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The sociological study of suicide and its theoretical and methodological implications

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The sociological study of suicide and its theoretical and methodological implications

Introduction

This section uses the study of suicide to demonstrate how different sociological methodologies (in this instance **positivism**, **realism** and **interpretivism**) have approached the problem of understanding and explaining suicidal behaviour. In this respect we can use the study of suicide to firm-up our knowledge of sociological methodology by understanding how different methodologies have been applied to the study of the same behaviour while also demonstrating the social causes of what may appear, on the face of things, to be a highly individualistic choice and act.

As this suggests, while there is clear agreement among sociologists that suicide has a social causality, there are substantial disagreements about what this causality might be and, most importantly, where it is to be found. We'll pick-up and develop this idea in more detail later, but we can begin by identifying some of the basic ideas, concepts and arguments that have surrounded the sociological study of suicide over the past century.

The Study of Suicide: Observations

We can start to examine some of the *sociological issues* surrounding the study of suicide by identifying three significant ideas:

1. Definitions: The 'problem of definition' is usually an issue whenever we study social behaviour (the idea of a **contested concept**, for example, is one we've come across many times). In this instance, however, problems relate not so much to how suicide can be *defined* (it has a reasonably straightforward definition) but rather how it is **classified**. For a variety of reasons, it can be difficult to determine whether or not a particular form of death is actually a suicide (as opposed to something else – such as murder or an accident). Our ability to clearly classify some forms of behaviour as suicide (and others as non-suicide) is a crucial methodological issue here.

2. Constructionism: One reason for problems of classification within sociology is the idea of human behaviour as *socially constructed*; in other words, the extent to which social behaviour has different:

Meanings and **interpretations** for different individuals and cultures. In this instance, "cause of death" in the UK may have many possible interpretations and the same is true when we broaden the scope to include the behaviour of people in other societies and cultures. A couple of examples should clarify this issue:

• **Crime**: Until 1961, suicide was a criminal offence in the UK. Euthanasia (killing someone at their request) remains a criminal offence, although in countries such as Holland it has been legal since 1984.

• **Deviance**: In the UK, suicide is seen as a deviant act. In traditional Hindu cultures in India, however, a form of *ritual suicide* (*suttee*) was practised (and in some cases still is, even though it was made illegal in 1829) – a widow commits suicide by throwing herself on her husband's funeral pyre.

To *not* commit suicide, in this instance, would be considered a deviant act.

Concepts of *construction* and *classification* suggest a further issue:

3. Typologies (a systematic classification into different types, based on shared qualities): Here, the question is whether we can *type* 'suicide' as a prelude to explaining it; in other words, if we can identify different types of behaviour (suicide, voting, families or whatever) it follows that something must *cause* individuals to behave in communal ways. Whether these causes are found in areas like genetics, psychology or sociology, the key point is that human group behaviour has a *causality* that can be identified and explained using typologies as "frameworks for speculation" (**Tatz,** 1999). In other words, if we can identify patterns in suicidal behaviour it should be possible to identify the causes of these patterns.

Suicide Typologies

By way of illustration we can look at a couple of classifications of suicidal behaviour based around how various categories correlate to different social factors.

Aside from **Durkheim's** (1897) pioneering work (*see below*) one of the most influential classifications in recent times is **Wekstein's** (1979) "10 Types of Suicide":

Type	Explanation
1. Chronic	The "suicidal individual" indulges in behaviour they know to be harmful over an extended period. General examples here are individuals who effectively "drink themselves to death" or engage in highly risky forms of drug abuse. A specific contemporary example might be the footballer George **Best** who continued (up until his death) to consume large quantities of alcohol even after a life-saving liver transplant.
2. Neglect	While similar to the above (it involves the individual engaging in risky behaviours detrimental to their long-term well-being) it is more specific in that the risky behaviour involves a decision to "ignore the reality of a situation". **Tatz** (1999) gives the example here of "the diabetic who indulges in dietary indiscretions and then 'forgets' to take his or her medication".
3. Sub-intentional	This relates to forms of behaviour involving both *neglect* (such as being unconcerned about the possible outcome of one's behaviour) and *risk* – in the sense that the outcome of one's behaviour (such as driving through a red light at a busy road crossing or taking a drug overdose when there's a chance someone may find the individual before they die) represent a "life or death gamble" (what **Baechler** (1979) calls **ludic** suicide).
4. Surcease	A form of rational suicide (or *auto-euthanasia*) where the individual consciously decides to take their own life (or, in some instances, pay or encourage others to do it for them) as a means of escaping from an intolerable situation. There are a range of recent examples of surcease suicide we can note – from that of the classical conductor Sir Edward **Downes** and his terminally-ill wife whose joint suicide, in 2009, was facilitated by the Dignitas clinic in Switzerland (where, unlike in the UK, assisted suicides are legal), to Daniel **James** in 2008 (the 23 year old had suffered paralysis from the chest down following a rugby accident and Reg **Crew** in 2003 – the first person from Britain to take his own life at the Dignitas clinic (**Downes** was the 118th).
5. Psychotic	This form is related to the psychological state of the individual in that although there is no clear and unequivocal intention to commit suicide the "psychotic suicide", by attempting to remove some aspect of their feelings of *psychological* inadequacy, engages in behaviour that on occasions results in death.
6. Focal	Suicide is the result of the individual attempting to remove some aspect of their *physical* self (through self-harm or mutilation).
7. Automatisation	This involves removing a source of pain through some form of drug use and, when no relief is achieved, the individual takes ever-increasing doses until they eventually kill themselves.
8. Accidental	Death is the result of the individual miscalculating the riskiness of their behaviour.
9. Suicide by murder	This involves deliberately attacking someone who has superior strength or weaponry in order to provoke the attacker's own death.
10. Existential	This occurs because the individual tires of life, sees little or no point to their continued existence or simply sees life as meaningless. This type may occur in a number of ways – from slaves and torture victims at one extreme to individuals who have grown old and lost the friends and family who gave their life some interest and meaning.

Former dock worker Reg Crew (left)

A second typology, created by **Tatz** (1999) in his study of (Australian) Aboriginal suicides, draws on and adds to **Wekstein's** classification to create what he termed "a different typology of suicide":

Type	Explanation
1. Political	This involves the individual making some kind of "political statement" – "a public declaration of anger or grievance designed to gain a hearing, possibly even a response. It is an attempt at power…an effort to move someone, or something, to a response". Political suicide has two main forms: **a. Organisational**: A classic example here is a "suicide bomber" – someone willing to kill both themselves and others as a political statement. **b. Individual**: The suicide is making a *personal political statement* – such as blaming others for "forcing" them to commit suicide. It can also be seen as a form of "revenge" against authority or an oppressor (by attempting to make them feel guilt or responsibility for the individual's death).
2. Respect	This form represents a means by which the individual "gets the respect from others they were denied in life". Suicide is a way, at least momentarily, of becoming the centre of others' attention.
3. Grieving	This is sometimes labelled "copy-cat" suicide since it results from the grief felt by the living for someone who has died. While this is normally someone close to the individual (such as a relative or friend), in some cases the suicide is influenced by the death of a celebrity (a sporting or film star, for example).
4. Ambivalently rational:	This occurs when an individual is well-integrated into a social group and, for whatever reason, they are suddenly removed from the comfort and protection of the group. Without the group the individual feels isolated, alone and friendless – and in such intolerant situations suicide becomes a rational option.
5. Appeal	Suicide occurs when an individual "has reached the end of their tether and feels unable to achieve a social aim unaided by others. It is a "cry for help"'. In situations where the individual is unable or unwilling to make a public appeal for help and is similarly unable to "persuade their family to share their (personal and social) responsibilities" violence is turned towards others and, ultimately, themselves
6. Empowerment	For individuals who experience a lack of "power, autonomy, self-fulfilment, or personal sovereignty over their physical, material or internal lives", suicide represents a moment of autonomy and empowerment – a time when they are completely in control of their own life (and death).
7. Lost suicides	This is characterised by the individual losing sight of "who they are" (their individual identity expressed, somewhat paradoxically, through their membership of a particular group). It can have a specific causation – the feeling of isolation and emptiness when excluded from a valued group – or a more general causation (such as suffering the effects of racism, sexism, bullying and the like).

The death of Michael Jackson saw an almost immediate increase in grieving suicides.

"DEVASTATED Michael Jackson fanatics have committed suicide because of the superstar's death, according to the singer's biggest online fan club.

Up to 12 heartbroken followers of the star have taken their lives - including one Brit — said the MJJ community website (http://www.mjjcommunity.com)".

The classifications we've just outlined reflect one basic type of "suicide typology" in the sense they focus on the concept of:

"**Suicide"** (in the singular): Here, suicide has a relatively clear, standardised, meaning deriving from the physical act itself. Once we establish the concept of "a suicide", therefore, we can move towards identifying different possible types. This general position is largely associated with **positivist** and **realist methodologies** where an attempt is frequently made to classify different types of suicidal behaviour as a means of explaining how and why these occur. This is *generally* based on two main assumptions;

1. That it's possible to distinguish between "suicidal" and "non-suicidal" behaviour.

2. Suicide is a quality of the intentions of those who choose it, rather than – as some Interpretivists argue – a quality of the choices made by significant actors surrounding the dead individual.

In general, therefore, this theoretical position sees suicide as largely *unproblematic* (not open to interpretation) and, from this, the task of sociology is to explore different possible causal explanations. Alternative typologies, however, focus on the concept of:

"**Suicides"** (plural): This interpretation – one largely associated with **Interpretivist** methodology - makes "suicide" *problematic* by thinking about two ideas:

a. The meaning people who kill themselves give to their actions.

b. The meaning given to the "fact of death" by others (such as a coroner).

Rather than talk about "suicide" as if it had a simple, clear and uncontested meaning, therefore, we should, according to writers like **Douglas** (1967), see this act as involving a wide range of possible meanings and interpretations – one 'suicide' is never the same as any other. **Berard** (2005) argues we should see suicide as an '*evaluative category*', one whose particular meaning is decided by 'persons, actions, institutions [and] social contexts'. In other words, 'suicide' is a socially constructed category whose meaning depends (as writers such as **Atkinson** (1978) have argued) on how the act itself is *interpreted by others,* especially those with the power (such as coroners) to decide whether an act is classified as suicide. In this respect the question here is the extent to which suicide can be considered a quality of what someone does (a quality of the individual and their chosen behaviour) or a quality of how people *react* to someone's behaviour? In other words, do theories that ask different questions about "the meaning of suicide" develop different types of explanation and arrive at different answers? This question is important in terms of two ideas:

1. Labelling: If we *accept* suicide is a quality of how a certain form of behaviour (death) is labelled by significant actors such as doctors, the police and coroners then the "causes of suicide" will be found in the behaviour of these people – we need to research them, rather than look for answers in the behaviour of victims (their psychological and sociological states, for example). We will examine this methodological position in more detail when we look at **Interpretivist methodology**.

Coroners are one of the most significant actors where decisions about suicide or non-suicide are concerned...

2. Essentialism: If we *reject* labelling explanations we accept suicide has some *essential* qualities that can be discovered through sociological research. We can discover, for example, why people commit suicide by examining their social situation prior ending their life. This general area will be explored in more detail when we look at **positivist** and **realist** methodologies.

People commit suicide by jumping from bridges - but they also jump for fun...

These two basic positions illustrate a further sociological issue, namely the distinction between:

1. **Objectivity**: The idea here is that we can produce objective knowledge about the social world; we can, therefore, produce factual knowledge that proves or disproves certain ideas and explanations based on the use of objective evidence. **Durkheim** (1895) classically expressed this idea as "consider social facts as things"; in other words, as something that has a real, objective, existence.

2. Subjectivity: This position suggests all knowledge is both partial (one-sided) and incomplete. In relation to suicide, **Berard** argues a crucial consideration in any understanding and explanation of social behaviour has to be "…the question of *how* the relevant data is identified and assembled". In other words, the types of official (statistical) data on which supposedly objective knowledge about suicide is based are, in reality, themselves the product of choices and decisions made by social actors. We can highlight a further range of issues related to *how* and *why* we collect different forms of data in terms of:

Methodology: The study of suicide brings into sharp relief a number of issues relating to both theory and method, some of which we can simply note and others we can develop. We can start by thinking about the issue of:

Data collection, mainly because the problems associated with the study of suicide, while unique (in the sense that perpetrator and victim are the same and the victim can't, for obvious reasons, be personally questioned), can be related to many other areas of social life. On the face of things, given the problems just noted, the obvious way to study suicide is to use:

Quantitative methods, such as official suicide statistics. This was the route originally taken by **Durkheim** (1897), for example. His technique was to compare different rates of suicide in different societies (hence the idea of a **comparative methodology**) in order to identify possible *patterns* of suicide, which he could then explain in terms of social forces acting on individuals that 'propel them into suicidal behaviour'.

Official statistics are a major source of quantitative suicide data

Correlations: Alternatively, it's possible to compare different sets of data to search for correlations - comparing **suicide rates**, for example, with factors such as levels of unemployment, poverty and family breakdown. This can be done on both *regional* (**Congdon**, 1996) and *national* (**Diekstra**, 1989) levels.

A major problem with this approach is that of demonstrating successful suicides actually had the correlated characteristics. To overcome this, a common statistical method is to work at the individual level, correlating known data about *successful* suicides to identify possible patterns in their behaviour, an approach taken by **Charlton** (1995) among others. Such individual data frequently includes a combination of *objective features* (employment and family status, age, gender, and so forth) and *subjective features* (mental health, for example). A problem here, however, is that the latter type of data are open to different interpretations, especially if data about a suicidal individual's "state of mind" is gathered from 'unqualified sources' (colleagues, friends and the like).

Evaluation

Quantitative methods, as writers such as **Douglas** and **Berard** have suggested, may be *problematic* because suicide statistics are, at root, the considered opinions of powerful definers (such as coroners). Decisions about how to define a "suspicious death" are open to different influences since, as **Berard** notes, "categorisations of suicide can . . . raise profoundly important questions of a religious, financial, moral or legal nature". Decisions about how to classify a "suspicious death" are, therefore, both:

1. **Evaluative**, in that they take account of subjective factors and interpretations (was the victim depressed, for example?) and:

2. **Consequential** – a suicide verdict can have significant consequences for the living. This might include the denial of an insurance payout, stigma attached to friends and family or blame attached to official guardians.

Qualitative methods share certain similarities with at least some of their quantitative counterparts in the sense they produce:

Reconstructed profiles of individual suicides using a variety of techniques based, by and large, around different forms of *witness testimony*. These include, of course, the testimony of the successful suicide in the form of:

Suicide notes, analysis of which may tell us why someone decided to kill themselves. . While this technique may produce highly valid data, it suffers from a range of potential problems, not the least being that the majority of suicides *don't* leave a note. In those instances where notes are left, problems remain – they may, for example, be removed from the scene *deliberately* (by friends or family) or *accidentally* (blown away by the wind, for example, if the location for suicide is a cliff top).

Alternatively, reconstructions involve things like:

• **physical evidence** at the scene, such as empty pill bottles or the mode of death.

• **eyewitness accounts**, such as evidence of someone jumping from a cliff top or under a train.

• **testimonies** from friends, medical staff and the like concerning the deceased's "state of mind".

A slightly unusual method of reconstruction involves the use of:

Observation over a specified period to complete what **Bose et al** (2004) termed a "*verbal autopsy*" – in this instance monitoring 100,000 people in an area of India over an eight-year period. Suspected suicides were investigated in the light of personal observations, life histories and witness testimonies about the victim.

Attempted suicides A further source of evidence comes from **unsuccessful** suicides since they can, of course, be questioned. A couple of issues are involved here, however. First, **ethical issues** surround the idea of asking failed suicides to revisit a painful period in their life, and, second, there is a possible qualitative difference between those who succeed and those who fail – was the failure evidence of a *real desire* to die that simply did not work or was it what **Kreitman et al** (1970) have termed a:

Parasuicide – an "attempt" to commit suicide that was not, ultimately, designed to succeed. Evidence here is further complicated by what **Baechler** (1979) calls:

Ludic suicide, a situation where the individual *gambles* with their life (if they survive this may be taken as evidence they are meant to continue living).

The Study of Suicide: Explanations

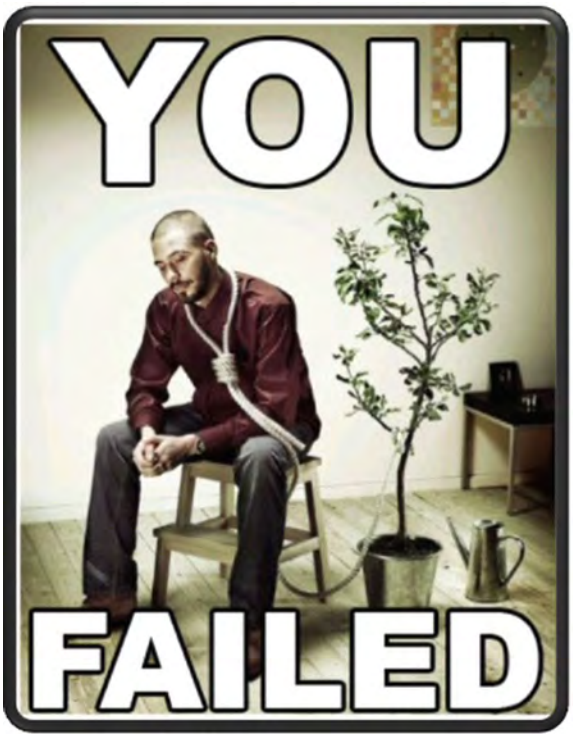
Thus far we've identified a range of sociological issues relating to suicide that we can now bring together by exploring three basic sociological methodologies (**positivism**, **interpretivism** and **realism**) that have been used by sociologists to study suicidal behaviour. We can look at each in turn by identifying some **key features** of the methodology and, where appropriate, linking these specifically to the study of suicide. Once we've done this we can demonstrate the sociological application of each methodology by briefly outlining how it has been used in a selection of **key studies**. Each section is completed by a short **evaluation** of the methodological application.

Positivist Approaches: Overview

We can begin by suggesting that positivist approaches can be characterised in terms of two major ideas:

1. Laws and **law-like relationships**: The social world is similar to the natural world in that both involve *patterned behaviour* (which, in the former, resemble law-like relationships) capable of being discovered through careful observation using a variety of **empirical** methods (questionnaires, observation, experiments and so forth).

2. Objectivism: The social world, because it is governed by causal relationships, has an objective existence over and above the control of individuals.



Questioning unsuccessful suicides about their behaviour is fraught with ethical issues.

Human society, therefore, consists of identifiable patterns of behaviour that display broad regularities (people go to school, work, form families, and the like) that must, by definition, have *social causes. S*uch causality resides in:

Social structures: Although the social and natural worlds are different (people have consciousness and are aware of themselves and their surroundings in a way that non-human objects – such as rocks - are not), this "problem of difference" is resolved by arguing that social behaviour is a:

Reaction to stimulation (that derives from structural imperatives such as socialisation). In other words, behaviour can be studied and explained by understanding the *cause* of the reaction (structural pressures) rather than its effect (individual actions). In this way, it's possible to generate *objective* forms of knowledge about behaviour – such as suicide - that, on the surface, appears wholly *subjective*. Thus, the study of suicide, like the study of any other form of human behaviour, can be informed by collecting and making sense of empirical evidence.

The belief in *external causality* (which, in terms of suicide can be translated into the idea that certain individuals in certain situations are literally *pushed* into committing suicide by some force or combination of forces outside the individual's control) coupled with the insistence on empirical evidence (which can be verified by replication) is important on two levels:

1. It means social behaviour cannot be satisfactorily explained by reference to individual meanings, beliefs and intentions for two reasons: firstly an individual may not objectively know why they behave in a particular way and, secondly, for a sociologist to simply accept an individual's account or explanation for their behaviour involves taking something to be true simply on the basis of trust, faith (or whatever).

2. It moves the object of social scientific study away from the *unknowable* (what people are actually thinking when they behave in certain ways) and the *untestable* (individual accounts of their own behaviour – if we simply accept what the individual claims then there is no possibility of objective verification or truth) to the *knowable* (the social stimuli that cause certain forms of behaviour) and the *testable* (since we can test which factors have what affect on people's behaviour). In terms of suicide, therefore, the focus of positivist approaches is the attempt to:

a. **Isolate** possible factors in the decision to commit suicide.

b. **Correlate** these known factors with incidents of suicide in a variety of ways (on both an individual and cultural level).

Suicide Studies

We can illustrate this focus in the following ways:

Statistical analysis of *known suicides* (an important caveat to which we will return at later points in this chapter) involves the collection and documentation of data that identify suicide patterns and trends. This allows us to make certain statements about the nature of suicidal behaviour and, more importantly perhaps, to *correlate* suicide with different *social characteristics* (age, gender and ethnicity, for example) and *situations* (the effects of unemployment, divorce and the like). **Sale** (2003), for example, notes differences in UK suicide rates based on:

A. Gender

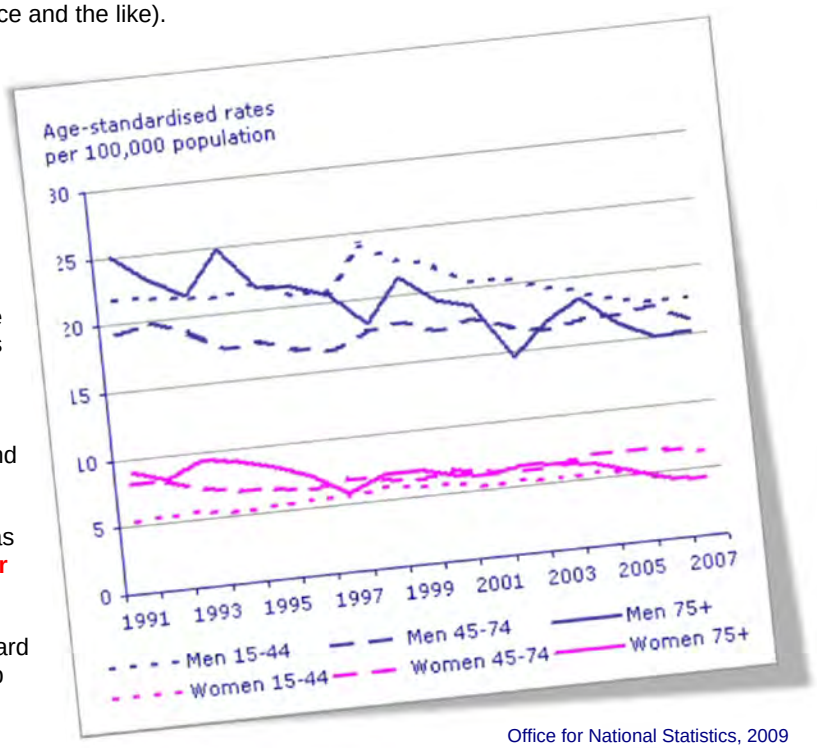
In terms of completed suicides, around 75% of suicides are **male** and this percentage, according to the **Office for National Statistics** (2009) has remained constant since 1991 (we can also note higher rates of male suicide are consistent across all age groups in Western societies). **Women**, on the other hand, attempt suicide more often and also think about committing suicide (**ideation suicide**) more frequently. The suicide rate for men in 2007 was 16.8 and for women, 5.0. (**Office for National Statistics**, 2009).

A sample of **explanations** put-forward to explain this statistical gender-gap include:

One careful owner, full service history, only 5,000 on the clock, new radials, license plate, Sat. Nav., GPS, NSPCC, RSPCA - trust me. I like yer face. Would I lie to you?

Lethality: **Stack's** (2000) review of the findings of 84 sociological studies published over a 15-year period suggests men generally use more lethal ways to kill themselves; that is, they use methods where there is both a high probability of "instant death" and a lower probability of being "discovered and revived" (and even where the method is the same for both sexes men are generally more successful at killing themselves).

Social Learning: Male and female socialisation differences in our society are well-documented and the argument here is that they translate into different suicide outcomes – women, for example, choose less lethal and more indirect methods (such as a drug overdose) because they have generally internalised the prevailing normative belief that it is less socially acceptable for women to take their own life.



Office for National Statistics, 2009

Masculinity: Two forms of explanation focus on this concept:

1. Stereotypes about what men "should be" (strong, unemotional, decisive, successful…) create "suicidal pressures" for those unable to meet the cultural ideal – those men who, for one reason or another, see themselves as "failures".

2. Crisis: **Scourfield** (2005) argue that an increasingly-popular belief in our society (perpetuated by writers such as **Faludi**, 1999) is the idea of a "**crisis of masculinity**". As they note: "The idea here is that working class men in particular are unsure how to respond to a changing world. They are confused by a mismatch between expectations of masculine privilege on one hand and a changing economy and social gains for women on the other". The outcome of this "identity crisis" is, for a certain number of men, suicide.

Crisis? What Crisis?

B. Age

The evidence from the UK (**Office for National Statistics**, 2009) over the past 16 years shows some differences and fluctuations in suicide rates for different age groups, although the current trend for convergence makes it difficult to draw firm conclusions about the long-term relationship between age and suicide (and we also need to keep in mind that the composition of "age groups" can be arbitrary, especially on the margins of each group – what, for example, distinguishes a 44 year old male from a 45 year old?). However, we can note that suicide age patterns reflect those for gender with significantly fewer females in each age group committing suicide.

As we've just seen, the broad way age groups are defined in official UK suicide statistics makes it difficult to identify the factors people in each age group might have in common. However, in general terms we can suggest the following:

Work: Twp particular areas correlate with male suicide:

1. High levels of **unemployment** correlate with suicide. **Department of Health** (2002) statistics, for example, show a strong link between young men, unemployment and suicide. However, unemployment may be a contributory factor in older male suicide, especially where they have a history of consistent employment.

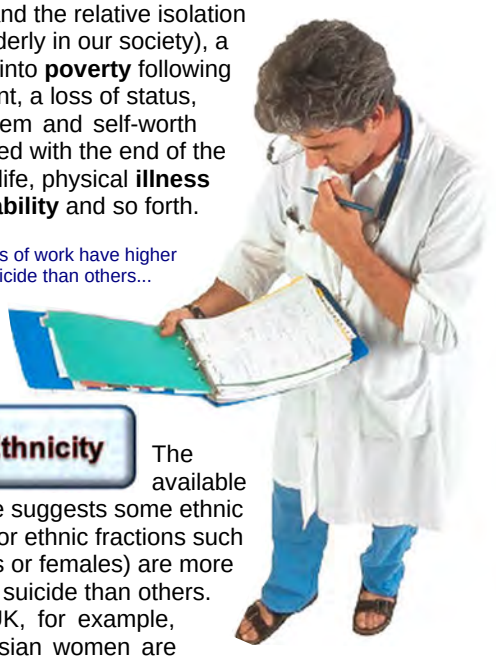
2. Different **types** of employment: According to **Meltzer et al** (2008) working class males are around 3 times more likely to kill themselves than professional males. The rates for females, however, are broadly similar. They also note that certain professional groups ("health-related occupations such as doctors, nurses, farmers (including horticulturalists and farm managers), the armed forces, students and artists") have a higher than average risk of suicide. One plausible explanation here is that many of these groups have easy access to lethal methods of suicide (such as drugs or, in the case of farmers, firearms).

Stability: The middle (45 – 74) age group generally shows greater consistency and fewer fluctuations than other age groups for both men and, to a lesser extent, women. One explanation for this is that people in this broad group are more likely to have relatively stable home and personal lives.

Psychological factors: A variety of factors, such as depression, psychiatric disorders, and problems with adjustment (as expressed through petty crime, dropping out from school and the like) have been correlated with *adolescent* suicides. However, as **Diekstra and Gulbinat** (1993) have pointed-out, many of these factors also tend to be present in non-suicidal adolescents.

Family background: Certain aspects of family background (such as social disadvantage, deprivation, divorce / separation, physical / sexual abuse and institutional care) correlate with adolescents who both attempt and achieve suicide – although once again the problem here is that the vast majority of adolescents in such family situations do not attempt suicide.

Life-cycle changes: **Stack** (2000) has noted how traumatic changes in and around mid-life (long-term relationship breakdown, the loss of employment with little or no prospect of working again and so forth) contribute to some forms of male suicide. In terms of **old age**, various studies have suggested that dramatic changes in the social, psychological or biological status of the elderly make this age group particularly prone to suicide. These changes include things like **loneliness** (brought on by the loss of loved ones, friends and the relative isolation of the elderly in our society), a descent into **poverty** following retirement, a loss of status, self-esteem and self-worth associated with the end of the working life, physical **illness** and **disability** and so forth.


Some types of work have higher rates of suicide than others...

C. Ethnicity

The available evidence suggests some ethnic groups (or ethnic fractions such as males or females) are more prone to suicide than others. In the UK, for example, South Asian women are around three times more likely to kill themselves than white women and **Hatloy** (2008) notes that "the suicide rate amongst young Asian

women is twice the national average…Wives who cannot have children or produce only daughters seem to be at greatest risk". **Raleigh and Balarajan** (1992), on the other hand, found that young Asian men were at less risk of suicide than their white British counterparts.

Indigenous ethnicities also tend, on average, to have lower rates of suicide than their non-indigenous counterparts, an observation that can be partly explained by factors associated with "problems of adjustment", alienation, discrimination and the like. **Lester** (1987), for example, found that minority ethnic groups located in mainly white regions had a higher than average suicide rate. However, we also need to bear in mind that non-indigenous ethnic groups often have a very different age structure to indigenous populations – greater numbers of young people in their population for example means larger numbers of individuals fall into the "at risk" category.

Explanations for differing rates of suicide among different ethnic groups generally focus on differing *demographics* (as we've suggested, population age profiles are significant), *life chances* (the class profile of different groups is important when risk factors such as long-term unemployment, poverty and the like are considered) and *life experiences* – aforementioned factors such as alienation and discrimination.

Identity: Higher rates of suicide among some minority ethnicities have been related by writers such as **Tatz** (1999) to a bundle of problems experienced by such groups – high rates of unemployment, low incomes, poor housing conditions, living in neglected localities and so forth. This "combination of deprivation" leads to what **Lawson-Te Aho** (1998) has called "cultural depression" – a situation in which a whole community is blighted by **anomie** to such an extent it creates a sense of hopelessness and despair in a higher than expected number of individuals.

Aggression: Studies in the USA (**Stack**, 2000) have noted that while black Americans have lower rates of suicide than white Americans, the situation for homicide is reversed. One explanation here is that black Americans are more likely to *externalise* their frustration and aggression whereas their white counterparts are more likely to internalise aggression (onto themselves rather than others).

D. Locality

Within the UK there are clear differences between both *countries* (Scotland, according to **Self and Zealey** (2007) had, until 2005 when it was overtaken by Wales, the highest rate of suicide with rates for both males and females being almost double those of England) and *regions* – Blackpool, for example, has the highest rate of male suicide in England while that distinction in Wales goes to Denbighshire. For females Camden in England, Glasgow in Scotland and Conwy in Wales have the highest rates. Overall, **Self and Zealey** report the highest suicide rates in England for men were in the North West and North East and, for women, the North West and London.

In terms of a comparison with different countries there continues to be a wide variation in suicide rates (even where rates within each country remain fairly constant over time). In developed countries such as the UK suicide rates for men are consistently higher than for women, although there is some evidence that in developing countries (such as China) female rates are higher. Historically and cross-nationally it's also the case that suicide rates tend to be higher in rural as opposed to urban areas.

In terms of possible **explanations** for these differences we can note:

Lethalities: The general evidence suggests that in countries where lethal methods, such as guns or poisons, are more-easily available to a population the suicide rate is higher (an observation that fits with the UK experience we noted earlier of certain occupations with access to lethal methods (farmers and guns, doctors and poisons) having higher than average levels of suicide). **Diekstra and Gulbinat** (1993) have also noted that where a country relaxes lethal weapon ownership, the suicide rate increases. On the other hand, where lethalities are removed, such as happened in the UK when domestic gas supplies were changed to a non-toxic variety, suicide rates fall.

Family Life: Countries and regions that experience high levels of family disruption and breakdown (separation and divorce for example) generally have higher levels of suicide.

Demographics: **Stack** (2000) suggests three explanations for suicide rate variations within a country:

1. Population composition*:* As we've previously noted, some migrant groups have age and gender profiles that place them in a higher "suicide risk category" than indigenous populations.

2. Selective migration*:* Where "higher risk" populations settle in a particular area this may account for higher than average suicide rates in a specific region.

3. Local social environments: This covers a range of factors, from the unsettling effects of migrating to a new country with different norms and values to problems new migrants may face accessing social and health care services (which may mean that those "at risk" do not receive levels of social care that may insulate them from suicide).

In the above we've outlined a *sample* of positivist statistical relationships that have been made between suicide and various social factors. We've also looked at various correlations in a relatively simple manner. As you might expect, positivists have analysed these correlations in more-complex ways. Methodologically, therefore, it's possible to note relationships between different characteristics. **Scourfield et al** (2006), for example, suggest: "Young people struggling with issues of sexuality and gender identity face an increased likelihood of attempting suicide".

The identification of *statistical associations* allows positivists to specify a range of correlations between suicide and associated factors (such as age). **Field** (2000), for example, notes how suicide can be correlated with a number of:

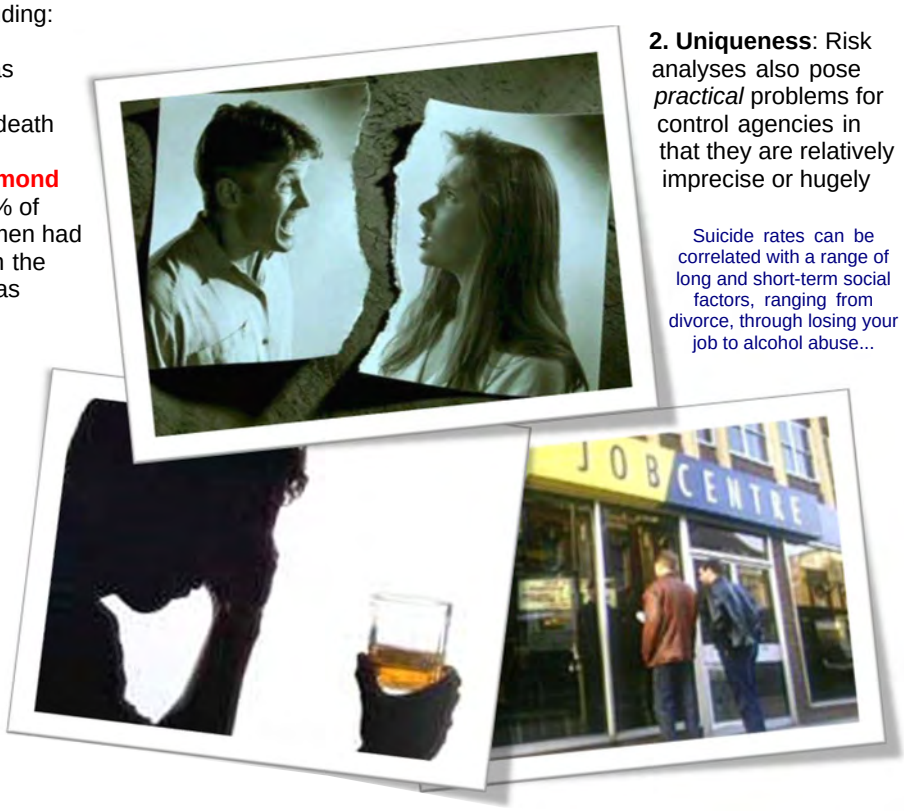
a. Long-term factors, including:

- **social isolation** (such as relationship problems).
- **loss of parents**, through death or divorce.
- **sexual abuse**: In **Van Egmond et al's** (1993) research, 50% of sexually abused young women had attempted suicide (although the sample - 158 women - was relatively small).

b. Short-term factors that, when occurring in combination with long-term factors, are likely to push people into suicidal behaviour. These include:

- **unemployment.**
- **substance abuse** (alcohol or illegal drugs).
- **financial problems**.

In turn, the positivistic identification of correlations can be linked to two further areas:



Suicide rates can be correlated with a range of long and short-term social factors, ranging from divorce, through losing your job to alcohol abuse...

1. **Risk**: One spin-off from this type of analysis is the creation of *risk assessments* for various social groups and categories. By identifying those groups most "at risk" and correlating these with known short and long-term risk factors, we can develop *intervention strategies* to identify, support and help individuals.

2. **Explanations**: These can be tailored to particular correlations, as we've seen with explanations for the lower rate of female suicide in the UK. A further example is **Moolakkattu's** (2005) explanation for the relatively low rates of suicide in Scandinavian countries like Norway when compared with countries like Britain and France. He argues for a strong correlation between suicide rates and *levels of trust* in public authorities. Thus, low Norwegian rates of suicide result from the fact the Norwegian authorities "often employ conciliation councils for the resolution of internal conflicts"; when potentially suicidal individuals are encouraged to talk-through and resolve their problems with people they trust, the rate of suicide is lower.

Evaluation

Positivist analyses of suicide are, as we've suggested, useful in a range of ways, not the least being their contribution towards *risk analysis*. However, there are a number of problems – **ethical**, **practical** and **methodological** we can note with this approach:

1. Profiling: Where positivist studies are used to provide risk analyses one *ethical* problem is how to act on such analyses – if, for example, risk analyses produce a profile of a typical "at risk" individual how, when and where should control agencies "intervene" to prevent suicide? Indeed, if suicide is seen as a "rational choice" taken by the individual the question becomes one of whether control agencies have the right to intervene at all.

2. Uniqueness: Risk analyses also pose *practical* problems for control agencies in that they are relatively imprecise or hugely difficult to compile when they involve a combination of risk factors (factors that may, individually, not be very precise indicators of risk but which, when they appear together, create a much greater sense of risk). The problem here is where does the analysis of risk stop? Is there a danger of the analysis becoming so detailed that each suicide is considered to be in some way unique?

3. Correlations: A *methodological* problem with some "simple positivist" analyses involves the question of "single issue" explanations of suicide risk factors. Although it's possible to identify major risk factors (unemployment, divorce, mental illness, disability…) that correlate with suicide this tells us nothing about (in positivist terms) causality; many people, for example, divorce without ever considering suicide.

A further problem here is that even if it was possible to hold a particular factor constant ("divorce" always has the same impact on individuals, for example) we would

be no further down the road to causality since individuals and groups interpret and experience such factors in different ways. "Unemployment" for an individual with dependents to support and no possible hope of feeding, clothing and sheltering them is an individual disaster; to a multimillionaire it is leisure. Less basic positivist analyses, however, seek to explain suicide in:

Algorithmic terms: That is, in terms of a general set of *rules* that can be applied variously to all forms of suicide. **Field** (2000), for example, suggests certain 'life events' (such as childhood abuse and divorce) create two basic types of state:

a. **Stable states** represent things "that won't go away" (such as feelings of pain or remorse).

b. **Global states** represent things that affect all areas of someone's life (such as continual depression stemming from feelings of remorse).

The combination of states in an individual's life are not, in themselves, causal factors (people frequently live with feelings of pain and remorse and by no means everyone who suffers from depression is suicidal); however, what seems to be a significant factor here is the existence of:

Triggers - something in an individual's life, related to the stable state in some way, that produces a much larger reaction and pushes the individual into a suicidal frame of mind. Triggers can be many and varied, relatively trivial or significantly serious; they may or may not be obviously and objectively related to individual stable states and they cannot, in themselves, "trigger suicide" – they are simply the catalyst that, when combined with certain stable and global states, lead the individual to choose suicide. **O'Leary and Gould** (2008) illustrate this process in their study of male childhood sexual abuse and its relationship to suicide. In a series of interviews they discovered that "men who were sexually abused as children were up to ten times more likely to have *suicidal tendencies*". Thus, abuse represents a stable state that, at various times, creates a global state (such as depression). Male abuse victims have increased suicidal tendencies and, at times, certain triggers tip the individual into actual suicide.

4. Probabilities: A more-substantial methodological criticism revolves around the approach itself. While we know positivist approaches can tell us something about *probabilities* (the presence of an identifiable risk factor in an individual's life results in a higher probability of their committing suicide), there are two fundamental problems here:

a. Probability should not be confused with causality or predictability. "Risk factors" are probabilities, not predictions (I might be right when I say that it's probable it will rain in January but this "educated guess" is not the same as being able to precisely predict the time, day and place it will rain).

b. The logic of this approach to understanding suicide is that if we can collect and process enough data about enough people it should be possible to predict how they will behave (A 51 year old male, recently divorced and made redundant with a history of abuse as a child *will* commit suicide...). In other words, the possibility of prediction is *simply* a problem of discovering sufficient data and being able to relate each piece of data statistically to all others (something that the contemporary development of powerful computers should be able to turn into reality). In other words, this approach eventually rests on the premise that computer processing power can turn probabilities into predictions...

These methodological criticisms of positivist approaches are at the heart of an alternative methodological approach to suicide (**Interpretivism**) that begins with a fundamental criticism of positivist approaches by asking the deceptively-simple question "What is 'a suicide'?". In other words, **Interpretivist** approaches start by questioning something positivist approaches take for granted, namely that what constitutes "a suicide" is clear and unequivocal. Interpretivist approaches argue that it is mistaken to study "suicide" in terms of such things as risk factors or socio-psychological variables and correlations precisely because there is actually no such thing as "a suicide", *per se*. Rather, what we have are a series of decisions about "suicide" made by significant social actors (such as doctors, police officers and, most importantly, coroners). In other words, when positivist approaches study "suicide" what they are actually studying is the **meaning** of suicide as it is socially constructed – and to see why this is a fundamental flaw in positivist approaches we need to understand something about Interpretivist approaches.

Interpretivist Approaches: Overview

Interpretivist approaches begin with the claim that the social world is different to the natural world and cannot be studied in the same way. Human behaviour needs to be studied and explained in ways that take account of this fundamental difference in subject matter. Thus, because people to act consciously (rather than simply react to social stimulation) the social world cannot be theorised objectively in the way positivism assumes. Rather it can only be theorised:

Subjectively – it has no objective existence independent of everyday behaviour. In other words, "society" (and a "social phenomenon" such as suicide) has no real existence. Thus, the social world can, simultaneously, mean different things to different people – and this means "social reality" is simply a *subjective projection* of whatever people, at a particular moment in time and space, believe it to be. This gives behaviour a constantly shifting quality that's difficult to explain quantitatively and means that in order to study suicide we should not assume suicide statistics are reliable and valid of (quite the reverse).

Super Sociologist?
Interpretivists do not see the sociologist as having a privileged insight into "The Truth"

If "reality" is whatever people believe it to be, the task is to describe how individuals see their world. This involves questioning and observing people to reveal the depth and detail of their perceptions and understanding since, as **Clarke and Layder** (1994) put it: 'People have thoughts, feelings, meanings, intentions and an awareness of being...They define situations and give meaning to their actions and those of others". In this respect **Thomas and Thomas'** (1928) idea of a:

Definition of a situation is useful here not only because, as they suggested, if people '…define situations as real, they are real in their consequences', but also because it suggests similar people may define the same situation differently (and behave differently in that situation). When studying suicide this concept is significant for Interpretivists because there are always a minimum of two viewpoints – that of the person who kills themselves and that of the people who try to interpret and make sense of this behaviour. Where positivist approaches have little or no interest in the former, the same is not true for Interpretivists.

Objectivity: Although behaviour has a fundamentally subjective quality this doesn't mean it's not possible to study such behaviour objectively – ether in terms of "personal objectivity" or methodological objectively. Where people share **a common definition of a situation** their behaviour will conform to patterns that may be open to objective quantification (as well as subjective description). This idea is important for the study of suicide because it relates to the way this behaviour is defined and labelled – the role of "significant definers" (such as coroners) is something that features prominently in numerous Interpretivist accounts.

The delicate balance between *subjective meanings* (what people think) and the *objective consequences* of group behaviour means that valid data can be produced by *understanding* how people see and interpret their world. In some respects, therefore, this involves the researcher's deep involvement with the people they are studying – the aim being to reveal, understand and explain behaviour from the viewpoint of those involved. In terms of understanding suicide, for example, suicide statistics cannot be "taken for granted" since, inevitably, such data is a product of social interaction. To "understand suicide", therefore, the researcher must dig deeply into the social processes that, in effect, create it – which means suicide can be understood in three general ways:

1. Individual intentions: In the normal course of events, such as studying an act of theft, the way to discover why an individual did something would be to question them to discover the meaning of the act. In relation to suicide, of course, this simple expedient isn't possible – but suicides do leave notes (or, in the electronic age, blogs and web sites) that may set out the both the meaning of the act (why they took their own life) and, of course, provide confirmation that the act really was suicide.

"Women weren't to blame for George Sodini's spree": Ellen (2009)

The idea of George Sodini, the 48-year-old systems analyst who shot dead three women, and wounded nine others, after randomly opening fire at a Latin dance class in Pittsburgh, Pennsylvania, is terrifying. For obvious reasons – he shot women dead in a gym – but also because details emerging from blogs he posted reveal him to be symbolic of a subculture of male rage that, despite all evidence to the contrary, blames women (dominating women, contemptuous women, icy women, just plain uninterested women) for everything bad that happens to them.

According to Sodini, he was a "total malfunction". No girlfriend since 1984. No sex since 1990, "rejected by 30 million" (his estimate of how many desirable single women exist). "Who knows why?" wrote Sodini. "I am not ugly or too weird." Really? Some might say that weird is a tame way to describe the act of driving to a gym to shoot people".

2. Failed suicides: A proportion of those who attempt suicide fail to carry it out successfully and these people are consequently available for research purposes (as are any notes, diaries, etc. they intended to "leave behind").

3. Group interpretations: Those "left behind" have to make sense of an individual's behaviour and the most important definers of a situation in this context are coroners (since they effectively have the final say about what kind of death will be officially recorded – although, as we will see, this decision is not made in isolation since a coroner may take evidence from a range of witnesses and sources).

The coroner's report is the final word on how a death is defined...

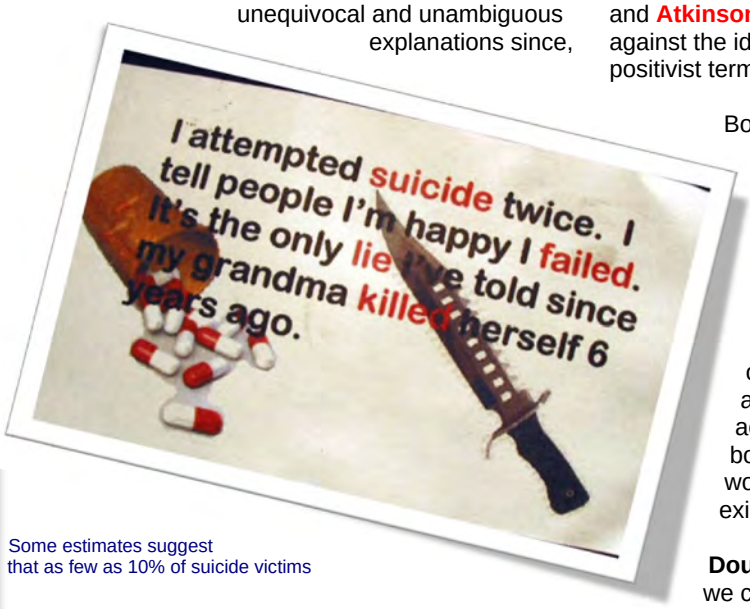
Evaluation

Each of these three methods present problems for the researcher:

1. The study of "individual intentions", for example, involves two major problems:

a. Although it might be assumed that suicide notes are a fairly common occurrence, **Gregory** (1999) suggests that only "About one in five who commit suicide leave a note" – which means that upwards of 80% of those classified as suicides leave no physical indication about why they killed themselves. Basing research on those who leave suicide notes, therefore, means the sample is both relatively small and unrepresentative (since the sample is effectively self-selected).

b. Suicide notes do not necessarily contain clear, unequivocal and unambiguous explanations since,



Some estimates suggest that as few as 10% of suicide victims

as **Gregory** argues "People who leave suicide notes rarely give a reason for killing themselves".

2. The study of "failed suicides" creates a different set of problems, not the least being that the individual "failed" to kill themselves – and while an unknown number may have genuinely tired to commit suicide, an equally unknown number either didn't actually want to kill themselves or were taking a "gamble with death" (if someone discovered them, they weren't meant to die). In this respect the motives of survivors are difficult to disentangle and we can't necessarily assume that failed suicides fall into the same explanatory framework as successful suicides (just as we can't necessarily assume the reverse – that a successful suicide actually intended to take their own life).

3. The study of group interpretations is much more fruitful ground for Interpretivist researchers, but not for what they can tell us about *why* people commit suicide; rather, they are more interesting for what they can us about how "suicide" is defined by others and, more importantly perhaps, how this category itself is socially constructed.

Suicide Studies

Interactionist sociologists have questioned a number of the most basic assumptions of positivist sociology - in particular, the idea the social world can be relatively easily quantified on the basis of agreed "facts" about people's behaviour. Two writers in particular - **Douglas** (1967) and **Atkinson** (1968) produced provocative arguments against the idea that we could understand suicide in positivist terms.

Both **Douglas** and **Atkinson** argue social "reality" is constructed consciously and actively by people who mean to do certain things (even though their intentions are not always fulfilled) and who attribute meanings to the behaviour of others. In this respect, the social world is experienced subjectively; it is effectively constructed and reconstructed on a daily basis and can be thought of as an "elaborate conspiracy" between social actors who behave in ways that suggest - both to themselves and others - that this world has some kind of meaningful existence.

Douglas, for example, criticises the idea that we can "discover facts" about the social world (such as the "fact" of suicide" or the "fact" that certain risk factors correlate with and can be used to explain this behaviour. All this does, **Douglas** argues, is impose a conceptual meaning (that of the researcher) on the behaviour of others in a way that is unjustified, untested and, in effect, untestable.

The basic argument here is that when positivists look at the social world, their theoretical perspective (in the sense of fundamental ideas and assumptions about the nature of the social world) lead them to the belief we can identify certain "facts" about the world that are somehow external to the individuals who create them.

For Interpretivists there can be no such things as "facts" - in terms of things that hold true for all time - about the social world, only a mass of meanings, beliefs and interpretations the sociologist chooses to categorise in some way. In other words, "facts" do not exist somewhere "out there" in the social world waiting to be discovered by rigorous and objective sociological research; rather, these "facts" are actually created by the process of doing research.

The Interpretivist approach to suicide suggests, as we've noted, there can be no such thing as "a suicide", as such. Rather, what we have is a death that has not been explained – and it is precisely the attempt to explain it that creates two "facts":

1. A category of death we call "suicide" (as opposed to homicide, manslaughter, misadventure, accident or whatever).

2. In creating this category we then have to populate it with features that make it unique and consequently different from some other, possibly related, category – and this is where, for Interpretivists, insurmountable problems arise.

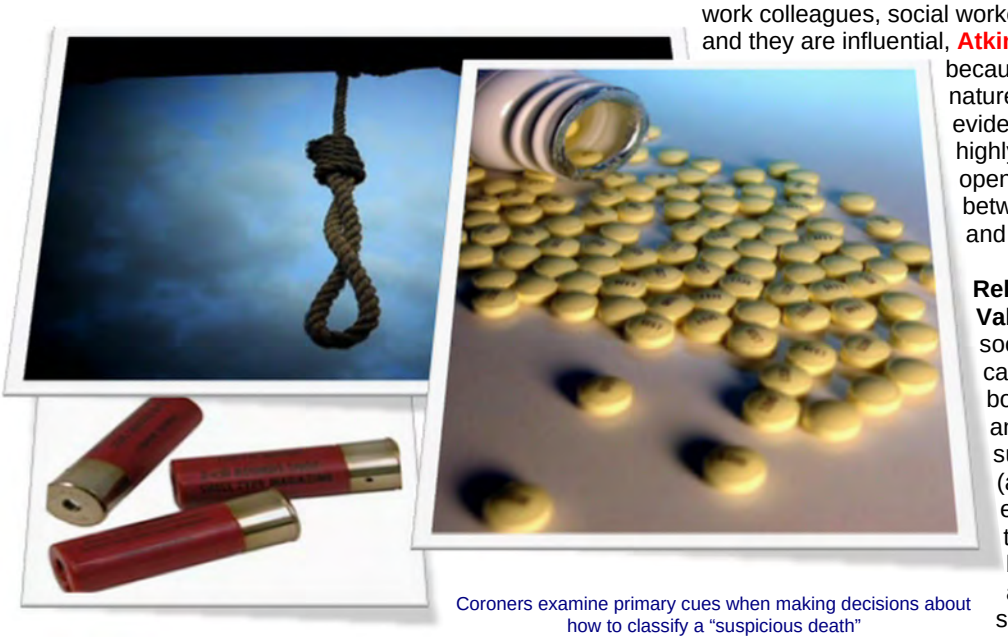
Indicators: While we can define "a suicide" in ways that differentiate it from a category such as homicide when we come to more "problematic deaths" (we can eliminate murder but can we be sure the individual *meant* to kill themselves?) we run into problems. This follows because suicide is a category of behaviour where the individual suicide can't unequivocally tell us whether they meant to take their own; all we can do is to look at various behavioural indicators that will allow us to classify the death. For example, an obvious indicator is a suicide note that tells us the individual meant to kill themselves (but, as we've seen, this indicator is only present in a relatively small number of suspicious deaths).

Reconstructions: Other indicators then have to be used (some of which look at the psychological state – was the individual depressed and so forth – and others that refer to sociological states (such as relationship troubles, money problems and the like). Whatever indicators we choose, however, the problem for Interpretivists is that they are an attempt to reconstruct someone's behaviour on the basis of judgements made by others about that behaviour; in other words, we're no-longer looking at the "fact of suicide", per se, but at how others interpret "a suspicious death" on the basis of the meanings they give to it.

Official definitions: **Atkinson** developed this argument further by arguing that the "facts" used by positivists as the basis of their theories are not simply things that exist in the social world, waiting to be "discovered". On the contrary, these "facts" are simply part of the everyday social construction of reality as defined by social actors who possessed the power to create "official" interpretations of reality. Thus, in relation to suicide, official suicide statistics are nothing more than "definitions of the situation" constructed by relatively powerful social actors such as coroners. Their role in the social construction of suicide, therefore, was one of providing official definitions of suicidal behaviour and, since different social actors may produce different definitions of the situation, it follows official statistics relating to suicide are not "facts" in the true sense of the word, but merely the interpretations of one (albeit socially significant) set of social actors. **Atkinson** further argues that coroners arrive at their decisions on the basis of two types of biographical cue:

1. Primary cues relate to the *physical biography* of the death - looking at things like the mode of death (some forms, such as shooting or hanging, are less likely than others to have been accidental) and whether or not a note was left. Primary cues can be hugely important in eliminating some possible types of death (such as homicide) but **Atkinson** argues that when it comes down to actual decisions about whether or not a suspicious death is classed as suicide:

2. Secondary cues are more significant. These involve the attempt to construct a *psycho-social biography* of the deceased, involving assessments of their state of mind, economic circumstances, emotional relationships and so forth. Witnesses in this biographical reconstruction may include family, friends, work colleagues, social workers and the like and they are influential, **Atkinson** argues, because the very nature of this evidence is both highly subjective and open to negotiation between coroners and witnesses.



Coroners examine primary cues when making decisions about how to classify a "suspicious death"

Reliability and Validity: This social process calls into question both the reliability and validity of suicide statistics (and, by extension, any theory of suicide based on the assumption such statistics

are objective indicators of suicide rates) for two reasons:

1. Different coroners (in different societies or within the same society) may use different cues (or, more-likely perhaps, give a different weighting to similar cues) which means "suicide statistics" are not objective, comparable across different societies or comparable from one year to the next.

2. We should not assume that witnesses in a coroner's court are simply neutral participants in the process – each may have their reasons and motives (personal, social, religious…) for painting a psycho-social biography of the deceased as either "suicidal" or, more-usually, "non suicidal". **Atkinson**, for example, argues that where family members are key witnesses, a suicide verdict is less likely to be given while both **Douglas** and **Taylor** (1982) found that where the victim was less socially integrated (there was, for example, no-one to bear witness to their pre-suicide behaviour) this increased the chances of a death being defined as suicide by a coroner.

Are suicide statistics simply the outcome of a process of negotiation?

Part of the reason for this, as **Linsley et al** (2001) explain, is that for coroners "Suicide is never presumed, but must always be based on some evidence that the deceased intended to take their own life. The evidence that the coroner seeks to record a suicide verdict must indicate suicidal intent *beyond reasonable doubt*; when this is not the case, an open (also known as undetermined) or accidental verdict is returned".

This "burden of evidence" leaves a great deal of scope for negotiation between the various participants in the decision-making process – and where there are numerous interested parties (family, friends, colleagues and so forth) with an interest in the outcome there is greater scope for "reasonable doubt". As the following table shows, where the **primary cue** (the method of death) leaves more room for different interpretations the greater is the likelihood of an open, as opposed to a suicide, verdict ("falling from a height", for example, shows a greater likelihood of an open verdict than death by hanging).

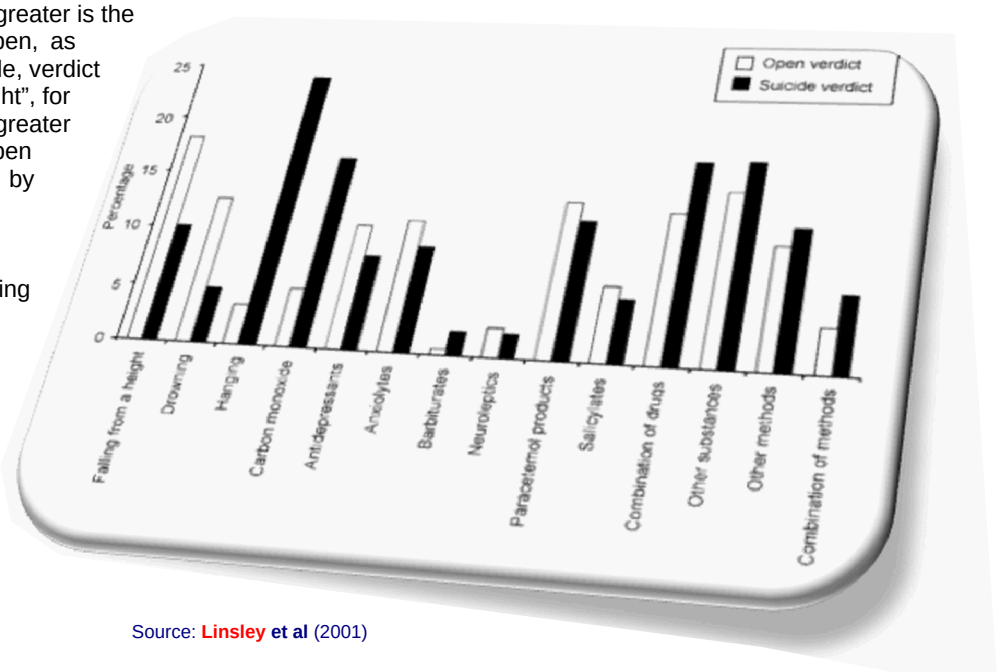
The problems associated with taking official suicide statistics at face value have, as you might expect, led Interpretivists to pursue a different approach to the study of suicide, focused mainly on two areas:

1. The "Successful Suicide" Approach: In this category we can note studies that have focused on how "successful suicides" defined their social situation. **Jacobs'** (1967) analysis of 112 suicide notes in Los Angeles, for example, "takes the perspective of the actor" to understand what they experienced, how they viewed these experiences, the constraints they felt against suicide and how they succeeded in overcoming them. He was able to categorise three main themes in the notes, in terms of the belief that:

a. Their situation is intolerable / not solvable.
b. It is beyond their power to control.
c. Death is the only answer.

In general the analysis of suicide notes suggests three common meanings. Suicide as a:

a. **Solution** to a problem.
b. **Communication** to other people (the suicide explains their actions, apportions blame and so forth)
c. **Gamble** with life and death ("**ludic suicide**")



Source: **Linsley et al** (2001)

These meanings are frequently inter-related in the sense that many suicide attempts (whether ultimately successful or not) are a form of calculated risk-taking – what **Kovacs and Beck** (1977) characterise as a form of "ordeal" or "trial". For the suicidal individual, therefore, the "gamble with fate" can always be considered successful in either of two outcomes:

a. Death: The individual's death solves whatever problem was troubling them and sends a message to those left behind.

b. Life: If the individual survives they may have successfully communicated their feelings to others and this may lead to a solution being found to their troubles.

Evaluation

Although only a minority of suicides leave a note, this type of analysis can work as a **case study** of "successful suicides" (although, clearly, it can't be **generalised** since it isn't representative of all suicides). However, suicide notes may be:

Ambiguous and **difficult to interpret** – suicidal individuals, for example, may be inarticulate and probably not in the best frame of mind to write clearly.

Rationalisations: Is it safe to simply assume that a suicide note is "the truth" as opposed to a suicidal individual attempting to justify or rationalise their behaviour?

Dramaturgy (the art of dramatic composition): As we've seen, if both "suicide professionals" (such as coroners) and "suicide witnesses" (such as family and friends) have a part to play in the social construction of suicide why should we assume that "suicide victims" do not similarly have a part to play in the construction and reconstruction of their own death? **Douglas**, for example, makes the point that the suicidal individual can, as with any form of labelling process, attempt to convey to others the meaning of their behaviour (through the use of suicide notes, the way they construct their death and so forth).

Strategy: If some suicides attempt to shape the perception of their behaviour by selecting certain *props* (**Goffman**, 1959) and discarding others then we cannot take suicide notes at face value since they may simply be one, albeit hugely important, prop in the drama. In other words, the fact that so few suicides leave notes may indicate their *atypicality*; that is, the suicide who attempts to justify or explain their behaviour in some way may be qualitatively different to the suicide who does not engage in such dramatalurgical constructions. **Baechler** (1979) captures something of this ambivalence when he suggests suicide should not be seen simply an *end in itself*, but also, most importantly, as *a means to an end*. He argued that suicidal behaviour was an extreme form of social strategy, consisting of four major types, adopted for the achievement of certain social ends:

1. Escapist: The suicide is fleeing from an intolerable social situation.

2. Aggressive: The intention is to harm others by blaming them for forcing the individual to commit suicide.

3. Oblative: The suicide is designed to draw attention to some political / moral ideal (which suggests "suicide bombers", for example, adopt this particular strategy).

4. Ludic: The attempt at suicide is a "calculated gamble" with life and death.

A variation here is the study of **parasuicides**; those who have tried – but failed – to commit suicide. This approach has an obvious advantage in that the suicidal individual is available for first-hand study (but a singular disadvantage, for some sociologists, is the question of whether "failed suicides" are qualitatively different to "successful suicides" and, if so, how?).

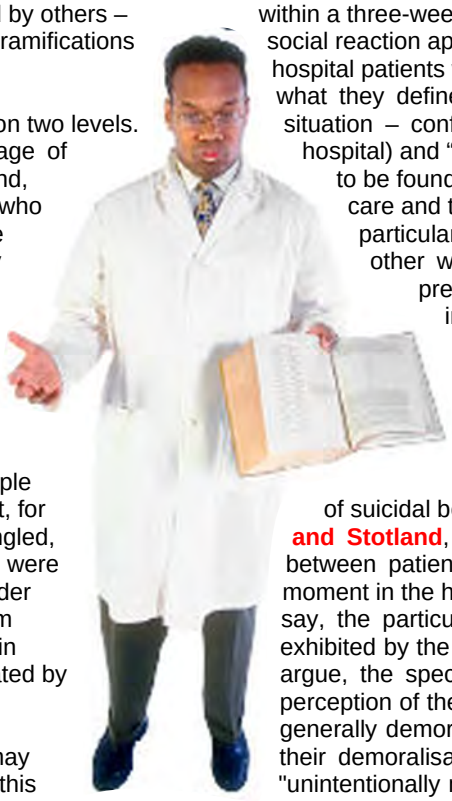
Nevertheless, both **Shneidman and Farberow** (1961) and **Fuse** (1997) suggest that failed suicides represent a form of communication designed to make someone – usually highly significant in the life of the attempted suicide – do or feel something. Failed suicide, in this respect, is a statement about the suicidal individual and their relationship to others.

The Problem with Parasuicide: While the problems associated with identifying completed suicides have been well-documented, parasuicide brings with it a slightly different range of problems – not the least being how we identify this group in the first place. As **Platt** (1992) argues, our (partial) knowledge of parasuicide is limited by the way it may (or, more relevantly perhaps, *may not*) be reported. Unlike completed suicides, our knowledge of parasuicide comes largely from hospital records (when the parasuicide presents – or is presented by others – for treatment). This has two important ramifications for data reliability and validity:

Unreliable recording: This operates on two levels. Firstly, we don't know what percentage of attempted suicides attend hospital and, secondly, our knowledge about those who do attend hospital – and how they are defined – is similarly limited since they may or may not be identified as "failed suicides".

Categorisation: A further problem with parasuicide is the question of how to categorise this behaviour; are they, for example "unsuccessful suicides" in the sense that such people actually intended to kill themselves but, for whatever reason (the attempt was bungled, they were revived before they died…), were not able to do so? Or should we consider parasuicide a separate category from suicide precisely because it results in different outcomes and may be motivated by different reasons?

The answer perhaps, is parasuicide may represent a combination of both – but this presents further methodological problems because we have no real way of distinguishing between the two. Although some parasuicides do go on to successfully commit suicide at a later date, the majority do not (but we can't simply conclude from this they were "not serious" about killing themselves since, as we have seen, the fact of their survival may function to remove the problem that led them to try to kill themselves in the first place). In addition, even where the parasuicide may be willing to talk about their behaviour, it's by no means certain a researcher can get at 'the truth' (either because the victim is unwilling to give it or, more likely perhaps, because there is the danger that accounts are simply *revisions* (reconstructions and reinterpretations) of a mass of confusing and possibly contradictory feelings and actions.



How reliable are parasuicide statistics?

2. The "Social Reaction" Approach: Unlike the previous approach, this holds that suicide can be best understood by studying how others react to this type of behaviour – an idea that can be illustrated by a number of different studies.

Kobler and Stotland's (1964) case study of the successful suicide of four patients and the attempted suicide of another in a psychiatric hospital over a six-month period (three of the suicides actually occurred within a three-week period) is illustrative of the social reaction approach in that they argue the hospital patients were looking for both "hope" (in what they defined as a largely hopeless situation – confinement in a psychiatric hospital) and "help". The source of both was to be found in the hospital staff and the care and treatment they could (or in this particular case, could not) provide. In other words, successful suicide prevention among the patients involved building or restoring hope through making them believe help was both available and could be successfully delivered.

What triggered the "epidemic" of suicidal behaviour, according to **Kobler and Stotland**, was the *social interaction* between patients and staff at a particular moment in the hospital's history (rather than, say, the particular psychological problems exhibited by the patients). In particular, they argue, the specific trigger was the staff's perception of the situation, in that they were generally demoralised about their work and their demoralisation was translated into "unintentionally negative" responses to their patients' situation. This, in turn, was interpreted by some patients as being, almost literally, the "end of hope". As they noted: "Our conception views suicidal attempts…as efforts, however misdirected, to solve problems of living, as frantic pleas for help and hope from other people; help in solving the problems, and hope that they can be solved".

Interviews may only give us a fuzzy picture of parasuicide

A different form of social reaction approach can be found in **Naroll's** (1965) argument that suicide is related to two forms of **disorientation**:

1. Social disorientation is defined in terms of the lack or loss of basic social ties, the removal of which serve to confuse and disorientate the individual. This state is a familiar one to many people in our society (from the teenager to the divorcee to the elderly person who lives alone) and social disorientation alone is not a sufficient cause of suicide; not all socially disorientated individuals take their own life. However, **Naroll** argued that while in this state the individual becomes uniquely-vulnerable to suicidal thoughts and tendencies – a **trigger** for which can be:

2. Thwarting disorientations: These are situations where the socially disorientated individual sees the behaviour of others as being personally disadvantageous, because they prevent the individual achieving desired and expected satisfactions. The "thwarting of hope and expectation" consequently produces feelings of anger, frustration and powerlessness that, ultimately, are turned inwards by the individual – but only where the thwarting disorientations are perceived as *personal*, not impersonal (as the result of design rather than luck or chance). As **Lester** (2008) puts it: "Storm damage to one's dwelling is not thwarting but, when another person sets fire to it and destroys it, it is thwarting. The widow is not thwarted, but the divorced spouse is thwarted. Under the conditions of thwarting disorientation, individuals are more prone to commit suicide in such a way that it comes to public notice, that is, **protest suicide**".

The reverse is also true in that where people constantly find their ambitions thwarted by what they see as the behaviour of others they become socially disorientated, with the range of attendant emotions (rage, powerlessness and so forth) that make suicide a distinct possibility. It is important to note, here, that thwarting triggers social disorientation and the individual's anger or despair is turned inwards (through suicide), rather than outwards (through homicide) because of their thwarted intentions. Variations on this general approach include:

This time it's personal...

Cultural theories: These focus on the way individual behaviour is held in check by cultural rules, whether those of a particular society or through membership of a particular group (such as a religious organisation) within a society. The argument here is that in societies and groups *intolerant* of suicide, the rate is lower than in more tolerant societies and groups. In other words, in groups where there are clear legal, moral and social sanctions against suicide the rate of suicide is lower – which suggests, at the very least, the importance of cultural reactions to individual behaviour as being a significant influence on that behaviour. As **Bille-Brahe** (1998) puts it: "Attitudes towards self-killing and self-murder have varied markedly through history, spanning from full acceptance (such as hara-kiri in Japan) to absolute condemnation (such as by the medieval Catholic Church). In modern societies more people seem to argue that nobody has the right to interfere in another person's life and that a person has the privileged right to decide when and how he or she will die".

Subcultural theories are a further refinement to this approach where the focus of study is on particular social groups, membership of which may predispose individuals to suicide for a variety of reasons - from groups with a preoccupation with suicide, through those where suicide is viewed as a generally positive, if not always desirable, option (ideas found, for example, amongst participants in some heavy metal, Goth and country music subcultures) to groups where various forms of social pressure may, at times, explode into suicide (such as **Lester's** (1987) study of three suicides in a group of five teenagers). Similarly, **Platt's** (1985) study of areas with high and low parasuicide rates found the former were characterised by

people with markedly different social characteristics (such as lower levels of education and owner-occupancy), subcultural beliefs and values (such as greater acceptance of sex before marriage and arguments between married couples).

Labelling theories are frequently applied by Interactionists to the study of deviant behaviour and suicide is no exception. At its most basic this approach to understanding suicide suggests people who attract certain types of negative label, particularly ones associated with failure, are more prone to suicide. Examples include the following types of failure:

• **Economic** (the classic "stockbroker / banker suicides" associated with economic disaster).

• **Personal** (such as relationship breakdown, divorce and so forth).

• **Social** (alcoholism or drug-abuse),

Self-fulfilling prophecy: This related concept is also used to explain the high rates of suicide for those labelled as being in a "high risk of suicide" category – the individual, knowing they have been labelled as having a higher than normal risk of suicide, comes to see themselves as suicidal and, in the process, becomes more-likely to kill themselves and self-fulfil the prophecy. A more-subtle version of labelling is introduced by the idea of:

Internalised attitudes: Throughout their primary and secondary socialisation individuals are exposed to ideas about suicide (both positive and negative) and this exposure crucially influences their perception of this behaviour. This approach rests on the idea that large numbers of people in any society will at some point *think* about suicide (the technical term for which is "**suicide ideation**"). For the vast majority these thoughts will be fleeting and disappear as quickly as they appeared, but a minority will take such thoughts further – into planning, rehearsal and actual enactment (a variation, it can be usefully noted, on **Matza's** (1964) concept of "subterranean values" in which deviants are aware of values (such as suicide) although these are not usually part of people's conventional value system). For labelling theorists there are two crucial influences that distinguish **suicide ideations** from ultimately successful suicides:

1. Internal opportunities refer to the extent to which an individual sees suicide as a viable solution to certain problems. Once suicide is seen, in principle, as a viable solution the next stage involves the degree to which suicide is considered – from just thinking about how to do it at one extreme to successfully doing it at the other. This will be influenced by internal opportunities and the reactions of others (the extent, for example, to which the troubled individual sees others as pushing them into a corner where death is the only escape). However, crucial variables within this "thinking stage" are:

2. External opportunities: Just because an individual is thinking about or has seriously planned their suicide doesn't mean they will actually commit suicide; however, when in this phase the easy availability of suicide methods that carry with them a degree of lethality may be the key to understanding the suicide. If access to lethal opportunities is restricted or denied, the "internal suicidal phase" passes. **Osgood** (1992), for example, argues "It is commonly believed that older adults who are suicidal will find a way to commit suicide, no matter what it takes. The truth is that even among older adults, suicide is often an impulsive act. If the method of self-destruction were not readily available, many suicidal elders would not commit the fatal act".

If, therefore, a society is able to restrict access to lethal methods there follows one of two distinct outcomes.

1. Method reduction: With this outcome there is simply a reduction in suicide that uses that particular method. The suicidal individual will eventually find an alternative method by which to kill themselves (the technical term for this being **displacement theory** – the individual is determined to kill themselves and, if denied one way will simply find a substitute method of death).

Is thinking about suicide qualitatively different to attempting suicide?

2. Suicide reduction: With this outcome there is a reduction in suicide because those who would have killed themselves if a particular, lethal, method had been readily available effectively decide not to kill themselves if that method is unavailable. The significance of this form of "suicide reduction risk model" is that it *reverses* the burden of risk:

Positivist risk models - whether *psychological* (where the emphasis is on the individual and their predisposition to risky behaviours) or *sociological* (where the emphasis is on identifying a range of "risky behaviours" that are indicators of suicide) – place the burden of risk on the individual and the act of suicide.

Interpretivist risk models (at least those of the labelling variety) place the emphasis on the **social milieu** within which the individual lives and acts. Thus, the burden of risk is to be found within a culture, subculture or community and the levels of risk it will accept or tolerate – the easy availability of guns being an obvious case in point. For this approach, therefore, risk becomes a quality of the actions of others (the social reaction to the possibility of suicide and the steps a society is willing or able to take to discourage it) not a quality of the behaviour of "suicidal individuals"

Research in this particular area does give some support to the suicide reduction model. **Clarke and Lester** (1989), for example, argue: "deeply unhappy people could be prevented from killing themselves by closing the exits"; that is, by restricting access to lethal suicide methods. Support for this argument comes from writers like **Osgood** who note "In Malaysia, where almost all brands of pesticides are cheaply and easily available…the most common mode of suicide is swallowing insecticides. Jumping is more common in San Francisco where the high and barrier-less Golden Gate and Bay bridges are located".

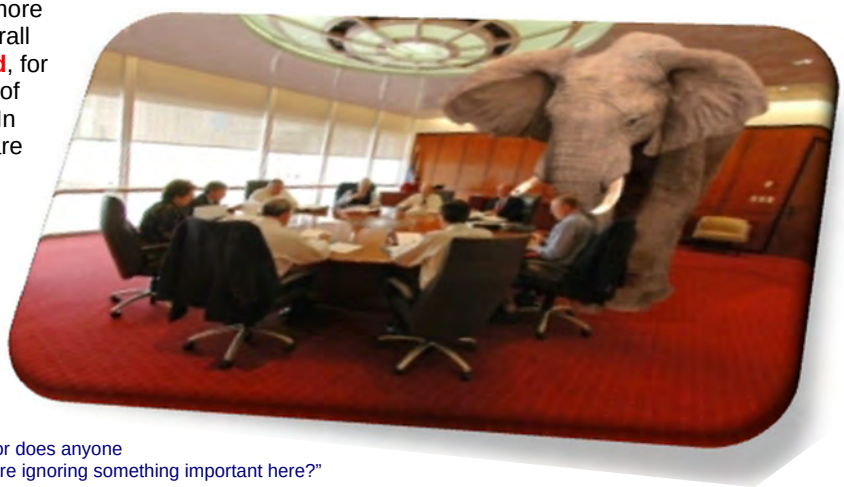
Clarke and Lester further note that the detoxification of domestic gas in the UK in the 1960s led to not just an obvious reduction in "gassing suicides" (where people would put their head in the oven and turn on the gas…) but, more significantly, a dramatic overall reduction in suicide (**Osgood**, for example, notes that the rate of elderly suicide was halved). In America, where hand guns are more easily available than in countries like the UK, shooting suicides are far more common. However, **Lester's** (1998) analysis of research in American states with relatively strict firearm controls (particularly handguns) found that not only did they have lower levels of firearm suicides than states with less-stringent firearm laws but, more significantly, they had lower overall suicide rates. **Conwell et al** (2002) also found that "among middle-aged and elderly adults, those with a gun in the home had higher rates of suicide… even after controlling for psychiatric illness".

Evaluation

The focus for criticism of this general approach initially lies in the rejection of official suicide statistics since a substantial part of the Interpretivist critique of positivist approaches to suicide resides in the claim that such statistics are socially constructed, unreliable and invalid. In consequence they are seen to be of little or no use in any explanation of suicide (unless, of course, the focus is on examining the social process by which the statistics are constructed).

If positivists can be accused (not always fairly when it comes to contemporary sociological studies) of an uncritical use of official suicide statistics, the reverse is true of Interpretivists; they can be accused of an overcritical view of such statistics. In their general enthusiasm to demonstrate how suicide statistics are little more than arbitrary behavioural classifications they lose sight of an important observation, namely that some people kill themselves, just as some people are killed by others. The distinction is real and significant if, arguably, a little fuzzy around the edges - some deaths, for example, will be misclassified as non-suicide. The question is whether it is possible to have any objective knowledge about suicide, as positivists claim, or whether such knowledge will always be wholly subjective? This leads us to note two distinctive, if not always entirely separate, strands in Interpretivist thinking about suicide:

1. The phenomenological approach (characterised by the work of **Atkinson**) that argues all features of social life are phenomena to be subjectively interpreted and understood, There are no objective features of social behaviour outside of the way it is interpreted and classified. "Suicidal behaviour", in this respect, is nothing more than the meaningful categorisation (by, for example, coroners) of a particular type of behaviour and, as such, what we need to (or all we actually can) study is the *process* by which this behaviour is categorised. There is nothing unique or special about "suicide" and it is impossible to study it as if it were an objective phenomenon



"Is it just me or does anyone else think we're ignoring something important here?"

When we think critically about this strand we necessarily return to what is a very large "elephant in the room"; the fact some people do kill themselves, just as some people are murdered while yet others meet their death accidentally. For this approach the solution is to say the best we can do (or the best we

should do) is to understand the official decision-making processes involved in classifying each type of behaviour – which is fair enough as far as it goes. However, a further strand of interpretivist thinking argues that, if suicide is *qualitatively different* to other forms of behaviour (such as murder), then this, in itself, is a factual statement – however, we want to interpret or label this behaviour there is actually something here that needs to be explained.

One problem with "interpreting the meaning of suicide" is that different people may interpret the same behaviour differently...

2. The Interpretation of Meanings Approach (characterised by the work of writers like **Douglas**) that argues we can understand suicide in terms of what it means for those who carry-out such acts (both successfully and unsuccessfully). While this approach tells us something about the meaning of suicide (and, more specifically, its reasons and, to a limited extent, possible causes) it's not altogether clear why we should give theoretical primacy to the accounts of "suicidal individuals" over and above the accounts of those whose job it is to decide whether or not behaviour is suicidal; why, in short, is this type of research account any more reliable and valid than the constructions of others? As we've also suggested, just as coroners and other interested parties are essentially "playing a role" in the social construction of suicide (using such things as "commonsense understanding" of the phenomenon) it's not altogether clear why we should accept that "the suicidal individual" is not also playing a role – one that may reflect a desire to shape how others perceive the individual's behaviour.

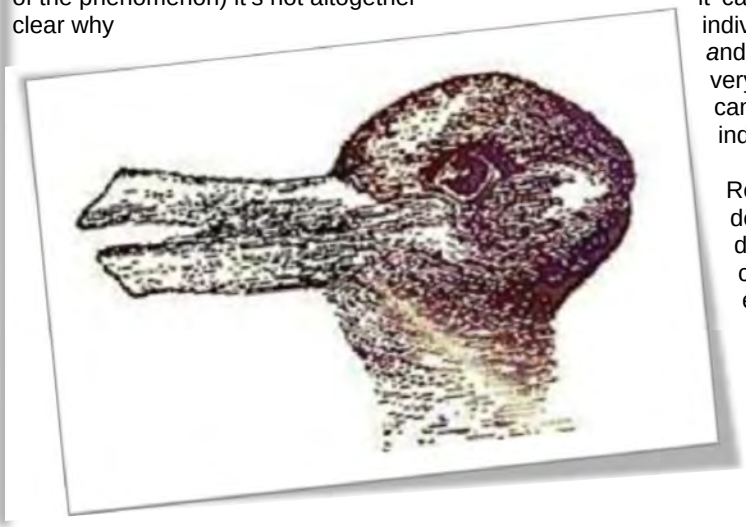
Hindess (1973), for example, argues that if official statistics are "no more" than the interpretations of coroners, then Interpretivist studies based around uncovering the meaning of suicide to the individual concerned are "no more" than their interpretations. **Hindess** argues that Interpretivists, while criticising the social construction of suicide statistics, simply ask us to believe their interpretations of the "reality" of suicide have greater validity – without providing any basis for such a claim. While **Hindess** agrees with writers like **Douglas** that "ultimately" official statistics are difficult to interpret he argues such "ultimate uncertainty" is a feature of all forms of science, both social and natural; it's not something peculiar and debilitating in the former that is avoided by the latter. The "problem of official suicide statistics" is one to which we will necessarily return – and go some way to resolving – when we look at our final approach to the study of suicide.

This general methodological approach is based on the idea that the social world has:

Objective features (or **structures**) that have an independent existence from individuals. Social structures, therefore, represent 'real forces' that make it possible to establish causal relationships (albeit a causality *limited* in time and space - what is true now, in one context, may not be true tomorrow in another context).

Empirical evidence through direct observation is *desirable*, but not in itself sufficient. Realists suggest the structures we experience 'as real' (and which positivists argue are what must be studied) are themselves the product of 'hidden mechanisms and forces' that may *not* be directly observable. **Durkheim's** (1897) analysis of suicide (which we will discuss in more detail in moment), for example, argues it can be explained in terms of how the individual is socially *regulated* and *integrated* and although such mechanisms can't, by their very nature, be directly observed their *effects* can be measured through the use of various indicators.

Realism, therefore, goes beyond "simple descriptions" of causal relationships to discover how such relationships are initially created. The social world "as we see and experience it" is governed by the operation of *social processes* (such as, in the case of suicide, levels of social integration and regulation) *that* we need to understand in order to explain the observable world. Since these social processes are *not directly observable*, "reality" is considered to be:



Problems of interpretation (part 2)
Is it a rabbit? Is it a duck? Is it both? Is it neither?

Multi-layered: **Searle** (1995), for example, argues "social reality" is constructed out of and around two main **facts**:

1. **Brute facts** or what we experience as *real* and:

2. Mental facts that represent the *meaning* of brute facts.

In terms of suicide, a *brute fact* is that someone kills themselves and a *mental fact* is the meaning we give to this action. In other words, *mental facts* represent a layer of meaning that underpins our interpretation of *brute facts*. However, a further layer can be added when we reflect on the idea that mental facts are, by definition, socially constructed (people have to agree about their meaning since they are never self-evident). In other words, just as brute facts are significant in terms of how they're interpreted, mental production is itself based on a further, underlying layer of meaning. We can apply this to understand suicide in the following way.

The 'top layer' is an observable act, such as someone taking their own life. Since, from statistical analysis, we know this act is not random (there are clear patterns to suicide – in the UK, for example, the majority of suicides are clustered around December and January), there must be something that causes a non-random distribution. The layer underpinning this patterned behaviour, therefore, involves identifying a range of factors 'underlying the fact of suicide' that correlates with the act (for example, social isolation resulting from divorce that leads to 'depression' and hence suicide).

Causality: For **positivists**, the hunt for causality begins and ends with observable and measurable relationships (for example, when a long-time partner dies and the remaining individual is over the age of 60 and they have no friends or family, suicide is likely). Realists, however, want to dig deeper into a further 'layer of reality' to discover what *causes* these *observable relationships*. In other words, although we know that under a certain combination of conditions individuals have an "increased risk" of suicide, why do these conditions (such as the individual finding themselves socially isolated and cut-adrift from a support network of relationships that "insulated them" against the risk of suicide) give rise to increased risk?

Knowledge: In order to generate reliable and valid knowledge about a social phenomenon such as suicide it has to be understood in its *totality*. While it's possible to study particular 'events' (such as an individual suicide), to validly explain *why* people commit suicide we have to think more widely in terms of how the interconnected parts of a social system impact on each other. The key to understanding suicide, therefore, is *not* to look at "the individual suicide" – to try, for example, to find clues about why someone killed themselves in their:

- **Behaviour** – did they have a history of mental illness?
.
- **Background** – was there a history of suicide in their family? – and:

- **Situation** - were they "under pressure" (work, family, personal life etc.) in some way?

and, from this, collate and extrapolate such data to generate explanations that will allow us to identify "patterns" or "types" of suicide. Rather, the key to understanding and explaining suicide is to be found in:

Group interactions and dynamics: **Durkheim's** notion of how individual's are integrated and regulated by social groups (or not, as the case may be) is an important case in point here.

Maybe there's something depressing about Christmas...

For realist sociologists explanations for suicide are to be found by looking at how the behaviour of the social groups to which people belong tips them into – or insulates and protects them from –suicidal behaviour. To understand something like suicide we have to study and understand the social context of such behaviour in order to make sense of it.

Realist methodology, therefore, sees reliability and validity in terms of constructing both an overall ('in depth') view of social behaviour in different contexts (something shared with Interpretivists) and, at the same time, producing specific, causal-type explanations for behaviour (something they share with positivists).

Suicide Studies

We can start to think about studies of suicide that illustrate and reflect the general realist approach by initially looking at **Durkheim's** (1897) classic analysis – a study that is significant here for two reasons:

1. Scope: **Durkheim's** study was the culmination of a much longer tradition of analysis stretching back to the 18th century. **Mercier**, for example, was one of the first to use statistical evidence to demonstrate that higher rates of suicide were part of a modernisation process, while **Falret** linked suicide rates to the dislocating effects of rapid social change (of which the Industrial Revolution was but one manifestation) and **Masaryk** noted how rising suicide rates were related to religious norms and controls (the stronger the religious influence of these, the lower the rate of suicide).

2. Methodology: It was one of the first attempts to apply a set of systematic principles of scientific investigation to a specific social phenomenon (suicide). These principles had initially been elaborated by **Durkheim** in his earlier book "The Rules of Sociological Method" (1895). Having outlined the principles involved in the scientific study of society, **Durkheim** used suicide as a means of demonstrating how sociologists could apply those principles to the study of any social phenomenon.

We can further note, by way of justification, that since its publication **Durkheim's** work has cast a giant shadow over the sociological study of suicide – both in terms of those who accept its basic methodological principles and arguments (and who have subsequently tried to build on and develop **Durkheim's** basic insights) and those who have criticised and rejected both the methodology and conclusions of his work.

Explaining Suicide

We can illustrate **Durkheim's** broad approach to the study of suicide by noting how he justified his sociological and methodological analysis:

"Since suicide is an individual action affecting the individual only, it must seemingly depend exclusively on individual factors, thus belonging to psychology alone. Is not the suicide's resolve usually explained by his temperament, character, antecedents and private history?...If, instead of seeing in them [suicides] only separate occurrences unrelated and to be separately studied, the suicides committed in a given society during a given period of time are taken as a whole, it appears that this total is not simply a sum of independent units, a collective total, but is itself a new fact *sui generis* [unique in some way], with its own unity, individuality and consequently its own nature - a nature, furthermore, dominantly social.".

Durkheim is arguing, therefore, that to "explain suicide" we need to look at it in two ways:

1. Collectively: We must look at the total number of suicides in a society over a given time period to establish the existence or otherwise of **patterns** of suicide; if there are no such patterns (as one would expect if suicide was simply an individual, psychological, phenomenon that occurred more or less randomly, depending on individual states of mind) there would be nothing to explain sociologically. However, since the early 19th century it had been reasonably well-known that suicide rates were seasonal - they peaked in late spring and reached their lowest point in mid-winter and **Durkheim** built on this basic observation using:

Official suicide statistics drawn from different countries to demonstrate a much wider range of suicide correlations – from the high level (different societies consistently demonstrated different levels of suicide) to the mid-level (men kill themselves more-frequently than women, the old and the young are more likely to kill themselves and so forth).

2. Social Facts: **Durkheim** considered suicide rates to be social facts – a certain class of phenomena that exist outside individual consciousness; in other words "a social fact" is something that exists outside the power, control and influence of individuals because it is a collective or aggregate feature of a society that is more than the sum-total of its individual parts. A social fact, in this respect, is something that has a quality of existence in its own right, regardless of whether people believe or want it to be true. Suicide rates are social facts because they cannot be influenced by the behaviour of any individual; they are something greater than the sum of individual intentions.

In this respect **Durkheim** discovered a number of correlations between suicide and social factors. For example, he found rates were consistently higher for:

- The **widowed**, **single** and **divorced** rather than the married.
- The **childless**.
- **Protestants** rather than Catholics or Jews.
- **Soldiers** rather than civilians (and in peace time rather than war time).
- **Officers** rather than lower ranks.
- **Scandinavian** countries.

Overall, Durkheim argued that suicide rates vary between different:

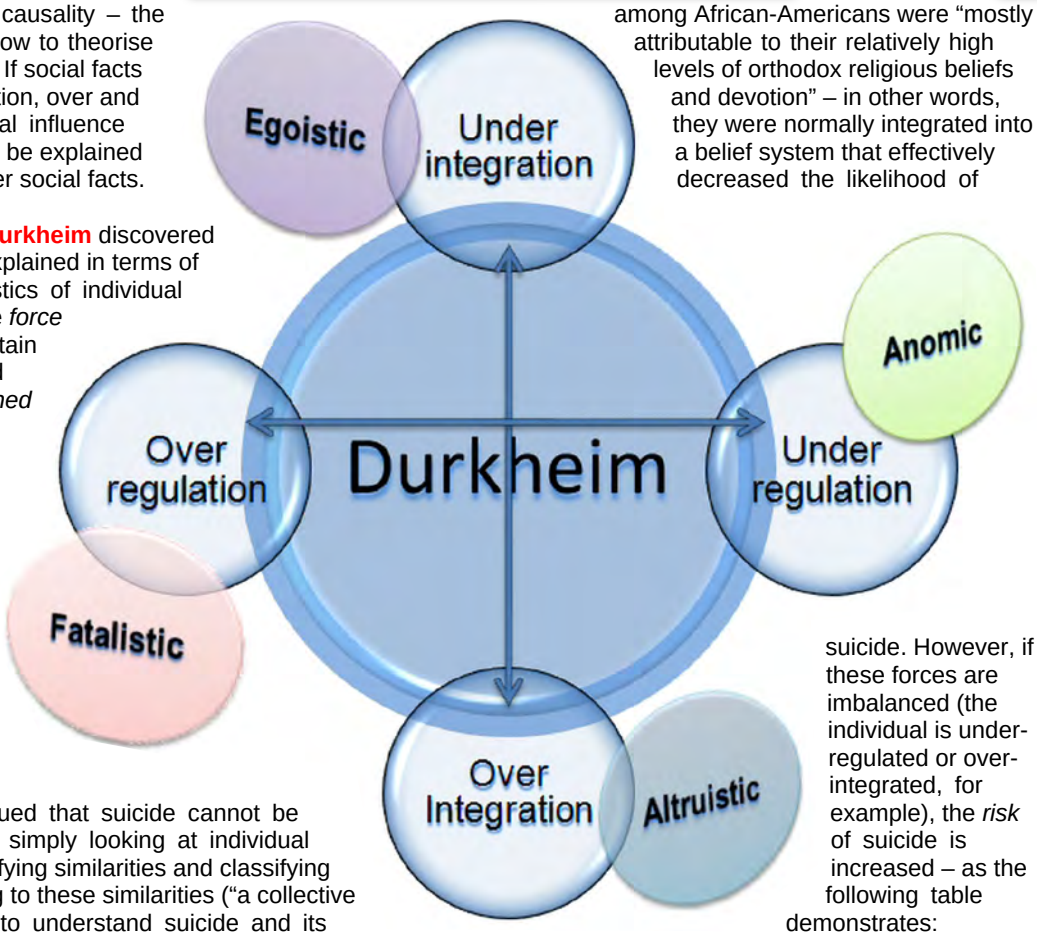
- **Societies**.
- **Groups within a society**.

Within single societies the suicide rate remains roughly constant over time. Every society has a "normal" rate of suicide – a certain number of people will take their own life each year – but this can be modified by the effects of different types of long and short term social change. During periods of acute economic crises, for example, the suicide rate will rise whereas during periods of wartime the suicide rate generally declines.

The various statistical patterns **Durkheim** discovered suggested suicide had a social, rather than individual

psychological, causality – the problem was how to theorise such causality. If social facts were, by definition, over and above individual influence they could only be explained in terms of other social facts.

The patterns **Durkheim** discovered could not be explained in terms of the characteristics of individual suicides. Some *force* acted upon certain individuals and effectively *pushed* them into suicidal behaviour (a suspicion reinforced by the observation that suicide rates varied in response to certain types of social change).



Durkheim argued that suicide cannot be understood by simply looking at individual suicides, identifying similarities and classifying them according to these similarities ("a collective total"); rather, to understand suicide and its causes we needed to examine it as a purely social phenomenon – and this involved thinking about the nature of:

Social order in any society since **Durkheim** argued that order was underpinned by two types of *organisational pressure*:

1. Social regulation, or the general rules that governed individual and cultural behaviour, and:

2. Social integration - the extent to which regulated individuals felt they belonged to a social group.

Regulation and integration, therefore, represent two important *forces* acting on the individual. When these are 'in balance' (the individual is 'normally regulated and integrated') there is no prospect of suicide. **Neeleman et al** (1998), for example, suggest lower rates of suicide among African-Americans were "mostly attributable to their relatively high levels of orthodox religious beliefs and devotion" – in other words, they were normally integrated into a belief system that effectively decreased the likelihood of suicide. However, if these forces are imbalanced (the individual is under-regulated or over-integrated, for example), the *risk* of suicide is increased – as the following table demonstrates:

In terms of four basic "types of suicide" (**Durkheim** noted sub-categories within some types but these need not concern us here) we can briefly outline them in the following way:

1. Egoistic suicide results from a failure of the members of a group whose membership the individual values to return their intense feelings of belonging. Suicide, in this instance, derives from a weakening of the social ties that bind the individual to the group. When people become detached from group values and expectations they suffer what **Durkheim** termed an 'excess of individualism', resulting in suicide becoming a strong behavioural response.

2. Altruistic: Individuals so closely associate themselves with a particular social group that their identity is submerged into the group itself. Someone who feels they have shamed or disgraced the group may see suicide as a means of atonement.

3. Anomic: **Nisbet** (1967) suggests this type of suicide is caused 'by the sudden dislocation of normative systems – the breakdown of values by which one may have lived for a lifetime'. In other words, where an individual becomes confused or uncertain about their world (through sudden, life-changing events, for example), the risk of suicide is increased.

4. Fatalistic: Suicide results when the individual sees no possibility of relief from 'oppressive social discipline and regulation'. Suicide, in effect, becomes a means of escape.

In the 100 or so years following **Durkheim's** study, **Taylor** (1988) notes "Although there have been hundreds of subsequent studies of suicide rates…no one since Durkheim has attempted to construct a complete, embracing theory of suicide. Many later studies have restricted themselves either to 'testing' the relationship between suicide and particular variables or to refining and developing aspects of Durkheim's theory".

Although **Taylor's** observations relate to a broad spectrum of sociological studies across a range of methodologies, they are pertinent here in terms of what we might term "realist revisions" to **Durkheim's** basic proposition that there is a clear relationship between levels of social integration / regulation and the risk of suicide.

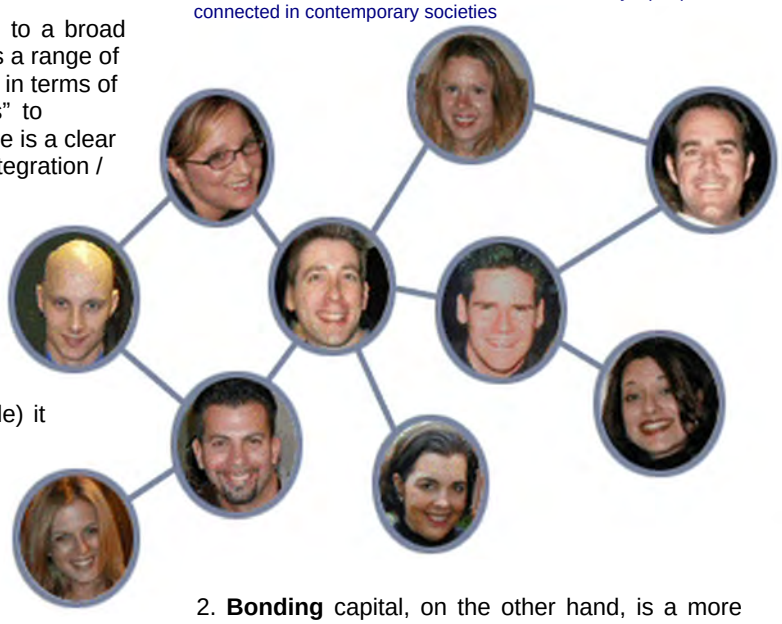
Social Network Theory: One "problem" with **Durkheim's** analysis is that although it suggests how *macro-level processes* (such as levels of integration and regulation) relate to *micro-level behaviours* (people committing suicide for example) it doesn't specify how and why some individuals are prone to, or are at risk of, suicide while others (the vast majority) are not – the general thrust of **Durkheim's** analysis would suggest that far more people *should* commit suicide than actually do kill themselves. **Pescosolido** (1994) attempts to fill-the-gap, as it were, using the idea of **network theory** – the basic idea here being that what links the individual to wider social structures are the social ties (family, work, friendship, peer group and so forth) that are created through social interaction. Such ties between people exist at both the individual level (the meaning of the tie between husband and wife, for example) and, because these ties link into wider social they form what **Cook** (2001) calls a **bridging tie** between "the individual" and "society".

The significance of social networks in the context of suicide is that, for **Pescosolido** (1990), the stronger and more durable are the particular community ties into which an individual is locked, the less likely they are to commit suicide - in the normal run of events. **Maris** (1997), for example, notes there are sometimes situations – such as the mass suicides carried out by religious cults and sects – where it the very strength of community ties that actually propels a group into suicide. In this respect, a related theory that focuses on the content of social networks involves:

Social capital: This refers to the ways people are connected in (or disconnected from) *social networks* and the implications these connections have for what **Putnam** (2000) calls 'norms of reciprocity' (what people are willing to do for each other). **Putnam** distinguishes *two types* of social capital relevant to the analysis of suicide:

1. **Bridging** capital relates to ideas about *inclusiveness* and involves notions of cooperation, trust and institutional effectiveness. In this respect, where the individual is effectively tied into inclusive networks (such as a Church or similar type of organisation) their social orientation is "outward" – they make extensive links and ties with a wide range of others. Their group memberships, in this respect, are likely to be heterogeneous and involve exposure to a wider range of different individuals and ideas.

Social Network theories focus on the various ways people are connected in contemporary societies



2. **Bonding** capital, on the other hand, is a more *exclusive form*, in the sense that while it serves to bond particular group members to each other it creates a certain level of group homogeneity that can set such groups apart from the influences of wider society.

This distinction is important because it suggests that while some argue that the higher the level of an individual's social capital – the more-tightly they are connected to social networks – the less likely they are to commit suicide (**Helliwell** (2004), for example, argues that **"**social capital does appear to improve well-being, whether measured by higher average values of life satisfaction or by lower average suicide rates"), this may not *always* be the case. Where an individual has higher measurable levels of bridging capital suicide does indeed become less likely. However, in some instances high measurable levels of bonding capital (such as when an individual is tightly tied into an organisation or community that is pro-suicide) may create the reverse – an increased risk of suicidal behaviour.

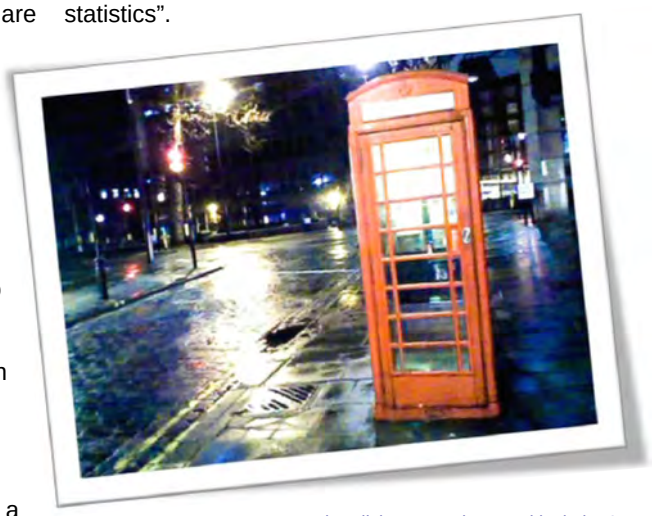
Putnam (2000) uses the image of "Bowling Alone" to illustrate how some people in contemporary societies become socially isolated and disconnected from social networks.

Kushner and Sterk (2005) take this idea a step further when they argue "the incidence of self-destructive behaviors (*sic*) such as suicide is often greatest among those with high levels of social integration" and **Cullen and Whiteford** (2001) argue the general health benefits – for both individuals and social groups - of high levels of social capital can only be achieved when individual levels of social capital are well-integrated in terms of *both* bridges *and* bonds.

Social isolation: In a much earlier study, **Halbwachs** (1930) implicitly referenced these kinds of ideas when he argued that suicide was closely correlated to the concept of "social isolation". Individuals who were socially isolated suffered from under regulation / a lack of social integration and this made them more-susceptible to suicide – an idea he illustrated by linking it to levels of **urbanisation**. There were, he argued, clear differences in suicide rates between rural and urban areas (the former had much lower rates) and he suggested this was due to differences in social integration. Large urban areas, such as cities, encouraged a way of life that was both transitory (people tended to move around from place to place a great deal) and impersonal (because it takes time to "put down roots" and get to know others urban dwellers tended to be part of much smaller, less intense, social circles). These two related factors created higher levels of social isolation and placed more people "at risk" of suicide.

Persons Under Trains: **Taylor's** (1982) **case study "**Persons Under Trains" - the title is a reference to the way London Transport reported accidents involving people who, for whatever reason, fell in front of tube trains on the London Underground - is significant because it confronts two problematic areas in the sociological study of suicide, namely the (positivist) problem of official suicide statistics and the (Interpretivist) problem of meaning. These two problems are not, as we've suggested, unrelated but for theoretical convenience we can consider each in turn.

1. Official statistics: "Persons Under Trains" had two main aims, the first of which, as **Taylor** (2009) notes, was to analyse the nature of official statistics in general - "I was not really that interested in suicide statistics, as such, but rather the larger aim was to use the realist experimental method and develop a model for analysing the viability of *all* official statistics".



Urban living - transitory and isolating?

To this end **Taylor** devised a clever way of testing how and why a "suspicious death" came to be classified for official purposes (as suicide or as something else).

One of the problems involved with observing the processes in a coroner's court is that a significant **variable** (how the victim died) is left uncontrolled. If the sociologist, for example, samples a range of "suspicious deaths" (hangings, shootings, drug overdoses and the like) over a given period there is likely to be a wide range of possible verdicts (from "obvious suicides" to "accidental deaths" and all points in between); if, on the other hand, the sociologist only samples a certain **type** of suspicious death – someone who has died under the wheels of a tube train, for example – this variable can be controlled and used as an objective basis for comparison.

As **Taylor** (2009) argues: "What we tried to do was to find out if the statistics were systematically biased by using an experimental design – that is, by holding the circumstances of death completely constant we could explore the impact of the [victim's] life history on the decision making process". In this respect he "…looked at every single case of people under trains in one year – you can't get much fuller than that and even as a proportion of cases in one year the percentage is still high - but, more importantly what I was trying to do was develop a model for analysing official data generally. For example, if you're looking at the influence of class, you hold circumstances constant and look at the variable you're interested in. It's really a scientific (i.e. experimental) way of analysing official data".

In this case the variable **Taylor** was interested in was not how someone died but how that death was interpreted and explained by others; because the circumstances of each death that went before a coroner's court were the same (**Taylor** used hospital records to establish exactly how an individual died; he then used this objective statistical standard as a way of understanding how coroner's construct the meaning of suicide) it would be possible to accurately record if, how and why coroners arrived at different verdicts for the same type of death. What he found (using non-participant observation and documentary analysis of court records) was that a range of **primary** and **secondary cues** (such as the testimony of witnesses, the psychological history of the individual and the like) did indeed influence the coroners' verdicts

Although **Taylor's** empirical demonstration that the same kind of death is interpreted differently by coroners seems to confirm Interpretivist criticisms of approaches based on official suicide statistics, his study is more sophisticated than this simple conclusion, for two reasons:

a. To conclude that the "same form of death, interpreted differently" means suicide statistics are flawed we would have to know, in advance of any coroner's decision, which of the deaths was "a suicide". This, however, is not possible since it is a coroner who decides what is and what isn't "a suicide". Until a decision is made it is nothing more than a "suspicious death". Rather than supporting Interpretivist views, therefore, what **Taylor's** research demonstrates is the very opposite – it exposes a major contradiction in their approach. In order to argue suicide is a wholly social construction suicide must actually have an *objective* existence; it is only by knowing "in advance" which deaths are suicide and which are not that we can say with any certainty that coroner's decisions are an unreliable and invalid measure of suicide…

b. While some Interpretivists (and positivists, albeit for very different reasons) see the "reality" of suicide in the decisions made by coroners and other Interpretivists see this "reality" in terms of the meanings held by those who commit suicide, realists take a different methodological approach. They argue that the reality of suicide exists in the fact that certain people try, sometimes successfully, sometimes not, to kill themselves. The problem, however, is how do we actually get at and understand this reality? The deceptively simple answer is to change the way we understand and measure the concept of "a suicide",

Suicide Redefined: Although "suicide" is, in official terms, an *objective* behavioural category, **Taylor** demonstrates it can only be operationalised *subjectively*. Thus, we have the apparent paradox of sociologists being unable to explain objective reality (why people actually kill themselves) because it can only be defined subjectively. To put it another way, although we know for sure some people take their own life we don't actually know who these people are because we can't objectively identify them in terms of their "known characteristics". A **realist methodology**, however, can resolve this paradox by looking beyond official categories to discover the reality that lies beneath their construction. **Taylor's** research on suicide statistics demonstrated that "suicide" is not a neutral, descriptive and objective category and instead of accepting this official definition (as both positivists and somewhat ironically, Interpretivists do) we need to widen it.

Rather than thinking about, for example, "successful" and "unsuccessful" suicides as if they were qualitatively different phenomena that need explaining in different ways we should think about "suicidal behaviour" in the abstract; as a term that covers any risky, self-harming, behaviour (whether it results in the death or otherwise of the individual). Evidence to support this idea comes from writers such as **Linsley et al** (2001) and their discovery of "many similarities" between the "suicide" and "open" (i.e. possible, but unproven, suicide) verdicts delivered by coroners. In other words, rather than focus on legal distinctions between "suicide" and "non-suicide" based upon assessments of "reasonable doubt" we should consider the behaviour itself as indicative of some form of suicidal risk. In this way we can theorise suicidal behaviour as a:

Continuum, with "completed suicide" at one extreme and "uncompleted suicide" at the other. This goes some way towards resolving the definition and measurement problem because to study suicide all we have to do is establish that someone either took, or intended to take, their own life, deliberately, accidentally or whatever. That is, we need to recognise that *legal definitions* of suicide are not necessarily appropriate for sociological investigations and rather than simply adopting official definitions that, as **Linsley et al** (2001) suggest, over-differentiate between "suicide", "possible suicide" and "non-suicide", we need to change the focus slightly. Instead of trying to study "differences in intention" (did someone really mean to take their own life or was it just a "cry for help"?) we need to accept "differences in outcome" (when people engage in risky behaviour some people live and others die).

Risk: **Taylor**, for example, argues, there is no real need to make distinctions between "real" and "fake" suicide attempts, mainly because few suicide attempts are so well planned and constructed as to ensure survival. While different attempts may increase or decrease survival chances the outcome of the attempt is hugely dependent on chance. He suggests, instead, that we need to think about suicide in terms of "risk" – a gamble with life and death where the outcome is framed in terms of both a desire to live and a desire to die. The significance of this idea is twofold:

Firstly, it challenges the assumption that "real suicides" involve people who are determined to die (with all other forms being variations on a "cry for help").

Secondly, it allows us to construct a theory of suicidal behaviour that combines two basic ideas:

a. That "the gamble" is a question of certainty and uncertainly.

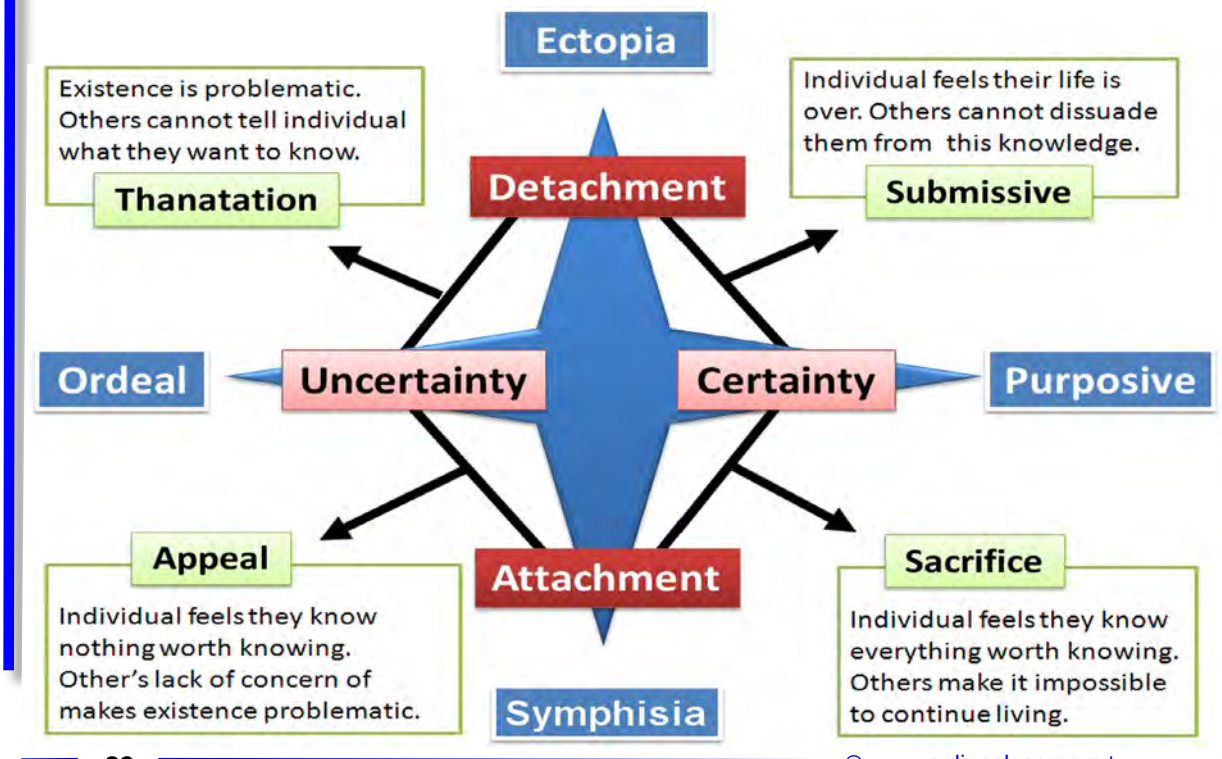
Risky behaviour?

b. That the decision to gamble in the first place is related to individual levels of social attachment and detachment (an idea based on the not unreasonable assumption that those most likely to gamble will, following **Durkheim's** lead, be those either well-integrated into certain groups (high attachment) and those least integrated (high detachment).

2. The Problem of Meaning: As the following diagram demonstrates, **Taylor** (1982) suggests a realist understanding of suicide involves thinking about individual behaviour in terms of two distinct but interrelated axes:

a. Uncertainty and Certainty: This axis relates to the individual's position in the social world in the sense of how others see them and, most importantly, what they feel about this.

b. Attachment and Detachment: This axis focuses on how an individual relates to others and the feelings these relationships (or, indeed, lack of same) engenders.



Types of Suicide

Taylor identifies four basic "ideal types" of suicide based on the extremes of each axis. In addition, four subtypes can be identified where elements of the two axes combine (detachment and certainty combine, for example, to produce submissive suicide):

1. Ectopic: This "inner directed" form results from **social detachment**. It is, for example, standard sociological knowledge that how others feel about us (love, affection, hatred, etc.) is a very important component of our **self-concept** (how we see ourselves and what we feel about this perception) and when we become detached from others - through things like death, desertion or illness (physical or mental) - we lose a sense of being; and in extreme cases this sense of loss results in suicide.

2. Symphysic: The reverse of ectopic, this type results from extreme forms of attachment to others (either individuals or social groups). This type, therefore, is "other directed" in that it results from the relationship the individual has with others. Group or mass suicides are an extreme manifestation of this type in that individuals have a very strong sense of attachment to a group that feels itself detached from – and possibly threatened by - the rest of society. We can note a couple of examples of this form I- the Peoples Temple and Heaven's Gate.:

a. The Peoples Temple:
On November 18, 1978 Jim Jones, the leader of this quasi-religious sect, ordered 918 of his followers (around 270 of them children) to take a soft drink laced with cyanide. The group believed themselves to be "under attack" from the American government when Congressman Leo Ryan arrived at their settlement ("Jonestown") in Guyana to investigate claims of abuse within the organisation. Ryan, plus three accompanying journalists and a Temple defector were shot dead by Temple security guards on the evening prior to the mass suicide.

The Heaven's Gate web site can still be viewed just as it was left in 1997(http://www.heavensgate.com/).

3. Ordeal suicide involves some kind of individual test about whether to live or to die and results from extreme uncertainly about both the world and the individual's place within it; the influence of others is again significant. In some cases they may show a lack of concern about the individual and their fate while in others significant people in the victim's life may not be able to help them overcome their "meaningless existence". While, for **Taylor**, all suicidal behaviour is effectively a gamble, the ordeal type is most explicitly so; in some respects suicidal behaviour represents a "roll of the dice" as part of a judgement by fate – if the individual "survives the trial" they were not meant to die.

4. Purposive: This form is undertaken with a distinct purpose in mind. At its most extreme (as in something like assisted suicide where death is virtually guaranteed) the individual commits suicide in the certainty of knowing their life is, for whatever reason, effectively over.

As we've just suggested, these four basic types have variations depending on the way they combine:

a. Submissive suicide is a combination of **Ectopia** and **Purpose** - detachment and certainty. The suicidal individual feels their existence is over and others cannot persuade them from what they know. There is

b. Heaven's Gate:
On March 26, 1997, 39 members of an American UFO cult committed suicide to coincide with the appearance of the Hale-Bopp comet. Their stated rationale for this act was the belief the earth was on the point of being "recycled" (that is, wiped clean and rejuvenated) by aliens travelling in the wake of the comet. Group members believed themselves to be "containers" for aliens (the "Kingdom of Heaven") who, on a previous visit to earth, had incarnated themselves into human bodies. As they expressed it: "Two thousand years ago, a crew of members of the Kingdom of Heaven who are responsible for nurturing "gardens," determined that a percentage of the human "plants" of the present civilization of this Garden (Earth) had developed enough that some of those bodies might be ready to be used as "containers" for soul deposits".

The cult's beliefs were bound-up in the Christian bible (Jesus was, for example, believed to be the first member of the Kingdom of Heaven to appear on earth) and their decision to commit suicide was, as they saw it, simply a jettisoning of their "earthly container" in order to revert to (or move to the next level of) their original form where they would be reunited with the other members of their race: "Hale-Bopp's approach is the "marker" we've been waiting for -- the time for the arrival of the spacecraft from the Level Above Human to take us home to "Their World" -- in the literal Heavens. Our 22 years of classroom here on planet Earth is finally coming to conclusion -- "graduation" from the Human Evolutionary Level.
We are happily prepared to leave this world".

a high level of certainty about themselves and their life – they are, in a sense, "already dead". A classic example of this type is "assisted suicide", examples of which – **Downes**, **James** and **Crew** - we've noted earlier. The 23 year old **James**, for example, felt his life was over following his almost complete paralysis in a rugby accident; his life had no more meaning to him. His disability detached him from others and meant he could no-longer enjoy the things (such as playing sport) that had given him a reason to carry on living.

b. Thanatation is a combination of **Ectopia** and **Ordeal** - detachment and uncertainty. An individual feels their existence is problematic to themselves and other people in their lives cannot tell them what they want to know in order to give meaning to their existence. Once again, suicidal behaviour is a gamble and a trial – albeit one where the individual my actually derive meaning from failure. In some instances repeated suicide attempts represent thrill-seeking through risky behaviour – the attempt and subsequent survival become almost ends in themselves.

c. Appeal suicide is a combination of **Symphysia** and **Ordeal** - attachment and uncertainty. The individual feels they know nothing worth knowing about themselves and the lack of concern from significant others makes their existence problematic. In some respects the uncertainty about the attitudes of others makes this type a form of communication where the suicidal individual effectively "tells" others, through their behaviour, about their concerns, to see how they will respond. The "ordeal", in this respect, may be as much a trial of others as of the suicidal individual. In some instances, for example, the latter may test the former by telling them about their suicidal intentions; they may also directly inform significant others they are about to commit suicide – which gives them a chance to respond by "saving" someone's life.

d**. Sacrifice** suicide is a combination of **Symphysia** and **Purpose** – attachment and certainty. The individual feels they know everything worth knowing and others have made it impossible for them to continue living. The individual, for example, may feel their attachment to others has made life unbearable and their "sacrifice" is an act of revenge and blame (by making others feel guilt and remorse for pushing them into suicide). In sacrifice suicides, therefore, the individual is effectively saying that what others have done (or not done) to them shifts responsibility for suicide from the victim to those who are left behind.

The former Pakistani Prime Minister Benazir Bhutto was killed by two suicide bombers in October 2007. Suicide bombing can be considered a form of sacrifice suicide.

Why are Catholics less prone to suicide than Protestants?

Evaluation

As we've seen, one of the major criticisms of **Durkheim's** work (and, by extension, all approaches to suicide that treat official statistics as largely unproblematic) put forward by Interpretivists such as **Douglas** and **Atkinson** is that such statistics are not objective representations of reality (the actual numbers of people who kill themselves) but subjective constructions of reality created by coroners (and hence unreliable and invalid sources of data).

One of the main ways Interpretivists have sought to criticise the work of **Durkheim** in particular is to seize on his claim that Catholics have lower suicide rates than Protestants *not* because of their different levels of social integration but because coroners are *less likely* to define the death of a Catholic as suicide. As **van Tubergen et al** (2005) note: "In *Suicide*, Durkheim stated that Protestant and Catholic churches are equally strong in their prohibitions against suicide, but because of their greater involvement in the religious community, Catholics have a lower risk of suicide than Protestants". In other words, because the Catholic faith defines suicide as "a mortal sin" those left behind (such as family and friends) are likely to suffer social and religious stigma if a death is defined as suicide; therefore, the argument goes, coroners – especially those in Catholic societies – are less-likely to define a death as suicide in order to pre-empt the suffering of the living.

If valid, this criticism is potentially devastating for **Durkheim's** analysis; if the statistics on which it rests are biased, unrepresentative and invalid then tso too is that hat analysis . However, there are two reasons for believing the Interpretivist case is not just overstated (a *theoretical* fallacy) but also that it is potentially incorrect (an *empirical* fallacy):

1. The Theoretical fallacy is demonstrated, as we've suggested, by **Taylor's** analysis of suicide. As **Taylor** (2009) puts it: "Douglas and later Atkinson had alleged that factors in life history influenced officials' decision making and caused systematic biases in the official statistics – but that was all they did. Their thinking was also contradictory in the sense they said there was no such thing as a 'true rate' as all suicide statistics are social constructions and also that the official statistics are systematically biased – but biased from what? – you can't have it both ways!...Douglas and Atkinson proved nothing, they only asserted".

Are criticisms of Durkheim's analysis misplaced?

2. The Empirical fallacy: One of the key assumptions about **Durkheim's** analysis of suicide is that, following **Atkinson** in particular, his analysis is, at best, based on faulty statistics and, at worst, invalid. However, as **Taylor** has suggested, Interpretivist critiques do not *disprove* Durkheim, even though it can be argued that suicide statistics are social constructions (which, as **Taylor's** subsequent approach to suicide suggests, is neither something that can be avoided – quite the reverse in fact, it has to be embraced – nor of any real consequence in terms of a realist methodology and explanation of suicide).

A further strand to this argument is provided by **van Tubergen et al** (2005) when they argue that in the case of suicide among religious groups (specifically Protestants and Catholics) suicide statistics are broadly reliable and valid when explaining the difference between these two groups. They argue this on the basis of their analysis of official suicide statistics in the Netherlands at the turn of the 20th century.

van Tubergen et al looked at death rates over a 5-year period (1905 – 1910) where they counted 155 male Protestant suicides in the 20 -29 age group. Assuming a similar rate of Catholic suicide (since, for Interpretivists, there should be no difference) "the expected number of Catholic suicides would be 94". The actual number was 52. On the face of things this suggests, **Durkheim's** critics are correct; Catholic suicides' were massively undercounted (even in the Protestant Netherlands). However, **van Tubergen et al** dug deeper into the statistics on the basis that if "Catholics hide suicides more often than Protestants… these hidden suicides should be buried in other death classifications". In other words, when someone dies it is recorded and classified in some way (suicide, murder, accident, etc.) and if "Catholic suicides" were being reclassified as something else these deaths would appear in other categories and these would, in turn, be **over-counted** when compared to Protestant deaths..

Thus, if 42 "Catholic suicides" had been "misclassified" (and under-counted) we would expect to find these "missing" 42 deaths in other categories (since these would, in effect, be over-counted – there would be proportionately more Catholic deaths in these categories than one would statistically expect). What **van Tubergen et al** discovered, however, was **no significant over-counting** of Catholic deaths in categories other than suicide (only one category – sudden deaths – recorded more Catholic deaths (+4) than would have been expected). Their analysis concluded that

"It appears that in 7 out of the 10 age gender groups [identified in the original statistics], the lower rate of suicide among Catholics cannot be attributed to systematic undercounting. We conclude that some undercounting of Catholic suicides might exist (and did at the beginning of the 19th century in the Netherlands), but it is restricted to older age groups. We see no reason to believe that this undercounting accounts for the Protestant-Catholic differential".

The tentative conclusion we can draw from this type of statistical analysis is broadly in line with **Durkheim's** original argument. Although, as **van Tubergen et al** suggest, both Protestant and Catholic religions were and are broadly similar in terms of their prohibition and condemnation of suicide, Catholics really do have lower rates of suicide than Protestants. This follows primarily because Catholicism demands greater individual involvement with a religious community – and this higher level of (moral, spiritual and physical) **integration** explains why fewer Catholics than might be expected commit suicide (or, if you prefer, higher numbers of Protestants commit, in **Durkheim's** terms, **egoistic** suicide).

Source: **van Tubergen et al (2005)**

Cause of Death	Males (20 – 29)
All suicides	
Protestant (actual)	155
Catholic (expected)	94
Catholic (actual)	52
Catholic (actual - expected)	-42
Sudden deaths	
Protestant (actual)	13
Catholic (expected)	8
Catholic (actual)	12
Catholic (actual - expected)	+4
All causes	
Protestant (actual)	972
Catholic (expected)	588
Catholic (actual)	520
Catholic (actual - expected)	-68

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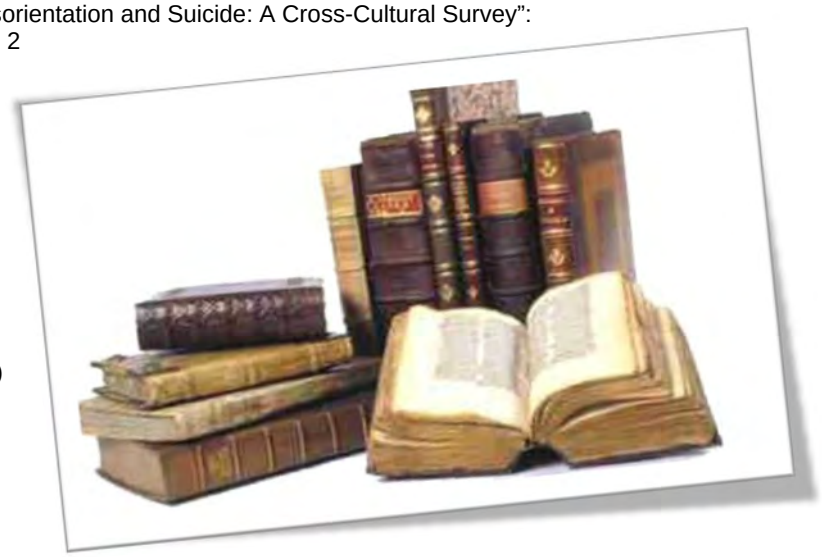

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