Individual and Societal Determinants of Suicidal Behavior

Why do people commit suicide? Is it because of an individual psychological defect, or have they simply become unable to resist massive social pressures? This paper analyzes census data on suicide rates in the German provinces and surrounding European countries to come to the conclusion that structural societal factors are indeed more powerful determinants of suicidal behavior. Recommendations for further study and on-the-ground policy are also made.

Introduction

Suicide is the third leading cause of death for youth aged 10 to 24 (Centers for Disease Control and Prevention, 2002). Women of all ages are three times as likely to attempt suicide in their lives as are men (Centers for Disease Control and Prevention, 2004). The U.S. Centers for Disease Control list family and community support as one of the key mechanisms for preventing suicide among those at risk (Centers for Disease Control and Prevention, 2004). Considering the above statistics and the federal government's attention to collecting them and offering suicide-prevention advice, we can see that suicide has been recognized as a social problem to which the government has allocated public funds to prevent. The CDC goes on to recommend, however, that clinical care for mental and substance abuse disorders is also key to preventing suicide, thus suggesting that individual psychological factors can be at fault. In this paper, I explore the relationship between suicide and individual versus social factors. Specifically, I ask whether micro level psychological factors or macro level societal factors are more significant determinants of whether a person will commit suicide. I hypothesize that social conditions, not psychological status, are more predictive of an individual's decision to take his own life. Such research is valuable and relevant as part of a larger effort to determine what causes people to take their own lives and an attempt to mediate those provoking factors.

Literature Review

Because of the grave social and painful individual implications of suicide, it has been the subject of much study among scholars. Many scholars believe that a persistent feeling of hopelessness is the driving force behind suicide in adults. They define hopelessness more specifically than its colloquial usage. Minkoff, in his work, describes it as, a feeling that "nothing will turn out right,

nothing will succeed, important goals are unattainable, and worst problems will never be solved" (Handout, 2005). Weishaar and Beck also focus on the role of hopelessness in suicide. Many other scholars, including Beck, Pearson, Brown, Conaghan, Davidson, Heisel, Hill, and Uncapher further emphasize the role of hopelessness in causing suicide among specific populations, such as psychiatric patients and the elderly.

Related to theories centering on hopelessness is what are called the "escape theory" and the "meaning-centered approach." Both of these theoretical approaches discuss a particular manifestation of hopelessness as center to suicidality. Escape theorists such as Baumeister and Hewitt posit that suicidal behavior results when a person perceives herself as failing or not meeting perfectionist goals. This state of negative self-awareness leads to "cognitive deconstruction" (Handout, 2005) in which the person's judgment and inhibition falters and they choose suicide to escape their painful state of disappointment and self-perceived failure. The meaning-centered approach similarly focuses on an individual's perception of her life. Frankl and Linehan in particular propose that a person's will to live depends on their ability to find meaning in new life events. Those who can find meaning even in negative events or suffering are thus less prone to suicide.

The medical profession has even gotten involved in the debate. Some scientific research indicates that predisposition to suicide may be a genetically inherited trait. However, psychiatrists and psychologists, such Americans Karl Menninger and Edwin Schneidman, still tend to focus on the role of hopelessness and inability to see solutions to problems as driving factors behind suicide (Handout, 2005).

All of the above literature focuses on traits of individuals that may cause suicide. There, however, a substantial body of literature that claims the individual factors causing suicide are

negligible when compared to the social forces influencing an individual's perceptions and actions. To understand such a seemingly counterintuitive position, we must first review the sociological literature on individual agency and social structure.

Two basic schools of thought dominate the structuralist camp. Many sociologists, including prominent scholars Emile Durkheim and Karl Marx, argue that social structures are so powerful that they completely control an individual, and leave no room for individual's actions or characteristics to determine her life. More recently, Berger and Luckmann have argued that Durkheim and Marx's ideal is too restrictive and that, in the beginning, individuals have agency in giving meaning to the world they see around them. After this first act of free choice, however, these meaning become institutionalized and then form the social structure which goes on to limit the future agency of the individual. In discussing suicide, structural sociologists would look at the influence of social institutions and practices on an individual's decision to commit suicide.

On the other side of the coin are sociologists who believe that individuals have considerable power in shaping their world and perceptions. These scholars, known as symbolic-interactionists, do not ignore the influence of society. They recognize the power of social forces such as stigma, situation, and peer groups and the limitations placed by society on individuals. They do believe, however, that individuals retain some agency and ability to effect change in their part of the world. Proponents of this theory include George Herbert Mead and others of the Chicago school.

Methodology

At this point, I will leave my discussion of previous literature and turn to my own research. Later, in the discussion section, I will support my conclusions by citing and integrating the above

scholarship to provide a complete picture of the driving forces behind tendency toward suicidal behavior.

The data set I work with has been compiled by examining public census records throughout the German provinces and in surrounding European countries in the 1880s. This data set is very similar to that used by Emile Durkheim in his landmark study on suicide in Europe. My dependent variable is number of suicides per a given number of inhabitants as indicated in the results tables. My independent variables are: race, insanity, alcoholism, marital status, country of residence, and religion. I will analyze the relationship between each of the independent variables and the dependent variable by listing the average results and visually comparing these averages. I choose to use publicly available data because it is most cost efficient while at the same time most complete because it was collected by an official government agency with the time and resources to create a comprehensive data set.

Results

Analyzing Durkheim's results we can see many interesting trends. In his comparison of suicide and race we see little correlation between the two. Purely German provinces and provinces with a small German population had approximately the same difference in suicides per million as did purely German provinces and majority German provinces. The suicide rate per million increased slowly for purely German, majority German, and important German minority provinces, but then dropped dramatically for provinces with a small German minority. There does not seem to be a correlation between race and suicide rates.

In his comparison of number of insane per 100,000 and average suicides per million inhabitants, there does not appear to be a correlation either. As the number of insane goes down incrementally from 215 to 84, the average suicides increase on the whole from 107 to 153.

Similarly, looking at consumption of alcohol in liters per capita and average suicides per million inhabitants, we see that suicides hover around 200 per million for inhabitants who consumed between 7.2 and 13 liters of alcohol in 1884 – 1886, then shoot up to 234 suicides for those who consumed 4.5 to 6.4 liters between 1884 – 1886, then fall again to 147 for those who consumed 4 or less. From a cursory non-scientific examination I see no correlation between the number of liters of alcohol consumed per capita between 1884 and 1886, and the average suicides per million inhabitants.

Examining the data concerning marital status and rates of suicide, however, we can see a much stronger correlation. Single men aged 16 to 65 are, on average, 3.16 times as likely to commit suicide as unmarried men the same age. This shoots up to eleven times as likely for men aged 66 to 75, and thirty-seven times more likely for men over 75. Women aged 16 to 65 are approximately 2.7 as likely to commit suicide as unmarried women the same age, while women 66 to 75 are 11.12 times as likely to do so. Clearly, these rates indicate that unmarried people face a substantially increased risk of suicide, usually on the magnitude of three times but sometimes as high as thirty-seven times.

An analysis of the suicide rates per million inhabitants of different European countries yields a similarly consistent result. Over a twelve year period in a survey of eleven countries, no country ever moved more than two rank positions away from its original rank. For example, Italy remained the country with the lowest number of suicides during the entire twelve year period, while Denmark and Saxony always held their positions as the those country with the top two

suicide rates. Each country in the survey basically ranked the same in terms of number of suicides in comparison with the others throughout all of the years examined. This indicates some correlation between citizenship and tendency toward suicidal behavior.

Finally, we see a notable correlation between the average number of suicides in a given period in Austria, Prussia, Baden, Bavaria, and Wurttemberg. Protestants averaged 171 suicides per million persons in those regions, while Jews averaged 111 and Catholics only 96. The relatively large discrepancy in these numbers indicates some sort of relationship between religion and suicidal behavior.

Discussion

These results demonstrate that macro level social factors are better predictors of suicidal behavior than individual forces. That is, a person's nationality/race, presence of insanity, and addiction to alcohol can all be considered characteristics inherent to a person – characteristics that are inseparable from her as a human being. Contrarily, marital status, country of residency, and religion are social factors – conferred by social institutions or social designations, and not an inborn trait of a person. This confirms Emile Durkheim's conclusion that individuals are less likely to commit suicide when they feel a part of a cohesive group and have strong social bonds, such as when they are part of a married couple, part of a strong, patriotic nation, or part of a community-oriented religion such as Catholicism or Judaism. The results of Durkheim's work suggest a structure-centered, not agency-centered, model of understanding individuals and suicide. That is, he recognizes the power of social and inter-personal circumstances in determining an individual's behavior, even suicide, and gives substantially less weight to personal characteristics. His research demonstrates that macro-level factors are more influential

in determining behavior than are traits we consider to be an individual's active choice or predilection.

This can be linked with other research that emphasizes the role of feelings of hopelessness in suicide, as ability to interact with others and have continuing new life events maintains higher levels of hopefulness and life-meaning. Members of communities can take advantage of the social bonds and group support discovered by Durkheim to dispel hopelessness, lack of purpose, and feelings of failure by maintaining positive interaction with others.

This study should be extended, even only on the variables already used, to contemporary times. Given the increase in religions in Europe as well as the more public existence of atheists and agnostics, one could study not only the effects of impersonal, Protestant v. community-based, Catholic or Jewish religions, but the effect of religion (Christian, Judaic, and Muslim) versus no religion. Suicide and insanity could be extended to study suicide rates and those who receive mental health services and those who don't. Tagging onto the debate over information technology, another interesting avenue would be to study rates of suicide among those who frequently use computers and the internet versus those who do not. Given the high rates of suicide among youth mentioned in the introduction of this paper itself, extending the study to suicide rates of youths from different socioeconomic, cultural, and familial situations would be a very interesting and relevant application of the survey. Government and non-profit sponsored programs geared at increasing social integration may be a particularly good area for expansion. In addition to providing individual psychological counseling services and identifying practical ways to physically protect suicidal patients, these programs can develop partnerships with community organizations. Such collaboration can provide a meaningful way for individuals receiving individualized services for suicidality to be linked with a organization that can

facilitate positive social and community-building experiences. The data analyzed above clearly indicates the importance of feelings of social integration and belonging in decisions to commit suicide. Connection of both public and private sector suicide counseling and prevention services with neighborhood-based, socially-oriented community organizations may be the critical link in creating an expanded, effective safety net for citizens vulnerable to suicidal behavior.

Conclusion

Clearly, much work remains to be done in the field of suicidality. A multitude of social variables intersect to determine one's susceptibility to suicide. Continuing down the road of individualized psychological services is not sufficient to stem the problem as we now confront it. Taking a new direction in which social services recognize the feelings of loneliness, alienation, and lack of social integration underlying suicide may provide new avenues for early identification of suicidal tendencies and the prevention of suicidal behavior in citizens of all ages and social groups.

Appendix

Comparison of Austrian Provinces with Respect to Suicide and Race

Racial composition of province	Average suicide rate per Million
Provinces purely German	106
Majority German	125
Important German minority	140
Small German minority	86

Relations of Suicide and Insanity in Different European Countries

Number of Insane per 100,000 Inhabitants	Averages of Suicides per Million inhabitants
215	107
202	107
185	63
177	63
175	63
146	164
137	164
134	164
98	153
95	153
86	153
84	153

Alcoholism and Suicide in Germany

Average of Suicides per Million Inhabitants	Consumption of Alcohol Liters per Capita, 1884 – 1886
206.1	13 to 10.8
208.4	9.2 to 7.2
234.1	6.4 to 4.5
147.9	4 and less

How Much More Frequent are Suicides of Unmarried than of Married Persons of Same Sex and Age

	16 – 25	26 – 35	36 – 45	46 – 55	56 – 65	66 – 75	Above 75
Men	0.5	2.4	3.5	3.7	5.7	11	37
Women	1.13	2.22	3.18	3.04	3.66	11.12	4.5

Rate of Suicides per Million Inhabitants in the Different European Countries (1 = fewest suicides / 11 = most suicides)

	Rank, 1866 – 70	Rank, 1871 – 75	Rank, 1874 – 78
Italy	1	1	1
Belgium	2	3	4
England	3	2	2
Norway	4	4	3
Austria	5	7	7
Sweden	6	5	5
Bavaria	7	6	6
France	8	9	9
Prussia	9	8	8
Denmark	10	10	10
Saxony	11	11	11

Suicides in Different Countries per Million Persons of Each Confession

	Protestants	Catholics	Jews
Average number of suicides in a given period in Austria, Prussia, Baden, Bavaria, and Wurttemberg	171	96	111

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