

## Review

## Precipitating and risk factors for suicidal behaviour among immigrant and ethnic minority women in Europe: A systematic review

Amanda Heredia Montesinos<sup>1,✉</sup>, Andreas Heinz<sup>2</sup>, Meryam Schouler-Ocak<sup>1</sup>,  
Marion Christina Aichberger<sup>2</sup>

<sup>1</sup> Department of Psychiatry and Psychotherapy at St. Hedwig Hospital,  
Charité - University Medicine Berlin, Germany

<sup>2</sup> Department of Psychiatry and Psychotherapy, Campus Mitte,  
Charité - University Medicine Berlin, Germany

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**Abstract:** Background: During recent decades, immigration to European countries has increased substantially. Immigrant and ethnic minority women in Europe have higher rates of suicidal behaviour than women from the majority population. This indicates that circumstances that lead to suicidal behaviour of immigrant and ethnic minority women may be different from the population of the host countries. Methods: A systematic literature review of publications about precipitating and risk factors for suicidal behaviour of immigrant and ethnic minority women in Europe was conducted. Results: 24 publications met the inclusion criteria. Five central themes emerged. (1) Familial problems, such as domestic violence, and pressures from the community were deemed important precipitating factors, whereas (2) psychiatric disorders, previous psychiatric history/treatment, and previous suicide attempts were less common among immigrant and ethnic minority women. (3) Issues related to migration, such as acculturative stress and discrimination, as well as (4) socio-demographic variables, such as being of young age were commonly reported factors. Lastly, (5) barriers for help-seeking such as the fear of stigmatization, and discrimination can cause a suicidal crisis when women feel they are in a desperate situation that they cannot escape. Conclusions: The risk and precipitating factors for suicidality of immigrant and ethnic minority women differ from the ones immigrant men and women in the host countries have. However, more in-depth and good-quality quantitative and qualitative research is needed to better understand the interface of gender, suicidal behaviour, ethnicity, and immigration.

**Keywords:** Suicide, suicidal behaviour, immigrants, ethnic minorities, women, risk factors

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Immigration to and within Europe has increased substantially in recent decades, and immigrants' countries of origin and their reasons for migration are very diverse (United Nations, 2009). In countries like Great Britain or France, immigration from their former colonies predominated for a long time, and in the 1960s and 1970s a wave of guest workers were recruited in several European countries like Germany, The Netherlands, and Switzerland.

With the formation of the European Union and successive accession of new member states, immigration within Europe was further facilitated, and a more and more culturally diverse Europe is emerging (Carta, Bernal, Hardoy, & Haro-Abad, 2005).

Several studies indicate that specific immigrant and ethnic minority women in Europe have higher rates of suicidal behaviour than immigrant and ethnic minority men or women of the majority population. In an analysis of the suicide attempt rates of immigrants from the 11 European centres participating in the WHO/EURO Multicentre Study on Suicidal Behaviour, 27 of 56 immigrant groups showed significantly higher, and only four groups significantly lower suicide attempt rates than

✉ Dipl.-Psych. Amanda Heredia Montesinos  
Department of Psychiatry and Psychotherapy at  
St. Hedwig Hospital  
Charité - University Medicine Berlin, Germany  
Große Hamburger Straße 5-11, 10115 Berlin  
[amanda.heredia-montesinos@charite.de](mailto:amanda.heredia-montesinos@charite.de)

their hosts (Bursztein Lipsicas, Mäkinen, Apter, De Leo, Kerkhof, et al., 2012). In a different analysis of the WHO data, the gender distribution of suicide attempts in immigrants and their host populations was investigated by calculating the female-to-male ratios of suicide attempt rates for hosts, European and other Western immigrants, non-European immigrants, and Russian immigrants (Bursztein Lipsicas, Mäkinen, Wasserman, Apter, Kerkhof, et al., 2013). In the host countries, women made 22 more suicide attempts per 100,000 than males, whereas among immigrants, women made 46 more attempts than males. Additionally, non-European immigrants had higher female suicide attempt rates than the Europeans (both hosts and immigrants); the difference in gender ratios of suicide attempts between hosts (ratio 1.52) and non-European immigrants (ratio 2.32) was highly significant. As explanations of the higher suicide attempt rates of immigrant women, difficulties and gender-dependent features in the acculturation and integration process have been proposed.

A review of self-harm among ethnic minority groups in the UK demonstrated that rates of self-harm were highest among younger female immigrants (< 25 years) (Bhui, McKenzie, & Rasul, 2007). Especially South Asian and Caribbean groups showed high rates of self-harm in the UK (Burke, 1976; Merrill & Owens, 1986, 1987, 1988; Neeleman & Wessley, 1999; Neeleman, Wilson-Jones, & Wessley, 2001; Soni-Raleigh, 1996). Soni Raleigh, Bulusu, and Balarajan (1990) examined the death certificates in England and Wales (1970-1978) and demonstrated that Indian women had high rates at the ages 15-24. Merrill and Owens (1986, 1987) showed that Caribbean born females under 35 years of age and South Asian women who were admitted to poisons units in Birmingham had higher rates of self-harm compared with White people born in the UK in the same age group. When compared with other ethnic groups living in the same area, rates of attempted suicide in South Asian women in West London were highest; they had a rate 1.6 times the rate among White women and 2.5 times the rate among South Asian men. Among younger South Asian women (< 30 years), the rates were 2.5 times those of White women and seven times those of South Asian men. Moreover, in the age range of 16-19 years, South Asian women attempted suicide 17 times more often than South Asian males (Bhugra, Desai, & Baldwin, 1999).

In the Netherlands, young women of Turkish, Moroccan, and South Asian-Surinamese descent have disproportionate rates of nonfatal suicidal behaviour (Schudel, Struben, & Vroom-Jongerden, 1998).

Especially women aged 15 to 24 years from these ethnic groups have rates two to four times higher than those of ethnic majority Dutch young women (Burger, van Hemert, Schudel, & Middelkoop, 2009).

Data from the German WHO/EURO Multicentre Study on Suicidal Behaviour centre in the city of Würzburg showed that non-German women had a significantly higher rate of attempted suicide than German women (177.4 vs. 99.9/100,000). High risk groups among immigrant women were Russian, Polish, and Turkish women. Russian women (439.9/100,000) had a rate more than four times that of German women, Turkish women a rate more than five times higher (521/100,000), and Polish women a rate more than six times higher (617.6/100,000). Further, Turkish and Polish women were significantly younger than German women (mean age: German women: 37.6, Turkish women: 24.9, Polish women: 33.0) (Löhr, Schmidtke, Wohner, & Sell, 2006). Another German study examining death statistics (1980-1997) reported that Turkish immigrants had lower rates than Germans in general, but young Turkish girls and adolescents (aged 10-17) had a relative risk of 1.79 compared to same aged German girls and adolescents (Razum & Zeeb, 2004).

A Swiss study of suicide attempts of Turkish immigrants in an emergency unit in the city of Basel (1990-1997) demonstrated that young women of the second generation had the highest rates of attempted suicide (Yilmaz & Riecher-Rössler, 2008). The Swiss WHO/EURO study comparing Turkish immigrants with Swiss suicide attempters reported that Turkish women had the highest suicide attempt rate (646/100,000 vs. 311/100,000 for Turkish men, 172/100,000 for Swiss women, and 81/100,000 for Swiss men) (Brückner, Muheim, Berger, & Riecher-Rössler, 2011).

A nation-wide study from Sweden analyzed all suicides and undetermined cases occurring during the period 1987-1991 including all immigrant groups, and found an overrepresentation of immigrants. The risk of an immigrant dying from suicide was found to be 1.5 times higher than that for a native Swede (Ferrada-Noli, 1997). Hjern and Allebeck (2002) investigated the rates of suicide death from the national registers in second generation immigrants and inter-country adoptees in Sweden in comparison with their parental generation and the majority population. They found that second-generation immigrants in all six minority groups tended to have higher odds of dying from suicide than the first-generation immigrants relative to the Swedish majority population (Hjern & Allebeck, 2002). Another Swedish cohort of 4.4 million individuals

aged 25-64 years was followed from 1994 to 1999 with regard to suicide. The highest risk of suicide was found among women from Finland, Poland, and Eastern Europe, even after adjustment for age, marital status, socioeconomic status, and hospitalization due to psychiatric disorders or substance abuse. With a suicide rate twice as high as Swedish women, Polish women had the highest risk (Westman, Sundquist, & Johansson, 2006). In Denmark, women with foreign background had a five-times-higher risk for suicide compared to Danes after controlling for marital status, income, place of residence, and psychiatric illness (Sundaram, Qin, & Zøllner, 2006).

The described publications indicate that immigrant and ethnic minority women in Europe are at special risk for suicidal behaviour. In order to provide appropriate care for the constantly growing population of immigrants and ethnic minority groups in Europe, the understanding of factors and circumstances that lead to suicidality among immigrant and ethnic minority women is crucial; especially since they might be very different to the better known factors of majority populations in Europe.

In the following review, publications about precipitating and risk factors for suicidal behaviour of female immigrants in Europe are presented. We use the term 'precipitating factors' to describe reported causes or contributors (e.g. a conflict with someone), and the term 'risk factors' to describe factors that increase the likelihood of getting into a suicidal crisis but are not causal per se (e.g. gender, ethnicity, or age).

## Methods

This review follows the PRISMA guidelines for performing systematic reviews (guidelines: Moher, Liberati, Tetzlaff, Altman, & PRISMA Group, 2009; Liberati, Altman, Tetzlaff, Mulrow, Gøtzsche, et al., 2009). It includes English and non-English publications with (a) original data on precipitating and risk factors for suicide, attempted suicide/self-harm, or suicidal ideation among immigrant and ethnic minority women in Europe, (b) publications that show precipitating and risk factors specifically for immigrant women (since some studies have mixed samples and do not analyze female participants separately), (c) publications that were published between 1960 and 2013, and (d) publications with either quantitative or qualitative design. Publications

that purely report standardized mortality rates (SMRs), prevalence, or incidence data were not included.

The following data bases were searched: MEDLINE, PsycINFO, WorldCat, Scopus, Web of Science, and OVID (final date for literature research: 05/08/2013). The following keywords (MeSH terms) were used: suicide, suicidal behaviour, suicidal ideation, (deliberate) self-harm, immigrants, migrants, ethnicity, and ethnic minority. As an example, the electronic search strategy used in MEDLINE is displayed in Table 1.

**Table 1: Search strategy Medline**

1. suicide
2. suicidal behaviour
3. suicide attempt
4. deliberate self-harm
5. suicidal ideation
6. 1 or 2 or 3 or 5
7. immigrant
8. migrant
9. ethnic minority
10. ethnicity
11. 7 or 8 or 9 or 10
12. 6 and 11

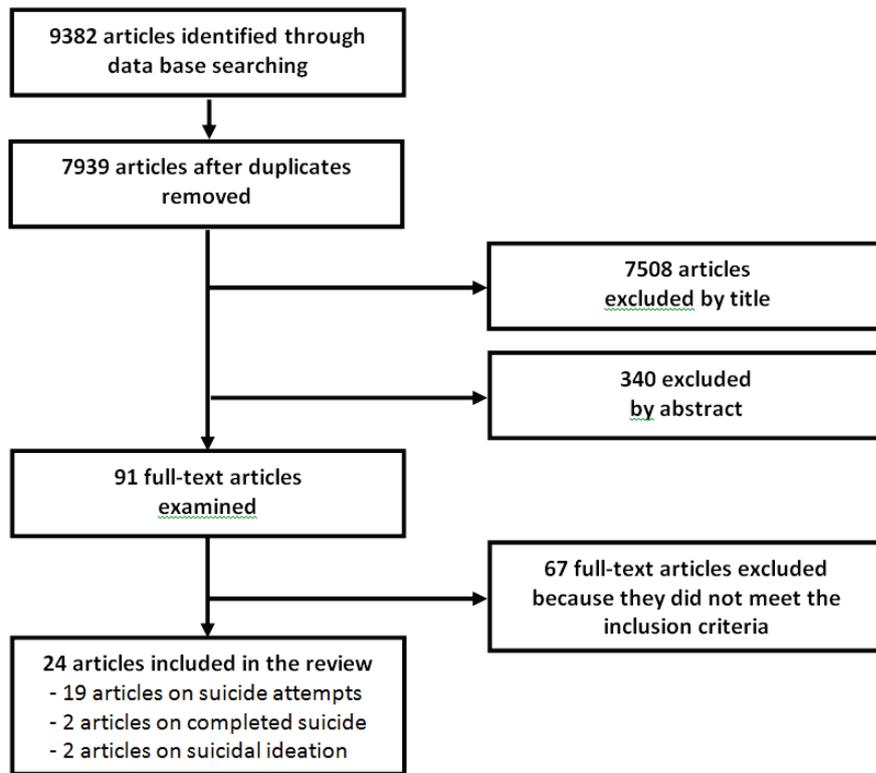
In total, there were 7939 hits, after all duplicates were removed. The titles of all studies were screened, and articles not relevant for the topic of the review were removed. The reference lists of the identified articles were also screened, and relevant articles were selected. This paper reviews the 24 publications that met the inclusion criteria. The flow chart of identified articles is displayed in Figure 1.

## Results

### *Terminology*

In suicide research and literature, a range of different terms like risk factors, causes, motives, reasons, influencing or precipitating factors are used to describe factors that influence suicidal behaviour indicating a conceptual confusion. Since suicidality is mostly described by a complex multifactorial model, it is difficult to decide where the causal chain begins, or to distinguish between cause and trigger. The conceptual confusion in suicide research and literature was reflected in the reviewed publications

**Fig. 1: Flowchart of identified articles during the systematic review**



by the fact that the terminology was very diverse. The reviewed publications used these terms: risk factors, (perceived) causes, predictors, contributing factors, factors with an impact on, precipitating factors, reasons, origins, and underlying and main problems. In the tabulated data and citations from the articles the terms used by the authors of the publications have been maintained.

Furthermore, the reviewed publications used different terminologies for the description of their samples. In the newer studies from the UK (1990-now), the term 'ethnic minority' is used for immigrants and their descendents. Furthermore, immigrants from the Indian Subcontinent are mostly called (South) Asians, regardless whether the person was born outside the UK or not. According to the Bhui et al. (2007) review, other ethnic groups in the UK are often called Black Caribbean or African Caribbean if of Caribbean origin and Black African if of African origin. The term Black and minority ethnic (BME) groups is also commonly used in the UK. The older studies from the UK used terms like Asian immigrants and West Indians (Afro-Caribbean). Publications from the other European countries used terms like (adolescent) immigrants, women of (e.g. Turkish) descent, ethnic minorities with a migration background, females of (e.g. Moroccan) origin, foreign-born minorities, first and second generation immigrants from (e.g. Turkey),

students with an immigrant background, and second-generation immigrant adolescents.

#### ***Samples and host countries***

(South) Asian women were by far the most studied population. In total, 18 publications included them in their sample (Bhardwaj, 2001; Bhugra, 2002; Bhugra, Baldwin, Desai, & Jacob, 1999; Bhugra & Hicks, 2000; Bhugra, Thompson, Singh, & Fellow-Smith, 2004; Burke, 1976a; Burke, 1976b; Chantler, Burman, Batsleer, & Bashir, 2001; Chew-Graham, Bashir, Chantler, Burman, & Batsleer, 2002; Cooper, et al., 2006, 2010; Hicks & Bhugra, 2003; Merrill & Owens, 1986; van Bergen, Smit, van Balkom, & Saharso, 2009; van Bergen, Eikelenboom, Smit, van de Looij-Jansen, & Saharso, 2010; van Bergen, van Balkom, Smit, & Saharso, 2012; van Leeuwen, Rodgers, Regner, & Chabrol, 2010), and 13 publications were exclusively about South Asian women. The term South Asian refers to persons whose origins are from the Indian Subcontinent: India, Pakistan, Bangladesh, Sri Lanka, Nepal, and Bhutan (Hicks & Bhugra, 2003). In this review, publications investigated women from the countries India, Pakistan, Bangladesh, Sri-Lanka, and South Asian women from Suriname.

Seven publications included Turkish women (Brückner et al., 2011; Löhr, et al., 2006; van Bergen, et al., 2009, 2010, 2012; Yilmaz & Riecher-Rössler, 2008, 2012), three publications Moroccan women (van Bergen, et al., 2009, 2010, 2012), two publications Black Afro-Caribbean or Black other women (Cooper, et al., 2010; Merrill & Owens, 1987), two publications Russian women/girls (Löhr, et al., 2006; Ponizovsky, Ritsner, & Modai, 1999), and one study Polish women (Löhr, et al., 2006). One study had a mixed sample of participants with immigrant background and did not differentiate between subgroups (van Leeuwen, et al., 2010).

Sixteen publications were conducted in the UK (Bhardwaj, 2001; Bhugra, 2002; Bhugra, et al., 1999, 2004; Bhugra & Hicks, 2000; Burke, 1976a, 1976b, 1978; Chantler, et al., 2001; Chew-Graham, et al., 2002; Cooper, et al., 2006, 2010; Hicks & Bhugra, 2003; Merrill & Owens, 1986, 1987; Soni Raleigh et al., 1990), three in the Netherlands (van Bergen, et al., 2009, 2010, 2012) and Switzerland (Brückner et al., 2011; Yilmaz & Riecher-Rössler, 2008, 2012), and one respectively in France (van Leeuwen, et al., 2010), Israel (Ponizovsky, et al., 1998) Germany (Löhr, et al., 2006), and Sweden (Johansson, et al., 1997). An overview of characteristics and main results of all publications are presented in Table 2.

### **Central themes**

We found five central themes around precipitating and risk factors for suicidal behaviour of immigrant women. The most frequently mentioned precipitating factors for suicidality among immigrant women were (1) *familial problems and community pressures*: 17 publications described a variety of facets of problems, ranging from arguments with the own family, the husband or the in-laws, domestic violence, to general oppression of women by their families and community. Frequently studied risk factors were (2) *psychiatric disorders, previous psychiatric history/treatment and previous self-harm* (12 publications). (3) *Issues related to migration*, such as racism, isolation and acculturation, were reported precipitating factors in seven publications, and (4) *socio-demographic variables*, such as age, marital status, education, socio-economic status, living situation, and unemployment, were reported risk factors in five publications. Lastly, (5) barriers for help-seeking were described in four publications. In the following, the central factors will be described and analyzed in detail.

#### ***Familial problems and community pressures***

Familial problems were the most commonly described precipitating factor for a suicidal crisis.

Some publications mentioned familial problems only in a general form ('interpersonal disputes', 'relationship problems within the family'). For instance, in two publications Burke (1976, 1976) examined case-notes of Asian immigrants who presented at a hospital in Birmingham after a suicide attempt. Female attempters reported 'interpersonal dispute' more frequently as a motive for attempting suicide than male attempters (68% vs. 46%). Among specific conflicts, 'dispute with the immediate lover' was reported in 76% of the cases. Cooper and colleagues (2006) analyzed rates of self-harm, socio-demographic and clinical characteristics, provision of services and risk of repetition of adult self-harm attendees in four emergency departments in two cities in the UK over a 4-year period. Compared to White women, South Asian women were more likely to report 'relationship problems within the family' as a cause for the suicide attempt (31.5% vs. 19.3%,  $p < .001$ ). Other publications were more specific in differentiating between marital problems, problems with the in-laws, or problems with the own family. In the following, the nature of these problems will be described in detail.

#### ***Marital problems and problems with the in-laws***

In a comparison of Asian and White patients who had been admitted to a hospital in Birmingham following deliberate self-poisoning between 1979 and 1981, 'marital problems' were stated significantly more often by Asian females than by White females (71.8% vs. 49.1%,  $p < .001$ ) (Merrill & Owens, 1986). Furthermore, Asian females indicated that the sources of marital conflict were that their husband wanted them to behave less westernized, arranged marriage, or that mothers-in-law interfered in their family lives.

In Switzerland, Yilmaz and Riecher-Rössler (2008, 2012) analyzed data of Turkish immigrants who attended an emergency room after a suicide attempt between 1991 and 1997, and 'relationship problems' were the most frequently mentioned underlying problem for the suicide attempt in both first- and second-generation immigrants. Sixty per cent of the first generation and 64.4% of the second generation stated 'conflict with partner' as the main problem, whereas 'conflict with parents' was mentioned by 20% of the second generation (Yilmaz & Riecher-Rössler, 2008). Further, among female suicide attempters 'domestic violence' was described as the main problem (21.4% first generation, 14.7% second generation). In their comparison with a matched group of Swiss female suicide attempters (Yilmaz & Riecher-Rössler, 2012), 18.2% of Turkish females stated domestic violence as the main problem, whereas none of the Swiss women did. (cont. p. 73)

**Table 2: Characteristics and results of studies about precipitating and risk factors of suicidal behaviour among immigrant and ethnic minority women in Europe**

Authors	Country	Ethnic group	Sample	Place of recruitment	Methods	Type of suicidal behaviour	Precipitating and risk factors
Bhardwaj, 2001	UK	Asian	Not provided in the article	Community organizations	- In-depth interviews (suicide attempters) - focus groups (Asian women) - structured interviews (service planners and providers)	Reasons for self-harm	<b>Reasons why Asian women self-harm:</b> <ul style="list-style-type: none"> <li>- Parental, family and community-related oppressions</li> <li>- Community and cultural oppression: rigidly defined matrimonial roles and the duty of women to maintain the family honor ('izzat')</li> <li>- Gender inequalities, violence and abuse</li> <li>- Parental control: gender roles and expectations</li> <li>- Racism, wider male domination and pressures from an active media</li> </ul>
Bhugra et al., 1999	UK	Asian White	Asian attempters: N=27 White attempters: N=46 Asian controls N=27	Hospital GP surgery	Comparison between Asian/White suicide attempters and Asian non-attempters	Risk factors for deliberate self-harm	<b>Risk factors (Asian vs. White attempters)</b> <ul style="list-style-type: none"> <li>- Less depressed (27% vs. 52%)</li> <li>- Less depressed on CIS-R (24% vs. 36%)</li> <li>- No psychiatric disorder (11% v 48%)</li> <li>- Had some psych disorder (20% v 58%; p=0.0003)</li> <li>- No psych disorder (51% v 27%)</li> <li>- Health related event (43% vs. 17%; p=0.0008)</li> <li>- Life event related to opposite sex (22% vs. 4%; p=0.04)</li> </ul> <b>Risk factors (Asian attempters vs. Asian control group)</b> <ul style="list-style-type: none"> <li>- Psychiatric history (59% vs. 3%; p= 0.002)</li> <li>- Physical disorder (24% vs. 2.7%; p=0.001)</li> <li>- Mean GHQ score (15.5 (s.e. 9.9) vs. 6.4(1.7); p=0.002)</li> <li>- CIS score (23.2(10.8) vs. 7.2(7.6); p&lt;0.001)</li> <li>- Born in the UK (1/3 vs.28%; NS)</li> <li>- Previous self harm (48% vs. 3.7%)</li> <li>- Arranged marriage good idea (30% vs. 88%; p=0.003)</li> <li>- Relationship with a white person (22% vs. 0; p=0.02)</li> <li>- Keep in contact with relatives abroad (74% vs.100%; p=0.01)</li> <li>- Miscellaneous events more common among self harmers (p=0.006)</li> </ul>

Table 2. cont.

Authors	Country	Ethnic group	Sample	Place of recruitment	Methods	Type of suicidal behaviour	Precipitating and risk factors
Bhugra & Hicks, 2000	UK	South Asian (India, Pakistan)	10 focus groups: N=43 (females)	GP surgeries Cultural centers Community organizations	Focus groups	Perceived causes of suicide attempts	<p><b>Perceived causes</b></p> <ul style="list-style-type: none"> <li>- Isolation after migration</li> <li>- In-law problems compounded by poor support or mistreatment by the husband</li> <li>- Marriage Problems</li> <li>- Dowry</li> <li>- Theme: Being 'Trapped'</li> <li>- Theme: Being unable to tell others: 'Attempting suicide is a distress in quietness' (Isolation, Shame &amp; Social Stigma, Cultural expectations of women to contain their thoughts)</li> <li>- Theme: Limited options for leaving a distressing situation – 'No way out' (lack of money, having small children, lack of support by her parents, having nowhere else to go, social stigma, identity being linked to the husband, or lack of knowledge of how to live independently)</li> </ul>
Bhugra et al., 2004	UK	South Asian (India, Pakistan, Bangladesh, Sri Lanka) White	N=76 adolescents, Females: N=12	Children and Adolescent services in Ealing, West London	Comparison between Asian/White suicide attempters and non-attempters	Reasons for suicide attempt	<p><b>Gender and ethnic group differences</b></p> <ul style="list-style-type: none"> <li>- Cultural conflict and intergenerational clashes: South Asian females more likely</li> <li>- Depressed: 16% of South Asian males and females vs. 42% white females, and 37% white males</li> <li>- Adjustment problems :Female adolescents more likely irrespective of ethnicity</li> <li>- Regular use of alcohol: 1/5 of white girls and 1/4 of South Asian girls</li> </ul> <p><b>Similarities:</b></p> <ul style="list-style-type: none"> <li>- Arguments with parents most common factor (29%)</li> <li>- School problems in over 45%</li> <li>- Alcohol problems at home very uncommon</li> <li>- Logistic regression model showed culture conflict and low self- esteem related to behavioral problems</li> <li>-</li> </ul>

Table 2. cont.

Authors	Country	Ethnic group	Sample	Place of recruitment	Methods	Type of suicidal behaviour	Precipitating and risk factors
Brückner et al., 2011	Switzerland WHO/ EURO - Multicentre study	Switzerland WHO/ EURO - Multicentre study	N=56 Turkish, Females: 36 N=291 Swiss, Females: 210	Population of Canton Basel	Surveillance study	Attempted suicide	<b>Turkish women:</b> - Peaks: 15-24 years, and 35-39 years - Neurotic, stress-related and somatoform disorders (F4): 45.7% vs. 25% Turkish men, 14.6% Swiss women, and 11.3 % Swiss men - Affective disorders (F3): 51.4% vs. 40% Turkish men, 30.6% Swiss women, and 42.5 % Swiss men - Personality disorders (F6): 2.9% vs. 10% Turkish men, 35.4% Swiss women, and 6.3 % Swiss men
Burke, 1976a	UK	Asian (Bangladesh, India, Pakistan)	N=52 Females: N=28	Hospital	Self-harm admissions Case notes	Attempted suicide	<b>Predictors</b> - Interpersonal dispute
Burke, 1976b	UK	Asian (Bangladesh, India, Pakistan)	N=55 Females: N=41	Hospital	Self-harm admissions Case notes	Attempted suicide	<b>Predictors</b> - Recent pregnancy - Young age - Being single
Chantler et al., 2001	UK	South Asian	8 senior managers of health services, 18 workers, 7 suicide attempt survivors, and 4 women's groups	Health service providers	Individual interviews and group discussions	Perceived causes of suicide attempts and self-harm	<b>Contributing factors (Survivor accounts)</b> - Key theme: Domestic violence (within the context of racist and sexist housing policy, racial attacks/harassment, domestic violence and immigration = an unholy alliance, cultural concepts such as honour and shame) - ('Allowing' of) forced marriages - Issues of loss (Through death, childhood migration) - Poverty and homelessness

Table 2. cont.

Authors	Country	Ethnic group	Sample	Place of recruitment	Methods	Type of suicidal behaviour	Precipitating and risk factors
Chew-Graham et al., 2002	UK	South Asian (Bangladesh, India, Pakistan)	N=31 (female)	Women's groups and projects	Focus groups	No suicidal behaviour	<b>Psychological distress as a symptom of external pressures</b> <ul style="list-style-type: none"> <li>- Systemic issues: social, political and economic pressures, domestic violence, poverty, language problems, family and children's issues, and health</li> <li>- Community grapevine: pressure for families to be 'doing well', competing for status and prestige, lack of privacy and space for women, continuous 'gossip'</li> <li>- Concept of <i>izzat</i> (honour): burden of a family's <i>izzat</i> unequally placed upon the women, misused to reinforce women's roles, coerce women into remaining silent, hard to-achieve high expectations of women, strict and tightly controlled lives</li> <li>- Racism: disadvantaged along lines of 'race' and gender, unequal treatment, stereotyping of Asian communities and Islam: increases sense of isolation and sense of being lesser</li> <li>- English-language problems: sense of isolation, lack of knowledge of services and support, or awareness of 'rights'</li> </ul>
Cooper et al., 2006	UK	South Asian White	N=7.185 South Asian: N=299 Female: N=171	Emergency departments	Cross-sectional Standard psychosocial assessment,  Self-harm specific structured assessment	Self-harm	<b>South Asian women were</b> <ul style="list-style-type: none"> <li>- Younger</li> <li>- Less likely to be unemployed or to live in circumstances commonly associated with self-harm risk</li> <li>- Less likely to have history of substance abuse</li> <li>- Less likely to present with repeated attempts</li> </ul>

Table 2. cont.

Authors	Country	Ethnic group	Sample	Place of recruitment	Methods	Type of suicidal behaviour	Precipitating and risk factors
Cooper et al., 2010	UK	South Asian Black White	N=14.997 Black females: N=228 South Asian females: N=345	Emergency departments	Prospective multicentre cohort study Psychosocial assessment	Self-harm	<b>Young Black women</b> - Showed increased risk - More likely to be unemployed - More likely to be having housing problems <b>South Asian women</b> - More often married - Conflicts with partners or family <b>Black and Asian women</b> - Less likely to have history of psychiatric disorder, self-harm or alcohol use prior to attempt
Hicks & Bhugra, 2003	UK	South Asian (Bangladesh, India, Pakistan)	N=180 females	GP Out-patient clinics Community organization	Cross-sectional survey study	Perceived causes of attempted suicide	<b>Perceived causes</b> - Domestic violence - Unhappy family situation - Depression
Johansson et al., 1997	Sweden	Sweden vs. Finland, West, East, South Europe, Outside Europe	N=8516	Central Cause of Death Register	Death register study (1985-1989)	Suicide	- Ethnicity is a signif. risk factor when controlled for sex and age <b>Predictor</b> - Being unmarried (both sexes)
Löhr et al, 2006	Germany	Polish Russian Turkish German	Only suicide attempt rates are reported	Health-care services in catchment area	Surveillance study Monitoring form	Suicide attempts	<b>Comparison with German women:</b> <b>Turkish women</b> - Younger (24.9% vs. 37.6%) - Adjustment disorder (54% vs. 24%) <b>Russian women</b> - Lower level of education (72% vs. 52%) - Separated/divorced (40% vs. 16%) - Married (40% vs. 28%) - Less likely to be single (15% vs. 48%) <b>Polish women</b> - Younger (33% vs. 37.6%), - Adjustment disorder (33% vs. 24%) - Affective psychosis (33%)

Table 2. cont.

Authors	Country	Ethnic group	Sample	Place of recruitment	Methods	Type of suicidal behaviour	Precipitating and risk factors
Merrill & Owens, 1986	UK	Asian (Bangladesh, India, Pakistan) White	N=196 Females: N=146	Hospital	Coding sheet Psychiatric assessment	Deliberate self-poisoning	<p><b>Precipitating factors</b></p> <ul style="list-style-type: none"> <li>- Marital problems</li> <li>- Arranged marriage</li> <li>- Husbands' expectation to behave less westernized</li> <li>- Interference of mother-in-laws</li> <li>- Rejecting arranged marriage and conflict with parents concerning customs (unmarried Asian women)</li> </ul>
Merrill & Owens, 1987	UK	West Indian (Afro-Caribbean) White	N=130 Females: N=95	Hospital	Coding sheet Psychiatric assessment	Deliberate self-poisoning	<p><b>Similarities</b></p> <ul style="list-style-type: none"> <li>- Marital problems: similar proportion (West Indians: males 66.7%, females 52.9% vs. Whites: males 48.3%, females 49.1%)</li> </ul> <p><b>Ethnic differences</b></p> <ul style="list-style-type: none"> <li>- Culture conflict only in single females (1.4% West Indians, 1.8% Whites).</li> <li>- Previous self-poisoning: more common in Whites (males 33.2%, females 34.0%) than West Indians (males 14.3%, <math>p &lt; 0.05</math>, females 15.8% <math>p &lt; 0.001</math>).</li> <li>- West Indian females aged under 35 years: less likely than Whites to have received previous psychiatric treatment (West Indians 10.2%, Whites 20.1%, <math>P &lt; 0.05</math>).</li> <li>- Diagnosed as suffering from a psychiatric illness: Significantly fewer West Indian females aged under 35 years (West Indians 17.4%, Whites 29.3%, <math>P &lt; 0.05</math>)</li> </ul>
Ponizovsky et al., 1999	Israel	Russian immigrants Israeli Russian	N=406 Females: N=198	Household survey	Self-administered questionnaires	Suicide ideation, Attempted suicide	<p><b>6-month prevalence rate of suicidal ideation</b></p> <ul style="list-style-type: none"> <li>- Significantly higher in immigrant sample (10.9%) vs. Russian controls (3.5%) but not Israeli natives (8.7%)</li> </ul> <p><b>Suicide ideators</b></p> <ul style="list-style-type: none"> <li>- more psychological distress and behaviour problems</li> <li>- more immigration difficulties (language, physical health, personality characteristics, family problems)</li> <li>- lower social support from the family</li> <li>- less socioeconomic and intercultural problems of migration</li> </ul> <p><b>Predictors of suicidal ideation</b></p> <ul style="list-style-type: none"> <li>- possessiveness (girls)</li> <li>- somatic complaints (girls)</li> <li>- anxiety and depression (both sexes)</li> </ul>

Table 2. cont.

Authors	Country	Ethnic group	Sample	Place of recruitment	Methods	Type of suicidal behaviour	Precipitating and risk factors
Soni Raleigh et al., 1990	UK	Indian Subcontinent (Bangladesh India Pakistan Sri Lanka)	N=231 Females: N=86	Death register study	Death certificates	Suicide	<b>Indian women</b> <ul style="list-style-type: none"> <li>- younger</li> <li>- married</li> <li>- high SES class</li> </ul>
van Bergen et al., 2009	The Netherlands	Turkish Moroccan South Asian-Surinamese Dutch	N=115 (female)	Hospital Mental health care centers	Case notes	Attempted suicide	<b>Risk factors</b> (D=Dutch, T=Turkish, M=Moroccan, SA= South Asian) <ul style="list-style-type: none"> <li>- In at least half of the cases: specific stressful life events related to family honour:</li> <li>- Overregulation: 50 % of cases for M, T and SA, D: 28 %</li> <li>- Demand of upholding chastity (T &amp; M)</li> <li>- Fear of being outcast (mostly T)</li> <li>- Being forced to maintain unwanted marriage</li> <li>- Rejection of partner</li> <li>- Physical abuse (T 31%, M 37%, SA 42%, D 21%)</li> <li>- Having a psychiatric or personality disorder D (79 %), T (59 %) and (60 %), SA (71 %)</li> <li>- Co-morbidity: D (59 %) SA (33 %), T (28 %) M (27 %)</li> </ul>
van Bergen et al., 2010	The Netherlands	Turkish Moroccan South Asian-Surinamese Dutch	N=4527 (female adolescents)	Schools, Youth Health Monitoring Longitudinal youth health surveillance system by Municipal Public Health Service	Self-report questionnaires	Attempted suicide	<b>Risk factors</b> <ul style="list-style-type: none"> <li>- Family environment (all ethnicities)</li> <li>- Less discussion of problems with parents (Dutch, Turkish)</li> <li>- Physical abuse (Turkish)</li> <li>- Sexual abuse (Dutch, South Asian)</li> <li>- Parental psychopathology (Turkish, South Asian)</li> <li>- Chronic illness (Moroccan)</li> <li>- Lower level of education (except South Asian)</li> <li>- Low SES (Turkish)</li> </ul>

Table 2. cont.

Authors	Country	Ethnic group	Sample	Place of recruitment	Methods	Type of suicidal behaviour	Precipitating and risk factors
van Leeuwen et al., 2010	France	North African, Spanish, Italian, Dominican, Portuguese, Asian, America	N=292 adolescents Females: N=122	High schools	Survey study questionnaires	Suicidal ideation	<b>Risk factors</b> - Borderline traits (girls) - Individualism (both sexes) <b>Protective factors</b> - Assimilation and marginalization (girls) - Parental attachment (both sexes)
Yilmaz & Riecher-Rössler, 2008	Switzerland Surveillance study	Turkish	N=70 Females: N=48	Emergency department	Surveillance study, case files review, standardized questionnaire for clinicians	Attempted suicide	<b>Main problems</b> - Relationship problems (62.9%) - Problems with parents (second generation 20%) - Domestic violence (first generation 21.4%, second generation 14.7%) <b>Risk factors</b> - Being second generation: 64.3% of all attempters (Among second generation 75.6% women)
Yilmaz & Riecher-Rössler, 2012	Switzerland Surveillance study	Turkish Swiss	N=70 Turkish and N=79 Swiss attempters Females: N=48	Emergency department	Surveillance study, case files review, standardized questionnaire for clinicians	Attempted suicide	<b>Main problems</b> - Relationship difficulties most frequently named in both groups - Violence in the partnership (18.2% Turkish females vs. 0% Swiss patients)

Domestic violence was one of the most frequently mentioned causes for suicidality in several other publications. For instance, in a retrospective analysis of case files of Turkish, Moroccan, South Asian, and Dutch women who demonstrated deliberate self-harm in the Netherlands, sexual abuse or harassment (Dutch women 38%, Moroccan 17%, South Asian 21%, Turkish 19%), and physical abuse (South Asian women 42%, Moroccan 37%, Turkish 31%, Dutch 21%) were stated as risk factors for suicidal behaviour (van Bergen et al., 2009). Further, 'threat of death' (most notably among Moroccan women) and 'being stalked by an (ex-) partner' were also reported. In another study, van Bergen et al. (2010) analyzed data from a questionnaire-based survey of adolescents in the Netherlands to identify risk factors for suicidal behaviour by ethnicity and gender. Physical and sexual abuse, and an impaired family environment, as well as parental psychopathology or parental substance abuse contributed to non-fatal suicidal behaviour of females across ethnicities.

Furthermore, Hicks and Bhugra (2003) studied perceived causes of suicide attempts in South Asian women residing in London. Violence by the husband (92%), being trapped in an unhappy family situation (90%), and depression (90%) were reported as the top three perceived causes for suicide attempts in Asian women in the UK. In another study, Bhugra and Hicks (2000) conducted a series of focus groups with female South Asian women. Besides 'isolation after immigration' to the UK, 'marital problems' including battering and infidelity, 'conflicts with in-laws', and 'dowry conflict' (torture by the in-laws for dowry) were the most-mentioned perceived causes for deliberate self-harm. Women described the feeling of 'being trapped' in their circumstances and being socially isolated because of a combination of control by the new, in-law family, and the loss of support from her natal family and community after immigration.

An important contributing factor as to why immigrant women who are victims of domestic violence are especially vulnerable for suicidal behaviour, is their legal status (Chantler, et al., 2001). If a woman immigrates by marrying a permanent resident, European countries have a specific time frame in which she has to stay married to be able to maintain her legal status (i.e. 'one year rule' in the UK, three years in Germany). Thus, many women are afraid they will be deported if they report the abuse, and so stay with their abusive husbands. Female South Asian attempters stated they are controlled via their immigrant status, 'with passports and other

forms of identification being withheld from women by their abusers' (Chantler et al., 2001, p. 89).

### ***Family honour and pressures from the community***

The pressures and conflicts caused by the duty to maintain their family's honour was a common theme in (South) Asian, Turkish, and Moroccan women's narratives. In the retrospective analysis of case files of young Turkish, Moroccan, South Asian, and Dutch women who demonstrated deliberate self-harm in the Netherlands, immigrant women experienced specific, stressful life events related to their family honour in more than half of the cases. Also, their lives were often characterized by a lack of self-autonomy (van Bergen, et al., 2009).

In a focus group study with Asian women in Manchester, the importance of 'izzat' (honour in Hindi-Urdu) and the power of the 'community grapevine' leading to oppression from within the community, as well as sexism and racism from without, were the main themes emerging from the discussions (Chew-Graham, et al., 2002). These external pressures were seen to lead to distress, and 'self-harm was seen as a logical response to the distress' (Chew-Graham, et al., 2002, p. 341). Asian women stated that since the burden of a family's 'izzat' is unequally placed upon the women of the family, 'izzat' could be misused to reinforce women's roles in family life, and to coerce them into remaining silent about their problems. 'Another layer to the concept of 'izzat' was the sense of competition that it engendered between families, each competing for status and prestige in the community' (Chew-Graham, et al., 2002, p. 342). Additionally, the community grapevine was described to as creating pressure for families to be 'doing well', either according to the maintenance of cultural values, academically or with respect to employment. The behaviour of the women and whether this is seen as 'good' behaviour according to community or religious values was mentioned as one factor adding to the status and prestige of the family. Women stated that if any hint of women behaving inappropriately is seen, they are faced with continuous 'gossip' or 'rumour'.

Bhardwaj (2001) interviewed young Asian women in Britain with and without a history of attempted suicide as well as service planners and providers. The interviewees described young Asian women as growing up with competing expectations in two different societies and experiencing a range of societal and political pressures. Women stated they suffer from community and cultural oppression, including rigidly defined matrimonial roles,

inequalities between men and women, the duty of women to maintain the family 'izzat' and being burdened by the unrealistic expectations related to this honour. Women saw themselves as 'bearers of community and family honour' (Bhardwaj, 2001, p. 58), and living under constant pressure because 'they can singularly jeopardize the standing and fortunes of their immediate extended kin' (Bhardwaj, 2001, p. 58).

### ***Conflicts with the own family***

The impact of conflicts with the own family on suicidal behaviour of immigrant women was reported in several studies (Bhardwaj, 2001; Bhugra, 2002; Bhugra, et al., 1999; Bhugra & Hicks, 2000; Burke, 1976; Hicks & Bhugra, 2003; Merrill & Owens, 1986; van Bergen, et al., 2009, 2010, 2012). Among female Turkish, South-Asian, and Moroccan adolescents and adults in the Netherlands, an unsatisfactory family environment characterized by insufficient discussion of problems with parents, lack of connectedness and affection, an upbringing that does not strengthen self-worth nor emphasize dignity and results in a sense of self lacking in worthiness, as well as parental morbidity (in terms of psychopathology) were important contributors to suicidal behaviour (van Bergen, et al., 2009, 2010, 2012).

In life story interviews with Turkish, South-Asian, and Moroccan immigrant women in the Netherlands, suicidal behaviour was mainly influenced by the ability and right to act autonomously with regard to strategic life choices and by the questioning of cultural values of self-sacrifice and protection of honour (van Bergen, et al., 2012). Conflicts with parents were mostly about marrying a partner that the family rejects, not being able to decide whether to stay married or opt for a divorce, demands of upholding chastity, forced marriage, movement in and outside the house, and the right to education.

Very similar precipitating factors are reported in the publications about Asian women in the UK. In the UK, South Asian adolescents acknowledged that having a disagreement with parents was the commonest precipitating factor for deliberate self-harm, but this was the case for White adolescents as well (Bhugra, et al., 2004). However, South Asian females were more likely to report home life problems (intergenerational clashes, communications problems, culture conflict, and being compared to other children), low self-esteem, and social isolation.

In the Merrill and Owens study (1986), Asian females state that conflicts with their parents arise when they reject proposed arranged marriages or rebel against their parents imposing what they saw as restrictive Asian customs (e.g. not allowing them to go out at night, mix with boys, or take further education). In the comparison of Asian women with and without suicide attempt, Bhugra and Hicks (2000) report that attempters generally had more 'modern' views than the control group; for instance, they were less in favour of arranged marriage, and believed more often that all tasks should be shared between a couple. Also, more of them had a relationship with a White person. Parental pressure, control, and overregulation, especially when women do not obey or meet the high demands and expectations of their families, were commonly reported as precipitating factors for suicidal behaviour (Bhardwaj, 2001; Hicks & Bhugra, 2003; van Bergen, et al., 2009, 2012).

### ***Psychiatric disorders, previous psychiatric history/treatment, and previous suicide attempts***

In the majority of the publications where psychiatric disorders were assessed, immigrant women in general had significantly lower rates, fewer histories of previous psychiatric history/treatment, and fewer previous suicide attempts when compared to women of the majority population.

In the two Merrill and Owens (1986, 1987) studies, West Indian and Asian women in the UK were less likely to be diagnosed with a psychiatric disorder, alcoholism, or personality disorder compared to White women after an episode of deliberate self-harm. Burke (1976) reported that only 33% of the Asian suicide attempters were given psychiatric diagnoses. In a more recent study from the UK, 48% of South Asian female suicide attempters were not diagnosed with a psychiatric disorder, while this was only the case in 11% of the White females (Bhugra et al., 1999). In the Cooper et al. (2010) population-based cohort study about patients presenting with self-harm at emergency departments in three cities in the UK, female Black and South Asians were less likely than White suicide attempters to present with a history of or current episode of a psychiatric disorder, have an earlier episode of self-harm or to have used alcohol prior to self-harm. Further, South Asian women were less likely to attend with a repeat episode. In line with the findings from the UK, van Bergen et al. (2009) report that while 79% of the Dutch women received a psychiatric diagnosis after a suicide attempt, only 71% of South-Asian, 60% of Moroccan and 59% of Turkish women did. Additionally, co-morbidity was higher in Dutch

females (59%) than in Moroccan (27%), Turkish (28%), and South-Asian women (33%).

Some studies assessed specific psychiatric disorders. Bhugra et al. (2004) report that, while depression was highly frequent in White female adolescents who attempted suicide (42%), rates were comparatively low in South-Asian females and male adolescents (16%). The rates for depression were also reported to be lower in South-Asian than White female suicide attempters by Bhugra et al. in 1999, with 52% White vs. 27% South-Asian females presenting with depression. Moreover, emotional problems were mostly described as being an outcome of social problems. For instance, when female South Asian focus group participants mentioned depressed mood, it was always implied 'as a result of a social problem, with the clear expectation that if the social problems were solved, suicidality would also be resolved' (Bhugra & Hicks, 2000, p. 23-24).

The only types of psychiatric disorders with which immigrant women were more likely to be diagnosed with were neurotic, stress-related and somatoform disorders. The EURO/WHO Multicentre Study of Suicidal Behaviour in Wurzburg, Germany, reports that Turkish (54%) and Polish (33%) women were more commonly diagnosed with an adjustment disorder than German women (24%) (Löhr, et al., 2006). Further, the EURO/WHO Multicentre Study conducted in Switzerland reports that Turkish women (45.7%) are significantly more often diagnosed with neurotic, stress-related and somatoform disorders than Turkish men (25%), Swiss women (14.6%), or Swiss men (11.3%). According to the International Statistical Classification of Diseases and Related Health Problems (ICD-10) adjustment disorders are 'States of subjective distress and emotional disturbance, usually interfering with social functioning and performance, arising in the period of adaptation to a significant life change or a stressful life event. The stressor may have affected the integrity of an individual's social network (bereavement, separation experiences) or the wider system of social supports and values (migration, refugee status), or represented a major developmental transition or crisis (going to school, becoming a parent, failure to attain a cherished personal goal, retirement)' (WHO, 2010). So the higher prevalence of adjustment disorders among suicidal immigrant women is in line with the explanation that emotional distress is mainly caused by specific social stressors. Also, in the UK 58% of South Asian female adolescents presenting with an act of deliberate self-harm reported adjustment problems compared to White females (39%) and

South Asian male adolescents (33%) (Bhugra, et al., 2004).

Two of the adolescent studies used questionnaires about psychiatric distress to assess the influence on suicidal ideation (Ponizovsky, et al., 1999; van Leeuwen, et al., 2010). The French adolescent study that explored the influence of social, cultural and psychopathological factors on suicidal ideation found higher rates of borderline traits among girls with suicidal ideation (van Leeuwen, et al., 2010). However, the sample only consisted of adolescents with an immigrant background, so potential differences to majority population adolescents were not examined. Ponizovsky et al. (1999) performed a multiple regression analysis to predict suicidal ideation for Russian immigrant girls and boys living in Israel. Specifically, for girls the best predictors were obsessiveness and somatic complaints, which accounted for 12% and 22%, respectively, of the total variance in levels of suicidal ideation. Anxiety and depression were common in both sexes, and these explained a total of 34% of the variance for girls (vs. 24% of the variance for boys).

#### ***Issues related to migration***

Stressors related to the experience of being an immigrant, as well as the interaction with the majority society, were mentioned in several of the reviewed publications. Sexism, racism, being stereotyped and treated unequally by their host society, as well as racial attacks in their home and neighbourhood were mentioned by three qualitative studies (Bhardwaj, 2001; Chew-Graham, et al., 2002; Chantler, et al, 2001). Cultural conflict perceived as stemming from racial prejudice was mentioned by 61% of the Asian participants in the study by Merrill et al. (1986).

Being and feeling socially isolated after immigration (Bhugra & Hicks, 2000; Chew-Graham, et al., 2002; van Bergen, et al., 2012), and having lost contact with relatives abroad (Bhugra, 2002) were other migration-related stressors. Furthermore, difficulties in the process of acculturation were found to be associated with an increased risk for suicidal behaviour: In the study by van Bergen et al. (2012) the interviewees reported distress related to acculturative stress and cultural alienation. The adolescent study by van Leeuwen et al. (2010) found an elevated risk for suicidal ideation concerning the acculturation style individualisation, but a reduced risk to be associated to assimilation as well as marginalization in female adolescents with an immigration background in France (van Leeuwen et

al., 2010). Two publications also mentioned (English) language problems as a potential stressor for South-Asian women in the UK (Bhugra & Hicks, 2000; Chew-Graham, et al., 2002).

### ***Socio-demographic variables***

Besides ethnicity, immigrant-specific factors, and general socio-demographic characteristics were also explored in some publications. Being younger (Brückner et al., 2011; Cooper, et al., 2006, 2010; Löhr et al., 2006; Merrill & Owens, 1986), belonging to the second generation (Yilmaz & Riecher-Rössler, 2008), being single (Cooper et al., 2010), and being separated or divorced (Löhr et al., 2006) were related to suicidal behaviour in different ethnic minority women.

Regarding education, social status, and living circumstances, the results were contradictory. Van Bergen et al. (2010) reported lower level of education to be related to suicidal behaviour in all female adolescents (Dutch, Moroccan, and Turkish), except for South Asian-Surinamese. Also, lower level of social status indicated an increased risk in Turkish females. Cooper et al. (2010) reported that female Black attempters had more housing problems than White women. However, two publications found that low social status was less likely to be related to suicidal behaviour when immigrant women were compared to women of the majority population, with Raleigh et al. (1990) reporting that Asian suicide attempters belonged to the highest social class more often than White women, and Cooper et al. (2006) describing that compared to White women, South Asian women were less likely to be unemployed or to live in circumstances that are commonly associated with high self-harm risk (i.e. being unemployed, living alone, homeless, or in a hostel).

### ***Barriers for help-seeking***

Four qualitative studies from the UK interviewing (South) Asian women assessed barriers for seeking help or experiences with service providers (Bhardwaj, 2001; Bhugra & Hicks, 2000; Chantler, et al., 2001; Chew-Graham, et al., 2002). Language barriers, lack of interpreters and little or no knowledge about services and support were mentioned as problems. Also, the fear of racist statements, being judged, a lack of understanding of the culture, the fear that women's problems would be viewed from a 'white' experience, and simplistic sweeping solutions like leaving the family without understanding the complexities of their experience, were mentioned for making it difficult for women to seek help in services that are not culture sensitive (Chantler, et al., 2001; Chew-Graham, et al., 2002).

Furthermore, the fear of breaches of confidentiality and the community grapevine (e.g. fear that family would be informed and the community would find out about the problems) made women feel unable to trust providers and reluctant to seek help. Culturally-based expectations that women should not speak out within or about the family, shame, the fear of being labelled, judged or blamed if women disclosed any family problems, and the feared consequence that the woman and her family could be stigmatized and their family honour ruined, were also paramount in the narratives (Bhugra & Hicks, 2000; Chantler, et al., 2001). Other barriers for seeking help were lack of money, having small children, lack of support by her parents, or having nowhere else to go (Bhugra & Hicks, 2000). The described barriers for help-seeking can cause a suicidal crisis when women feel they are in a desperate and hopeless situation that they cannot escape, and their only 'way out' becomes taking their own life.

## **Discussion**

### ***Summary***

The main finding of this review is that familial problems are the most frequently described precipitating factor for suicidal behaviour for immigrant and ethnic minority women, whereas well known risk factors commonly associated with high self-harm risk in Western countries, such as psychiatric disorders, previous psychiatric history/treatment, or previous suicide attempts, appear to have less impact. Issues related to migration, such as racism, being stereotyped, treated unequally, acculturative stress, and cultural alienation, also play an important role, particularly since they can lead to further social isolation of immigrant women. The various described barriers for help-seeking, such as lack of language proficiency, little knowledge about services, lack of culture sensitive services, mistrust, fear of racism, breaches of confidentiality, social stigma or having nowhere else to go, create circumstances where women feel they cannot solve their problems and they have to 'suffer in silence' and feel 'trapped'. If the situation becomes unbearable and hopeless, women may perceive suicide as the only 'option'. Concerning the results about the impact of socio-demographic variables on suicidal behaviour, results are scarce, but being young or belonging to the second generation were reported as risk factors in three publications, and being single, separated or divorced in two publications. Findings about the role of education,

social status, and living circumstances are contradictory.

### **Limitations**

The most relevant limitation of the research on suicidal behaviour among ethnic minority and immigrant women is that, to our knowledge, certain immigrant women groups with high rates of suicidal behaviour have not been studied. Most existing publications are about (South) Asian women, and most of them were conducted in the UK. Turkish and Moroccan women have been studied in only a few publications, and, unfortunately, there is almost no information about Polish women, who reportedly have a suicide attempt rate more than six times higher than German women in Wurzburg, Germany, and a suicide rate twice as high as Swedish women (Löhr, et al., 2006; Westman, et al., 2006). For them and for other immigrant groups, precipitating factors might be very different to the better studied factors of (South) Asian, Turkish, and Moroccan women. For instance, family honour and the community grapevine may not play a role in their communities.

Another relevant limitation is that none of the reviewed articles examined well-known influencing factors for suicidality, such as religion and spirituality, social integration, or genetic risk factors. Regarding religion and spirituality, a recent review about the influence of religion and spirituality on mental disorders (Bonelli & Koenig, 2013) reports that 'there is good evidence today that religious involvement is correlated with mental health in three major domains of psychiatry: depression, substance abuse, and suicide' (p. 668). Further, the protective nature of social integration has been a topic in the suicide literature for a long time. In 1986, Trovato and Jarvis already reported that the rate of suicide of immigrants in Canada varies inversely with a group's degree of social integration, supporting the Durkheimian proposition. Additionally, Stack (2000) states in his review of sociological studies about suicide, that 'migration can break up ties between the individual and the social systems, including bonds to relatives, co-workers, family geography, and neighbours' (p. 171), showing that especially for immigrants social integration can be a crucial protective factor for suicidality.

In a meta-analysis about the association of immigrant and country of birth suicide rates, Voracek and Loibl (2008) demonstrate a strong correlation between the two for 50 nationalities in seven host countries, supporting genetic risk factors for suicide. Religion, social integration, and genetic risk factors are examples of influencing factors that are well-known in suicide research, and that should be studied

in future studies about suicidality of female immigrants and ethnic minorities.

Concerning the methodological limitations of the quantitative studies, there were very few national studies, sample sizes were generally small, and most studies did not compare their sample with the majority population as a control group. Also, two studies had mixed samples where a comparison between subgroups could not be made. In regard to qualitative studies, we only found studies conducted in the UK and the Netherlands. There is a lack of qualitative studies from other European countries, where reported risk is high and precipitating factors and circumstances around suicidal behaviour are completely unknown. Qualitative studies are crucial here, especially since there is so little knowledge about causes for suicidal behaviour, barriers for help-seeking, and recommendations for possible solutions, and these aspects are difficult to be assessed with quantitative measures.

Furthermore, we did not find any population-based studies that follow individuals through their care pathways. In the review about rates and risk factors of self-harm among ethnic minority groups in the UK (Bhui, et al., 2007), the authors state that because of this lack of information, it is not possible to 'fully discern whether culturally determined patterns of help seeking or whether limited access to services account for the ethnic variations in rates of services' (p. 12-13). Also, there were no publications about female refugees and asylum seekers.

### **Common risk profiles of immigrant and ethnic minority women**

Since the reviewed publications did not cover all groups of immigrant and ethnic minority women in Europe who have high rates of suicidal behaviour, one should be careful with the generalization of the results. For instance, even though the precipitating factor 'familial problems' was very prevalent, up to now, it was only reported for (South) Asian(-Surinamese), Turkish, Moroccan, and West Indian immigrant women. Also, the nature of familial problems was only studied in (South) Asian(-Surinamese), Turkish, and Moroccan women. However, the evidence does suggest that these three groups might have similar risk profiles. The issue of family honour and the community grapevine has been described for Turkish immigrants as well. Schouler-Ocak and colleagues (2008) describe that in Turkish culture its female members in particular uphold family honour. Because of the pressure to protect the family's honour, women are subject to especial scrutiny and control. The 'namus' (honour in

Turkish) of a woman is above all related to sexuality, chastity, and modesty. To restore the honour of the family, in some cases 'families will renounce their children or relatives' (Schouler-Ocak, Reiske, Rapp, & Heinz, 2008, p. 656). So many women can develop a strong feeling of responsibility to keep the family intact, regardless of what the circumstances are. Because of these similarities, the culture-specific help-seeking barriers concerning family honour and gender roles described in studies with (South) Asian women in the UK may apply to Turkish or Moroccan women as well. Moreover, culture-sensitive interventions that were already developed successfully for (South) Asian women living in the UK (e.g. Bhugra & Hicks, 2004; Husain, et al., 2011), may be applied to Turkish and Moroccan women as well (with certain changes, of course). Several other help-seeking barriers like language, little or no knowledge about services and support, or lack of interpreters and culture-sensitive services, are not culture-specific and can affect all immigrant and ethnic minority women in the same way.

A precipitating factor for suicidal behaviour irrespective of cultural background or ethnicity is domestic violence. Its impact on mental health in general and suicidal behaviour in particular has been demonstrated in several studies, e.g. in the WHO Multi-country Study on Women's Health and Domestic Violence (Devries, Watts, Yoshihama, Kiss, Schraiber, et al., 2011; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008). Unfortunately, most of the reviewed studies did not include a control group of native women nor non-suicidal immigrant women, so it is hard to discern whether domestic violence is more common among immigrant women, or whether domestic violence is more common among the suicidal immigrant women than the non-suicidal women. Nonetheless, immigrant women can be additionally exposed to immigration-related abuse (Raj & Silverman, 2002). Immigration-related forms of abuse include threatening women with deportation of them or their children, keeping, destroying, or threatening to destroy the passports or immigration documentation, placing immigrant women at risk for deportation, limiting their contact with family and prohibiting friendships, keeping them from working, not allowing them to learn the language of the host country, or employing economic abuse to control women. Especially women with less protected immigration status (undocumented or no permanent legal immigrant status) may not leave their abusers for fear of deportation (Raj & Silverman, 2002).

In the three studies of adolescents, problems at home were the major influencing factor for suicidality across ethnicities. Disagreements with

parents (Bhugra, et al., 2004), an impaired family environment and stressful life experiences concerning family, school, and personal and interpersonal relationships (van Bergen, et al., 2010) were risk factors, and attachment to parents (van Leeuwen, et al., 2010) a protective factor in all groups. These results indicate that problems immigrant adolescents face are rather age-specific problems, yet aggravated by cultural conflict (Bhugra, et al., 2004) and acculturation styles (van Leeuwen, et al., 2010).

### **Future directions**

National and epidemiological studies focusing on universal and immigrant-specific risk and protective factors that use culturally validated measures are urgently needed. Just as much, in-depth qualitative research aimed at exploring causes, help-seeking behaviour and possible solutions in specific immigrant groups where little or no research has been conducted to date is crucial to better understand the association of gender, suicidal behaviour, ethnicity, and immigration.

For the planning, management and delivery of adequate services, gender- and culture-specific issues need to be considered. To address issues like familial conflicts, community pressure or domestic violence and their impact on suicidal behaviour, the existing conventional interventions and treatments are not sufficient to meet the needs of immigrant and ethnic communities. Other types of interventions and treatments like culture-sensitive community or social interventions or interventions targeting specific subgroups (i.e. youth, families, perpetrators) might be possible solutions.

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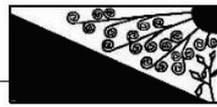
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Editorial Office  
Assoc. Prof. Dr. Nestor Kapusta  
Suicide Research Group  
Department of Psychoanalysis and Psychotherapy  
Medical University of Vienna  
Waehringerguertel 18-20  
1090 Vienna, Austria  
[office@suicidology-online.com](mailto:office@suicidology-online.com)  
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