Chapter 31

SUICIDE: A BROAD VIEW

“Suicide is a very complex, multicausal human behavior with many ‘causes’ and several biological as well as psychosocial and cultural components”

Rihmer, 2007

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Illustration. Wolfgang Priklopil suicided in 2006. He had kidnapped Natasha Kampusch in Vienna, when she was 10 years of age. He kept her as a secret captive for 8 years. When Natasha escaped, and the police were summoned, Priklopil threw himself under a train. He was a communications technician, who owned his own house and car (Kampusch, 2010). His death appears to have been motivated by his fear of apprehension.

A caution

Many psychiatric suicide experts believe that psychiatric disorder underpins all, or almost all, suicide. (This is currently the prevailing view.) From this perspective, suicide will be eradicated from a community by the provision of sufficient psychiatric services.

The current author has a different view, believing that while psychiatric disorder underpins much, it by no means underpins all suicide. From his perspective, the reduction in suicide in a community is the responsibility of the entire community.

The difference between these two views depends, in large part, on different concepts of “diagnosis” (see Chapter 31, Medicalization).

The first part of this chapter presents the prevailing view. The latter part gives some details of other views.

Prevailing psychiatric view

The prevailing psychiatric view is that suicide is primarily the result of psychiatric disorder and is therefore predictable and preventable (Barraclough et al, 1974; Mann et al, 2005).

Suicide represents “a huge human tragedy”, with a rates from 3 (Greece) to 16 (Australia) to 31 (Russian Federation) per 100 000 per year (De Leo & Evans, 2004). Major depressive disorder and bipolar disorder is associated with at least 60% of suicides (Bertolote et al, 2003; Goldney, 2003). The lifetime risk of suicide of people with major depression is 3.4% (Blair-West & Mellsop, 2001). Up to 83% of those who complete suicide have had contact with a physician in the year before their death (Luoma et al, 2003).

Research groups dedicated to the understanding and prevention of suicide conduct “psychological autopsies”, that is, they sift through all the information available regarding the events of the individual’s life prior to suicide. They report evidence of diagnosable mental disorder in 90% of those who suicide (Arsenault-Lapierre et al, 2004) and argue that the remaining 10% probably suffered a mental disorder which they were unable to detect (Ernst et al, 2004). [The “psychological autopsy” is not without scientific difficulties (Pouliot & De Leo, 2006). Retrospective investigations are notoriously inaccurate, and it is possible that distress is misdiagnosed as depression.]

The prevention strategy which is a natural consequence of these observations has been described as “improved screening of depressed patients by primary care physicians and better treatment of major depression” (Mann et al, 2005).

With respect to people who are admitted to psychiatric wards, there are two peaks in the completion of suicide, one is immediately after admission and the other is immediately after discharge (Qin & Nerdentoft, 2005). The prevention strategy which is a natural consequence of these observations has been described as “enhanced follow-up”.

Evidence indicates that in certain areas, the introduction of antidepressants has reduced the suicide rate among depressed individuals (Nettelbladt et al, 2007). However, this has not reduced national suicide rates.

Schizophrenia is associated with a lifetime risk of completed suicide of 9-13% (Pinikahana et al, 2003), and may therefore be more lethal than depression. Other diagnoses, including anxiety, are also associated with greater risk (Friedman et al, 1999).

In recent research, psychiatric disorder leading to hospitalization was the most prominent risk factor, but unemployment, low income, single and divorced marital status, and family history of suicide additional important risk factors (Qin et al, 2003; Rihmer, 2007).

As mental disorders are associated with a higher risk of suicide, those treating patients need to be aware and, when possible, take appropriate action to prevent this outcome.

There is little opposition to the orthodox psychiatric view of suicide in the western academic literature. Earlier, Stengel (1970) estimated psychosis, neurosis or personality disorder to be present in 34% of cases, but recent work (Nettelbladt et al, 2007) found evidence of psychiatric or alcohol disorder in 93 % of cases.

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But, this very high relationship with mental disorder is not always reported. Wang and Stora (2008) found evidence of psychiatric or drug disorders in only 61% of suicides in the Faroe Islands. Recent work in China found a "startlingly" low rate of mental disorder among completers (Law & Liu, 2008), and a recent editorial stated, "the crucial and causal role of depression in suicide has limited validity in Asia" (Vijayakumar, 2006).

Genetics

The genetic contribution to suicide is important. Adoption (Schulsinger et al, 1979), family (Wender et al, 1986), and twin (Baldessarini and Hennen, 2004) studies have demonstrated that genes have a powerful influence on suicide risk. Risk is shared by biological but not adoptive relatives, which demonstrates that the familiality of suicide is due to genes rather than family environment (Wender et al, 1986).

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 that psychiatric disorder is transmitted which then leads to suicide.

Heritability accounts of 30-55% of the risk for suicide (Voracek & Loibl, 2007). Gene/s for suicide are not proposed, rather this effect probably comes via genetic influences on the personality features of neuroticism/hopelessness and impulsivity/aggression, which underpin some suicidal behavior. (See Chapter 10, 'Personality' for more on these features.)

A recent comprehensive study did not reveal any genetic variants which predicted suicide risk, and studies of rare variants are now recommended (Uher & Perroud, 2010).

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From possession to psychiatry

Suicide is known in all cultures and periods of history. It is known in the Jewish, Christian and Islamic faiths (Lester, 2006).

The Bible provides accounts of suicide and suicidal thinking. Mathew 27: 5 details the actions of Judas when the priests refused to allow him to retract his betrayal of Jesus: "And he cast down the pieces of silver in the temple and departed, and hanged himself." Revelations 9: 6 refers to a time when the air will be filled with smoke and flying scorpions: "And in these days shall men seek death and shall not find it, and shall desire to die, and death shall flee from them". These excerpts indicate that individuals in particular circumstances may choose and complete or desire death.

In ancient Greek and Roman times suicide was permissible (Anthony and Cleopatra suicided). However, for most of history, suicide, like homicide, has been forbidden. Among East African tribes the tree from which self-hanging had occurred had to be felled and burnt (Bohannan, 1960).

The Koran is said to condemn suicide. (Detail of the appropriate passages will be included in subsequent editions, if they can be identified.)

While the Bible does not contain a clear prohibition (Koch, 2005), the Christian church has considered suicide to be the result of satanic possession, and refused to bury the body with the usual religious rites. From pre-Christian times, in various countries, a stake was driven through the body, which was then buried at the crossroads. This custom was last performed in Britain, in London, in 1823.

After the 1820's, the moral/religious debate became "medicalized". At a time when the recognized mental disorders were mainly the organic mental states and the psychoses, the notion was advanced that every person committing suicide was suffering a mental disorder. Berrios (1996) designated this position, the "psychiatric thesis", and the contrasting view, that suicide is not always due to psychiatric illness, the "standard view". He summarized the arguments and concluded that by the end of the 19th century, the debate had been decided in favor of the standard view.

In the 20th century, when the neuroses (mild depression and anxiety disorders) and personality disorders were described under the rubric of mental disorders, the debate flared up again. As mentioned, the most widely held current view is that mental disorder is always, or almost always, the result of a mental disorder.

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Acute and chronic risk

Suicide risk may increase rapidly (to the acute level) as a result of sudden overpowering distress, or intoxication, in people both with and without mental disorder.

Wyder (2004) examined individuals who had survived a suicide attempt; 51% reported acting after thinking about their actions for 10 minutes or less. Of those who had been affected by alcohol, 93% had thought about their actions for 10 minutes or less. Impulsive acts make prevention problematic.

The mental disorder most commonly associated with acute suicide risk is major depressive disorder. The risk is particularly great when the depression is severe and psychotic symptoms (delusions of guilt and loss) are present. Mental disorders may be complicated by unhelpful personality features, and alcohol use. Dumais et al (2005) investigated cases in which suicide was completed during an episode of major depression. They found that impulsive-aggressive personality disorders and alcohol abuse/dependence were two important, independent predictors of suicide in major depression.

When acute suicide risk is the consequence of a mental disorder, appropriate treatments (outlined in other chapters) should be administered without delay. Compulsory admission and treatment may be necessary.

Some individuals are at long term (chronic) risk of suicide. Chronic risk is a common feature of personality disorder, particularly borderline personality disorder. The personality disorders differ from conditions such as major depressive disorder, which manifest discrete episodes of difficulties. "Personality" refers to the characteristic (long-term) manner in which the individual responds to the environment. Personality disorder is diagnosed when features of the personality lead to "distress and impairment". When the suicide risk is due to personality disorder, as personality disorder is a long-term (rather than episodic) disorder, the suicide risk will be, at least, chronic.

While personality disorder is a chronic condition, there may be superimposed periods of more acute distress and acute risk of suicide. Borderline personality disorder, characterized by a pervasive pattern of instability of interpersonal relationships and mood, and marked impulsivity, has a 10% lifetime risk of suicide (Plakun et al, 1985). Impulsive suicide is usually triggered by adverse life events (Zouk et al, 2006).

The personality of people with personality disorder may mature and distress may lessen over a period of years, particularly with the assistance of ongoing outpatient care. Lengthy inpatient periods in psychiatric facilities are at best useless and at worst, damaging; they remove individuals from the real world in which they must learn to function, and delay the development of a sense of personal responsibility. However, brief hospitalization of individuals with personality disorder may be helpful during crisis periods (no longer than 72 hours) to allow the settling of acute episodes of distress (Krawitz & Watson, 2000). Wyder (2004) reports that of those who attempt suicide, in 79% the impulse has passed within 12 hours.

The management of patients with borderline personality disorder is legally perilous for doctors because of the lack of understanding in the community of the chronic risk of suicide and the optimal treatment mentioned in the above paragraphs (Gutheil, 1985). There are some informed jurisdictions, however, and the Ministry of Health (New Zealand) Guidelines (1998) state, “In order to achieve therapeutic gains it is sometimes necessary to take risks. A strategy of total risk avoidance, could lead to excessively restricted management, which may in itself be damaging to the individual”.

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Distress

There is general agreement that all those who perform suicide are emotionally distressed at the time. This probably includes those who suicide “for the greater good” of their community, such as political protesters, Kamikaze pilots and suicide bombers.

Illustration. Thich Quang Duc burned himself to death in Saigon (Vietnam) in 1963. He was protesting the way, the government was (in his view) oppressing the Buddhist religion.

Not infrequently, we learn of the suicide of people who are suffering intractable physical pain. Chronic pain doubles the risk of suicide (Tang & Crane, 2006)

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Illustration. Jo Shearer, a 56 year old accomplished journalist who suffered intractable pain. She advised colleagues of her intention and ended her life.

Distress occurs in people who are facing legal charges. At the time of writing, Steve Wright, the alleged Suffolk Ripper, is on 'suicide watch'. The suicide of Wolfgang Priklopil in 2006 was mentioned on the first page of this chapter. Other examples of apparent distress leading to fatalities appear to include the suicide in 1987 of Budd Dwyer a disgraced Pennsylvanian (USA) public figure, who shot himself in front of television cameras, the suicide in 1996 of Admiral Jeremy Boorda (USA) who was being investigated for wearing a medal to which he was not entitled, the suicide in 2000 of Wolfgang Huellen, the chief financial officer of the Christian Democratic Union (Germany) who was being investigated for embezzlement, and the suicide in 2003 of Dr David Kelly a British Ministry of Defense scientist who had been blamed for a political scandal relating to the Iraq War.

Illustration. Budd Dwyer shooting himself in front of television cameras (1987).

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. Thus, for this group, problem acne generated distress which could not be classified as depression or anxiety.

The sociological model

"Experience indicates that for effective suicide prevention, the appropriate treatment of people with mental disorders is just one of the main components. Actually, biological and psychological characteristics, and factors pertaining to the cultural, social and physical environment, although more difficult to approach in quantitative ways, should receive much more attention…"

Bertolote et al, 2004

In 1897, Emile Durkheim, a French sociologist, published his important text, "Suicide" (translated, 1951). He proposed that social factors were the setting and major cause of most suicide. He is misunderstood by those who have not read his work. His critics claim he paid no attention to the mental state of individuals and mental disorders – this is not accurate (Pridmore, 2010), but such debate is not appropriate in a basic text.

Not surprisingly, as a sociologist, Durkheim drew attention to the sociological factors of suicide, and this is a great and enduring contribution to the field of suicidology. He emphasized, 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". And, 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. It is noted here that egoistic suicide may occur because of features in the individual, it is not necessarily the result of an unhealthy society, but simply that this particular individual does not well integrate (find meaning and support) with this particular society.

Moral regulation refers to the limitation and modulation of "the passions" (including aspirations). Durkheim used the term "anomie" to describe the situation when society provides 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. This is 'anomic' suicide. The example of anomie which Durkheim observed was the Industrial revolution, however, many others have existed, such as the fall of the communism in USSR, and Durkheim believed that "in the sphere of trade and industry" (a field in which acquisition is the goal and there are no limits to profits) anomy is "a chronic state".

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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. Durkheim believed this could lead to 'altruistic' suicide (such as the Kamikaze pilots, Thich Quang Duk, above; 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 'fatalistic suicide'(Jo Shearer, above. Altruistic and fatalistic suicide are rare and of little importance here. Egoistic and anomic suicide, or associated factors are probably far more common than currently accepted.

Durkheim was the first to demonstrate that the suicide rates of the different nations were different, but relatively stable over time (naturally, this encouraged him to look for a sociological explanation). This remains the case.

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.

Current sociological studies of suicide continue to support Durkheim's work. A major study by Zimmerman (2002) concluded, "Overall, the findings are consistent with the Durkheimian view that suicide is a statement about the characteristics of those institutions that normally function to bind individuals to each other and the larger society – marriage, community, workplace, social welfare – linking macro-level phenomena with the actions of individuals". Qin et al (2003) while finding that psychiatric disorder was a prominent risk factor for suicide, also found support for the Durkheimian theory that the protective effect of marriage is largely an effect of being a parent.

The impact of social factors (in particular, anomie) on suicide rates is currently well demonstrated in 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 and family conflict, alcohol abuse and hopelessness are believed to be important factors leading to suicide (Strickland et al, 2006). The 2003 SARS epidemic in Hong Kong was associated with a marked increase in the suicide rate of the elderly, and biopsychosocial factors have been implicated (Chan et al, 2006). Psychosocial stresses have been associated with the suicidal behavior of adolescents in rural China (Liu et al, 2005) and Korea (Kim et al, 2010).

The importance of social factors in suicide in Australia was demonstrated by Page et al (2006), across the period 1979-2003, socioeconomic status differentials in suicide persisted for both men and women. Low socioeconomic status was consistently associated with higher suicide rates, high socioeconomic status was consistently associated with lower rates and middle socioeconomic status was consistently associated with a suicide rate between these extremes.

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Further, for working age people, suicide rates are influenced by "business cycles"; rising during periods of recession and falling during periods of growth (Luo et al, 2011).

The importance of social issues was recently highlighted in England, where suicidal ideation was generally lower in ethnic minority groups (Crawford et al, 2005). These authors found that risk factors were common across the different ethnic groups and that, "current symptoms of mental distress being the most important". Their use of the term 'mental distress' rather than mental disorder is applauded.

With respect to religion/culture, evidence suggests a lower suicide rate among Muslims than other groups (Shah & Chandia, 2010; Gal et al, 2011).

The relationship between perinatal circumstances and subsequent young adult suicide has recently been examined (Riordan et al, 2006). A higher suicide risk was demonstrated for those who were, 1) the offspring of young parents, 2) the children of mothers of high parity, 3) the children of non-professional parents, and 4) of low birth weight. This study suggests that less than optimal perinatal circumstances impact on the individual, perhaps through personality development, limiting coping skills in later life.

Sociological factors have a profound effect on the rate of suicide. Thus, suicide is not simply a matter for mental health services. In Durkheim's view, for suicide rates to be reduced, society has to create greater integration and support for members (there will also be need of changes in educational, economic and employment opportunities, and illegal drug availability).

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Prediction and prevention

In the majority of cases, the prediction and prevention of suicide is not possible.

In efforts to identify individuals at high risk of suicide, various lists of "risk factors" have been identified, such as, male, older, widowed, single or divorced, childless, high density population, residence in big towns, a high standard of living, economic crisis, alcohol consumption, broken home in childhood, mental disorder, physical illness (Stengel, 1970). It was/is expected that equipped with such lists, helpers would be able to identify those at high risk and then provide help which would prevent suicide. The attempt to predict uncommon behavior such as suicide unavoidably generates a huge number of false-positive and false-negative cases (Sher, 2011).

An excellent examination of the validity and utility of categorizing inpatients with respect to risk of suicide (Large, et al, 'in press') concludes, "Risk categorization of individual patients has little or no role to play in preventing suicide amongst psychiatric inpatients".

Some medically orientated groups make observations which encourage the belief that mental health professionals can prevent suicide. For example, a recent study (Beautrais, 2004) of people who had made a suicide attempt found that after 5 years, 6.7% had died by suicide. The paper concludes, "These findings imply the need for enhanced follow-up, treatment, and surveillance of all patients making serious suicide attempts". This argument is logical, but impractical; most services are already doing their best and there is no evidence that any form of therapy is effective (see later).

In another example (Burgess et al, 2000), “Data on patient and treatment characteristics were examined by three experienced clinicians” and they found that “20% of the suicides were considered preventable.” The danger of retrospective studies aside, there is no proof in such statements that had the apparent shortcomings identified by experts been altered, suicide would have been prevented. An exemplary admission procedure does not stop the patient out on leave getting drunk or being rejected by a lover; it does not strengthen the last straw for that individual.

Beck et al (1999) studied outpatients at high risk of suicide, people 100 times more likely to suicide than members of the general population. They found the suicide rate among this high risk population 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 compared those who had suicided as inpatients with a control group and identified risk factors. However, 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”.

Appleby et al (1999) conducted comprehensive analysis of 10 040 suicides. 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 attempt to predict which 39 had suicided. 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 groups have been given sustained attention with special counseling and additional support. In none of these was there a significant difference in outcome when the experimental was compared to a control group. Reviewing these studies, Gunnell and Frankel (1994) found, “No single intervention has been shown in a well conducted randomized controlled trial to reduce suicide”. Similar conclusions have recently been made with respect of suicide among young people (Robinson et al, 2010).

To date, 5 men have completed suicide at Guantanamo prison camp. Even with the reputation of the most powerful nation in the world in the balance, in the most secure environment on the planet, and with all possible resources, suicide could not be indefinitely prevented.

The benefit of hospital admission

Not infrequently, following a suicide, there is criticism of mental health professionals and systems for failing to admit people to hospital or, having admitted them, failing to provide flawless supervision. Most psychiatrists, however, have known closely supervised patients

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who have suicided. Powell et al (2000) described their experience, "…two inpatients were under continuous observation. One of these two jumped through a window and deliberately cut his neck with the broken glass, the other ran to a railway line and was hit by a train." Thus, admission to hospital and continuous observation is not a guarantee that suicide of a particular individual will be prevented.

With respect to community suicide rates, Garlow et al (2002) reported a natural experiment. In response to budgetary constraints, admissions to psychiatric hospital in Fulton County Georgia, USA, had to be reduced. Admissions were cut by 56%. Over the same time period, the suicide rate of the county did not increase, but fell, from 12 to 10/100 000 (not statistically significant). Thus, ready admission to hospital does not improve the suicide rate of a general population.

The impact of suicide on others

'Do not speak ill of the dead', Mimnermis (650-550 BC)

Impact on relatives and friends. There is surprisingly little standardized data on the effect of relatives and friends of those who suicide. Anecdotally, suicide causes much suffering in at least some relatives and friends. This may be greater when the relationship has been difficult between the person who suicides and those who are left. Some authors believe suicide can represent an aggressive act, an angry rejection and punishment of friends and relatives.

Impact on mental health professionals. For mental health professionals, suicide of patients is inevitable and has been designated an "occupational hazard" (Ruskin et al, 2004). The impact may be severe.

Ting et al (2006) described the impact of client suicide on mental health social workers, which in extreme cases included refusing to see further clients who appear to be at some risk, leaving the place of work and even the state.

Alexander et al (2000) studied psychiatrists and reported that following the suicide of a patient, a large proportion develop symptoms suggestive of depression, which last for at least a month, and 15% consider taking early retirement.

Dewar et al (2000) studied trainee psychiatrists and found 31% reported the suicide of a patient had an adverse impact on their personal lives. Following a suicide the trainees became "over cautious" in their management of patients, which was to the disadvantage of patients. 9% of trainees considered a change of career, and a small proportion decided not to pursue careers in general adult psychiatry because of its higher risk of patient suicide.

Eagles et al (2001) state, "it seems probable that onerous expectations of prediction and prevention…contribute to the distress which suicides cause psychiatrists". Such expectations of prediction are based on an incomplete understanding of the field and are unfair. There is a world wide shortage of trained mental health professionals, and any process which further depletes this pool exposes rather than protects patients.

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The impact of criticism on systems. Scrutiny of systems may ensure the maintenance of high standards. Excessive criticism, however, may be destructive. Critics of systems frequently suggest that additional steps need to be taken to protect patients. This results in the introduction of additional paper work, so that every aspect of patient care is fully documented and staff are more, but not completely, legally protected. A problem which can arise is that staff need to spend so much time on defensive documentation that there is little left to spend with patients.

An additional consequence of post suicide criticism has been the locking of open wards. With the closing of the old psychiatric hospitals, new psychiatric wards were established in general hospitals. Initially these were open wards. Overtime many general hospital psychiatric wards have been converted into secure (locked) facilities. This is, at least in part, a response to criticisms made during the scrutiny of the suicide of unrestricted patients who have been able to leave wards and complete suicide. On balance, the closure of open wards to prevent the unpredictable is a retrograde step.

Patfield (39) described "Creeping Custodialism". He observed that, "Progressive removal of 'hazards' in order to prevent self harm, often in response to coronial inquests or law suits, is leading to inpatient units becoming stark and oppressive". His view is that "The person who suicides in an inpatient setting is frightened, sad, lonely, disaffected, tired from sleepless night and feels that life is hopeless and futile". He believes that in the psychiatric ward there is a need to provide "warmth, human connection, reality and hope". Finally, he stated that some strategies designed to "protect" patients serve to further isolate them and "paradoxically make suicide more likely".

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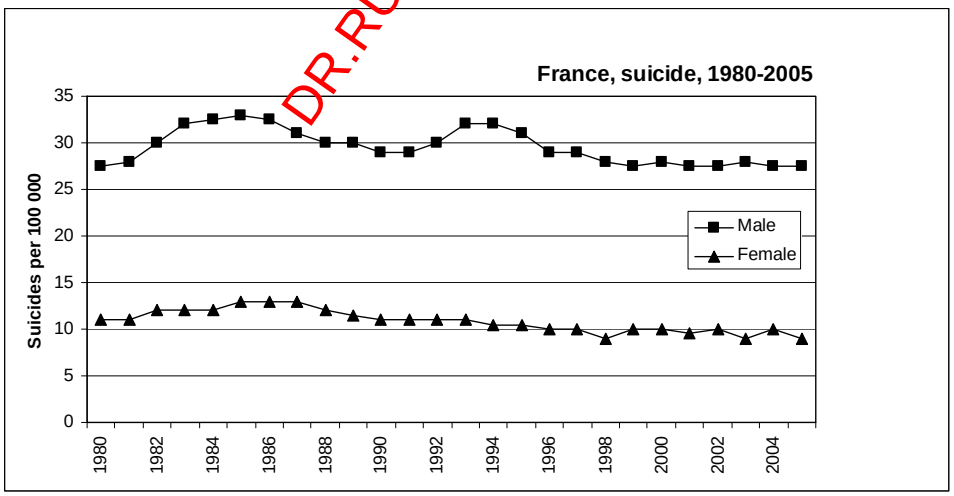
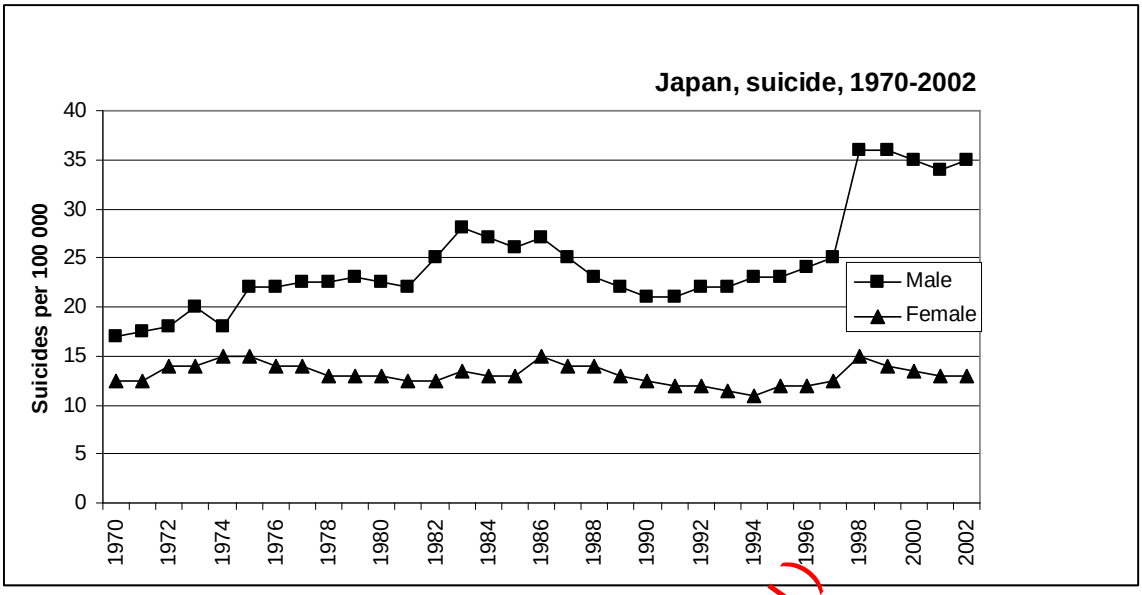
Rates of suicide

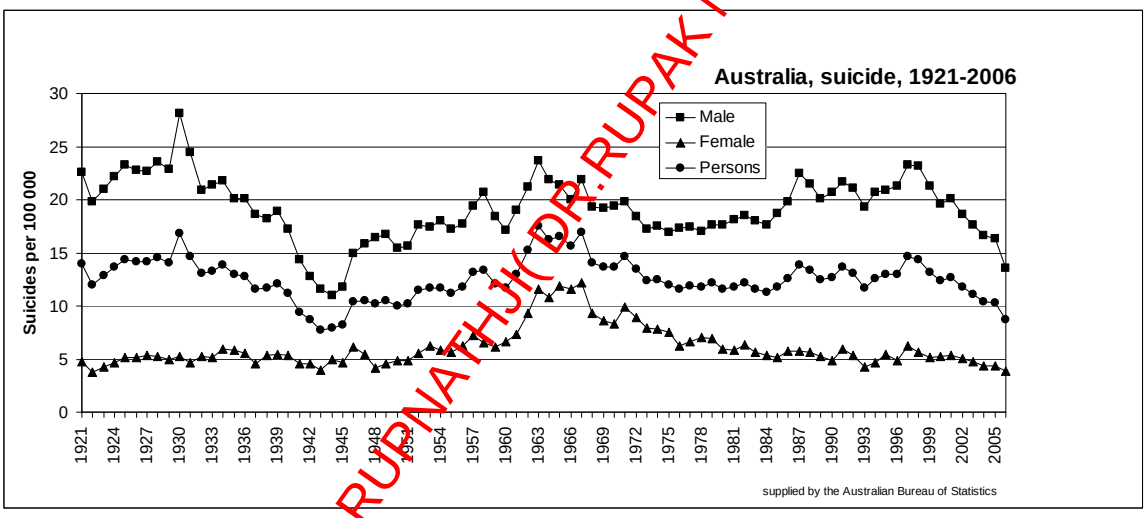
As Durkheim observed, the rates of suicide differ from one country to another, and they are relatively stable. While this difference may to some extent reflect different methods of "diagnosis" and data management, cultural factors are of overwhelming importance.



Suicide in France over a quarter of a century. An example of a relatively stable suicide rate.



Suicide in Japan over a 32 year period. A sharp rise in the suicide rate of men in the late 1990s reflects an economic downturn.



Suicide in Australia over an 85 year period. During the 1990s there was an increase in suicide rate which largely remains unexplained. From 1997, there has been a general reduction in suicide rate, again, largely unexplained. Of interest is a fall in suicide rates from 1935 to 1945. These are the years of the Second World War. This is the usual response during wartime, and is believed to be because the community draws together against a common enemy. Also of interest is the increase in suicide rate from the early 1960s, lasting till the late 1960s. This was the years of the Vietnam War. This increase is contrast to the rule. However, the Vietnam War divided the people of Australia, with public protests and great public unease, which may explain this apparent anachronism.

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