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# Suicide and Predicament


**Author:**
Saxby Pridmore
University of Tasmania
Australia

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# Suicide and Predicament:
## life is a predicament

**Saxby Pridmore**, MB, BS, BMedSc, DPysio, MD, AM
FRANZCP, FAChAM, FAFPHM, FFPMANZCA

**Professor of Psychiatry**
**University of Tasmania**

**Director, Pain Management Unit**
**Royal Hobart Hospital**
**Australia**

**Cover design: Mary Pridmore, BA(Hons), DipEd, BFA(Hons), PhD.**

**Dedication:**
**To my wife, Mary Elizabeth**
**children, Emma and William**
**grandsons, Dempsey and Isaac.**

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## FOREWORD

**"There is but one truly serious philosophical problem and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy."**

Albert Camus, 1942.

We have confronted the spectre of suicide throughout recorded history. It is always ready, in every dark moment, in both hemispheres of the world.

Professor Pridmore has demonstrated in this book, that in many, perhaps most cases, it is not mental illness which precedes suicide, but a predisposition plus social circumstances and acute stress. He brings all such factors together in his concept of 'predicament'. This 'predicament paradigm of suicide' is the breakthrough of the early 21st century, in this troubled field. I strongly encourage medical people, psychologists and social workers, the judiciary and indeed, everybody working within the social system to pay attention.

The prediction of human behaviour is a difficult, and some would argue, not really a medical problem. Even accurate prediction of the course of a relatively simple medical condition suffered by a particular individual may be difficult, or impossible.

I quote Camus above. He also wrote that we see some people die because they judge that life is not worth living, and that paradoxically we see others get killed for the ideas or illusions that give them a reason for living. The question of the meaning of life, of course, remains unanswered – but this is by no means a question only for the medical community, as the answer lies at the heart of *conditio humana*.

Many now accept that social and psychological facts may play a major role when it comes to commission of the act. The two great wars left the world in turmoil with values torn to pieces- maybe as never before. This led to a 'fatherless society' in many western countries, the development of the student revolts, the hippie movement, the sexual revolution and the emancipation of women.

The price of the two great wars was high; 55 million were killed by their counterparts, and a few killed themselves. Some killed themselves to escape justice, but more out of shame and overwhelming consequent anxiety.

Today we are facing problems in a different form. International transport and migration have brought people together who do not understand each other. Some people affected by traumatic experiences make it to friendly foreign shores. But, they carry their burdens with them. With globalisation, there is no escape.

We must seek, as psychiatrists or citizens of an unquiet world, freedom and communication between those with different opinions, as every act of discrimination (race, religion, whatever), is ultimately degrading to all mankind.

**Gerhard W Schmitt**
FA für Neurologie und Psychiatrie
Frankfurt am Main
Germany

# PREFACE

**"If you are going from A to B you do not necessarily go in a straight line."**
Margaret Thatcher (1980)

Current medical and psychological wisdom holds that all (Ernst *et al.*., 2004), or almost all (Bertolote *et al.*, 2004) those who complete suicide, do so in response to a mental disorder. This book is opposed to that notion.

A typical example of contemporary advice comes from the well intentioned website (TeensHealth, 2009):
*"Most teens interviewed after making a suicide attempt say that they did it because they were trying to escape from a situation that seemed impossible to deal with… And at that particular moment dying seemed like the only way out."*
An entirely reasonable statement.

*"Some people who end their lives or attempt suicide might be trying to escape feelings of rejection, hurt, or loss. Others might be angry, ashamed, or guilty about something."*
Again, an entirely reasonable statement.

*"What makes a person unable to see another way out of a bad situation besides ending his or her life?... The answer to those questions lies in the fact that most people who commit suicide have depression."*
This last sentence expresses a notion to which this book is opposed.

There is no doubt that these authors are describing a mental disorder. Under the heading of 'depression' they write about "*hormones*" and "*bipolar disorder*". Then comes:
*"They are unaware that it is the depression – not the situation – that's influencing them to see things in a 'there's no way out'…kind of way."*
Again, a notion to which this book is opposed; sure, a mental disorder may be present, in which case, it will be argued that the mental disorder is *"the situation"*.

People with mental disorder are at greater risk of suicide than those without mental disorder. But it is a leap of faith, a distortion of logic, to therefore contend that therefore, all those who complete suicide have a mental disorder. This leap of faith is assisted by the WHO definition of health: "a state of complete physical, mental and social well-being". There can be little doubt that people who suicide are distressed and are therefore not in a state of "complete…well-being". However, an occasional measure of distress is part of the normal human experience, and to label this a mental disorder is to medicalize "the human condition".

A 'scientific' mantle for the view that suicide is exclusively the result of mental disorder comes from the practice of retrospective "psychological autopsy". In this book, space is given to the ignored opinion that this process is methodologically flawed.

To demonstrate that suicide can occur in the absence of mental disorder, case studies have been examined. Cases have been chosen from the public record, so that individual privacy is not offended, and the reader can obtain further details if not convinced. Suicide has troubled every nation, every political system and every religious group of the last three millennia. 138 cases are detailed, of whom 14 suffered, or may have suffered, a mental disorder.

But more can be gained from this public record material. As all behavior is motivated, we can ask, what motivated these people without mental disorder to complete suicide? It is proposed that individuals suicide when they find themselves in predicaments (unacceptable situations from which there are limited escape options). These include the loss of honour of the defeated military leader, the shame of the prosecuted paedophile, the avoidance of pain and indignity of the terminally ill person, and the mixture of negative emotions of the bankrupt former billionaire.

A "predicament model of suicide" is presented which allows the incorporation into a single model, of the majority of what is known about the etiology of suicide. The essential element is that suicide results when the individual is in a "predicament". A unique notion here is that mental disorder (or more precisely, the distress experienced as a result of a mental disorder) can be usefully cast as a form of (internal) predicament. Mental disorder predicament is construed as comparable to the distress which can result from environmental factors. A combination of these two is, of course, common.

The term "predicament model" has been used to draw attention to the importance of the stimulus. This is not to deny the importance of individual vulnerability. Individual vulnerability, in the medical model context, depends on genetics and life experiences. Individual vulnerability, in the sociological context, is also important, and refers to individuals who are insufficiently integrated into, or regulated by, society.

The sociology of suicide is celebrated. The mistaken idea that Durkheim found no place of psychopathology in suicide is laid to rest. The stories of the suicides of influential individuals have been transmitted through painting, sculpture, literature and music such that western culture now has a tradition of suicide as an escape option when trapped in a predicament. Suicide rates are discussed.

"A typology of suicide" is presented, based in the notion of predicaments and the observations of others. Four types of suicide are offered, into which all suicide can be categorized.

"Medicalization" is the process by which non-medical problems are re-classified as medical problems. By this process normal distress and disappointment have become synonymous with mood disorder. It is agued here, that suicide has also become medicalized, making prevention the responsibility of health professions (who have relatively little to offer in the absence of mental disorder). Further, this approach leaves without a role, the community and politicians, who have the ability to modify the values and behavior of society.

A "pathway model of suicide" is presented in which distress is the central element. This distress has three possible outcomes: it can 1) be "medicalized" (incorrectly

called a mental disorder) and when suicide occurs this is (incorrectly) identified as a death attributable to mental disorder, 2) result in a mental disorder and suicide may follow as a consequence of the mental disorder, and 3) lead directly to suicide as a means of avoiding distress (egoistic/anomic or simple reaction).

The wisdom that all or almost all suicide is the result of mental disorder has spawned the prevailing suicide prevention strategy: the "high risk approach", which focuses on identifying and treating people with mental disorder. This approach has failed to have an impact on national suicide rates anywhere in the world. This comes as no surprise, when we consider the evidence that, 1) suicide often occurs in the absence of mental disorder, and 2) treatment has never been proven to reduce the suicide risk for an individual or a group of individuals. This book provides a broader approach to suicide prevention, which will take a long time and involve cultural changes.

We have an ethical obligation to provide all possible care to people suffering mental disorder, but this is not going to reduce the suicide rate. A "population-based approach" to prevention attempts not to treat distress in particular individuals, but to reduce features of the society which underpin distress and dissatisfaction (such as unemployment, poor education and housing, and alcohol abuse). As cultural factors have a profound effect on suicidal behavior, to reduce the suicide rate, it will be necessary to change our culture (responses). Whether this is desirable and how it may be achieved will be matters for discussion. For example, shame lies at the root of a proportion of completed suicide and whether our culture can be reorganized to eradicate this emotion is yet to be determined. A prevention strategy is recommended which incorporates features from both the "high risk" and the "population based approaches".

Should we decide to a population based approach, regular attention to annual suicide rates will do more harm than good. The person trying to lose weight who looks at the scales every day courts frustration (which increases the desire to eat); the society which is trying to reduce suicide by reshaping itself must embrace a long term project and will not benefit from slavish attention to annual suicide statistics.

Medical treatment is expensive and stigmatizing. Where suicidal thinking and behavior are not associated with mental disorder, the involvement of non-medical support people is recommended.

Finally, if we want to improve the satisfaction rating of a TV show, we don't identify dissatisfied looking people and give them smiling classes and amphetamines, we improve the quality of the show.

**Saxby Pridmore**
University of Tasmania
and
Royal Hobart Hospital
Australia

# CHAPTER 1

## INTRODUCTION

**Abstract**: Suicide is conceptualized as an action which occurs in a variety of settings. The importance of personality, genetics, alcohol abuse, socioeconomic status and relationship with partner is introduced. The hegemony of mental disorder in suicide is disputed. The potency of multiple factors acting concurrently is described, giving details of twenty cases.

**"Suicide is a complex behavior carried out by diverse people, under varied conditions and situations. To attempt to uncover single causal factors and implement solitary interventions is naïve and simplistic."**

K S Jacob (2008)

Suicide accounts for almost 2% of the world's death (WHO, 2005). It is time to start paying attention to the predicaments of these people, and the responses they make, rather than just keep wondering which "illness" they have, and which "treatment" they need. It will be argued that suicide is an escape option which regrettably, is frequently chosen.

Suicide is more common in people with mental disorder than people without mental disorder. But the widely made statement of the last three decades, that mental disorder is the cause of more than 98% of suicide (Bertolote *et al.*, 2004) is fanciful. Accordingly, the "high risk" suicide prevention strategy (which states that the best approach to preventing suicide is to focus on people with mental disorder) is built on poor foundations. After decades, national suicide rates have not been (and were never going to be) even slightly influenced by the introduction of the high risk suicide prevention strategies.

All those who complete suicide, both those with and those without a mental disorder, are in predicaments (difficult situations/circumstances) and take action. A model with a broad view, which can incorporate all the available evidence, is urgently needed.

In 1996, **Jeremy "Mike" Boorda**, 56 years, was an Admiral in the US Navy. He joined the Navy at 16 years, and was the first person to rise through the enlisted ranks to become the Chief of Naval Operations. He served in Vietnam. Two Newsweek magazine journalists made an appointment to question him about a small brass V which he had worn on the ribbon of one of his medals. There were rumours that Boorda was not entitled to wear this decoration, a "Combat V", because his war service had not met the necessary criteria. Boorda shot himself in the chest, where he wore his decorations, hours before the appointment.

In 1998, **Wendy Hughe**s was 43 years of age and her husband **Richard** (a former computer company director) was 47 years; they lived in the Sunshine Coast hinterland, Australia. They had been married for 11 years and both had been married before. They had a long standing agreement that they would die together. Ms Hughes developed terminal cancer. She refused treatment. The couple took a one month tour of Africa, then "shopped around for a good funeral director". They packed up their

home and left their car at a garage. They booked into a luxury resort on the Sunshine Coast. They ate at an exclusive restaurant, paid their bill, went back to their room and took lethal doses of medication. They left a detailed suicide note apologising for their actions.

In 1999, **Ronald Veenstra**, 37 years, a married man of Mornington Peninsula, Australia, was noticed by two police officers to be sitting in his car in a car park with a hose attached to the exhaust pipe and leading into the interior of the vehicle. The windows were down and the engine was cold. In 2009, the High Court of Australia heard that Veenstra told the officers that he was in a loveless marriage and that he had thought of "doing something stupid", but he had changed his mind and now wanted to go home and discuss matters with his wife. He had not been reported as missing and had no outstanding charges (which the officers could discover), there was no evidence of alcohol or other drug use, and he "appeared to them to be rational, cooperative and very responsible the entire time". The officers offered to contact Veenstra's family or a mental health professional, but he declined. The officers concluded that Veenstra was not suffering from a mental disorder and could not therefore be taken into custody and conveyed to a place for medical assessment. Veenstra did return home and have a conversation with his wife, but later that day, during her absence, he completed suicide using car exhaust fumes. The court also heard that Veenstra had withheld from the officers that arrangements had been made through his solicitor for him to be served that afternoon with papers relating to fraud charges arising out of his former employment as a financial manager of a car dealership.

In 2002, **Wafa Idriss**, 26 years, lived where she was born, at the al-Amari refugee camp, Ramallah, Palestine, and worked as an ambulance driver for the Red Crescent. As a young woman she had been the only asset of her family, and married her first cousin Ahmed. However, she produced only one stillborn female child and after 9 years of marriage, she was declared infertile. This was a matter of shame, and Ahmad yielded to pressure from his family to divorce his wife. Wafa may have suffered a depressive disorder as she cried inconsolably for some weeks, but there is no convincing evidence that this was more than a normal reaction. Her mother, Mabrook, said, "Wafa knew she could never marry again because a divorced woman is tainted…She was young, intelligent, and beautiful and had nothing to live for." At a public rally, Yasser Arafat urged women to become his, "army of roses", and that afternoon Wafa blew herself up in Jerusalem, killing one Israeli man and wounding 131 others. She was the first of the *Shahida*, the female Palestinian suicide bombers.

In 2003, **Louis Rogers**, 24 years, was living with his girlfriend, Vanessa Belino, on the 25$^{th}$ floor of a Philadelphia, Pennsylvania, upmarket apartment building. Ms Belino owned the apartment and was an assistant public defender. She had defended Rogers in at least two criminal cases. Rogers was upset by an argument and was witnessed to be slashing a samurai sword around. He wrecked their apartment, threw furniture off the balcony and started a fire. He then jumped down to the balcony of a 24$^{th}$ floor, broke into an apartment, threw furniture from the balcony and started another fire. When the police arrived, Rogers had descended to an apartment on the 23$^{rd}$ floor. He threw a mobile phone at police and jumped from the balcony. A police-person grabbed his sleeve but he fell and died amid a demolished leather couch and armchairs, a dining table and chairs, a wooden dresser, drawers and crockery fragments. His death was attributed to anger.

In 2008, **Erin Berg**, 39 years, was an Occupational Therapist and mother of 4. She was involuntarily admitted to a psychiatric ward of a Perth (Australia) hospital with severe post-natal depression, when she talked openly about ending her life. Her early life had not been easy, mother had been partially disabled by a brain aneurysm and there had been domestic violence. Ms Berg had suffered episodes of depression; she and her husband, Norman, separated but cooperated in caring for the children. Before and during hospitalization Ms Berg received support from her three sisters, all of whom were social workers. She appealed against her involuntary hospitalization and was released on a community treatment order (meaning she could live at home, but had to continue to accept treatment). Her depression had not fully resolved, but she told case workers that she had abandoned any plan to suicide. Three weeks after discharge from hospital she went to Norman's house and asked him to take care of Elizabeth (1 year). She took a plane to Tijuana (Mexico) where she purchased a strong barbiturate, which she swallowed with whisky (as recommended by a book on euthanasia). She left a note: "No one else was involved in this, it was my choice…to euthanize myself". She died without regaining consciousness. She was motivated by post-natal depression, which did not adequately respond to treatment.

In 2008, **Choi Jin-Sil**, 40 years, mother of two, hanged herself in her bathroom in Seoul. For 20 years she had been South Korea's "cinematic sweetheart" (TIME) and had starred in 16 movies and more than a dozen soap operas. She married a baseball star in what was termed "the century's union". The marriage ended in 2004 and Choi had custody of the children. She entered a business relationship with Ahn Jae-Hwan, who completed suicide in September, 2008. Internet gossip commenced, claiming that Ahn had owed Choi money and her demands for repayment had led to his death. Choi denied these claims, but was known to be distressed by them. Less than a month after Ahn's death, Choi also completed suicide. There was no history or convincing evidence of mental disorder, the suicide was attributed to public criticism and the example set by her business partner.

In 2009, **Neil Puttick**, 34 years, and his wife **Kazumi Puttick**, 44 years, jumped off a 500 foot (150 m) cliff near Belle Tout lighthouse in East Sussex (UK). They had lived in Brokerswood and had driven 150 miles (250 km) to the coast. They had two rucksacks with them, one contained the body of their deceased son, Sam, 5 years, and the other contained his favourite toys. Sam had died 2 days previously of meningitis. When Sam was 16 months of age he was made quadriplegic in a car accident. His parents gave up work and devoted their lives to caring for him. They established a website and raised money to provide him with all necessary equipment. There was no evidence of mental disorder. It is believed the couple found the prospect of living without their son to be intolerable.

In classical antiquity (van Hooff, 1990), suicide was classified as being motivated by *purdor* (shame), *taedium vitaie* (disgust/weary with/of life), *inpatientia doloris* (unbearable pain), *dolor* (grief), *fides* (loyalty), and *furor* (madness). The ancients had another category: *iactatio* (ostentation), which does not fit with the notion of "predicament suicide", but this refers to the style rather than the principle "driver" of the action.

Plato (c 424-348 BCE) taught that suicide was disgraceful and that perpetrators should be placed in unmarked graves. He did, however, recognize exceptions,

including, 1) when the self-killing is compelled by extreme and unavoidable misfortune, and 2) when the self-killing results from shame and having participated in grossly unjust actions (*Laws IX* 873c-d).

The first recorded joke about suicide appears in the Greek book, Philogelos, a collection of 265 jokes written in the 4th century CE (Baldwin, 1983). It concerns a man who was trying to hang himself and struck his head in the process. He went to the doctor to get treatment for his injury, and then hung himself.

It is reasonable to suppose that, before death, people who go on to complete suicide, experience great distress; this probably includes most suicide bombers and other individuals who expect their death will be subsequently rewarded. After the death, the family and friends experience great distress. Nothing in this book should be read as diminishing the distress associated with, and caused by, suicide.

Suicide, like coughing, is a physical act. Like coughing (one thinks of the discrete cough of the gentleman's butler coming into the boudoir), non-fatal suicidal acts may be used to draw attention to the individual. And like coughing, suicidal acts (fatal or non-fatal) may be a symptom of severe organic illness. Here, tuberculosis of the lung is like treatment resistant depression.

Suicide, like homicide, may or may not be the result of mental illness. Both may be impulsive acts (Fawcett, 2001; Woodworth and Porter, 2002; Blaustein and Fleming, 2009).

Suicide, like laughter, can have roots in many emotional experiences. Laughter can express happiness, embarrassment and even sadness; suicide can express sadness (as a feature of, or distinct from, mental disorder) and rage, in addition to the desire to avoid predicaments.

Suicide, like combing your hair, has much to do with culture and fashion. When the Japanese glam-rock star **Hideto Matsumoto** (34 years) completed suicide in 1998, at least 4 fans copied him. After the soccer goal-keeper for Germany **Robert Enke** (32 years; 2009) threw himself under a train, German Rail reported a one week four-fold increase in such deaths. Like combing your hair, if you can't do it yourself, you may be able to get help. Should you have a terminal illness, certain doctors my offer "assisted suicide". If you do not have a terminal illness, you may be able to provoke a police-person into killing you; this is called "suicide-by-cop" (Lindsay and Lester, 2008).

As with contemplating going to the football, or buying a house, contemplating suicide involves consideration of a range of competing options, and short-term and long-term consequences. With going or not going to the football, in the end, you decide to go or not to go. For those who live nearby the football ground, watching the game on television is a half-way position. The half-way position for suicide is a suicide-like act which does not result in death. This introduces the complex topic which goes by many terms, 'suicide attempt', 'failed suicide', 'suicide gesture' and 'parasuicide', among others, which is not the focus of this book and thus, will not be fully explored. It is important to know that even the individuals who perform such behaviour may not be clear about whether they intended to die and failed, or did not intend to die. Often people who have survived a suicide-like act report indifference; frequently

(particularly with an overdose of medication) they report that they wanted a period of unconsciousness, a break from their predicament, and simply left the outcome of their actions (life or death) in the hands of fate.

Our probability of becoming an Olympic athlete, developing breast cancer or completing suicide is influenced by our genes. For both breast cancer and suicide, our genes account for 30-55% of our risk (Voracek and Loibl, 2007).

Personality may be defined as "the predictable responses the individual makes to the environment (or life situation)". Personality features greatly influence the manner in which we manage any bodily conditions such as diabetes and epilepsy. In the same way, personality features greatly influence the way we manage our interpersonal relationships and other life events (Zeyrek *et al.*, 2009). Personality features can predispose the individual to social conflict, and greatly influence the response of the individual (adaptive or maladaptive) when dealing with such conflicts. Naturally, personality features strongly influence suicide behaviour (Brent *et al.*, 1994).

Excessive alcohol use and the use of illegal substances are closely associated with the risk of suicide (Mann *et al.*, 2008; Schneider, 2009). This is not surprising. In addition to causing liver disease and pancreatitis, alcohol precipitates interpersonal conflict, mental disorder, and relapse in the case of people who have recovered from an episode of mental disorder. Very importantly, acute intoxication lowers inhibition (increasing impulsivity and aggression), and makes suicidal behaviour a more likely response to any conflict. Countries with high per capita consumption of alcohol are those with high rates of suicide. Nearly one quarter (24%) of US residents who complete suicide have a blood alcohol level above 0.08 mg/dl, with the highest percentage (37%) occurring among American Indians and Alaska Natives (Crosby *et al.*, 2009). One third (34%) of Swedes who complete suicide have taken alcohol, and "many are heavily intoxicated" (Holmgren & Jones, 2010). Not yet replicated elsewhere, recent research in Croatia (Coklo *et al.*, 2008) found the average blood alcohol in completed suicide to be 0.068 mg/dl (well over the legal driving limit) for males and 0.029 mg/dl for females. These authors also demonstrated a relationship between blood alcohol level and the choice of method, with the highest average level (0.171 mg/dl; three times the legal driving limit) being associated with the use of explosives. Alcohol use appears to be a common feature when cultures are under pressure, and has been associated with suicidal behavior among the Navajo (Grossman *et al.*, 1991), Inuit and First Nations of Canada (Overholster *et al.*, 1997), and Australian Aboriginal people. Alcohol and other drug use is an obvious target in the difficult struggle to reduce suicide rates, especially in communities in which rates of both alcohol consumption and suicide are high (Razvodovsky, 2009; Landberg, 2009).

As with smoking, alcohol excess and physical violence, suicide is more common in lower socio-economic groups, which raises the issue of the impact of social inequalities (Page *et al.*, 2006; Saurel-Cubizolles *et al.*, 2009). The exact mechanism by which lower socio-economic group membership leads to higher suicide rates is yet to be determined. There is a clear link between material disadvantage, unemployment and suicide (Yamasaki *et al.*, 2008; Inoue *et al.*, 2010; Cororan & Arensman, 2010). A contextual study suggests that suicidal behavior in young people living with household poverty occurs, at least in part, because in such households, the young are

exposed to suicidal behavior (Bernburg, 2009). While frequent, it is harder to find examples of the suicide of individuals from the lower socioeconomic group on the public record, because their deaths are less newsworthy.

Suicide does, of course, occur in the higher socio-economic group, for example, **Cleopatra** (30 BC) and **Amschel Rothschild** (1996). Cleopatra was Queen of Egypt and Rothschild (41 years) was a very wealthy, well connected British banker.

Suicide is often associated with poor physical health. Chronic disabling conditions add a further burden to people who are dealing with other life difficulties (loneliness and debt, for example). On the other hand, poor physical health may be the primary driver, for example, in the deaths of **Arthur Koestler** (1905-83) and **Jo Shearer** (1946-2002). Koestler was a polymath author who found the burden of weakness and movement difficulties resulting from leukemia and Parkinson's disease to be intolerable. Shearer was an accomplished Australian war correspondent who developed intractable back pain; she announced to fellow journalists she would take her life to avoid her pain.

Suicide is associated with loss of reputation. **Shoichi Nagagawa** (2009) a 56 year old Japanese politician died of an overdose in Tokyo, having lost his seat in the aftermath of disgraceful drunkenness at a Group of Seven meeting. Loss of reputation is dealt with in Chapter 5.

Suicide is also associated with loss of other valuables. **Rene-Thierry Magon de la Villehuchet** (2008) a 65 year old French aristocrat money manager living in New York died by cutting his wrists, following huge financial losses through his investments with Bernard Madoff. **Major William Foxon OBE** (2009) a 65 year old Englishman who had served in the French Foreign Legion and the British Army, and as head of the European Commission Monitoring Mission, also lost his life savings in investments with Bernard Madoff. One armed (he had lost an arm in military service) and fearing bankruptcy, he sat in a park near his home in Southampton, UK, and shot himself in the head. **Adolf Merckle** (2009) a 74 year old German billionaire was "broken" by the global financial crisis, he wrote a note and placed himself in the path of a train.

**Pete Tovey** (2008) an 81 year old man living on the Gold Coast, Australia, feared the loss of his independence, by being removed from his home and placed in geriatric care. He researched means of suicide on the web and built a mechanical device which fired bullets from a pistol into his head. In the days before his death his neighbors reported he appeared "normal and not depressed".

Suicide is more common in marital separation than divorce or other marital states (Wyder *et al.*, 2009). This applies for both males and females, but is particularly high for young males (15 to 24 years). This fact can be explained in different ways. For example, the loss of a loved one per se (by death or rejection) is painful, particularly in the early stages (separation being the initial stage, compared to divorce), and could be considered sufficient to trigger suicide. Others draw a distinction between the trauma of the process of loss and the value of what is lost. There is also the potential impact of separation on the sense of self-esteem and status, and a sense of failure to be taken into account. Yet others interpret the loss of the "connections" to be the most

damaging aspect of separation. While the loss of connection with one other person may not seem sufficient to qualify as loss of "integration with society" (the central plank of the leading sociological theory of suicide), things may not be simple. Separation may mean relocation of residence, with the loss of connections with the neighborhood shop owners, petrol station, pizza-outlet, next-door neighbors and other locals, and often with parents-in-law and some mutual friends (more than half in the case of the male, as it is usually the female who builds the social circle). There is, most often, for both parties, at least some reduction in contact with any children. Thus, separation may reduce integration in the local society to a more than trivial extent.

## A combination of factors

In many cases, suicide appears to be driven not by a single factor, such as a recent or impending loss, but by a host of factors impacting simultaneously (Stallones *et al.*, 2007). The stories of **Peter Davies** and **Samson** are illustrative.

**Peter Davies** was born in England in 1897, and was the inspiration for the character "Peter Pan", (Fig.1) made famous by J M Barrie. Davies died by placing himself in the path of a train in 1960.


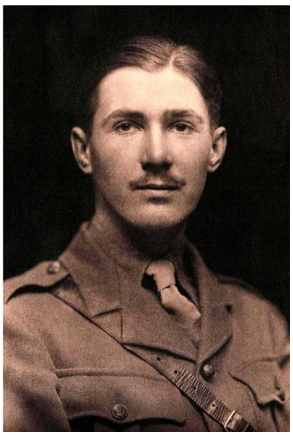

**Fig 1.** Left, a bronze statue of Peter Pan, by Sir George Frampto. Right, Peter Llewelyn Davies, photograph made in 1917.

Davies was the middle of 5 boys who were befriended in a park by Barrie. Davies father died when he was 10 years, and his mother died when he was 12 years of age. Barrie became the guardian of the boys. These early life losses may have predisposed Davies to suicide.

Davies fought in World War I. He was commissioned as an officer and won the Military Cross, which indicates considerable capability. However, he was emotionally traumatized by his war experiences.

At 20 years of age, while still in the Army, Davies commenced a two year relationship with a married woman in her 30's, who had one child. Davies lived with this person when he was on leave. Their relationship was scandalous and caused a rift between Davie and Barrie. It is possible that Davies was seeking a mother figure, consequent to the early loss of his mother.

When Davies was 24 years of age, his younger brother, Michael, died by suicide. This was doubtless a traumatic event. In addition, suicide in a first degree relative strongly suggests a genetic predisposition.

Davies married at 34 years of age and had 3 children. He became a successful publisher.

In his adult life Davies detested being linked with the character, Peter Pan. He was unexpectedly excluded from Barrie's will: another unhappy event.

Davies became alcoholic and developed emphysema. Just prior to his suicide, Davies was working on family documents dealing with the death of Michael.

Also at about this time, Davies learned that his wife and all of his children had inherited Huntington's disease, a particularly nasty, terminal brain disease.

On the day he took his life (63 years) he had been drinking at the Royal Court Hotel.

Peter Davies carried many risk factors for suicide: 1) probable genetic loading, 2) early maternal loss, 3) traumatic war experience, 4) chronic alcohol use, 5) physical illness (emphysema), 6) severe recent stress (wife and all children afflicted by Huntington's disease), and 7) acute alcohol use.

**Samson** was a biblical character (probably born in the 11$^{th}$ century, BCE) who lived at a time when the Israelites were oppressed by the Philistines. His parents had been unable to conceive. The story goes that an angel appeared and told them they would have a child, and that he should abstain from alcohol and never cut his hair. Samson was raised accordingly. He developed great physical strength and a propensity to violence: on one occasion killing 1000 Philistines with the jawbone of an ass. He took alcohol and associated with bad company.

The Philistines paid a woman to discover the secret of his strength. She learned that his strength lay in the fact that he had never cut his hair (Fig 2). While he slept, she cut his hair; thus an oath was broken and God left him.

**Fig 2.** Delila schert Simson die Haare L.6, by E S Meister, 1460-1465.

Subsequently, Samson was easily captured by the Philistines. They blinded him with hot irons and made him grind grain. They took him to a temple for their entertainment. Here, Samson prayed to God to have his strength restored so "that I may be at once avenged of the Philistines for my two eyes" (Judges 16:28).

His prayer was answered and he was able to push down pillars which caused the temple to collapse and he "killed many more as he died than when he lived" (Judges16:30).

The story of Samson is an example of the difficulty of categorizing suicide. It would be possible to ascribe his suicide to vengeance (Judges 16:28), shame (Chapter 5), fatalism (avoiding the inevitable; Chapter 8), or physical pain (constant flogging and other brutality). It could also be seen as an act of redemption or altruism. Durkheim (1987/1951) describes altruistic suicide as that which benefits the individual's group (in many cases by killing numbers of another group). A classification as an altruistic suicide would identify Samson as the forerunner of current suicide bombers. There have also been claims that he suffered a mental disorder (Altschuler *et al.*, 2001). Samson was in an exceedingly difficult predicament, and it is reasonable to expect that other factors, in addition to vengeance, played a part in motivating his death.

**Serge Serykh** (43 years) is a more recent example. In 2010, in Glasgow, Serykh, his wife and her son, tied themselves together with rope, broke a hole in protective screening around their balcony and jumped from the 15$^{th}$ floor of their apartment block. This accommodation had been declared unfit for human habitation in 1980, but continues to be used to house asylum seekers. Serykh and his family were originally from Russia. They had been refused asylum in the UK, their financial benefits had been withdrawn two months earlier, and they were to be evicted from their flat on the day they died. This combination of stressors was considered sufficient to have caused these suicides, and 200 people protested in George Square, Glasgow, against the UK treatment of asylum seekers.

It was later became clear that Serykh had been suffering a serious mental disorder. The family had left Russia and arrived in Canada in 2000. In Canada, Serykh claimed they were escaping from the Russian secret police. Their refugee status was approved, and in 2005, he became a 'protected person' as defined by Canada's refugee laws. He was also given permanent residency. However, his application for Canadian citizenship was denied in 2006. He then began accusing Prime Minister Peter Harper of pumping radiation into his Toronto home, and changing his brain patters. Subsequently Serykh came to believe that Harper and former President Putin of Russia were colluding in attempting to kill him with a mind altering device, and that Harper was working on a plot to assassinate Queen Elizabeth II. In 2007 the family left Canada and sought asylum in Germany, the Netherlands and Spain, but without success. They next went to the UK.

Serykh consulted three immigration lawyers and a number of politicians to whom he showed letters sent to him from Canada, which he claimed contained anthrax. (Independent examination revealed no evidence of anthrax). He also wrote a letter of warning to Queen Elizabeth of the plot against her life.

Serykh consulted Barry Gardiner, Brent North MP and told his story. Subsequently, Gardiner stated, "My overwhelming impression is that this was a tragedy that was always going to happen. He was not an ordinary person driven to suicide by the Kafkaesque immigration system, as some people have been suggesting".

This case illustrates two points. First, the public believe that a combination of social and environmental stressors may be sufficient to result in suicide. Second, multiple factors may compound each other, and one of these can be mental disorder.

## Conclusion

An idea proposed in this book is that suicide may occur in the absence of mental disorder, and does so more often than is accepted by some clinicians and members of the public. This is consistent with the legal view. In the case concerning the death of Ronald Veenstra, mentioned above, the High Court of Australia (2009) made various statements to this effect, including 1) "Suicide and attempted suicide are seen as reflective of psychological or psychiatric issues which may or may not involve 'mental illness' according to established diagnostic conventions", and 2) "Given the complexity and variety of factors which may lead to suicidal behavior, it would be a bold legislative step indeed to sweep it all under the rubric of mental illness, however widely defined".

Suicide is a physical action, and like most of our actions, it is a reaction to our external and internal circumstances, and depends on our typical reaction style. A mental disorder may be a significant driver. However, a mental disorder is not always present. Suicide is multifactorial; important factors include genetic contribution, poor physical health, low socio-economic status, adverse early life experiences, personality features such as impulsivity, culture, and chronic and acute alcohol and substance use.

Thus, the scene is set: many different factors can influence suicidal behaviour, each may influence the suicidal behaviour of a particular individual at a particular time, and different factors can combine to increase the risk of suicide. In the next chapter a model is presented in which mental disorder and environmental factors trigger suicide, either alone, or in combination.

# CHAPTER 2

## PREDICAMENT SUICIDE MODEL

**Summary**: A model is presented with 'predicament' being the central feature; the predicament may be a mental disorder or environmental factors (or both). The degree to which the predicament (or stressors which compose the predicament) draws the individual toward completed suicide is influenced by nature and nurture. The accuracy of 'psychological autopsies' is challenged. Social factors and a 'sociological autopsy' are discussed. Cases are mentioned, including "the jumpers of 9/11".

**"Life is not a spectacle or a feast; it is a predicament."**

George Santayana (1942)

**"In order to render suicide a medical issue, it is perhaps natural for Chinese psychiatrists to promote the view that depression causes suicide."**

S Lee (1999)

A model of suicide will be described which can accommodate two conditions: that, 1) suicide may be the result of psychiatric disorder, and 2) suicide may occur in the absence of psychiatric disorder (in which case environmental/social factors are the important forces). These conditions are not mutually exclusive. Importantly, the outcome of psychiatric disorder is clearly less favourable when compounded by social stressors.

A predicament is situation, especially an unpleasant, troublesome, or trying one, from which extraction is difficult. The predicament model of suicide construes suicide as an escape mechanism. The predicament may be a set of difficult external facts, (such as debt or disgrace) or internal facts (such as mental disorder which is untreated or unresponsive to treatment). There can be discussion about whether these factors can be separated. For example, a parking ticket (an external event) may cause distress at different levels, not simply that of financial loss. The individual with an overdeveloped conscience may interpret a parking ticket as evidence of inexcusable irresponsibility and feel guilt/remorse (an internal event). The individual with intractable pancreatic pain is justified in believing he/she has a serious internal fact. For simplicity, however, in this book the term internal facts is used to indicate the presence of mental disorder and external facts is used to indicate non-mental disorder events (including physical illness and pain).

'Predicament suicide' is distinct from 'rational suicide', as by definition, rational suicide can only occur in the absence of mental disorder (Choron, 1964). Rational suicide involves existential choices when life becomes "a burden they can no longer bear" (Kjolseth *et al.*, 2009), and in this way the two are similar.

The current orthodox medical view is that suicide is primarily the result of psychiatric disorder (Barraclough *et al.*, 1974). In his influential book, 'The Final Months', Dr Eli Robins (1981) examined the suicides of 134 people and concluded that 94% had been psychiatrically ill at the time of their death. More recently, 98% of people who

**Saxby Pridmore (Ed.)**

completed suicide were assessed as having at least one mental disorder (Bertolote *et al.*, 2004). Some suicide researchers go further and conclude that even those suicide completers who are reported as having no evidence of psychiatric disorder, "probably have an underlying psychiatric process", which the investigators "failed to detect" (Ernst *et al.*, 2004).

The studies which find that all or almost all of those who complete suicide have a mental disorder are called "psychological autopsies". In these studies, all the evidence which can be gathered about the thinking and behaviour of the deceased from records and witnesses is collected and considered by the researchers, and conclusions are drawn. These are retrospective studies; for good scientific reasons, retrospective studies are not accepted as being of high scientific value in any area of psychiatry or psychology. Those who gather and evaluate the evidence in psychological autopsies have an investment in the outcome of these studies, and however much we aspire to objectivity, avoiding bias is always difficult (Selkin and Loya, 1979). There are various types of psychological autopsy (Scott *et al.*, 2006), leading to the belief that one study can not be compared to another (Abondo, *et al.*, 2008). Many authors have raised concern about the validity (whether they measure what they are supposed to measure) and reliability (whether the same result would be reached if the process was repeated on another occasion; Ogloff and Otto, 1993; Biffl, 1996; Hawton *et al.*, 1998a; Werlang and Botega, 2003, Snider *et al.*, 2006). Finally, "the vast majority have used ill-defined instruments" (Pouliot and De Leo, 2006), which means the formulas used to make the diagnoses of mental disorder in "the vast majority" of psychological autopsies were probably not valid. Psychological autopsies have influential supporters, but good science needs more, and the claims made based on these studies are not proven.

The prominent psychiatrist/suicide researcher Erwin Stengel (1964) estimated mental disorder was present in only 37% of those who complete suicide. Pilcz (1908) estimated that one third of suicide was associated with diagnosable mental disorder. Colt (1991) was critical of after-the-fact diagnoses, and stated that only 22% of those who were assessed before suicide were diagnosed with a metal disorder. Recent work by Wang and Stora (2009) found evidence of psychiatric or drug disorders in only 61% of suicides in the Faroe Islands, and work from China found a "startlingly" low rate of mental disorder among completers (Law & Liu, 2008). Other work (Zhang *et al.*, 2009) has confirmed that suicide in China is less commonly associated with mental disorder than is reported in the west, and that, "Psychological strain, resulting from conflicting social values between communist gender equalitarianism and Confucian gender discrimination, was associated significantly with suicide in young rural Chinese women, even after accounting for the role of psychiatric illness". Research in India also finds a low rate of mental disorder (but a high rate of "stresses stemming from social practices and perceptions") among completers (Vijayakumar *et al.*, 2005; Jacob, 2008; Bastia and Kar, 2009). In adult women living in Goa who attempted or completed suicide, Maselko and Patel (2009) found common mental disorder in only 37% of cases, with other significant factors being exposure to violence, physical illness and recent hunger. In a careful study in rural south India Manoranjitham *et al.* (2009) found that only 37% of those who completed suicide were suffering a psychiatric disorder. The main two identified disorders were alcohol dependence and 'adjustment disorder' (which is transient difficulty in dealing with an event). They found "psychosocial stress and social isolation rather than psychiatric

morbidity" were the important factors. The East may need to be put aside, in the present discussion, due to the considerable cultural differences. Nevertheless, while it is clear that psychiatric disorder may result in suicide, not all suicide in the west is the direct result of mental disorder (Cheah *et al.*, 2008; Pridmore & McArthur, 2008). Finally, the most comprehensive study to date, involving the face to face examination of 108 664 people in 21 countries found that only half the people who had seriously considered killing themselves had a mental disorder (Editor's summary, 2009).

For over a century, sociologists (Durkheim, 1897/1951) have been reporting that national suicide rates are essentially stable over time, that the rates of nations are different from each other, and that these differences are stable over time. For example, over a recent 35 year period (1955-1989), the suicide rate of men in Finland was seven times greater than that of men in Greece, and the suicide rate of women in Denmark was seven times greater than that of women in Ireland (Frenquist & Cutright, 1998). This presents major, unanswered questions for the 'all suicide is the result of mental disorder' adherents. Cultural influences on suicide rates have been repeatedly demonstrated.

Exploring the importance of social bonds across the life-course, Shiner *et al.* (2009) conducted a "sociological autopsy". They studied 100 cases of suicide in the UK and found that relationship problems and breakdown were present in 55%, and that relationship breakdown was the main trigger in 34% of cases. These authors acknowledged that "depression or some other mental health diagnosis" was frequently present, but did not hold this to be the transcendent issue. Instead, they listed mental disorder alongside social issues, and emphasized "the importance of the protective value of social bonds".

Long term social disadvantage has a negative impact on health. Education level and occupational group are reflected in deaths from external causes which includes suicide (along with accidents and violence; Saurel-Cubizolles *et al.*, 2008). Lower socioeconomic status is associated with higher suicide rate across nations (Page *et al.*, 2006) and even within cities (Lemstra *et al.*, 2006). Unemployment rate is significantly related to suicide rate for both males and females (Yamasaki *et al.*, 2008; Ying and Chang, 2009).

Long term social disadvantage may contribute to less than adequate social bonds and less than robust personality development (discussed below). Norwegian researchers (Gravseth *et al.*, 2009) studied 610 359 young people who were born during the period 1967-1976 and followed them up to 2004. They found not being first born, instability of maternal marital status and low education of the individual were risk factors. These authors conclude that suicide in young adults is rooted in early childhood and is linked to the composition and stability of the parental home.

Body mass index (BMI) and suicide was studied in a prospective cohort of 1.1 million people (Mukamal *et al.*, 2009). They found that for married men and women, the risk of suicide was inversely related to BMI (highly significantly; $p = 0.009$). Gravseth *et al.* (2009) have reported suicide rate was inversely related to BMI, but they only had access to male data.

Before going to the model, we should look at 'personality'. A useful definition: personality is those features of the individual which determine his/her unique

adjustment to the environment. In practical terms, we can usually predict how the people we know will react to situations (a spilled cup of copy, being propositioned by a married person), and these predictable reactions reflect the personality. Another way of viewing personality is as a constellation of features, or traits. This is the way personality tests 'measure' personality. Features include, extraversion-introversion, warmth, dependency, irritability, aggression, pessimism, and many others (depending on which test is being used).

Personality is frequently described as being "lifelong and persistent" (although personality does change somewhat over time, as we mature, and personality change is the aim of sustained psychotherapy of some forms). Personality is also described in terms of "enduring characteristics and attitudes", and accordingly, personality naturally influences our ways of thinking, feeling and behaving.

Personality development involves both nurture and nature. It is accepted that early life experience, particularly a warm relationship with supportive parents, is important for optimal personality development. The corollary of course applies, that unwanted early life experiences, such as physical or sexual abuse, abandonment (including the unavoidable separation of mother and child through the illness of either) and even a bad fit between the temperaments of the child and parents, can have detrimental effects on the emerging personality. Specific to the issue at hand, adverse early life experiences increase the risk of suicidal be behaviour in later life (Roy and Janal, 2005).

The Commission on Social Determinants of Health (2008) concluded that social justice "is a matter of life and death". It stated that early childhood and education "lay critical foundations for the entire lifecourse". Thus, socioeconomic status and life opportunities also have powerful personality crafting influences.

With respect to the influence of nature, genetic studies using family, twin and adoption study designs have all demonstrated powerful genetic effects on the development of normal personality and personality disorder (Reichborn-Kjebberud, 2008).

With specific reference to suicide, adoption (Schulsinger *et al.*, 1979), family (Wender *et al.*, 1986), and twin (Baldessarini and Hennen, 2004; Segal, 2009) studies have also demonstrated that genes have a powerful influence. Heritability accounts of 30-55% of the risk for suicide (Voracek & Loibl, 2007), in other words, genes are one of the most powerful factors contributing to suicide. Recent work demonstrates that suicide and social behaviour is transmitted within families independently from the transmission of psychiatric disorder (Brent & Melhem, 2008). Thus, it is not the transmission of a psychiatric disorder, but another factor/s, which predisposes to suicide.

In recent research, three separate gene variations have been statistically associated with suicidal behavior (Omrani, *et al.*, 2009).

Does this mean there is a gene for suicide? No, there is no evidence for a single gene, there are probably many genes all contributing small effects, and not for the suicide act itself, more likely, for characteristics or tendencies to respond to the world in

certain ways (Cogdon and Canli, 2008). We start coming back here, to personality features. There appear to be two main clumps of personality features which underpin suicide: neuroticism/hopelessness, and impulsivity/aggression.

Neuroticism is a fundamental personality trait, an enduring tendency to experience negative emotional states (a tendency, for example, toward anxiety, guilt and unhappiness). People with high neuroticism scores are inclined to interpret environmental stresses as insurmountable and distressing. (The glass is half-empty individuals.) Neuroticism is strongly influenced by genetic factors (Viken *et al.*, 1994) and childhood trauma (Roy, 2002), and is associated with suicide (Duberstein *et al.*, 1994).

Impulsivity and aggressiveness are both influenced by genetics (Mann *et al.*, 1999) and early life experiences (Brent& Melhem, 2008), and both are strongly associated with completed suicide (Apter *et al.*, 1993; Ernst *et al.*, 2004). Not surprisingly, violent behaviour in the last year of life, irrespective of alcohol use, is a significant predictor of suicide (Conner *et al.*, 2001). Putting these precise, tiny, scientifically proven building blocks aside, common sense tells us that an individual who has a tendency to negative emotional states and impulsivity-aggressiveness is more likely to complete suicide than an individual without these tendencies.

Personality and personality features have been discussed. Personality disorder is a psychiatric diagnostic category in which some personality features (eg, irritability, seductiveness, dependency) are present in excess while others (such as the ability to accept responsibility and agreeableness) are stunted. Personality disorder leads to maladaptive responses to life events. Such people are at increased risk of suicide. Borderline personality disorder is an example, and the type most commonly associated with suicide (Frances *et al.*, 1986). Borderline personality disorder development also depends on both early life experiences and genetic endowment (New *et al.*, 2008).

"Resilience" has received many column inches in the lay press of recent times, but is yet to be properly scientifically investigated. It would be reasonable to expect that highly resilient people would be less inclined to suicidal behaviour. Predictably, one study of currently abstinent substance dependent patients found that those with a history of suicidal behaviour had low resilience scores on a newly developed "resilience test" (Roy *et al.*, 2007). Further work on resilience is needed.

Gender influences suicidal behavior. In all nations, males complete suicide more commonly than females (with the probable exception of China). Males complete suicide 3-4 times more commonly than females in English speaking and European countries. This could reflect a physiological difference, with testosterone possibly having a driving effect in males. However, the different norms and expectations of the genders have been proposed as the most powerful drivers. Males have greater familiarity with violent acts (hunting, slaughtering, and war service) and greater access to violent means such as firearms. Coping strategies of males more commonly involve the use of alcohol and drugs. There is also a theory that males are more achievement-oriented than females, and are thereby more vulnerable to unemployment and work-related problems (Girard, 1993). An observation of interest is that when only those people with a history of psychiatric treatment are considered,

the gender difference is much reduced (Liu *et al.*, 2009). This suggests suicide can occur in the absence of mental disorder, that socio-cultural factors affect the genders differently, and that when suicide occurs as a result of mental disorder, the genders are affected equally.

Alcohol use, both chronic and acute, has a powerful impact on suicide behavior, and has been detailed in Chapter 1.

Suicide depends on the combination of a predicament and an individual. Shiner *et al.* (2009) have used the terms "contextual" and "personal" factors. The same predicament may lead individuals to different responses. A parking ticket may lead to an angry out-bust, a feeling of guilt or failure, a laugh, or complete indifference. **Caren Jennings** (75 years; 2008; Sydney) and others have responded to terminal illness by completing suicide, but many in the same predicament have not.

And, different predicaments may lead individuals to the same response. **Elizabeth Stebbins** (44 years; 2003; California), **Lee Crisp** (19 years; 2005; Staffordshire, UK), **Helen Cole** (48 years; 2007; Cheshire, UK) and **Michel Veillette** (34 years; 2008; Ohio) all hanged themselves in custody. None had been sentenced. They faced different charges: Stebbins, assault; Crisp, burglary; Cole, murder of son; Veillette, murder of wife and 4 children. Of course, they were all in custody, but they faced very different futures.

The belief that all suicide is a result of mental disorder spawns major problems. First, it makes suicide an exclusively medical issue, and turns attention away from the many social and cultural issues which contribute to suicide, and about which, things need to be done. Medical/Psychiatric/Emergency Room services are not able to provide much help with acute social problems. If "Health" departments decide to provide comprehensive "well-being" assistance for people expressing suicidal thoughts in a setting of social crises, new social crisis/well-being services will need to be established. Second, police forces deal with many angry and regretful people, and because police forces are frequently (and frequently unreasonably) criticised when "deaths in custody" occur, they attempt to pass many simply angry people over to psychiatric wards, with the argument that these individuals have threatened suicide and must therefore have a mental disorder. Thus, psychiatric wards become crowed with inappropriate admissions. An aside: this latter process usually results in people not being charged for offences including assault, and it has been argued that the avoidance of charges encourages angry individuals to continue to behave in a maladaptive manner.

Both mental disorders and environmental problems can lead to suicide; it is not a matter that one occurs and the other does not. Very commonly, there is an explosive mixture of the two (Phillips *et al.*, 1999). Evidence indicates that the more factors are operating, the greater the risk of suicide (Phillips *et al.*, 2002).

**Example: "the jumpers" of 9/11**

Between 190 and 220 people jumped from the burning Twin Towers on September 11, 2001 (TIMEONLINE, 2006). "They began jumping not long after the first plane hit the North Tower, not long after the fire started. They kept jumping until the tower

fell" (Junod, 2009). These are facts which many try to ignore, and derisively, those stricken individuals have been referred to as "the jumpers". Ignored or not, videos of these events available on Youtube.

These people were faced with a predicament, and chose death rather than await the inevitable. It would be facetious to suggest they were all suddenly struck with a mental disorder. While most predicaments which lead to suicide are less immediate than this one, these facts establish that predicaments can lead to certain death. There can be, of course, semantic argument about whether this was suicide.

## Description of the Suicide Predicament Model (Diagram 1)

A Suicide Risk Ladder (SRL) is conceptualized as starting at zero (no risk of suicide) and going through to 10, a threshold at which suicide is completed. This ladder is based on clinical experience, but is purely theoretical and no quantitative accuracy is claimed.

An Individual Base-line Suicidality (IBS) is conceptualized. The idea is that we all have some base-line tendency to suicide, but as we are all different, we all have a different IBS. The IBS of the individual is relatively stable. It is determined in part by personality features (which in turn, are determined in part by genetic endowment and early life experience). It is also influenced by culture, gender and long term social disadvantage. It can be impacted by major events, such as episodes of mental disorder, severe psychologically traumatic experiences, and head injury (Kuipers and Lancaster, 2000). The IBS is conceptualized as being relatively impervious to current minor events.

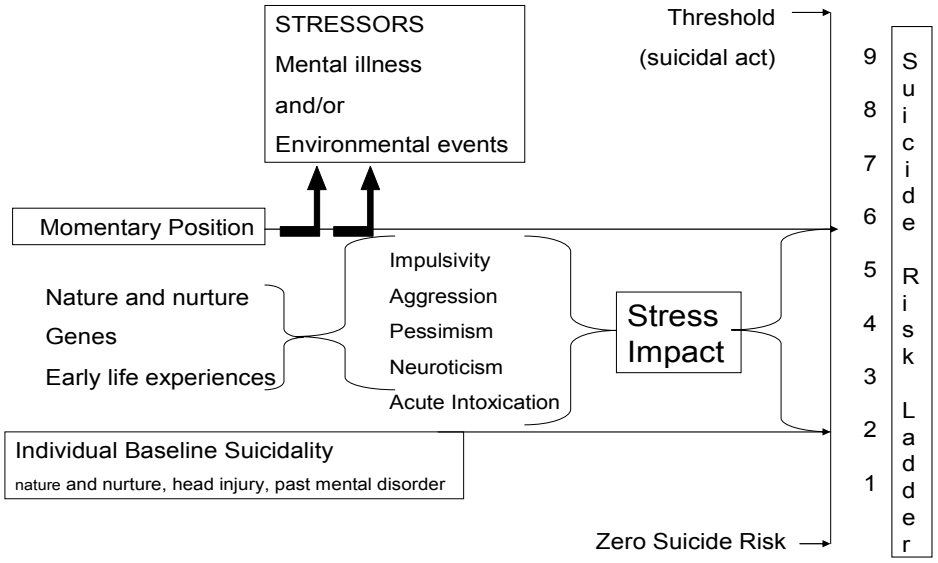


**Diagram 1.** Suicide predicament model

The Momentary Position (MP) represents the suicide risk of an individual at a particular point in time.
Stressors (current mental illness or environmental events, or a combination) pull the MP toward the threshold at which suicide will occur.

The Stress Impact (SI) is the extent to which stressor/s are able to shift the MP. The SI of a particular stressor, is different for each person. The SI depends on the stressor (minor to major), individual characteristics (including neuroticism and impulsivity/aggression), acute intoxication, culturally (and sub-culturally) sanctioned responses, and probably other factors. Some of these features (neuroticism, impulsivity/aggression, culture) are of relatively long standing. Others, such as acute intoxication are largely features of the moment.

The stressor total constitutes the predicament in which the individual is embedded. The model is better illustrated by considering a single stressor.

A worst case scenario begins with a high IBS; a severe stressor impacting on a particular individual can produce a large SI with the result that the MP moves to the threshold of suicide.

Psychotherapy, new promising relationships, psychotropic medication and good luck, can all reduce the magnitude of the SI, and perhaps the level of the IBS, thereby reducing the likelihood of suicide. For the sake of simplicity, these elements are not shown on the illustration.

The advantages of this model include that it allows mental disorder and environmental stressors to operate separately, or in combination, and provides a means of diagrammatically illustrating the important factors which influence suicide risk.

# CHAPTER 3

# A WESTERN OPTION

**Abstract**: Many westerners view suicide as having a place in other cultures, but not in their own. The place of suicide in eastern cultures is briefly mentioned. The suicide of historical western figures (Ajax, Pyramus and Thisbe, Lucretia, Cato, Judas, Anthony and Cleopatra, Seneca, Cordelia and Boudica) is described. Their stories are traced over time through fine art, music and literature to the present. Western culture is currently shaped with suicide being an option in response to shame, anger, protest and sorrow and grief.

**"The thought of suicide is a great comfort: it's a good way of getting through many a bad night."**

Friedrich Nietzsche (1886)

Ignorance of other cultures is a universal problem. A common western belief is that many non-western cultures endorse and even encourage suicide. Indeed, that suicide has a "place" in some non-western cultures.

This is correct, to a large extent, after all, culture is "the way of life of a society" (Robertson, 1987). However, westerners are generally unaware of the place of suicide in their own culture.

Examples of non-western suicides which cause some discomfort to western observers include:

- the Buddhist practice, mainly performed by monks, of self-burning (termed self-immolation, although the Latin root of immolate means sacrifice rather than burn), which was and is usually an act of protest;
- the Hindu practice of *suttee* (or *sati*), the suicide of the widow on the pyre of her husband (Fig. 3), which was a sign of respect as well as justified by scripture;
- the Japanese practice of *seppuku* (or *hara-kiri*), voluntary disembowelment, which was a means of avoiding the predicament of disgrace, and of expressing loyalty to a deceased leader;
- the Japanese practice of *Kamikaze* attacks, the flying of explosives laden aircraft into enemy targets;
- and more recently, the Islamic fundamentalist practice of suicide bombing.

**Fig 3.** Early colonial drawing of suttee. Artist unknown.

Individual cases can be identified. Self-immolation was famously performed in protest by the Buddhist monk **Thich Quang Duc** in Vietnam in 1963 (Chapter 8). It was performed in Australia in 2001 by Pakistani, **Shahraz Kayani** (48 years) who was protesting the refusal of the Australian Immigration Department to provide his wife and children with an entry visa.

**Roop Kanwar**, 18 years, died by *suttee* in 1987 in Rajasthan, India, following the death of Maal Singh (24 years) to whom she had been married for 8 months. Subsequently, the practice was outlawed, but sporadic cases continue to occur.

*Seppuku* has been strongly discouraged in Japan and is now rare. In 1970, **Yukio Mishima** (45 years) and one of his followers performed *seppuku* in the office of a General at Japan Self-Defence Forces headquarters. Mishima, who was nominated 3 times for the Nobel Prize for literature, had gone to the General's office to inspire a *coup d'etat* and restore the emperor to his rightful place. When he failed he performed his well planned suicide.

The *Kamikaze* pilots of WWII are detailed later (Chapter 8). Suicide bombing is a current practice. **Wafa Idriss**, the first female suicide bomber was been mentioned earlier (Chapter 1).

## Suicide and western culture

The place of suicide in western culture is less well recognized. Suicide is an escape option for individuals caught in particular predicaments. Nonmaterial culture consists of ideas, beliefs, rules, customs, language, myths, skills, family patterns and political systems. Culture shapes our behaviour, and is shaped by our behaviour. Cultures change over time, and some aspects of culture change more rapidly than others: we no longer obtain confessions by torture or keep slaves, but we still pass-on our estates to our off-spring and reward musical ability.

The suicide rates of countries are relatively constant, but they are different (Diekstra, 1993). The suicide rate in Hungary is always higher than that of Australia, which is always higher than that of England. The suicide rate in every country (except perhaps China) is higher in males than females. It was these stable relationships in suicide rates which alerted Durkheim (1897/1951) to the importance of social/cultural factors.

Clinical experience is that people who survive a suicidal act report their actions as having been a response to particular predicament. For example, **Napoleon** took poison on April 13th, 1814, shortly before his arrival on Elba (an uncomfortable predicament). He planned to die and would have succeeded, except that his poison had degraded over time to non-fatal potency.

In this chapter the stories of famous individuals from antiquity who completed suicide are examined. A pathway is outlined by which these events have reached current western culture, and so contribute to the behavioural options of people in similar predicaments.

## Examples from the public record

### Ajax

**Fig 4.** Ajax burying the handle of his sword, so that it will stand upright. (Vase painting)

Ajax was a mythological Greek hero of great stature and physical strength who bravely fought the Trojans. He is a major character in the Iliad, and had two memorable fights with Hector. When Achilles died, both Ajax and Odysseus sought ownership of his of magic armour. It was agreed, ownership would be decided by a public speaking contest. Odysseus won. Ajax, disappointed, fell to the ground exhausted. When he awoke, under a spell of Athena, he misidentified a flock of sheep as Achaean soldiers, and killed them. Later, he came to his senses, and covered with blood, he felt great shame. He killed himself by throwing himself on his sword (given to him by Hector; Fig 4).

The story of Ajax has entered current culture via the following (among other) routes:

- Poem: Iliad, Homer.
- Paintings on vases: numerous.
- Seal: Corinth, circa 700 BCE.
- Play: Ajax, Sophocles, circa 440 BCE.
- Bronze Statue: The Suicide of Ajax (from Populonia), 5$^{th}$ century BCE.
- Book: The Ajax of Sophocles, A C Pearson, 1912.
- Name given to current naval ships, towns, cleaning agents, foot-ball clubs.

## Pyramus and Thisbe

**Fig 5.** Pyramus and Thisbe, drawing by Hans Schaufelein (1480-1540)

Pyramus and Thisbe lived in adjoining houses in Babylonia (which was destroyed in 689 BCE). Their story was been recorded by others, but a favourite account is given by Ovid.

Pyramus was handsome and Thisbe was beautiful. They were in love but their families would not allow them to associate. They spoke to each other through a crack in the wall which separated their homes. They arranged to meet one night near the tomb of Ninus. Thisbe arrived first, but was scared away by a bloody mouthed lion. The lion chewed on a veil which she dropped. Pyramus then arrived and assumed his beloved had been eaten by a wild animal. He blamed himself for not arriving first; "…my spirit is guilty. I killed you…" (line, 110). He stabbed himself to death (Fig. 5). Thisbe then came back and realized what had happened and blamed herself, "…your death's cause and companion…" (line, 152), and longed for reunion, "…nor can you be torn away by death… (line,153). She stabbed herself and died.

Thisbe expressed the belief that death would result in a reunion. Both expressed the pain of separation from a loved one, and guilt.

The story of Pyramus and Thisbe has entered current culture via the following (among other) routes:

- Fresco: Pyramus and Thisbe, Pompeii, c 79 CE.
- Poem: Metamophoses, Ovid, Book IV, 8th century CE.
- Tympanum: Pyramus and Thisbe, 12th century, stone.
- Painting: Pyramus y Thisbe, Niklaus Deutsch, 1520.
- Play: Romeo and Juliet, Shakespeare, 1595 (also a comic version, A Midsummer Night's Dream).
- Painting: Landscape with Pyramus and Thisbe, Gaspard Dughet 1656.
- Opera: Pyramus and Thisbe, John Frederick Lampe, 1745.
- Musical Comedy: Pyramus and Thisbe, The Beatles, 1964.

## Lucretia

**Fig 6.** The Rape of Lucretia, by Tiziano Vecelli, 1570.

Lucretia was a married Roman noblewoman. In 509 BCE, she was raped by the son of the last king of Rome, Tarquinius Superbus (Fig 6).

Lucretia called for her husband and father, asking each to bring a trusted friend (one of these was Brutus), and told them what had happened. They comforted and forgave her, but Lucretia took a knife which she had concealed beneath her dress and stabbed herself to death in their presence. Brutus took an oath against the king. He carried her body into the streets and urged the citizens to take up arms. As a direct response, the monarchy was replaced with the Roman Republic.

Lucretia's death has been attributed to her sense of shame. She was probably also angry.

Lucretia's actions had political consequences. It is unclear whether this was her intention. Feminist, Jane Newman (1994) described "Lucretia's suicide as the only form of political intervention available to women". If this was a politically motivated suicide, it was the most effective one to date, as it resulted in a change in government.

The story of Lucretia has entered current culture via the following (among other) routes:

- Poem: The Legend of a Good Woman, Geoffrey Chaucer, c 1387.
- Painting: The suicide of Lucretia, Albrecht Durer, 1518; Rembrandt, others.
- Poem: The Rape of Lucrece, Shakespeare, 1594.
- Woodcut: Death of Lucretia, Paulus Moreelse, 1612.
- Sketch: Lucretia, Richard Dadd, 1854.
- Opera: The Rape of Lucretia, Benjamin Britten, 1946.

## Cato the Younger

**Fig 7.** The Death of Cato of Utica, Guillaume Guillon Lethiere, 1795 (public domain).

Marcus Porcius Cato (95-46 BCE) was known as Cato the Younger, to distinguish him for his grandfather of the same name. He was a politician in the late Roman Republic and student of Stoic philosophy.
Plutarch wrote, "…even from his infancy, in his speech, his countenance, and all his childish pastimes, he discovered an inflexible temper, unmoved by any passion, and firm in everything". He was orphaned and raised by his uncle.

As an adult Cato displayed an intense devotion to the principles of the early republic. He had a reputation for honesty and incorruptibility, and was above the graft and

bribery of his day. In accordance with Stoic thinking he lived simply, he endured cold with minimum clothes, ate only when necessary and took vigorous exercise.

From the first Cato was a vigorous political and personal opponent of Julius Caesar. Pompey left Rome to raise an army against Caesar and Cato accompanied him. Pompey was initially successful against Caesar, but was then comprehensively defeated at the battle of Pharsalus (48 BCE). Cato fled to Africa to continue his resistance from Utica. Caesar crushed the last resistance, led by Scipio, at the battle of Thapsus (46 BCE).

Cato told his people to make peace with Caesar, went into his bedroom and stabbed himself with his sward (Fig 7). His falling attracted his friends who found him covered in blood and partially disembowelled. Plutarch wrote that a physician was called, but Cato "thrust away the physician, plucked out is own bowels, and tearing open the wound, immediately expired".

The motivation for Cato's suicide is unlike most others in this section. The politics of the time were that Caesar would probably have spared his life and pardoned him. Cato was probably not concerned with shame or guilt. It is believed he died 'on a matter of principle', he would not live under Caesar, and would not give Caesar the opportunity to pardon him. This was an act of defiance, a political statement. Cato was renowned for his temper (once aroused) and anger may have played a part.

The story of Cato the Younger has entered current culture via the following (among other) routes:

- Coinage: Silver denarius of Cato (47-46 BCE)
- Poetry: La Divina Commedia, Alighieri Dante, circa 1307
- Etching: The Suicide of Cato, Pietro Testa, 1648.
- Play: Cato, a Tragedy, Joseph Addison, 1713.
- Paintings: Death of Cato the Younger, Guerin Pierre Narcisse, 1797. (others)
- Novels: Masters of Rome series, Colleen McCullough, late 20th century.
- Television: Julius Caesar (Cato played by Christopher Walken), 2002.

## Judas

**Fig 8.** The death of Judas, by Gislebertus, French, 12th century sculptor.

Judas, who died in April between 29 and 33 CE, was one of the twelve disciples. He took a bribe from priests, 30 pieces of silver, to identify Jesus (he kissed him in a public garden). This led to Jesus being captured and placed in the custody of Pontius Pilate. He was subsequently crucified.

The generally accepted version of events which occurred before the crucifixion comes from Matthew 27:3-5, "Then Judas, which had betrayed him, when he saw that he was condemned, repented himself, and brought again the thirty pieces of silver to the chief priest and elders, saying, I have sinned in that I have betrayed the innocent blood. And they said, What is that to us? See thou to that. And he cast down the pieces of silver in the temple, and departed, and hanged himself." (Fig. 8)

As can be expected of a multi-author document, compiled over centuries some two thousand years ago, there are occasional points of contradiction. Judas is described as dying in two other ways, but his hanging is generally accepted.

Judas has become the archetype of the betrayer in western culture, and his suicide is regarded as being a response to guilt and sorrow.

The story of Judas has entered current culture via the following (among other) routes:

- Ivory panel: The death of Judas and the crucifixion of Christ. Early 5$^{th}$ century CE.
- Relief sculpture: The hanging of Judas, Antun Cathedral, France, built 1130.
- Manuscript illumination: Judas Hanging, Italo-Hungarian, 14$^{th}$ century.
- Painting: Kiss of Judas, Giotto di Bondone, 1226; Judas Iscariot, Nikolai Ge, 1891.
- Rock opera: Jesus Christ Superstar, Tim Rice and Andrew Lloyd Webber, 1970.

## Anthony and Cleopatra

Anthony (83-30 BCE) was a commander and administrator in the army of Julius Caesar. When Caesar was assassinated (44 BCE), Anthony joined forces with Caesar's heir (Octavian), and was awarded control of Egypt.

Anthony (although already married in Rome) became the lover of the Queen of Egypt, Cleopatra, in 41 BCE. They had twins the following year. Military and political machinations saw Anthony return to Rome, divorce his wife and marry Octavian's sister. In 37 BCE, Anthony returned to Egypt and Cleopatra and their third and final child was born the following year. Anthony fell from favour in Rome. He divorced Octavian's sister and Octavian declared war on Egypt.

In the battle of Actium (31 BCE) the naval forces of Anthony and Cleopatra were decisively beaten by those of Octavian. Before the battle was ended, Cleopatra, and later Anthony, fled the scene. A year later, with Octavian's forces approaching Alexandria, Anthony (believing Cleopatra had already suicided) committed suicide by falling on his sword.

**Fig 9.** Part of "Der Tod der Kleopatra", by Hans Makart, 1875, Germany.

Cleopatra was of Macedonian descent (an ancestor having been a General of Alexander the Great) but was born and raised in Alexandria (the then capital of Egypt) in 69 BCE. She inherited the throne of Egypt, along with her younger brother, when she was 17 and he was 12 years of age (51 BCE). Three years later she was dethroned and exiled. But with the assistance of Julius Caesar, she regained her position.

Cleopatra met Caesar while she was in exile. Caesar was in Alexandria, but Cleopatra was afraid to enter the city. She had herself rolled up in an oriental rug, which was taken to Caesar. When the rug was unrolled, they were introduced. They became lovers that night. Next year she gave birth to a son.

Caesar returned to Rome, leaving Roman legions in Egypt for her protection. On his invitation, Cleopatra went to Rome (46 BCE) and lived in his villa for two years. Caesar showered Cleopatra with gifts and titles and conducted a scandalous extra-marital affair. When Caesar was assassinated (44 BCE), knowing she was in danger, Cleopatra fled back to Egypt.

Cleopatra met Anthony after Caesar's assassination and the Roman Empire was divided between Octavian and Anthony (who was given control of Egypt).

Finally, Octavian declared war on Egypt (Anthony and Cleopatra). In 30 BCE, with Octavian at the gates of Alexandria, and incorrectly believing Cleopatra was already suicided, Anthony, as mentioned above, stabbed himself. Discovering Cleopatra was still alive, he had himself carried to her, and died on her bed.

Octavian, believing Cleopatra intended to suicide, kept her under close guard. She arranged for a basket of figs to be delivered to her quarters. This was searched for dangerous objects and nothing suspicious was found. Cleopatra sent a letter to Octavian asking to be buried in Anthony's tomb. She was found dead, presumably bitten by a snake which had been hidden in the bag of figs (Fig 9) .

Both Anthony and Cleopatra believed the other to be dead. They had lost the armed struggle (and thus their status) against Octavian. They could both expect denigration and probably execution.

(An aside: an example of *fides* (loyalty; Chapter 1), when Cleopatra died, a eunuch and two female maids, Eiras and Charmion, also took their lives.)

The story of Anthony and Cleopatra has entered current culture via the following (among other) routes:

- Play: Anthony and Cleopatra, Shakespeare, 1609.
- Engraving: Cleopatra's death, Henry Tresham, 1801; Robert Strange, 1840.
- Painting: The Meeting of Anthony and Cleopatra, Lawrence Alma-Tadema, 1883.
- Movies: at least 20. Notable - Anthony and Cleopatra, 1908; Cleopatra, 1963.
- Opera: Anthony and Cleopatra, Samuel Barber, 1966.

**Stoicism/Seneca/Pompeia**

**Fig 10**. La mort de Seneque, by Luca Giordano, 1684

Stoicism is a school of philosophy which was founded in Athens in the third century BCE. It became the foremost philosophy among the elite of the Greco-Roman Empire. Stoicism argues that self-control and reason is the means of overcoming destructive emotions, and that through mastering the emotions it is possible to reach equilibrium in oneself and the world.

The stoics believed that if difficulties could not be surmounted, as "in circumstances of personal ruin or disgrace, or in the agonies of a terminal disease…the rational thing was to end one's own life".

Seneca (4 BCE – 65 CE; Fig 10) was one of the later and most compelling stoic philosophers. He was Nero's advisor (54-62 CE). In 65 CE he was charged with being a co-conspirator in a plot to kill Nero. Rather than face execution (he may have been

given this option by Nero) Seneca cut his wrists. He did not die immediately and took poison, which did not work. He jumped into a hot pool to increase the rate of bleeding and eventually died.

Pompeia Paulina, his wife, who was not charged and was not at risk of execution, also cut her wrists. However, Nero gave orders that her wounds be bound, and her life was saved.

Seneca and Pompeia were both in difficult circumstances, he faced execution loss of status and execution, she faced loss of status and her life-long partner.

The story of Seneca and Pompeia has entered current culture via the following (among other) routes:

- Prose, poetry: Extensive writings of Seneca remain available.
- Painting: The Death of Seneca, Gerard Van Honthorst, 1590-1656; Rubens, etc.
- Woodcut and poem: The suicide of Brutus, Geoffrey Whitney, 1586.
- Painting: Death of Seneca, Peter Paul Rubens, 1615.
- Etching: Seneca, Francois Perrier, 1640.
- Education: public-school education, the "stiff upper lip".

## Queen Cordelia


**Fig 11.** Queen Cordelia, illustration from book by Raphael Hollinshed (died 1580).

Cordelia (Fig 11) lived in Leicester in the 1st century BCE, the youngest of three daughters born to King Lear. The King wished to determine the degree to which his daughters loved him, with a view to gifting his estate to them proportionately (well prior to his death). The older sisters made favourable statements and were rewarded with land and married off to Dukes.

Cordelia, however, refused to make a statement and was, accordingly, disinherited. In spite of her lack of dowry, The King of France (Aganippus) proposed marriage, she accepted and went to live in France.

Later, the older sisters exiled their father. Destitute, he sailed to France to Cordelia. She raised and army, returned to Britain, and fought and defeated the armies of her sisters. She reinstated King Lear, and he reigned until his death three years later.

Cordelia then inherited the throne of Britain and returned from France in 56 BCE. She ruled for five years, but her nephews raised armies and laid claim to her throne. After many battles, in which she was an active combatant, Cordelia was defeated. She was imprisoned by her nephews and suicided by stabbing herself.

Shakespeare used her story (King Lear) but changed the timing and manner of her death.

It is believed that Queen Cordelia suicided because she was in goal and her prospects were much reduced. She had helped her father and suffered at the hands of her nephews, and may have been troubled by feelings of sorrow, injustice and anger.

The story of Queen Cordelia has entered current culture via the following (among other) routes:

- Poem: Legend of Queen Cordelia, John Higgins, c 1570.
- Prose and illustrations: The Chronicles of England, Scotlande and Irelande, Raphael Holinshed, 1577.
- Play: King Lear, Shakespeare, 1623.
- Painting: Cordelia, William Yeames, 1888.
- Name taken by modern band.

## Queen Boudica

**Fig 12.** Boadicea Haranguing the Britons by English painter, John Opie (1761-1807)

Boudica (Fig 12) was the queen of the Icenic people (in roughly what is now Norfolk). When her husband died the Romans annexed her land, flogged her, and raped her two daughters.

While the Roman governor (Suetonius Paulinus) was leading a campaign in Wales (61 CE), Boudica rallied troop and led a revolt. She had initial success, killing 70 – 80 000 people in three cities. Her soldiers performed atrocities. In spite of superior numbers, Boudica was thoroughly defeated by the Romans in "The Battle of Watling Street".

Boudica was imprisoned and completed suicide by poison. She was in very difficult circumstances, she had lost her husband, lands, her ability to fight, her daughters had been raped and she could expect no mercy from the Romans.

The story of Queen Boudica has entered current culture via the following (among other) routes:

- Prose and illustrations: The Chronicles of England, Scotland and Ireland, Raphael Holinshed, 1577.
- Play: Boudica, Francis Beaumont and John Fletcher, 1610.
- Poem: Boudica, Alfred Lord Tennyson, 1859.
- Sculpture: Boudica and her daughters, Thomas Thornycroft, 1905.
- Song: Boudica, Steve McDonald, 1997.
- Chapter: Heroes, Paul Johnson, Weidenfeld & Nicholson, 2008.

## Conclusion

| Individual/s | Circumstances | Probable Emotions |
|---|---|---|
| Ajax | Killed sheep while enchanted | Shame |
| Pyramus,<br>Thisbe | Loss of lover | Grief/Sorrow<br>Guilt |
| Lucretia | Raped | Shame<br>Anger |
| Cato | Intolerable<br>circumstances | Defiance<br>Anger |
| Judas | Betrayal | Guilt |
| Anthony<br>Cleopatra | Loss of lover<br>Loss of authority<br>Potential punishment | Grief/Sorrow<br>Fear |
| Seneca,<br>Pompeina | Inescapable<br>intolerable<br>circumstances | Fear<br>Shame |
| Queen<br>Cordelia | Lost of throne<br>Imprisonment | Grief/Sorrow<br>Anger |
| Queen<br>Boudica | Loss of throne<br>Imprisonment | Grief/Sorrow<br>Anger |

**Table 1.** Summary of circumstances and probable emotions associated with described ancient suicides.

These historical figures from thousands of years ago provide examples of suicide as an appropriate response to unacceptable predicaments and negative feelings. Tracing the passage of this information to the present time is a straightforward matter. Thus this history (and option) forms part of our current culture.

It may be argued that the man in the street has been too busy earning a living to have been aware of these "high culture" events. But this did not apply to Rousseau, Goethe, and Flaubert, whose novels made available to the time-poor citizenry, a romantic, idealized view of suicide as the inevitable response of the anguished (Lieberman, 2003). Tracing an unbroken pathway is relatively unimportant, what is important is that this information (this option) has become a feature of current western culture.

In 1954, **Edwin Armstrong**, 64 years, one of the greatest electrical engineers and inventors of all time (he stands with Alexander Graham Bell and Marconi), dressed in overcoat, scarf and hat and walked out of the window of a 13$^{th}$ floor of his New York apartment. His wife of 31 years had, after an argument, gone to stay with friends a few weeks earlier. His life was marred by a succession of legal battles concerning some of the more valuable of his 42 patents. He was facing another long and ruinously expensive legal battle at the time of his death. In 1996 a biographer wrote that his was "suicide-by-lawyer".

In 2004, **Nafisa Joseph**, 26 years, a Catholic and former Miss India Universe and Miss Universe finalist hanged herself in Mumbai, when she discovered that her betrothed was already married. (It could be argued that Joseph was a woman of the east, but participation in the Miss Universe contest suggests a certain familiarity with western culture.)

Behaviour is influenced by, and in turn, influences culture. It is not enough to simply recommend counselling or antidepressant drugs; to reduce the suicide rate we need to change the culture (remove the option).

# CHAPTER 4

# MILITARY LEADER SUICIDE

**Abstract**: Suicide by defeated military leaders is well known. Prominent examples (Eleazar, Brutus, Samsonov, Korechika Anami, Hatazo Adachi, Himmler, Goring, Goebbels) are detailed, however others are those who attempted suicide during peace time. The triggers for these suicides are discussed along with the influence of rank. Mention is made of the current misrepresentation of the suicide rate of US troops serving overseas.

**"*morte prima di disonore*"**
**(death before dishonour)**

Catiline (108 - 62 BCE)

Military leaders are promoted according to demonstrated ability. While some exhibit personality quirks (e.g., the self-aggrandizement of General George Patton), as a group they are highly functioning individuals with little if any evidence of major mental disorder. Nevertheless, suicide is not uncommon among military leaders.

The suicide of military leaders is of two main forms, when 1) the suicide occurs during action, and is directed toward achieving victory, and 2) the suicide occurs after action, and is a function of defeat.

## Suicide by military leaders during action

Examples of suicide during battle include those of Eleazar and Decius Mus (and his son and grandson, by the same name). These were not "suicides" insofar as, while these individuals did not deliver the fatal blows to themselves, they exposed themselves to such danger that death was inevitable.

**Eleazar** died in the Israelo-Selucid war (162 BCE), at the battle of Bet-Sacharaja. He attacked the elephant on which Antiochus Eupator was riding. He killed the animal, but it fell on him, crushing him to death (1 Maccabees 6:43).

**Decius Mus** was a Roman consul. In 340 BCE, during the Latin War, when his wing began to falter he plunged his horse into the enemy with such vigor and violence that they were awe-struck. He was killed, but a momentary weakness in the enemy created by his action allowed the Romans to win the battle (Livy). Decius Mus had called on the gods for assistance, and (with or without divine intervention) he inspired his soldiers. His son set a similar example at Sentinum in 295 BCE, and his grandson, at Asculum in 279 BCE.

Methods of war change over time. In modern times the death of a military leader is more likely to demoralize than inspire troops. The destructive force of the Gatling gun put an end to open field warfare and began the reign of trench war. In his 1897 poem, Vitai Lampada, in the line, "The Gatling's jammed and the Colonel dead", Sir Henry Newbolt captures the negative impact on modern troops of the loss of command personnel. Thus, this form of sacrifice is now rare.

**Saxby Pridmore (Ed.)**

## Suicide by military leaders as a function of defeat

### Brutus (died, 42 BCE)

**Fig 13.** Brutus commits suicide. Illustration from a book by Geoffrey Whitney, published in 1585

Brutus, 43 years, was born into a well connected Roman family and made a fortune lending money. As a senator he had a falling out with Caesar, but wrote an apology and was accepted back and made governor of Gaul. He took a leading role in the assassination of Julius Caesar (44 BCE), after which he was not punished, but required to leave Rome. However, when Octavian became the Consul of the Senate he immediately declared the assassins to be murderers, and moved against them. Brutus was defeated in battle by the combined forces of Octavian and Antony, at the Second Battle of Philippi. To avoid capture, he threw himself on his sword (Fig 13).

### Masada (936 died, 73 CE)

**Fig 14.** Masada.

Masada is the name of a site of ancient palaces and fortifications on top of an isolated rock plateau (Fig 14) on the edge of the Judean Desert, overlooking the Dead Sea. Herod the Great fortified Masada three decades BCE, for his own use in the event of revolt. At the beginning of the First Jewish-Roman War a group of Jewish extremists (the Sicarri) overcame the garrison and occupied the place themselves.

In 72 CE the Romans laid siege to Masada. Over months they constructed a rampart against one face of the plateau, using thousands of tons of stone. They brought up a battering ram and breached the wall. When they entered they found the leaders and more than 930 other inhabitants had suicided rather than face slavery or execution. In an act of defiance they set fire to their buildings so nothing remained for the conquerors. However, they did not burn their food stores, it is claimed they wanted it to be known that they had not been starved into submission.

## Alexander Samsonov (died 1914)

**Fig 15.** General Alexander Samsonov (public domain).

Alexander Samsonov (Fig 15), 54 years, joined the Russian Army at 18 years of age and fought in the Russo-Turkish War, the Boxer Rebellion and the Russo-Japanese War. In World War I, he was General in command of the Russian Second Army for the invasion of East Prussia. When his men were surrounded and captured by German forces, Samsonov shot himself in the head.

## Korechika Anami (died, 1945)

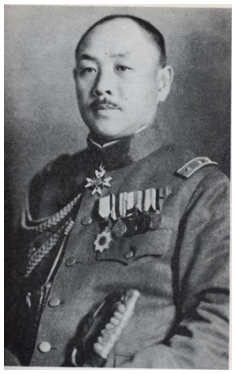

**Fig 16.** General Korechika Anami (public domain)

Korechika Anami (Fig 16), 58 years, was a General in the Imperial Japanese Army during World War II, and was War Minister at the surrender of Japan. He spoke

against the surrender, despite Japan's heavy battlefield losses and the American bombing of cities. Even after the bombings of Hiroshima and Nagasaki, Anami opposed surrender.

Eventually, Emperor Hirohito directed him to surrender. Anami signed a surrender document and next morning he committed suicide by seppuku.

## Hatazo Adachi (died, 1947)

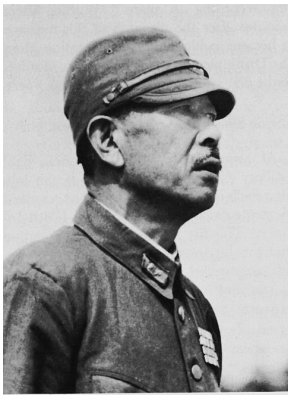

**Fig 17.** General Hatazo Adachi (public domain).

Adachi (Fig 17), 63 years, came from an impoverished family and was a career soldier in the Imperial Japanese Army. He was injured during the Second Sino-Japanese War (1937). During the Second World War, he was promoted to General and was the ranking Japanese officer in Papua New Guinea. His forces were defeated, he surrendered and was taken into custody by the Australian forces. He was convicted of war atrocities (although he was not directly responsible) and sentenced to life imprisonment. He committed ritual suicide.

## Heinrich Himmler (Died, 1945)

**Fig 18.** Heinrich Himmler, deceased (public domain).

Heinrich Himmler, 44 years, was a Nazi German politician and head of the SS. He was the main architect of the Holocaust, responsible for the extermination of millions of Jews, Gypsies, Poles, communists, people of different racial and political affiliations, and the physically and mentally infirm. At the end of WWII he offered to defect to the allies as long as he was spared prosecution and was appointed "minister of police" in Germany's post-war government. His offer was refused. He was scheduled to stand trial with other suspected war criminals at Nuremberg, but suicided by taking cyanide before the proceedings started (Fig 18).

Himmler always had a great interest in the military, although he was not physically gifted. He joined the army in WWI, but did not see active duty before war ended. He married and had one daughter; he later took a mistress and fathered another daughter and a son. Between the world wars he became head of the Gestapo, the German secret police, and held various other positions of authority. He strongly argued for selective breeding to bolster the "Aryan master race".

## Herman Goring (died, 1946)

**Fig 19.** Herman Goring circa 1935 (public domain)

Herman Goring (Fig 19), 53 years, had been a highly successful German pilot in WWI, with 22 confirmed 'kills'. He joined the Nazi Party in 1922 and was nominated by Hitler as his successor "if anything should befall me". He was the highest figure in the Nazi hierarchy to issue written orders for "the final solution of the Jewish Question". He was convicted of war crimes at Nuremberg and sentenced to be hanged. He appealed, requesting he be "shot like a soldier". His request was denied. He killed himself with cyanide the night before he was to be hanged. Nevertheless, his dead body was hanged.

Goring was born into a wealthy, well connected family. He married twice and fathered at least one child. He became a morphine addict secondary to treatment for a painful gunshot wound. He amassed a huge fortune from bribes and commandeering the possessions of others. He was known for his extravagant tastes and garish clothing.

## Joseph Goebbels (died, 1945)

**Fig 20.** Joseph Goebbels speaking at a rally in 1932. (Wikimedia Commons)

Joseph Goebbels (Fig 20), 47 years, was Minister for Public Enlightenment and Propaganda in Nazi Germany. He was famous for the burning of books rejected by the Nazis, and venomous anti-Semitism. After he learned that Hitler had suicided, he arranged for his six children to be murdered, then he shot himself and his wife took cyanide.

Goebbels was born to Catholic parents of modest means. Due to deformity of his right leg he was rejected for military service in World War I, which he bitterly resented. He was highly intelligent and obtained a PhD in 18$^{th}$ century romantic literature. He wrote books and plays for which he could not find publishers, which became another matter of resentment. He was an incorrigible womanizer who believed Hitler was a genius.

## Peacetime suicides

**Hannibal** (died, 183 BCE; Fig 21), 64 years, of Carthage, was one of the great military commanders of history. He fought many battles against the Romans. His most famous achievement was at the outbreak of the Second Punic War, when he marched an army, which included war elephants, from Iberia over the Pyrenees and the Alps into northern Italy. A Roman counter-invasion from North Africa forced him

to return to Carthage. After the war he became a judge and was politically active. His reforms were unpopular and he went into voluntary exile, and assisted other leaders in their struggles against the Romans. He was betrayed and when about to be passed over to the Romans, he took his life with poison.

**Fig 21.** Hannibal, statue by Sébastien Slodzt, 1704, Louvre (public domain).

Hannibal is a special case, he was a military leader who died by suicide, but not as a function of the defeat of his forces. He was about to be handed over to his enemies, who were interested to acquire him, in part at least, as a function of his victories. It is noted that his reforms were unpopular, and he was betrayed, which is a form of defeat. There is no doubt that Hannibal was a highly functioning individual, and no convincing evidence of mental disorder has been recorded. However, (Mackowiak and Batten, 2008) speculated that he may have suffered post-traumatic stress disorder. Given he had achieved great military victories for his people and had sought to reform civil society, but was nevertheless betrayed, perhaps his suicide comes close to what the Greeks termed *taedium vitaie* (disgust/weary with/of life).

The suicides of Captain **Ernest Blanchard** (died, 1995), 46 years, of the US Coastguard, and Admiral **Jeremy 'Mike' Boorda** (died, 1996) 56 years, of the US Navy, are discussed in Chapter 5.

## The influence of rank

Following defeat, it is generally the leaders rather than the lower ranks who suicide. There are, of course, exceptions. A web search will reveal images of ordinary Japanese soldiers based on the Gilbert Islands, who shot themselves rather than surrender to US Marines in 1943. These men may have completed suicide as an expression of their loss of honour, but also, they probably believed the propaganda that they would be imprisoned and tortured by the victorious allied troops.

Lower ranks were used as kamikaze (suicide pilots; Chapter 8) in the WWII, and this continues with the suicide bombers, their counter-parts in the current era.

Durkheim (1897/1951) considered all military suicide to be "altruistic suicide". Altruistic suicide is named to indicate that the act is for the good of other members of

the group; but this does not apply precisely in the suicide of military leaders. Altruistic suicide occurs when the individual is excessively integrated into the group, ceasing to exist as an independent individual, and it was this aspect which led Durkheim to label military suicide as altruistic.

Durkheim (1897/1951) found a higher rate of suicide among soldiers than members of the general public: "He must be trained to set little value upon himself, since he must be prepared to sacrifice himself upon being ordered to do so". In the current era, however, the opposite is the case, military personnel having a lower suicide rate than the general population (Wong *et al.*, 2001; Mahon *et al.*, 2005; Fear, *et al.*, 2009; Yamane & Butler, 2009). This is consistent with the military selection process identifying fit, capable young people, and the need to remain in good health, so as to remain "battle ready".

Durkheim (1897/1951) believed there was a greater propensity of officers as compared to lower ranks to suicide, and that this was a reflection of the greater strength with which they held a code of honour. Whether there was a greater propensity for officers to suicide at the time that Durkheim was writing is unclear. However, in recent decades it is the lower ranks who are at greater risk of suicide (Mahon, 2005), and this may be because these individuals have greater access to firearms.

## Current US troops overseas

For the sake of completeness, mention is made here of recent media reports of high rates of suicide among American troops serving overseas. These media generated rates are usually overstated (discussed more fully in Chapter 10). Also, the media has stated that the suicide risk of war veterans is greater than non-war veterans, but the scientific studies show this is not so (Miller *et al.*, 2009).

With respect to American troops serving overseas, Durkheim's statements may have relevance: "In all armies, the coefficient of aggravation (suicide rate) is highest among the elite troops". This he attributed to the greater discipline (obedience and integration) of the elite troops. Whether this holds in the present day is unknown.

US Army Chaplain Lt Col Ran Dolinger draws attention not to fighting per se, but to the absence of the soldiers from their homes and the consequent breakdown in their relationships with family, friends and loved ones (CNN.com, 2008)

## Conclusion

There is a clear history of defeated military leaders taking their own lives. To those detailed in this chapter may be added Queen Boudica and Queen Cordelia, and Anthony and Cleopatra (Chapter 3). To be a military leader is to be a highly functional individual, which counts against all of these deaths being the result of mental disorders.

These individual find themselves in uncomfortable predicaments. In the past they could anticipate humiliation, torture, slavery or death at the hands of their captors. At

present, defeated leaders can anticipate being treated with reduced respect by their captors, and when released, by their countrymen. Presumably there is a sense of failure and possibly, shame.

There is some overlap between this chapter and the next (Chapter 5), which is concerned with suicide and shame. In this chapter any shame arises out of failure, whereas in the following chapter, dealing mainly with death of civilians during peacetime, the shame is mainly associated with breaking a moral or legal code.

Durkheim (1897/1951) believed that the high level of social regulation at the upper military echelons is expressed in a code of honour which predisposes defeated military leaders to suicide (he believed, altruistic suicide).

It could be expected that many of the above described individuals were inured (made tough through habitual exposure) to death. It would have been necessary for them to objectify (treat as an object) certain other human beings. Whether one can be inured to death in general, and therefore one's own death, thereby increasing the risk of suicide, is unknown, but this is a possibility.

Importantly, contrary to what Durkheim (1897/1951) found in an earlier time, in current armed forces, the suicide rates are below those of civilian populations (Wong *et al.*, 2001; Mahon *et al.*, 2005; Fear, *et al.*, 2009). Further, the suicide risk of war veterans is not greater than non-war veterans (Miller *et al.*, 2009).

# CHAPTER 5

## SHAME AND ANGER SUICIDE

**Abstract**: Shame is frequently overlooked as an emotion leading to suicide. Examples from the public record in which shame is believed to have played a major role (Bud Dwyer, Ernest Blanchard, Jeremy 'Mike' Boorda, Takayuki Kamoshida, Mervyn Jenkins William Lucan-Roberts, Wolfgang Huellen, Vlajko Stojiljkovic, David Kelly, Arthur Teele, Wolfgang Priklopil, Shinichi Yamazaki, J D 'Roy' Atchison, Christopher Forster, Bruce Ivins, Michael Todd, Michael Pigott Roh Moo-hyun, Dudu Topaz, and others) are detailed. Anger is also believed to be a factor in some completed suicides. Examples are less common, but may include some men who kill their offsprings and themselves in the settings of disputed access to children.

**"There is no refuge from confession but suicide; and suicide is confession."**
Daniel Webster (1782-1852)

This chapter examines the peacetime suicide of people with no evidence or history of psychiatric disorder, who were believed to be responding to shame or anger.

The emotions drive behavior and can be divided into two broad categories: the positive/pleasant (e.g., joy and excitement) and the negative/unpleasant (e.g., shame, guilt and anger). The negative/unpleasant emotions may lead to suicide.

The cases examined below are of separate, unique civilians and who can not be easily fitted into a single category. However, they all faced unacceptable predicaments, and completed suicide as a means of extraction.

### Shame

As mentioned, Plato (424-348 BCE) considered suicide to be disgraceful and that perpetrators should be placed in unmarked graves. However, he did recognize exceptions, including when the self-killing results from shame and having participated in grossly unjust actions (*Laws IX* 873c-d). Thus, suicide as a response to shame has a long history.

A review of 36 suicides recorded in classical mythology found shame, guilt and grief to be commonly associated emotions (Preti & Miotto, 2005). Recent studies of suicide notes found the theme of "apology/shame" in 74% (Foster, 2003; Chia *et al.*, 2008). Another study of suicide notes (Lenaars, 1988) found avoidance of anticipated rejection to be a common feature.

Shame may have been a motivating factor in the suicides of Ajax, Judas and Lucretia (Chapter 3) and some of the earlier mentioned defeated military leaders (Chapter 4). In wartime, shame may be associated failure to complete the task (win), whereas in peacetime, shame is mainly associated with being caught breaking moral or legal codes. This is a generalization, and failure in peacetime can of course be associated with shame, as in the cases of financial failure as described in the cases of Rene-

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Thierry Magon de la Villehuchet (2008), William Foxton (2009) and Adolf Merckle (2009) (Chapter 1).

Shame is also reported as a risk factor for suicidal ideation (Kolves *et al*., 2010) and non-fatal self inflicted injury (Brown *et al.*, 2009).

The quality of the data does not allow the fine distinction to be made between shame and guilt. Where one is present there is usually also at least a shadow of the other. For current purposes, they will be discussed together, under the heading of "shame".

## Examples from the public record

All of the following people were highly successful in their chosen field. Being successful is an indicator of the absence of serious mental disorder, as serious mental disorder handicaps to some degree, and makes success more difficult. In addition, the accounts of the last days of these people have been examined using all accessible sources, and only those with no evidence of an extant mental illness have been included.

**1922: Lewis Harcourt, 1st Viscount Harcourt**, 59 years, was born to a well connected family and educated at Eaton. His father, Sir William, had been Home Secretary. Harcourt married at 33 years and fathered four children. He had been a liberal MP (1904-1916), and had held various ministerial positions, including Secretary of state to the colonies. He was described as a sexual predator and attempted to rape both males and females. His behavior was tolerated and kept private. However, he attempted to rape a 12 year old boy, whose mother made the matter public. Harcourt could not face the impending disgrace and shot himself in his study at his London home.

**1987: Bud Dwyer**, 47 years, had a Master's Degree in education and served as a member of the Pennsylvania House of Representatives. He spent a decade in the Senate, and at the end of his tenure in 1980, he took the post of Treasurer of Pennsylvania. He was convicted in a bribery scandal. In 1987, the day before his sentencing, he called a press conference to "provide an update on the situation". He declared his innocence, and while the TV cameras were rolling, pulled a gun out and shot himself in the mouth.

**1995: Captain Ernest Blanchard**, 46 years, was Chief of Public Affairs at Coast Guard Headquarters in Washington. He had a distinguished afloat career and his shore assignments included Professor of Political Science at the Coast Guard Academy. He was married with two adolescent children. In the preceding year he had given an address at a dinner at the Coast Guard Academy. He had told a number of sexist jokes. This caused a political scandal. Investigations dragged on for months. He shot himself in the head with his grandfather's pistol. A Naval psychological autopsy concluded, "The emotional pain that Captain Blanchard felt he had brought upon himself and the Coast Guard led him to choose suicide as a solution".

**Circa 1996: The Wood Royal Commission** inquired into corruption in the New South Wales (Australia) Police Force. It sat from 1994 to 1997. Toward the end, it

investigated the protection of paedophiles. In 2007, The Sydney Morning Herald journalist Malcolm Brown summarized the outcomes. He listed the names of 8 people who had been, or were about to be, called before the commission, who had suicided. These included a retired Judge, a police Inspector, and two police Detectives. Brown stated that four other people who had been "enmeshed" had also suicided. The retired Judge appeared before the Commission and made an admission of illegal acts, including sex with boys in public toilets, and five days later gassed himself in his car.

**Fig 22.** Admiral Jeremy M Boorda (public domain)

**1996: Jeremy "Mike" Boorda**, (Fig 22) 56 years, was an Admiral in the US Navy. His case is detailed in Chapter 1, but in essence, questions had been raised about his right to wear a particular decoration which he had worn in public, and he shot himself some hours before he was to be interviewed on the topic by two Newsweek journalists.

**1998: Takayuki Kamoshida**, 58 years, was the Manager of the Bank of Japan. He hanged himself. His death was attributed to the bank's poor performance and his loss of face. Suicide by businessmen is not uncommon in Japan, particularly in difficult economic times.

**1999: Mervyn Jenkins**, 48 years, formerly an army lieutenant colonel (electronic warfare expert), described as a "top Australian spy", was stationed in Washington. He was interviewed by security officers about "breaches of information handling matters" and a few days later he hanged himself in his luxury home. Sources stated the "breaches" had not resulted in "substantial" damage to Australia's national security.

**2000: William Lucan-Roberts**, 61 years, was a classics teacher and cricket coach at a prestigious Sydney (Australia) high school. He was facing 67 child sex charges, and was dreading his picture appearing in the newspaper. He left a suicide note, "…I felt it was better I go…" and drowned himself in a private swimming pool.

**2000: Wolfgang Huellen**, 49 years, was the married father of two, who had been Chief Financial Officer of the Christian Democratic Union of Germany for 18 years.

The police began investigating embezzlement of party funds. Huellen hanged himself, leaving a suicide note which confessed to the crime.

**2002: Vlajko Stojiljkovic**, 65 years, was law graduate from the University of Belgrade who became Vice-Prime Minister and Minister of the Interior of Serbia in 1997. Charges of crimes against humanity were laid against him, arising from the 1998-9 crackdown by Serb forces on ethnic Albanians. In 2002, when the Yugoslav parliament approved his extradition to face the UN war crimes tribunal, he walked out of the federal parliament building, took out a gun and shot himself in the head. Shortly after, his suicide note was publicly released, stating, "…patriots will know how to avenge me".

**2003: David Kelly**, 59 years, was a British based expert in biological warfare and a UN weapons inspector. He received his PhD from Oxford in 1971, had held many important positions in the UK Ministry of Defense, and had been nominated for the Nobel Peace Prize.

He was uncomfortable with part of a dossier regarding Iraq military capabilities, prior to the invasion. He had a conversation with a journalist which led to a major political scandal. Rightly or wrongly, he was identified as the source of a "leak" to the press of sensitive information.

On July 15, Kelly appeared before the Foreign Affairs Select Committee, the next day he appeared before the Intelligence and Security Committee. One or both of these were televised. The next day (17$^{th}$) he died of self inflicted overdose and blood loss from writs lacerations.

**2004: Operation Auxin** was an Australia wide police investigation into Internet child pornography, which commenced in September 2004. Almost 200 people were charged, including policemen, soldiers, teachers and ministers of religion. In November 2004, TIME journalist, Rory Callinan, reported that six people had suicided after being charged or questioned about child pornography. One of these was Queensland Policeman and another was a Victorian Prison Officer.

**2004: William Brown**, 52 years, had once worked in the Australian Embassy in Jakarta, however, "his overt homosexuality had led to his dismissal as a diplomat" in 1984. He then worked as an English teacher in a tourism school in Bali. He was found guilty of sex offences and goaled for 13 years in Bali. Within days he hanged himself.

**2005: Arthur Teele**, 59 years, was a decorated Vietnam War veteran and held a position on the Miami City Commission. In 2005, he was charged with 26 counts of fraud in the order of US$ 20 million, and money laundering. He stated he was not being fairly treated by The Miami Herald. Teele walked into the foyer of that newspaper, put a gun to his head and shot himself in front of a security guard.

**2006: Wolfgang Priklopil**, 44 years, was a communication technician with a good work history. He owned his own house (which he inherited from his grandfather) and a luxury car. He abducted 10 year old school-girl, Natasha Kampusch, near Vienna, in 1998. He kept her prisoner in the basement of his house for 8 years. When Natasha escaped and the police were alerted, Priklopil suicided by jumping in front of a train.

**2007: Shinichi Yamazaki**, 76 years, was the former head of Japan Green Resources Agency. He had been linked to a vote rigging scandal. Police had raided his apartment and interrogated him several times. Hours before he was to be interrogated again, he jumped from the window of his 6th floor apartment. **Toshikatsu Matsuoka,** 62 years, a graduate of Tottori University Faculty of Agriculture, was Japan's Minister for agriculture. He hanged himself the next day, hours before he was to be questioned in parliament. These men were believed to have collaborated.

**2007: J D "Roy" Atchison**, 53 years, was an assistant United States prosecutor in Florida. He was married with 3 children. He was a volunteer coach of girls' softball and basketball teams. He was charged with traveling from Florida to Michigan to have sex with a 5 year old girl. He pleaded guilty and less than three weeks later, and before sentence was passed, he hanged himself in a Michigan goal.

**2008: Christopher Foster**, 50 years, was a self-made tycoon millionaire. He lived with his wife and their 15 year old daughter in Osbaston House, a mansion in Shropshire (England). Foster made his fortune in oil pipeline technology. He lived the life of a wealthy land owner, his daughter at an expensive private school, he drove a Ferrari, his wife also drove a luxury car, and he kept horses and farm animals. However, his company passed into liquidation almost a year prior to his death. He transferred money from one company to another, which was described by a judge as "an exercise in asset stripping", and went on to describe Foster as "not to be trusted".

**Fig 23.** Orbaston House in flames. (Picture released by Shropshire Fire and Emergency Service)

Foster, his wife and daughter attended a party the day they died, and pictures show them smiling and interacting. A witness said, "Christopher seemed absolutely fine, in good spirits and there was nothing in his state of mind which gave me any cause for concern". Hours later he shot his wife, daughter and their livestock. He set fire to their mansion (Fig 23) and shot himself. It is believed the imminent loss of his status and belongings motivated this murder-suicide.

**Fig 24.** Bruce Ivins at an award ceremony, 2003. (public domain)

**2008: Bruce Ivins**, (Fig 24) 62 years, was a United States government microbiologist and biodefense researcher at the United States Army Medical Research Institute in Maryland. At school he had been involved in extracurricular activities including track and cross-country running. He obtained his PhD in microbiology and had studied anthrax for some decades. He was married for 33 years and he and his wife had adopted 2 children. He was a conservative Roman Catholic and played the organ at his local church. In 2003 he was awarded the Decoration for Exceptional Civilian Service – the highest award given to Defense Department civilian employees.

Ivins was about to be charged with multiple murder. It was believed that in 2001, he mailed letters contaminated with anthrax to senators, television stations and newspapers, resulting in the death of 5 people and the injury of many others. It is stated that while under investigation he had been hospitalized for depression and had harassed a social worker, but there was no evidence of unstable behavior prior to the investigation. He took his life by overdose after he was told by Defense and security authorities that charges were pending.

**2008: Michael Todd**, 50 years, was the Chief Constable of Greater Manchester Police, and was tipped to take over as head of Scotland Yard. He lived with his wife and three children in Nottingham, but travelled to Manchester for work. He attended the University of Essex and gained a first class honours degree in 1989 and a masters degree in politics in 1994. He had a three year affair with a high profile business woman whose husband had terminal bowel cancer. When the newspapers were about to publish an expose he drove 100 miles to a mountainous area of Wales where he took a large amount of alcohol, removed outer clothes, send multiple text messages indicating an intention to take his life to family friends and colleagues and died on the slopes of Snowdon. An inquest found he died of exposure. His last text message read, "I'm sorry…forgive me in another life".

**2008: Michael Pigott**, 46 years, was a Lieutenant in the NYPD Emergency Services Unit. He was married and had 3 children. He had a bachelor's degree in aeronautics, and joined the police force when a hearing problem prevented him joining the air force. Lt Pigott had completed 21 years of service and earned 20 medals for bravery and meritorious duty.

On September 24 his unit attended a disturbance involving a naked, mentally disturbed man (Iman Morales) who was standing on a first floor balcony. Mr Morales was armed with what appeared to be a white pole, with which he threatened police. After attempting to negotiate, Lt Pigott gave the order to shoot Mr Morales with a Taser gun. Morales fell to the ground and was killed. This was against regulations, which state the Taser is not to be used where there is a risk of falling. Lt Pigott was stripped of his badge and his gun and assigned to a job with the department's motor vehicle fleet: a huge demotion and disgrace. A new commander was appointed to the Emergency Services Unit, and all members were ordered to take a refresher course in dealing with the mentally disordered. Lt Pigott accepted responsibility for Mr Morales's death and made a public apology. The following week he wrote a suicide note, again accepting responsibility the death, and stating that he did not want to bring further disgrace (he may have been imprisoned) to his family. He shot himself in the head with a colleague's gun, which he found in a locker room.

**Fig 25.** Roh Moo-hyun and President Bush at the Whitehouse, 2003. (public domain)

**2009: Roh Moo-hyun**, (Fig 25) 62 years, was the former (2003-2008) President of South Korea. He was married and had 2 children with whom he had close relationships. He came from an under privileged background; he did not attend university but taught himself law and passed the Korean bar examination in 1975. Roh became a human rights lawyer and had defended students accused of sedition. In 1988 he was elected to the National Assembly, he was a liberal lawmaker and fought corruption.

On April 30, Roh was summoned to the Supreme Prosecutor's Office. He was accused of having taken $7.71 million in bribes, some of which it was claimed, had gone to his family members. He was to be indicted in the near future. On May 23, Roh jumped to his death from a cliff near his home. He left a suicide note which stated, "Many people have been suffering too much because of me…I am deeply ashamed before my fellow citizens. I am sorry to have disappointed you…I am no longer qualified to speak of such things as democracy, progressiveness and justice".

**Fig 26.** Dudu Topaz, 2006. (public domain)

**2009: Dudu Topaz**, (Fig 26) 62 years, was a leading Israeli TV celebrity. He hanged himself when goaled. He could be included here, because shame was presumably involved. This case is described in more detail in Chapter 8, under the heading Fatalistic Suicide.

## Shame summary

| | | Sex | Age | Occupation | Means |
|---|---|---|---|---|---|
| 1 | Harcourt | Male | 59 | MP | Shooting |
| 2 | Dwyer | Male | 47 | Public Servant | Shooting |
| 3 | Blanchard | Male | 46 | Captain | Shooting |
| 4 | Boorda | Male | 56 | Admiral | Shooting |
| 5 | Kamoshida | Male | 58 | Banker | Hanging |
| 6 | Jenkins | Male | 48 | Public Servant | Hanging |
| 7 | Lucan-Rob | Male | 61 | Teacher | Drowning |
| 8 | Huellen | Male | 49 | Accountant | Hanging |
| 9 | Stojiljkovic | Male | 65 | Politician | Shooting |
| 10 | Kelly | Male | 59 | Public Servant | OD & cutting |
| 11 | Teele | Male | 59 | Politician | Shooting |
| 12 | Priklopil | Male | 44 | Technician | Train |
| 13 | Matsuoka | Male | 62 | Politician | Hanging |
| 14 | Yamazaki | Male | 76 | Executive | Jumping |
| 15 | Brown | Male | 52 | Former Diplomat | Hanging |
| 16 | Atchison | Male | 53 | Public Servant | Hanging |
| 17 | Foster | Male | 50 | Businessman | Shooting |
| 18 | Ivins | Male | 62 | Scientist | Overdose |
| 19 | Todd | Male | 50 | Chief Constable | Exposure |
| 20 | Pigott | Male | 46 | Police Lieutenant | Shooting |
| 21 | Roh | Male | 62 | Former President | Jumping |
| 22 | Topaz | Male | 62 | TV Personality | Hanging |

**Table 2.** Summary of suicides associated with shame.

Thus, from the public record of the last century, details are available of 22 people who completed suicide following actual or threatened shame predicaments. Less comprehensive details are available of a further 18 people who died in association with the Wood Royal Commission and Operation Auxin.

None of these individuals had a past history of mental disorder and reports around the time of the deaths gave no evidence of mental disorder (except for the case of Bruce Ivins who reported distress after police investigation commenced).

Chapter 3 gives examples from antiquity, of people who completed suicide, at least in part, as a consequence of shame (Lucretia, Judas). The pathway by which this option for dealing with difficult predicaments has been passed down to the present time has been described. The current chapter confirms that when shame is the predicament, and this option continues to be chosen.

## Anger

Suicide attributed predominantly to anger would appear to be less common. At least, examples are less commonly found on the public record.

In a sociological autopsy, Shiner *et al.* (2009) found that punishment/revenge was an important factor in 5% of completed suicides.

Studies have clearly illustrated that those who complete suicide score significantly higher than control groups on tests of irritability (Chapter 2). It has also been demonstrated that those who perform serious suicide attempts (but survive) score significantly higher than control groups on aggression and hostility scales (Diohara *et al.*, 2008) and anger inventories (Engin *et al.*, 2009; Giegling *et al.*, 2009). Given this, it was surprising that anger appeared in only 3% of suicides in one study of suicide notes (Chia *et al.*, 2008). However, in another study, "rejection and aggression" appeared in 32% of US suicide notes and 50% of suicide notes written in Mexico (Chavez-Hernandez *et al.*, 2009). One recently reported (Shiner *et al.*, 2009) suicide note read in total, "Congratulations. You win".

In an 8 year longitudinal study, Goldney *et al.* (1997) found an equivocal association between anger and suicidal ideation and attempted suicide.

**Andrew Joseph "Joe" Stack** (53 years, died 2010) was a software engineer living in Texas. He set fire to his house and flew his plane into an office block in Atlanta. In 1986, Section 1706 of the federal tax code was changed so as to force software engineers to be classified as employees rather than self-employed workers, depriving them of certain tax deductions. Three times, companies he established were closed down by tax agencies. At the time of his death he was under investigation for undisclosed income. The building he flew into housed the IRS. Family and friends denied any evidence of mental disorder. He left a 3200 word, angry suicide note on the web, and anger appears to have been a major factor in his suicide.

**Cedric Tornay** (34 years, died 1998) was a French speaking lance corporal in the Vatican Swiss Guard, a soldiery dedicated to the protection of the Pope.

Alois Estermann was the recently appointed (some hours before his death) Captain Commander of the Swiss Guard. Estermann was German speaking and is said to have devalued his French speaking soldiers. He is said to have bullied Tornay for more than 3 years.

Tornay expected to receive the *benemerenti* medal, a decoration routinely awarded to Swiss Guards on the completion of 3 years of service. When he found his name was not listed among those who were to receive the medal, Tornay went to the Estermann residence. He shot Estermann and his wife, and then himself.

Tornay was described by other Guards as "idealistic". He had invited his mother and some friends to the medal presentation. Conspiracy theories have been advanced regarding these deaths, which include homosexuality and secret societies, but none of which have been substantiated. This may have been a simple act of anger and revenge.

Anger appears to have been the primary motivating factor in the suicide of **Louis Rogers** (Chapter 1), it was probably an important feature in the suicide of some of those who hanged themselves in custody (Chapter 2), and in the suicide of the raped **Lucretia** (Chapter 3). It may also have been a feature in the suicide of the disgraced **Bud Dwyer** and **Valajo Stojiljkovic** and others discussed earlier in this chapter.

There can be no certainty, but when males kill their children and then themselves, and there have been custody battles, anger rather than psychotic mental disorder, may be a driving feature. In 1985, in Sydney (Australia) **Sergio Gianfrancesco**, 38 years, shot his wife and 3 children (Sonny 3; Patricia, 6; and Linda, 7), before shooting himself. Gianfrancesco was known to be angry when the Family Court denied him access to his children. Similar behavior by females is very uncommon, but not unknown. In 2002, in Fort Worth (Texas), **Dee Etta Perez**, 39 years, shot her 3 children (Bianca, 3; Diego, 9, and Sergio, 10 years), before her estranged husband arrived for an access visit. When he did, Ms Perez shot him (he survived) and then herself (she died).

In 2008, **Bruce Pardo**, 45 years, disguised himself as Santa Clause and turned up uninvited at a Christmas Party and killed his former wife and 7 others. He later killed himself. This was not an anger driven murder-suicide, as first appeared, but an anger driven, bungled multiple-murder. The Californian couple had been married for 3 years and had no children; the divorce settlement was reached on December 18. A well liked, church-going computer engineer, Pardo had been planning revenge for months. He ordered an extra-large Santa suit (so as to carry guns and other items undetected) on November 8. He built a flame-thrower with which to ignite the party house, and placed second get-away car outside his wife's lawyer's house (which he never reached). He had money and an air ticket to Canada taped to his body. In the event, his flame thrower malfunctioned and he was seriously burned, his Santa suit melting onto his skin. He got away to a safe place, but in difficult circumstances, he booby-trapped as much of the Santa suit as he could disrobe, and shot himself.

Freud (1917), a genius human behavior theoretician believed that all suicide is underpinned by (in addition to an inherent death wish) the intention to harm those whom the suicidal person believes are responsible for the unbearable pain which has led to the self-imposed death.

## Conclusion

This chapter focuses on suicide associated with the negative emotions of shame and anger. There is irrefutable evidence from the last couple of thousand years, and from

the present time, that shame can lead to suicide. There is some evidence that anger can be a predominant factor and abundant evidence that anger can be a contributing factor in completed suicide. Thus, the negative emotions, alone or in the presence of mental disorder, have a role to play in suicide and need to be considered in suicide prevention.

# CHAPTER 6

# MENTAL DISORDER SUICIDE

**Abstract**: Evidence indicates that major depression, schizophrenia and personality disorder are associated with an increased risk of suicide. Recent work suggests that anxiety is also associated with suicidal thinking. Studies have shown that a significant proportion of people with a major depression do not have suicidal thinking, and a significant proportion of people with suicidal thinking do not have major depression. Cases from the public record (Ernest Hemingway, Daniel Cumerford, Sonia McMullen, Greg Wilton, Rebekah Lawrence, Charmaine Dragan, Vicki Van Meter, Erin Berg, and Robert Enke) are detailed. It is likely that women who kill their children and then themselves, especially when there are no clear social stressors, have suffered unrecognized mental disorder.

**"…only half of people who have seriously considered killing themselves have a mental disorder."**

Editors' Summary (2009)

In 1883 Esquirol wrote, "all those who commit suicide are insane", and in 1845 Bourdin wrote that suicide "is always a disease and always an act of mental insanity" (cited in, Bertolote, 2004). This position continues to attract staunch advocates (Mann *et al.*, 2002). The current author believes that suicide can occur in people without mental disorder, but agrees the evidence is clear that suicide is more common among those with mental disorder.

When considering suicide associated with mental disorder, two assumptions are often made, 1) that the suicide was a direct result of the mental disorder (that is, the mental disorder had as a central feature, emotional pain so profound that suicide was chosen as a means of escape), and 2) that successful treatment of the disorder would expunge the possibility of suicide.

While mental disorders may have as a central feature, intolerably emotional pain, other aspects deserve consideration. For example, reduced drive and energy, reduced ability for quick, clear thinking, and reduced social and occupational functioning may generate disappointment and also, underpin a reduced ability to deal with disappointment. In this way, the central feature of a mental disorder may not be as important as the more peripheral features can render the individual vulnerable to the trials of life.

It is reasonable to assume that the successful treatment of a mental disorder would remove the risk of suicide. However, this does not appear to be the case in schizophrenia. In a 10 year prospective study in China (Ran *et al.*, 2009) there was no significant difference in the suicide rate of people with schizophrenia who had been treated, compared to those with schizophrenia who had never been treated. In fact, no study has ever demonstrated that treatment makes any difference to the risk of suicide.

With current treatments there are almost no cures of mental disorders. Frequently, the best outcome of acute episodes of disorders is remission (a diminution of symptoms) and relapses (return of symptoms) are not uncommon. A regrettably large number of

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cases are resistant to treatment and only partial remissions are achieved. Thus, current treatments offer less than complete protection against mental disorder related suicide.

Support for the view that up to 98% of those who complete suicide have a mental disorder comes from psychological autopsy studies (Cavanagh *et al.*, 2003; Bertolote *et al.*, 2004). Reservations about the validity and reliability of this process have been presented in Chapter 2.

Major depressive disorder and bipolar disorder are stated to be associated with at least 60% of suicides (Goldney, 2003). It has long been believed that the life-time risk of suicide of people with major depression is 15%. Recent work suggests the figure is much lower, closer to 3-4% (Blair-West & Mellsop, 2001), but this difference matters little, as even at the lower level, the risk of suicide for people with major depression is far above that of the general population.

An alternative method to the psychological autopsy (a process in which the individual is no longer available to participate in the exploration) is to study living people who are experiencing suicidal thoughts and performing suicide-like behavior. The disadvantage of this method is that while people "say" they have been thinking about suicide, they have not yet (at least) completed suicide, and those who think about and those who complete suicide may be quite different groups. Be that as it may, recent research (Rhodes *et al.*, 2006) used information concerning the previous 12 months, gathered from 36 984 individuals over 15 years of age, in the Canadian Community Health Survey of Mental Health and Well-Being. Major depressive disorder was diagnosed using the Composite International Diagnostic Interview, and "suicidality" was defined as suicidal ideation and nonfatal behaviors. The authors found that of the population, 4 % reported suicidal ideation, <1% reported a suicide attempt, and 4.8% suffered major depressive disorder. The overlap was not great. (Remember, random selection will provide a degree of overlap.) Only 36% of the suicidal group had major depressive disorder, and only 28.7% of those with depression were suicidal. This is an important study; yes, there was some overlap, but those who were depressed and those who had been contemplating suicide, were in the main, different groups.

A study from Harvard University (Nock *et al.*, 2009a) which examined attempted suicide found that 'depression' predicts suicidal ideation, but not the formation of a suicidal plan or a suicide attempt, that is, depressed mood caused people to think about suicide, but not go further. It found that disorders characterized by anxiety (such as posttraumatic stress disorder) and poor impulse control and substance abuse were better predictors of suicide attempts.

A recently reported huge study (Nock, 2009b) conducted face to face interviews with 108 664 subjects in 21 countries looking at the presence of mental disorder and suicidal behaviours. Of those with mental disorders, only disorders characterized by anxiety and poor impulse control predict which people with suicide ideation act on their thoughts. This appears to be a restatement of the Nock *et al.* (2000a) paper. However, this important work will move attention away from depression (where it has been located for decades) to the anxiety disorders.

In a recent study (Fairweather-Schmidt *et al.*, 2009) data were derived from a large community sample (7 485) regarding suicidality and depression. Statistical analysis showed this data fitted a two-factor better than a one-factor model. This was taken as

proof that suicidality is distinguishable from depression, although these may occur together. The authors conclude that this finding "highlights the need for suicidality to be reconceptualized as a separate syndrome".

Schizophrenia is associated with a lifetime risk of completed suicide of 9-13% (Pinikahana *et al.*, 2003) and may be more lethal than depression (Osborn *et al.*, 2007). Whether schizophrenia is slightly more or less lethal than depression is incidental; importantly, people suffering schizophrenia are at higher risk of suicide than those with no mental disorder.

Other psychiatric disorders, including the anxiety disorders and somatoform disorder, are also believed to carry an increased risk of suicide. However, two of the anxiety disorders, obsessive compulsive disorder (Alonso *et al.*, 2010) and posttraumatic stress disorder (Krysinska & Lester, 2010), do not appear to carry increased risk of suicide.

Suicide is strongly associated with personality disorder (Cheng *et al.*, 1997). Personality disorder is classified as a psychiatric disorder, but unlike the main mental disorders such as schizophrenia and bipolar disorder, it does not come and go in episodes. Personality is the characteristic manner in which the individual responds to the environment. Personality disorder is diagnosed when the individual responds to the environment (especially other people) in a more extreme manner than the majority (e.g., with undue irritability, seduction or avoidance). When normally functioning individual is faced with a predicament, that individual makes an adaptive response (accepts responsibility as appropriate, apologizes, works harder or does whatever it takes to fix the problem), while the individual with a personality disorder makes a maladaptive response (such as offering the boss violence or sexual gratification), which often makes the predicament worse. Thus, the difference between those with personality disorder and those without is quantitative (not qualitative); the diagnosis is arbitrary and problematic, and even experts may disagree on particular cases.

Some authorities believe that personality disorder simply represents a variant of normal and should not be classified as a mental disorder. For example, Kurt Schneider (1950) a famous German psychiatrist who developed a diagnostic system for schizophrenia, wrote that personality disorders are "abnormal varieties of sane psychic life". The debate is pointless, however, as there are no universally accepted definitions of either mental disorder or personality disorder (Kendell, 2002). In the end, schizophrenia, criminality, personality disorder, child neglect and asthma are all problems for people, and the important issue is how to provide the best assistance. Lewis and Appleby (1988) surveyed 240 psychiatrists and found that people with personality disorder were considered to be "in control of their suicidal urges and debts", rather than these being the result of illness.

When a person without a mental disorder completes suicide, and the case is reviewed by certain experts, there is the danger of circular thinking. If one starts with the belief that suicide is inevitably a maladaptive response, then any person who completes suicide can be diagnosed retrospectively (and incorrectly) with a personality disorder, that is, with a mental disorder. This trap is almost unavoidable.

Alcohol and drug abuse has been identified as a contributor to suicide in 19-63% of all suicides (Schneider, 2009). A recent study from Hungary found alcohol problems

in 31% and other drug problems in 14% of suicide completers (Zonda, 2006). Alcohol appears to be a factor in some aboriginal suicides. With respect to Australian Aboriginals, Earnest Hunter (2002) wrote, "most suicides are impulsive acts in the context of heavy alcohol intoxication following what may appear a trivial confrontation or loss".

Alcohol abuse greatly increases the risk of suicide (Murphy & Wetzel, 1990). There are many routes to this end; alcohol may induce a depressive disorder or decrease inhibitions such that impulsive acts are completed. Alcohol impairs judgment, leading to social, family, employment and legal problems. The alcohol abuser has reduced ability to repair interpersonal problems and may become angry and isolated.

Drug abuse carries a high risk of death rate from suicide and accidents, especially among the young (Stenbacka *et al.*, 2010). It is frequently associated with personality disorder and may lead to difficult circumstances including family breakdown, unemployment and imprisonment.

Personality disorder and alcohol and drug abuse may be classified as mental disorders, but they are very different from the major mental disorders of schizophrenia and bipolar disorder. They represent maladaptive patterns of behavior, and are notoriously unresponsive to treatment. As long as maladaptive patterns of behavior are included under the heading of mental disorder, the proportion of suicide believed to be associated with mental disorder will be erroneously inflated.

## Examples from the public record

The media report many examples of people who complete suicide, and in the majority of cases, hard working journalists are unable to find any concrete evidence of mental disorder. On this point, those who believe that suicide is exclusively the result of mental disorder reply that journalists are not trained to recognize the clinical evidence. In fact, the journalist does not attempt to "recognize the clinical evidence" but instead, seeks information from those with relevant knowledge (including local health authorities), who were involved with the individual. If evidence is not found by this process, it is more probable that it does not exist rather than it exists but was not "recognized" by the journalist.

There are few media reports of people who have completed suicide for whom there is clear evidence that mental disorder was the mainspring of the suicide. Why are there few such reports? To be reported in the media the individual needs to be prominent or there has to be some bizarre feature to the death (such as jumping out of an aircraft over the artic circle). Prominence depends on skill and hard work. People with major mental disorders are often seriously handicapped and are therefore less likely to become prominent.

## Examples from the public record

**Ernest Hemingway** (died 1961)

**Fig 27.** Ernest Hemingway, 1939 (Wikimedia Commons).

Ernest Hemingway, (Fig 27) 61 years, won the Pulitzer Prize for "The Old Man and The Sea" in 1953, and the Nobel Prize for Literature in1954. He died by gunshot to the head two days after discharge from a psychiatric hospital.

Hemingway was born in Chicago (USA), the second of 6 children to a doctor and his wife. His father (Clarence) died by suicide, as did 2 of his siblings (Ursula and Leicester), his son (Gregory) and his niece (Margaux). Other more distant relatives had also died by suicide, indicating a strong genetic predisposition.

Hemingway's early years were not easy. His father was a harsh disciplinarian and his mother he later described, with hatred, as having been selfish and controlling. At school, Hemingway was a gifted athlete and scholar. When he left school he became a trainee reporter. He lived a life of great adventure. Because of poor eyesight he was not accepted as a combatant for WWI, so he joined the Red Cross Ambulance Corp and was awarded the Silver Medal of Military Valor by the Italian government. He lived in Paris, moved to Spain to cover the Spanish Civil War and came to know Fidel Castro. He reported WWII and formed his own partisan group which he later claimed took part in the liberation of Paris. He enjoyed fishing and hunted big-game in Africa. He married 4 times. He was a prolific writer: "The Sun Also Rises", "A Farewell To Arms", "For Whom The Bell Tolls", and many more.

Hemingway suffered a number of head injuries, which some have attributed to vanity preventing him wearing spectacles, but his life long excessive use of alcohol may also have contributed. The evidence (Martin, 2006) indicates that he had borderline and narcissistic personality features. He suffered episodes of depression and elevated mood. He suffered liver disease and high blood pressure. He was first hospitalized for depression at 60 years and was treated with ECT. In the following year he suffered a relapse and on this occasion there were also paranoid delusions. He was admitted to hospital a second time. Two days after discharge he got up one morning while his wife slept and shot himself.

**Daniel Cumerford** (died 1987)

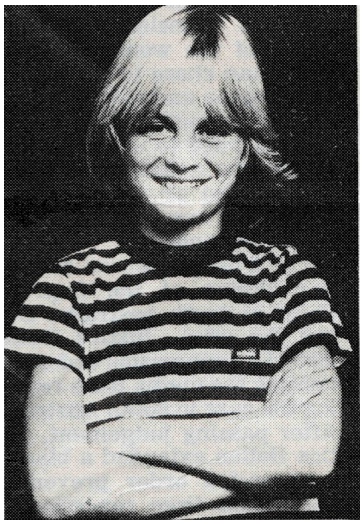


**Fig 28.** A young Daniel Cumerford (public domain).

Daniel Cumerford, (Fig 28) 19 years, was well known in Australia, having played in a number of motion pictures in his early teens; most notably, a leading role in "Ginger Meggs". One Christmas Eve, he kissed his mother (Lesley Armstrong), left their Sydney home and stepped into the path of a train.

Daniel was a bright, promising youngster with a charming smile. He was artistic, interested in sport and had many friends. However, he changed. Ms Armstrong reported, "He became eccentric at an age when eccentricity is not the norm". He became isolative and spent most of his time alone at home listening to music. "He would stare at things like pretty bits of paper for a long time". At 16 years of age Daniel was diagnosed with schizophrenia.

Daniel had the full support of his parents and grandparents. Unfortunately, his condition did not respond well to treatment. The clinical picture became more difficult as he used marijuana, LSD and volatile solvents.

Ms Armstrong reported, "It was a full-time job keeping him alive". Nevertheless, at the time he died, he gave no indication of his intentions and his death was unexpected.

The case Daniel Cumerford illustrates many classic features of schizophrenia and the diagnosis is beyond doubt. Young people with this condition frequently use illegal substances which is understandable given their suffering, but which exacerbates their disorder. Suicide in this group is sadly high. Contributing factors may include the belief that others intend to do the individual harm, voices directing them to kill themselves, and even having "insight" (having an understanding that they have a severe mental disorder and that they need long-term treatment) which has advantages, but can also be dangerous.

**Sonia McMullen** (died, 1997)

Sonia McMullen, 32 years, was the daughter of a football hero, and had been (as Sonia Weir) the Miss Queensland beauty queen of 1988. She had been educated in

Brisbane (Australia) and the USA, and had worked as cabin crew for Qantas. She married in 1995 and had one child (Blake, 1 year and 4 months). However, she suffered post-natal depression, from which she did not recover. In 1997, when Mr McMullen returned home from work he found Blake deceased from a medication overdose inside the house, and Ms McMullen hanging from a down-pipe in the back yard. She left a long, apologetic note. Ms McMullen is believed to have died as a result of intractable post-natal depression, and her family planned to contribute to post-natal depression research.

**Greg Wilton** (died, 2000)

Greg Wilton, 44 years, was an Australian federal politician; a member of the Australian House of Representatives. He is believed to have suffered 'depression', but few details are available. He died in his car, overcome by exhaust fumes.

Wilton was born and raised in Melbourne. He obtained a Batchelor of Science degree from Monash University. He later studied at the London School of Economics and traveled extensively in North America. Most of his working life was spent in the workers union movement. He joined the Labour Party at 33 years of age and won his seat in parliament at 40 years of age.

His marriage failed and he suffered 'depressive episodes'. Two weeks before he died Wilton was apprehended by the police while in charge of his car. His two children were in his care and the newspapers indicated a murder-suicide had been averted. He then spent two weeks in psychiatric care. There was media speculation about him resigning from parliament and the next day he took his life.

**Rebekah Lawrence** (died, 2005)

Rebekah Lawrence, 34 years, was the personal assistant of a Sydney (Australia) chief executive officer. She unexpectedly stripped naked, abused her colleagues and jumped from a window to her death.

Lawrence was described at her inquest as a "shy, modest and gentle woman". She was happily married, but she wanted children and her husband did not. Ten months before her death she attended a counsellor and talked of hopelessness, despair and fear of loneliness; concerns of which her husband and family were unaware.

Two days before she died, she attended a week-end self-development course run by unqualified people, which involved confrontational techniques and regression back to childhood. The Inquest heard from expert witnesses and accepted, that the self-development course had caused the development of a mood disorder, and Lawrence had been psychotic when she died.

Unlike the other cases in this chapter, this individual was not in psychiatric treatment before her death, and she appears to have been acutely unwell for only days. However, she may have been significantly depressed 10 months earlier when she attended the counsellor. This case is somewhat speculative.

**Charmaine Dragun** (died, 2007)


**Fig 29.** A Charmaine Dragun tribute (with permission).

Charmaine Dragun, (Fig 29) 29 years, was a well-known Sydney television news-reader. She jumped from The Gap, a famous suicide cliff. She had suffered 'depression' over many years and was taking antidepressant medication at the time of her death. Over the weeks preceding her death she had several times driven to The Gap, where she would sit alone for periods of hours.

Some years previously, Dragun had suffered anorexia, apparently triggered by a wolf whistle and a comment that she had a "fat arse". Her weight fell from 52 kg to 39 kg.

Dragun had been born and raised on the other side of the country (Perth, Western Australia). She attended Corpus Christi College, the daughter of a music teacher, she had once aspired to be a concert pianist. She graduated from the Western Australian Academy of Performing Arts and began her career as a radio journalist. She had been an ambassador for a number of local charities and causes, including the Perth Zoo, and was involved in fund raising for charities including Anglicare and the Breast Cancer Foundation of WA.

She moved to Sydney for professional opportunities two years before her death; she had felt lonely and wished to return to her home state. She was engaged to a man she had known for many years, and they had planned to marry on her 30 birthday.

**Vicki Van Meter** (died, 2008)

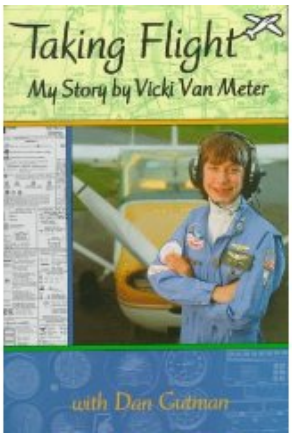



**Fig 30.** Front cover of her book, showing a young Vicki Van Meter.

Vicki Van Meter, 26 years, had been a national figure as a child, a prodigy pilot. She was known to have suffered severe 'depression' but would not accept medication. She died in her home by gunshot.

Van Meter attended primary school in Pennsylvania. At 11 years of age she flew a single-engine Cessna from Augusta, Maine, to San Diego, California, becoming the youngest person to fly across the United States. Shortly after, she became the youngest person to have flown across the Atlantic. At 13 years of age, assisted by Dan Gutman she authored, *Taking Flight: My Story* (Fig 30)..

Van Meter graduated from Edinboro University, Pennsylvania with a degree in criminal justice. She served two years in the Peace Corps in Moldova, and was planning to return to university. Her mother spoke to her by telephone on the day she died. Van Meter was cooking and was apparently in good spirits. Her family was well aware of her long struggle with 'depression'.

**Erin Berg** (died 2008)
See Chapter 1.

**Robert Enke** (died 2009)

Robert Enke, the 32 year old soccer goalkeeper of Germany wrote a suicide note and threw himself under a train.

Enke was married to Teresa, and they has an adopted a baby girl. Their only biological child died at 2 years of age, in 2006, due to a congenital heart defect.

Enke had a distinguished soccer career, first representing Germany in 1997. He represented his country eight times and was expected to do so again in the 2010 World Cup. After the death Teresa revealed that her husband had suffered from depression for 6 years, and had remained under active treatment.

**Julien Tologanak** (died 2009)

Julien Tologanak, a 20 year old Inuit man was traveling in a light aircraft from Yellowknife (Canada), North East to Cambridge Bay. While the plane was 7 kilometers above the ground, he forced open the door and jumped out.

Tologanak had been living with a female in Kugluktuk (which is above the Artic circle, North West of Yellowknife), and had one child (male). He was described as a family friend as an apprentice mechanic and as having "so many good things going for him". However, he had been unemployed for some time and had made various attempts to find work without success.

Tologanak had been in Yellowknife playing hockey for the Kugluktuk team. On Monday 13th April he was to fly back to Kugluktuk with his team mates, but unexpectedly "pulled his stuff off the plane". The player with whom he had had been

sharing a hotel room in Yellowknife stated that Tologanak had asked him and others many strange questions including, "What rumors have you heard about me?" The room mate also stated that Tologanak was concerned about being arrested because someone was supposed to have sold a couple of bottles of alcohol on his behalf. This account strongly suggests paranoid delusions.

Tologanak spent the evening of the 14th in the hotel room of another friend, and at 1a.m. on Wednesday 15th April, the Royal Canadian Mounted Police were called to a disturbance in a hotel. They determined Tolonganak was in need of medical attention, detained him under the Mental Health Act and conveyed him to the Stanton Territorial Hospital (Yellowknife). The hospital contacted Tologanak's mother in Cambridge Bay, and she asked that he be sent to her. The hospital then contacted a local aircraft operator saying, "This boy needs to go home to his mother". The aircraft operator who knew the family agreed, and the hospital sent Tolonganak to the airport by taxi. Air craft staff found that Tolonganak listened to them, appeared normal and was not under the influence of alcohol or drugs. The aircraft took off at 4.30 pm, and Tolonganak jumped about 150 Km south of Cambridge Bay.

This case highlights some of the difficulties of caring for people with suicidal ideation. The available evidence suggests that the hospital staff did what they thought was best in the circumstances, but that may not be sufficient to protect them against criticism and even legal consequences. It is likely that Tolonganak suicided as a result of a mental disorder.

**Suicide associated with the death of dependent children**

All local newspapers publish occasional stories of parents who kill one or more of their children and then themselves. The more children killed, the more likely the story is to make national newspapers. Perhaps because this is a not unknown occurrence, and those involved are usually ordinary (rather than high profile) people, these stories rarely make international news.

When perpetrators are female, there is no custody battle in progress, and the events come without any warning whatsoever, the only possible explanation is that these women have acted in response to a psychotic illness. (There is some evidence suggesting that when males are the perpetrators, and custody battles are in progress, anger may play an important role.) Psychosis means that the person is out of touch with reality, such as believing something which the rest of us would not believe. It is probable that many of these women have been suffering unrecognized major depressive disorder and have developed secondary psychotic features. Thus, they are suffering very low mood and come to believe that the world is a terrible place of suffering from which they want to escape. In this situation the parent may not want to leave their children in this place in which they too, will suffer, and killing them can be an act of love (sparing them from a fate worse than death). It is possible that in very rare cases, the parent is experiencing another form of psychosis, that is, a primarily paranoid disorder, and believes that evil forces are out to murder or torture the family. Accordingly, the decision is made that all should die gently, rather than more terribly.

In 1999, **Barbara Ann Wyrzkowski**, 25 years of age, drove her 5 children (Jayde, 1 year; Jesse, 4; twins, Sarah-Ann and Luke, 5; and Mark, 8) from their home in Perth

(Western Australia), 50 km in the family van, to an isolated track in the Karragullen forest. There she put one end of a hose onto the exhaust pipe and the other, through a window into the cabin. All died. Prior to leaving Perth, the family had celebrated one of the children's birthday. Ms Wyrzkowski's partner had no idea the children were in danger. Police said, "There was no inkling anything like this could happen". A suicide note was subsequently found. This was not an impulsive act and is likely to have been the result of an unrecognized major depression with psychotic features.

In 2007, **Gilberta Estrada**, 25 years, hanged her 4 children (Evelyn, 8 months; Magaly, 2 years; Yaneth, 3; and Maria, 5) and herself from a rail in the wardrobe of their dilapidated residence in a Mobile Home Park in Texas. Evelyn survived. Ms Estrada was from Mexico, had no medical insurance and had been denied Medicaid benefits. The residence did not have electricity. Ms Estrada worked as a cleaner and had recently purchased dresses for the baptism of her daughters. She had been the victim of domestic violence; she had custody of her children and a restraining order against the father of 3 of the children (he had an extensive forensic history). Again, it is probable that Ms Estrada suffered major depressive disorder with psychotic features.

In 1993, **Carl Gobbert**, 39 years, got up in the middle of the night and shot his pregnant wife Valerie, 37 years, their two children (Debbie, 11 and Brooky, 7) and then himself. They lived on their 40 hectare property, "Hampton Court", in south-west Queensland (Australia). Gobbert was a churchgoing non-drinker. He was a successful wheat farmer, he was happy with his recent harvest and had just finished plowing and planting his next crop. He also owned a small air-craft and operated a crop-dusting business. He had built their home himself and it contained religious icons. Friends said that when Gobbert was troubled (they knew of no current problems), he would go flying at night. Waking and getting up in the middle of the night is consistent with major depressive disorder. The only reasonable explanation is that Gobbert and his family died as a direct result of a mental disorder, probably of depressive type.

In 1997, **Peter Shoobridge**, 52 years, a land owner/farmer, poet and furniture restorer lived in Tasmania (Australia). He was a divorced father of four girls. His daughters were delivered by his former wife to his farm, where they had a dinner to celebrate to commencement of his new furniture restoration business. After the girls (Georgia, 9 years; Sara, 12; Anna, 14; Rebecca, 18) were asleep, Shoobrige fatally cut their throats. He then wrote and delivered letters to the post box, returned to the farm, cut off his right hand with an axe and shot himself in the head. Other letters were found which he had addressed to his daughters giving them instructions on how to live good lives; at the inquest, this was taken to indicate that he initially intended to take only his own life. When, the girl's mother delivered them to their father, she found him to be in a normal state of mind. The Coroner found that Shoobridge was "acting under some form of delusion" and "Whether taking their lives was seen as a way of protecting them from the world as a result of some depression or delusion will remain speculation". It is reasonable, however, to conclude that Shoobridge died as a result of an undiagnosed mental disorder.

## Treatment of mental disorder and suicide

As suicide is a risk for people with severe mental disorder, it is reasonable to assume that effective treatment will help to preserve the lives of individuals with mental disorders. That is not always the case. Earnest Hemingway, Daniel Cumerford, Sonia McMullen, Greg Wilton, Charmaine Dragun, Vicki Van Meter, and Erin Berg had all received medical treatment. Of course, it could be argued that their doctors were all incompetent, but there is no evidence to that effect.

There is no doubt that antidepressant medications are more effective than placebos in the treatment of depression. However, there is no evidence that, even among depressed people, they are more effective than placebos in preventing suicide (Australian Institute for Suicide Research and Prevention, 2003). There is no evidence whatsoever that increasing the prescription rate of antidepressants will reduce the suicide rate of a country. Nor is there convincing evidence that psychotherapy is useful in preventing suicide (Australian Institute for Suicide Research and Prevention, 2003). There is some evidence that specialized psychotherapy may reduce the suicide rate in borderline personality disorder (Linehan, 1993), but this has not been replicated.

The above paragraphs should not be read as indicating that therapy is not helpful in the individual case. The experience of many individuals with severe mental disorder, their families and their doctors, is that therapy can be life-saving.

If mental disorder is the cause of 98% of suicide, it would be reasonable to assume that the introduction of mental health and suicide prevention policies and plans would greatly reduce national suicide rates. However, studies of 100 countries have found no such effects (Burgess *et al.*, 2004; De Leo, 2004).

To reduce the suicide rate of a society a change in culture is necessary.

## Conclusion

Suicide is more common among people with mental disorder than people without mental disorder. However, most people with mental disorder do not complete suicide.

This chapter focuses on the suicide of people with mental disorder. There are fewer examples in the media of people who have completed suicide who have mental disorder. This is largely because mental disorder is a disadvantage and those suffering a mental disorder less commonly achieve fame and fortune, and are therefore less "news-worthy".

Nevertheless, clear examples are available on the public record. People who died as a result of schizophrenia or major depressive disorder have been detailed.

Personality disorder (features of the personality leading to maladaptive functioning within society) is also frequently associated with completed suicide. This is a more difficult diagnosis to make from the reports appearing in the lay press and no examples have been offered.

Personality disorder and alcohol and drug abuse represent maladaptive patterns of behavior (which are notoriously unresponsive to treatment). They are distinct from

mental disorders such as schizophrenia and bipolar disorder. The classification of maladaptive patterns of behavior as mental disorders inflates the proportion of suicides associated with mental disorders.

It is a mistake to automatically accept that all the suicides which occur in association with mental disorder are the direct result of the central features of the mental disorder. While mental disorder may make people more vulnerable to succumb to the difficulties and disappointments of life, the importance of the difficulties and disappointments are at least a large part of the problem, and we should look to better managing them and reducing such impacts.

It is important that no study has ever demonstrated that treatment significantly alters the suicide risk of people with mental disorder. It may be that treatment may prevent suicide in an individual case, but this has not been proven. Current treatments of mental disorders have only modest potency, and more than the current 'best practice' treatments of mental disorder symptoms will be necessary to reduce national suicide rates.

The introduction of mental health and suicide prevention policies and plans have not reduced national suicide rates. Nor, have increased rates of antidepressant use reduced suicide rates.

However, the experience of many individuals with severe mental disorder, their families and their doctors, is that therapy can be life-saving, and the importance of treatment in appropriately selected cases can not be overemphasized.

# CHAPTER 7

# MEDICALIZATION OF SUICIDE

**Abstract**: "Medicalization" describes the process by which non-medical (social) problems are reclassified as medical problems. The process is facilitated by the absence of clear definitions of "health" and "mental disorder". The drivers of medicalization include not only the medical profession. Everyday distress is medicalized into depression. Suicide has been medicalized and the response to distress and suicidal thinking has become antidepressant medication rather than appropriate social support. Two cases are presented (Robert FitzRoy and Lord Clive). The medicalization of distress and suicidal thinking is damaging rather than being helpful.

**"De-medicalization of personal and social distress and focusing on other underlying causes of human misery, including poverty, unmet needs and the lack of rights."**

(A recommendation for reducing suicide by) Jacob (2008)

"Medicalization" describes the process by which non-medical (social) problems are reclassified as medical problems (Zola, 1972). For example, shyness has been called (reclassified) "social anxiety" and promiscuity has been called (reclassified) "sexual addiction". The naturally following expectation is that a medical "treatment" is appropriate (Zola, 1972). For example, everyday worrying is treated with mind-altering medication and baldness is treated with surgery.

There is an extensive social sciences literature on this topic, which is largely ignored by the medical profession. Van Praag (2000) described medicalization as process by which "normal" human behavior and experience is "re-badged" as a series of medical conditions. Chodoff (2002) stated, "To medicalize the human condition is to apply a diagnostic label to various unpleasant or undesirable feelings or behaviors that are not distinctly abnormal but fall within a gray area not readily distinguishable from the range of experiences that are often inescapable aspects of the fate of being human".

This phenomenon has been described (decried) in Serbia (Opalic, 2009), Spain (Iriart, 2008), France (Kiefer, 2007), Norway (Holm, 2005), Germany (Engelhardt, 2004) and most other countries around the world. Lee (1999), in a related discussion, describes the "commercialization of suffering" in China.

A number of factors have prepared the path for medicalization. Prominent among these is a universally accepted broad definition of health, and the absence of precise definitions of the terms mental health, mental disorder and mental health problems.

The World Health Organization (WHO, 1948) defines health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

Definitions of wellbeing include, "a contented state of being happy, healthy and prosperous". In current "health industry" parlance, the terms health and wellbeing are

**Saxby Pridmore (Ed.)**

used interchangeably, and are taken to indicate the optimal state of "being as well as one can be".

More recently, the WHO Commission on Social Determinants of Health (2008) advocated for global equality in the "distribution of power, income, goods and services", so that all can live a "flourishing life".

"Mental health" has been described in similarly rosy terms: "In general, mentally healthy individuals value themselves, perceive reality as it is, accept its limitations and possibilities, respond to its challenges, carry out their responsibilities, establish and maintain close relationships, deal reasonably with others, pursue work that suits their talent and training, and feel a sense of fulfillment that makes the effort of daily living worthwhile" (Hales & Hales, 1995). Again, a laudable, optimal state is described, but when critically applied, the current writer has not, nor have many readers been able to achieve this standard.

"Mental disorder" lacks a satisfactory definition. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; American Psychiatric Association, 2000) is the most influential currently available diagnostic instrument. It states, "…no definition adequately specifies precise boundaries for the concept of mental disorder" (p xxx). In the absence of a definition, it provides a description which begins (p xxxi), "…each of the mental disorders is conceptualized as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability…" This description employs vague undefined terms including "clinically significant", "psychological syndrome" and "distress" and is unable to differentiate mental disorders from normal human experiences such as guilt and grief.

The category "Mental health problem" has been used (and apparently invented) in Australia (Australian Health Ministers, 1992). "A mental health problem also interferes with how a person thinks, feels, and behaves, but to a lesser extent than a mental illness…Mental health problems are more common and include the mental ill health that can be experienced temporarily as a reaction to the stresses of life" (National, 2009). Thus, the temporary reactions to the stresses of life have, in Australia at least, have been designated the responsibility of the mental health services.

The WHO has a broad view of the definition of health and advocates for a "flourishing life", but Health departments have little influence over most things which foster a "flourishing life" (freedom, democracy, fairness, justice, educational and employment opportunity, affordable housing and transport, etc). Medical services strive to contribution to a "flourishing life" for all, and medicalize the "human condition" in the process. The inability of authorities to provide a clear definition of mental disorder and a sharper definition of health renders chaos unavoidable.

## Medicalization

As mentioned above, medicalization is the process of reclassifying non-medical problems in medical terms (Zola, 1972). In consequence, "treatment" is offered for

"everyday emotional suffering" (Aho, 2009) and "inescapable aspects of…being human" (Chodoff, 2002).

Here, "non-medical problems" refers to problems which large sections of the community do not believe to be legitimate medical problems.

Medicalization is orchestrated by sections of society. It is opposed or ignored by other sections, which do not believe in the medical legitimacy of the proffered problem/"patient". Medicalization was initially attributed to doctors who were seen as attempting to increase their "power" (and the term "medical imperialism" was coined). However, balanced views now identify many "drivers" of medicalization (Conrad, 2007).

Suggested major drivers include drug companies who seek to sell their products (Doran & Henry, 2008; who coined the term "disease mongering"). Examples include shyness, which became labelled social anxiety and is now treated by selective serotonin reuptake inhibitors (SSRIs), and flagging sexual desire, which became labelled impotence and is now treated with 'Viagra'. Smoking cessation is now assisted by "nicotine replacement therapy", but most success is still achieved by going "cold turkey".

Other drivers include the advantages of the sick-role, which are attractive to some. For more than half a century sociologists (Mechanic, 1968) have drawn attention to the benefits of the sick role: relief from the responsibly of caring for oneself and family, and from going to work.

Other sociologists believe that governments encourage medicalization as a means of dealing with difficult social problems (lowering unemployment figures by placing people on invalid pensions).

Life presents challenges. Buddha stated, in the Sermon at Benares (3$^{rd}$ century, BCE): "Birth is painful; old age is painful; sickness is painful; death is painful; sorrow: lamentation, dejection, and despair are painful. Contact with unpleasant things is painful; not getting what one wishes is painful". A current challenge is to decide which problems are health problems and which (if any) are not.

In striving for a more humanitarian world the WHO (1948) has mandated that loneliness and domestic violence are "health" issues.

## Distress medicalized into depression

People who suffer major depressive disorder (MDD) are at higher risk of suicide than people who do not suffer any mental disorder. Thus, MDD deserves mention in any discussion of suicide.

MDD is a serious and usually recurring disorder. Episodes usually last months, but may be shortened by treatment. Early episodes may be triggered by unhappy events (loss); later episodes (relapses) may occur without detectable triggering events.

The DSM-IV symptoms of depression are listed below (Table 3). To justify the diagnosis of MDD there must be persistent depressed mood or loss of the ability to experience pleasure, along with at least four of, significant change in appetite, sleep problems, agitation or retardation, loss of energy, feelings of worthlessness, inability to concentrate, and thoughts of suicide.

| DSM-IV Criteria for major depressive episode: |
|---|
| At least one of the following for at least two weeks: |
| *persistent depressed mood |
| *Loss of interest and pleasure. |
| At least four of the following: |
| *significant weight loss or gain |
| *insomnia or increased sleep |
| *agitation (worrying, physical restlessness) or retardation (slowed thinking/moving) |
| *fatigue or loss of energy |
| *feelings of worthlessness or inappropriate guilt (Illustration) |
| *diminished ability to concentrate or indecisiveness |
| *thoughts of death or suicide. |

**Table 3.**

When individuals are faced with a significant negative life event, such as a broken engagement, they frequently experience sufficient symptoms from this list for the diagnosis of MDD to be made, yet they are clearly experiencing a temporary, normal reaction, which should not be labelled as a mental disorder.

The DSM-IV pays no attention to the context in which the symptoms occur (except in the case of bereavement). If your house burns down, your spouse runs off and you are diagnosed with cancer, all in the same week, as long as you have five of the above symptoms for two weeks, you can be diagnosed with MDD, even though in the opinion of your friends you are adjusting very well to a nasty run of bad luck. Horwitz & Wakefield (2007) make this criticism in their important monograph, "The Loss of Sadness: How Psychiatry Transformed Normal Sorrow Into Depressive Disorder".

While the DSM-IV criteria of MDD may be flawed, in the hands of trained objective professionals they are usually used appropriately. However, self-help groups and quasi professional bodies often publish the DSM-IV criteria for depression and advised readers that if they can tick five boxes they should go along to their doctor and ask for treatment. Self diagnosis of MDD cannot be performed by the individual with a checklist any more than self heart surgery can be performed by the individual who cuts her/his own hair.

In the absence of scientific rigor, distress of any form may be medicalized and called MDD. When any individuals reports feeling "depressed", they are now believed by police officers and many other social services workers to be suffering from a mental disorder and conveyed to clinicians for "treatment" (even though there is an obvious, recent negative life event and no other symptoms).

The medicalization of distress into MDD may be, in small part, due to the fact that people with MDD are known to be at higher risk of suicide than people without that disorder. A major contributor is that coroners, the media and others are alert and quick

to criticize "service providers" when a suicide occurs. Thus, if a prisoner expresses sadness about being in custody, police tend to bring them to hospital (to avoid a death in custody) and demand "assessment" (admission) for "depression". This, of course, is usually palatable to the prisoner.

The social supports available to individuals have been reducing over recent history, and the mental health team in now providing the psychological and social support which was previously provided by the family and local community (Jacob, 2006).

It is not difficult to understand how ordinary sadness/distress has been medicalized into MDD. To some extent this has been facilitated by well meaning attempts to increase public awareness of MDD and reduce suicide. The lack of clear definitions of health, mental health, mental disorder, and mental health problems has made resistance to this lamentable trend impossible.

## Example from the public record

**Robert FitzRoy** (1805-1865)

**Fig 31.** Vice-Admiral Robert FitzRoy RN, circa 1844 (public domain).

FitzRoy (Fig 31) was a highly successful man who died by suicide at 59 years. In recent a publication The Royal Society (2008) stated, "He took his own life while suffering from depression", and Wikipedia (2008) stated, "He suffered from depression and in 1865 he died as a result of suicide". Thus, two sources made unambiguous statements that FitzRoy was suffering a mental disorder which led him to suicide. However, an examination of his life reveals no evidence whatsoever of mental disorder.

FitzRoy was a grandson of Charles II, and born into the aristocracy of Suffolk. He was received an excellent education, applied himself to his studies and achieved excellent results. At 14 years, he graduated form the Royal Naval College in Portsmouth.

When FitzRoy was 15 years (1822), his uncle, Viscount Castlereagh, cut his throat and died.

When FitzRoy was 25 years, Captain Pringle-Stokes of the HMS Beagle (a hydrographic survey vessel, charting South American waters) shot himself in the head. The Beagle was sailed to Rio de Janeiro where FitzRoy came on board and was given command.

He sailed the ship back to England. In the following year FitzRoy was made Captain of the Beagle and took her back to South America to continue charting operations.

Mindful of that loneliness had bedevilled Pringle-Stokes, FitzRoy sought a gentleman companion with whom he could converse. He selected Charles Darwin, a Divinity graduate who was, at this stage, deeply religious and preparing to take religious orders.

FitzRoy was also deeply religious (and remained so). His private objective for this voyage was to find scientific proof that the Biblical Book of Genesis was literally true. The conversations between these men were at times heated, as would be expected. The voyage was a great success.

FitzRoy was 31 years when they returned. He married within weeks. Much has been made of the fact that in the nearly 5 year voyage, FitzRoy did not mention to Darwin, that he was engaged. This has been given as evidence of a personality failing of FitzRoy. It could, of course, be cast as a personality strength, or as a reflection of the personality of Darwin.

On return, Darwin was clearly the "star". But, Fitzroy was by no means forgotten. He wrote about the voyage and at 32 years, was awarded the Premium (gold) medal of the Royal Geographical Society.

At 36 years he was elected to the House of Commons.

At 38 years he was appointed to the position of Governor of New Zealand. He was recalled after only two years. However, his recall was because of his principled defence of the Maori in the face of unscrupulous immigrant settlers, rather than administrative failure.

At 43 years he was made Superintendent of the Woolwich dockyard. At 44 years he was given his final sea command (HMS Arrogant). At 46 years he retired from active duty ("partly due to ill health" – details unavailable) and in the same year was elected to The Royal Society.

At 49 years, FitzRoy was appointed Meteorological Statistician by the Board of Trade, and was to collect data on the weather at sea. He did much more; he built the department in size and skill and invented a number of meteorological devices, one being a barometer which bears his name and is still in use. When he was 55 years his daily weather forecasts began to be published in the Times. Inevitably some predictions proved incorrect and some criticism was forthcoming. When he was 59 years, the Times temporarily ceased publishing his weather predictions.

On the basis of seniority, at 52 years he became Vice Admiral and at 58 years, Rear Admiral.

When FitzRoy was 54 years, Darwin published Origin of Species. These ideas were heretical to FitzRoy, and he no doubt he felt he had aided and abetted Darwin in

developing his heresy. At 55 years FitzRoy protested at a British Association meeting, holding a bible aloft, and was escorted from the building.

At 59 years FitzRoy got up one morning without waking his wife, kissed his daughter, went to his dressing room, cut his throat and died.

What is the evidence that FitzRoy suffered a mental disorder? The facts are that FitzRoy was a religious man of great ability who achieved great success. He was an outstanding sea captain and cartographer and developed the fundamental techniques of modern weather forecasting. He had some disappointments in life, including that he was recalled as Governor of New Zealand, due to a principled stance. He was distressed that he had taken Darwin on the Beagle, and thereby contributed to what he believed to be a diabolical theory. He was escorted from a public meeting, and the Times temporarily ceased publishing his weather forecasts. But disappointment does not mean mental disorder; on the contrary, disappointment is an inevitable feature of life/health, particularly when it is balanced by much success. In short, there is no evidence that FitzRoy suffered a mental disorder. Such statements appear to have arisen from the fact that he took his own life, and serve as an example of the medicalization of disappointment and suicide.

The argument goes, as he completed suicide, he must by definition, have suffered a mental disorder. FitzRoy may have had a genetic predisposition as his uncle (Viscount Castlereagh) had completed suicide, and he had been set the example by the Captain who immediately preceded him on the Beagle (Pringle-Stokes). Presumably, the argument goes that Viscount Castlereagh and Captain Pringle-Stokes were also mentally disordered.

## Suicide

Suicide is not a medical diagnosis, but a legal court finding. Nevertheless, it is strongly medicalized by Coroners, newspapers, family members, helping groups (Fig 32), researchers and some clinicians. Legal historian Jeffrey Watts (2006) reports suicide was "decriminalized, secularized and medicalized" by the end of 18th century.


**Fig 32.** This illustration comes from an organization devoted to suicide prevention. The influence of medicalization is stark. The message is that to prevent suicide, depression must be treated (rather than

distressing predicaments addressed). And, "If you feel suicidal, see a doctor" (rather than a friend, social worker, church officer, politician or family member).

Those individuals who are at a risk of suicide as a consequence of a mental disorder should receive all possible help. At time of acute risk, they should be kept safe (as safe as possible) and the mental disorder treated. Special supervision and support may be necessary, and this may involve admission (at times, involuntarily) to hospital. The individual who has lost all interest in food and fluid may need special treatment for malnutrition and dehydration, with a view to keeping him/her alive long enough for treatment to take effect. In extreme cases, electroconvulsive therapy (ECT) may be necessary. This is not medicalization, but appropriate medical care.

Suicide is medicalized when it is conceptualized as a mental disorder. It may accompany mental disorder, but suicide is not, per se, a mental disorder.

When there is suicidal thinking but no mental disorder present, there are various routes to medicalization. One route is the simple, faith based belief that all suicidal thinking is evidence of a mental disorder, and that any individual doing such thinking needs to be conveyed to hospital. Another route is that distress means MDD (all of those who are thinking or talking about suicide are in some distress). Another is that suicidal thoughts are terrifying to the individual and her/his associates, and there is a rush to "safety" (the hospital). Yet another route to the medicalization of suicide is the pronouncement of coroners, the police and others that suicidal people are the unique responsibility of health professionals (completely overlooking presence of unpleasant social predicaments).

It is stated in Chapter 1 that suicide is a piece of behavior, like coughing or killing someone else. There may be a range of motivating factors.

If you say to someone, "Give me some money, or I will kill you", there is a high likelihood that you will end up in goal. If you say to your father, "Give me some money, or I will kill myself", there is a high likelihood that you will end up in hospital. (Alternatively, if your father is wealthy and you are "spoilt", you might end up with the cash.)

But, if your father decides not to give you any money, he is left with the problem that you might hurt yourself. Rather than take you to the police, who could provide a safe place, he takes you to the hospital. You are no longer your father's problem. You have become the hospital's problem. Scenarios such as this (sometimes less stark, but in principle the same) are common. While the desired/denied entity may be money, it is more often, to be allowed to associate with certain people or to attend certain overnight events.

Again, those who think, talk or act in a self destructive manner are usually in some degree distressed. But, not all distressed people think, talk or act in a suicide-like manner. Some pursue more adaptive responses such as genuine apology or hard work. One of the many problems with the medicalization of suicide is that it leads to suicidal behavior becoming a socially acceptable response to distress. Thus, medicalization of suicide makes suicidal responses more, rather than less, common.

It is not unusual for people to respond to loss with suicidal thoughts and actions. Examples have been given in chapter 5 of the suicide of "respectable" people who are

in distressing predicaments and choose suicide as an extraction method. In certain circumstances, this can be understood: what, for example, did **Adolf Hitler** (1889-1945) have to look forward to? Commonly, it is the loss of lovers/partners which are associated with suicidal thinking and behavior. "Left" people are distressed, but usually not "sick", nevertheless, they currently many end up in the socially acceptable safe place, the hospital.

Special mention should be made of people with borderline personality disorder. This is a poorly understood disorder. Currently considered a personality disorder, it may be a variant of mood disorder, and a case has been made for it to be reclassified in the next edition of the DSM (New *et al.*, 2008). People with this condition have a tendency to anger and rapid mood swings, which may result in self-cutting (as a means of dealing with distress) and determined suicidal acts. With current knowledge, the best management of such individuals is long term out-patient psychotherapy, but with brief periods of hospitalization (place of safety), at times of acute distress and high suicide risk. This is a special category of patient, for whom long term admissions to hospital are more damaging than helpful and should be avoided.

When people without a mental disorder are at suicidal risk (thinking, talking, acting in a suicide-line manner) they need support. This can come from family, friends, clergy, teachers, and a wide range of people with experience of the world. If there is doubt, a psychiatric assessment should be sought, but in the absence of a mental disorder, clinician support is not necessary.

Times have changed. The traditional extended family and religious officers now provide less social support; medicalization has emerged (to a considerable degree) as a compensatory mechanism (Summerfield, 2004; Jacob, 2008). If the state decides to replace such functions with salaried operatives, well and good. But, in the absence of mental disorder, the requirement is for sensible, humane people, not doctors and nurses.

Once the crisis is past, it is a good thing if people who have responded to distress in a suicidal manner can learn alternative, more adaptive coping skills. This should be done in a community (not a hospital) setting. When mental disorder is present, this can be provided by clinicians on an out-patient basis. But what may be lacking is good models and good advice, and in the absence of mental disorder, this can be provided by sensible humane citizens.

Faulty calculation in the foundations of a building may result in people being hurt (residents and service personnel alike). So it is with the calculation that all people with suicidal thinking have a mental disorder.

The damage done to people who do not have a mental disorder by managing them as if they do have a mental disorder is that they may come to rely on the treatments which are necessary in the treatment of mental disorders. That is, they may come to unnecessarily rely on medication and hospitalization. Further, if people respond to the vicissitudes of life by recourse to unnecessary medication and hospitalization, they do not have the opportunity to learn new, adaptive skills. Finally, once people are stamped with the stigma of being psychiatrically "sick", their employment and other life opportunities shrink accordingly. It may appear kindly to admit non-mentally

disordered but distressed people to the psychiatric ward, but in the long term, the results are frequently negative.

Inevitably, if people are thinking and behaving in a suicide-like manner, some will complete suicide. This applies to both people with and without a mental disorder. In some cases death will be via a determined, lethal act, in other cases it will be by miscalculation when a mere gesture, for example, goes wrong. In other cases, people will die by accident (struck by a car) but because they are on leave from hospital or have recently consulted a health professional, the assumption is made that this was a deliberate suicidal act.

If a person strongly desires to end their life, prevention can be very difficult. In the most secure facility in the world (Guantanamo prison camp), with all possible resources and the reputation of the most powerful nation in the history of the world in the balance, suicide remains possible. (Incidentally, there is no evidence that any of the Guantanamo inmates who have died by suicide so far have ever suffered a mental disorder. Their deaths have been construed as a form of attack and there has been no attempt to medicalize these events.)

Coroners and others criticize clinical staff when suicide occurs. A convincing body of evidence shows that such criticism is damaging to staff and causes staff losses (Alexander *et al.*, 2000; Dewar *et al.*, 2000; Eagles *et al.*, 2001; Ruskin *et al.*, 2004; Masterton & Cavanagh, 2004; Ting *et al.*, 2006; St John-Smith *et al.*, 2009; Challender & Eagles, 2009; Daniel, 2009). Paradoxically, this creates less care for patients.

**Example from the public record**
**Robert Clive** (1725-1774)

**Fig 33.** Robert Clive, 1st Baron Clive, 1764 (public domain).

Clive (Fig 33) is a leading figure in British History. He died at his London home at 49 years of age. Recent accounts make various claims regarding his mental health and the method of his death. The BBC (2008) stated that Clive "suffered from mental illness – now thought to be bipolar disorder". NationMaster (2008) stated that soon after Clive arrived in India (1744, 19 years), "his health began to show itself in those fits of depression during which one of which he eventually ended his life". Thus, sources authoritatively claim a major mental disorder and death by suicide. However, an examination of his life reveals no substantial evidence of either mental disorder or suicide.

Clive was born in 1725, into minor gentry in Shropshire, England. He was an unruly child and stories tell of a number of daring escapades, including climbing to the top of a church steeple and forming a group of boys who demanded "protection money" form shopkeepers. His uncle with whom he lived for some years wrote, "I do what I can to suppress the hero" (Malcolm, 1836). Clive attended four schools; the headmaster of a Cheshire school wrote, if he "lived to be a man, and opportunity enabled him to exert his talents, few names would be as great as his" (Malcolm, 1836).

Clive made 3 trips to India: at 18 years (1743-53), 32 years (1756-60), and 40 years (1765-67).

He first went to India as a clerk for the East India Company, but was soon in the military component of the company, fighting the French and their Indian allies, performing acts of great flair and courage. He escaped from a besieged town dressed as a woman and fought a duel with a card cheat. When he devised a plan and led the attack to captured Arcot in 1751, the Prime Minister of Britain described his as a "heaven born general". Clive achieved a small fortune in the form of "booty" and other rewards, in accordance with the custom of the day, and returned home as a hero.

During his second trip Clive commanded a small number of soldiers against a much greater force of French and their Indian allies, and won The Battle of Plassey. This action entered military history as an exemplary operation. He destroyed pirate enclaves and dispatched the Dutch from India. Again, he secured gains in the form of "booty" and other inducements. Then, as Governor of Bengal, he began administrative changes aimed at curtailing exploitation of the local people and resources. Again, he returned home a hero; he was knighted, became a Peer (Baron Clive of Plassey) and entered parliament.

His third trip to India was as an administrator, his assignment was to arrange regulations which would put an end to corruption and improve the profitability of the Company. He returned home due to poor health (the nature of his condition will be discussed shortly).

On his last return to England, his reception was unlike the others. He was criticized in the streets, in the Court of Directors of the East India Company, and in parliament. Public opinion had changed and the acquisition of wealth through colonization and warfare was no longer acceptable. Clive was portrayed as greedy and hypocritical. Clive's morality has been attacked (Mill, 1820), but his defenders (there are relatively few) point out that Clive had gained a considerable fortune (legitimately at the time),

which was a cause of jealousy, and he had established regulations limiting the opportunities for corruption, which were unpopular with those who accused him.

**Suicidal behavior in early life.** Various sources state that Clive had been suicidal in his early years in India. The only relevant information is a story told by a young soldier who stated that one day he entered Clive's room and a pistol was on a table. The soldier stated that Clive asked him to fire the pistol out of the window. He did so. The soldier stated that when the pistol discharged, Clive said "Well, I am reserved for something. That pistol I have twice snapped at my own head".

This event is related by Malcolm (1836) who goes on to say, "This is unlikely to be true". Nevertheless, subsequent authors have cited this source. Clive never spoke of the event himself. It is unlikely that a pistol misfires twice and then fires when someone else pulls the trigger. There is no verification of what the young solider said, or if Clive did say those words, that he was speaking accurately. Thus, there is no clear evidence that Clive ever engaged in suicidal behavior in his early life.

**Health throughout life.** Clive appears to have had a complex personality. He was forthright, determined, and energetic. His detractors found faults: "Clive was a person to whom deception, when it suited his purpose, never gave a pang…" (Mill, 1820). Clive's correspondence, however, clearly demonstrate sustained loving relationships with his parents, friends, wife and children.

His mood is a matter of interest. Much is made of the fact that he was unhappy during his first trip to India: in a letter to his cousin, February 1745, he wrote, "I have not enjoyed on happy day since I left my native country" (Malcolm, 1836). At this point Clive was homesick, had very little money, was exposed to a hot climate, doing clerical work to which he was not suited, and had not made friends in the new country. In such circumstances, it is not surprising that he was not happy.

With respect to his first return to England, in 1953, some evidence indicates that he was due to ill health (no clear details are available). However, he had been away from home for a decade and his return was planned for some months. Nevertheless, he did not leave until "after his marriage to Miss Margaret Maskelyne" (Malcolm, 1836), which is not the behavior of a depressed individual with a bleak view of the future.

It is stated that his spirits were tinged with "melancholy" (Malcolm, 1836). But this word was frequently used in that and subsequent eras. In 1756 Clive wrote to the Court of Directors, "Upon this melancholy occasion…", and Malcolm (1836) referred to Clive's "melancholy duty", regarding the "melancholy news" of Mr. Watson's death.

Robert Orme, a military historian who knew Clive personally and had sent him on military expeditions made no mention of Clive suffering ill health, rather, he described (Orme 1763) "indefatigable activity, unshakable constancy, and undaunted courage". Mill, a critic, also, made no mention of Clive suffering ill health. On the contrary, he noted that in 1756 Colonel Laurence had an asthmatic complaint and could not be sent to Bengal, so that "Clive, to whom none of these exceptions applied" was dispatched instead (Mill 1820).

Malcolm (1836) described "a fever of a nervous kind attacked his constitution and much affected his spirits". However, he goes on to say, "his complaint…was accompanied with a hard swelling at the pit of his stomach". Gleig (1848) states that in October 1766, Clive "became alarmingly ill, that for a day or two, his life was despaired of" (p 247) and "Not only had the digestive organs lost their tone with him, he suffered from time to time with such spasms of acute pain" that opium was required (p 253), and "He looked as those do who have not long shaken aside an attack of jaundice, and walked with an infirm step" (p 258). McFarlane (1853) states "His liver was entirely deranged, his attacks of bile were frequent and fearful; he suffered excruciating agonies from gall-stones".

Clive wrote little of depressed mood and almost nothing about nervous complaints. One example, in a letter to his father in 1757 he wrote, "I enjoy my health better than could be expected, and think my nervous complaint decreases" (Malcolm, 1836).

There is no evidence to suggest mania; through his war experiences and his prolonged conflicts with the East India Company and the Parliament he was frequently described as being "cool tempered" (Malcolm, 1836). He is described as "calm, collected resolute, yet just, he faced every danger that presented itself, and met every difficulty as it rose with a perfect self-possession which ensured success" (Gleig, 1848).

Thus, the evidence suggests that Clive suffered gall-stones with episodes of cholycystitis (or a similar chronic abdominal disorder). There is no convincing evidence of major depressive episodes, and nothing whatsoever to suggest bipolar disorder.

**Health at the time of death.** There are clear accounts that Clive used opium when he suffered abdominal pain. There is no evidence that he misused this substance. Gleig (1848) states that in the period before he died, Clive was using an increased amount of opium, but "his reason was not clouded, not his self-possession taken away".

There is no evidence that Clive was suffering a diagnosable mental disorder at the time of his death. He no doubt found himself in a disagreeable predicament, having had his reputation damaged and he was suffering episodes of severe abdominal pain. He was taking opium at the time, but apparently not to the point of interfering with his thinking.

**Suicide.** To responsibly make the conclusion that suicide has occurred, there needs to evidence that the individual performed the act that resulted in death and that the individual intended the act to cause death. There is no evidence about how Clive died. His family always denied that he had completed suicide, saying instead that he died by accident, taking excessive opium for pain control. Mervy Davies (1939) states, "Clive cut his throat", Wards Book of Days (2008) states that he died by "stabbing himself", Shropshire Tourism (2008) indicates that may have "shot himself", and Harvey (1998) has proposed foul-play. No one has yet suggested natural causes, which is not unknown, especially among people sick enough to require opium analgesia. Simply put, there is no evidence to indicate how Clive died, and the conclusion that he completed suicide is irresponsible.

It is a mystery how and why Clive came to be identified as having suffered a mental disorder and ended his life by suicide. Once a national hero he became reviled,

perhaps well deserved, perhaps because he was a prominent example of "the old way" at a time when social attitudes were changing, and perhaps as a result of jealousy or resentment, particularly because his efforts against corruption hampered the ambitions of others. Perhaps the stigmatizing labels of mental disorder and suicide were attached in an additional attempt to degrade his reputation. Lists of famous people who were/are left-handed, or epileptic, or suffer mental disorder are generated with the intention of de-stigmatizing such differences. Perhaps a number of these possibilities worked simultaneously.

## Conclusion

Suicide is a piece of behavior which has a range of "drivers". People with mental disorder are at greater risk of suicide than those who do not have mental disorder. There is a widespread belief that all those who suicide have a mental disorder. However, this is incorrect, and a considerable proportion people who complete suicide do not have a mental disorder.

Medicalization, the process of redefining a non-medical problem in medical terms, is one process which lends support to this false belief. Medicalization is in turn supported by the WHO (1948) definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease". In the light of this definition, any form of distress (including losing money at the races or a domestic dispute) becomes a health issue.

Mental disorder has not been satisfactorily defined. The DSM-IV does not take context in which symptoms arise into account in the diagnosis of MDD, so that natural reactions to loss can be classified as a mental disorder. Thus, lack of a clear definition and comprehensive diagnostic criteria for mental disorders leads to faulty diagnosis and promotes the medicalization or normal, reactive distress.

Suicide is not a medical diagnosis, but has come to be medicalized, and is widely regarded as a medical disorder. People without a mental disorder (as well as those with a mental disorder) can come to suicidal thinking and behavior via distress which relates to difficult predicaments. The medicalization of suicide also occurs as distressed individuals and their contacts become fearful about what "could happen", and take the problem to a safe place, the hospital. Suicide is also medicalized by the pronouncements of coroners, the media and others, that when suicide has occurred, health professionals have failed in their duties.

The "downside" of managing people who demonstrate suicidal thinking and behavior but do not have a mental disorder, as if they do have a mental disorder, is the danger they may become unnecessarily reliant on the treatment strategies which are necessary in the presence of mental disorder, that is, medication and hospitalization. This can stunt the learning of new adaptive skills. Also, being stigmatizes as "sick", reduces employment chances and prospects for a "flourishing life".

# CHAPTER 8

# SOCIOLOGY AND SUICIDE

**Abstract**: Durkheim argued that suicide is largely a social phenomenon. He did not deny vulnerability of individuals due to what would now be called mental disorder, as is commonly stated. He found that the regulation and support provided by society to the individual (these could be too little or too much) were the key to suicide. He described egoistic, anomic, altruistic and fatalistic forms of suicides. These ideas are assessed and supplemented with current research. Bullying and the influence modern communication systems have on suicide are mentioned, and examples from the public record are detailed.

**"The fact that a disproportionately high percentage of young rural women commit suicide speaks to a conglomeration of gendered social forces impinging on their local worlds."**

Lee (1999)

The sociology of suicide begins with Emil Durkheim (1897/1951), who argued that suicide is largely a social phenomenon, rather than the result of individual psychopathology. His views have been widely misunderstood in the psychiatric literature. At the risk sounding grandiloquent, this can only be because few psychiatrists have read his original work, and most have simply accepted the misunderstandings of earlier skim-readers.

The primary misunderstanding by psychiatrists of Durkheim's work is the notion that he found no place for mental disorder in suicide. In fact, Durkheim made frequent reference to the suicide of the "insane" (psychotic). However, it is correct that he believed, "There are suicides, and numerous ones at that, not connected with insanity".

At the time he was writing, insanity (the psychoses) formed the bulk of the recognized mental disorders. The less severe conditions (neuroses) and personality disorders had yet to be fully described. (The neuroses subsequently became the anxiety disorders and mild mood disorders of the present day.) Durkheim observed that not all the members of a given society responded to extant social conditions by suicide, this course of action was chosen only the vulnerable ones. He observed that "the normal person who kills himself is in a state of dejection and depression". (Here, by "depression" Durkheim did not mean a depressive disorder, but simply, what we would call temporary distress or low mood.)

At the time Durkheim was writing, "neurasthenia", described by Beard in 1869 was a frequently diagnosed non-psychotic mental disorder. Neurasthenia, a disorder characterized by fatigue, anxiety, headache, impotence and depressed mood, remains a diagnostic entity in the 10$^{th}$ edition of the International Classification of Diseases. It has been removed from the DSM, having been subsumed under a variety of disorders including dysthymia, anxiety, somatoform and personality disorders. These disorders, along with the psychoses, are known to have a high risk of suicide.

**Saxby Pridmore (Ed.)**

Durkheim wrote, in describing those most vulnerable to suicide, "The temperament most predisposing man to kill himself is neurasthenia in all its forms", and that suicide occurs when the "mental constitution, as elaborated by nature and events, offers less resistance". Thus, Durkheim was not opposed, in fact, he supported the notion that the mental state of the individual played a part in selecting which individuals would suicide.

Durkheim maintained that social factors were the setting and major cause of most suicide (for all but those who were insane). However, he proposed that the mental state of individuals was the determining factor when it came to which individuals would attempt suicide and which individuals would survive, and this point has been missed by many.

The social factors emphasized by Durkheim as important to suicide were 1) social integration (attachment to society providing a sense of purpose and meaning), and 2) moral regulation (the healthy society providing limits to the aspirations, behavior and thereby, the disappointments of the individual).

Social integration refers to shared beliefs and relationships between individuals. Appropriately integrated societies give both meaning to life and emotional support. When the individual becomes less attached to society (Durkheim gives the example of the Stoic philosophers and intellectuals in general), there is an increased risk of suicide. Durkheim wrote of the dangers of "excessive individualism" and the associated loss of "object and meaning". Finally, when integration is inadequate, "The individual yields to the slightest shock of circumstances because the state of society has made him a ready prey to suicide", this is egoistic suicide, and will be discussed below.

Moral regulation refers to the limitation and modulation of "the passions" (including aspirations). Durkheim used the term "anomy" to describe the situation of inadequate regulation. He believed that in a state of anomy, society no longer provides regulation through shared values and beliefs, "the passions" are without limit, and the consequent exhaustion (due to unquenchable aspirations) and dejection may lead to suicide. Anomy is most commonly described when there are chaotic social changes, and Durkheim saw the industrial revolution as an example. However, he also found that "in the sphere of trade an industry", anomy is "a chronic state". Anomic suicide will be discussed below.

For the sake of completeness, mention must be made of excessive integration and excessive regulation. Excessive integration pertains when the individual is "completely absorbed in the group" and has no independent identity. This may lead to altruistic suicide (such as suicide bombing; and is the opposite of egoistic suicide). Excessive regulation pertains to "futures pitilessly blocked and passions violently choked by oppressive discipline", and is observed among prisoners and the incurably sick. This was termed suicide, but appears only as a footnote in Durkheim's monograph.

Durkheim's theory suffers because of the overlapping of his proposals. Loss of integration, for example, must be associated with some degree of anomy. Of egoistic and anomic suicide he wrote, "They are often found combined with one another, giving rise to composite varieties".

At the time of writing, there was a boat load of asylum seekers who had been attempting to reach Australia, who had been held in Indonesia. They claimed to be Tamil refugees from Sri Lanka. They appeared to be fleeing anomy, their lives lacking adequate regulation. However, they had been refused entry to Australia and were on a hunger strike, to the point of death if necessary. This can be interpreted as excessive regulation of the individual by the group.

Durkheim established the importance of society in suicide, but his work is largely ignored in current suicide prevention policies.

Durkheim came to his conclusions when he discovered that suicide rates of the different nations were different, but relatively stable over time.

This remains the case. For example, over a recent 35 year period (1955-1989), the suicide rate of men in Finland was seven times greater than men in Greece, and the suicide rate of women in Denmark was seven times greater than women in Ireland (Frenquist & Cutright, 1998).

Mean Age-Standardized Suicide Rates by Gender: 1955–1989

| Nation | Gender | |
|---|---|---|
| | Male | Female |
| Finland | *52.2 | 12.9 |
| Denmark | 40.0 | 22.3* |
| Ireland | 9.2 | 3.4* |
| Greece | * 6.7 | 2.9 |

**Table 4.** Adapted from Frenquist & Cutright (1998).

Recent major work (Hansen & Pritchard, 2008) examined the relative levels of suicide rates among 22 developed countries over the last quarter of the 20th century, and among 11 countries over a 112 year period, including the entire 20th century. Highly significant correlations were found for men, women and total suicide rates in both groups. Although actual national rates fluctuated over differing socio-economic cycles, they broadly moved together.

## Measuring Integration

Durkheim measured integration using domestic, religious, economic, educational and political indices.

With respect to domestic integration, Durkheim wrote, “Just as the family is a powerful safeguard against suicide, so the more strongly it is constituted, the greater is the protection”. He found that the divorce rate is positively related to the suicide rate. This has been recently confirmed (Trovato, 1987; Stack, 1998). He found that the presence of children is associated with lower suicide rates for both men and women, and this has been confirmed (Veevers, 1973). He believed that the presence of children in a marriage protects women more than men, and speculated that this was because mothers are generally more involved with their children than are fathers.

While being single is a risk factor for suicide in the west, there is less evidence of this effect in developing countries, probably because the extended family system remains strong (Vijayakumar *et al.*, 2005).

Religious activity is an important indicator of integration. Durkheim found that religion aids in social integration and protects against suicide, and that Catholics who stress communal activities have lower suicide rates than Protestants, who stress individuality in seeking salvation. This work has been frequently replicated (Stack, 1983; Lizardi & Gearing, 2009). Recent researchers have invariably demonstrated an inverse relationship between national suicide rates and religious book publication. Reduced religious participation is associated with increased suicide rates in both developed (Nisbet *et al.*, 2000) and developing countries (Kurihara *et al.*, 2009).

Economic integration depends on the stability of the economy. Durkheim observed that dramatic economic changes, whether fortunate or unfortunate, "result in unusual circumstances" which disturb the "order and social equilibrium". In such circumstances, the activities of individuals are no longer regulated as they were during the previous social order. These original observations have been confirmed in more recent studies (Pierce 1967). Interestingly, in addition to suicide rates, homicide rates increased following the swift political change in Russia following the collapse of the Soviet Union (Pridemore 2006).

There have been changes in the society over the last century. While most, not all of Durkheim's theories/observations have currency at the present time. For example, Durkheim believed that "Poverty may even be considered a protection" against suicide. He theorized that poverty regulates/limits the aspirations/passions. Recent studies do not support this view. There is some evidence to support this view in the case of poorer (and less well researched) nations, but it does not hold in the developed nations. Poverty is associated with an increase in suicide rates in nations in which there is a marked disparity of wealth (Rehkopf and Buka, 2006; Ferretti & Coluccia, 2009).

Page *et al.* (2006) took into account Australia for the period 1979-2003, and demonstrated that socioeconomic status had a reciprocal suicide rate of both men and women: low socioeconomic status was consistently associated with higher suicide rates and high status consistently associated with low suicide rates. Lemstra *et al.* (2006) demonstrated a significant inverse relationship between socioeconomic status and suicide rate across the neighbourhoods of a single city (Saskatoon).

Research demonstrates that being born to a younger mother, a mother with other children, and a father with a non-professional occupation (Riordan *et al.*, 2006), and being the second or subsequent child in a sib-ship, and the child of a mother with an unstable marital relationship (Gravseth *et al.*, 2009) increases suicidal risk. Such findings can be construed as linking social disadvantage, personality development, and social bonds and integration.

Yamasaki *et al.* (2008) working on Japanese data for the period 1953-96, and Ying & Chang (2009) working on data from the G7 countries, demonstrated a clear link between unemployment and suicide. But, similar results have been found everywhere from Ireland (Corcoran & Arensman, 2010) to India (Inoue *et al.*, 2010).

Durkheim argued that the education of women would increase suicide rate, as this would weaken traditional beliefs and encourage individualism. However, the broader values of society have changed in the last century, and the education of women can

now be conceptualized as increasing rather than decreasing social integration. Durkheim also argued that female labor force participation would cause a decline in domestic integration and increase both male and female rates of suicide. There is some recent support for this view (United Nations, 1962; Ying and Chang, 2009), and Yamasaki *et al.* (2008) have shown that in Japan, at least, female labor force participation was significantly related with mortality of young and elderly males, and young females. However, again, the structure of society has changed, and female employment (outside the home) has become the norm (in most regions). The implications of this particular change are many, and the effect on suicide, if any, is yet to be fully characterized.

Different cultural norms and expectations of the genders have a powerful impact on rates of completed suicide; worldwide, males are 3-4 times more likely to suicide than females. Males tend to have more familiarity with and access to deadly means (firearms), and the coping strategies of males more commonly involve the use of alcohol and drugs. There is also a theory that males are more achievement-oriented than women, and are thereby more vulnerable to unemployment and work-related problems (Girard, 1993).

Interestingly, when only people with a history of mental disorder are considered, the differential between male and female suicide is much reduced (Liu *et al.*, 2009). This suggests that mental disorder triggers suicide evenly across the genders, and adds to the importance of the cultural and social factors mentioned in the last paragraph.

In summary, the impact of social integration (particularly domestic, religious and economic) on suicide rates has been comprehensively demonstrated in highly focused studies (Breault, 1986; Stack, 1998; Lester, 2000). In addition, in more general studies, such as state welfare spending and suicide rate (Zimmerman, 2002), exposure to violence and hunger (Maselko & Patel, 2009), population density and suicide rate (Bridges, 2008), and national register-based studies of suicide (Qin *et al.*, 2003), there is frequent support for the importance of social integration.

## Egoistic Suicide

Egoistic suicide occurs 1) when societies evolve such that individual agency moves beyond a collective social focus to excessive individualism, and 2) when the individual is particularly disposed to individualism or disconnects from society by devotion to a philosophy or way of life which promotes individualism. Put simply, egoistic suicide occurs when an individual is inadequately integrated into society, and is socially isolated. When individuals depend less on the group and more on their own interests, there is a loss of meaning beyond the individual perspective, which translates to decreased protection and increased suicide risk.

Currently, individual "freedom" is encouraged and promoted as a marker of a mature and liberated society. Durkheim cautioned against "…the refined ethics which sets human personality on so high a pedestal that it can no longer be subordinated to anything". Theoretically, increased liberation may leave people "out on their own" which may increase the suicide rate (that is not to deny the huge benefits of liberation).

## Example from the Public Record

**Screaming Lord Sutch** (1940-1999) was born, David Sutch, in London. He changed his name by deed pole "to become a peer". He began adult life as an early 60's rock 'n' roll identity. He first attempted to enter Parliament in 1963. He founded a political party, The Official Monster Raving Loony Party, and remained leader until his death. Accordingly, he was the longest serving party leader in the UK. He contested tens of elections, but never secured sufficient votes to earn the return of his deposit. He dressed in outrageous clothes and made outrageous statements, and while self-promotional, he was a significant political satirist. He never married but had one child. He hung himself. At a coroner's inquest, statements were made claiming he had suffered depression. Irrespective of the presence or absence of depressive disorder, his death, in a setting of marked eccentricity and limited integration into main-stream society may represent egoistic suicide.

## Anomic Suicide

Anomic suicide occurs when the rules, expectations and the economy of a society begin to fail. That is, when social or moral norms are confused, unclear, or simply not present, there is a lack of regulation. Durkheim believed that for certain individuals in certain states of anomy, "there is no restraint on aspirations" and "in the end" individuals "cannot escape the futility of endless pursuit".

At the time of writing, there had been 25 completed suicides over 20 months, among France Telecom employees. The company claimed that with 102 000 employees, this is not a statistically significant number. That may be the case. However, anomy may have played a part. France Telecom had been part of the public sector until privatization in 1998. There had been massive restructuring, the workforce had been cut by one third and there were three yearly forced relocations. Commenting on the way different peoples define themselves, Christian Baudelot, a Paris based professor of sociology, stated that in France, "The workplace is the cement of our society". Employee, Fabrice Sahunt said, "We have earphones on our heads all the time now. All the camaraderie is gone. All that's left of the public service we once knew is nostalgia". The French Labor Minister, Xavier Darcos has promised "increased counseling services"; this is the typical bureaucratic response, and indicates complete ignorance of causative factors.

Evidence indicates an increased suicide rate in China, as a result of social changes which commenced in 1978 (Phillips *et al.*, 1999). Similar findings have been reported for the Inuit of Canada (Krug *et al.*, 2002). The clearest current example, however, may be the North American Indians, who have the highest suicide rate of all ethnic groups in the United States (Olson & Wahab, 2006). This culture is under extreme pressure, with high rates of family conflict, alcohol abuse and hopelessness. The same appears to be the case among the Australian Aboriginal community (Tatz, 1999). A recent study of Arctic households found suicidality to be lower among those individuals with a preference to use traditional language (Inuktitut), suggesting a protective effect of maintaining cultural traditions (Haggarty *et al.*, 2008).

Alcohol abuse is a common feature when cultures are under pressure, and has been associated with suicidal behavior among the Navajo (Grossman *et al.*, 1991), Inuit and First Nations of Canada (Overholster *et al.*, 1997), and Australian Aboriginal people.

## Example from the Public Record

**Fig 34.** Marshal of the Soviet Union Sergey Akhromeyev, 1988 (public domain).

**Sergei Akromeyev** (1923-1991; Fig 34) was born in Russia and served with distinction as a junior officer in WWII. He remained in the Army and became Chief of the General Staff of the Soviet Armed Forces. He resigned in protest at the dismantling of a ballistic missile project. In 1990, he became the Adviser to the President of the USSR on military affairs. After the failure of the 1991 Coup, he hanged himself in his office in the Kremlin. He left a note explaining that he could not continue living when the institutions to which he had devoted his life were disintegrating. His death, in a setting of great political change and loss of social structure may represent anomic suicide.

## Altruistic Suicide

Altruistic suicide (Durkheim, 1987/1951) occurs when the individual is excessively integrated into society and the needs of the individual are seen as less important than the needs of society as a whole (thus, the opposite of egoism).

## Examples from the public record

**Lawrence Oates** (1880-1912) was born in London and fought in the Boer War, during which he sustained a serious leg injury. He joined Scott's expedition to the South Pole. On the return journey, Oates was in poor physical health and was slowing down the group, placing them in peril. He wanted the others to leave him, but they refused. On March 17th Oates said to his companions in the tent, "I am just going outside and I may be back sometime". He performed altruistic suicide by walking off into the snow.

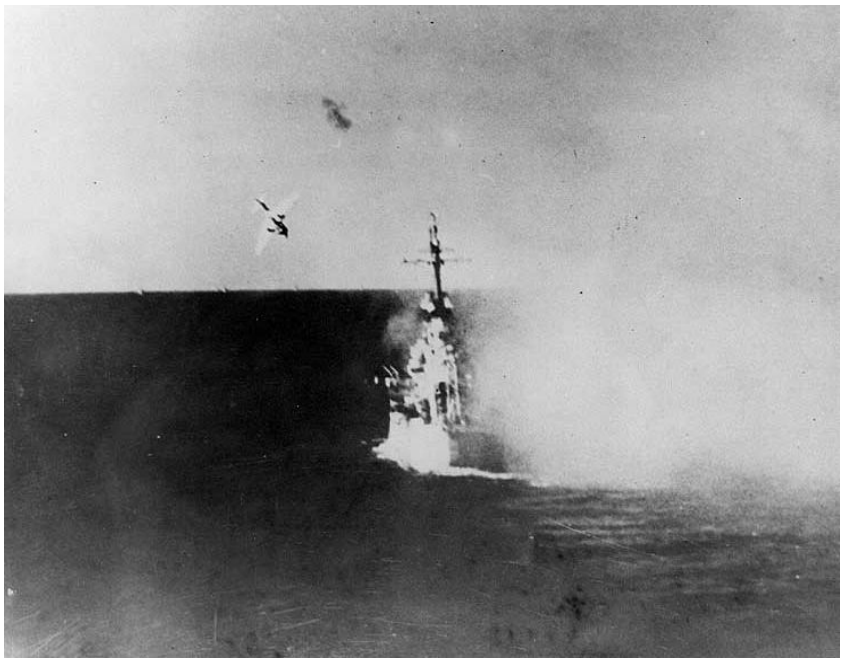


**Fig 35.** Kamikaze pilots attacking the USS Columbia, 1945 (public domain).

**Fig 36.** Ensign Kiyoshi Ogawa, kamikaze pilot, 1945 (public domain).

**The Kamikaze pilots** of WWII are famous examples of altruistic suicide. In 1945, Japan appeared to be losing the war and in desperation, the leadership decided that pilots would henceforth fly planes loaded with bombs into enemy ships (Fig 35). Lieutenant **Youkio Seki** was the first successful Kamikaze pilot when he flew his Zero into, and sank, the US carrier St Lo. **Ensign Kiyoshi Ogawa** (Fig 36) died in a kamikaze attack on USS Bunker Hill, in May, 1945. Some 2000 other Japanese pilots performed altruistic suicide, sinking 56 Allied ships.

More recently, self-immolation emerged as a form of political protest (Ben Park, 2004). One of the most widely reported was the suicide of **Thich Quang Duc** (66 years), a Buddhist monk who self-immolated at a busy intersection in Saigon, in 1963. In the weeks before his death, he had explained his motivation in writing to other monks and South Vietnam government officials. He described his death as a protest against government repression of Buddhism.


**Fig 37.** Plaque in memory of Jan Palach (public domain).

**Jan Palach**, a 20 year old student self-immolated in 1969 in Prague, in protest against the Soviet invasion of Czechoslovakia (Fig 37). **Malachi Ritscher**, a Chicago musician self-immolated in protest against the Iraq war, in 2006.

**Suicide bombers** and the like (**Twin Towers terrorists**) are currently active around the world. This is a disparate collection, united only by the practice of suicide and murder as a means of promoting the interests of their ideological group. It seems, although a formal count has not been conducted, that this form of suicide is more common at present than at any other time in history. **Zainab Abu Salem** was a beautiful 18 year old female children's television celebrity who blew herself to pieces at a Jerusalem bus station in 2004. Soldiers were killed and injuring civilians. Her severed head can be viewed on the web by placing her name in a search engine.

## Fatalistic Suicide

Fatalistic suicide occurs in oppressive societies, in which people prefer to die rather than continue living. Durkheim (1887/1951) placed these "at the high extreme of the regulation continuum". This type of suicide is the least convincingly argued of the four proposed by Durkheim. Nevertheless, it has faced validity as a category of suicide.

Fatalistic suicide has been described as occurring among prisoners held with no prospect of release, and terminally ill people, particularly those with painful and disabling conditions.

Fazel *et al.* (2010) surveyed 12 countries and found the suicide rate of prisoners to be at least 3 times higher than the respective general population. At least some of these deaths may be fatalistic, but further analysis is necessary as in recent years prisons have become de facto mental hospitals, housing large proportions of people who need psychiatric care.

**Examples from the Public Record**

**George Savvas** was a convicted drug baron who was serving an indeterminate sentence. In 1997, soon after an escape plan was scotched, he hanged himself in his NSW (Australia) prison cell.

**Rory Jack Thompson** was an American born marine biologist who immigrated to Australia. He murdered his wife (in Hobart), dismembered her body and flushed it down the toilet, in 1983. He pleaded not guilty by reason of insanity, and this was accepted, although he had no significant psychiatric symptoms and had rehearsed and tried to hide his crime (thus, demonstrating that he knew the nature of his actions/crime and that the crime was wrong). The mental health tribunal 3 times recommended his release (there being no psychiatric disorder present). However, three different governments (one each of the major political parties) refused his release (presumably for political reasons). In 1999, (at 57 years of age), he escaped from goal, but was recaptured within hours. A few days later he hanged himself in his cell.

**Dudu Topaz** (Fig 25.) was the leading Israeli TV comedian and game show host in the 1990s. Born as David Goldberg, he changed his first name to sound less formal and his last name to sound more glittering. He had long been a controversial celebrity. In 1984, as a spokesman for the Labor Party, he made racist remarks against the supporters of the right wing Likud Party, which are believed to have back-fired and contributed to the election of Likud. In 1995, he physically attacked and broke the glasses of a TV critic who had given him a negative review. In the early 2000's, his rating fell, American-inspired reality television became the new rage, and in 2005 he lost his employment. Topaz tried but failed to interest various Israeli TV executives and agents in his ideas for new shows. In early June 2009, Topaz was arrested on charges of assault and battery, conspiracy to commit a crime, extortion and obstruction of justice. It was claimed that, over a 6 month period, he had paid thugs to bash at least 4 of those who had refused to assist him to return to TV. In August 2009, at 62 years, and less than a week before he was to return to court, he hanged himself in a prison shower room. An Israeli suicide expert (Israel Orbach) described Topaz as "narcissistic" and stated, "What did he see in his future? He saw many years of imprisonment."

Mention has been made in Chapter 4 of the suicide of military leaders, including some high ranking German military figures at the end of WWII. Using the Durkheimian classification system, they can be considered to have completed altruistic suicide.

Fitting better under the heading of fatalistic suicide are the deaths of the lower ranking German soldiers and people described below, who also died at the end of WWII. These individuals had lower levels of responsibility and were at no risk of being charged with war crimes. They were disappointed, but most importantly, they believed they faced a very unpalatable future at the hands of their victors.

**Fig 38.** The suicide of Alfred Freyburg, his wife and daughter, 1945 (public domain).

The German city of Leipzig surrendered to US troops on April 20, 1945. At the Town Hall, the mayor, **Alfred Freyburg**, his **wife** and their 18 year old **daughter** (wearing a Nazi armband) were found to have completed suicide in his office (Fig 38) by taking poison. In a nearby office, the city treasurer, **Dr Kurt Lisso**, his **wife** and their 20 year old **daughter**, were also found to have completed suicide.

**Fig 39.** The suicide of General Walter Donnicke, 1945 (public domain).

On the same day, in yet another room at the Leipzig Town Hall, the General of the local Volkssturm, **Walter Donnicke**, (Fig 39) had also taken his life using poison.

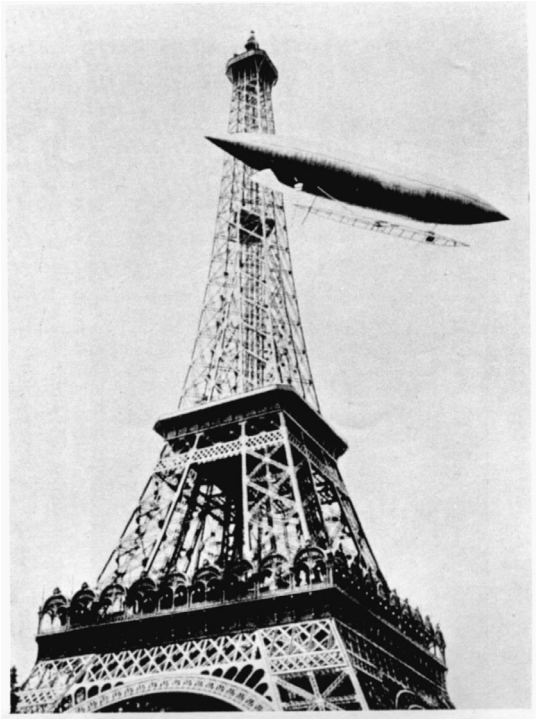


**Fig 40.** Santos-Dumont flying his dirigible around the Eiffel Tower (public domain).

**Alberto Santos-Dumont** (1873-1932) was a Brazilian who spent most of his adult life in Paris, France, where he designed, built and flew the first practical dirigible (steerable) balloons. His flight of a dirigible balloon around the Eiffel Tower in 1901 (Fig 40) made him world famous. He took his life when he became seriously ill with multiple sclerosis.

**David Stove** (1927-1994) was an internationally renowned Australian philosopher; a humorist and a "dazzling defender of common sense". He developed terminal esophageal cancer and hanged himself.

Others include **Arthur Koestler** (78 years) and **Jo Shearer** (56 years), who are mentioned in Chapter 1.

**Craig Ewert** (1947-2006) was born in the USA, where he became a professor of computer science. When he retired he lived in Britain. He had been married for 37 years and had a 35 years old son and a 33 years old daughter . He had never suffered a physical or mental disorder. In April 2006, he was diagnosed with motor neuron disease. His health rapidly deteriorated. He elected to end his life in a Swiss euthanasia clinic. He had his death filmed (released on British television, 2008), during which he said, "If I don't go through with it (suicide), my choice is essentially to suffer, and inflict suffering on my family, and then die".

**Daniel James** (1965-2008) of Worcester (UK) also chose to die in a Swiss euthanasia unit. He had been a successful engineering student at Loughborough University, with outstanding sporting ability. Following a rugby accident, he had been paralyzed from the chest down and experienced severe, constant pain. He tried to end his life a number of times before his parents assisted him to travel to Switzerland.

**Sir Edward Downes** (1924-2009) and his wife **Lady Joan** (1935-2009) lived in Britain and completed suicide together in a Swiss suicide clinic. Sir Edward was a famous conductor who had worked with the BBC Philharmonic orchestra and the Royal Opera House. He conducted the first Sydney Opera House performance. Lady Joan had been a ballet dancer, choreographer and arts administrator. They had been married for 54 years. Sir Edward became almost blind and deaf and increasingly dependent on his wife, and Lady Joan had recently been diagnosed with terminal cancer. Their children supported them in their decision and released a statement which included, "They both lived life to the full and considered themselves to be extremely lucky to have lived such rewarding lives, both professionally and personally".

## Durkheim and Mental Disorder

As mentioned in the introduction, a common misunderstanding is that Durkheim found no place for mental disorder in suicide. He saw social factors as the primary cause of suicide (in all but insane individuals). However, he wrote that those who completed suicide were the most vulnerable, and that neurasthenia, "organic-psychic temperament" and adjustment difficulties strongly contributed to vulnerability. He made frequent mention of the suicide of insane (psychotic) people.

The concept of mental disorder is much broader today than it was when Durkheim was working. If he were writing today, he may have adjusted his position slightly (but probably not much).

It is necessary to acknowledge flaws in Durkheim's efforts to disprove a primary role for mental disorder in suicide. The information available to him was puny by comparison to that which is currently available. Durkheim stated that mental illness was higher among Jews than among Catholics and Protestants, but that their suicide rate was lower – there is no evidence to support this first part of this statement. He stated that if heritage was a factor, there should be an equal number of suicides across the sexes. Modern genetics, however, does not support this premise. Accordingly, Durkheim did not disprove a role for mental disorder in suicide. But, this inaccuracy does not disprove the importance of social factors as he portrayed them.

Fernquist (2007) set out to discover whether Durkheim's integration variables have effects which are separate from the effects of mental disorder. He used proxy measures of depression and alcoholism, two disorders known to impact on suicide rate, as well as classic integration variables of Durkheim, and examined the suicide rates of eight European countries from 1973-1997. He found that the integration variables retained an influence on suicide rates which was independent of the effects of mental disorder. His conclusion was that Durkheim's theories of egoism and anomy, while not completely supported in statistical analysis, received moderate support and remained valuable in explaining differences in suicide rates.

It is beyond doubt that people with mental disorder are at greater risk of suicide than people without mental disorder. But there is also strong evidence that people without mental disorder complete suicide, and that for both groups, social factors are important drivers.

## Relationships up close

Durkheim described the impact of social integration on suicide. In keeping with his discipline he concentrated on "the big picture", and left to others, the issues of psychological life and "how it feels" to be in a predicament. For the feelings associated with being in a predicament, the word "distress" has been used in this book; Jacob (2008) used the word "misery", O'Connor *et al.* (2010) used the word "upset". Perhaps a better, broader, but longer term is, "negative emotion".

With respect to an apparent increased suicide rate, the Lancet (McCurry, 2008) recently quoted a counsellor for Japan's largest suicide telephone helpline, "Most of the people we talk to are in a bad place mentally because of relationships – at work, at school, among their family or neighbours".

There have been recent reports of increased suicide among members of the US Army overseas. Col Elspeth Ritchie, psychiatric consultant to the Army's surgeon general, told reporters (Bowman, 2008) that these suicides were mainly the result of failed relationships; that the majority of the soldiers who completed suicide did not have a known history of mental disorder; that only 6% of those who completed suicide had a prior diagnosis of post-traumatic stress disorder (PTSD); and that the majority had not sought mental health care before taking their own lives.

"All too commonly, a soldier will get a 'Dear John' or 'Dear Jane' email and then go and shoot themselves, and that is very hard to prevent" she said.

At the same news conference Army chaplain, Col Charles Reese said, "When those relationships break, it tends to be a strong contributing factor to the consideration of death as an option".

On this topic, CNN.com (2008) quoted US Army chaplain Ran Dolinger: "The real central issue is relationships. Relationships, relationships, relationships. People look at PTSD, they look at the length of deployments…but it's that broken relationship that really makes the difference."

A recent New Zealand study (Purvis *et al.*, 2006) found that 'problem acne' was associated with an increased risk of suicide attempts. This association remained after controlling for depressive symptoms and anxiety. This suggests problem acne generates distress which is independent of the psychiatric diagnoses of depression or anxiety, and that acne can cause social problems.

## Examples from the Public Record

The importance of relationships to the individual was demonstrated by the death of **Megan Meier**, 13 years, who hanged herself in 2006. The mother of a girl who had fallen out with Megan created a fictitious admirer (Josh; along with a spurious photograph) who communicated with Megan via MySpace. After six weeks "Josh" said that he had heard that Megan was "cruel" and that the world would be better off without her. "He" did not respond to her further messages, and Megan died some hours later.

Bullying has recently been identified as a trigger for suicide (Kim and Leventhal, 2008). On the pubic record, parents have claimed bullying was responsible for the suicides of **Jared High** (13 years, died 1998, Florida), **Kasey Hone** (16 years, died 2001, Utah), **Ryan Halligan** (13 years, died 2003, Vermont), and **Carl Walker-Hoover** (11 years, died 2009, Massachusetts), among many others.

**Brodie Panlock** (19 years, died 2006) jumped from the top of a four story building in Melbourne (Australia). One of three children to loving parents, her ambition was to work to save enough money for an overseas trip and then to return home and fall in love. However, at the restaurant where she was employed she was relentlessly bullied (spat on, called fat and ugly and had beer and fish oil poured over her) by three male employees. The court concluded that her death was a direct result of bullying, and there was no mention of mental disorder. In 2010, her tormentors and the business owner were fined a total of $335 000.

It is reasonable to suppose that if people live in a supportive (more integrated) society, they will be less likely to select suicide as a means of predicament extraction.

## Past and Future

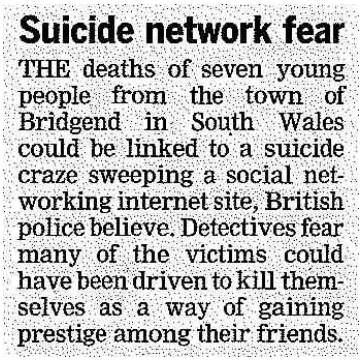
Durkheim drew attention to the importance of social factors in suicide. While his work is complicated, at times difficult to grasp and has attracted detractors, the main thrust (based on his observations of the suicide rates of different countries over time) remains intact.

He offered four types of suicide: egoistic, anomic, altruistic and fatalistic, which offer a useful means of conceptualizing suicide in the broader context.

He focused on social integration and regulation, and these continue to find scientific verification.

More recent work looks at the impact of social inequalities on suicide (Saurel-Cubizolles *et al.*, 2008) and the "life and death" matter of social justice (Commission on Social Determinants of Health, 2008).

New data, unavailable to Durkheim, but which he would doubtless have found interesting, include increased suicidal behavior of adolescents in rural China (Liu *et al.*, 2005), and lower rates of suicidal ideation in ethnic minority groups in England (Crawford *et al.*, 2005).



**Suicide network fear**

THE deaths of seven young people from the town of Bridgend in South Wales could be linked to a suicide craze sweeping a social networking internet site, British police believe. Detectives fear many of the victims could have been driven to kill themselves as a way of gaining prestige among their friends.

**Fig 41.** A new fashion in suicide, 2008

New methods and fashions of suicide emerge, involving new technology and new ways of "relating". This newspaper clipping (Fig 41) describes one example: dying with others (sometimes strangers). The death of **Abraham Biggs** (19 years; 2008; Florida) is another. Biggs was a College student who announced on an online forum that he was going to suicide and provided a webcam link. He then took an overdose of benzodiazepines and opiates and over a period of hours, he died. Viewers posted messages, some trying to be helpful, others, insulting. Such technology allows people to share intimate details of their lives with strangers, and opens new chapters in the sociology of suicide.

Bullying has recently been identified as a trigger for suicide. Parents have stated that **Iain Steele** (15 years, died 2009, Chicago, USA) and **Chanelle Rae** (14 years, died 2009, Geelong, Australia) suicided as a result of bullying over the internet. The terms Cyber bullying and Cybercide have recently been coined.

A sociological view of suicide reveals that more is needed than improved antidepressants and mental health services. In the prevention of this behaviour, the problems of social inequality, sub-optimal employment and educational opportunities, legal and illegal drug use and other social evils and predicaments will need to be addressed.

For Durkheim, all ameliorative measures must be directed to the arrangement of social structure. In, Division of Labor in Society, he suggested the formation of occupational work groups (compact voluntary groups based on work-interests) as a means of building co-operative and supportive relationships. With work becoming less available and less a focus of individual identity, this suggestion may be old fashioned. Be that as it may, to prevent suicide, we need to find a means of integrating people, rather than providing pos-hoc integration of "patients" with "health professionals".

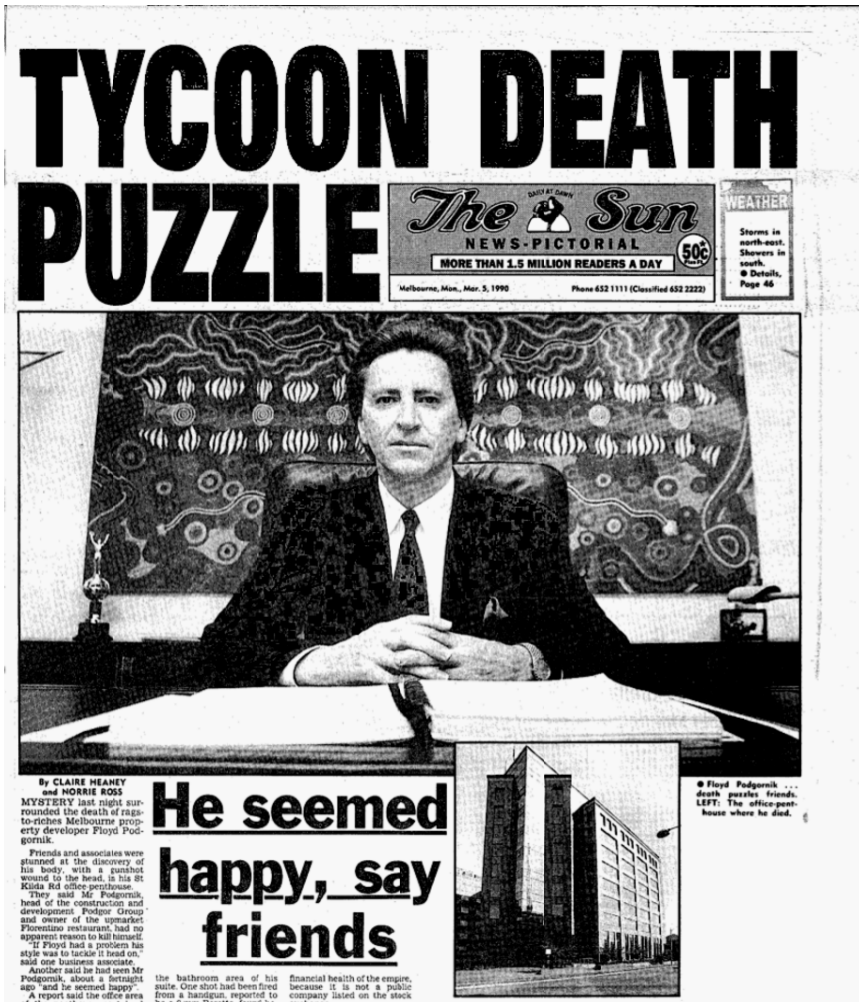
# CHAPTER 9

## LESS CLEAR PREDICAMENT SUICIDE

**Abstract**: Not infrequently, we read of an unexpected suicide, and examination of the available evidence offers no sign of mental disorder. It is argued that these are examples of egoistic suicide. Examples from the public record (Sedeq Hedayat, Alan Turing, Larry Walters, Carolyn Heilbrun, Hunter S Thompson, Ruslana Korshunova, and Branden Bremmer, among others) are detailed. Perpetrators of school shootings who suicide may also manifest egoistic components.

**"Man is more vulnerable to self-destruction the more he is detached from any collectivity, that is to say, the more he lives as an egoist"**

Durkheim, 1897


TYCOON DEATH PUZZLE

The Sun
NEWS-PICTORIAL
MORE THAN 1.5 MILLION READERS A DAY
Melbourne, Mon., Mar. 5, 1990
Phone 652 1111 (Classified 652 2222)

WEATHER
Storms in north-east. Showers in south.
Details, Page 46

By CLAIRE HEANEY and NORRIE ROSS

MYSTERY last night surrounded the death of rags-to-riches Melbourne property developer Floyd Podgornik.

Friends and associates were stunned at the discovery of his body, with a gunshot wound to the head, in his St Kilda Rd office-penthouse.

They said Mr Podgornik, head of the construction and development Podgor Group and owner of the upmarket Florentino restaurant, had no apparent reason to kill himself.

"If Floyd had a problem his style was to tackle it head on," said one business associate.

Another said he had seen Mr Podgornik, about a fortnight ago "and he seemed happy".

A report said the office area

He seemed happy, say friends

the bathroom area of his suite. One shot had been fired from a handgun, reported to

financial health of the empire, because it is not a public company listed on the stock

● Floyd Podgornik ... death puzzles friends. LEFT: The office-penthouse where he died.

**Fig 42.** Floyd Podgornic, unexpected suicide, 1990 (with permission).

Not infrequently, we hear of an acquaintance or read in the newspaper of an individual who has completed suicide for no apparent reason. Sometimes, even for those in close contact with the individual, the reasons for the death remain a mystery.

**Saxby Pridmore (Ed.)**

An example was **Floyd Podgornic**, (Fig 42) 50 years, a rags-to-riches multi-millionaire land developer who shot himself in his penthouse in Melbourne in 1990.

A common way of conceptualizing these suicides is to imagine them as the result of mental disorder which the individual did not disclose, or that she/he and others did not recognize.

It can be assumed that all those who suicide are distressed, but distress does not necessarily indicate a mental disorder. Shneidman (1993) proposed that suicide was associated with "psychache", a term he coined to describe psychological pain. He believed, "The problem of suicide should be addressed directly, phenomenologically, without the obfuscating variable of psychiatric disorder" (Shneidman, 1992).

Sociologists observe that while suicide appears to be a phenomenon relating to individuals, it is explicable with reference to social structure. The work of Durkheim (1897/1951) has been discussed in Chapter 8. He wrote, "…very often the normal person who kills himself is also in a state of dejection…" The individuals described in this chapter were considered "normal" by those who know them best, but of course, normal individuals experience periods of dejection and psychological pain.

Durkheim (1897/1951) described (Chapter 8) egoistic suicide as occurring when the individual is insufficiently integrated into society (due to conditions within the society, or the particular pursuits of the individual). He wrote that "excessive individualism" leads to a loss of meaning in life, with the result that the vulnerable individual "yields to the slightest shock of circumstances".

Durkheim (1897/1951) described (in Chapter 8) anomic suicide as occurring when society does not adequately regulate the "passions" (aspirations) of the individual, who in the end, "cannot escape the futility of an endless pursuit". Anomic suicide is frequently described in states of social chaos (examples include the suicide among some Aboriginal groups, among the peasants of economically challenged Kyrgyzstan, and the women of the war-torn Western Provinces of Afghanistan).

Perhaps relevant to **Floyd Podgornic** and some other individuals mentioned in this chapter, however, is the view of Durkheim that wealth bestows a sense of limitless power and that anomy (and anomic suicide) is the "chronic state" of "the sphere of trade and industry".

Chapter 5 dealt with suicide which occurs in the setting of massive damage to the reputation. In such cases, the trigger is obvious to the observer; usually the individual has behaved in a corrupt or otherwise illegal manner. In the current chapter, however, no such trigger is apparent. It is proposed that these deaths represent egoistic or anomic suicide; that unnoticed by others, these individuals were poorly integrated into, or regulated by society, making them vulnerable and primed to respond "to the slightest shock of circumstances".

## Examples from the public record

**Sadeq Hedayat** (1903-1951)

Hedayat (Fig 43), one of the most important Iranian writers, thinkers and reformers of recent centuries, was born to an aristocratic family in Tehran. In 2006, all his work, novels, plays, literary criticism and travelogues, were banned (in Iran).

**Fig 43.** Sedeq Hedayat, Paris, 1928 (public domain).

At about 6 years of age, Hedayat became introverted and avoided the company of other children. In his late teens he broke with his family. Although he occupied a room in his ancestral home for most of the rest of his life, he did not participate in family social activities. He attended St Louis Academy (Tehran) and was interested in the lives of great men and learning, and the French and English languages.

Hedayat was particularly interested in Omar Khayyam, Zoroaster and Buddha. At 21 years, he published his first work on the philosophy and writing of Omar Khayyam. At 22 years, he was sent with other gifted students to study in the west. The expectation was that these would return and as teachers.

He studied dentistry and then engineering for brief periods, but then returned to the study of literature and the arts.

At 24 years, Hedayat attempted suicide by throwing himself into the river Marne in Paris, but was rescued. He later wrote, “I did something really crazy, but luckily it did not do me in”.

At 27 years, Hedayat returned to Tehran and worked at the National Bank (3 years) and published a collection of short stories. He wrote progressive, anti-monarchy, anti-Islamic material, and criticized the conservative literati.

Hedayat led a small group of progressive intellectuals; “He was the centre and we were the satellites moving around him”, one remembered. At 33 years, to avoid criminal charges, he closed the group down and went to India to study religion. There, he met many prominent people, but when he started to be invited to palace

formalities, he returned to Tehran. He again worked at the National Bank, then for The Journal of Music and the Faculty of Arts.

Hedayat was reclusive by nature, and voiced his opinion about contemporary socio-political issues through essays and stories. He pointed to abuses of power by the monarchy and the clergy. In his late 30's, alienated and troubled by the social problems of Iran, he turned to alcohol and drugs. By 46 years he had lost his artistry and his writing had become thinly veiled abuse. He wrote, "The crux of the matter is that I am tired of it all…Nothing gives me incentive or comfort and I cannot deceive myself any more".

At 48 years he returned to Paris and 4 months later, he completed suicide using domestic gas.

In his masterpiece, The Blind Own, Hedayat wrote, "I have realized that a frightful chasm lies between others and me". There was no convincing evidence of mental disorder at the time he died. The predicament he was escaping was not a sudden loss or threat. He had voluntarily withdrawn from his own family and the broader community such that he derived no sense of support or meaning from interactions. He thought and wrote subversively such that he threw off the regulation (moderation) offered by society. Hedayat's life and death illustrated elements of Durkheimian egoism and anomy.


**Fig 44.** Alan Turing memorial sculpture (Wikimedia Commons).

**Alan Turing** (1912-1954)

Alan Turing was born in London. He is considered to be the father of computer science and received the OBE for breaking German military codes during WWII.

There was evidence of genius before he attended school; he taught himself to read in 3 weeks. He attended Sherborne School in Dorset, where he fell in love with another

boy (the affection was not reciprocated). He attended King's College, Cambridge, where he demonstrated outstanding ability. He obtained his PhD from Princeton University (USA) in 1938 (aged 26 years).

Turing was a fine athlete and ran marathons in near world record time.

During WWII he devised an electromechanical machine which was principally responsible for breaking the German Enigma Code. After the war he worked at Manchester University and made further important contributions on the field of artificial intelligence.

Turing was homosexual and in 1952 he was convicted of "gross indecency" (homosexual activity). He was given the choice of imprisonment or a course of hormone treatment (which was considered, at that time, to be an effective means of reducing homosexual libido). He accepted treatment. This conviction led to loss of his security clearance, which disrupted aspects of his work.

Two years later he completed suicide using cyanide applied to an apple. Since his death there have been many posthumous honours and celebrations of his work. In the above bronze sculpture (Fig 44) he is holding an apple.

"Alan Turing's death came as a shock to those who knew him. It fell into no clear sequence of events. Nothing was explicit – there was no warning, no note of explanation. It seemed to be an isolated act of self-annihilation. That he was an unhappy, tense person; that he was consulting a psychiatrist and had suffered a blow that would have felled many people – all this was clear. But the trial was two years in the past, the hormone treatment had ended a year before, and he seemed to have risen above it all. There was no simple connection in the minds of those who had seen him in the previous two years. On the contrary, his reaction had been so different from the wilting, disgraced, fearful hopeless figure expected by fiction and drama, that those who had seen it could hardly believe that he was dead" (Hodges, 1983).

Turing was not well integrated into ordinary society, not only because of his homosexuality, but because of his genius and personality eccentricities. Although, for many years, he belonged to an athletics club and interacted with fellow scholars, he was socially awkward, made inappropriate observations and did not pick up on social cues. His few close friends made allowances for him. The nature of his academic life defied the notion of limits and regulation. His death was unexpected by his friends and was probably reflected various egoistic and anomic factors.

**Larry Walters** (1949-1993)

Larry Walters (later known as "Lawnchair Larry") was born in Los Angeles (California). Little has been published about his early or later life. He had two sisters and had wanted to become a US Air Force pilot, but was rejected due to poor eyesight. He was a Vietnam veteran and subsequently worked as a truck driver. He never married (although he had at least one long-term female friend) and had no children.

In 1982, Walters fulfilled his boyhood dream. He made an "air craft", which he called *Inspiration I*, from a lawn chair and 45 helium filled weather balloons. In preparation for his flight he packed a parachute, sandwiches, beer, a CB radio, a camera and an air-rifle, with which to shoot the balloons, to enable him to land.

*Inspiration I* was tied to his car in San Pedro. When released it quickly rose to 16 000 feet (4.8 km) and drifted into controlled airspace near Long Beach airport. After flying for 45 minutes Walters shot some of the balloons and descended. Dangling balloon ropes caught in power lines, and blacked out a Long Beach neighbourhood. Authorities were furious and Walters was charged with various offences. He was convicted and fined US$ 4 000, but this was reduced on appeal to US$ 1 500.

For a time, Walters was a celebrity, giving motivational talks and appearing on television talk-shows. However, he made little money from his adventure. Later he hiked the San Gabriel Mountains and performed volunteered work for the United States Forest Service. "I love the peace and quiet", he said in 1988. "Nature and I get along real well". He shot himself in the chest and died (44 years) in the Angeles National Forest. He left no note, and his mother (Hazel Dunham) could give no reason for his suicide.

Walters was not strongly integrated into society, and preferred long periods of solitude. His life suggests egoistic suicide.

**Carolyn Heilbrun** (1926-2003)

Caroline Heilbrun was born in New Jersey. Described as "the mother of academic feminism", she was the author of many academic papers and books and 14 fictional detective novels (under a non-deplume).

Heilbrun graduated from Wellesley College in 1947, then attended Columbia University receiving her MA in 1951 and PhD in English in 1959 (33 years). She became the first tenured female professor at Columbia University. However, she resigned this position in 1992 (66 years) in protest against what she believed to be sexual discrimination (against a student).

She married James Heilbrun (an urban-economics professor) during WWII. They had 3 children, and all were on good terms at the time of her death. At 68 years, in spite of her loving marriage she bought a separate house for herself, away from the "family togetherness", a place she described as "small, modern, full of machinery that *worked*, and above all habitable in winter, so that I might sit in front of a fire and contemplate, meditate, conjure, and, if in need of distraction, read".

She disliked "chit-chat" and at 50 years of age she announced that henceforth her meetings with friends would be one-on-one (rather than bustling social gatherings). For years she stated that she planned to kill herself by her 70$^{th}$ birthday, expecting that the 60s would be "downhill all the way". However, at 70 years she wrote, "I entered upon a life unimagined previously, of happiness impossible to youth or the years of being constantly needed by both work and home. I entered into a period of freedom, and only at 60 learned in what freedom consists…".

At 77 years, while he husband was away, she took an overdose of medication, put a plastic bag over her head, and died.

Strenuous investigations reveal that she was not depressed, ill or facing unusual stressors at the time of her death. She was in the process of reorganizing the apartment which she shared with her husband and had submitted an academic paper in the previous week. Her son said that she was not unwell but "wanted to control her destiny". Her suicide note read, "The Journey's over. Love to all. Carolyn."

While influential, concerned with social conditions and with many friends, Heilbrun was highly individualistic and not strongly integrated into society in the ordinary sense. Nor did the rules and regulations of society constrain her thinking and responses.

**Hunter S Thompson** (1937-2005)

Thompson was born in Louisville, Kentucky. A highly successful journalist and the author of "Fear and Loathing in Los Vegas" (34 years), he lived an extraordinary life fueled with alcohol and other drugs, and moved in a wide range of social circles.

Thompson had a troubled early life. He was arrested for robbery at 19 years of age and as part of his penalty, he enlisted in the Air Force. His writing career began when he started an Air Force base newspaper. As a journalist he traveled widely. He was briefly a copy editor for Time Magazine. He spent a year riding with Hell's Angels, but left when they observed that he was making money from writing about his exploits with them, and wanted a share of his earnings. He took large amounts of alcohol, LSD, ether, adrenochrome, THC and other drugs. He was fond of guns and explosives, and kept a keg of gunpowder in his basement. A period of his life was made into a movie, and he was played by Johnny Depp. Thompson was famous for saying, "I hate to advocate drugs, alcohol, violence or insanity to anyone, but they've always worked for me".

Thompson married twice, his first marriage lasted 17 years. At the time of his suicide his son and daughter-in-law were in the next room and he was talking to his wife on the telephone (she was at the gymnasium). He shot himself in the head.

His suicide note read: "No more Games. No More Bombs. No More Fun. No More Swimming. 67. That is 17 years past 50. 17 more than I needed or wanted. Boring. I am always bitchy. No Fun – for anybody. 67. You are getting Greedy. Act Your old age. Relax – this wont hurt.

In accordance with his wishes, his ashes were mixed with fireworks and fired from a cannon mounted on the top of a tower into the night sky at his home in Aspen, Colorado.

Thompson was admired by many and reviled by some. He lived an unorthodox life and exhibited extreme individuality.

**Ruslana Korshunova** (1987-2008)

Ruslana Korshunova was born in Almaty, Kazakhstan. From the age of 17 until her death at 20 years, she was a world famous model, featured on the front cover of Vogue, Elle and other leading fashion magazines.

Korshunova grew up in Kazakhstan with her mother and brother. Her father died when she was 6 years of age. Korshunova spoke fluent Russian, German and English. When she was 15 years of age, a scout had noticed her picture in a magazine, in an article about an Almaty German language club, of which she was a member. She was immediately "signed up" by a modelling agency and rapidly rose to international fame. She sent money home to support her mother and brother.

Soon after retuning from a modelling job in Paris to her plush 9th floor apartment in Manhattan, and shortly before her 21st birthday, she cut a hole in netting around her balcony and leapt to her death.

Her modelling agency stated that she was hard working and reliable and "she was always happy". Her 24 year old boyfriend had dropped her off at her apartment several hours before her death and reported there had been nothing out of the ordinary. Friends remarked that she had been "On top of the world", and "She loved life so much. She was an angel". However, she is reported to have written notes on the Web page indicating discontent, including, "I'm so lost. Will I ever find myself."

While highly successful in the beauty and modelling business, it is likely that this young woman who was far removed from her roots was poorly integrated into a social environment which gave her security and meaning. Her fame and wealth removed the moderating effects of society which are experienced by those less privileged.

**Brandenn Bremmer** (1992-2006)

Brandenn lived in Venango (population, 165), Nebraska, with his parents. As a small boy his IQ was measured at 178. He did not talk until 15 months, at which point he began speaking in complete sentences (this phenomenon has also been described in the life of Einstein). He was home schooled so that he could learn at his own pace, and completed the high school curriculum at 10 years of age. He won piano trophies and released a CD of his own compositions at 12 years of age. He was a good looking youth, had an engaging manner and mixed easily with adults and other young people. At 14 years of age he shot himself in the head.

His suicide was a mystery to everyone. His mother remarked, "Brandenn wasn't depressed. He was a happy up-beat person. There weren't sudden changes in his behavior".

While a member of a loving family and well regarded by others, Brandenn's exceptional abilities may have worked to his disadvantage, making integration into, and regulation by society less effective.

**School shootings associated with suicide**

"Cynical shyness", an extreme form of shyness which appears particularly in males, has been recently described by psychologists (Carducci & Nethery, 2007). The authors suggest this condition as an explanation for high school shootings. It is proposed that this small group of shy people want to make contact with others, but

when they are rejected they become angry and vengeful. The notion is new and awaits substantiation, but is not inconsistent with the concepts of reduced integration and regulation by society.

It has also been suggested that to poorly integrated individuals, such events offer the perpetrator, "a shot at fame".

## Examples from the public record

Cynical shyness, revenge and a quest for fame could apply in the cases of **Thomas Hamilton**, 43 years, who killed 17 people before completing suicide at Dunblane Primary School (Scotland) in 1996, **Robert Steinhauser**, 19 years, who killed 15 people before completing suicide at the Erfurt school (Germany) in 2002, and **Seung-Hui Cho**, 23 years, who killed 32 people before completing suicide at Virginia Tech (USA) in 2007, among others.

## **The Jonestown suicides** (1978)

**James Warren (Jim) Jones** (1931-1978; Fig 45) was born in rural Indiana, USA. An only child, he was a gifted student and public speaker, but had difficulty making friends: "Jim Jones Always Led – Or Wouldn't Play" (Kilduff and Javers, 1978). From an early age he was interested in death and religion, and was keen to conduct funerals for animals. A voracious reader, his favourite subjects were Stalin, Hitler, Gandhi and Chairman Mao.

The facts of his life include the following (Reiterman & Jacobs, 1982; Hall, 1987; Kilduff and Javers, 1987)**:**
1948-9: graduated early and with honors from Richmond High School, Richmond, IN.
1949 (18 years): married and attended Indiana University at Bloomington. Later, moved to Indianapolis where he attended Butler University.
1951 (20 years): joined the Communist Party, USA.
1952 (21 years): became a student pastor in Sommerset Southside Methodist Church, however, he left when he was not allowed to integrate the congregation. Earlier, Jones had explored other churches (Quaker, Nazarene, Apostolic, and Church of Christ).

**Fig 45.** James Jones. (Retrieved from the website of the Jonestown Institute: http://jonestown.sdsu.edu.)

1956 (25 years): formed his own church (The People's Temple) in Indianapolis, IN. The Peoples Temple was initially structured as an inter-racial mission for the sick, homeless and unemployed. The congregation soon grew to over 900.
1960 (29 years): The People's Temple joined the Disciples of Christ (a mainline Christian denomination). Jones was appointed Director of Human Rights Commission, by the Indianapolis Democratic Mayor, Charles Boswell. In this position he desegregated movie theaters, restaurants, hospitals, the telephone company, and the city police force.
1961 (30 years): the Joneses were the first white couple (in their region) to adopt a black child. Earlier they had adopted a part-Native-American girl and 3 North Korean-American children. Subsequently, they adopted a white boy and had one biological child (male).
The Jones family was harassed in Indianapolis. Jones became concerned about a possible nuclear war, and read that is such an event, among the safest places on earth would be South America and southern California. He took his family to Brazil and worked in the slums of Rio de Janeiro.
1964 (33 years): Jones was ordained.
1965 (34 years): advised that the People's Temple in Indianapolis was floundering in his absence, he returned.
1967 (36 years): relocated People's Temple to northern California, then (1971) to San Francisco.
1970s-early (around 40 years): Jones stated he was an atheist. He began to deride religion and wrote critically of the Bible (Jones, undated).
1975 (44 years): appointed Chairman of the San Francisco Housing Authority, by Mayor George Moscone.
1976: (45 years): Jones met several times with First Lady Rosalyn Carter. He also met privately with Walter Mondale, Presidential Candidate. Awarded a testimonial dinner, attended by Governor Jerry Brown, where he was likened to Martin Luther King and Chairman Mao.
1977 (46 years): investigated for religious tax exemption infringements, and alleged criminal diversion of donations for his personal use. Aware that Marshall Kilduff was seeking to publish an expose claiming physical, emotional and sexual abuse of the congregation, Jones relocated about 1000 people to a 4000 acre Peoples Temple Agricultural Project, Guyana (construction had begun in 1974).
1978 (47 years): Public concerns were raised in the USA about the well-being of members of the People's Temple, for example, by a group of 'Concerned Relatives', mainly people who had left the organization and were unable to obtain access to kin who had remained.
November 17: Congressman Leo Ryan on a fact-finding mission, a group of journalists and some people seeking contact with their relatives, arrived at Jonestown. About 15 People's Temple members indicated a wish to leave with the visitors.
November 18: Ryan was attacked by a man with a knife. This brought the visit to an end. When Ryan and those leaving with him arrived at the isolated airport, People's Temple security staff opened fire, killing Ryan, 3 members of the press and one departing People's Temple member. Others were wounded.
Later that day, over 900 members of the People's Temple died. The majority suicided by drinking juice laced with cyanide, some appear to have been injected with cyanide and others, shot. Jones died by shot to the head.

**The deaths of the People's Temple members.** Jones preached a sermon before and during the suicide of the People's Temple members. This was recorded and has been transcribed (Jones, Tape Q042). Jones had also recoded hundreds of other sermons, which are available through the Jonestown Project: San Diego State University.

While some members may have been murdered, most agree the majority were not subjected to physical violence. Members had over years, rehearsed mass suicide, in exercises which they called "White Nights". While some of these were known by the members to be dress rehearsals, on some occasions, members took what they believed to be poison, only to be subsequently informed by Jones that they had not been given poison, but their faith had been tested. Also, Jones had developed a theory of "Translation": he believed that if the members died together they would be moved to another planet where they would live in bliss.

On November 18, Jones told the members, that because of the murder of Ryan and the others, government forces would parachute in and torture and murder them.

He told members "Don't be afraid of death" and that death was "just stepping over into another plane". He said "Let us die with dignity", and "We didn't commit suicide, we committed an act of revolutionary suicide protesting the conditions of an inhumane world".

Thus, there was coercion. Be that as it may, the majority performed the acts which ended their lives, and are considered to have completed suicide.

These people were in a difficult predicament. They believed that in retribution for the recent murders, they would be tortured and then murdered. Accordingly, elements of fatalistic suicide could be applied. Also, Jones stated in his last sermon (Jones, Tape Q042) that they were making a political statement, "an act of revolutionary suicide protesting the conditions of an inhumane world". It is possible there were elements of altruistic suicide.

**The death of Jones**. Jim Jones appears to have shot himself in the head. A minority speculate that he instructed someone to shoot him, but there is no meaningful difference. Evidence indicates that Jones was an unusual person. He had difficulty forming close, equal friendships. He was expert in controlling others; to this end he prevented families living together so that the most important relationship for each individual was with him.

His morality was flawed. Jones forbade sexual activity between man and wife, yet he voraciously engaged in sexual activity with both male and female members. On one occasion he had public sex with a man, which he claimed, demonstrated the homosexual tendencies of the other man. Over many years he made extensive use of illegal drugs.

Jones believed in communism. The direct expression of this belief in the USA was problematic. During one sermon (Jones, Tape Q134) Jones told the congregation that he had asked himself, "How can I demonstrate my Marxism?" and that he came to the answer "…infiltrate the church". It is probable that Jones was attracted to both communism and religious ideas, that he wove them together and that at different times and places, his activities highlighted one over the other.

Jones can be dismissed as a maladjusted, manipulative psychopath. However, at least in the early years, he was preaching a 'social gospel' of human freedom, equality, and love, which required helping the lowliest of society's members. He held important

positions (Director of the Human Rights Commission, Indianapolis, and Chairman of the San Francisco Housing Authority) through which he achieved benefits for the disadvantaged. Jones had some psychopathic, narcissistic traits, but these do not provide a complete description.

Jones has also been dismissed as "paranoid" and mentally disordered. No doubt his mental state was impaired by illegal and prescription drug use. But, many have studied the events of his life and death, and the case for a primary mental disorder has not been seriously argued.

Jones was a clever man with good public speaking abilities who had trouble making friends. He was attracted to religion and communism. These areas may have provided him with some sense of having contact with people and contributing positively to the lives of others (even though they were not friends in the usual sense of that word). He succeeded in becoming prominent and influential. As time passed, he moved from preaching Christianity with a social flavor, to preaching Apostolic Socialism (Layton, 1999).

In the end, Jones was in a difficult predicament. He was involved in murder and there would be consequences. Similarities, of course, exist between the death of Jones and the deaths of other members of the People's Temple; fatalistic and altruistic elements may have been present.

Distinct from the other members of The People's Temple, however, we have some details of the life and personality of Jones. As a man who had never established close, reciprocal friendships, and whose activities had not been moderated by societal limits and norms, his death appeared to have incorporated elements of both egoistic and anomic suicide.

## Conclusion

This chapter addresses the suicides of people with no evidence of mental disorder, which have frequently occurred in the absence of readily apparent reasons/triggers. Durkheimian theory describes the importance of social integration and regulation of the individual, with reduced integration leading to egoistic suicide, and reduced regulation leading to altruistic suicide. These ideas fit well with most of the individuals detailed here.

The people described in this chapter were "different", or eccentric. Eccentricity does not perforce indicate mental disorder, or a predisposition to suicide. However, eccentricity tends to be associated with reduced social integration, and this can expose the individual to a loss of meaning in life and to greater risk of egoistic suicide.

Durkheim (1987/1951) believed that in the world of trade and commerce, anomy is a chronic state. He based this belief on the observations that great wealth removes limits, and that the ethos of trade and commerce is one of progressive accumulation. A lack of limits may expose the individual to the exhaustion and disillusionment of endless pursuit. Such anomy may have played a role in the suicide of Floyd Podgornic.

For most of the other individuals described above, personal attributes removed limits: the genius of Hedayat, Turing and Bremmer removed the intellectual constraints of the common man, the beauty of Korshunova opened doors closed to others, while Heilbrun and Thompson simply refused acknowledge the authority of doors.

In the case of Jones, the evidence indicates a wide range of influential factors, and scholars may debate which was the most influential. He was at risk of serious legal consequences, thus it may be argued that the trigger for his suicide was clear. However, he is included in this chapter because of his egoistic features, which in all likelihood played an important part. (The suicides of the members of the People's Temple are included in this chapter because it is difficult to discuss them in isolation from Jones.)

The cases of the murder-suicides of Hamilton, Steinhauser and Cho also present complex puzzles. These individuals were "outsiders" who had made efforts to connect with others, but had remained "detached from society". In addition, in the murder of others, these individuals demonstrated their rejection of the regulations offered by society.

# CHAPTER 10

# A TYPOLOGY OF SUICIDE

**Abstract**: Suicide is an escape option from predicaments. Two predicaments are conceptualized, 1) the presence of mental disorder, and 2) external factors. These may co-occur. From the perspective of the observer, the predicament may be very clear or less clear, leading to 4 types of suicide. Examples are also provided.

**"In many cases, the suicidal impulse is a temporary phenomenon – one that will pass. We must be on guard not to lose ourselves or talented colleagues in a fleeting moment of despair."**

Sansone and Sansone (2009)

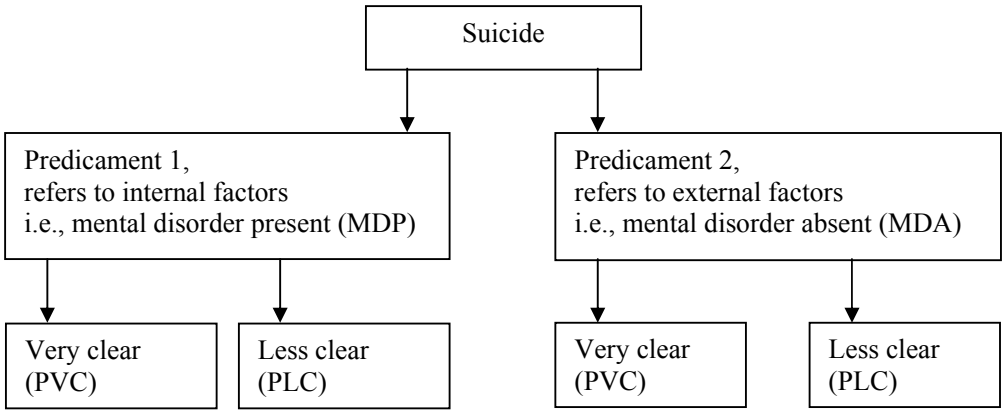



**Diagram 2.** A typology of suicide

Suicide is an option by which the individual extracts her/himself from a predicament (an unpleasant set of circumstances with limited extraction options).

Suicidogenic predicaments take two forms: Predicament 1 refers to "internal factors" by which is meant a mental disorder is present (MDP) and is the primary driver of the suicidal behavior, and Predicament 2 refers to "external factors" by which is meant mental disorder is absent (MDA) and the primary driver of the suicidal behavior is external factors. A combination of these predicaments is common.

For the observer, each predicament takes two forms: the predicament is very clear (PVC) or less clear (PLC). Thus, there are 4 types of predicament/suicide.

| Predicament 1 | | Predicament 2 | |
|---|---|---|---|
| Type 1 suicide | Type 2 suicide | Type 3 suicide | Type 4 suicide |
| Berg, Erin (1) | Wyrzkowski B. (6) | Blanchard, E (5) | Hedayat, Sadaq (9) |
| Cumerford, Dan. (6) | Estrada, Gilberta (6) | Boorda, "Mike" (5) | Heilbrun, Carol. (9) |
| Dragun, Charm. (6) | Gobbert, Carl (6) | Ivins, Bruce (5) | Korshunova, R. (9) |
| Hemingway, E. (6) | Shoobridge, P. (6) | Judas (3) | Sutch, Lord (8) |
| McMullen, S. (6) | Tologanak, J (6) | Kelly, David (5) | Thompson, H. S. (9) |
| Van Meter, V (6) | Lawrence, R (6) | Priklopil, Wolf. (5) | Turing, Alan (9) |
| Wilton, Greg (6) | | Samson (1) | Walters, Larry (9) |
| Enke, Robert (6) | | Roh Moo-hyun (5) | FitzRoy R. (7) |

**Table 5.** Examples of suicides arranged according to type. (Numbers refer to chapters).

**Saxby Pridmore (Ed.)**

This typology allows the ordering of the suicides of individuals (Table 5).

**Type 1 suicide (MDP-PVC)**

For this type of suicide mental disorder is present and is the primary driver of the suicide. There are a limited number of such cases on the public record. Mental disorder tends to reduce the ability of the individual to lead an illustrious career, and thus, the suicides of people with mental disorder are less likely to be extensively reported in the media.

However, suicide is more common among people with mental disorder than people without mental disorder, and all mental health professionals can recall numbers of people who have completed suicide as a result of mental disorder.

**Type 2 suicide (MDP-PLC)**

It can be reasonably assumed that unrecognized/untreated mental disorder is the major driver of some cases of suicide. However, designating cases as being of Type 2 suicide is a retrospective and speculative process and accuracy is therefore greatly limited. The current author has designated only 6 cases as being Type 2 suicide, and in the first 4 cases the unexpected death was preceded by the murder of dependent children.

The 5$^{th}$ case is Julien Tologanak (Chapter 6); a young man was taken into custody under a Mental Health Act by the Royal Canadian Mounted Police, and conveyed to the Stanton Territorial Hospital in Yellowknife. However, he was released on the same day and jumped from a light aircraft 7 km about the ground. Initial evidence suggests Julien's predicament (paranoid mental disorder) and possible choice of action was recognized by police but not by clinical staff. The 6$^{th}$ case is Rebekah Lawerence (Chapter 6), a young woman who may have had a pre-existing mental disorder, who appears to have been tipped into psychosis by a self-development course.

Claims that almost 100% of suicide is due to mental disorder (Bertolote *et al.*, 2004), depends on retrospectively designating the majority of suicides as Type 2 suicide. In this book, arguments against this practice have been presented.

**Type 3 suicide (MDA-PVC)**

In Type 3 suicide, the predicament does not involve mental disorder, but external factors, and these are very clear to the observer. Examples include people dealing with painful, terminal illness, and formerly high-profile individuals who have experienced reputation damage as a consequence of the public exposure of immoral behavior.

This document contains many examples from the public record. Such accounts are "newsworthy" and eagerly reported.

However, this category also contains less newsworthy individuals and less dramatic examples. Many suicides follow breakdown of marriage/partnerships, and business

failures. Should these suicides be designated as the consequence of an "adjustment disorder" (a mental disorder of very doubtful validity) they will be placed under Type 2 suicide.

There can be debate over what constitutes a "very clear" and a "less clear" predicament. It can be argued that a broken relationship is an "insufficient" justification for suicide, and therefore such suicides should not be designated "very clear". **Brodie Panlock** (Chapter 8) suicided in response to bullying at work, but many people in similar situations do not choose this escape option. It is impossible to be certain of the impact of certain events on particular individuals. The recommended approach is that when there is no mental disorder and a clearly distressing event has preceded the suicide, it be classified as Type 3 suicide.

## Type 4 suicide (MDA-PLC)

In Type 4 suicide there is no mental disorder present, nor is there known (to others), a clear and distressing preceding event. However, all behavior is motivated and such suicides probably represent escape from a predicament which is less clear to the observer. The capacity for relatively minor (or, less clear to the observer) events to trigger suicide is attested by both psychodynamic (Zilboorg, 1936) and sociological theory. Durkheim (1897/1951), in discussing individuals less than adequately integrated into society states, "The individual yields to the slightest shock of circumstances because the state of society has made him a ready prey to suicide".

The "less clear" predicament is "less clear" to the observer, not to the individual who completes suicide. It is less clear because the observer does not have a complete knowledge of the individual's mind and recent experiences. It is recommended that Type 4 suicide be designated when mental disorder is not present and only minor events or no known adverse events have preceded the death. When no adverse events are known to have occurred, it is reasonable to assume that events have occurred which were of significance to the individual, but which have not been identified by the observer.

## Conclusion

This 4 category typology of suicide is consistent with information derived from clinical experience, the public record, psychodynamic and sociological theory, and some recent scientific scholarship and research (Horwitz & Wakefield 2007; Jacob, 2008; Maselko & Patel, 2009). It has the advantage of allowing suicide to be categorized without recourse to faulty medicalization. It is inconsistent with work based on psychological autopsy (Bertolote *et al.*, 2004), but offers a credible alternative to the current conceptualization of suicide.

# CHAPTER 11

# A SUICIDE PATHWAYS MODEL

**"It is silliness to live when to live is torment".**

Shakespeare, 1642

**Abstract**: In this chapter, the medical, sociological and medicalization models are drawn together. Stressors (predicaments) have an impact on vulnerable individuals. Vulnerability takes two forms, one from the sociological perspective (due to the regulations and support provided by society) and the other from the medical perspective (due to nature and nurture factors). These vulnerabilities reinforce each other and lead to the central element of distress. Three aspects that may be considered here are; i) distress can be called a mental disorder (medicalized) and if suicide results, the death is incorrectly attributed to medical disorder. ii) distress can lead to mental disorder and if suicide results, the death is correctly attributed to mental disorder, and iii) distress can lead directly to suicide, and mental disorder is not involved or mistakenly thought to be involved. In this latter pathway, when distress is clear to others, the suicide is akin to rational suicide. When distress is less clear to others, the suicide is akin to egoistic/anomic suicide.

This chapter draws together material which has been presented in earlier pages.

## The Mental Disorder Model of Suicide

Chapter 6 informs that suicide is more common among those with mental disorder than among those without mental disorder. The suicide literature presents a view that 98% of those who complete suicide have a mental disorder. Chapter 2 argues that this estimate is unduly elevated.

The simplest form of the mental disorder model of suicide states that people suicide because they have a mental disorder, i.e., suicide = mental disorder, and, mental disorder = suicide. Many 'authorities' consider suicide and mental disorder to be synonymous (Diagram 3).

It is true that in rare cases, mental disorder can lead directly to suicide. However, in most cases, this equation can be unpacked to provide a more sophisticated understanding. Usually, environmental "stressors" can be identified. When stressors impact on vulnerable individuals they give rise to distress. (Vulnerability, in this medical model context depends on the genetic makeup and life experiences.) When distress persists and perhaps worsens, it is sometimes possible to make a diagnosis of a mental disorder. If this disorder is untreated or unresponsive to treatment, and is sufficiently painful, suicide may be completed as a means of escape (Diagram 3).

In very rare cases of psychotic illness, suicide may be completed not as an escape, but in compliance with hallucinatory directions or delusional expectations.

**Saxby Pridmore (Ed.)**

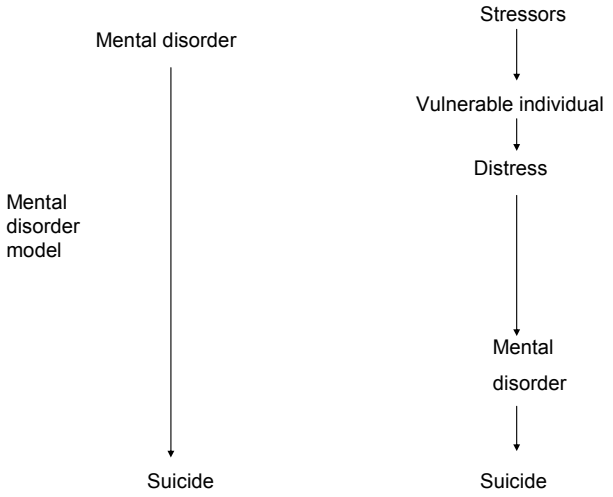



**Diagram 3.** The simple (left) and detailed (right) relationship of mental disorder and suicide.

## The Sociological Model of Suicide

Chapter 8 presents sociological information. As given in the Durkheimian model, when stressors impact on individuals, two sorts of vulnerable individuals will attempt suicide. Vulnerability, in this sociological context means that 1) those who are insufficiently socially integrated may complete egoistic suicide, and 2) those who are inadequately regulated by society may complete anomic suicide (Diagram 4). Durkheim stated that egoistic and anomic suicide are inextricably interwoven and that, "Both spring from society's insufficient presence in individuals".

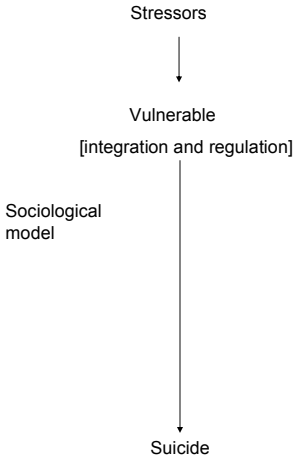



**Diagram 4.** The sociological model of suicide

Durkheim was mindful of the importance of personality and individual psychopathology (that is, vulnerability in the medical context). Using the terminology

of the day he stated, "…neurasthenia may reasonably predispose to suicide; by temperament, neurasthenics seem destined to suffer". However, he looked beyond the individual to society: "(while)…neurasthenia may predispose to suicide, it has no such necessary result".

## A Medicalization Model of Suicide

Chapter 7 discusses medicalization. This process occurs when a non-medical problem is incorrectly labeled as a medical problem. In this model of suicide, stressors acting on a vulnerable (from either or both the medical and sociological perspectives) individual produce distress. This distress is called "depression" or some other mental disorder by the individual, another lay person, or a health professional. Should the distressed individual then complete suicide to escape their predicament, that suicide will be (incorrectly) attributed to a mental disorder (Diagram 5).

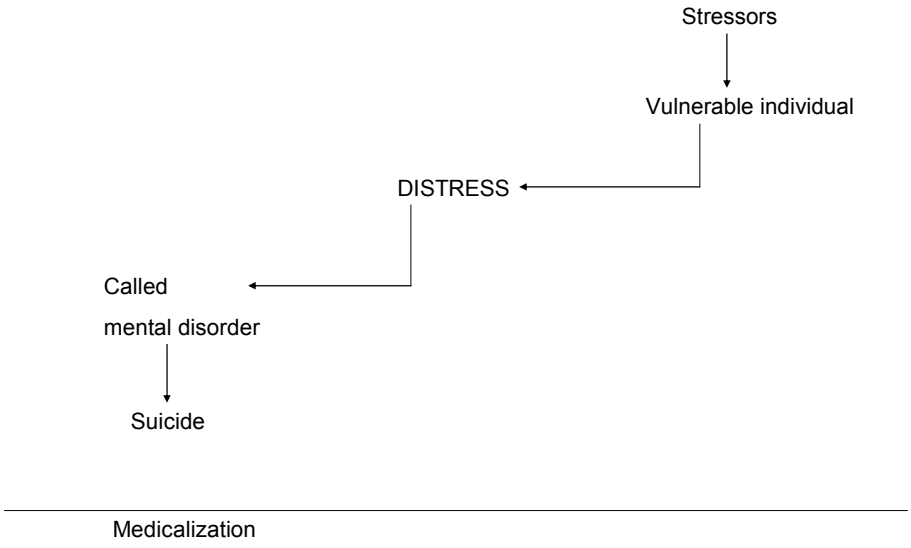



**Diagram 5.** A medicalization model of suicide

## A Combined Suicide Pathways Model

The mental disorder and sociological models are not antithetical. Both acknowledge a role for external stressors, but the sociological model claims a more potent role for "slight shocks". Both acknowledge a category of vulnerable individuals. In the mental disorder model, vulnerability is primarily a feature of the individual; in the sociological model, vulnerability is a feature of the relationship of the individual and society. These vulnerabilities compound each other. In discussing why one individual may attempt suicide and another may not, Durkheim wrote that the "…mental constitution, as elaborated by nature and events, offers less resistance to the suicidogenic current".

In this combined suicide model, distress is the central driver and suicide may result *via* one of the three pathways. First, mental disorder may lead to suicide, and this can be termed mental disorder suicide. Second, when there is no mental disorder, distress has been called a metal disorder and subsequent suicide has been attributed to a mental disorder, this can be termed medicalization suicide. Third, when there is no mental disorder or incorrect claim of mental disorder, and the individual suicides to escape a predicament, this can be termed a non-mental disorder suicide.

This latter pathway is viewed as having two sub-types; in one, the stressor may be minimal and social integration and regulation are inadequate (egoistic and anomic suicide), and in the other, there has been significant stress. This latter sub-type could be called altruistic or fatalistic suicide (depending on the circumstances) by Durkheim, or rational suicide by others. Rational suicide conjures the notion of long and deliberate contemplation, although this is not necessary by definition. To avoid the notion of long deliberation, in the current model, the term "reaction" suicide has been used.

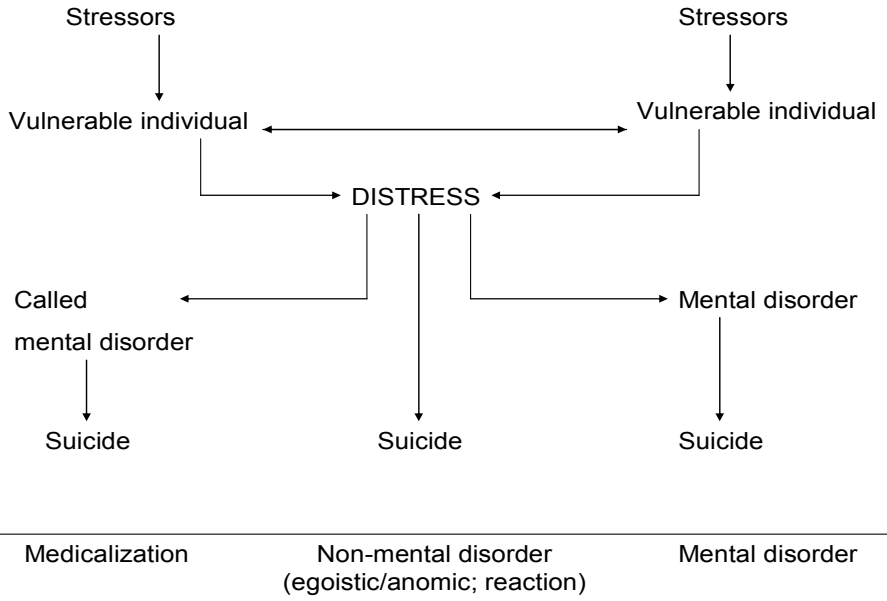



**Diagram 5.** A combined suicide pathways model. See text for details.

## Conclusion

Suicide may be a response to either (or both) mental disorder and environmental stressors. Both cause distress, which is the central element of the combined suicide pathways model. Distress has three run-offs: 1) mental disorder, 2) non-metal disorder (egoistic/anomic; reaction), and 3) medicalization (diagnosed incorrectly as mental disorder), and all may end in suicide.

The term predicament has been withheld from this model for the sake of simplicity. In the combined pathways model, the predicament can be conceptualized at various levels. Both the stressors and the distress they create can be considered the predicament. In the case of those who develop a mental disorder, this becomes autonomous and can be considered the predominant predicament.

The predicament model of suicide (Chapter 2) and the combined pathways model of suicide are separate but supplementary; one dealing with etiology and the other with the way the completed suicide is labeled and reported. The typology of suicide (Chapter 10) is again, separate but supplementary, providing a convenient method of classification of type.

# CHAPTER 12

# RATES OF SUICIDE

**Abstract**: The suicide rates of different groups are different and relatively stable. This fact cautions against simplistic explanations and quick-fixes for the problem of suicide. The global suicide rate remained relatively stable from 1960 to 2000, however the gender gap widened. In western and English speaking countries, the male suicide rate is around 3 times greater than the female. Globally, there is an increase in suicide rate with age, but in western and English speaking countries, there is bimodality, with one peak for young adults and another for the aged. The much publicised increase in suicide rate among the young has receded since 1997. Individual nations have different, relatively stable suicide rates. There are very high suicide rates among some indigenous people (the Inuit of Canada and Greenland, the First Nations of North America, the Maori of New Zealand and the Aborigines of Australia), which can be attributed to exposure to a "dominant culture".

**"Comment is free, but facts are sacred."**

C P Scott (1921)

The suicide rates of different groups are different, and relatively stable. This chapter supports these facts. They caution against simplistic explanations and quick-fixes for the problem of suicide.

The suicide rate is the number of completed suicides per 100 000 population. Rates can be determined for the total population of a country or region, for gender, age group (e.g., 15-19, 20-24, 25-29 years, etc), year/period of birth, religion, employment or marital status, for a point in time, or for a period of time, the list of boxes is extensive. These can be combined and compared, so the amount of "results" is limitless. In this chapter, however, we will exercise self-control and concern ourselves only with the basics.

As with all biological and scientific studies, there is normal variation in suicide rates, and (in spite of best efforts to the contrary) some experimental error.

Sources of error include administrative and data collection issues. Suicide is a legal, rather than a medical finding. That is, suicide is a cause of death which is "found" after a legal process, such as a coroner's inquest. As suicide is usually a private activity, the legal process is often hampered by lack of witnesses and "proof". It is probable that at least some court decisions are wrong. In places where suicide is stigmatized (not to mention religiously forbidden), for the sake of surviving relatives, when there is doubt, findings other than suicide may be made. Legal systems differ from place to place; some jurisdictions have options such as 'open finding', 'death by misadventure', etc, which others do not. Thus, the legal structure may introduce complications. Also, the coronial process may take years, so that decisions are delayed, and slightly different rates for the same year may be published over time, due to the eventual completion of outstanding cases.

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[The importance of stigma of suicide was demonstrated in the aftermath of the September 11 attacks on the World Trade Centre. Hundreds of people jumped to their deaths. One image taken by Richard Drew, became known as "The Falling Man". This person was 'identified' as the father of a Catholic family. The family was outraged; one daughter telling a reporter, "You're saying that his soul is damned. You're telling me he's in hell." They moved house to avoid the issue. Eventually, the falling man was identified as someone else (TIMESONLINE, 2006).]

Further, the classification of suicide depends to some extent on medical coding systems. A prominent coding system is the International Classification of Diseases (ICD). Revisions occur from time to time, and these may impact on published rates. A sudden increase in suicide rate was reported in Australia in 1997. The Australian Bureau of Statistics recently stated that this apparent increase was probably influenced by the move from the ICD 9$^{th}$ Edition (ICD-9) to ICD-10.

Finally, a well established principle of statistics is that if one looks at data repeatedly, from ever more different angles, eventually, an event which occurred by chance will be discovered and interpreted as having not been possible by chance (and event will then be called statistically significant). Caution is necessary when we progressively divide the data in search of 'positive' findings, for eventually, we will find some/one (Taleb, 2001). Nevertheless, one of the aims of epidemiology is to find changes/trends which can alert us, and even point toward etiological factors. We need to balance the fact that repeated 'looks' will eventually produce some 'positive' finding/s, with the need to apply fine analyses to data so as to identifying 'at risk' sub-populations.

A recent USA study (Hu *et al.*, 2008) reported that "Whites aged 40-64 years have recently emerged as a new high-risk group for suicide". This comes after years of work which established that the young and the old are at greatest risk. The Los Angeles Times (2008) asked a range of experts, some connected and some not connected to the study, about these results. Offered explanations were, 1) a recent increase in drug abuse (but no explanation as to the cause of that), 2) a decrease in the use of hormone replacement therapy, and, 3) the aftermath of September 11, 2001. None suggested this unusual result could be a chance finding in a setting of repeated examinations. Only further work will indicate the importance of this finding.

It is best not to 'jump at shadows'. Given normal variation, experimental error, the legal system, the medical classification system, and that we have numerous 'looks' at the data to identify 'at risk' sub-populations, it is unwise to place excessive importance on the findings of a single year. The newspapers often make this mistake (albeit with the assistance of a 'media-savvy' academic) in the quest for a good story. Some examples are given later in the chapter.

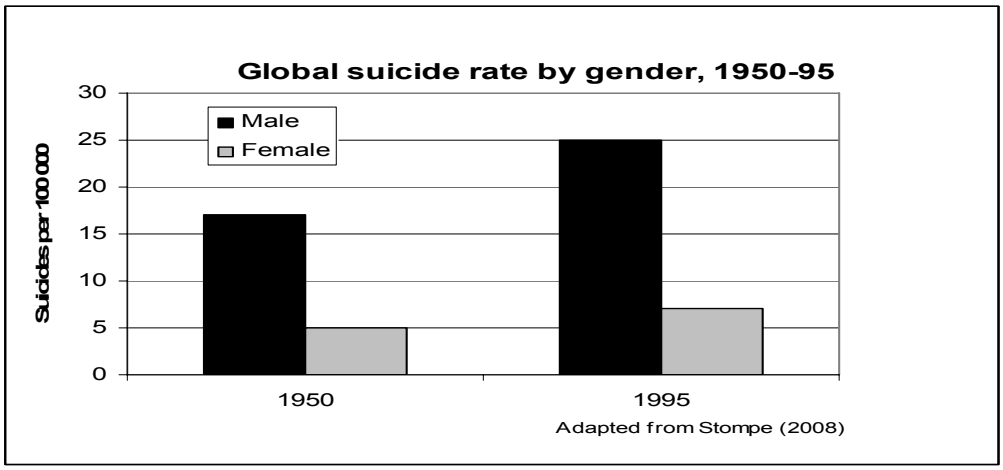
## Global trend

A comprehensive study of 32 countries, (De Leo and Evans, 2003) found the suicide rate remained relatively stable from 1960 to 2000. There was a 7% increase in the male rate (up to 17.6 in 1995-99) and a 27% decrease in the female rate (down to 5.6 in the same period).

Most countries experienced a substantial increase in the suicide rate of adolescents (15-24 years) during the 1980s and 90s, but since 1997, there has been a clear rate decline.

## Rates by gender and age group

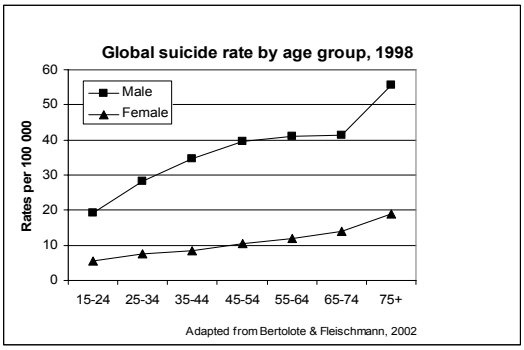
Males have a higher suicide rate than females in every country, with the exception of China (Phillips *et al.*, 1999), where rural women contribute greatly to the total. World wide males complete suicide about 4 times more than females. Recent work indicates that cultural norms and expectations underpin this general population difference, but that among people with a history of mental disorder, this difference is greatly reduced (Liu *et al.*, 2009).



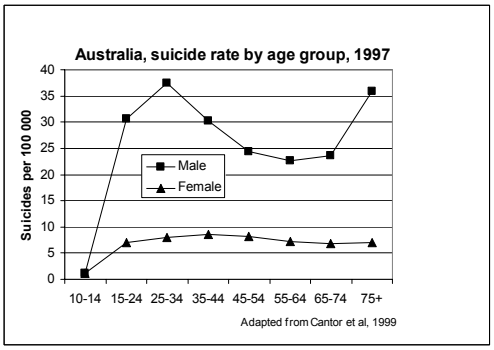

**Graph 1.**

Graph 1 shows the global gender difference for two time periods, 1950 and 1995 (1995 could be considered relatively recent). It illustrates the consistently higher rate of male suicide. This graph does not show the 27% decrease in the female rate mentioned above, because much of that decline occurred in the last dozen years. This serves as a warning of the need for caution when considering the epidemiology of suicide.

An aside: for mental disorder to be the primary driver of suicide, mental disorder would need to 3.6 times greater in males than females, but this is not the case. For example, 'depression', the mental disorder most commonly identified as associated with suicide is 1.5-3 times more common in females than males (Kaelber *et al.*, 1997). Instead, there are physiological differences, probably sex chromosome factors (Fiori *et al.*, 2009) and culturally prescribed ways of behaving which probably explain the higher suicide rates in males.




**Graph 2.**




**Graph 3.**

Globally, there is a gradual increase is suicide rate with age (Graph 2; Bertolote & Fleischmann, 2002). However, in many western countries, including the UK, USA and Australia (Cantor *et al.*, 1999) there are two peaks, one in adolescents and early adulthood and one in old age.

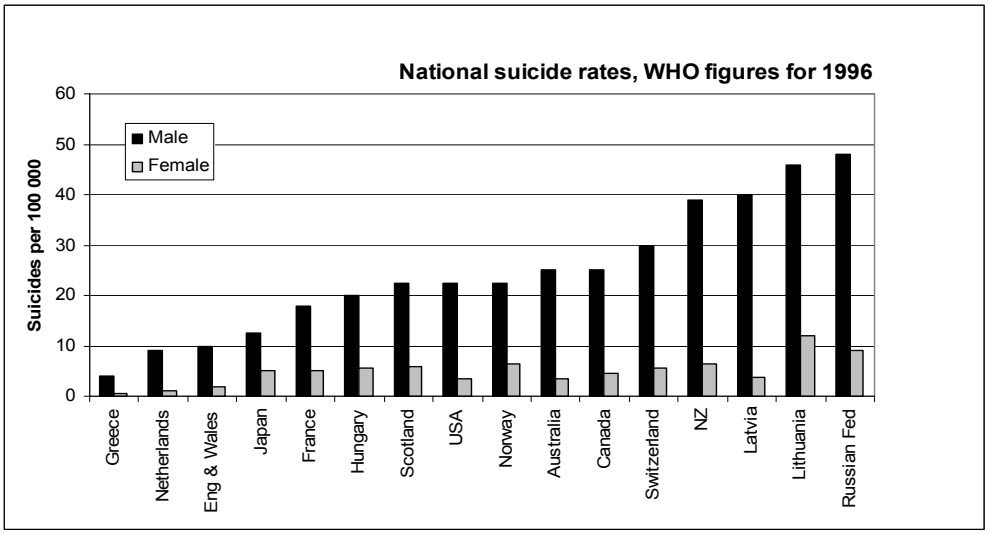
The peak in old age is probably influenced by the loss of spouse and other social contacts, the capacity for independent living, and the burden of chronic, often painful disorders (Carney *et al.*, 1994). However, there has been a decrease in the suicide rate in the 65+ group in many countries since the early 1990s. In Australia, at least, this appears to be related to increased services to this group, in the form of greater community support and availability aged care beds, and the creation of respite care and carer's benefits.

The peak in adolescent and early adulthood suicide rates in western countries is likely to be influenced by cultural factors; this is a life period of increased activity, independence, a range of challenges and alcohol consumption. Following a global increase in rate, there has been a global decrease in suicide in adolescent and early adult suicide over the last decade (De Leo & Evans, 2003; National Institute, 2008; Pompili *et al.*, 2009).

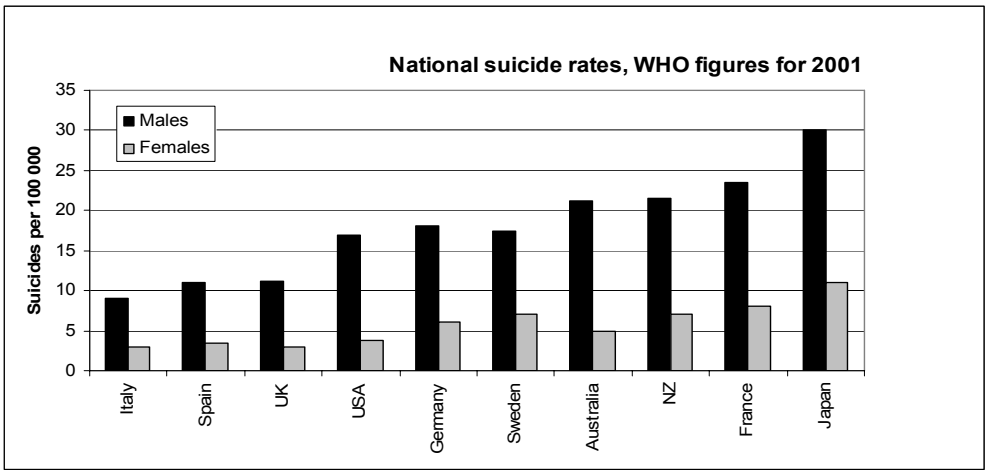
## National Rates

The suicide rates of the nations of the world maintain a fairly constant relationship. There is need for some caution when examining this information, of course, as rates are impacted by the different systems of counting and classifying in different countries, and the most recent figures published by nations may relate to different points in time (there may be up to 6 years difference). Nevertheless, there are clear national rate differences: the suicide rates in the Russian Federation and Lithuania, are always higher than those in the USA and Australia, which in turn, are always higher than those of Italy and Greece.

To illustrate this point, World Health Organization (WHO), national suicide rates are presented in the flowing graphs for two periods of time, 1996 (Graph 4) and 2001 (Graph 5).

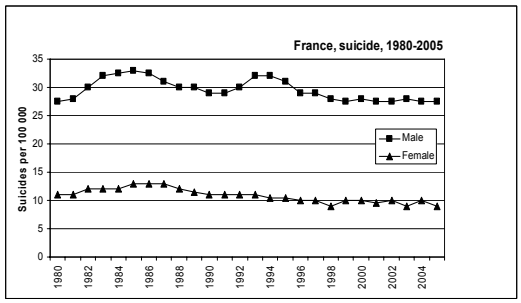



**Graph 4.**

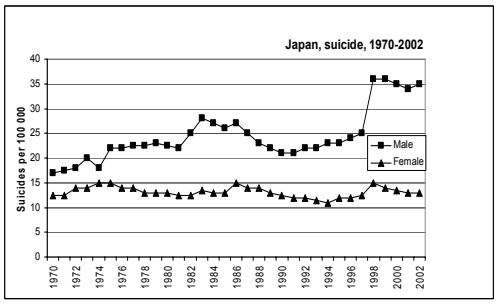



**Graph 5.**

Comparing these two time periods, the USA continues to have a lower rate than Australia, which continues to have a lower rate than NZ. However, France and Japan, which had lower rates than the USA in 1996, moved to the right, and presented higher rates than NZ in 2001. In the case of France, this was because the figures of that nation remained stable (Graph 6), while those of the USA, Australia and NZ fell slightly. In the case of Japan, this was due to an increase in the rate of suicide (which has been attributed to a decline in economic prosperity; Graph 7).




**Graph 6.**




**Graph 7.**

The relatively constant relationship of the nations with respect to suicide rates was noted by (and influenced the theories of) Emile Durkheim in 1897. Details of national rates of selected countries for the years from 1921 to 1988 are presented in Table 6. (Diekstra, 1993).

| | 1921-25 | 1951-54 | 1961-7 | 1972-4 | 1982-4 | 1987-8 |
|---|---|---|---|---|---|---|
| Austria | 28 | 23 | 22 | 24 | 28 | 25 |
| Belgium | 13 | 14 | 14 | 16 | 23 | 22 |
| Denmark | 14 | 23 | 18 | 25 | 29 | 28 |
| Finland | 13 | 17 | 21 | 24 | 25 | 27 |
| France | 20 | 16 | 16 | 16 | 22 | 22 |
| Germany | 22 | 19 | 19 | 21 | 21 | 18 |
| Ireland | 3 | 2 | 3 | 3 | 8 | 7 |

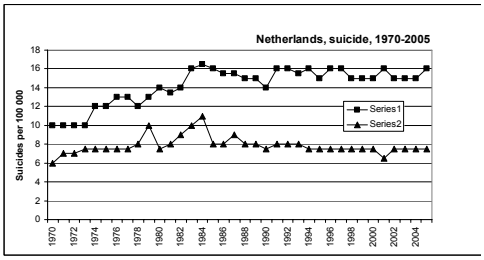
**Table 6.**

Table 6 provides details of suicide rates of 7 European countries arranged in alphabetical order. There appears to have been an increase in the rates in Belgium,

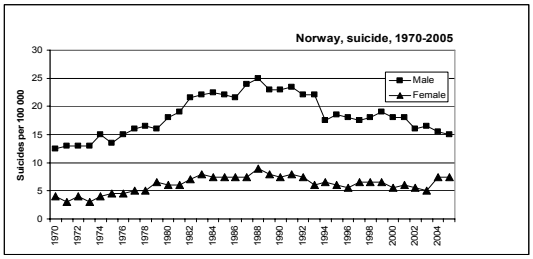
Denmark, Finland and Ireland. The rates for Austria, France and Germany appear to have remained constant. However, this material illustrates that relative relationships of national suicide rates have generally been maintained over six decades: in all decades, Austria has had the highest rates and Ireland the lowest, and in all decades, Belgium had a lower rate than Denmark.

(If mental disorder is the primary driver of suicide, as is frequently stated, this must mean that the Irish are the most mentally healthy, and the Austrians the least mentally healthy in Europe, and the Belgians are more mentally healthy than the Danish. No evidence supports this contention and other factors need to be considered.)

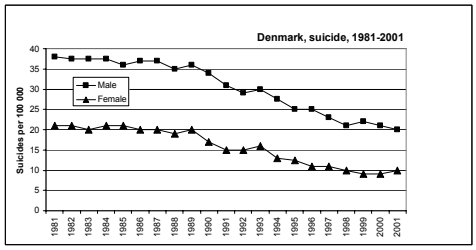
## Individual nations



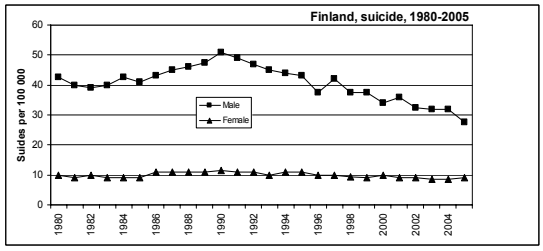

**Graph 8.**




**Graph 9.**




**Graph 10.**

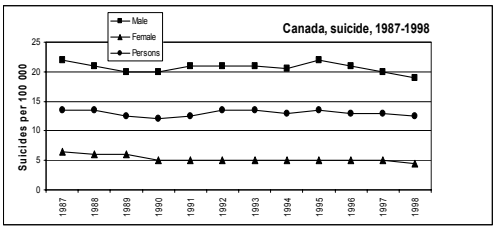



**Graph 11.**

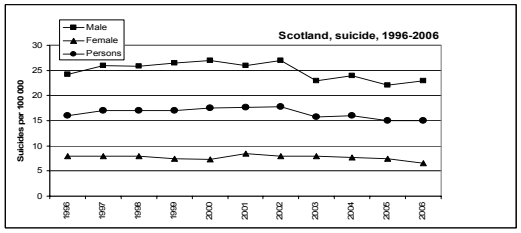
A striking features of the above graphs (WHO figures) is the universal distinction between male and female rates.

In general, the Netherlands (1970-2005), Graph 8, shows a gradual increase in the male rate, with a consequent widening in the male-female gap; Norway (1970-205), Graph 9, shows an increase in the male rate to 1990, followed by a return to the 1970 level; Denmark (1981-2001), Graph10, shows a fall in the rate of both genders, with a probable reduction in the male-female gap; and Finland (1980-2005), Graph 11, shows a slight rise in the male rate to 1991, followed by a fall to well below the 1980 rate, while the female rate remains remarkably constant.

An aside: in Table 6, which ended in 1988, the suicide rate of suicide in Denmark appeared to be increasing, while in Graph 10, which extends to 2001 demonstrates a decline from that high point.




**Graph 12.**



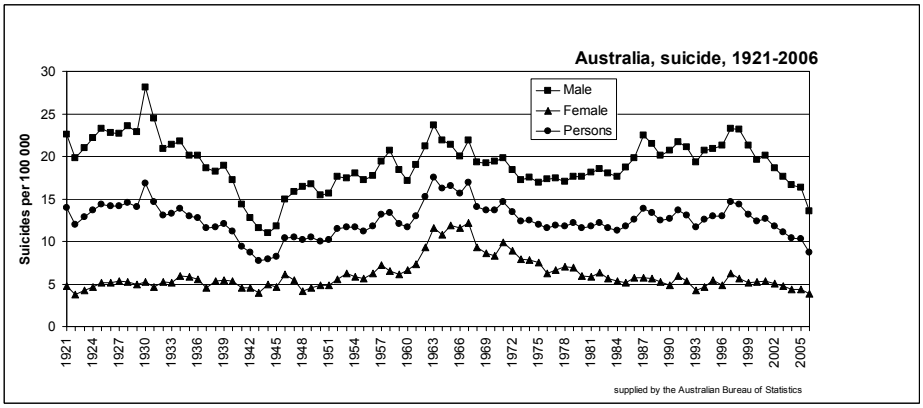

**Graph 13.**

The available data for Canada (1987-1998), Graph 12, and of Scotland (1996-2006), Graph 13, are over brief periods. Nevertheless, both demonstrate remarkable rate stability. They are not for the same period, so comparisons cannot be made with certainty, but from these data, the rates for Canada (suicide of persons <15/100 000) appear to be lower than those for Scotland (suicide of persons > 15/100 000). This is confirmed by WHO figures for Canada in 2004 as 17.3 for males and 5.4 for males, and Scottish Government figures for 2002/04 as 30 for males and 10 for females.

## Within nations and cities

Across nations (Phillips, 2009) and cities (Lemstra, 2006) wide regional variations in health status and suicide rate have been reported. These appear to be related to a range of socioeconomic variables.

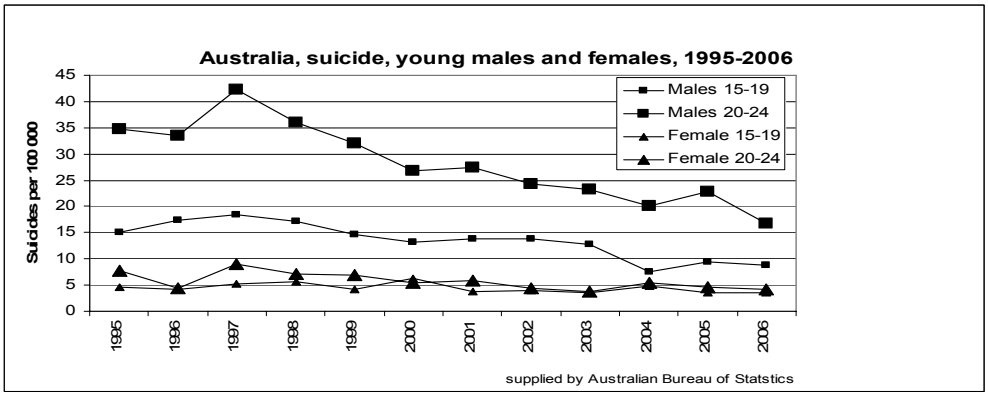
## Australia




**Graph 14.**

The suicide rate in Australia for an 85 year period (1921-2006) shows a relatively constant male to female relationship (Graph 14). In accordance with the theory of Durkheim, there was a marked decrease in suicide during the Second World War. Such declines are purported to be due to society's need to co-operate and work together against the common enemy. In contrast to this general rule, starting in about 1960 there was an increase in suicide, which corresponds with Australian participation in the Vietnam War. However, rather than uniting the population, the Vietnam War was unpopular and divisive, with factions of protesters and supporters.

There was much concern in Australia with increasing suicide rates in the mid to late 1990's. Fortunately, there has been a steady decline in suicide since 1997. In the mid 1990s, close examination of the data showed a worrying increase in the suicide rate of young males. However, Graph 15, there has been a subsequent decline in the suicide rate of this sub-group (in keeping with global trends).




**Graph 15.**

A consistent finding and concern in Australia has been a higher rate of suicide in rural compared to urban areas (particularly among young males). This is believed to be the result of isolation and the relative lack of opportunities in rural areas.

In Australia, as in the UK and USA, there are consistent differences in the rate of suicide in different administrative regions (states/counties). The Australian Bureau of Statistics provided the following details of 2006 state suicide rates (Table 7).

| | NSW | Vic. | Qld | SA | WA | Tas. | NT | ACT | Aust. |
|---|---|---|---|---|---|---|---|---|---|
| Males | 11.9 | 13.0 | 13.8 | 16.7 | 15.3 | 23.2 | 22.1 | 13.0 | 13.6 |
| Females | 2.9 | 4.2 | 3.1 | 4.9 | 4.9 | 6.8 | 3.6 | 6.3 | 3.8 |
| Persons | 7.3 | 8.5 | 8.3 | 10.7 | 10.0 | 14.7 | 13.0 | 9.5 | 8.6 |

**Table 7.**

The prosperous eastern seaboard states (Victoria, New South Wales and Queensland) have the lowest rates. The highest rate was in Tasmania, an island state with a small population (500 000). While naturally beautiful and peaceful, this state lacks a road link to the mainland, there is a sense of isolation and young people have fewer professional possibilities. Also, Tasmania has a high proportion of retirees (from the mainland), and older people are at greater risk of suicide.

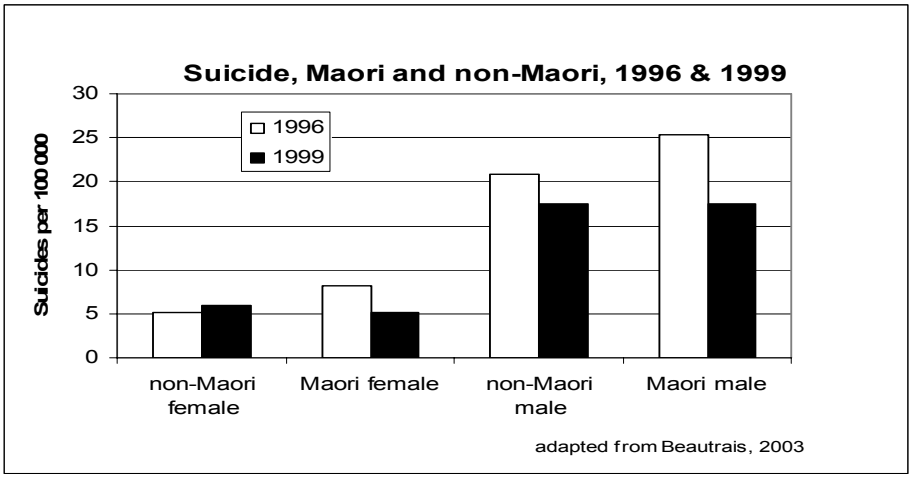
The Northern Territory has the second highest suicide rate. Again, the opportunities for people are limited, the distances are enormous and the sense of isolation is great. While the number of aboriginal people is low relative to the eastern seaboard states, it is high, relative to the non-aboriginal population. For the period 2001-2006, the Aboriginal people form 26% of the population but provided 51% of the completed suicides (Pridmore & Fujiyama, 2009).

## Indigenous people

High suicide rates have been reported among some indigenous people, including the Maori of New Zealand, the First Nations people and Inuit of Canada, the Inuit of Greenland, and the Aborigines of Australia. It is not clear that contact with other (dominant) cultures inevitably has this effect, for as Lester (2008) points out, most nations have an indigenous people, and the information available on many such peoples is limited.

Durkheim (1897/1951) stressed the importance of social integration and regulation provided by society as a factor in suicide. With the dilution of indigenous cultures due to contact with another culture, protections against suicide provided by the indigenous culture may be reduced. Another way of viewing these matters is through the lens of "acculturation", which "occurs when a culture encounters a dominant alternative culture". There is a pressure for changes in the non-dominant culture: physical (housing, urbanization), biological (new diet and diseases), political, economic, cultural, social and psychological (Silvers, 1965) changes. The stress of change perhaps leads to an increase of suicide.

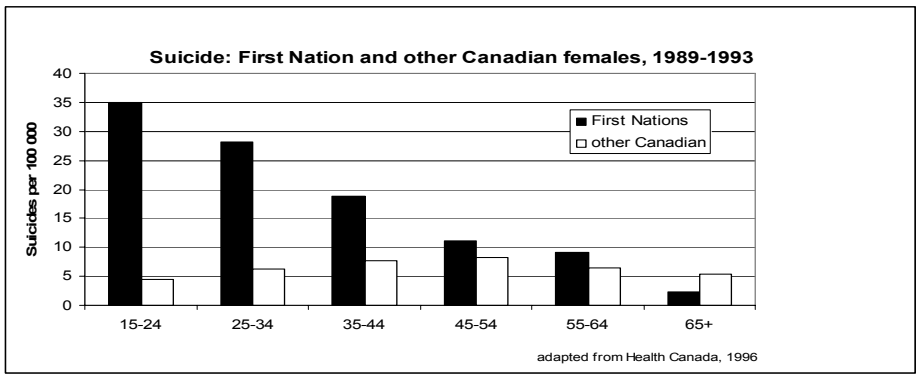
Maori




**Graph 16.**

Due to a change in the method by which ethnicity has been defined in New Zealand, it is not possible to compare current rates with those prior to 1995 (Beautrais, 2003a). In 1996, the suicide rate of Maori (males and females) was greater than that of non-Maori. However, in 1999, there was no statistically significant difference. This statistic, however, hides information (Beautrais and Fergusson, 2006). The Maori population is young compared to the total population of New Zealand. Among Maori, suicide is rare after 45 years, and unknown after 60 years. In 2002, while Maori comprised 19% of the 15-24 year age group of New Zealand, they comprised 35% of the suicide of this young group. Thus, while the total rate of Maori suicide was similar to that of the non-Maori, it consists of proportionately more young and less old Maori deaths.

First Nations people of Canada and the Inuit




**Graph 17.**

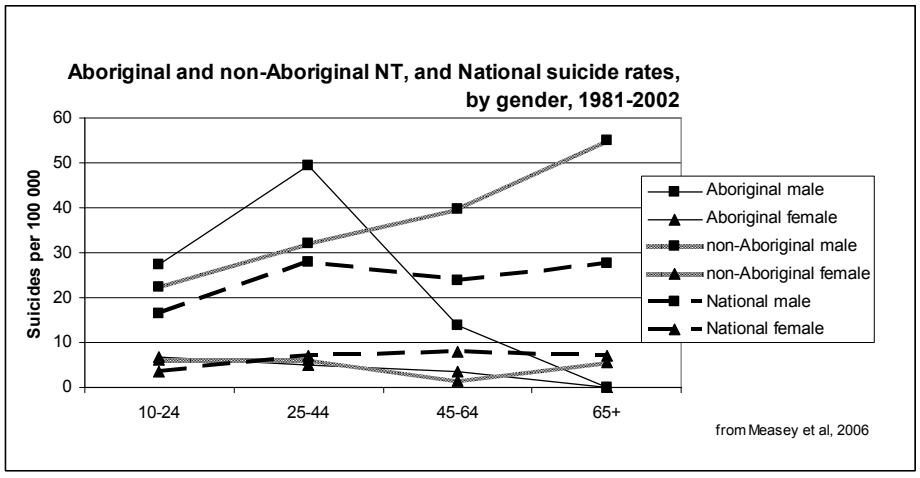
Across Canada, in the period 1989-193, First Nations males had a suicide rate 2.6 times that of other Canadian males, and First Nations females had a suicide rate of 4 times that of other Canadian females. The difference was greatest in the 15-24 year group, but, as with the Maori, First Nations suicides declined with age, such that in the 65+ group, there was less suicide among First Nations females than other Canadian females (Graph 17; Health Canada, 1996). Others have reported overall rates of suicide among the Canadian Inuit and First Nations to be 5-7 times greater than the national average (Kirmayer *et al.*, 1998).

The Inuit of Greenland also have an extremely high suicide rate in the 15-24 year group (400-500/100 000). A marked increase has been apparent "since modernization started in the 1950s" (Bjeregaard & Lynge, 2006).

## Australian Aboriginals

Suicide among "pre (western) – contact" Australian Aboriginals appears to have been either unknown or very rare. Rapid social transformations occurred for these people in the late 1960s, and this appears to have resulted (commencing some 15 years later) in a rapid increase in suicide rate (Hunter & Milroy, 2006).

Due to technical and administrative difficulties, combined with low numbers and wide geographical distribution, the quality of suicide statistics for Australian Aboriginals is somewhat lacking. In 2006, national figures included that suicide accounted for 4.9% of all Aboriginal deaths, compared with 1.8% of other Australian deaths (thus, death by suicide was more than twice as common among Aboriginal people). In 1988-1998, in the states of Western Australia and South Australia and the Northern Territory, the rate was calculated to be 17/100 000 for the Aboriginal and 13.3/100 000 for the non-Aboriginal people (Steenkamp & Harrison, 2001).




**Graph 18.**

Measey *et al.* (2006) provided data which was graphed (Graph 18). Males and females are plotted for 3 different groups: Aboriginals (of NT), non-Aboriginals (of NT) and the national general population. The expected two peaks (one in the 25-44 group and the other in the 65+ group) are discernable in the national general population males. Aboriginal males have the highest rate in the 10-44 year groups; this rate then falls (along with Aboriginal females) to zero at 65+ years.

For the Northern Territory, for 2001-2006, the suicide rate of indigenous people (36.7) was significantly higher than that of non-Indigenous people (14.7/100 000) Nevertheless, there is evidence of a decline in NT Aboriginal suicide over this period (Pridmore & Fujiyama, 2009).

## Need for caution

Published suicide rates and graphs should be viewed with caution, particularly when they appear in the lay press. Examples include many recent newspaper reports about the rate of suicide in the US Army.

London Times Online (2007) stated that "More American military veterans have been committing suicide than US soldiers have been dying in Iraq". This is an emotive, but totally meaningless statement. There are a huge number of veterans in the US, from multiple wars, going back to WWII. There is no justification for comparing the suicide rates of those at home and those in a theatre of war.

CNN.com (2008) ran the headline, "Concern mounts over rising troop suicides". The first sentence was, "Every day, five US soldiers try to kill themselves. Before the Iraq war began, the figure was less than one suicide attempt per day." This is misleading. The headline was about suicide, but the first sentences were about "suicide attempt". These are very different events which should not be conflated. The impression created, was that the suicide rate since the commencement of the Iraq war had increased by 500%, which is quite wrong.

The Chicago Tribune (2008) gave raw figures rater than rates per 100 000 members. It stated that in 2007, 115 troops had completed suicide, and that this was an increase of 13% on the 102 completed suicides of 2006. These numbers are meaningless, as we don't know how many people were in the armed forces in these two years. If the number of people in the armed forces grew by 15% over the year (which is possible, given that the USA was engaged in various wars), a 13% increase in the raw number could actually represent a decrease in the rate of suicide.

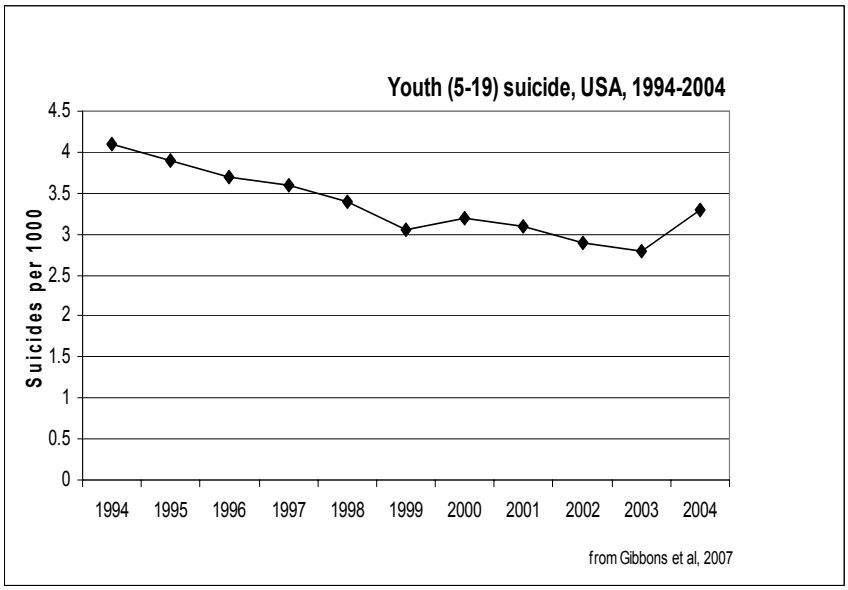
This newspaper then went on to state that there had been 144 suicides among nearly 500 000 service members who had left the military from 2002-2005. Again, this raw number is meaningless. These people had been discharged for between 3 and 6 years, let's say an average of 4 years, and there were 5 X 100 000 individuals. Thus, the annual suicide rate for these people was around 7/100 000, which is below national average (11/100 000 for the general population, and 17.7/100 000 for males in 2005).

In the same article, other meaningless statements were attributed to high ranking Army personnel. A Lieutenant General was quoted as saying the Army was concerned about suicide as it was the fourth leading cause of death, "exceeded only by hostile fire, accidents and illness". What else is there? Homicide, perhaps, or friendly fire?

NPR (2008) stated that the "number of soldiers who committed suicide this year is on pace to be an all-time high". This is a brave prediction. The article continues, "(t)he record was set in 2007 when there were 115 suicides". This is wrong, the highest number of deaths was 285 in 1988.

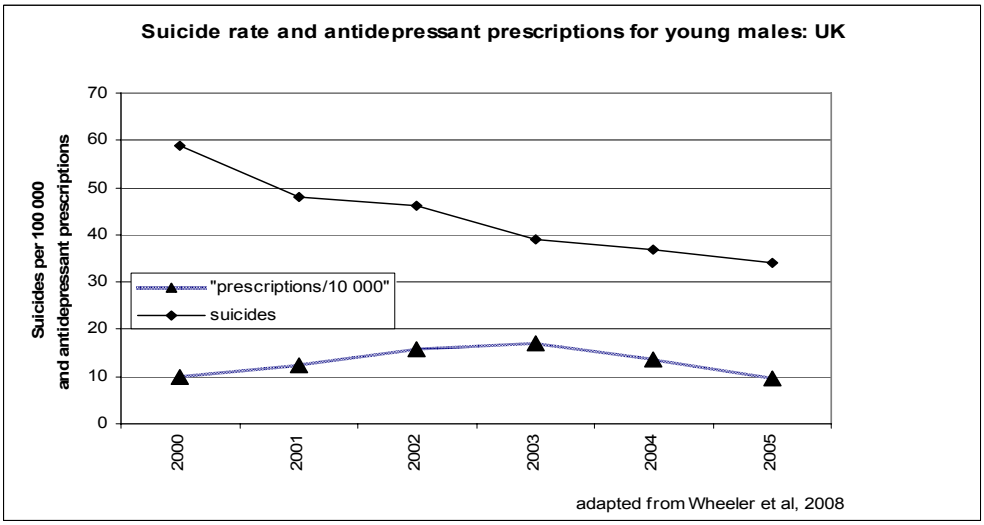
The Los Angeles Times (2009) presented the misleading headline, "Marine suicides in 2008 at yearly high since Iraq invasion". In the first sentence the raw figure was given of 41 active duty Marines as possibly or confirmed suicides for the year.

However, in the second sentence was the all important statement: "The rate per 100 000 troops remains about the same due to the Corps' increased size". The article then reveals a miniscule rise in Marine suicide rate, 16.5 in 2007 and 16.8 in 2008. Finally, further down, the rate of suicide in the civilian populations with similar demographics was given as19.5/100 000, and for the Army as 18.1/100 000. Thus from the perspective of suicide, it would be safer to be a Marine in active service than to be a civilian at home or a member of the Army.



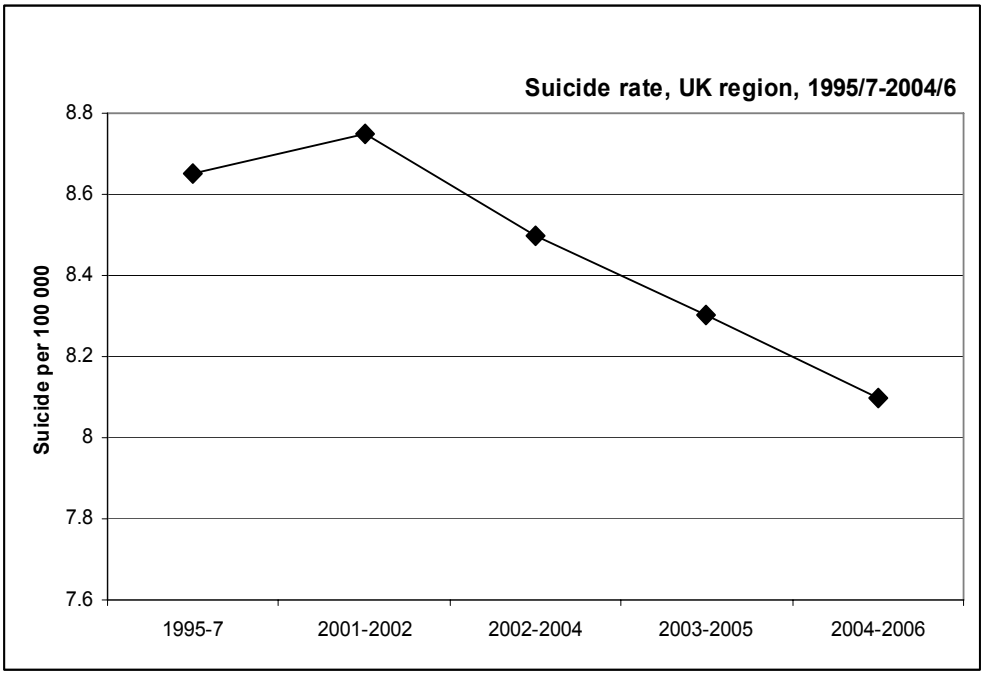

**Graph 19.**

From the professional literature (Gibbons *et al.*, 2007) came Graph 19, showing a tiny blip in 2004 in the suicide rate of the youth (5-19) of the USA. This was related by the authors to a reduction in the sales of antidepressants. They expressed concern that reduction in the sales of antidepressants may have been the cause of an increase in suicide rate of this group. It is unwise to make conclusions on changes in suicide rates in the short term, particularly a change in a single year, and even more so when the change is small.




**Graph 20.**

However, subsequent studies (Biddle *et al.*, 2008; Wheeler *et al.*, 2008) have shown the rate of antidepressant prescribing has had no influence whatsoever on the suicide rate of young people in the UK. Graph 20 shows that prescribing of antidepressants to this group climbed steadily from 2000 and then fell from 2003. While the suicide rate fell as the antidepressant sales increased, it continued to fall as sales fell.




**Graph 21.**

Finally, keep an eye on the axes. Graph 21 was published by a UK county (which need not be named). On first glance, someone seems to have done a fine job of reducing suicide in this jurisdiction. The y axis, however, has multiple flaws. The x axis is accurate enough, but the scale is misleading. A closer look shows that in over a decade, the rate fell by only 0.5/100 000 (which is not worth graphing).

## Conclusion

Rates of suicide are expressed as the number of suicides occurring per 100 000 of a population. There are many variables to be considered including gender, age group and region. Areas of study which have not been addressed in this chapter include mode of death, and emigrant status (people who die in a country of a culture different to that in which they were born).

When comparing different nations and the same population over great distances of time, it is necessary to age-standardize, meaning to make corrections for the difference in age structure – as we have seen, the different age groups may have different suicide rates, which can introduce distortions. The details of age-standardization is a level of sophistication which is beyond the current chapter, but where necessary, age-standardized information has been used.

There is much confusion about the rates of suicide, particularly among the lay public. However, the experts make similar findings, when the gender, age group, location and period under consideration are agreed.

Important findings are that over many decades, there appears to be gradual change in the global figures. Over 4 decades, in 32 countries, De Leo and Evans (2003) found a 7% increase in male and a 27% decrease in female suicide.

In all countries (except China) the male is higher than the female suicide rate (usually in the order of a factor of about 3).

In the UK, USA, New Zealand, Australia and many other countries there are two suicide peaks. One is in the older population (65+) although, which increasing social services to this group, the rate may be falling.

The second peak is in younger people (25-24). It appears that the challenges of modern life may have an influence. However, evidence suggests that this peak is also flattening (for uncertain reasons).

Many of the indigenous populations of the world are currently suffering high to very high suicide rates. This is more marked among the young people; in fact, older indigenous people appear to have lower rates than their counterparts in the "dominant" population. The destruction of the indigenous culture appears to be responsible for the high rate among Indigenous younger people.

Methods of data collection and other administrative practices introduce some difficulties, but for those countries which regularly report suicide rates, cautious confidence about the quality of the data is justified. It is important not to place undue confidence on sudden, dramatic, public pronouncements.

# CHAPTER 13

# PREVENTION

**Abstract**: The current approach to suicide prevention (high risk approach) focuses on improved identification and treatment of mental disorder. Around the world, this approach has failed to lower national suicide rates. The prevention of suicide even in people known to be at high risk is difficult and sometimes impossible. As the majority of the total suicides comes from the low risk population, a population health approach is necessary, which means reducing risk factors within the community. The high risk (treatment) and the population health approach should be conducted concurrently. Generally recommended components include; 1) education of health and other helping professionals, 2) reduction in the stigma associated with asking for help, 3) active alcohol and drug abuse treatment and prevention, 4) improving the well-being of the community, and 5) reduction of access to lethal means. Arising from this monograph, additional suggestions include, a) de-medicalization of non-medical suicidality, b) changing the culture, and c) changing the predicament.

**"Individual approaches will help people in distress and prevent individuals from committing suicide, but will not reduce population suicide rates."**

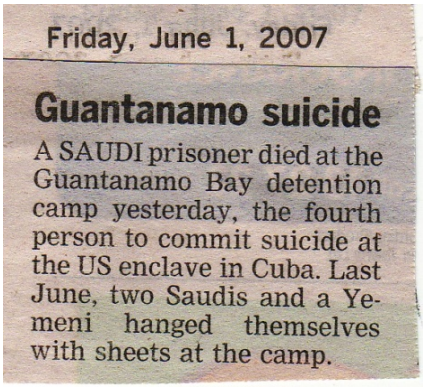
Jacob (2008)

**"From an anthropological perspective, the more powerful strategies for reducing suicide in China should be social and structural (e.g., more education, job opportunities and legal protection for rural women), not pharmacological."**

Lee (1999)

## Introduction

Prevention of undesired outcomes is the aim of much human endeavour, and suicide is a special target. But, efforts have been guided more by hope than reason. With benevolent intentions, the public statements by health departments, support groups, Armed Forces spokes-people and others, commence with the claim that "suicide is preventable". What is meant by "suicide is preventable"? Is this statement supposed to apply to individual cases, or to an entire population? And for how long? For individual "A", is her/his suicide preventable for 5 hours or 50 years?


Friday, June 1, 2007

**Guantanamo suicide**

A SAUDI prisoner died at the Guantanamo Bay detention camp yesterday, the fourth person to commit suicide at the US enclave in Cuba. Last June, two Saudis and a Yemeni hanged themselves with sheets at the camp.

**Fig 46.**

**Saxby Pridmore (Ed.)**

A case can be made to the contrary, that suicide is not preventable. It was known by the USA that suicide at Guantanamo prison camp would be damaging to the nation's international standing. Prior to June, 2006, when three detainees completed suicide, 23 separate individuals had made at least 41 suicide attempts. In June 2009, **Mohammed Saleh Al-Hanashi** (30 years) was the fifth Guantanamo detainee to complete suicide (Fig 46).

This facility had the most advanced surveillance equipment available, and the staff were well trained in suicide prevention. Even with the reputation of the most powerful nation in the history of the world in the balance, in the most secure environment on the planet, the suicide of some "at risk" individuals can not be indefinitely prevented.

A typical lay comment comes from Zion Amir, attorney for **Dudu Topaz**, who hanged himself in goal in August, 2009: "All the signs pointed to the fact that he was likely to harm himself. Why did they not guard him?" As mentioned in Chapter 8, Topaz was a disgraced TV celebrity with no known mental disorder, who was facing a long goal term. It is true that Topaz was at risk, he had earlier attempted suicide using insulin overdose. Accordingly, he was placed in a cell with video surveillance, along with 4 other men. However, there was no surveillance in the shower room and Topaz hanged himself from the shower fitting. The authorities claimed (reasonably, in the opinion of many) that Topaz was responsible for his actions and they could not have done more to protect him.

With respect to preventing suicide in an entire population, we must bear in mind the irrefutable evidence that cultural factors have a predominant influence on suicide rates (Ritter *et al.*, 2008). For over a century the same relative rates have existed between countries, with Greece near the lower end of the scale, Australia about the middle and Hungary near the top of the scale. There are world wide fluctuations, with an increase leading up to 1997, and a decrease since that time. The explanations behind such fluctuations are unknown, and they do not influence the relative positions of the different nations with respect to rates. To significantly change suicide rates will require significant change of culture.

To this point, in the west, prevention efforts have been guided by the theory that suicide is the result of mental disorder. The favored suicide prevention approach has been (to attempt) to reduce mental disorder. This book acknowledges that people with mental disorder are at greater risk of suicide than people without mental disorder, but also illustrates that people without mental disorder also complete suicide. Consequently, in addition to treating mental disorder, other factors deserve consideration.

There are two methods of approach to reducing "health problems". Which will give the best results depends on the nature of the problem. One is to manage/treat the high risk individuals (e.g., reducing deaths by giving blood to those who have lost blood in accidents), the other is a population base approach (reducing deaths from heart attack by anti-smoking campaigns). To reduce suicide it will be necessary to provide both high risk individual treatment, and population based prevention.

One approach focuses on the group composed of people who are, or should be, known to clinicians: those who suffer mental disorders, and constitute a 'high risk group'.

The other approach focuses on the general population, which is at low risk (not at no risk). Justification for adding the low risk group approach is that "a large number of people exposed to a small risk may generate many more cases than a small number of people exposed to a high risk" (Rose, 1992).

## Risk and the suicide total

To the current time, suicide prevention activities have focused exclusively on the high risk population. However, the following discussion highlights the need to take low risk population into account, as the majority of the total number of suicides comes from this group.

Consider a general population which has a suicide rate of 10. This means 10/100 000 completed suicides per year. The risk of suicide for the individuals of that population is 0.01%. Put another way, each year, 1 person in 10 000 will die by suicide - this is a tiny number, and in spite of what we read in the newspaper, this rate is classed as rare to moderately rare.

Say we identify 500 people (from 100 000) who are at 100 times the risk of the general population. They are at 1.0% risk. From this group, generally speaking, there will be 5 completed suicides each year.

However, the general population is not at no risk, it is at low risk. Each individual is at 0.01% risk. Thus, from the remaining 95 500 people of the general population there will come an additional 9.55 completed suicides each year. This means that twice as many suicides will come from the low risk group as will come from the high risk group.

This book is packed with examples of people who were at low risk of suicide (as judged by all published markers of risk) who completed suicide. This is supported by population based studies which confirm that suicide occurs in patients both with and without mental disorder (Osborn *et al.*, 2007).

## The high risk approach

The high risk approach is concerned with, 1) people with mental disorders, and 2) people with high risk factors. To the present time, these have been considered to represent the same group of people, and the high risk factors are often simply taken as a means of evaluating the degree of risk of suicide of the individual with mental disorder. However, it is commonly the case that people without a mental disorder carry one or more high risk factors.

### People with mental disorder

Evidence to support that mental disorder carries a high risk of suicide is given in Chapter 6. Using the psychological autopsy method (discussed in Chapter 2) one estimate finds a spectacular 98% of people were suffering from mental disorder at the

time of suicide (Bertolote *et al.*, 2004), and others are around 90% (Cavanagh *et al.*, 2003). Such results have been challenged in this book. Nevertheless, estimates of the life-time risk of suicide among people with major depressive disorder are 3.4 to 15% (Blair-West *et al.*, 2001). Thus, people with severe mental disorder are at high risk of suicide and deserve the best possible care and protection.

## Risk factors and treatment

Various lists of "risk factors" have been identified, including: male gender, older, widowed, single or divorced, childless, living in high density population, residence in big cities, a high standard of living, economic crisis, high alcohol consumption, broken home in childhood, mental disorder, physical illness (Stengel, 1964). From time to time different factors are identified, and in some reports, rural residence has replaced residence in big cities. In recent research, after the presence of psychiatric disorder, the prominent risk factors were unemployment, low income, divorce, and family history of suicide (Qin *et al.*, 2003; Rihmer, 2007).

Stengel (1964) identified "a high standard of living" as a risk factor. However, all systematic studies of the topic have found as significant inverse relationship between income/socio-economic group and suicide (Lemstra *et al.*, 2006; Page *et al.*, 2006; Rehkopf & Buka, 2006; Saurel-Cubizolles *et al.*, 2008; Yamasaki *et al.*, 2008; Jablonsk *et al.*, 2009), and this relationship can now be accepted.

There have been other minor clashes between lists. King *et al.* (2001) found that "misuse of non-prescribed substances" (cannabis and other illegal drugs) reduced the risk of suicide. This is in contrast to all earlier studies and is not credible. Not surprisingly, these authors closed their paper with, "Identifying which patients are at higher risk of suicide remains an inexact science".

A significant relationship had been demonstrated between suicide and exposure to violence and recent hunger (Maselko & Patel, 2009). The Commission on Social Determinants of Health (2008) concluded that social justice is "a matter of life and death", and social disadvantage in general can now be accepted as a risk factor for suicide.

Alcohol excess and the use of other substances are closely associated with the risk of suicide (Grossman *et al.*, 1991; Overholster *et al.*, 1997; Coklo *et al.*, 2008; Power & Brophy, 2008; Crosby *et al.*, 2009; Holmgren & Jones, 2010; Stenbacka *et al.*, 2010) and represent a modifiable risk factor (Razvodovsky, 2009; Landberg, 2009).

Unemployment is closely associated with the risk of suicide (Yamasaki *et al.*,2008; Ying & Chang, 2009: Corcoran & Arensman, 2010; Inoue *et al.*, 2010).

Divorced has long been recognized as risk factor for suicide (especially for men). Recent evidence finds that marital separation represents a higher risk than divorce for both males and females, (but is particularly high for young males; Wyder *et al.*, 2009); perhaps because separation represents a more acute disruption. Similarly, "problems with current or former intimate partners" has been identified as a risk factor for US females (Ortega & Karch, 2010).

It was expected that, once equipped with lists of risk factors, helpers would be able to identify those at highest risk and provide them with special attention, thereby preventing suicide (Suicide Prevention Australia, 2008). So far, lists of risk factors have been of limited use. This is because current lists identify very large numbers of individuals, the majority of whom do not go on to complete suicide. That is, the risk factor method identifies a large numbers of "false positives". This means extensive resources are devoted to the "wrong" individuals. The tool is "sensitive" (easily triggered) but not "specific" (it also triggered by "non-cases"). Caution is also required because even if we can identify the "right" individuals, there is little evidence that we really know how to prevent suicide.

That the high risk approach has serious limitations was demonstrated by Beck *et al.*, (1999). They studied outpatients at high risk, that is, people 100 times more likely to suicide than members of the general population. They found the suicide rate among this group was only 0.2% per annum. Thus, to save one life, even in this high risk group, it would be necessary to provide infallible care, 24 hours per day to 500 people for one year. Also, the support offered would need to be in a form acceptable to the individuals.

Powell *et al.* (2000) studied psychiatric inpatient suicide. They identified and compared the risk factors of two groups: 1) a group of people who had completed suicide while they were inpatients, and 2) a control group (patients who had not completed suicide). They concluded, "Although several factors were identified that were strongly associated with suicide, their clinical utility is limited by low sensitivity and specificity, combined with the rarity of suicide, even in this high-risk group". The point being made is that even with hospitalized patients, suicide cannot be effectively predicted using risk factors.

Appleby *et al.* (1999) conducted comprehensive analysis of 10 040 suicides among people who had been in contact with mental health services in the 12 months prior to death. They found, "Most… (of the deceased)…were thought to have been at no or low immediate risk at the final contact".

Fahy *et al.* (2004) asked 7 experienced mental health professionals to read the notes of 78 psychiatric patients, and to attempt to identify which 39 had completed. The readers considered all known suicide risk factors. The result was that these skilled clinicians did no better than chance. The authors state, "…these disappointing findings call into question the clinical utility of risk factor findings to date".

There have been a number of well resourced small studies, in which high risk patient groups have been given sustained attention with special counselling and additional support. Very importantly, in none of these was there a significant difference in outcome when the experimental was compared to a control group. Reviewing these studies, Gunnell & Frankel (1994) found, "No single intervention has been shown in a well conducted randomized controlled trial to reduce suicide". Similarly, it has not been possible to demonstrate a clearly effective management for people who repeatedly deliberately self-harm (Hawton *et al.*, 1998b).

In fact, no study has ever demonstrated that treatment makes any difference to the risk of suicide (Deykin *et al.*, 1986; Shaffer *et al.*, 1988; Currier *et al.*, 2009; Sverrison *et*

*al.*, 2010; Rossow *et al.*, 2010). In a recent 10 year prospective study in China (Ran *et al.*, 2009) there was no significant difference in the suicide rate of people with schizophrenia who had been treated, and those with schizophrenia who had never been treated. It may be that treatment may prevent suicide in an individual case, but even this has not been proven. In Taiwan, Chen & Yip (2008) found that over a recent decade, there was a 300% increase in the suicide rate in spite of a 100% increase in the number of psychiatrists.

Suicide occurs, from time to time, on psychiatric wards, and there are constant calls for improved ward design and staff attention. Psychiatric wards in developed countries have modified their policies and procedures and their architecture (removing hanging points, fitting video cameras to cover corners, etc) so that in most facilities there is nothing else to be done. Nevertheless, after each death on a psychiatric ward there is an enquiry and evermore changes are recommended (sometimes reversing earlier recommendations). A thoughtful paper, "Creeping Custodialism" (Patfield, 2000) argues that psychiatric wards have, through this process, become progressively dehumanized and clinical, such that they are now alien rather than nurturing and encourage rather than discourage suicide. There is a need to remain alert and professional in approach, but it is doubtful that further changes will completely prevent suicide on psychiatric wards.

A US nation wide survey of suicide among psychiatric inpatients found that 25% of completers had absconded form the hospital (Hunt, *et al.*, 2010). The authors stated that patients at high risk of absconding would likely have been under a high level of observation. Nevertheless, they called for "tighter control of ward exits, and more intensive observation". Finally, they suggested that "a supportive and less intimidating experience may contribute to reduced risk". No mention was made that these recommendations were contradictory.

Some institutions which adopt every recommendation of various inspectors do so primarily for the purpose of avoiding liability (cash compensation), rather than for the good of patients.

In view of a demonstrated increased suicide rate among patients immediately after discharge from psychiatric wards, there are calls for "enhanced follow-up" (Qin & Nerdentoft, 2005; Beautrais, 2003b). In a study of people who had been in contact with mental health services in the year before their suicides (Appleby *et al.*, 1999), 26% had been non-compliant (had not co-operated in taking medication or following advice), and 28% had lost contact with the service. When patients complete suicide in post discharge period it is not usually because the mental health professionals are unaware of the dangers or are negligent. Community based mental health services are notoriously under-funded, and consequently, under-staffed. It is possible that more "assertive" follow-up may be helpful, however, this can only be offered on receipt of more generous funding for community based mental health services. We need to accept that such increased funding may help individuals, but will not make a major impact on national suicide rates.

There is a widespread belief among Coroners that anyone who presents to an Emergency Medicine department claiming suicidal thoughts should be admitted to hospital as this saves lives, and not to admit such people represents negligence. From

the Guantanamo experience, we see that incarceration/admission to a "safe" place is no guarantee life will be preserved. In fact, evidence indicates that well developed community based care is more effective in preventing suicide than inpatient treatment (Pirkola *et al.*, 2008).

It is now clear that national suicide prevention strategies based on the "high risk approach", the early detection and treatment of mental disorder, have not reduced regional or national suicide rates anywhere in the world (De Leo & Evans, 2004; Dumesnil & Verger, 2009; Shah *et al.*, 2009).

Current suicide prevention strategies call for "improved screening of depressed patients by primary care physicians and better treatment of major depression" (Mann *et al.*, 2005). It is important that medical staff be alert to the issue of suicide, treat mental disorders and refer patients to social support agencies appropriately. However, in most developed countries, general practitioners and nurses are now well trained in this regard, and it is unlikely that further efforts and expenditure will yield great benefits.

It has been demonstrated that as many people who complete suicide have seen a police officer in the 3 months prior to their suicide, as have seen a mental health professional within 12 months prior to suicide (Linsley *et al.*, 2007). Thus, the education of police regarding suicide prevention may be indicated. Teachers, clergy, and workplace welfare officers, in most developed countries have been alerted to the problem, but further training may have yield some benefits.

It may be possible to avert suicide in certain high risk individuals. Risk factors are of some assistance in identifying those people with mental disorders who are at especially high risk, but it is most unlikely that this method will be of assistance in preventing suicide among members of the general community (Lewis *et al.*, 1997).

## Non-medical asylum

It has been demonstrated in this book that not all those people who complete suicide have a mental disorder. The highest incidence of suicide in the world at the moment is among the Inuit of Greenland, the First Nations of the USA and Aboriginal Australians. This is understood to be the result of the destruction of the culture and personal support structure of these people. Sociologists (Durkheim, 1897/1951; Frenquist & Cutright, 1998; Zimmerman, 2002) have been demonstrating the importance of social factors in suicide for over 100 years. Accordingly, it is appropriate to reconsider the current practice of managing all people with suicidal thinking as if they are sick and in need of medical treatment.

A busy general hospital Emergency Medicine department is not the place to manage social disintegration and disappointment. Of course, if a mental disorder is suspected, there should be ready medical assessment. But, when mental disorder is not present, mental health professionals are less appropriate than a range of mature caring (less expensive) people who bring a range of life experiences to the task. A precedent exists in the management of people with alcohol and drug problems who are frequently

assisted with withdrawal from substances in non-government "social detox" centres (where detoxification is supervised by non-medical, socially orientated workers).

In some instances, a period of asylum (allowing time for a crisis to settle) can be beneficial. Thus, any alternative (non-medical) suicide management system will require some form or residential option. If the individual does not have a mental disorder, he/she should not reside on a psychiatric ward designed for those who are mentally disordered. This is a theoretically sound argument, but the hurdles preventing the implementation are considerable.

## The population-based approach

Suicide may be better managed as a public health issue, that means, by reducing the risk factors across the community.

Rosenman (1998) states, "We do not have to identify the individuals within the population to save them". He draws analogies with death from road trauma and cardiovascular disease. Road death has been reduced in Australia since 1960, not by focusing on high risk drivers, but by measures such as seat belts, random breath testing, speed-limit enforcement, and better roads and cars. The decline in cardiovascular death was not achieved by targeting the habits of people at high risk (already very sick), but by changing legislation and community attitudes to smoking, diet and exercise.

Many risk factors have been discussed above. The focus here is not on the risk factors as they apply to selected individuals, but as they apply to communities: not to treat the individual with the risk factor, but to treat the risk factor in the community.

Alcohol and drug abuse has been identified in around 22% of completed suicides in the general population (Bertolote *et al.*, 2004). It is probably even more important in some Aboriginal communities. With respect to Australian Aboriginals, Earnest Hunter (2002) wrote, "most suicides are impulsive acts in the context of heavy alcohol intoxication following what may appear a trivial confrontation or loss".

Alcohol abuse increases the risk of suicide (Murphy & Wetzel, 1990). There are many routes to this end; alcohol may induce a depressive disorder or decrease inhibitions such that impulsive acts are completed. Alcohol impairs judgment, leading to social, family, employment and legal problems. The alcohol abuser has reduced ability to repair interpersonal problems and may become angry and isolated.

National initiatives to reduce substance abuse reduce suicide rates. Substance abuse policies appear to have greater effect on reducing suicide rates than either mental health programs or suicide prevention strategies (De Leo & Evans, 2004). A two pronged attack is needed: an active treatment and rehabilitation program, and strong population-based initiatives such as public education and limitations on access (restricted trading hours, increased tax), to reduce the incidence of new cases.

Current public health opinion states that "the greatest health problem in the world is socio-economic inequality within countries". By this, attention is drawn to the fact that opportunity influences education, work environment, income, diet, access to

medical care, access to a healthy life-style, and exposure to physical and emotional stress. Similarly, the Commission on Social Determinants of Health (2008) concludes that social justice "is a matter of life and death". It states that early childhood and education "lay critical foundations for the entire lifecourse". Thus, socioeconomic status and life opportunities also have powerful personality crafting influences, and a just society provides the opportunity to develop a positive attitude to life and adaptive mechanisms to deal with adversity. An unjust society throws up challenges and fails to give the individual the skills or opportunity to deal with them. For the individual to enjoy a "flourishing" life, and be protected against suicide (and other harms) we need to raise the opportunities and quality of life of the common man. The term for such improvements is "community development".

This general statement incorporates many of the risk factors discussed earlier. For example, unemployment is strongly associated with suicide. The current wisdom of public health experts and the WHO is that employment improves health, including mental health. Thus, if a nation is serious about preventing suicide, that nation must look to increase the availability of meaningful employment. Socio-political/cultural factors underpin suicide, and major socio-political/cultural change is required if there is to be a national reduction of suicide rate.

Lower socioeconomic group membership is strongly and consistently associated with higher suicide risk (Lemstra *et al.*, 2006; Page *et al.*, 2006; Saurel-Cubizolles *et al.*, 2008). Socioeconomic group is powerfully influenced by employment, which in turn, depends on level of education. Therefore, a serious approach to suicide prevention calls for increased educational opportunities, greater school retention and flexibility in training approaches. Housing is another "big ticket" socioeconomic factor which requires long term political investment.

Recent research (Riordan *et al.*, 2006) has demonstrated that low birth weight, and being born to a younger mother, a mother with other children, and a father with a non-professional occupation (or when paternal details are unavailable, a mother with a non-professional occupation) is associated with a greater risk of suicide in later life. Also, (Gravseth *et al.*, 2009) that being the second or subsequent child in a sib-ship, and being the child of a mother with an unstable marital relationship increases suicidal risk. Thus, a long term plan to reduce suicide will include focusing on antenatal environments and the early childhood conditions of the population.

Suicide is strongly associated with personality disorder (Cheng *et al.*, 1997). Personality has been defined as the characteristic manner in which the individual responds to the environment. Personality disorder is diagnosed when the individual responds in a more extreme manner than the majority (e.g., individuals may be unduly angry, seductive or avoidant). When people with robust personalities are faced with a predicament, they make (generally) adaptive responses, while the individual with a personality disorder may make a maladaptive response, failing to deal with the circumstances in an efficient manner.

Improved parenting and education along with vocational training and the opportunity to work will assist in the development of a robust personality, and increase the ability to make adaptive responses to the environment. In this way, governments and other influential bodies can contribute to personality development.

We have just survived the 'greed is good' era and people are looking for a more personally satisfying way 'of being'. The 'celebrity culture' persists; young people are constantly told they should be beautiful, narcissistic and shallow. (It is relevant here that Durkheim identified excessive individualism as leading to egoistic suicide.)

Counselling or psychotherapy should be available for people seeking help with interpersonal difficulties. However, it would be highly appropriate to conduct public debates on values, and for leading figures to advocate and demonstrate by example, social justice and the benefits of tolerant, responsible reactions to challenges.

Suicide prevention is not a simple matter. What seems like a good idea may not be. School-based suicide prevention classes may be damaging (Shaffer *et al.*, 1991; Hazell & King, 1996; Lester 1992), and are not currently recommended.

An issue which sits astride the high risk and population-based approaches is the reduction of the stigma associated with asking for help. For those at high risk, help will be more readily accepted if the community attitude was more tolerant of help-seeking behavior. While therapy may be helpful for those who are sick, for those who are sick of their lives, a "therapy" approach is short-sighted, and an improvement in people's lives is required.

Reducing access to lethal means deserves consideration. Australia reduced access to firearms nationwide following a civilian perpetrated massacre in 1996. Previously there had been the detoxification of car exhaust (with the introduction of catalytic converters) and limitations on the prescribing of barbiturates. In the UK, a similar initiative had been the detoxification of domestic gas. In Japan there has been extensive work on building barricades to prevent jumping from high places. In the USA, guns, and in Fiji, paraquat (a pesticide used in the sugar industry), remain ever present options.

The jury is still out on whether the restriction of lethal means produces a lasting benefit. The con view is that people wanting to end their lives will simply use another means. In Fiji, when moves are made to regulate the use of paraquat, the answer is always, "but how can you out-law rope" (hanging being the second major method in Fiji). The natural fluctuation in the rate of suicide has made the question difficult to answer. All that can be said at this time is that if lethal means are unavailable, it would be reasonable to assume that some 'impulsive' suicides would be prevented.

From the public health perspective, the prevention of suicide will require "community development" to increase the health, well-being, adaptability and productivity of future generations. In this context, education, employment and housing are components of "health". Changes will need to be expensive and require long term planning and political will. Handing out SSRIs to help people tolerate wretched lives is not going to do it, what is needed is less wretched lives.

## Recent prevention programs

The United States National Strategy for Suicide Prevention is an evolving document which is hosted by the US Department of Health and Human Services. It has roots in

the National Strategy for Suicide Prevention which was published in 1999 (Ramsay, 2001).

Points in the Preamble of the initial document were encouraging:

1. recognition and affirmation of the value, dignity and importance of each person;
2. suicide is not solely the result of illness or inner conditions; it can stem from societal conditions and attitudes;
3. there is a need for collaboration at all levels of a community.

However, 10 years later the current National Strategy for Suicide Prevention statement (United States, 2008) has not advanced any of these points. Instead, it lists 11 goals, including the perennials: "Promote Effective Clinical and Professional Practices", "Training For Recognition of At-Risk Behavior", "Support Research on Suicide", and "Reduce the Stigma Associated with Being a Consumer of Mental Health". The fourth Goal is "Develop and Implement Suicide Prevention Programs" – it turns out that after a decade, not all states have them. The first Goal is, "Promote Awareness that Suicide is a Public Health Problem that is Preventable". This is a totally unproven statement of faith. Individuals would be howled down if they made such statements on another issue.

The National Suicide Prevention Strategy for England (Department of Health, 2002) has 6 Goals. The first is to reduce risk in key high risk groups, such as, people who have recently been in contact with mental health services, young men, and prisoners. The second goal is, "To promote mental well-being in the wider population". This sounds promising, but the recommended approach is to, "Promote mental health among people from black and ethnic and minority groups", "Promote mental health of people who misuse drugs and alcohol", "Promote the mental health of those bereaved by suicide", etc. This plan appears to be a response to pressure groups rather than a grasping of the nettle and saying to the people, "Suicide is a problem of the well-being and the culture of the general population. The suicide rate will not change until there are fundamental changes in our well-being and culture. If we want that, how do we go about it?"

Japan experienced a marked increase in the suicide rate in the late 1990's, and this has persisted. There is evidence that the suicide rate of Japanese businessmen is related to the economy, when the profits go up, the suicide rate of businessmen (at least) goes down. Thus, fundamental cultural change will be required if there is to be a reduction in suicide. There have been a number of unsuccessful attempts to reduce the rate (McCurry, 2008), including the building of barricades and fences to prevent jumping from high places. Two new intervention programs are being trialed by Japan Ministry of Health, Labor, and Welfare. For one of these (Ono *et al.*, 2008) "The program stresses that bonds between human beings, social support, and social capital within communities are key factors for reducing suicide". Hopefully these words will be put into action. If so, the outcome of these studies will be of great interest.

Massive modernization took place in Greenland in the post WWII period. The suicide rate (particularly among young males) rose alarmingly and is in the order of 100/100 000. A proposal for a national strategy of suicide prevention was put to the Greenlandic parliament in late 2004. It has been translated from Greenlandic into

English, and is unique, as in the translation process, spin and politically correct expressions were lost, leaving an understandable document (Anonymous, 2008).

The usual statements are made, such as, attention must be paid to high risk groups, and that professional competence must be increased. But, then a number of other sensible statements are made,

1. People suicide "to get away from a situation or an emotional state of mind which is experiences as unendurable – rather than a wish to be dead."
2. "…initiatives should be taken at all levels to give people the best conditions of life and levels of support so that they will not consider attempting or committing suicide an acceptable solution or the only way out when life becomes too hard."
3. "Various supportive and remedying initiatives of a psychological, educational and social nature with the purpose of increasing peoples quality of life and ability to control their own lives, the focus being on strengthening individuals' resources and ability to manage life crises and tackle the problems that inevitably occur in a person's life."
4. " a number of fundamental factors…cannot immediately be changed…citizens be given the opportunity of employment and suitable housing, that all children be ensured good and safe conditions in childhood and adolescence…further training or education…vocational or an academic nature…"
5. "Ways of life were broken down without new ones suitable for human beings have been built up."
6. "…society, families and individuals struggle to find the values, norms and attitudes that tie us together as a people and give our lives and actions direction."
7. "…effective prevention of suicide in Greenland must deal with current norms, values and attitudes – or lack of such norms, values and attitudes."
8. "It may be necessary to change some attitudes – or at least to make sure they are debated."
9. "…teaching new generations the social skills of responsibility and humbleness."
10. "…preparing them to the fact that life may include hardship and frustration that they have to learn to tackle."
11. "Broken hearts are a naturally occurring experience in the years of youth."
12. "…have not developed a wide range of useful problem solving strategies."
13. "The immature personality easily risks becoming caught in immediate needs and desires, letting spur-of-the-moment impulses control behavior – including suicidal behavior."
14. "Parents and significant adults are important: they must not be afraid to tell children and young people that they sometimes have to postpone the satisfaction of some of their needs. In this way they will learn impulse control and consequently their personality will mature."
15. "Many of the processes suggested in the strategy will only change over several generations…"

## Recommended approach to suicide prevention

A comprehensive suicide prevention package must take from both the high risk and the population-based approaches. The high risk approach has intuitive and political appeal. In circumstances of high risk, we have a clear moral obligation to provide all possible care. The low risk group (or general population) however, provides a large proportion of the completed suicide total, and will only be reached by a population-based approach.

Suicide is a multifactorial issue and primary factors include cultural and political and economic elements (in addition to mental disorder). Should the decision be made to embrace a public health approach, change will be gradual (cultural, political and economic factors do not change over night). Accordingly, a preoccupation with annual suicide statistics will engender frustration. A longer term view is necessary.

The following deserve consideration:

1) Education of general practice and mental health services staff.
   This has already commenced and should continue. Important aspects include:
   a) Improved diagnosis and treatment of mental disorder
   b) Referral to social support services as appropriate
   c) Improved follow-up in the post discharge period. This calls for an immediate increase of funding of community based mental health services.

2) Education of other helping professionals (guidance officers, clergy, police) in recognizing distress and on pathways of referral for medical assessment. However, helping professionals must also learn that distress does not necessarily require help from a health professional, and it is the helping professional who is sometimes better placed to provide help.

3) Reduction of community stigma related to asking for help. This will be a society attitude change and will need to be led by governments and influential figures. This item refers to mental health help, and is based on the belief that all those people who complete suicide are sick. For those people who are simply sick of their lives, they too should be encouraged to ask for help (with e.g., education, employment and housing) from the appropriate Minister.

4) Active drug and alcohol abuse treatment and prevention. Such initiatives have been shown to lower suicide rate more effectively than mental health policies and suicide prevention programs (De Leo & Evans, 2004). Accordingly, this topic should receive very high, if not the highest priority, in suicide prevention programs. Alcohol abuse lowers the productivity, educational and employment opportunities, family life satisfaction, and very importantly, impulse control. The measures to be implemented depend on local factors but should include both rehabilitation and population-based initiatives.

5) Improving general well-being. This to be achieved by promoting a just and supportive social environment, with equal opportunities. The following are examples, not a complete list:
   a) Assistance for pregnant women, particularly those disadvantaged
   b) Assistance for mothers and babies

c) Access to high quality education and training, and assistance to remain in education and training
d) Access to work
e) A move away from 'greed is good' and the 'celebrity culture', assisted by leaders advocating and demonstrating the benefits of tolerant, responsible reactions to challenges.
f) Studies to examine means of assisting children maintain contact with both parents, and means of combating loneliness.
g) Explore the potential of fostering small groups working together so as to develop a sense of common purpose and integration.

6) Reduction of access to lethal means.

**Additional action**

The above 6 points have been made in one form or another by others. Three further points are offered.

1) De-medicalization of non-medical suicidality

When friction occurs between people, particularly when alcohol or other drugs are involved, there is frequently some destruction of property and mention of suicide. At the moment, such words result in individuals being brought to Emergency Medicine departments and subsequently admitted to psychiatric wards.

While admission to a psychiatric ward is appropriate if the individual has a psychiatric disorder, it is wasteful of resources and damaging to the individual if social difficulties are managed as though they are psychiatric disorders.

When the suggestion of suicide is raised, it is entirely appropriate that a psychiatric opinion should be available, so that any psychiatric disorders can be appropriately diagnosed and treated. In the absence of a treatable psychiatric disorder, a separate non-medical service should be available. Such a service would be staffed by caring, mature non-medical people with wide life experience, who would be better placed to give assistance to people with personal or social non-medical problems. The precedent exists in the social detoxification of people with alcohol and drug problems.

The advantages would include that individual would learn means of dealing with life issues without adopting the sick role. (Hospitals make people into patients.) Additionally, there would be financial savings, such facilities operated by non-government agencies would operate at much lower costs than general hospitals.

In such an arrangement there would need to be some form of residential option, as a period of "time-out" can assist the resolution of social crises.

2) Changing the culture

Cultural factors have a profound effect on suicidal behavior. For over 2000 years leading cultural figures from Judas, Anthony and Cleopatra to Hitler, from Dr David

Kelly to Hunter S Thompson, have demonstrated suicide as a means of dealing with predicaments. To reduce the suicide rate, we must change our culture. By this is meant, not simply our attitude to suicide, but elemental cultural values and modes of behavior. Do we want to change our culture? Who has the right to change a culture? If it is decided that we need new values/attitudes, how and by whom are these to be decided? If a new set of values/attitudes are agreed, how will these be woven into our culture? These are not insoluble questions. But, they are questions which must be solved by the people.

3) Changing the predicament

When people are in unacceptable predicaments they complete suicide. Focusing on apparent predicaments rather than presumed psychopathology will be useful. Support (non-medical) for recently separated people deserves consideration.

The predicament of painful terminal illness cannot currently be changed.

The predicament of disgrace deserves consideration. People apprehended on pedophilia charges are at special risk of suicide. Is there a solution? It may be that as long as there is shame there will be suicide.

## Conclusion

A high risk approach to suicide prevention will not significantly reduce the national suicide rate. However, high risk people deserve all possible assistance. In addition, a population-based approach which reduces alcohol abuse, and promotes the well-being of the people is required. Simplistic approaches such as school-based suicide prevention classes are dangerous (waste resources) and should be avoided.

The de-medicalization of non-medical suicidality is strongly recommended. Caring mature non-medical people have much to offer people in social crises. They have life experience, they are not stigmatizing and are less expensive that mental health professionals.

The suicide rates of different countries are different and have remained in the same relative positions for 100 years. From this we learn that culture is profoundly important in suicide. If we are going to significantly change our suicide rate we will need to significantly change our culture. Whether this should and how it might be attempted is a matter for public discussion.

If a public health approach to suicide is embraced and the decision is made to modify the cultural, political and economic elements which contribute to suicide, a longer term view will be necessary. Such changes take time and progress will not be immediately reflected in the annual suicide rate.

A cultural matter which must be faced: while there is shame there will be suicide.

# CHRONOLOGY OF MENTIONED SUICIDES

Total: 138
Clear evidence of mental disorder (marked with **): 8
Probable mental disorder (marked with *): 6

| Year | | Age | Page |
|---|---|---|---|
| Mythical times | **Ajax** | | 20 |
| 11th C BCE | **Samson** | | 8 |
| Before 689 BCE | **Pyramus** | | 21 |
| | **Thisbe** | | 21 |
| 509 BCE | **Lucretia** | | 22 |
| 340 BCE | **Decius Mus** | | 32 |
| 295 BCE | **Decius Mus (son)** | | 32 |
| 279 BCE | **Decius Mus (grandson)** | | 32 |
| 183 BCE | **Hannibal** | 64 | 37 |
| 162 BCE | **Eleazar** | | 32 |
| Circa 51 BCE | **Queen Cordelia** | | 28 |
| 46 BCE | **Cato the Younger** | 49 | 23 |
| 42 BCE | **Brutus** | 43 | 33 |
| 30 BCE | **Anthony** | 53 | 25 |
| | **Cleopatra** | 38 | 25 |
| 33 | **Judas** | | 24 |
| Circa 61 | **Queen Boudica** | | 29 |
| 65 | **Seneca** | 61 | 27 |
| 1865 | **Robert FitzRoy** | 60 | 69 |
| 1912 | **Lawrence Oates** | 32 | 85 |
| 1914 | **Alexander Samsonov** | 54 | 34 |
| 1922 | **Lewis Harcourt** | 59 | 42 |
| 1932 | **Alberto Santos-Dumont** | 59 | 90 |
| 1945 | **Walter Donnicke** | | 89 |
| | **Alfred Freyburg** | | 89 |
| | **Joseph Goebbels** | 47 | 37 |
| | **Heinrich Himmler** | 44 | 35 |
| | **Adolf Hitler** | 56 | 73 |
| | **Kiyoshi Ogawa** | | 86 |
| | **Korechika Anami** | 58 | 34 |
| | **Kurt Lisso** | | 89 |
| | **Youkio Seki** | | 86 |
| 1946 | **Herman Goring** | 53 | 36 |
| 1947 | **Hatazo Adachi** | 63 | 35 |
| 1951 | **Sadeq Hedayat** | 48 | 96 |
| 1954 | **Edwin Armstrong** | 64 | 31 |
| | **Alan Turing** | 42 | 198 |
| 1960 | **Peter Davies** | 63 | 7 |
| 1961 | **Ernest Hemingway** ** | 61 | 55 |
| 1963 | **Thich Quang Duc** | 66 | 87 |
| 1969 | **Jan Palach** | 20 | 87 |
| 1970 | **Yukio Mishima** | 45 | 20 |

| | | | |
|---|---|---|---|
| 1978 | **James (Jim) Jones** | 47 | 103 |
| 1983 | **Arthur Koestler** | 77 | 6 |
| 1985 | **Sergio Gianfrancesco** | 38 | 50 |
| 1987 | **Daniel Cumerford **** | 19 | 57 |
| | **Bud Dwyer** | 47 | 42 |
| | **Roop Kanwar** | 18 | 20 |
| 1990 | **Floyd Podgornic** | 50 | 96 |
| 1991 | **Sergei Akromeyev** | 68 | 85 |
| 1993 | **Carl Gobbert *** | 39 | 62 |
| | **Larry Walters** | 44 | 99 |
| 1994 | **David Stove** | 67 | 90 |
| 1995 | **Ernest Blanchard** | 46 | 42 |
| 1996 | **Jeremy "Mike" Boorda** | 56 | 1 |
| | **Thomas Hamilton** | 43 | 103 |
| | **Amschel Rothschild** | 41 | 6 |
| 1997 | **Sonia McMullen **** | 32 | 57 |
| | **George Savvas** | | 88 |
| | **Peter Shoobridge *** | 52 | 62 |
| 1998 | **Hideto Matsumoto** | 34 | 4 |
| | **Jared High** | 13 | 93 |
| | **Wendy Hughes** | 43 | 1 |
| | **Richard Hughes** | 47 | 1 |
| | **Takayuki Kamoshida** | 58 | 43 |
| | **Cedric Tornay** | 34 | 49 |
| 1999 | **Mervyn Jenkins** | 48 | 43 |
| | **Lord Sutch** | 59 | 84 |
| | **Rory Jack Thompson** | 57 | 88 |
| | **Ronald Veenstra** | 37 | 2 |
| | **Barbara Ann Wyrzkowski *** | 25 | 61 |
| 2000 | **Wolfgang Huellen** | 49 | 43 |
| | **William Lucan-Roberts** | 61 | 43 |
| | **Greg Wilton **** | 44 | 58 |
| 2001 | **Kasey Hone** | 16 | 93 |
| | **Shahraz Kayani** | 48 | 20 |
| 2002 | **Wafa Idriss** | 26 | 2 |
| | **Jo Shearer** | 56 | 6 |
| | **Robert Steinhauser** | 19 | 103 |
| | **Dee Etta Perez** | 39 | 50 |
| | **Vlajko Stojiljkovic** | 65 | 44 |
| 2003 | **Ryan Halligan** | 13 | 93 |
| | **Carolyn Heilbrun** | 77 | 100 |
| | **David Kelly** | 59 | 44 |
| | **Lewis Rogers** | 24 | 2 |
| | **Elizabeth Stebbins** | 44 | 16 |
| 2004 | **William Brown** | 52 | 44 |
| | **Nafisa Joseph** | 26 | 31 |
| | **Zainab Abu Salem** | 18 | 87 |
| 2005 | **Lee Crisp** | 19 | 16 |

| | | | |
|---|---|---|---|
| | **Rebekah Lawrence *** | 34 | 58 |
| | **Arthur Teele** | 59 | 44 |
| | **Hunter S Thompson** | 67 | 101 |
| 2006 | **Brandenn Bremmer** | 14 | 102 |
| | **Craig Ewert** | 59 | 90 |
| | **Megan Meier** | 13 | 92 |
| | **Brodie Panlock** | 19 | 93 |
| | **Wolfgang Priklopil** | 44 | 44 |
| | **Malachi Ritscher** | 54 | 87 |
| 2007 | **J D "Roy" Atchison** | 53 | 45 |
| | **Helen Cole** | 48 | 16 |
| | **Charmaine Dragun **** | 29 | 59 |
| | **Gilberta Estrada *** | 25 | 62 |
| | **Seung-Hui Cho** | 23 | 103 |
| | **Shinichi Yamazaki** | 76 | 47 |
| | **Toshikatsu Matsuoka** | 62 | 47 |
| 2008 | **Choi Jin-Sil** | 40 | 3 |
| | **Erin Berg **** | 39 | 3 |
| | **Abraham Biggs** | 19 | 94 |
| | **Christopher Foster** | 50 | 45 |
| | **Bruce Ivins** | 62 | 46 |
| | **Daniel James** | 43 | 90 |
| | **Caren Jennings** | 75 | 16 |
| | **Ruslana Korshunova** | 21 | 101 |
| | **Bruce Pardo** | 45 | 50 |
| | **Michael Pigott** | 46 | 46 |
| | **Michael Todd** | 50 | 46 |
| | **Peter Tovey** | 81 | 6 |
| | **Michel Veillette** | 34 | 16 |
| | **Vicki Van Meter **** | 26 | 59 |
| | **Rene-Thierry Magon de la Villehuchet** | 65 | 6 |
| 2009 | **Sir Edward Downes** | 85 | 91 |
| | **Lady Joan Downes** | 74 | 91 |
| | **Robert Enke **** | 32 | 60 |
| | **William Foxon** | 65 | 6 |
| | **Adolf Merckle** | 74 | 6 |
| | **Mohammed Saleh Al-Hanashi** | 30 | 131 |
| | **Kazumi Puttick** | 44 | 3 |
| | **Neil Puttick** | 34 | 3 |
| | **Chanelle Rae** | 14 | 94 |
| | **Rho Moo-hyun** | 62 | 47 |
| | **Shoichi Nagagawa** | 56 | 6 |
| | **Iain Steele** | 15 | 94 |
| | **Julien Tologanak *** | 20 | 60 |
| | **Dudu Topaz** | 62 | 88 |
| | **Carl Walker-Hoover** | 11 | 93 |
| 2010 | **Stack Joe** | 53 | 49 |
| | **Serykh Serge** | 43 | 9 |

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