Essay

Violence against women and suicide in the context of migration: A review of the literature and a call for action

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Abstract: Domestic violence and other forms of violence against women and coercion are well known to be substantial and widespread, with women more likely than men to be abused by partners and other family members. Domestic violence is a major precipitating factor for suicide, and ethnic minority, immigrant and refugee women are at higher risk for suicidal behaviour. This article reviews literature about suicide and domestic violence among ethnic minorities, immigrants and refugees to examine the relationship between the two. Further, it presents a 'call for action' for academics, policy makers and service providers engaged in suicide prevention. Higher risk of being victim of violence, additional forms of violence (immigration-related abuse), and greater barriers to seeking help, contribute to make women from immigrant and refugee backgrounds particularly vulnerable to suicidal behaviour. While violence against women is now widely recognized as a significant global problem, a major public health issue, and one of the most widespread violations of human rights, suicidal behaviour among immigrant women has received limited attention as a public health concern, and even less as a human/women's right issue. Suicide prevention must be addressed as a public health issue, and it is time for suicide to be considered also as a women and human rights issue.

Keywords: domestic violence, family violence, violence against women, gender-based violence, suicide, suicidal behavior, immigrant, refugee, ethnic minority, NESB, CALD, women.

Violence against women

Twenty years ago, violence against women was not considered an issue worthy of international attention, but this began to change in the 1980s, as women's groups were organized locally and internationally to demand attention to the physical, psychological, and economic abuse of women (Alhabib et al., 2010). Gradually, violence against women has come to be recognized as a legitimate human rights issue and a significant threat to women's health and well-being (Ellsberg & Heise,

2005, cited in Alhabib et al., 2010). In particular, the landmark report published by the World Health Organization in 2002 gave global relevance to the epidemic rates and serious and long-term impacts of violence by positioning it as a leading worldwide public health concern. In 2005, the prevention of violence against women was set as a high priority (WHO, 2005). In this report, it was highlighted how domestic violence 'continues to be frighteningly common and to be accepted as 'normal' within too many societies' (p.VII), and that the perpetrators of the violence are often well known to their victims.

Domestic violence can encompass a wide range of behaviors including verbal abuse, threats, coercion, harassment, intimidation, manipulation, physical and sexual abuse, criminal damage, rape,

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and homicide Colucci, E., O'Connor, M., Field, K., Baroni, A. & Minas, H. (in press). While women represent the overwhelming majority of victims of violence occurring in the home, men are sometimes victims too; however, the experiences of violence are far from symmetrical. This is so to the point that it has been observed that the biggest risk factor for becoming a victim of sexual assault and/or domestic and family violence is 'being a woman' (National Council to Reduce Violence Against Women and their Children, 2009).

It is not possible to accurately quantify the number of people affected by domestic violence annually, as most incidents go unreported (Wilcox, 2006). However, violence against women is a universal phenomenon that persists in all countries and societies of the world, affecting all communities irrespective of race, gender, class, religion, cultural background or ethnicity (Bannenberg, 2003).

A recent multi-site study found that domestic violence was widespread in all of the countries included in the study, although there was great variation between countries. The proportion of ever-partnered women who had ever suffered physical violence by a male intimate partner ranged from 13% in Japan city to 61% in Peru province, with most sites falling between 23% and 49% (WHO, 2005).

Even a country like Norway, characterized by welfare and gender equality, is not immune to violence against women, as it was strongly captured by a recent campaign by Amnesty Norway (http://www.imow.org/wpp/stories/viewstory?storyid=178). In Australia and Germany well over one-third of women (40%) indicated physical and/or sexual violence (Schröttle & Müller, 2004; VicHealth, 2011).

Alhabib and colleagues (2010) systematically reviewed the worldwide evidence on the prevalence of domestic violence against women (in particular, physical, sexual and emotional violence). Although the 134 studies reviewed showed variations between countries (ranging from 1.9% to 70%) and populations (i.e. clinical vs. general populations), the authors concluded:

> The results of this review emphasize that violence against women has reached epidemic proportions in many societies and suggests that no racial, ethnic, or socio-economic group is immune. (…) Our results indicate that prevalence of all types of violence has increased over time, despite the provision of legal services for victims of violence (p. 373; 375).

Several factors have been associated with low or high risk of violence against women (Colucci & Pryor, in press). Higher risk of violence is found in societies with traditional gender norms and roles, unequal distribution of power and resources between men and women, a normative use of violence to resolve conflicts, and cultural approval of (or weak sanctions against) violence against women. In particular, gender and culture represent 'meta-factors' that influence attitudes towards violence against women at multiple levels of social order. Together with unequal power relations between men and women and the way gender roles, identities and relationships are constructed and defined within communities and societies, a lack of access to resources and systems of support has been identified as a key determinant of violence.[1]

Low use of formal services reflects in part their limited availability. However, even in countries relatively well supplied with resources for abused women, barriers such as fear, stigma and the threat of losing their children stops many women from seeking help (WHO, 2005). Persisting societal and/or cultural 'silence' on the problem, together with fears of not being believed, ostracized or re-victimized by people around them, can also determine or intensify women's reluctance to take help-seeking steps. This article discusses the relationship between domestic violence and suicidal behavior, including barriers to help-seeking, particularly among immigrant and ethnic minority women.

Violence against women and suicide

The impact of violence against women, particularly domestic/family violence, on physical and mental health and suicidal behaviour has been highlighted in several studies. Based on research from the United States, Fiji, Papua New Guinea, Peru, India, Bangladesh and Sri Lanka, UNICEF (2000) established a close correlation between domestic violence and suicide, since suicide resulted to be 12 times as likely to have been attempted by a girl or a woman who has been abused than by one who has not.

A highly significant relationship between domestic violence and suicidal ideation has been reported in many low income countries. For instance,

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[1] As indicated in this document, these key determinants are expressed and function differently in specific cultural, geographic and political settings. In addition, these determinants are visible at different levels of society, from the 'micro' level of individuals and relationships to the 'macro' level of social structures and institutions. An 'ecological' model of violence against women, as pioneered by the World Health Organization, provides a useful illustration of the complex interplay of personal, situational, and socio-cultural factors that contribute to violence against women.

in Brazil 48%, Egypt 61%, India 64%, Indonesia 11% and in Philippines 28% of women who had experienced physical abuse by their intimate partner thought of killing themselves (WHO, 2001).

A population-based cohort study of 1750 married Indian women on the association between spousal violence and health outcomes found that only two associations were confirmed at longitudinal analyses: sexually transmitted infections and attempted suicide (Chowdhary & Patel, 2008). In this line, a cross-cultural study on youth suicide showed that young Indians often saw several forms of harassment, abuse and violence against women as leading factors for female suicide in their country (Colucci, 2012). In the Indian sample, the belief that suicide is not only accepted but an expected (if not forced upon) response in some circumstances, and that women might thus be 'forced' to kill themselves, was indicated by some participants. Furthermore, participants expressed a general social view of women not only as inferior but as 'the ones to blame' for whatever happens to them and to others.

The 'WHO Multi-Country Study on Women's Health and Domestic Violence against Women' consisted of standardized population-based surveys between 2000 and 2003 with women aged 15-49 years in 15 low and middle income countries (Devries et al., 2011; Ellsberg et al., 2008). In this study, 24,097 women were interviewed about their experiences of physically and sexually violent acts by a current or former intimate male partner and about selected symptoms associated with physical and mental health.
For all settings combined, women who reported partner violence at least once in their life reported significantly more emotional distress, suicidal thoughts, and suicidal attempts than non-abused women. Intimate partner violence, non-partner physical violence, childhood sexual abuse and having a mother who had experienced intimate partner violence were the most consistent risk factors for suicide attempts after adjusting for common mental health disorders. These significant associations were maintained in almost all of the sites.

The study showed that violence is not only a substantial health problem by virtue of its direct effects, but that it also contributes to the overall burden of disease as a risk factor for several other serious health problems. In addition to being a breach of human rights, intimate partner violence is associated with serious public health consequences that should be addressed in national and global health policies and programs, and mental health policies and services must recognize the consistent relationship between violence against women and suicidal behaviour (Devries et al., 2011; Ellsberg et al., 2008).

Domestic violence among immigrant and ethnic minority women

Researchers and service providers have brought attention to the higher levels of violence experienced by women from refugee and immigrant backgrounds (e.g. Bonar & Roberts, 2006; Erez, 2000; O'Donnell et al., 2002; Vives-Cases et al., 2010; Vives-Cases et al., 2008). Walker (1999) argued that 'migration from one country to another seems to foster isolation that breeds more domestic violence no matter where a woman lives' (p. 26). A study carried out in US with nine immigrant communities showed that 'for these women, domestic violence occurs against the backdrop of social and economic marginalization that is similar to and extremely different from women who are mainstream (Bhuyan & Senturia, 2005, p. 896).

Immigration-related abuses

Besides the above mentioned forms of violence and abuse, immigrant women may be additionally exposed to immigration-related abuses. Batterers may isolate women by limiting their contact with family and prohibiting friendships, or keep them from working. They might limit their immigrant partners' ability to function by not allowing them to learn the language of the host country thereby increasing women's dependence on these men. Further, by demeaning women based on their lack of or limited language skills and/or lower levels acculturation, education, or work skills, women's insecurities about their ability to function in the new society without their spouses may be fostered (Raj & Silverman, 2002).

If women want to leave the abusive relationship, men may threaten women with deportation of them or their children, keep, destroy, or threaten to destroy the passports or immigration documentation placing immigrant women at risk for deportation, and/or employ economic abuse to control their immigrant partners (Colucci et al., in press; Raj & Silverman, 2002). Especially women with less protected immigration status, like undocumented or nonpermanent legal immigrant status, often do not leave their batterer for fear of deportation (Raj & Silverman, 2002).

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Reasons for increased domestic violence in immigrant populations: An example

Turkish immigrants in Central and West Europe were indicated to be a high risk group for domestic violence because of a migration-related social disintegration and isolation of the family, economic deprivation and societal degradation (Yilmaz & Battegay, 1997).

Lacking preparation prior to migration, poor introduction to the way of life of the country of arrival, insufficient language proficiency, difficult living and working conditions, and a stepwise migration of family members can cause strain. Additionally, the hierarchical structure of the family and the way of life in their home country where cohesion, loyalty, and obedience are important, are forced to be changed during the migrations process. That way, familiar coping strategies are overstrained so that conflicts within the family and psychosocial crises with the use of domestic violence can occur.

Yilmaz and Battegay (1997) hypothesized that violent behaviour of male Turkish immigrants is caused by hidden invalidations through the receiving society. These invalidations generate feelings of humiliation that on their part cause feelings of aggression that cannot be acted out in public because of the fear of consequences or language barriers, and are acted out in a familiar environment instead.

Suicidal behaviour among female immigrants in Europe

A number of studies in Europe have demonstrated that immigrant and ethnic minority women are at high risk for suicidal behaviour. In the UK, South Asian and Caribbean women showed higher rates of suicidal behaviour than White women, South Asian, and Caribbean males (Bhugra et al., 1999; Bhui, 2007; Burke, 1976; Merrill & Owens, 1986, 1987, 1988; Neeleman & Wessley, 1999; Neeleman et al., 2001; Soni-Raleigh, 1996; Soni-Raleigh et al., 1990). Young women of Turkish, Moroccan, and South Asian-Surinamese descent had disproportionate rates of nonfatal suicidal behaviour in the Netherlands (Burger et al., 2005; Schudel et al., 1998; van Bergen et al., 2010).

In Germany, the WHO/EURO Multicentre Study on Suicidal Behaviour reported that Turkish, Polish and Russian immigrant women had a significantly higher rate of attempted suicide than German women (Löhr et al., 2006), and young Turkish women had a suicide risk almost twice as high compared to same aged German women (Razum &

Zeeb, 2004). A Swiss study about suicide attempts of Turkish immigrants in an emergency unit demonstrated that young women of the second generation had the highest rates of attempted suicide (Yilmaz & Riecher-Rossler, 2008). Women of both first and second generation stated domestic violence as the most common precipitating factor (42.4%). In Sweden, nation-wide studies of suicide found an increased risk for immigrant women from Finland, Poland, and Eastern Europe (Ferrada-Noli, 1997; Hjern & Allebeck, 2002; Westman et al., 2006). Finally, in Denmark women with foreign background had a five times higher risk for suicide compared to Danes, even after controlling for marital status, income, place of residence, and psychiatric illness (Sundaram et al., 2006).

Domestic violence as a precipitating factor for suicidal behaviour among immigrant and ethnic minority women in Europe

Since suicidal behaviour among female immigrants and ethnic minorities in Europe is high, several studies have been conducted to investigate the possible reasons for these high rates. Van Bergen and collaborators (2010) analyzed data from a survey of 4527 adolescents of Dutch, South Asian-Surinamese, Moroccan, and Turkish origin in the Netherlands to identify risk factors for suicidal behavior by ethnicity and gender. Physical and sexual abuse contributed to non-fatal suicidal behaviour of females across ethnicities.

A series of focus group discussions with South Asian women gathered community opinions on perceived causes of suicide attempts in British South Asian women (Bhugra & Hicks, 2000). Besides isolation after immigration to the UK (being separated from supportive natal family, lack of English skills, mismatch between husband and wife), marital problems (including battering, infidelity, and bearing the burden of the husband's problems, in-law problems including torture by the in-laws for dowry, and lack of support from other family members and society) were considered the primary causes of suicide attempts. Arranged marriage has been indicated as a risk factor for suicidal behaviour since:

(…) newly married couples even in the UK may share the house with the groom's family having little or no space of their own and under such conditions the cultural expectation is that the bride will make all the compromises thereby contributing to the stress (…) These systematic social, economic and cultural pressures are more likely to affect the females than their male counterparts (Bhugra et al., 1999, p.1137).

Another study looked at perceived causes for suicide attempts in a cross-sectional convenience sample of 180 South Asian women residing in London, who filled out a questionnaire with a list of possible causes for deliberate self-harm (Hicks & Bhugra, 2003). Domestic violence (92%), and 'being trapped in an unhappy family situation' (90%), were reported as the top two perceived causes for suicide attempts. Another focus group study with female South Asian suicide attempters in the UK described a range of factors that were mentioned as contributing to their suicide attempts and self-harming (Chantler et al., 2001). Sexual and physical abuse, domestic violence, forced marriages, issues of loss and bereavement, immigration issues, and racism were the most commonly mentioned precipitating factors of a suicidal crisis. The authors state that 'A key theme clearly emerging from the survivor accounts are the links between domestic violence and attempted suicide and self-harm, as all but one of the survivors interviewed had experienced domestic violence' (p. 14). In relation to South Asian women, Waters (1999) argued that for many of these women, suicide is the endpoint of a suffering woman's life and that the abetment to suicide is considered so ubiquitous and powerful that many social activists have claimed, 'Every suicide is a murder' (p. 526).

The role of domestic violence as a precipitating factor for suicidal behavior

Although there is evidence that domestic violence is associated with suicidal behaviour, only a limited number of studies have explored the role of this contributing factor (Devries et al., 2011). There is discussion in the literature about the role of having a dowry/bride price, control over choosing one's husband, and being childless in marriage in increasing suicide risk, but evidence only from a handful of studies, mainly in Asian communities (Devries et al., 2011). Each of these factors may result in poor mental health status and suicide, but also may be associated with restricted autonomy and loss of control, which can then in turn cause poor mental health status and suicide (Canetto & Lester, 1998).

For immigrant women, being away from their natal family and community may result in a lack of or reduced social support and social isolation making women easier victims for men or other perpetrators. In the study by Bhugra and Hicks mentioned above (2000), analytic themes which emerged from discussions of suicide were the feeling of 'being trapped' (i.e. socially isolated and 'trapped' by a combination of control by the new, in-law family and loss of support from her natal family and community after immigration), 'distress in quietness'

(being unable to tell others, isolation, language barriers, shame/social stigma because of telling of marital or family problems, not being supposed to talk about your family, shame in admitting that anything is wrong, cultural expectations of women to contain their thoughts and not speak out within the family or about the family), and 'no way out' (limited options for leaving a distressing situation, 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). Furthermore, mental distress was always implied as a consequence of the social problems. Depressed mood, when it was occasionally mentioned, was always a result of a social problem, with the clear expectation that if the social problem was solved, suicidality would also be resolved. A similar point was made by Chantler et al. (2001) who stated that,

> *The question of pathology needs to be shifted from seeing women as pathological in encountering or tolerating abuse to seeing the environment she lives in as pathological. What seems very clear from the survivors accounts in this study (…) is that suicide attempts and self-harming appear to be a 'rational' response to such violence and brutality, rather than a mental illness* (p. 86).

Patel and Gaw (1996) conducted a review of studies of suicide among immigrants from the Indian subcontinent (India, Pakistan, Bangladesh, and Sri Lanka) to better understand social and psychological factors contributing to suicide in this group. Family conflict and domestic violence appeared to be a precipitating factor in many suicides. More specifically, moving to a foreign country and living in a hostile, unfamiliar, and lonely family situation may leave the vulnerable woman in a particularly unsupported environment at a critical time. These women might experience a sense of desperate entrapment and hopelessness about their future when they have to choose between continued abuse in the new situation and being an outcast in their own community at a time when they most urgently need support. It is in this scenario that suicide might appear, to some of those women, as the only option (Patel & Gaw, 1996).

Finally, a qualitative psychological autopsy study of suicide in post-conflict Northern Uganda (Kizza et al., 2012) suggested that the key issue for young men's suicidality was living up to their expectations, which they could not, whereas 'for the young women it was an issue of not wanting to live up to social expectations' (p. 2). This can be said true also for many immigrant and refugee men and

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women, where the changes in roles due to resettlement in a new country, including gender roles, can also bring about the same power struggles and conflicts associated to challenges of cultural norms, which could then lead to suicide.

Gender roles and expectations

As mentioned before, in cultures with more traditional gender roles, a greater acceptance of violence can be observed, and domestic violence might not be seen as 'bad' (Brabeck, 2009; Colucci et al., in press; Websdale, 1997). Traditional male gender roles that promote their dominance, power, and economic control may be used to justify the use of physical violence if the women do not stay within their prescribed role (Dasgupta & Warrier, 1996; Raj & Silverman, 2002). On the other hand, traditional female gender roles that require women to put family harmony before themselves, obey their husbands, be submissive, be passive, not to challenge men or say 'no', and that indoctrinate ideals of 'good' wife and mother that include sacrifice of personal freedom and autonomy, may make women view abuse as their fate and impede them to seek help or report the abuse.

Conflicts may arise when immigrant women become more acculturated and alter their ideologies to accommodate the presence of comparatively more egalitarian Western gender roles (Raj & Silverman, 2002). Studies of immigrant Asian and Middle Eastern communities indicate that changes in gender role ideology occur more quickly for women than men. When women are no longer willing to conform to certain traditional gender-based norms and change their ideologies and behaviors, males may increase their efforts to control women, including use of violence (Raj & Silverman, 2002). The violence due to a conflict between traditional and modern values held by the couple may increase the risk of suicide. A comparison of South Asian women with and without a suicide attempt showed that attempters have more 'modern' views than non-attempters (for instance, non-attempters thought significantly more often that arranged marriage is a good idea; Bhugra et al., 2002).

Structural barriers to escaping or help-seeking

In addition to barriers to seeking help faced by women from the broader community, women from immigrant and refugee backgrounds might face further barriers. Barriers for seeking help among immigrant women include lack of language proficiency, social isolation, lack of financial resources, lack of knowledge about services, lack of culturally-sensitive services, lack of knowledge of legal rights, and the fear that seeking help will influence their legal and migration status (Bhugra & Desai, 2002; Bhugra & Hicks, 2000; Bhuyan & Senturia, 2005; Chew-Graham et al., 2002; Intouch, 2010; Orloff & Little, 1999; Patel & Gaw, 1996; Raj & Silverman, 2002; Sawrikar & Katz, 2008; van Bergen et al., 2012).

Lack of cultural competence and responsiveness of service providers has also been highlighted as an important barrier (Colucci et al., in press, Colucci & Pryor, in press). For instance, South Asian immigrant women pointed out that service providers are usually White and lack understanding of Asian culture. Therefore, they feared to be judged and felt they would be offered simplistic yet unrealistic solutions such as 'leaving the family', without understanding the complexity of their socio-cultural situation (Chew-Graham et al., 2002).

Cultural barriers to escaping or help-seeking

There is a gap in the literature with regard to understanding the interplay of domestic violence and help-seeking among ethnic minority and immigrant populations that has been widely acknowledged among researchers and practitioners engaged in service delivery (Colucci et al., in press). However, there is a growing recognition that understanding how various communities perceive and respond to domestic violence is essential for improving access and delivery of services for specific Culturally and Linguistically Different (CALD) communities.

In some cultures, seeking help from outside is not encouraged, and families are pressured to solve their problems within the family to avoid social stigmatization and to protect their reputation and honour (Bhardwaj, 2001; Bhugra & Hicks, 2000; Raj & Silverman, 2002, Colucci et al., in press). As a result, women are pressured to contain their thoughts and not speak out of their family or about the family, and to put their community and family over themselves. The importance of the family's reputation and honour and the pressure that it causes on women has been described in a number of studies (Bhardwaj, 2001; Chantler et al., 2001; Chew-Graham et al., 2002; Colucci et al., in press; van Bergen et al., 2012).

For instance, in a retrospective analysis of case files of South Asian, Turkish and Moroccan women in the Netherlands who demonstrated suicidal behaviour, in at least half of the cases, women experienced specific stressful life events related to their family honour (van Bergen et al., 2009). In line with this finding, in a focus group study

with Asian women living in the UK (Chew-Graham et al., 2002), the main themes emerging from the discussions was the importance of 'izzat' (i.e. honour/respect) and the power of the community grapevine leading to oppression from within the community. Participants said that 'izzat' could be misused to reinforce women's roles in family life, often to coerce women into remaining silent about their problems. The burden of a family's 'izzat' is unequally placed upon the women of the family, which in turn creates hard to achieve high expectations. Similar findings were reported in another qualitative study about self-harm among Asian women in the US and the authors state that, 'In a powerful contradiction, the treatment of Asian women is restrictive not because they have so little power, but as bearers of community and family honour, they can singularly jeopardize the standing and fortunes of their immediate extended kin' (Bhardwaj, 2001, p. 58).

Schouler-Ocak and colleagues (2008) stated that maintaining the family´s honour plays an especially important role in Turkish culture as well. The family's honour is in particular upheld by its female members, and as a result women in the family are subject to special scrutiny and control. The 'namus' (honour) of a woman is above all related to sexuality, chastity, and modesty, and in some instances, families will renounce their children or relatives to somehow restore the honour of the family. As a result, many women develop a strong feeling of responsibility to keep the family intact regardless of domestic violence and suffer in silence. Honour, therefore, can be a cause or contributor to violence as well as represent a barrier for help-seeking.

Cultural barriers to escaping or help-seeking: an example

A recent theatre-based study was carried out in Australia to explore Indian immigrant women's perceptions of 'domestic/family violence' in their community and access to community's expertise and knowledge about the specific barriers that prevent disclosure and help-seeking (Colucci et al., in press; Colucci & Pryor, in press). Forum Theatre is a powerful tool that uses theatre for generating community understanding around hard to address issues such as domestic violence. Scenes are created by non-professional actor volunteers from the community who understand the issues being investigated. They develop the scenes utilizing theatrical games and, through such activities, participants are encouraged to investigate the social context in which the struggle under study takes place.

Having 'explored and investigated' the subject matter, short scenes are then created and performed in front of the other members of the community. Using such theatre-based ethnography, key issues, challenges and needs of Indian immigrant families when accessing and using services that could assist in situations of domestic/family violence were identified.

Participants indicated the presence of several forms of domestic/family violence in their community and discussed attitudes that sustain such practices and barriers. Suicide was construed as connected to domestic violence among Indian immigrant women in a number of ways. For instance, a few women in this study presented suicide as the only way out for some women 'to stop the violence' or because the woman 'is already socially dead'.

A participant also reported the story of 'a friend who couldn't have children and she killed herself because her in-laws were looking for another bride for their son'. Furthermore, a link between witnessing violence and suicide was also indicated, as in the following case, where a participant told the following story:

> 'Her husband was beating her like anything. She was black and blue. And her son committed... wanted to commit suicide. He cut his artery and after this the police came.'

Participants described barriers for help-seeking ranging from generic barriers to receiving help (e.g. acceptance of inequality and violence against women, fear for the possible consequences of the disclosure, lack of awareness about domestic violence) to barriers specific to accessing services (e.g. lack of information about services, culturally-inadequate services, bureaucratic barriers such as lengthy waiting lists, assessment and consent forms, and social stigma towards mental health services). Although several of these barriers are shared by the general population, cultural differences and migration seems to further complicate the issue (Colucci et al., in press).

Immigration status-related barriers to escaping or help-seeking

Several other studies have highlighted that barriers to escape the situation of violence are often linked to migration issues and immigration-related abuses. A study examining the association of intimate partner violence (IPV) and immigration status among South Asian women residing in Boston reported that the odds of reporting IPV were lower for women who reported that their partners refused to change their

immigration status (Odd Ratio= 7.8) or threatened them with deportation (OR= 23) and for those on spousal dependent visas (OR=2.8) than they were for other women (Raj et al., 2005).

The role of the state and immigration laws also play a crucial role in violence and suicide prevention: 'Immigration policies that prevent women on spousal visas from working and petitioning to change their status increase women's vulnerability to partner abuse' (p. 26). In most countries immigration policies and laws require that a married couple stays together for a certain amount of time after immigration (e.g. 'one-year-rule' in the UK, 3 years in Germany) until they are able to apply for a change of status. So immigrations laws may make it very difficult for women to escape abuse and finally make them feel 'trapped' in their situation and, thus, more vulnerable for suicidal behaviour and mental health problems in general (Alaggia et al., 2009; Burman & Chantler, 2005; Orloff & Little, 1999).

Chantler and collaborators (2001)[2], referring to the 'one year role', argued that domestic violence against immigrant women and immigration is an 'unholy alliance' since 'the state can be seen to be an active partner in the violence against immigrant women' (p.14). The same kind of problem is described in the literature from other countries. For instance, a study about intimate partner violence and immigration laws in Canada described that,

> (...) in cases of sponsorship breakdown due to intimate partner violence, the criteria required for a viable immigration application are unrealistic, and in many cases impossible to meet in situations of domestic abuse (...) Systemic and structural barriers (...) for abused women are still clearly present in immigration laws and policies (p. 335).

The result is that 'many women stay in abusive relationships, often with their children, for prolonged periods of time accruing serious negative mental health effects' (Alaggia et al., 2009, p. 335).

According to Raj and collaborators (2005) 'legal barriers may constitute human rights violations and should be reformed to protect immigrant battered women and their children' (p.26). The feeling of being trapped in a situation with no way

out and remaining silent has been reported frequently by immigrant women as a cause for suicidal behaviour (e.g. Bhugra & Hicks, 2000; Chew-Graham et al., 2002; Hicks & Bhugra, 2003). Additionally, the lack of financial resources, having nowhere else to go, or the lack of knowledge of how to live independently makes women stay in abusive relationships (Bhugra & Hicks, 2000; Orloff & Little, 1999).

Summary and Future Directions for Research and Prevention

Domestic violence is not only a serious breach of human rights, but has major health, social and economic consequences for women, their families and communities, including an increased risk of suicidal behaviour. The impact of domestic violence on suicide is particularly strong among immigrant and ethnic minority women. Although the generalities of domestic violence and commonalities with women's experiences in general are important, the specificities of immigrant and refugee women's experiences of domestic violence also need to be attended to. Besides the common forms of violence, immigrant women are exposed to immigration-related violence like threats to get deported and be separated from their children. Immigration laws and policies play an important role in silencing immigrant women when women's legal status is threatened if they leave their husbands. Structural barriers to escaping or seeking help include the lack of knowledge of social and legal services and legal rights, the lack of financial resources, having nowhere else to go, and few culturally sensitive services. Furthermore, culture-specific barriers like traditional gender roles that demand women to put family and community before themselves, obey their husbands, and not speak out, and the pressure to keep the family's honour intact, cause women to suffer in silence and feel trapped in their situation. As a result, the inability to escape the unbearable situation of experiencing domestic violence, may create an unsolvable dilemma where suicide is perceived as the only 'solution' or 'way out'.

In sum, higher risk of being victim of violence, additional forms of violence (immigration-related abuse), and greater barriers to escaping or seeking help contribute to make women from immigrant and refugee backgrounds particularly vulnerable to suicidal behaviour.

While violence against women is now widely recognized as a significant global problem, a major public health issue, and one of the most widespread violations of human rights, suicidal behaviour among

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[2] The accounts of suicide attempt survivors in this study highlighted a number of ways of controlling women via their immigration status, with passports and other forms of identification being withheld from women by their abusers, thus further restricting opportunities for participating in public life (e.g. enrolling at colleges, access to benefits and the right to escape abusive relationships).

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immigrant women has received limited attention as a public health concern, and even less as a human/women's right issue. In conclusion, we recommend the following points are addressed by academics, policy makers, government and non-government organizations, and service providers engaged in suicide prevention:

1) Research is urged to further explore and highlight the relationship between suicidal behaviour and various forms of violence against women, including the role that migration laws and policies play in developing and exacerbating the violence. Although there is some evidence that domestic violence is associated with suicidal behaviour, only a limited number of studies have explored the role of this contributing factor. More concentrated and culturally sensitive research can lead to a clearer understanding of the scope and causes of violence against women, which in turn may lead to more effective preventive and intervention efforts (Alhabib et al., 2010). Such research would also help to understand in what circumstances suicide 'protective factors' such as being married and having a close social network may in fact represent potential risk factors.

2) Awareness and advocacy role among service providers (e.g. mental health, family/relationship and violence services), especially for services dealing with immigrant and refugee women must increase. Especially in view of the fact that access to services for these women is far more difficult. Changes are required at community, system and service level to improve utilization of services (Colucci et al., 2012).

3) More light needs to be shed on the link between such a violation of human/women rights and suicide, and suicide prevention programs must embrace a human rights perspective. Violation of rights, abuse and violence may play a bigger role as determinants to suicide than psychiatric illness. This should include a greater role played by suicidologists and mental health scholars and professionals in the defense of human rights and in the protection of women who are victims of violence.

Global concerns about suicide prevention need to be linked to relevant local conditions and in certain communities the victimization of women is a priority (Parkar et al., 2009). Vijaykumar (2007) stated that, in India, suicide prevention is more of a social and public health objective than a traditional exercise in the mental health sector. We believe suicide prevention must be addressed as a public health issue in every country. It is time for suicide to be considered also as a women and human rights issue, and this shift is especially urgent in those countries and among those immigrant and ethnic minority groups where women are at greater risk of violence; a violence too many women feel they can only stop through taking their own lives.

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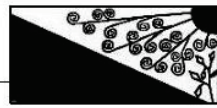
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