

Suicidality of young ethnic minority women with an immigrant background: The role of autonomy

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Diana D van Bergen

Groningen University, the Netherlands

Sawitri Saharso

VU University Amsterdam, the Netherlands

Abstract

Ethnic minority status and female gender convey a risk for suicidal behavior, yet research of suicidality of ethnic minority female immigrants is scarce. The authors of this article conducted qualitative interviews with 15 young women (of four ethnicities) in the Netherlands, who either had attempted suicide or contemplated suicide, and analyzed these in a narrative psychology tradition. Suicidality was associated with despair and frustration over the violation of the women's personal autonomy and self-integrity regarding strategic life choices. Autonomy restrictions and violations followed two patterns, which are interconnected with four criteria regarding the capacity for autonomy. Findings are discussed with referral to Durkheim and feminist theories of autonomy.

Keywords

Durkheim, ethnic minorities, immigrant women, personal autonomy, suicidal behavior, suicidal ideation

A remarkable finding with regard to the epidemiology of non-fatal suicidal behaviour and suicidal ideation is the predictive role that gender plays. Young women demonstrate high levels of non-fatal suicidal behavior and suicidal ideation compared to males (Bursztein Lipsicas et al., 2012). Nevertheless, there is a paucity of research investigating the

Corresponding author:

Diana D van Bergen, Department of Education at Groningen University, Faculty of Behavioral and Social Sciences, Grote Rozenstraat 38, 9712 TJ, Groningen, the Netherlands.

Email: d.d.van.bergen@rug.nl

background to this phenomenon. Suicidal ideation refers to the contemplation of suicide, while non-fatal suicidal behavior is understood by us as: 'A nonhabitual act with non-fatal outcome that the individual, expecting to, or taking the risk, to die or to inflict bodily harm, initiated and carried out with the purpose of bringing about wanted changes' (De Leo et al., 2004: 3). 'Non-fatal suicidal behavior' is hereafter referred to as 'suicidal behavior' for brevity reasons while we will use the concept 'suicidality' when it applies to findings concerning both attempted suicide and suicidal ideation.

Several studies showed that the rates of suicidal behavior among in particular young women of specific ethnic minority immigrant groups in Europe and in the USA are high (Bursztein Lipsicas et al., 2012). In the US, Baca-Garcia et al. (2011) found Puerto Rican American women to have increased rates of suicidal behavior. In the Netherlands, women of Turkish, Moroccan, and South Asian-Surinamese descent (age 15–44) were two to four times more likely to demonstrate suicidal behavior than majority Dutch women (Burger et al., 2015).¹ The Dutch case corresponds with research showing a heightened vulnerability to suicidal behavior of women of Turkish descent in Germany and Switzerland, and women of South Asian descent in the United Kingdom (Aichberger, 2015). The European and American findings underpin the urgency to examine the suicidal behavior of ethnic minority women as a critical step in the development of prevention measures. In this study, we therefore address the origins of the suicidal behavior of young women, notably those belonging to groups that have shown a heightened risk for this behavior.

Turks, Moroccans, and Surinamese are the largest immigrant groups in the Netherlands (i.e. 7% of the Dutch population or 1.2 million people; see Dagevos and Gijsberts, 2011). Turkish and Moroccan immigrants from predominantly rural areas arrived as guest workers to fill the lower segments of the labor market in the 1970s. South Asian-Surinamese are a minority group from Surinam. 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. Turkish and Moroccan communities are in a disadvantaged socioeconomic position compared to the Dutch majority (Dagevos and Gijsberts, 2011), while the Surinamese occupy an in-between position. Turkish and Moroccan immigrants are mostly Sunni Muslims, while South Asian-Surinamese are Hindus, although there is a Muslim minority among them.

Psychological theories of relatedness and autonomy are increasingly recognized as important to suicidal behavior (Hill and Pettit, 2013; Van Bergen et al., 2012). Researchers (see e.g. Deci and Ryan, 2008) argue that relatedness and autonomy are psychological needs which are essential components in a universal model of wellbeing. Nevertheless, the relatedness component (e.g. interpersonal relationships, social connectedness, and isolation; see e.g. Van Orden et al., 2010) has received more attention in suicidology than the autonomy factor (e.g. self-awareness, self-insight, degree of sensitivity to others; e.g. Hill and Pettit, 2013). Relatedness and autonomy have also been addressed in sociological theories of suicidal behavior. Emile Durkheim (1952 [1897]) argued that suicide results from a distorted equilibrium between social integration (i.e. relatedness) and regulation (i.e. autonomy) in social groups in and across societies.² When individuals are overembedded and enmeshed in their social group (i.e. their lives bear *altruistic*

features), or vice versa when they lack connectedness to their social group (i.e. their lives bear *egoistic* features), the risk of suicide increases. Durkheim also maintained that when individuals are overly constrained by social norms and demands (i.e. their lives feature a lack of autonomy and *fatalism*), or by contrast, when they experience a strong lack of moral guidelines (i.e. they are confronted with a sense of *anomie*), this enhances the risk of suicide (Durkheim, 1952 [1897]).

In a previous study (Van Bergen et al., 2012) we examined the life stories of young women of South Asian-Surinamese, Moroccan, Turkish, and Dutch descent with a history of suicidality, and found that abuse and disturbed family relationships were related to their suicidality. Yet, for ethnic minority women in particular we found that restrictions on their autonomy played an important role in their suicidal behavior. Little is known about how autonomy restrictions and suicidality are related. Moreover, there is a paucity of knowledge built on the narratives of suicide attempt survivors. Therefore, in this article we focus on the life stories of women for whom autonomy restrictions played a key role in their suicidality.

The article unfolds according to the following structure: first, using feminist and liberal philosophy, we elaborate on the concept of capacity for autonomy, culture, and socialization. Subsequently, we explain our methodology, and in the results section, we outline two patterns in which we observed capacities for autonomy influencing suicidality in young women within their social and cultural contexts.

Autonomy, agency, and culture

(Personal) autonomy generally means that individuals are able to lead their lives in accordance with their own values.³ Central in definitions of autonomy – ranging from cross-cultural psychology (e.g. Rudy et al., 2007) to philosophy (e.g. Christman, 1989) and feminist theory (e.g. Friedman, 2003; Phillips, 2007) – is the idea that people have freely chosen their lives and that their values or actions are indeed their own. Chirkov et al. (2003: 98) for instance write that: ‘A person is autonomous when his or her behavior is experienced as willingly enacted and when he or she fully endorses the actions in which he or she is engaged and/or the values expressed by them.’ The freedom to decide how one wants to live can be restricted by others; hence, autonomy presupposes the absence of external coercion. Autonomy also requires certain intrapsychic abilities. Young children or the severely mentally disabled are, for instance, usually considered as not (yet) in (full) possession of the capacity for autonomy because they are not (fully) able to rationally reflect upon their lives. Also, there is not (yet) enough of a separate self, an individual identity, that is stable across time, to speak in a meaningful way of self-choice or freedom of will (Christman, 1989). Following Dworkin (1989), Mackenzie (2007), Friedman (2000), and Saharso (2007) we distinguish four main intrapsychic capacities involved in the concept of autonomy. These are: (1) an understanding of one’s values, needs, and wants in life, and the ability to act upon them, (2) an awareness of alternative life options, (3) a capacity for evaluative reflection, and (4) the ability to experience a sense of coherence and maintain a strong mental representation of oneself in spite of restrictive conditions. The first criterion means that a person knows what matters to her. It requires that she is able to experience herself as a separate person with

wishes of her own (see also Dworkin, 1989). Having a sense of who one is also entails, as Mackenzie (2007: 117) explains, that a person has a sense of self-respect and trust in her own judgment. It means that a person experiences herself as an individual who is worthy of respect from herself and others. Furthermore, a person would need to be able to act upon her judgment. The second criterion, an awareness of alternative life options, means that a person can imagine herself living a different life irrespective of whether she can, in reality, leave her present situation (Burchardt and Holder, 2011). Third, the capacity for evaluative reflection means that one is able to critically reflect on the desirability of the life one is leading and to compare it with alternatives. These capacities are all conditional on the fourth and last capacity, to be able to experience a sense of wholeness (Ewing, 1991) or internal coherence (Antonovsky, 1987). The reflection and choosing must be reflexive of and integrated into a personality that does the reflecting and choosing and that is able to do so in spite of restrictive conditions one might face.

While some authors treat autonomy as a universal concept or human capacity, this is disputed by others who suggest that autonomy is an ideal particular to individualistic cultures, while in other collectivistic cultures not autonomy, but social harmony, respect for authority, and/or filial piety are considered important values (Parekh, 2000). Moreover, cultural variation has been observed in issues in which a young woman is free to decide and those that are considered family issues (e.g. in the West, the choice of a marriage partner is an individual decision, while in many non-Western locations, the family plays an important role in partner selection).⁴ There is cultural variation in the extent that young people, in particular, young women, are free to act on their own (Phillips, 2007). Autonomy restrictions lead, according to Chirkov et al. (2003), not to dependence, but what they call a situation of heteronomy 'in which one's actions are experienced as controlled by forces that are phenomenally alien to the self or that compel one to behave in specific ways regardless of one's values or interests' (2003: 98). Some claim that in collectivistic cultures, child-rearing practices are aimed primarily at socio-centric goals as opposed to autonomy-oriented goals, thereby giving rise to interdependent versus independent personalities (Kağıtçıbaşı, 1996). These differences have sometimes led to the claim that only in individualist cultures do people have a need for autonomy and that in collectivistic cultures, autonomy is less relevant to human wellbeing (see Rudy et al., 2007).

All-encompassing claims based on rigid distinction between collectivistic and individualistic cultures easily result in an over-generalization. Therefore, we argue that one needs to carefully delineate and elaborate on the concept of autonomy to decipher how and if it varies cross-culturally. We distinguish between autonomy as a moral ideal, autonomy as a right, and autonomy as a mental capacity (Saharso, 2007). Our perspective is that autonomy is not a universally shared moral ideal. We recognize that across cultures, there is variation in what are considered important values, and that differences exist between cultures in terms of socialization as well as regarding the extent to which young women can exercise their right of autonomy. In most cultures, there are designated spheres or contexts, notably the family, where the young and women, in particular, are not supposed to act autonomously (Saharso, 2007). Yet, the cultural expectation of conformist behavior is never total, nor is socialization ever total (Saharso, 2007). On account of its over-generalizability, we reject the claim that persons raised in collectivistic

cultures have a less developed capacity for autonomy. Moreover, following Ewing (1991), the intrapsychic capacity for autonomy may help women survive circumstances in which their autonomy is severely restricted (see Saharso, 2000). We do recognize that certain external circumstances can incapacitate the development of autonomy; however, we assume that these can be found across cultures. We follow feminist theorists (e.g. Mackenzie and Stoljar, 2000) who claim that generally, and not only in so-called collectivistic cultures, persons are socially embedded and that, therefore, we should focus on the social relations that are both a conditional and causal contribution to autonomy. By emphasizing critical influences of social relations, family bonds, and social support systems, Mackenzie and Stoljar (2000) coined the term ‘relational autonomy’ for a feminist adaptation and reflection on the concept of autonomy. In the cases, we first establish the extent to, and ways in which restrictions or violations of personal autonomy are present and second, how this has impacted on the women’s intrapsychic capacity for autonomy.

Methodology

Sample

This article is based on life story interviews with women who had a history of suicidality (as indicated by healthcare staff, by participants themselves, and verified by the interviewer). The subsample ($N = 15$) used for this article is part of a larger sample of female interviewees ($N = 47$) of Asian-Surinamese (12), Turkish (10), Moroccan (11), and native (14) descent (Van Bergen et al., 2012). The same type of life story interviews (see ‘Method and analysis’) were used in both samples. For this article, we selected *only* those 15 out of 47 participants for whom we had established in our initial analysis of the total sample that autonomy played a key role in their suicidal behavior (see ‘Method and analysis’). This resulted in a theoretical sample, i.e. a subset of 15 interviewees of Moroccan (6), Turkish (6), South Asian-Surinamese (2), and one native descent – mean age 31). Two of the minority women belonged to the first generation of immigrants, five were second generation, while seven women belonged to the in-between generation.⁵ Eleven participants had attempted suicide, while four had seriously ideated suicide (yet not attempted). Nine participants were married or had a partner, three were single, and two were divorced, one was a widow. The participants had all been enrolled in mental healthcare. According to participants’ self-report, they had suffered from depression (8 cases), or borderline personality problems (1 case); six women did not make a reference to psychiatric problems. Healthcare professionals did not refer any patient as participants whose mental health was considered very poor at the time of the interview request.

Procedure

Participants were invited for an interview by either their healthcare worker (12 women), the organizer of a self-help group (1 woman), or via a call on websites (2 women). The in-depth interviews were conducted in Dutch by the first author, and were conducted after informed consent was given. Two interviews however were conducted with the help

of a female Turkish interpreter. An interview topic list was used which included (family) history of migration, childhood, upbringing, family relations, cultural values, abuse, suicidal behavior and emotions or motives behind this. However, additional topics were included if this seemed relevant based on the interviewees narratives. Permission for the study was granted by a Dutch Medical Ethical Committee.

Method and analysis

We chose life story interviews as they are suitable for capturing the emotions and critical turning points in the life course of participants, as played out in their social and cultural contexts. Also, they take participants' perspectives on their emerging suicidality as pivotal (Fitzpatrick, 2011). The analysis of the dataset of the larger sample of 47 interviews (Van Bergen et al., 2012) was conducted conforming to the initial procedures of grounded theory (Glaser, 1998). We identified and coded themes based on critical life events and emotions, and turning points derived directly from the transcriptions. From these codes, categories were constructed, linked, and integrated. Through ongoing comparisons within and between interviews, the first author searched for similarities and differences regarding women's viewpoints and emotions about themselves and suicidality as contextualized in (family) relationships and sociocultural dynamics. Autonomy was a key theme emerging from this procedure in almost half of all cases of minority women (Van Bergen et al., 2012).

As a second step, we studied the theme of autonomy in relation to female suicidal behavior by shifting back and forth between the 15 cases and our four criteria for autonomy outlined in the theory section, hereby arriving at two patterns relating to autonomy. If interviewees' narratives featured oppressive experiences (abuse, including those of entrapment, heavy care-duties, and self-sacrifices), which went hand in hand with the criteria of the struggle to recognize personal needs and to imagine alternatives, a weak ability to reflect on oneself, and troubled sense of coherence, we listed them under pattern one. Phrases describing such experiences in their lives were for instance: *We weren't allowed to go outside and were imprisoned in our own house. ... I only had these four walls around me ... I did not think for myself. I did not think about myself.* (Derya, Turkish, age 24) If restriction-related experiences were present in narratives yet an external conflict with women's spouse and/or family (in-law), over gaining autonomy (in the sphere of education, work, dating, marriage or divorce), existed as well and was mentioned in combination with interviewees' clear recognition of their personal needs, alternative life choices, and combined with self-reflection and a strong sense of self-coherence, they would fall under pattern two. An example of such narrative was given by Hanife (Turkish, age 26): *I was searching for 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. ... I choose a study with a compulsory exchange program at a foreign university so I would gain more freedom.*

The first author initially categorized interviews as falling into one of the two patterns. This was checked and in case of disagreement discussed with the second author who also studied all the transcripts. A third researcher, who had not classified the data initially, scrutinized the categorization of a random selection of 10 interviews and an inter-reliability of 90% was obtained. These two patterns are presented in the results section,

following an interpretative mode of analysis in the tradition of narrative psychology (see Hiles and Čermák, 2008). Interviewees are represented by pseudonyms, and information which could identify participants has been changed without altering central themes.

Results

Increasing autonomy leading to increasing criticism over self-sacrifice

Being severely restricted or denied the right to make strategic life choices emerged as an important contributor to suicidality among eight women in the study; they belonged to the first or in-between generation of Turkish, Moroccan, and South Asian immigrants. For them, strategic life choices consisted, in particular, of the choice of whether to marry and with whom, movement in and outside the house, and the right to education. Four participants stated that their family (including in-laws) or husband made these strategic life choices during their early adolescence, while the remaining four mentioned that this happened in their mid-to-late adolescence. Interviewees indicated that their lives featured coping with the daily hardships of housework and care for their families (including in-laws), while they were simultaneously denied a life and voice of their own. Their families and husbands set restrictive conditions (e.g. interviewees being locked up or expected to never leave the house, denied the right to go to school, forced into marriage) often upheld by abuse. This was expressed, for example, in the life story of Gül, a woman of Turkish descent (age 40), who came with her family to the Netherlands during her early adolescence:

Shortly after we moved here, my uncle said ‘I am going to have my son engage Gül.’ My mother did not have the right to speak out, and my father did not stand up either. Culturally, we have to obey older family members. I had to marry [age 13], quit school, and I moved in with my in-laws. The day after my wedding I had to wake up at 6:00 am to make breakfast for eight people ... It was very heavy ... I was not allowed to go outside. I was always at home, cooking and cleaning. Even when I was eight months pregnant [age 14] ... my parents-in-law instructed me to carry groceries up to the third floor ... My mother-in-law constantly made it clear that I was worth less than the rest of the family ... My husband never asked how I was doing or if I needed support.

Some women in this category faced threats of being sent back to their country of origin where they anticipated further abuse or poverty. This was the case for Usha (age 33, South Asian descent) who grew up in Suriname in a family where her father physically abused her mother and treated her mother as a ‘slave’ for most of her life (original transcript). When she was in her late adolescence, her father arranged a marriage for her; she then migrated to live with her husband and in-laws.

My father said he would throw me out of the house if I did not marry. My mother-in-law ruined everything ... I was allowed to go to school for one year and then had to stay home ... the sink was always full of washing up for me to do ... my mother-in-law would throw water in the corridor and tell me to clean it. After one year, she told me I should make babies ... Every evening, she came into my room to check if we were ... Three months later, she threatened,

'I'm going to send you back to Suriname because you cannot bear children.' My husband was always hitting me. Once he tied me to the bed and placed a sock in my mouth to seal it.

Women like Usha and Gül lived the very opposite of an autonomous life. Initially, they had little awareness of what they envisioned from life and they abided by the wishes of their families (and in-laws). We suspect that their traditional gender role socialization, including the idea that young women are not the owners of their life as prevailing in their extended families, coupled with their isolation from society, made it difficult for them to consider to offer resistance against their circumstances. The immigrant women in this category had little knowledge of alternative options in life, which was also due to the fact that they had migrated to a foreign country and were not provided with opportunities of support or for learning (e.g. school, Dutch language skills) hampering positive change. At the same time, the stories of Usha and Gül demonstrated that they had some idea about their desires; they both wanted to finish school, they showed an awareness of the fact that they were treated as people of a lesser kind, and that they were wrongly treated. Their capacity for autonomy gradually increased as their frustration with the abuse accumulated. Over their life courses, they increasingly trusted their own judgment and built up their capacities to critically evaluate their life circumstances. It was exactly within such a shift towards focusing on their personal wellbeing, that suicidal behavior emerged. Usha explained the meaning of her suicide attempt:

I once tried to commit suicide. I wanted to jump from the balcony. I was like, what kind of life do I have? I have to work as a slave in the house, and my husband is having affairs with other women. When I say anything at all to my mother-in-law, I am beaten up. I didn't want to continue like this ... I wanted to end my life, and everything would be over ... At that moment, I was thinking purely about myself, about nobody but myself.

From Usha's statement, we derived that she pictured suicide as an expression of self-care, though in the absence of other viable options. Over time, Usha's ongoing reflections that she had suffered enough – which influenced her suicidal behavior – were substituted with positive actions to establish personal change. An acquaintance assisted her to obtain a residence permit and signed her up for social housing. She then divorced her husband and left her in-laws' house. Gül also increasingly reflected on her abusive situation and began to desire an alternative life. When her parents-in-law were away in Turkey, she filed for divorce. However, in her case, the emerging capacity for a critical reflection of the denial of her autonomy precipitated suicidal ideation:

I am very angry with myself that I was never able to say how upset I was that they did not care for me ... I took my anger out on my children by beating them ... I cannot forgive myself for this. I blame myself for a lot of things. Why have I allowed so many things to happen to me? Why me? Why was I never able to say 'no'? ... When you think over and over about your life in this way, at some point, you can't bear it anymore, and you just don't want to live anymore.

Gül's suicidal ideation emerged as a manifestation of self-loathing, resulting from a perceived inability to act autonomously and regret over compliance with serious autonomy restrictions. Her story makes clear that while the capacity for critical reflection and

self-consciousness appear to be necessary conditions for autonomy, the process of regaining autonomy and self-care is often difficult, painful, and not without the risk of suicide.

For some women belonging to this pattern, later on in their lives resources were present which helped them to overcome restrictive conditions. These resources included the sister of a husband who advised a Turkish interviewee to escape to a women's shelter; an acquaintance who helped Usha to obtain a resident permit and apply for social housing; and a mental healthcare worker of minority background (but of a different ethnicity) who explained to a Turkish interviewee how she could negotiate more influence regarding whom she were to marry.

Restrictions over autonomy were also present in the case of a native Dutch woman, Marleen (age 24), who explained that her parents wanted to be in control of her life during her childhood and adolescence (e.g. prescribing daily activities, homework structure, and friendships). Her family belonged to an orthodox Protestant Christian Church, which emphasizes the sinfulness of human beings. Marleen understood this as an imperative of ongoing self-sacrifice and was constantly trying to give more care to others than she already did. Her parental restrictions, as well as her religiosity, inspired her self-sacrifice and contributed to her suicidal ideation:

My mother has a very strong personality and very much insisted that I had to do things her way. It was very depressing. I was constantly belittled; I felt that I could not be myself, and that there were huge expectations that I just could not meet. And she said things like you're lazy; you're incapable. Later, I literally became ill from all those things she had planted in my head ... I felt like a caged animal. [When I left home] I was not used to making my own decisions ... I felt very down and restless ... I constantly felt that life did all kinds of things to me.

Marleen, like some of the other women, was initially not able to identify and express her own needs in terms of goals, nor could she imagine how to act upon this on her own. Her account indicated that in the case of most Western majority women, autonomy restrictions can also lead to an underdeveloped mental representation of self and impaired autonomy competencies, which eventually result in suicidal ideation. However, what made Marleen's case different is that her parental restrictions did not influence strategic life choices; for example, she received a college education and married a spouse of her choice. Furthermore, while Marleen's mother seemed obsessed with developing her daughter in the direction she preferred, there was no focus on self-development in the adolescence of Usha, Gül, and the others.

Open conflict and struggle over autonomy needs

A second important category of life stories concerned conflicts of participants who wished to act in accordance with their autonomy in *strategic life choices*. This pattern was found exclusively in second generation immigrants. Altogether, eight women fell into this category. Unlike the type of narratives that made up the first category, these young women had already – during puberty – developed a strong sense of themselves in relation to their desired future direction. They had identified goals for themselves, which

underpinned their strategic life choices on the freedom of movement, relationships, choice of spouse, education, and career. Many women exhibiting this pattern had openly expressed their desired choices to their families or husbands; these choices conflicted with the gender norms prevailing in their sociocultural context. In some cases, women in this category attempted to enact their choices secretly, for example, meeting with friends after school or having a boyfriend without the knowledge of parents. The interview fragment of Hanife is illustrative in this respect. She reflects on the suicidal ideation that started in her late teens and continued until her early twenties:

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 resented many things my parents did ... But what could I have done? Run away from home? ... the idea was just too painful. I love my parents ... I had a boyfriend for a while, but it was just too heavy ... I had to come up with all sorts of excuses at home to see him ... I wanted to fit in so desperately ... I tried to be the normal and nice girlfriend for him, yet I could never become a serious part of his life ... I was lying bluntly in my parents' face ... In those days, I was staring to the ground a lot, my head bent down, searching for a solution for problems that were almost impossible to solve.

As indicated by Hanife, participants who belonged to this category entered a deadlock due to a discrepancy between their own wishes concerning strategic life choices versus their families demanding chaste and/or traditional behavior of females. Simultaneously, these participants' however often felt strong loyalty to their parents because they knew their parental restrictions were inspired by care. Nevertheless, their interests and those of their families appeared irreconcilable. If women in this pattern openly stood up for their choices, manipulation, physical abuse, and violence often followed as repercussions, which, in turn, triggered suicide attempts. This was illustrated in the life story of Hajar (age 22), who is married against her will to a man from rural Morocco. Hajar explained how her ongoing conflict with her mother around her unwanted marriage and her unfulfilled educational ambitions influenced two suicide attempts:

I had agreed with my girlfriend to go to the playground with my children. My husband said I was not allowed to go ... When I returned home, he had called my mother ... She grabbed me and shouted 'Where have you been? You're a whore!' ... My mother then tried to stab me ... When she finally left, I no longer dared to go out on my own. The following day, I attempted suicide ... I want my parents to accept me as I am ... my husband and I don't match at all. I want to finish my education and achieve something, but my parents just don't support my wishes. I cannot choose, and it makes me crazy ... I feel so sorry that I am not the daughter they wanted.

As the interview fragment demonstrates, women in this category had a strong sense of who they were and were aware of what they wanted in life. They were also capable of critical reflection upon their lives. The main problem, which drove them to desperation, was that they were hampered by oppressive circumstances and were unable to realize their desired lives. They had difficulty choosing between different life options, not because they were not able to choose, but because every choice was accompanied by

very high costs (i.e. give up their desire for a different life or loss of family ties). Women with narratives of this type felt anger towards their families, who obstructed their autonomy regarding strategic life choices and who were sometimes violent, manipulative, or denigrating towards them. On the other hand, they maintained that in spite of the turmoil, they still loved their parents. As they saw no escape from their situation this resulted in intense frustration, which then motivated their suicide attempt.

Discussion and conclusion

The 15 life stories recorded from the narratives of young women of Moroccan, Turkish, South Asian-Surinamese, and Dutch descent in the Netherlands showed that their suicidality was associated with violations of their autonomy and self-integrity. These violations were in opposition to their strategic life choices, i.e. critical decisions in the domain of sexuality, education, marriage, and freedom of movement. We found two patterns regarding the impact of these impairments to participants' autonomy.

First, a number of women in the study had been forced into strategic life choices that their families made for them. A number of them were denied an education in adolescence. This resulted in a life in which they as teenage girls had to care for others, and their personal autonomy was of no concern to their families (in-laws), or to themselves. The impact this had on them was that they initially had difficulty to feel as a person who is worthy of respect from herself and others and to act to claim respect for her needs and wishes. On the other hand, we found that suicidal behavior could also be expressive of a transitioning phase of regaining autonomy in terms of increasing the capacity for critical reflection, thereby invoking strong feelings of anger or regret over being entrapped in a life that featured ongoing abuse from others.

A second pattern consisted of clashes between women and their family contexts over the enactment of critical life choices (Kabeer, 2011). Unlike pattern one, women whose life story matched this pattern experienced no difficulty in their capacities for autonomy. They experienced themselves as individual persons with their own wants and needs; they were aware of alternative options, and they were self-reflexive. Their capacities for autonomy were much more central in their narratives compared to women from pattern one. Here, suicidality emerged as a result of frustration caused by the curtailment of their right of autonomy as they were subordinate to family interests.

In both patterns, we recognized the relevance of Durkheim's *fatalistic suicide*: many young women in this study faced a lack of control over their lives and experienced a sense of powerlessness and dehumanization. As in Durkheim's *fatalistic suicide* archetype (1952 [1897]) they faced harsh moral demands that were upheld through restrictions, violence, and abuse. The pressure and abusive conditions in their social context to ensure they would follow cultural norms led to an absence of freedom over crafting their life course that is characteristic for fatalistic suicide. In Durkheim's theory of fatalistic suicide individuals are confronted with the long-term situations of over-control upheld through force in their immediate social contexts, and then enter a prolonged state of entrapment and hopelessness, precipitating suicidal behavior (Van Bergen et al., 2009). On the basis of our findings we are inclined to believe that the need for autonomy is universal (cf. Rudy et al., 2007).

In the first pattern the young women did what they were told to do, because they had been raised with the cultural message that that is the right thing to do. It meant not, however, that they had no sense of self or were fully unaware of their wishes. We suspect that it is no coincidence that all minority women falling in this category are of the first and in-between generation. They grew up with probably fewer alternative normative messages and fewer alternative lifestyles around them. The women who exhibited the second pattern, by contrast, were in full possession of all characteristics of the capacity for autonomy, yet were blocked from living the life they wanted to live. Again, we suspect it is no coincidence that the women falling in this pattern consisted mostly of second generation women. As they grew up in Dutch society they were exposed to alternative norms.

Obstructions of strategic life choices were characteristic especially of women of South Asian-Surinamese, Turkish, and Moroccan descent, but less so for Dutch majority women. We hold it plausible that in ethnic communities with a more collectivistic culture, there is a greater risk than in individualist cultures of family relations becoming derailed by restricting the autonomy of young women. However, the life stories we provided are not representative of the 'average' non-Western immigrant woman. Also, we do not wish to conflate the violation of strategic life choices with general claims about cultures. The narrative of a majority Dutch woman, for whom autonomy impairment and a lack of self-direction were critical in her suicidal process, underpins the cross-cultural relevance of autonomy in suicidal behavior. The results of the study guide us to take a stance against autonomy restrictions which decrease psychological wellbeing in *both* majority and minority women, while we simultaneously distance ourselves from equating deprivation with non-Western immigrant women per se (see also Khader, 2011).

The findings echo the body of suicide literature which emphasized the critical role of physical and sexual abuse in relation to suicidality (Zakar et al., 2013). The relationship between abuse and suicidal behavior is believed to occur through the manifestation of an impaired self-concept, shame, self-blame, and low self-esteem (Brodsky and Stanley, 2008). For female immigrants belonging to honor cultures (for instance found in Morocco, Turkey, and India), the harmful effects of abuse are worsened due to personal shame over being a disappointment to oneself combined with the social shame of losing family honor (Heredia-Montesinos et al., 2013).

A tragic lesson to be learned is that oppressive circumstances seriously impaired the capacity for autonomy (see also Mackenzie, 2007) so that even when opportunities for a better life became available, many women were, for a long time, unable to grasp them. One needs a strong sense of self and the feeling that one's choices deserve to be respected in order to be able to act upon them. A positive lesson is that many of these women who were not encouraged to exercise autonomy and/or drastically restricted in their rights hereof, still developed a critical reflection on their (lack of) autonomy and, moreover, were able to act accordingly. Autonomy competencies and behavior can be learned or enhanced later in life and we were struck by participants' resilience and strength in spite of harsh conditions.

We want to conclude with a policy implication. A disturbing finding is that many of the immigrant women we researched grew up in or came to the Netherlands at a young age. They were oblivious to the sociopolitical and juridical-economic dynamics of Dutch

society and vice versa, Dutch society was oblivious to their existence. Many were under-age at the time of their arranged or forced marriage, and they were still of school age when they were kept at home. Yet, these violations of the law went unnoticed. Furthermore, for a long time women in pattern one did not know of the opportunities that Dutch society offered them, neither were most of them aware of the support (in the form of counseling and shelter) that existed, and when they were finally offered such support this often was via informal resources. Clearly there is ample room for improvement for all institutional actors involved – from the immigration services to teachers to medical doctors – in recognizing and reaching out to these young women.

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Notes

1. However, the latest registration available (Van Bergen et al., 2010) indicated that the rates for women of Moroccan background have changed, indicating a potential decreasing trend.
2. Although Durkheim's focus is on suicide his concepts seem also relevant to suicidal behavior, as research indicates that those young individuals who die by suicide and those who attempt suicide are a rather similar group in terms of common sociological characteristics, psychiatric diagnostic and psychiatric history features (Beautrais, 2003).
3. For reasons of brevity, we refer to personal autonomy as 'autonomy' throughout the article.
4. In Europe the couple-initiated marriage is actually a relatively recent phenomenon (see Stone, 1977).
5. By in-between generation immigrants, we refer to individuals who migrated to the Netherlands when they were between 7 and 14 years old.

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