last name and age. Two researchers assessed the files whether they belonged to the selection.
30
31 The files were available from the archives of a public mental healthcare centre (95 per cent
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33 of the cases for the years 1995-2005) and an academic hospital in the city of Amsterdam (5
34
35 per cent of the cases for the years 2003-2005). Permission was granted from the Medical
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37 Ethical Committee. The case files were a collection of notes of the treatment made by
38
39 psychiatric nurses, psychologists or social workers and psychiatrists (in training). Although
40
41 the files were not filled out systematically, since several professionals were involved with
42
43 one patient and wrote the notes, this functioned as a cross check and increased triangulation.
44
45 Research indicated that immigrant females appear most at risk in the age group of 15 to 24
46
47 years old, yet our research subjects were aged between 12 to 41 years old. The rationale
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49 behind this is that suicidal behavior is known for its repetitive character (Arensman &
50
51 Kerkhof, 2003).
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56 To clarify the extent to which social and economic class could possibly be related to
57
58 overregulation, we selected Dutch control cases of which the parents had a low professional
59
60 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

1
2
3 suicidology to be clear risk factors for suicidal behavior (Beautrais, 1998) e.g. demographics,
4
5 childhood, relationship with parents, social support, relationship with partner, life events,
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7 sexual and physical abuse as well as psychiatric and psychological disorders. In addition, we
8
9 also collected the occasion and method used for suicidal behavior. In a later stage, by
10
11 shifting back and forth through the data on the life events of ethnic minority women, the
12
13 principal researcher recognized elements of *fatalistic suicide* and subsequently included
14
15 factors of overregulation in the analysis.
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21 *Table 1, 2 and 3 about here*
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23 24 25 **The Relevance of Risk Factors of Psychiatric or Psychological Disorders and Physical** 26 27 **or Sexual Abuse**

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29 A plausible contribution to the suicidal behavior of young immigrant women is the
30
31 manifestation of psychiatric and psychological disorders. In addition, the rates of suicidal
32
33 behavior are elevated amongst those having multiple diagnoses of psychiatric disorders (co-
34
35 morbidity). Some studies into psychiatric diagnoses among immigrants in The Netherlands
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37 hint at increased rates of certain psychiatric diagnoses e.g. an elevated prevalence of anxiety
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39 disorder and depression for Turkish immigrants aged 12 to 65, while schizophrenia appears
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41 to be more often diagnosed in Surinamese and Moroccans, whether born in the country of
42
43 origin or in The Netherlands (Van Oort *et al* 2007, de Wit *et al*, 2005). However, research
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45 from the United Kingdom indicated that psychiatric disorders were significantly more
46
47 common in British majority women than in South Asian immigrant women who had
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49 demonstrated suicidal behavior (Bhugra *et al*, 1999). These contradictory findings have
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51 prompted us to examine the psychiatric and psychological risk factors of Dutch majority
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53 young women versus the ethnic minority women who displayed suicidal behavior.
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60 *Table 4 about here*

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3 Overall, having a psychiatric or personality disorder appears more relevant as a risk factor
4 for Dutch (84 per cent) in comparison to Turkish (59 per cent) and Moroccan women (57 per
5 cent) while South Asian women differ less substantially from Dutch women (67 per cent).
6
7 This difference in the Dutch majority as opposed to minority women originates in seemingly
8 higher incidences of mood and anxiety disorder in Dutch majority women. Co-morbidity is
9 notably more often found in Dutch women (68 per cent) compared to South Asian (33 per
10 cent), Turkish (28 per cent) and Moroccan women (27 per cent).
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18 Research into the role of sexual and physical abuse unanimously shows that these
19 experiences are a serious risk factor for suicidal behavior (Salander-Renberg *et al*, 2004,
20 McHolm 2003). These findings motivated us to examine their contribution to our research
21 subjects and compare the results.
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29 *Table 5 about here*
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33 In correspondence with previous research findings, the frequency of sexual abuse and
34 physical abuse in our sample is quite high. Sexual abuse is more often mentioned in the files
35 of Dutch young women compared to ethnic minority women, whereas physical abuse is
36 equally reported across ethnicities. This may reflect actual disparities, but it seems plausible
37 that a taboo around sexual abuse in cultures that value chastity and virginity, like the
38 Turkish, Moroccan and South Asian culture (Brouwer *et al*, 1997) has resulted in some
39 underreporting.
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49 In sum, previous research findings on immigrants being more vulnerable to
50 psychiatric disorders were not confirmed in our study and incidences of abuse were equally
51 distributed as risk factors across ethnicities. These findings led us to suggest that psychiatric
52 or psychological illnesses and abuse are not the key to explaining why minority women
53 demonstrate more often suicidal behavior than majority Dutch women. Hence, we turn to
54 explore the relevance of *fatalistic suicide*.
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Durkheim's Fatalistic Suicide

A theoretical prism that continues to be beneficial in suicidology today is Durkheim's standard work 'Le Suicide' (Hamlin & Bryn, 2006; Kushner & Sterk, 2005). 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 of suicide as resulting from an entirely personal phenomenon, such as the existence of mental illness (Durkheim 1952). Durkheim's work, which resulted in a typology of suicide, must be understood as Weberian ideal types (Acevedo, 2005). 'Le Suicide' focuses on two core elements: the amount of social integration and 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 at the extent to which society or a social group has control over the emotions, motivations and behaviors of its individual members through the 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 behavior (Acevedo, 2005).

Fatalistic suicide is characterized by a situation of extremely high levels of social regulations, 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 a suicide as a result of over-regulated and thus unrewarding lives: 'futures are pitilessly blocked and passions violently choked by oppressive discipline' (Durkheim, 1952, pp. 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 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 under regulation or *anomic suicide* following from the decline of importance of social norms due to processes of modernization.

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Despite the under reporting in Durkheim's work on *fatalistic suicide*, we have indicators that its features of overregulation are highly relevant to the suicidal behavior of young immigrant women in The Netherlands. For reflections of the mechanisms involved in *fatalistic suicide*, we turn to the arguments of scholars who have discussed it. Pearce (1989) described the subservient situation of slaves who were considered the property of their masters, as inferior and dehumanizing and 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, pp. 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 one's fate, which results in a sense of powerlessness and meaninglessness.

One of the few other examples mentioned by Durkheim on *fatalistic suicide* is the suicide of housewives who remain without children. Even though at first the example seems rather outdated in the 21st century, for the sake of the argument we investigate it. Durkheim argues (1952) 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. 520-521). This touches upon a crucial aspect. The experience of constraint begins when the regulation is not (anymore) based in accepted norms, but when these norms are not (any

longer) internalized, judged as external and hence they can only be upheld through force.

Fatalistic suicide is a reaction to a force coming from outside, perceived as unjust and that 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 one's 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 describe these as a clear case of *fatalistic suicide*, mostly because of the restricted sex roles for women. Central to these restrictions are practices of marrying off daughters by all-powerful families. These daughters subsequently live in unhappy marriages under the tyranny of the 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 behavior is associated with the rural family system as well as demonstrates 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 this 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. While 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 to have meaningful relations and lacks a sense of connectedness.

Overregulation in Young Immigrant Women's Lives: Intersections of Gender and Culture

Since it concerns females from specific ethnic minority immigrant groups in The Netherlands who display disproportionate rates of suicidal behavior 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 if there is a relation between gender and ethnicity on the one hand, and overregulation on the other. Hierarchal

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3 and oppressive structures of gender and ethnicity intersect in different ways for different
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5 groups. Identities cannot be reduced to a single marker because they are interlocked. Because
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7 of this entanglement, it should be investigated how the gender system and its relation with
8
9 other systems of inequality and oppression may function. Multilayered and routinized forms
10
11 of domination that often converge in women's lives, prompts for analysing multiple grounds
12
13 of identity when considering how the social world is constructed (McCall, 2005).
14

15
16 Ethnic minority groups deploy cultural practices that originate in distinct sets of
17
18 behavior and beliefs that often distinguish groups from a larger culture of which they are a
19
20 part. As Geertz (1973) argued, cultural practices are symbolized and enacted by social actors
21
22 and the context that gives such practices meaning and significance. Some cultural practices
23
24 seem to have a much greater influence on the lives of (young) women than on men. In
25
26 particular, in the domain of the sexual and reproductive life that is central in many cultures,
27
28 women's role is often pivotal (Yuval Davis, 1997). The sphere of sexuality and reproduction
29
30 is a crucial theme in cultural practices since it enables the continuity of the ethnic group. As
31
32 a result, it is women in particular who are 'considered to be the guardians of the
33
34 collectivity's identity and honor and who demarcate with their behavior the moral
35
36 boundaries of their group' (Yuval Davis, 1997: 25). In addition, cultural traditions and
37
38 sometimes the re-invention of traditions are often used as ways of legitimizing the control
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40 and oppression of women in situations in which individual men as well as the collectivity
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42 feels threatened by others.
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50 **Empirical findings on Fatalistic Suicide in the Lives of Young Immigrant Women**

51 After analysing the accounts of young immigrant women, 8 factors of overregulation
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53 emerged that referred to *fatalistic suicide*. These factors were not established a priori but
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55 emerged cross-culturally as a result of the analysis of the case files when we studied the
56
57 circumstances that led these young women into suicidal behavior.
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Table 6 about here

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5 Table 6 shows that factors of overregulation emerge in about 50 per cent of the cases of
6
7 Moroccan and Turkish and South Asian young women, as opposed to 24 per cent in the
8
9 Dutch cases. Issues around demands of upholding chastity were found almost equally in all
10
11 ethnic minority groups. (The fear of) Being outcasted appeared relevant to Turkish and
12
13 Moroccan young women in particular. Incidences of forced marriages were observed mostly
14
15 in Turkish young women, whereas the impossibility to opt for a divorce because of family
16
17 pressure to stay in an unwanted marriage was observed in Turkish as well as Moroccan
18
19 young women. Rejection of the partner by their families was found in particular in South
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21 Asian young women and Turkish young women. The threat of death could be found across
22
23 ethnicity, most notably however this appears to happen to Moroccan women. Being stalked
24
25 by an (ex) partner emerged as a cross-cultural problem for women. Being forced into
26
27 prostitution happened to two Dutch women and one Turkish woman. In sum, 3 factors were
28
29 found that affected both minority and majority women, while 5 factors around family honor
30
31 were observed in ethnic minority women only. To illustrate how overregulation originating
32
33 in honor related issues emerge and to illuminate the extent to which a lack of agency exists,
34
35 case summaries of minority women are discussed below.
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42 **Chastity Regulation: Accusations, Control and the Threat of Being Outcast**

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44 Accounts indicate how safeguarding the family honor through maintaining a chaste (decent)
45
46 reputation is felt deeply by young minority women, who face serious consequences if they
47
48 fail to live up to this prescription. The case files demonstrate how the status of a chaste
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50 woman was jeopardized, and how they were subsequently faced with repercussions that
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52 appear to be associated with their suicidal behavior. As a result, some women felt they had
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54 little choice but to runaway from home:
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Her mother migrated to The Netherlands just before giving birth to her. She used to be dad's favorite, although she knows that he 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 at her shoulder instead of the other way around. When her mother was pregnant with her sister, her mother had a fight with her father and left home, but returned later. One day in her mid puberty, her father hit her on the head. She then went to stay with friends in a city. She then 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 happened between them, but her mother was jealous of this and therefore talked bad about her to her father. She concludes that her parents see her as a bad child. (a Moroccan student, aged 20 who took an overdose)

The account above shows how violent repercussions of their families 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 behavior rejected their partners. In South Asian families, this often concerns a rejection on the basis of the caste, religion or ethnic background. When family members attempt to control a woman's spouse choice, they attempt to safeguard ethnic and cultural reproduction,

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2
3 and such efforts are often reinforced after migration. Rejection of the partner choice is also
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5 interlocked with agreements with family members, e.g. a match between cousins of
6
7 befriended families. This is often thought to guarantee a match between upbringing, religion
8
9 or class and expected to result in the continuation of steady family relations (Sterkx & Bouw
10
11 2005). The following example illustrates the rejection by a South Asian family of the
12
13 daughter's partner:
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16 *Her partner of Surinamese Creole background, cheated on her and she then took many pills.*
17
18 *They have now ended their relationship, which lasted three years. Her family has always been*
19
20 *against her relationship, because of his ethnic background. They have forbidden her to ever meet*
21
22 *him again. On her family background, she describes how her father avoided the family and let*
23
24 *her mother take care of everything. She has never gotten on well with her mother, since she felt*
25
26 *her mother was more in favor of her brother than her. Also her mother always claimed that she*
27
28 *resembled her father's family, which she understood as criticism. She gets on really well with her*
29
30 *brother. Only when she had her first boyfriend he had remarked that this was something she*
31
32 *could not do to her mother. (22-year-old South Asian woman who took an overdose of pills at*
33
34 *least on two occasions. Employment status unknown)*
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37
38 An account of a Turkish young woman also demonstrates lack of individual choice in partner
39
40 selection:
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43 *She arrived in The Netherlands when she was 12 years old and she lives with her mother. She*
44
45 *introduced her boyfriend to her father two weeks ago. Her father is against her spouse choice*
46
47 *because he already has a partner for her in mind and he threatens to deport her mother from The*
48
49 *Netherlands back to Turkey when she proceeds with her relationship and marriage. Her father*
50
51 *has a Dutch partner now. Possibly, her father wants to save his honor by marrying his daughter*
52
53 *off to his village friend. After consulting a counselor she found out that she would need to wait*
54
55 *two years to have her own marriage otherwise her mother could indeed be expelled. During these*
56
57 *two years, she fears she will be married off to her father's choice of spouse from his village in*
58
59 *Turkey. She subsequently took an overdose. (a 17-year-old Turkish woman who took an overdose*
60
of pills. Employment status unknown)

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5 The effect of migration in the above account is the fact that the young woman's mother is
6 dependent on her husband for her residence permit. The father who wants to force a marriage
7 upon the daughter exploits this dependency. In the next account of a Moroccan woman, it is
8 shown that cultural value regarding what is considered to be a respectable female, does not
9 end when a woman is divorced:
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16 *Her family is against her relationship with a Moroccan man who has been married twice before.*
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18 *Previously, her aunt supported her, but now her entire family is against the marriage. She*
19 *demonstrated serious life threatening behavior. She does not want her family to find out about*
20 *this; because she feels that they could blame her relationship- for her suicidal behavior. She also*
21 *has serious worries about her infertility and she feels bad about the fact that her parents are*
22 *divorced and her mother does not want any contact anymore. She used to be married herself but*
23 *went through a divorce after 6 years of marriage, even though her husband did not agree; her*
24 *family supported this, since the two of them had too different personalities. She herself is very*
25 *outgoing and active, while her ex husband was more timid and preferred to stay at home. She*
26 *married at a very young age with a countryman, since she felt this was the appropriate thing to*
27 *do for a Moroccan woman. She is described as someone with big circle of multi- ethnic friends.*
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29 *(a 28 year old Moroccan woman, method unknown, employed and part-time student)*
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42 Interestingly, we observed that the woman featured above had internalized certain cultural
43 demands around her spouse choice earlier in her life, i.e. he should be a Moroccan and that
44 she should marry young. Later in her life, her choice for a partner clashes with her family
45 who wants to control her partner selection in order for her to become respectable again.
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51 52 53 **Force to Maintain an Unwanted Marriage by Threats of Violence or Death**

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55 The following account indicates how family members of a Turkish woman exercise control
56 through threatening her with isolation and how physical abuse intersects with gender and
57 culture:
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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 would opt for a divorce. She then took an overdose. To the psychologist, her suicidal behavior 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 can be 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 favorite. Her father was sweet and kind, while her mother was very strict and punished her very 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 moved 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 a few children from his previous marriage. He puts pressure on her to take birth control pills and to have an abortion when she gets pregnant. Her relationship with her husband has not turned out as she had hoped for. Since she has given birth to a child, her husband has changed substantially. He became a very religious man and this clashes with her views. She struggles what to do now, if she wants to stay in her marriage, she would have to give up her own perspective of raising the children. If she would follow her heart, she would lose her family and family honor. (Moroccan woman, aged 34 who took an overdosed on several occasions, employed in education)

Conclusion and Discussion

Our data shows that well known risk factors in suicidology that consist of psychiatric and psychological illness as well as sexual and physical abuse do not appear to be sufficient to clarify the rationale of the suicidal behavior 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 behavior. By studying 24 to 32 cases per ethnic group that provided details of the values and beliefs in their cultural milieu and family context, we wanted to overcome pitfalls of studying aggregated level data that often places 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 behavior among Turkish, Moroccan and South Asian young women. Honor related life events were intertwined with excessive regulation and pressure by family members to ensure a woman abided with cultural norms. This led to an absence of freedom of creating one's own life course and an underdeveloped sense of autonomy that 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 young minority 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 behavior, violence and sometimes (threats of having) 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 reporting to the police. The latter however subsequently rendered some women an outcast in their own community or led to a lack of residency permit. Strict control of their 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 the efforts to ensure continuation of the family and ethnic

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3 community. The honor related rules prevented young women from individuation and goal
4 fulfillment. Their suicidal behavior thus bears elements of a *fatalistic suicide*. It seems
5 plausible that suicidal behavior of females in these ethnic groups can be understood as an
6 expression of a deeper underlying need to influence their life course.
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11 *Since we matched a group of Dutch majority women with low social and economic*
12 *status it seems safe to assume that the factors of overregulation are not a result of class*
13 *background. Our data indicated that Dutch young women who displayed suicidal behavior*
14 *did not experience as much overregulation in their lives compared to minority women. On*
15 *the occasions when they did face overregulation, it concerned forced prostitution and*
16 *stalking by partners rather than honor related events. It appears that overregulation that*
17 *originates in honor protection is culture bound.*
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27 Durkheim asserted that the suicide rates found in various cultures were indicative of
28 the level of social pathology (1952). This precipitates the question why some immigrant
29 families maintain such strict enforcement of rules and moral guidelines. It appears that many
30 immigrant communities in west are undergoing a process of cultural transition towards more
31 individualism and greater freedom for women. Durkheim also argued that the suicide rate is
32 a proxy for social solidarity (Bearman, 1991). Hence, the alarming rates of suicidal behavior
33 and the fatalistic components we discovered hint at prevailing contestation in certain
34 immigrant communities around cultural prescriptions and implying gendered traditional
35 power relations. Tensions develop when parents employ traditional culture rationale for
36 exercising honor related regulations in spheres where young women wish to employ their
37 own wishes. This process may also be influenced by ‘a general frigidity of cultures which
38 takes place in diasporic communities’ (Yuval Davis, 1997: 67), as a response to their
39 localization in the dominant society at large that is characterized by modernization and
40 individualization. The exercised honor regulation prevented young women from
41 experiencing connectedness with their family and ethnic community and appears to
42 precipitate disintegration rather than the cultural stability as desired by the family.
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3 The information on the lives of young women was not reported systematically and
4 exhaustively. However, the fact that psychologists and psychiatrists wrote the notes in the
5 files rather than sociologists renders underreporting plausible on social and cultural factors
6 of overregulation. In addition, we focused on young women who were seen for treatment at
7 the mental health services. It may be expected that societal regulatory factors play an even
8 larger role among ethnic minority women who are not in touch with mental health care.
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Difficulties exist in translating the background and social meaning of suicidal behavior across different cultures. Anthropological studies into attitudes on suicidal behavior could help to illuminate if suicidal acts are recognized in an ethnic community as a response to certain kind(s) of distress. South Asian women are known to be vulnerable to suicidal behavior world wide, which may indicate a lower threshold and cultural rationale for suicidal behavior since it is engrained in their cultural repertoire (Patel & Gaw, 1996; Raleigh *et al* 1990). By contrast, since the Islam fiercely forbids suicide, the threshold for suicidal behavior 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. Analogous to the work of Kushner and Sterk, who asserted that (2005, pp. 1141): '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 behavior of males is more often lethal, it is frequently taken as a yardstick for research on suicidal behavior (Canetto & 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 1970's and the majority stayed in The Netherlands. The South Asian migration history goes back to late 19th 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 1970's, many Surinamese moved to The Netherlands. The South Asians-Surinamese mostly settled in The Hague. It is therefore expected that the ethnic group among the Surinamese that is at risk for suicidal behavior is mostly South Asian. Approximately 85% of the South Asian- Surinamese population is Hindu and 15% is Muslim.

² Incidences of suicidal behavior as registered by hospitals and emergency agencies in the city of The Hague in 2002-2003: Turkish young females aged 15-19: 5.0 incidences per 1000 per year. Turkish young women: 20-24 year old 7.0 per 1000 per year. Surinamese young women aged 15-19 year old 4.5 per 1000 and aged 20-24 year-old, 4.0 per 1000 per year. Moroccan young women aged 15-19 year-old 2.3 per 1000 per year and aged 20-24 year old, 2.0 per 1000 per year. Dutch majority women aged 15-19 year old 1.0 per 1000 per year and 20-24 years old: 1.5 per 1000 per year.

³ Statistics show that men commit 2-3 times more suicide than women in The Netherlands. South Asian men have increased rates compared to Dutch men, while rates of Moroccan and Turkish men were about 80% of that of Dutch men (100%). South Asian and Turkish men commit suicide 3 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 et al, 2006)

⁴ Two women, from India and Bangladesh were added to the sample of South Asians because of commonalities in their region of origin.

References

- 1
2
3
4
5
6
7
8 ACEVEDO, GABRIEL A. (2005) Turning Anomie on its Head. Fatalism as Durkheim's
9
10 Concealed and Multidimensional Alienation Theory. *Sociological Theory* vol. 23,
11
12 no. 1 pp. 75-85
13
14
15
16 ARENSMAN, ELLA and KERKHOF, AD J.F.M. (2003) Repetition of Attempted Suicide:
17
18 Frequent, but Hard to Predict. in Diego de Leo, Unni Bille Brahe, A.J.F.M. Kerkhof
19
20 and Armin Schmidtke (eds) *Suicidal Behavior. Theories and Research Findings*,
21
22 Göttingen,: Hogrefe & Hubers Publishers
23
24
25
26
27 BEARMAN, PETER S. (1991) The Social Structure of Suicide. *Sociological Forum* vol. 6,
28
29 no. 3 pp. 501-24
30
31
32
33
34 BEAUTRAIS, ANNETTE L. (1998) Risk Factors for Suicide and Attempted Suicide among
35
36 Young People. In: *Commonwealth Department of Health and Aged Care, National*
37
38 *Youth Suicide Prevention Strategy - Setting the evidence-based research agenda for*
39
40 *Australia (A literature review)*, Canberra, Australia
41
42
43
44
45 BEAUTRAIS, ANNETTE L. (2003) Suicide and Serious Suicide Attempts in Youth: a
46
47 Multi-Group Comparison Study. *American Journal of Psychiatry* vol. 160: 1093-
48
49 1099
50
51
52
53
54 BHUGRA, DINESH, DESAI, MANISHA, BALDWIN DAVID S. BALDWIN and JACOB
55
56 KS (1999) Attempted Suicide in West London 2. Intergroup Comparisons. In
57
58 *Psychological Medicine* vol. 29 pp. 1131
59
60

- 1
2
3 BROUWER, LENIE, LALMAHOMED, BEA and JOSIAS, HENNA (1992) *het Weglopen*
4
5 *van Turkse, Marokkaanse, Hindostaanse en Creoolse meisjes*. Utrecht: Van Arkel
6
7
8
9
10 BURGER, IRENE, HEEMERT BERT VAN, BINDRABAN CLAUDIA A. and SCHUDEL
11
12 JOOST (2005) Parasuicides in Den Haag: Meldingen in de Jaren 2000-2004.
13
14 *Epidemiologisch Bulletin*, Vol. 40, no. 4 pp. 2-8
15
16
17
18 CANETTO, SILVIA SARA and LESTER, DAVID (1995) Epidemiology of Women's
19
20 Suicidal Behavior. CANETTO SILVIA SARA and LESTER, DAVID (eds) *Women*
21
22 *and Suicidal Behavior*. New York, Springer 1995, pp. 35-57
23
24
25
26
27 DAVIES CHRISTIE and NEAL, MARK (2000) Durkheimian Altruistic and Fatalistic
28
29 Suicide. in Pickering W.F.S and Walford Geoffrey (eds) *Durkheim's Suicide, a*
30
31 *Century of Research and Debate* pp. 36-53
32
33
34
35
36 DE LEO, DIEGO, BURGIS, SHELLY, BERTOLOTE, JOSE M, BILLE BRAHE, UNNI
37
38 and KERKHOF Ad J.F.M. (2006) Definitions of Suicidal Behavior. *Crisis, the*
39
40 *Journal of Crisis Intervention and Suicide Prevention*, vol. 27, no.1 pp. 4-15
41
42
43
44 DE WIT, MATTY (2005) *Psychische Stoornissen bij Migranten*, Amsterdam: GGD
45
46
47
48
49 DURKHEIM, EMILE (1952) *Suicide*. New York: The Free Press
50
51
52
53 HAMLIN, CYNTIA L. and BRYN ROBERT J. (2006) The Return of the Native: A Cultural
54
55 and Social-Psychological Critique of Durkheim's Suicide Based on the Guarani-
56
57 Kaiowa of Southwestern Brazil. *Sociological Theory*, vol. 24, no. 1, pp. 42-57
58
59
60

1
2
3 HJELMELANDT, HEIDI, KNIZEK, BIRTHE and NORDVIK HILMAR (2002) The
4
5 Communicative Aspect of Nonfatal suicidal behavior--are there Gender Differences?
6
7 *Crisis, the Journal of Crisis Intervention and Suicide Prevention*, vol. 23 no 4 pp.
8
9 144-55
10

11
12
13
14 GARSSSEN, JOOP M. HOOGEBOEZEM, JAN and KERKHOF AD J.F.M (2006)
15
16 Zelfdoding onder Migrantengroepen en Autochtonen in Nederland. *Nederlands*
17
18 *Tijdschrift voor Geneeskunde* vol. 150 no. 39 pp.2143-2149
19
20

21
22
23 GEERTZ, CLIFFORD (1973) *The Interpretation of Culture. Selected Essays*. New York,
24
25 Basic Books
26

27
28
29 IGA, MIMORU (1981) Suicide of Japanese Youth. *Suicide and Life Threatening Behavior*,
30
31 vol.11, no.1 pp.17-30
32
33

34
35
36 KRIKKE, HANS, NIJHUIS, HANS and WEESENBEEK, RIANNE (2000) *Aan de Grenzen*.
37
38 *Suïcidaal Gedrag onder Allochtone Meisjes en Jonge Vrouwen*. Den Haag, Bureau
39
40 Public Health Service.
41
42

43
44 KUSHNER, HOWARD and STERK, CATHERINE (2005) The Limits of Social Capital:
45
46 Durkheim, Suicide and Social Cohesion, *American Journal of Public Health*, vol.
47
48 95, no. 7 pp. 1139-43
49
50

51
52
53 MC CALL, LESLEY (2005) the Complexity of Intersectionality. *Signs, Journal of Women*
54
55 *in Culture and Society* vol. 30, no. 3 pp. 1771-1800
56
57

58
59 MCHOLM, ANGELA E. MACMILLAN, HARRIET L, JAMIESON, ELLEN (2003) The
60

1
2
3 Relationship Between Childhood Physical Abuse and Suicidality Among Depressed
4
5 Women: Results From a Community Sample. *American Journal of Psychiatry* vol.
6
7 160 no. 5 pp. 933-938
8
9

10
11 PATEL, S.P. and GAW, A. (1996) Suicide among Immigrants From the Indian
12
13 Subcontinent: A Review. *Psychiatric Services*. Vol.47 no.5 pp.517-521
14
15

16
17
18 RALEIGH, VS., BULUSU, L., and R. BALARAJAN (1990) Suicides among Immigrants
19
20 from the Indian Subcontinent. *British Journal of Psychiatry*. 156 pp. 46-50
21
22

23
24
25 PEARCE, FRANK (1989) *The Radical Durkheim*, London: Unwin Hyman Ltd
26
27

28
29 SALANDER-RENNBERG, ELEONOR, LINDREN, SYBILLA and OSTERBERG, INGER
30
31 (2004) Sexual Abuse and Suicidal Behaviour. In Diego de Leo, Unni Bille Brahe,
32
33 A.J.F.M. Kerkhof and Armin Schmidtke (eds) *Suicidal Behavior. Theories and*
34
35 *Research Findings*, Gottingen,: Hogrefe & Hubers Publishers
36
37

38
39
40 SALVERDA, ELIZABETH (2004) *Laat me los hou me vast. Een kwalitatieve studie naar*
41
42 *het welbevinden van Hindostaanse meisjes in Den Haag*, Den Haag, GGD rapport
43
44

45
46
47 STERKX, CAROLIEN and BOUW, LEEN (2005) *Liefde op Maat. De Partnerkeuze van*
48
49 *Turkse en Marokkaanse jongeren*, Amsterdam: het Spinhuis
50
51

52
53 TRAVIS, ROBERT (1990) Suicide in Cross Cultural Perspective. *International Journal of*
54
55 *Comparative Sociology* vol. 16, no. 3-4 pp: 237-248
56
57

58
59 VAN BERGEN, DIANA D., SMIT, JOHANNES H, KERKHOF, A.J.F.M and
60
SAHARSO, SAWITRI (2006) Gender and Cultural Patterns of Suicidal Behavior.

1
2
3 Hindustani young Women in The Netherlands. *Crisis, the Journal of Crisis*
4
5 *Intervention and Suicide Prevention*, vol. 27, no. 4 pp.181-188
6
7
8
9

10 VAN OORT, FLOOR A., JOUNG, I.M.A, VAN DER ENDE , JAN, MACKENBACH

11 JOHAN P, VERHULST FRANK C and CRIJNEN ANTON.A.M. (2007)

12 Development of Ethnic Disparities in Internalizing and Externalizing Problems from
13
14 Adolescence into Young Adulthood. *Ethnicity and Health*, vol. 48, no. 2 pp. 176-84
15
16
17
18
19
20
21
22
23
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25
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Table 1: the marital status of female outpatients of four ethnic groups in Amsterdam

	Turkish	Moroccan	South Asian	Dutch
	N=32	N=30	N=24	N=29
	N (%)	N (%)	N (%)	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)

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Table 2: Method used in suicidal behavior of female outpatients of four ethnic groups in Amsterdam

	Turkish	Moroccan	South Asian	Dutch
	N=32	N=30	N=24	N=29
	N (%)	N (%)	N (%)	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)

Table 3: Extent of repetitive suicidal behavior and lethal intent of suicidal behavior of female outpatients of four ethnic groups in Amsterdam

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

For Peer Review Only

Table 4: Risk factors of psychiatric & personality disorders of female outpatients who displayed suicidal behavior, in 4 ethnic groups

	Turkish	Moroccan	South Asian	Dutch
	N=32	N=30	N=24	N=29
	N (%)	N (%)	N (%)	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)
<i>No disorder</i>	13 (41)	12 (40)	7 (29)	6 (21)
<i>One or more disorders</i>	19 (59)	18 (60)	17 (71)	23 (79)
<i>Co morbidity</i>	9 (28)	8 (27)	8 (33)	17 (59)

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

** Anxiety disorders reported on include generalized anxiety, panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder & 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 behavior, in 4 ethnic groups in Amsterdam

	Turkish	Moroccan	South Asian	Dutch
	N=32	N=30	N=24	N=29
	N (%)	N (%)	N (%)	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)

Table 6: Factors of overregulation in female outpatients who displayed suicidal behavior, in four ethnic groups in Amsterdam

	Turkish	Moroccan	South Asian	Dutch
	N=32	N=30	N=24	N=29
	N (%)	N (%)	N (%)	N (%)
Chastity jeopardized	8 (25)	9 (30)	4 (17)	0 (0)
(Fear of) Outcasted by family	3 (9)	4 (13)	0 (0)	0 (0)
Pressure to maintain unwanted marriage	2 (6)	3 (10)	0 (0)	0 (0)
Threatened to death	2 (6)	4 (13)	2 (8)	1 (3)
(Threatened to have 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 two partners does not have the agency in the marriage arrangement and disagrees to the marriage arrangement. This includes those partners who have cooperated under physical or psychic treat.