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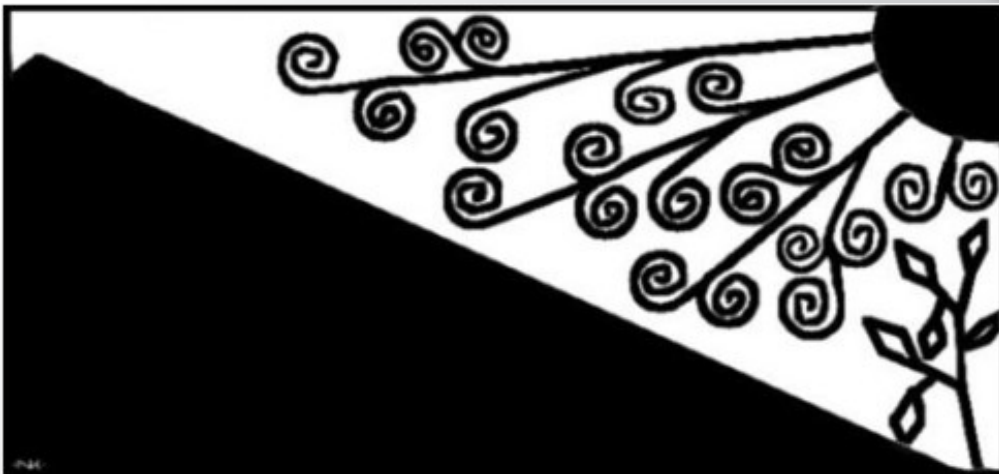
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Editorial

Suicidology Online: Continuity and Innovation**Marco Sarchiapone** ^{1,2,3}¹ Department of Medicine and Health Sciences, University of Molise, Campobasso, Italy² National Institute for Health, Migration and Poverty (NIHMP), Rome, Italy³ "G. d'Annunzio" University Foundation, Chieti-Pescara, Italy**Zoltán Rihmer** ^{4,5}⁴ Department of Clinical and Theoretical Mental Health, Semmelweis University, Budapest, Hungary⁵ National Institute of Psychiatry and Addictions, Budapest, Hungary

In March 2013, we became the Editor and Co-Editor of SOL. It took us a while to get acquainted with the journal and its practices. This time was also needed to consider new growth opportunities and, therefore, to refine our editorial plans for the future.

Even if the bio-psycho-social model of Engel (1977) is now well accepted, it is often difficult to apply it to clinical practice, as well as to develop research hypotheses appropriate for taking into account all the different components and their interactions.

Following this approach, the editorial philosophy of SOL looks at suicide and suicidal behavior as complex human phenomena, affected by a multitude of factors and interpretable from different points of view. In particular, SOL gives voice to research on cultural and sociological aspects of suicide that are often overlooked. Our efforts will be aimed at preserving this multidisciplinary perspective while also increasing the number of published papers on genetics and the neurobiology of suicide. Our objective is to expand the dialogue and discussion between different disciplines.

Our current understanding of suicidal behavior is all too often based only on data coming from western countries. In recent years SOL published papers exploring suicide in eastern and southern countries (Eskin, 2012; Fong, Shah, & Maniam, 2012; Henson, Taylor, Cohen, Waqabaca, &

Chand, 2012; Kahn & Lester, 2013; Medina, Dahlblom, Dahlgren, Herrera, & Kullgren, 2011; Park, Kim, & Lester, 2011; Yoshimasu et al., 2011), as well as in minorities (Garrett, Waehler, & Rogers, 2012; Kaiser & Salander Renberg, 2012; Montesinos, Heinz, Schouler-Ocak, & Aichberger, 2013). The goal for the future is to take into account multiple points of view on suicide prevention, publishing research reports from all regions of the world and by enhancing the Editorial Board with experts from areas, such as Asia, Africa and South America.

SOL is an open access journal. It is widely recognized that open access increases the visibility, readership and impact of published articles (Davis, Lewenstein, Simon, Booth, & Connolly, 2008; Eysenbach, 2006). The EU supports open access as a tool for broadly and quickly disseminating results of publicly-funded research («Open Access to scientific information - Digital Agenda for Europe - European Commission», s.d.). However, to be an open access journal is not enough. In order to increase SOL's impact it will be necessary to not only continue publishing high quality papers, but also to boost its visibility, establishing links and collaborations with other journals and various types of important organizations.

Another distinguishing feature of this journal will continue to be its effort to integrate quantitative and qualitative research in suicidology, by providing a

forum for debate, in an open manner, regarding methodological issues relevant to this integration (Fitzpatrick, 2011; Hjelmeland & Knizek, 2011; Lester, 2010; Rogers & Apel, 2010). Following the modern concept of scientific, we often only look at quantifiable aspects, potentially losing the specificity and subjectivity of the human beings behind the numbers. We believe that the use of mixed methods is essential for both, understanding the suicidal process and evaluating the effectiveness of suicide preventive actions.

Finally, in order to encourage research in suicidology, we believe it is essential to shift the focus of SOL from the near exclusive investigation of risk factors and attempt to increase our understanding of potential protective factors against suicide and suicidal behavior. This “positive” approach to the problem should help to generate the development of more effective, universal, selective and indicated preventive interventions.

Moreover, we also want to focus on specific topics by regularly publishing essays and reviews. Offering such reflections on the state of the art should be useful in encouraging our readers to consider previously unexplored areas, as well as to promote new insights on old issues.

Thus, this first issue of 2014 has been developed within this context of continuity and innovation. Indeed, this issue includes both quantitative and qualitative research papers, as well as an essay on the role of oppression in suicide (pg.59) and a review exploring suicide bereavement (pg.1).

Starting with this issue, we will also periodically send a copy of the journal to researchers involved in the field of suicidology. We think this will increase the number of SOL readers and, hopefully, citations, because people will no longer need to search for the journal, now the journal will come to people who can use it.

We want to extend our deepest gratitude to Prof. Nestor Kapusta, Founder and former Editor-in-Chief of SOL and to Prof. Heidi Hjelmeland, Co-Editor. They successfully brought together different perspectives in suicidology and created an important, ongoing dialogue. Thanks to their brilliant work SOL became a point of reference in suicide research. We hope to be able to continue their work with the same commitment.

Thanks are also due to members of the Editorial Board who supported and advised us in this transition.

Last, but not least, we wish to thank the many outstanding authors and reviewers, who, because of their invaluable contributions, made the publication of this issue possible.

We will endeavor to deserve the trust of our readers and we kindly invite researchers in any domain of suicidology to submit papers to SOL.

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Review

Uncovering and Identifying the Missing Voices in Suicide Bereavement

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Abstract: The field of suicide postvention remains relatively immature in terms of the current knowledge base. This manuscript examines the existing knowledge regarding suicide bereavement and describes the limitations of the suicide bereavement knowledge base using a critical review of the literature specifically relating to suicide bereavement published in the previous 10 years. Six limitations are identified in the literature: concern about samples used in research, sampling only people who have been help-seeking, women being overrepresented in studies, additional design issues including limitations by research ethics boards, definitional problems in who is suicide bereaved, and determining the size of the population bereaved by suicides. This is followed by a discussion of the need to define the suicide bereaved population, as well as understand the effect of suicide bereavement. The paper closes with suggestions for future directions that are required in the field of suicide bereavement in order to best understand and help those people left behind in the wake of suicide deaths.

Keywords: Suicide, bereavement, postvention

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Using the best available data, approximately 2000 Australian deaths are reported as attributable to suicide each year. Yet, suicide is treated very

differently from other causes of death in terms of how it is championed in the public arena. Suicide causes approximately the same number of deaths, or more, as those who die by breast cancer, yet footballers and cricketers who proudly don pink uniforms to highlight breast cancer as a public health issues do not wear a colour for suicide; there are no massive public safety campaigns for suicide as there are for road accidents (again with similar fatalities attributable each year); and, there is no national television advertising about self-check and

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preventative measures that can be individually or collectively taken for suicide as there is for prostate cancer.

Across many countries this same lack of a significant public health agenda in relation to suicide is evident. For example, in the United States where 38,000 lives are lost to suicide each year, grocery shelves are full of pink products for breast cancer, the news reports describe homicides and traffic accidents, but it is difficult to get television or newspaper reporters to cover suicide prevention activities, and there is little in the way of a nationally coordinated awareness and prevention campaign.

Broad-scale prevention messages are much more complicated for suicide prevention (and mental health self-care more generally), and may need to be discussed in specific ways that differ from other public health campaigns. While often suicide may be absent, or partially absent, from both broad-scale and concentrated public health campaigns that these other health issues experience, what is similar is that, like these other modes of death, suicide deaths can be prevented. Indeed, prevention should be at the front and centre of our concern in the whole of government and whole of community manner that our suicide prevention strategies at the state and national levels advocate.

While prevention and intervention strategies across the globe have reported success, and there have been decreases in suicide deaths in many countries with active suicide prevention campaigns, death by suicide continues to be an option for too many people who find their situation intolerable for myriad complex and inter-related reasons. Notwithstanding these reported results, many countries have also reported very little change in the overall suicide rate since the commencement of national suicide prevention strategies. For example, in the United States, the suicide rate has remained virtually unchanged or has even increased slightly in the past decade despite considerable attention (McIntosh, Drapeau, & for the American Association of Suicidology), 2012. Further, in many countries with active suicide prevention strategies in place, there remain groups within the population where rates are much higher (for example, Indigenous or First Nation peoples in Australia, the United States and Canada). There are also significant differences between genders (with males dying more frequently than women in most high income countries), the issue of suicide as a top three cause of death for youth, as well as increases in suicide risk among the elderly.

We must therefore recognise that suicide deaths will continue to occur, and continue to occur with greater frequency among some groups – groups that are often already vulnerable. Suicide will also occur within groups where it could not have been

predicted – where prevention strategies and interventions may simply not be present. What also cannot be denied is that whenever and wherever a suicide death occurs, people are left behind grieving their loss, with a long bereavement ahead of them.

Further, when considering death, and in particular death by suicide, it is important to recognise that there are always two parties to any death; the person who dies and the survivors now bereaved. While suicide is ultimately a solitary act leading to a lonely death, those left behind need to rebuild their lives, trying to understand the reasons for the decision their loved one made (Cerel, Jordan, & Duberstein, 2008). Following each suicide, spouses, partners, parents, siblings, offspring, extended family members, friends, mentors, colleagues, and professionals, all commence a new chapter in their lives – lives devoid of the person now deceased.

With this background in mind, this paper will focus on the following four areas:

1. the existing knowledge regarding suicide bereavement;
2. the limitations of the suicide bereavement knowledge base;
3. the need to define the suicide bereaved population, as well as understand the effect; and,
4. the future directions that are required in the field of suicide bereavement.

In the United States, where much of the research in this area has been conducted, those affected by the loss of a person to suicide are known as 'suicide survivors', or 'survivors of suicide'. For the public, this can clearly be confusing with those who attempt suicide and survive. Much of the rest of the world use the term 'bereaved by suicide,' which is an arguably more accurate description. Consequently, this paper will refer to suicide bereaved or bereaved by suicide.

Existing knowledge around suicide bereavement

Several factors are reported to be more prominent or intense in the bereavement through suicide due to the nature of the type of death (Jordan, 2001; Jordan & McIntosh, 2011b). In short, suicide death, along with accidental death, is viewed as a life cut short, a waste of life. There is often no time to tie up any unfinished business with the deceased due to the often sudden nature of suicide, which is particularly problematic where the relationship had previously been ambivalent or conflictual. While the popular media often portrays suicide notes as the final word from the decedent describing their reasoning and decision to end their lives, in reality, less than 20% of suicides leave notes. Even when a note is left, one of the most universal

themes in suicide bereavement is the “Why” question – the need to answer the question about why did this person do this? The act of self-death is wrapped in dilemmas of traditional moral, ethical, spiritual constructs, thus resulting in the need to find some type of rationality must be attached to the death (see Minios, 1999). From this foundation, the search for meaning and reason remains.

Analysis of the literature on suicide bereavement identifies the primary concerns typically found in response to a suicide death. In line with suicide being perceived as ‘a life cut short’, the feeling often initially associated with suicide bereavement is that of shock, which has been linked to post-traumatic stress disorder (Clark & Goldney, 2000). Feelings of guilt and blame have also been reported and these may be interconnected. Guilt can be conceptualised as the perceived ability to prevent the suicide from occurring, but a failure to do so. Often accompanying guilt are feelings of helplessness, a perceived inability to prevent the death. These two emotions in combination can create a very difficult and contradictory set of feelings. (Bartik, Maple, Edwards, & Keirnan, 2013; Chapple, Ziebland, & Hawton, 2012; Clark & Goldney, 2000; Ellenbogen & Gratton, 2001). Blame is also reported and may be attached to people considered ‘close’ to the bereaved who others perceive should have done something. These feelings of blame can be felt internally, within the family, or perceived as being directed from the wider community (Bailey, Kral, & Dunham, 1999; Bartik et al., 2013; Dunn & Morrish-Vidners, 1987/88; Jordan, 2001). Additionally, horror may be experienced by the bereaved as they realise the pain the person was experiencing before their death; pain of which others may not have been aware.

Connected to this, shame may also be experienced by someone who is suicide bereaved. However, while guilt and blame are feelings potentially experienced by people bereaved through other deaths, shame appears to be elevated among the suicide bereaved and these feelings can lead to social isolation (Clark & Goldney, 2000). One of the factors argued to also cause feelings of shame and acts of social isolation has been the stigma attached to suicide, and subsequently those bereaved by it, where there is arguably an extraordinary fear of suicide in Western culture (Minios, 1999). There has been ongoing debate about whether stigma is real or perceived, or indeed self-stigmatising by the bereaved person (for an example, see Kneiper, 1999). Self-induced or not, feelings of stigma tangibly impacts on help-seeking as ‘suicide survivors are less likely to seek or receive social support’ (de Groot, de Keijser, & Neeleman, 2006, p.419).

Access to effective social support has long been associated with better outcomes for people experiencing trauma, with the degree of stigma attached to the deceased impacting upon the degree of distress and complication in the grieving process for the bereaved by suicide (Feigelman, Jordan, McIntosh, & Feigelman, 2012). This may be a reason behind researchers’ paradoxical finding that members of social support networks of the suicide bereaved individual attest to offering support, while at the same time the bereaved report that social support is not available, or when available is not sustained over a long period of time (for example, Brabant, Forsyth, & McFarlain, 1995; Van Dongen, 1993). However, if appropriate social support networks are both sought and utilised, they have been found to facilitate the grieving process in bereaved people at the same time as lowering separation anxiety, feelings of rejection and depression (Reed, 1998).

Indeed, the grieving process of suicide bereavement can be different from other bereavement. Those bereaved by suicide are often left seeking answers as to why the person chose to end their life; given the stigma around suicide, this is a decision that can leave, and historically has left, dramatic imprints upon the next-of-kin. As a result, it has been suggested that most (although not all) suicide bereaved find the need to settle on an explanatory narrative of the death that helps to answer the why questions. This fits well within narrative approaches to understanding the bereavement process (Robert Neimeyer, Baldwin, & Gillies, 2006; R Neimeyer & Sands, 2011), and with research that demonstrates the crucial role of meaning-making after suicide and other types of traumatic loss (Currier, Holland, & Neimeyer, 2009). Research has so far, however, provided only partial information as to the need for people bereaved by suicide to be able explain the act or what purpose this serves internally. The functions of meaning making may be somewhat explained by Sands and Tennant’s (Sands & Tennant, 2010; Sands, Jordan, & Neimeyer, 2011) tripartite model of suicide bereavement – the bereaved person is said to ‘try on the persons shoes’, ‘walk in their shoes’ and then ‘take off their shoes’. In this way, the bereaved individual comes to understand how and why the person made their decision to end their life.

As researchers search for reasons behind suicide, the family has become the site for significant research focus, especially concerning histories of suicide deaths and attempts (Cerel et al., 2008; Jordan, 2001; Kaslow, Samples, Rhodes, & Gantt, 2011). Some factors that have been found to be over-represented in families where a person has died by suicide include: domestic violence; over- or under-

protective parenting, or a mixture of both; drug and alcohol problems; and/or, a predisposition to mental illness, especially depression (Qin, Agerbo, & Mortensen, 2002). Ratnarajah and colleagues (Ratnarajah, Maple, & Minichiello, in press) demonstrate that family fractions and dysfunction pre-dating the suicide were cause for considerable reflection following the suicide event. Where family fractions were evident, these split further after the death.

While emotions such as guilt, shame and blame have been constructed as a 'normal' suicide grief, not all people who are suicide bereaved feel these same emotions, or in the same way. While suicide is typified as unexpected, this is not always the case. Where suicide may be 'the epitaph to a visibly troubled life' (Ellenbogen & Gratton, 2001, p.86), some families may also feel relief over and above the grief and trauma connected to bereavement (Jordan, 2001). This is not to suggest that the person will not be greatly missed; rather, the family may experience reduced stress and be relieved that the individual is now free from distress. They also feel relief that they do not have to care for or worry about the safety of the deceased (Maple, Plummer, Edwards, & Minichiello, 2007).

These factors appear to cause an existential crisis in the person as they struggle to find meaning in a world that feels meaningless following on from the death. Further complicating this bereavement are the cultural and historical perceptions of suicide and the involvement of the legal authorities based on legislative requirements to determine the cause of death.

The limitations of the suicide bereavement knowledge base

In a comprehensive review of previously reported research, Jordan (2001) concluded that the thematic content of the grief, the social processes the survivors must face, and the impact the death has on the family system, are much more prominent after this form of death. While it has been previously argued that the bereavement following suicide is similar to that following other forms of sudden or traumatic death, Jordan and McIntosh have demonstrated that suicide bereavement is qualitatively different in some domains (Jordan & McIntosh, 2011a, 2011b).

While this difference is now well established in the literature, significant methodological problems exist in the research base that has created this knowledge. These limitations need to be explored, as well as the effect this has on the 'facts' of suicide bereavement. Rather than negatively-framing the research to date, identifying these methodological challenges allows for resolutions to be made so as to better identify

where gaps in our knowledge lie and whose voices are missing so they can be uncovered and heard.

Methodology

The methodological challenges examined in this paper were identified through a critical review of the literature specifically relating to suicide bereavement published in the previous 10 years (date range 2003 to early 2013). It must be noted that this was not a systematic review; rather it was one that sought to be representative of the samples used in different suicide bereavement studies across the world. The search terms used were 'bereave*' AND 'suicide' and 'sample'. Studies had to include a sample bereaved by suicide; reviews or theoretical papers, or papers in a language other than English, were not included.

From this review, six challenges have been identified in the current knowledge base regarding suicide bereavement. These challenges are explored below, and then provide the foundation for the recommendations for future research in this field.

Findings

Limitation #1: Who has contributed to the knowledge base?

A primary concern relates to the samples used in research to date. In suicide bereavement research, the obvious inclusion is people who can shed light on the experience of suicide bereavement, yet this also creates the first challenge. The knowledge base that currently exists is drawn almost exclusively from those with first-degree kinship to the deceased person. Most often participants are parents bereaved by their child's death (for example, Bolton et al., 2012; Feigelman, Jordan, & Gorman, 2008-2009; Lichtenthal, Neimeyer, Currier, Roberts, & Jordan, 2013; Lindqvist, Johansson, & Karlsson, 2008; Maple, Edwards, Minichiello, & Plummer, 2012; Miers, Abbott, & Springer, 2012; Murphy, 1997; Owens, Lambert, Lloyd, & Donovan, 2008; Rostila, Saarela, & Kawachi, 2012) with smaller bodies of literature reporting on the experiences of children bereaved through the death of a parent and siblings (for example, Brent, Melham, Donohoe, & Walker, 2009; Clarke, Tanskanen, Huttunen, & Cannon, 2013; Cohen-Mansfield, Shmotkin, Malkinson, Bartur, & Hazan, 2013; Dyregrov & Dyregrov, 2005; Melham, Porta, Shamsedden, Walker Payne, & Brent, 2011; Melham, Walker, Moritz, & Brent, 2008; Muniz-Cohen, Melham, & Brent, 2010; Ratnarajah et al., in press; Ratnarajah & Schofield, 2008; Schaewe, 2007; Segal, 2009), and through the death of a spouse (Ajdacic-Gross V et al., 2008; Barrett & Scott, 1990; Constantino & Bricker, 1996; Gallagher-Thompson et al., 1993).

The largest published study of suicide bereavement comes from the United States. Feigelman and colleagues (2012; 2008-9) implemented a large-scale survey of participants who attended support groups that were listed in either the American Association of Suicidology or the American Foundation of Suicide Prevention support group databases. Two online support groups were also included in the sample. From these sources, 540 bereaved parents participated; of these, 462 were suicide bereaved (86%), the remaining 78 were bereaved through sudden death or illness. This research aimed to explore the grief experiences of parents bereaved by suicide in comparison to parents bereaved through other sudden death or natural causes in terms of grief experience. These researchers found that traumatically bereaved parents (suicide and drug overdose) in general did more poorly on measures of grief, complicated grief, stigmatization, and trauma than parents of accidental or natural cause deaths.

In a prior publication of the same study, Feigelman and associates (2008-2009) used a scale based on findings previously reported in Australian research in terms of parent's expectation, or preparedness, for the suicide of their child to occur (Maple et al., 2007). They reported that parents were less surprised at their child's suicide death where there had been previous attempts. Indeed, those parents whose children had a history of attempt/s experienced greater grief differences. The authors surmised that when a child had made more previous attempts, the parent experienced more feelings of survivor guilt and blame following the suicide death.

Feigelman and colleagues sourced their sample primarily through support groups. Support groups play an important role in offering support to people bereaved by suicide. As such, they are a commonly used source of recruitment and have also been used by many researchers (see for example, Begley & Quayle, 2008; Farebrow, Gallagher-Thompson, Gilewski, & Thompson, 1992; Ann Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004; Reed, 1998; Wojtkowiak, Wild, & Egger, 2012). However, in so doing, the findings reported need to be understood from the point of view of those who are willing and able to attend this type of support following a loss to suicide.

Limitation # 2: Access to existing support

Current understanding of the grief process experienced by suicide-bereaved individuals has been predominantly gained through those who are already seeking support, and as seen above primarily through support groups. Yet, this is not the whole population of suicide bereaved, and probably not the majority. For example, Andreissen (2009) suggests that only

approximately one-quarter of those bereaved by suicide attend support groups following their loss. While many studies have recruited through support groups, this is not the only method of sampling in this field. Another common method of recruitment is through formal clinical or therapeutic supports (for example, Cerel & Campbell, 2008; de Groot, 2008; de Groot, ve der Meer, & Burger, 2009; Dyregrov et al., 2010-2011; Gaffney & Hannigan, 2010; Hawton, Houston, Malmbergand, & Simkin, 2003; Houck, 2007; Lindqvist et al., 2008; Wong, Chan, & Beh, 2007). Like those recruited through support group, those receiving therapeutic interventions in relation to their loss, may not be representative of the broader bereaved population, given that these individuals are those who are willing and able to access supports, or have developed help seeking skills. Further, they are either previously or currently supported by a service in relation to their loss.

To overcome the challenges in recruiting solely through those who are already accessing services, some researchers have recruited from the broader population through the use of media, utilising print, radio and television sources (for example, Maple et al., 2007; Melham et al., 2011; Muniz-Cohen et al., 2010; Ratnarajah et al., in press; Ratnarajah & Schofield, 2008). Not only does media recruitment attract significant interest from bereaved people, it also provides an opportunity to highlight some of the challenges of suicide bereavement to a broader population. However, it must be noted that a limitation of this form of recruitment is the high degree of literacy often required – the participant needs to be able to read about the study, or engage with the media genre where the study is publicised, to then decide on whether to make contact with the researcher. In addition, this method also relies on potential participants making the first contact with researchers. There may be costs (for example, long distance phone call) or equipment (for example, email) requirements to make contact that may prevent some from taking the step in contacting the researcher. For people who are grief-stricken, these types of proactive requirements may simply be too much to do and, as such, these people may be missed as participants.

Limitation #3: Gendered bias

The prior two limitations relate to the ways in which people enter studies of suicide bereavement. An unanticipated, and mostly undesired, outcome of these challenges with recruitment is the gender balance in the resultant samples. In all published suicide bereavement research, there remains a considerable gender imbalance, with between approximately 60% and 90% of participants being female. For example, 85%

of Feigelman and colleagues' (2012) large sample were female. Moreover, these women involved in this research are primarily reporting on male suicide. Therefore, the information that has been so far published in the suicide bereavement field is a heavily gendered perspective of women reporting on the bereavement experienced after the suicide of a man (mostly with whom they share a first degree kinship relationship). For example, in the study undertaken by Maple and colleagues (Maple et al., 2007) 73% of the participants were mothers. More recently, similar percentages were found in a study using a random digit dial recruitment method; 70% of the 302 participants were women (Cerel, Maple, Aldrich & van de Venne, 2013). Therefore, the male voice has been little heard in suicide bereavement research to date and the experiences of losing a female partner, relative or friend are rarely examined.

Limitation #4: Additional design issues

Three inter-related points need to be made that add further complexity to any research design of projects wanting to include a diverse set of voices of suicide bereaved individuals. The first relates to research ethics. All research is governed by ethical conduct of research, commonly referred to in Australia as Human Research Ethics Committees. In the United States, these are Institutional Review Boards, or IRBs. Other terminology is used elsewhere, however, all serve similar functions for overseeing the ethical conduct of research. The influence that these ethical reviews have on suicide bereavement research cannot be underestimated. Moore and colleagues (2013, p.5-6) note:

"While it is critical to maintain the highest standards in ethical review of proposed research involving human subjects, there is now documented concern within the small, international suicide bereavement research community that some ethical boards may be going beyond their intended mandate. Evidence from this pilot study suggests that, in some situations, suicide bereavement researchers are being subjected to scrutiny, and that, at some institutions, researchers are amending or even shaping their research to appease what may be unfounded and uninformed concerns by ethical board members in order to get their suicide bereavement studies approved."

While ethical review of research must protect those who will participate and ensure no harm, if this same process is inhibiting well designed research from being undertaken which will allow a fuller exploration of this experience, the knowledge base will continue to be flawed. In the authors'

experience, ethical review of research has been overshadowed by (mis)perceptions and stigmatised views from the committees in their responses to such submissions.

The second inter-related point regarding research design, and imperative in the conduct of ethical and sensitive research, is the need to understand what motivates people to participate. The research that has mentioned motivation has tended to identify the altruism demonstrated by participants (Dyregrov, 2004; Henry & Greenfield, 2009; Maple, Edwards, Plummer, & Minichiello, 2010). In Norway, Dyregrov and colleagues (2010-2011) have examined this more deeply reporting several motivations for participating in suicide bereavement research, being: (1) Altruism, as a means of helping the individual make meaning from the event; (2) The need for insight to assist in comprehending the incomprehensible; (3) The need to vent as a method of reducing internal pressure; and, (4) 'Just Because', which combined a group of other less obvious needs. Overall, the primary motivation was still the hope that the gain in knowledge made by research would help others who would later experience the same bereavement.

The third consideration for research design relates to those attracted to participating. In his extensive and comprehensive research looking at traumatic bereavement trajectories, Bonanno (2009) reported that around 20-30% of individuals bereaved by a trauma do not feel a great sense of grief either immediately following the death, or later. It can be reasonably argued that these people who are not affected by their grief are unlikely to seek out support services, such as clinical providers or support groups. Consequently, given that these support services provide a significant proportion of participants recruited into suicide bereavement studies, it is unlikely that these same people will be among the samples studied. In this way, people who demonstrate resilience in suicide bereavement – even after the death of someone with whom they feel connected – may be completely absent from the literature.

Limitation #5: Definitional problems

These gaps in the research have contributed to the next issue – that is, consistent definitions for suicide-bereaved or suicide survivors. While it can be presumed that the immediate family will be the most likely to experience intense reactions to a suicide death, this focus is extremely limiting. Focusing on family or kinship ties ignores the complexity of relationships that individuals engage in, and neglects those who may not immediately be recognised as connected to the deceased but are significantly affected by the loss. These people can include

counsellors and therapists, school communities, friends, and work associates for example. As a result, while kinship to the deceased has been used for inclusion in most studies in the suicide bereavement field, those people who feel close to, or identify with, the deceased, but were not related to them, are largely absent from the research.

Notwithstanding these challenges, the current research literature demonstrates compelling evidence that those exposed to suicide are a significant population at risk not only for adverse health, social and economic outcomes but, at the life-threatening end of the spectrum, suicidal ideation, behaviours and death following their loss (Jordan & McIntosh, 2011b). However, the definitions used must be broadened so as to understand the overarching impact of suicide on the community, beyond that of immediate family and kinship, allowing for the extent of these negative morbidity and mortality outcomes to be examined more deeply.

Several authors have recently offered definitions that aim to be inclusive:

Andriessen (2009, p.43) suggests: 'a survivor is usually regarded as a person who has lost a significant other (or loved one) by suicide, and whose life is changed because of this loss.' It can be argued that a broad definition of relationships remains excluded in this definition. Berman (2011, p.111) offers the following definition, which is perhaps more inclusive: 'survivors of suicide were defined as those believed to be intimately and directly affected by a suicide; that is, those who would self-define as survivors after the suicide of another person.' This definition is useful in that it relies on self-report for distress in the absence of knowing why some people are more distressed than others. It is broad enough to capture those who may not be intimately related to the deceased, but are negatively affected nonetheless. It does rely on the problematic terminology of 'survivor of suicide'. However, this could be used interchangeably with bereaved by suicide for those outside North America.

Jordan and McIntosh (2011b) provide a most useful definition, being: 'Someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person.' (p.7) This definition may be problematic in that it relies on symptomatology and lacks a way to operationalize 'a high level' of distress and 'considerable length of time.' Nevertheless, this definition is useful in that it provides the foundation for research to operationalize these concepts, and to view survivorship along a continuum, as is currently being suggested by Cerel, McIntosh, Neimeyer, Maple, and Marshall (2014). This continuum would range from suicide exposure to having a slight affect from suicide to short-term and long-term

bereavement. Agreeing on a single definition, or culturally appropriate variations of a single definition will result in consistency among the research being undertaken.

Limitation #6: Size of the population

Settling on a standard definition to identify those bereaved by suicide for research purposes will assist with the next challenge; that is, a way in which to determine the size of the population of those bereaved. In the first reference to the number of those bereaved by suicide, Shneidman (1969, p.22) originally stated that for each suicide death there 'are an estimated half-dozen survivor-victims whose lives are thereafter benighted by that event.' This 'guesstimate' has become ingrained in the postvention field where it is often used as fact, or merely presented as the best 'evidence' available (Andriessen & Kryszynska, 2012).

In the only nationally representative sample to date of individuals self identifying as having been exposed to suicide published, Crosby and Sacks (2002) found exposure to suicide (in the 12 months prior to the interview) among 7% of surveyed households in the United States. When this finding is extrapolated to the whole of population of the United States, 1 in 14 Americans were arguably exposed to suicide in the survey year. Of this 7% of households reporting exposure, 1.1% knew a family member who had died by suicide. Again drawing this conclusion to the whole of the United States population, 3.3 million Americans had arguably experienced the suicide death of a family member in that year. Another 5.4% reported exposure to the suicide of another associate. These authors further reported on suicide risk and concluded that exposed individuals were 1.6 times more likely to report suicidal ideation, 2.9 times more likely to have suicidal plans and 3.7 times more likely to have made an attempt than those not exposed to suicide. While the authors did not ask the sample about their experience of being affected following the suicide, it is clear that exposure to suicide is related to increases in suicidality among those exposed.

In an attempt to obtain more representative data pertaining not only to exposure, but also to effect of a suicide death on a self-identifying individual, Cerel and colleagues (2013) conducted a random-digit dial telephone survey in the state of Kentucky (USA). The findings of interviews conducted with a random sample of 302 people indicated that, across their lifetime, 64% of those surveyed knew at least one person who had attempted or died by suicide; almost 20% identified as a 'survivor'. Perceived psychological closeness to the individual was found to be significant in self-identification of survivor-hood, rather than solely the kinship

closeness of the relationship as previously reported. While this study is relatively small, it provides initial epidemiological data examining both exposure and effect of suicide bereavement.

In the Australian context, Botha and colleagues (2009) used a crude formula to determine the number of Australians affected by suicide loss between the years 2000 and 2005. Using the average Australian household size (3.7-3.8 people), the authors calculated the number of people affected by suicide; this number ranged between 7763 Australians in 2004 to 9080 Australians in 2001, depending upon the number of suicide deaths in that year.

Using these studies estimates of the total newly bereaved population can be calculated. For example, Botha et al (2009) estimated an average of ten people would be bereaved through each death, thus calculating that around 20 000 Australians are newly bereaved each year by the 2000 suicide deaths recorded. Crosby and Sacks (2002) suggest that approximately 13.2 million Americans may have been exposed to suicide death at some point in their lives.

While these few studies have attempted to provide a clearer picture of the suicide bereaved population, no agreement has been reached – no census of survivors has been conducted, nor clear socio-demographic information documented in the suicide bereavement literature (Berman, 2011). This gap in current knowledge means that people who are suicide bereaved continue to be poorly identified by, or even invisible to, the services that can provide support and help. Over four decades ago, Edwin Shneidman (1968) made the assertion: 'Postvention is prevention for the next generation.' If this is true, then greater efforts need to be made in these prevention efforts.

Indeed, throughout the world suicide bereavement has been identified as a risk factor for suicide - those bereaved by suicide are at greater risk of suicidal ideation, self-harm and suicide death as a result of their experience (Agerbo, 2005; Bartik et al., 2013; de Groot et al., 2006; Melham et al., 2008; Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2005; Mitchell, Sakraida, Kim, Bullian, & Chiapetta, 2009; Segal, 2009). Clinical experience, and an unfortunately small amount of empirical research suggests that when those bereaved by suicide are identified early, and provided with tailor-made services, they are less likely to go on and develop poor health outcomes. Thus, prevention is more cost effective than cure.

Suicide bereavement is therefore a significant public health issue that support and services can help to address, and can do so in a cost effective manner. Yet, the only published economic evaluation of a postvention service was examined by

the StandBy Response service (2011). Over 10 years, and in 10 Australian sites, the StandBy Response model has relied on local community services and supports, with overarching coordination. Bereaved individuals have been provided with the services they need at the time that they need them, whether it be immediately post-loss, or any time into the future. The economic evaluation reported that the provision of a postvention response service to one individual bereaved by suicide cost \$2334 Australian dollars. This was demonstrated to save the community \$800 Australian dollars per person who received the service.

While being in existence for almost 40 years, the field of suicide postvention remains relatively immature in the knowledge base so far generated. As examined throughout this paper, there are many limitations, restrictions and challenges highlighting the opportunities that exist in this field for new, innovative research to be undertaken. Well-designed research, both qualitative and quantitative in nature, is required to be able to better transform our knowledge into practice, into better supporting people when and if they need it.

Future Directions in Suicide Bereavement

We add to previous commentaries calling for both research and clinical agendas going forward (Cerel, Padgett, Conwell, & Reed, 2009; McIntosh & Jordan, 2011). In our opinion, there are four key concepts that need now to be addressed in the suicide postvention field within different cultures, nations and internationally:

- 1) Definition of survivorhood – there needs to be agreement on one definition or continuum of 'suicide bereaved' that is useful across countries and cultures and adaptable to many environments and sub-groups.
- 2) Size of population – with a clear definition, epidemiological studies are needed to determine the size and breadth of the population exposed to, affected by and bereaved by suicide and where within this population the impact of exposure results in adverse outcomes.
- 3) Resilience within the population also needs to be explored to better understand why some who are both exposed to and affected by a suicide death are able to demonstrate resilience where others are not.
- 4) Better understanding is required of the best kinds of support (depending on exposure and effect), at what times these supports are best implemented, and how these can be used in varying populations and regions.

Given the infancy of this field it is not surprising that these challenges exist and it is now necessary to

embrace the needs of those bereaved by suicide in what is termed the third pillar of suicide – postvention. As the field matures, targeted support services will be able to be provided to those who need them at times when they are required, and more broadly assist in building a more resilient community. In this way, postvention is prevention for the next generation.

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Original Research

Suicide risk, reasons, attitudes and cultural meanings among young German students: An exploratory study

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Abstract: In Germany, suicide is the second cause of death among 15-24 years olds. Several studies have focused on risk factors and rates, but only a few have analyzed the impact of cultural aspects on youth suicide. This study aimed at exploring the cultural meaning, beliefs, attitudes and opinions among young German people in relation to suicide. Two-hundred and ten German students aged 18-24 years olds participated in the study by filling in a semi-structured questionnaire. The main results showed that gender, suicidal risk, and ethnic identity have a strong influence on students' opinions regarding reasons and attitudes associated with youth suicide.

Keywords: Youth Suicide, Culture, Ethnicity, Germany, Attitudes, Meanings

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The increase of suicide in young people is a matter of concern in many countries. According to the World Health Organization (WHO, 2006), in the last 45 years suicide rates have increased by 60% worldwide. Suicide represents the second leading cause of death in the 10-24 age group. These statistics do not include attempted suicides,

which are estimated to be 20 times more frequent than suicide deaths.

The main literature about suicide in Germany

In 2011, 1,924 people between 20-25 years of aged died in Germany; from this, 409 (330 males and 79 females) died by suicide and self-inflicted injury (Bundesministerium fuer Gesundheit, 2013). Studying youth suicide is particularly relevant as generally this is one of the first two or three leading causes of death among young people (Tarchi & Colucci, 2013). This is true also for Germany (Lester, 2003; Weinacker, Schmidtke & Lohr, 2003), where

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suicide attempts were prevalent in the younger age groups and among females (Schmidtke, Weinacker & Löhr, 2003), and young people score the highest rates of suicidal thoughts (Bernal, Haro, Bernert, Brugha, de Graaf, Bruffaerts et al., 2007).

Few scholars tried to identify psychological and social predictors of suicidal ideation among adolescents. In a study, a quarter of the boys reported having wished they were dead, in contrast to more than half of the girls (Kirkcaldy, Eysenck & Siefen, 2004). Although these data might look alarming, the authors associated them with “fantasies about death”, rather than suicidal ideation. German girls also scored high rates in suicidal ideation (twice as common among female as male adolescents), and in suicide attempts (three to four times as many girls).

Youth suicide and culture

Although it is possible to find multiple studies on the topic of suicide and youth suicide in Germany, the literature exploring this phenomenon from a cultural perspective is surprisingly scarce. This is a problem characterizing the scientific literature of youth suicide in general. Even those studies that looked at suicide cross-culturally focused on differences in suicidal rates and methods (Colucci & Martin, 2007a), and on psychiatric risk factors, such as depression and substance abuse (Domino, 2005), rather than on the cultural meanings and understanding of this phenomenon. Even more lacking is research specifically addressing youth suicide (Watt & Sharp, 2002). Only few studies have analyzed in-depth the impact of culture or ethnicity on youth suicide (Barrett, 2001; Borowsky, Ireland & Resnick, 2001; Bracken, 2002; De Leo, 2002; Eckersley & Dear, 2002; Eshun, 2003; Eskin, 1999; Everall, 2000; Leenaars, Haines, Wenckstern, Williams & Lester, 2003; Tortolero & Roberts, 2001; Tseng, 2001). In particular, very few have researched an essential aspect of culture: meanings (Colucci, 2009; Colucci, 2012a; Colucci & Lester, 2012; Eckersley & Dear, 2002; Leenaars, Maris & Takahashi, 1997). Domino (2005) reported that Germany is a very interesting focus for suicide research, as a few cultural characteristics that could possibly lead to an explanation of youth suicide can be found in this country's insecurity and tendency for order and certainty. Furthermore, individuals are highly concerned with spirituality, and often feel threatened by conflicts, due to their central geographical location (Domino, 2005).

A few scholars (Phinney, 1992; Roberts, 2000; Yamada, Marsella & Atuel, 2002) have underlined the centrality of ethnic identity. Indeed, relying only on the ethnical status is limiting, as ethnicity is a very complex biopsychosocial construct

that is only partially expressed by demographic categories of race or ethnic status (Roberts, 2000). For this reason, scholars interested in the cultural components of youth suicide could focus on the subjective component of ethnicity: the ethnic identity (Roberts, 2000). Some scholars (Yamada et al., 2002) proposed to dimensionalize the construct of ethnic identity into two components: ethnic affiliation, the degree of attachment one feels towards one's cultural background, and impact of ethnicity, the influence and the role of one's ethnocultural identity in one's life.

Two reviews on cross-cultural studies on youth suicide have been recently published, one focused on rates and methods of youth suicide (Colucci & Martin, 2007a) and another one on risk factors, precipitating agents, and attitudes toward suicide (Colucci & Martin, 2007b). They reported only 82 worldwide cross-cultural studies on youth suicide, most of which (30) were on US only (mainly comparing Blacks, Whites, and Hispanics) or on US in comparison to other countries (Colucci & Martin, 2007a). Only a few of these studies had a clear focus on culture, whereas most of them inserted culture as just one among many other variables. The two authors (Colucci & Martin, 2007b) identified eight main themes in which cross-cultural variation is strong: previous suicidal behavior and exposure, interpersonal factors (e.g. “family and friends support” and “closeness”), personal and psychological factors (e.g. coping style, anxiety, hopelessness and religion), psychiatric diagnoses and care, alcohol and substance abuse, immigration issues, precipitating factors, impact of risk factors. One of the main conclusions was that although some risk factors might seem generalizable to almost all groups, they might have a greater or lesser impact on suicide, depending on the culture. Some risk factors, instead, appear to be culture-bound.

One of the most studied aspects of culture is people's attitude towards suicide. The main group of work in this regard is Domino's research based on the Suicide Opinion Questionnaire, which has been administered in several countries, usually comparing them to US (Colucci & Martin, 2007b). Attitudes about youth suicide change cross-culturally, and increasing our knowledge on them would have an impact on the design of suicide prevention strategies (Dervic, Gould, Lenz, Kleinman, Akkaya-Kalayci, Velting et al., 2006). For instance, the degree to which individuals perceive suicide as acceptable might determine an increase in the risk of suicide, in their life or in their social network (Stack & Kposowa, 2008). Indeed, there is agreement among scholars that suicide is “contagious” (Gould, Wallenstein, Kleinman, O'Carroll & Mercy, 1990). This is particularly true among young people. Generally,

when individuals are exposed to someone else's suicide, the probability that they are going to take their own life increases, but such increase in suicidal risk is 2 to 4 four times higher in 15-to-19-years-olds than any other age-group (Gould et al., 1990).

Besides emphasizing the importance of studying cultural aspects of suicidal behaviour, scholars have also recommended to develop suicide prevention and intervention strategies more culturally insightful and differentiated (Colucci, 2006).

Research aims and questions

Previous research has demonstrated that cultures differ in terms of several aspects related to the concept of suicide: the meanings of suicide, the reasons why young people might choose to live or to die, and the opinions and attitudes towards youth suicide (Colucci & Lester, 2012). However, the concept of culture is probably one of the most debated in any discipline and there is very little agreement on its definition (Colucci, 2012b; Lenzi, Colucci & Minas, 2012). In this study, culture will be defined as:

shared acquired patterns of behavior and meanings that are constructed and transmitted within social-life context for the purposes of promoting individual and group survival, adaptation, and adjustment. These shared patterns are dynamic in nature (i.e., continuously subject to change and revision) and can become dysfunctional (Yamada et al., 2002, p. 50).

Symbolic interactionism (Mead, 1934) is based on three main premises: people act toward things and people on the basis of the meanings they have for them; meanings are social products arising during interaction; people individually, basing on the situation and their experience, select, interpret, reconstruct and transform meanings.

Both the definition of culture provided and the discussion in symbolic interactionsims suggest a relation between social life and human behavior. Phenomena such as suicide are particularly influenced by the social context, thus it becomes crucial to explore the meaning people of a specific culture attribute to it. For this reason, in this study we explored the opinions and attitudes young German student have on youth suicide.

Method

Instrument

In order to explore the cultural meaning of

youth suicide in Germany, the questionnaire "Exploring the meaning of youth suicide" was used (Colucci, 2009; Colucci, 2012b). First, the Italian version of the questionnaire was translated into German by the first author. This first German version was back-translated in Italian by two bilinguals. Their versions were compared with the original questionnaire and, when agreement was reached, a second version was created. This translated questionnaire was then piloted with six German students (between 22 and 24 years old) from the University of Ulm (Germany) with the aim to check ambiguity of any item. Participants in this pilot study were asked to fill in the questionnaire and to underline ambiguous or unclear items; every item was then discussed in group and, after a final review by a scholar in Psychology at the same university, the final German version of the questionnaire was produced.

The questionnaire investigated social representations, attitudes, values, views and meanings of youth suicide both through structured (i.e. attitude scale, ranking order task, multiple-answer questions) and semi-structured (i.e. case scenarios, open-ended questions, word association) sections. This paper focuses on the quantitative data on attitudes, opinions and beliefs towards suicide in young people, as well as presence of suicide thoughts, plans, and attempts, and exposure to suicide. Also, a section on ethnic identity was included. A manuscript reporting the remaining findings is currently under preparation.

Participants

Participants involved in the study were young people between 18-24 years old, studying at University of Ulm. The faculties where the data were collected were: Human Medicine, Chemistry, Informatics, Biology, Economics and Math. The selection criteria for the sample were: age range between 18 and 24 years, student, born in Germany with both parents born in Germany (i.e. at-least second generations). Two-hundred and ten students matching these criteria filled in the questionnaire (91 males and 119 females), with an average age of 21.0 (± 1.3).

Nearly 90% of the subjects were at least third-generation (i.e. all the grandparents were born in Germany).

Table 1. Relationship between suicidal behaviour and age.

	Age					
	19	20	21	22	23	24
Never attempted suicide	11	77	63	20	14	15
Attempted suicide	0	1	0	0	3	0

When students were asked to identify the ethnic group(s) to which they felt they belong, 92% of them referred to a region or a city of Germany. The students were divided into three socio-economic bands, based on parents' occupation: 65.4% of the students were in the highest socio-economic band, 30.8% in the middle one and 3.8% in the low one. The only statistically significant difference between males and females, in the socio-demographic question, was the course of study: 40% of males were enrolled in an economics and mathematics course, whereas 46% of the females were enrolled in medicine ($F_5 = 22.6$, $p < .01$).

When asked about religion, 52.9% of the students stated not to be religious/spiritual. Among the students who stated to be religious/spiritual, 29.9% were Anglican, 61.3% Catholic, 2% Islamic, 2% Buddhist, and 5.9% were following other religions and/or spiritual principles.

Data analysis

Each variable's extreme outliers were individuated and eliminated by observing the relative box-plots. The normality of each dependent variable's probability distribution was explored; in those cases in which a variable distribution was not similar to a Gauss curve, the appropriate monotone increasing transformations were applied before carrying out the statistical inferential analysis (Fox, 2008).

Results

Previous suicidal behavior and exposure to suicide

Almost half of the sample (45.6%, $n=93$) reported having thought about killing themselves at least once in their lives, 9% ($n=19$) of the students reported having made plans to kill themselves, and 2.4% ($n=5$) of students reported to have tried to kill themselves. When asked about previous exposure to suicide attempt, 11% ($n=23$) of the students stated that they had experienced a suicidal attempt in their family and 29.2% ($n=61$) among their friends. As for death by suicide, 6.7% ($n=14$) of students experienced a suicide in their family and 18.2% ($n=38$) among their friends.

From the answers to the questions about previous suicide ideation, plan, and attempt, a score on a suicide risk scale was derived, where a value of 1 means the presence of suicide ideation and a value of

8 represents presence of suicide ideation, plan, and repeated and recent (less than one month) suicide attempts.¹ According to this measure, suicidal risk among participants was low ($.70 \pm 1.16$); there were no statistically significant differences between males and females, although females showed a slightly higher suicide risk (.74 in F vs. .65 in M).

Table 2. Religion Preference and Suicide Ideation. Plans and Attempts.

	Religion Preference	
	Yes	No
Never thought of suicide	35	56
Thought of suicide	57	52
Never planned to suicide	12	7
Planned to suicide	82	102
Never tried to suicide	5	0
Tried to suicide	89	109

Age had a significant effect only on the previous suicidal behavior ($\chi^2 = 24.13$; $p < .01$): 25% of the individuals who had tried to kill themselves were 20 years old, 75% were 23 years old (see table 1). This data is particularly interesting considering that not only 23-year-old students attempted suicide more often than other ages, but also that within this age the ratio is 3 out of 17 students.

The variable Religiousness/Spirituality had an effect on the variable "Suicidal thought" ($\chi^2 = 3.82$; $p < .05$): 61.5% of the participants who had thought of killing themselves were not religious/spiritual (see table 2).

Reasons for youth suicide and suicide attempt

To investigate students beliefs about the reasons for youth suicide attempts, participants were asked "In your opinion, when a young person makes a suicide attempt, what are the reasons?" and were offered seven possible reasons (and blank spaces where participants could add other reasons) to be scored on a 5 points-Likert scale where the highest disagreement (i.e. "no") was coded as 0 and the highest agreement ("yes") as 4.

¹ This score was obtained assigning 1 point if the subject had reported having thought about killing him/herself, 2 points if he/she had planned to suicide, 3 points if the subject reported having tried killing him/herself. Another additional point was added if the subject had made a suicide attempt more than once and another one if he/she had attempted suicide in the last month.

When inquired about what they believed were the reasons for some youth to make a suicide attempt, German students showed greatest agreement with the following items: escaping from problems (mean= 3.3 ± .8), illness (3.0 ± 1.0), call for help (2.8 ± 1.1); on the other side, they disagreed most with the following reason: "to force others to do what he/she wants" (1.6 ± 1.2). Females agreed more than males on the reasons: call for help (2.6 in M vs. 3.0 in F, $F_{1,207} = 8.83$, $p < .01$, $\eta^2 = .04$) and emotional support (2.2 in M vs. 2.6 in F, $F_{1,208} = 7.36$, $p < .01$, $\eta^2 = .03$).

The question about reasons for youth suicide was a ranking order task; students were provided with 14 categories of possible reasons for young people to kill themselves and they were asked to rank them from the most important (rank 1) to the least important (rank 14). Students could use the same number more than once if they thought more reasons had the same importance. For each item two variables were created: one was the mean score for that item (i.e. the exact number the participant wrote) and the second considered the items that scored the first three highest positions (ranking 1, 2 or 3) and the lowest one. This variable was created because at times participants did not start with number 1 or did not finish with number 14. Reasons written in the blank spaces were also included in the rank scores. Participants indicated mental health problems, loneliness, and abuse as the three main reasons for suicide number more than once if they thought more reasons had the same importance.

Males considered a severe disability or illness as a more important reason for suicide than girls did (2.00 in M vs. 3.37 in F; $F_{1,110} = 4.72$, $p < .05$, $\eta^2 = .04$), whereas females considered a mental problem a more important reason compared to males (2.50 in M vs. 1.71 in F; $F_{1,110} = 4.35$, $p < .05$, $\eta^2 = .03$).

To explore the association between attitudes and previous suicidal behavior, an analysis of variance was conducted using suicide risk as a factor. According to the analysis and the post-doc test, students who had previously thought of suicide rated infertility, illegitimate pregnancy, or exam failure higher than students who had never thought of suicide.

Attitudes towards youth suicide

Attitudes towards suicide were investigated through a 21-items scale (with a 5-points Likert scale from "Strongly agree" to "Strongly disagree"). All questions referred to youth suicide and one question was repeated referring to the general population ("People do have the right to suicide") or young people ("Youth do have the right to suicide").

The items that received the highest agreement were that suicide occurs without warning

signs; suicide is among the worst things to do to one's family; and most people avoid talking about suicide. The items with the lowest agreement were that suicide is a subject that one should not talk about; if someone wants to suicide, it is their business and we should not interfere; and there may be situations where the only reasonable thing to do is suicide.

There were some differences by gender. Males agreed more than females that it is always possible to help a young person with suicidal thoughts; people avoid this topic; a severe illness can justify a suicide; and heroic suicides are different from the other suicides. Males disagreed more than females that suicidal people cannot be stopped. Females disagreed more than males that we should not talk about suicide; suicide cannot be forgiven; some situations justify suicide; and we should not interfere in this act. Also they disagreed on the fact that those who talk about suicide do not suicide, and they would feel ashamed if a member of their family took his/her own life.

Participants differed in their attitudes towards suicide depending on whether they were religious/spiritual or not. Religious/spiritual persons (R/S) agreed more that suicide can never be justified. (2.24 in R/S vs. 1.79 in notR/S, $F_{1,202} = 8.64$, $p < .01$, $\eta^2 = .04$). In contrast, non-religious/spiritual persons agreed more that people do have the right to suicide (1.78 in R/S vs. 2.40 in notR/S, $F_{1,202} = 12.84$, $p < .01$, $\eta^2 = .06$), and that almost everyone has thought about killing him/herself (1.79 in R/S vs. 2.28 in notR/S, $F_{1,203} = 9.15$, $p < .01$, $\eta^2 = .04$).

When looking at student scores on the suicide risk scale, only two statistically significant results were obtained: it is always possible to help a young person with suicidal thought ($F_{4,198} = 2.55$, $p < .05$, $\eta^2 = .04$), and suicide is among the worst things to do to one's family ($F_{4,198} = 2.70$, $p < .05$, $\eta^2 = .03$), which were disagreed more by students with the highest score on the suicidal risk scale.

Cultural Identification Battery-Rev and suicidal behavior

Students were asked to write the ethnic group(s) to which they felt they most belonged. On the basis of the answer they gave to this question, they were then asked to fill in the Attitudinal Index of a reduced version of the Cultural Identification Battery (Yamada et al., 2002), which is divided into two subscales: Ethnic Affiliation, which assesses the degree of attachment one feels towards his/her cultural background, and the Impact of Ethnic Identity, assessing the influence and role of ethnocultural identity in one's life. Students were asked to express their answers (depending upon the question) on a 5-points or 7-points Likert scale, where

0 or 1 was the lowest score and 4 or 7 the highest, for a maximum possible score on the index of 50.

Germans students identified themselves with their ethnical background quite strongly, were quite proud of it, and were comfortable with it. However, they also reported not being active in learning more about and becoming more attached to their ethnocultural roots and traditions, did not feel very much the influence of their ethnicity on their life, nor that it is very important, and they were not very keen on teaching their children about their cultural heritage. Overall, German students reported a medium level of cultural identification.

When students with different suicidal risk were compared in terms of cultural identification, only one item resulted to be statistically significant: students with a higher suicidal risk score felt more proud of their ethnic group ($F_{4,191}=2.99$, $p<.05$, $\eta^2=.06$).

Discussion

Youth suicide still represents one of the leading causes of death among young people in Germany. Scientific literature has mainly focused on the epidemiological or demographic aspects of suicide, often restricted to clinical samples. Studies providing a deeper insight into the cultural meanings of this behavior, including the meaning that suicide has in a specific culture, are lacking. This study aimed to address this gap by exploring the cultural meanings, social representations, beliefs, attitudes and opinions towards youth suicide among young Germans. Meanings and beliefs are further explored in an article analyzing qualitative data in the questionnaire (currently under submission).

According to the research data presented in this paper, nearly half of the sample had thought about suicide, one every ten had planned a suicide and only a minority had tried to kill themselves at least once in their life. These data are very similar with those reported in previous literature (Bernal et al., 2007). Though half of the young population in the sample reported suicidal thoughts, suicidal behaviours are much lower, therefore it could be concluded that there is no strong or direct relationship between suicidal ideation and suicidal act. It is nevertheless important to note that suicide ideation and behavior are meaningful phenomena in themselves and not just potential risk factors for suicide deaths; as such, they need attention on their own. Students involved in this project showed differences based on gender on some dimensions. Males reported having thought about suicide more than girls did, but females reported more suicidal plans and attempts, partially confirming previous studies, which generally reports more suicidal ideation among females (e.g., Bernal et al., 2007;

Colucci, 2012b). This difference can partially be due to the fact that what in literature is generally considered "suicidal ideation", in our questionnaire has been divided in two different items: suicidal thoughts and suicidal plans. It is worth to note that although the number of participants who reported having made a suicide attempt was limited, three quarters of them were 23-year-olds. In Germany 23 years old people are supposed to have finished their formation and to begin working; this period is characterized with pressures and expectations that could possibly lead to seeing no other way out but suicide. Beside age and gender distribution, another issue considered in this study was the influence of religion/spirituality on participants' suicidal ideation and behavior. Interestingly, the percentage of Catholics was the same as previous studies (Schmidtke et al., 2004). Previous exposure to suicide is a factor generally associated to suicidal risk (Colucci & Martin, 2007b). In our study, a relevant number of participants had experienced a suicidal attempt and/or a suicide.

Two questions explored students' explanatory thinking about youth suicide. Suicide attempts were seen not only as a way to escape from problems or from an illness, but also as a "cry for help", a way to make the others notice how big the problems of the suicidal person are, but not to force others to do what he/she wants. Females gave more importance to the communicative role of suicide: they thought that people attempt suicide to make others more aware of their problems and to get emotional support. This suggests that, from an intervention point of view, we can expect a more explicit communication from girls, whereas with boys we have to find alternative ways to discuss the topic of suicide. According to our data there was no difference in terms of opinions on why young people suicide among German students in relation to scores on the suicide risk scale. It can be hypothesized that there is a general agreement on the reasons that could lead to youth suicide, so the preferences outlined in the previous section can be considered as realistic indicators and be included in a culturally-relevant assessment tool (structured interview, questionnaire, and the like). When asked about main reasons for youth suicide, German students indicated, in order of importance, mental health problems, interpersonal problems, physical/sexual abuses. The first and the second are confirmed by other research in the Country (Kirkcaldy et al., 2004; Leenars et al., 1997), whereas physical/sexual abuses had not been taken in consideration by other scholars; Kolves and collaborators (2006) stated that unfavorable life events are normally associated with increased risk of suicide, but these experiences mainly concern interpersonal losses, conflicts or financial troubles.

Therefore, there is a need to explore the association between physical/sexual abuse and suicide as this has not previously been done in Germany (Colucci & Pryor, 2014; Colucci & Heredia Montesinos, 2013). When different sub-samples regarding the suicide risk scale were compared, interesting results emerged: students with a previous experience or exposure to youth suicide considered infertility, illegitimate pregnancies, and failure at school as stronger reasons for attempted suicide than their peers with a lower score on the suicide risk scale. Firstly, this results shows that there is a difference in how attempted suicide is perceived as opposed to suicide deaths. Secondly, it can be hypothesized that it is very difficult to predict the impact that such experiences have on one's personal life until they actually happen.

This study contributed to the understanding of young Germans' attitudes toward youth suicide. Participants thought that people usually suicide without giving any advice or sign. They generally also agreed that suicide is a topic that most people avoid talking about. These two aspects underline the primary source of difficulties in predicting who is going to take his/her own life. Importantly, German males were more aware than females that most people avoid talking about suicide. This is probably not because males are more sensitive to the topic, but because males experience more difficulties in talking about suicide than females do (Colucci, 2009; 2012b). A similar finding was also found in the previous study on Italian, Indian and Australian youth (Colucci & Lester, 2012).

German students considered suicide a bad thing to do to one's family, that there are no situations in which suicide is a reasonable thing to do and agreed that if someone wants to suicide one should not interfere with his/her intentions. One strong difference between German males and females was that the former considered heroic suicide a specific type of suicide, whereas females did not, probably because males are more attracted by a character who would give his/her life for heroic purposes, an image frequently set in a war situation and confirmed by media. German males agreed more than females on the feeling of shame associated to a suicide in family: this data suggests again the possible barriers males might have in communication. It is crucial for future research to explore how we can empower males' communication skills about suicide.

There were a few differences on participants' attitudes towards youth suicide based on religious/spiritual factors. Religious/spiritual students thought that suicide can never be justified, whereas students who were not religious/spiritual thought that everyone has the right to suicide and that everyone has thought about it at least once. Religion can play an important role in the prevention

of suicide, both primary and secondary (Siegrist, 1996), and our data showed how religion can affect people's attitudes: thinking that suicide is a sin could block the empathy towards suicidal attempters. On the other hand, not religious/spiritual people thought that everyone has the right to suicide: thinking that way could refrain our involvement in the suicidal person's decision to end their life (see also Colucci, 2012a). These two different perspectives, considering suicide or as a sin or as a right, are probably associated with a will not to get involved and feel responsible for this act.

According to students with a higher score on the suicide risk scale, it is not always possible to help a young person with suicidal thought. These two results add a lot of complexity to the design of effective interventions. In fact, students with previous experience with suicide might consider it as something that cannot be helped, supported, or changed. Those are two important predictors of efficacy of psychotherapy, and need to be primarily addressed in relation to youth suicide to enhance our success to prevent it.

Evidence supporting the hypothesis of a connection between culture and suicide comes from the analysis of answers given to the cultural identification battery by students with a different score on the suicidal risk scale. Students with previous experience with suicide felt more pride when identifying with their ethnic group. This is an extremely interesting result, as it could represent one potential therapeutic source.

In conclusion, according to our data, an age particularly affected by suicide is 23 years, probably because it is a key-age for German students, an age in which they are asked to take decisions about their future. This is a stage of life that requires particular preventive efforts. Furthermore, many German students considered suicide as a solution or as a mean of communication, with girls more in agreement with the latter. When asked about reasons for suicide, they indicated mental health problems, interpersonal problems and sexual abuse. Similar results points out the necessity to further study the explanatory models of suicide and the cultural understandings of what leads to suicide because these are likely influences on a person's own consideration of suicide in similar circumstances (Colucci, 2012b). German students showed two main beliefs that might constitute challenges for the prevention of youth suicide. Prevention program should tackle these issues, and they should also be gender-focused: girls attempt suicide more often than boys do; boys have more problems in discussing the topic than girls do, and they associate feelings of guilt and shame with suicide. In regard to the ethnic affiliation and pride, future researches should explore

possible negative effects of the reject of one's own culture, which could also lead people to feeling alone and isolated.

This study had a few limitations. In particular, the sample of this study was formed by students of a university placed in a small city in Germany, so they do not represent the German population of young university students. Furthermore, in order to control potential confounding variables, only at-least-two-generation German participated. However, Germany is becoming a progressively multicultural country and further studies should also focus on people from migrant and refugee backgrounds. Finally, this study relied on a theoretical definition of culture, without verifying the ecological impact of such definition that is whether participants define culture (and ethnic identity) in the same way as authors intended it.

In conclusion, the aspects of suicidal behavior in Germany discussed in this paper are important to develop culturally-sensitive suicide prevention strategies and more studies are needed to further explore the influence of culture and suicide and, therefore, prevention. It is important, for instance, to determine whether it is possible to implement the same prevention strategy with both genders or if, according to what this study suggests, we should differentiate strategies, given the strong differences in prevalence and opinions between boys and girls. Furthermore, it would be important to explore the role that subcultures have in prevalence, attitudes, and meanings towards suicide.

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Appendix

Descriptive statistics

Questionnaire section	Items	Mean	Standard deviation
Reasons for youth attempted suicide	To force others to do what he/she wants	1.57	1.15
	To make others notice how big his/her problems are	2.84	1.06
	Because he/she wants to die	2.71	1.25
	Because he/she is mentally ill	2.98	.93
	To get attention	2.55	1.04
	To get emotional support from others	2.45	1.08
	To escape from problems	3.34	.83
Reasons for youth suicide	Financial problems	5.02	5.06
	Incurable illness/ sever chronic pain/ becoming severely disabled	2.72	3.42
	Revenge/punish someone	11.61	4.74
	Mental Disease/ Depression/ Anxiety	2.03	2.19
	Infertility or illegitimate pregnancy	6.98	5.84
	Loneliness/ interpersonal problems	2.20	2.05
	Rational decision to an unsolvable problem	3.16	3.49
	Cowardice/weak personality	9.07	5.85
	Family difficulties (e.g., separated parents, lack of family ties)	2.72	2.56
	To protect self/family honour	12.44	4.00
	Physical or sexual abuse	2.46	2.51
	Failure in love/refused love/ end of a love relationship	2.50	2.46
	Exam failure/ lack of success at school	6.48	5.78
Death of a loved one	4.35	4.70	
Attitudes towards youth suicide	It is always possible to help a young person with suicidal thought	2.54	1.10
	Suicide can never be justified	1.99	1.10
	Suicide is among the worst thing to do to one's family	3.03	1.06
	Once a young person has decided to suicide, no one can stop him/her	1.49	1.12
	People do have the right to commit suicide	2.11	1.27
	Youth who make suicidal threats seldom kill themselves	2.23	.92
	Suicide is a subject that one should not talk about	.36	.66
	Almost everyone has at one time or another thought about killing him/herself	2.04	1.17
	There may be situations where the only reasonable thing to do is suicide	.85	1.02
	Suicide occurs without warning signs	3.06	.96
	Most people avoid talking about suicide	2.86	.76

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	If someone wants to suicide, it is their business and we should not interfere	.62	.78
	A youth suffering from a severe, incurable disease expressing wish to die should be helped to do it	1.90	1.06
	Youth who talk about suicide do not suicide	1.62	.82
	When a young person suicides it is something he/she has considered for a long time	1.52	.87
	Youth suicide can be prevented	2.71	.86
	I would feel ashamed if a member of my family suicided	1.07	1.03
Cultural Identification Battery-Rev.	To what extent do you identify with your ethnic background	4.39	1.87
	How much pride do you feel when you identify yourself with your ethnic group	4.11	1.85
	To what extent are you comfortable with your ethnic background	5.30	1.56
	How currently active are you in learning more about and becoming more attached to your ethnocultural roots and traditions	1.27	.84
	Do you think your ethnicity has a strong influence in your life	3.75	1.85
	When you think about yourself, do you think your ethnicity is important	3.38	1.85
	Have you taught or would you (if you were to have children) teach your children about their ethnic group(s) and cultural heritage	2.43	1.53
	Ethnic Affiliation	13.79	4.59
	Impact of Ethnic Identity	16.23	5.37
	Ethnicity Total	30.18	9.04

Original Research

Health Care Professional Attitudes Toward Interventions to Prevent Suicide

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Abstract: Health care professional (HCP) attitudes towards suicide prevention vary with their training and could influence assessment and management of suicidal patients. We aimed to examine attitudes towards suicide and health care interventions to prevent suicide in mental health and other health care professionals. The sample was obtained from two separate study cohorts: 1) a controlled psychological autopsy study of suicide (n = 301), with HCP interviewed by telephone or face-to-face in Queensland and New South Wales, Australia, and 2) an anonymous online survey (n = 61) by email invitation to mental health service clinicians and general practitioners (GP) in eastern Sydney. Attitudes towards suicide and suicide prevention were measured by a 14-item survey. The sample of HCP included GPs (n = 172), psychiatrists and trainee psychiatrists (n = 67), mental health nurses (n = 36), psychologists (n = 28), medical specialists (n = 26), and other health professionals, including counsellors, social workers, allied health professionals, general nurses and dentists (n = 33). The majority were male (66.3%), were in private practice (62.2%) and had experienced a suicide in their practice (84.0%). Medical specialists had significantly more negative attitudes towards suicide prevention than the other HCP groups. Mental health professionals had more positive attitudes towards suicide prevention and felt more competent about identifying and managing suicidal patients than other HCPs. Psychiatrists had more positive attitudes than mental health nurses. Attitudes towards suicide prevention interventions vary significantly between HCP occupational groups, and this has the potential to affect the assessment and management of suicidal individuals.

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Health care professional (HCP) attitudes towards interventions to prevent suicide may influence their assessment and management of potentially suicidal patients. Negative attitudes can be a barrier to effective clinical care including a willingness to implement suicide prevention strategies (Morgan & Evans, 1994).

Previous investigations of HCP attitudes have mainly been undertaken on frontline staff in general hospital and mental health settings and have found that more positive attitudes towards suicidal patients and suicide prevention tend to occur in older, more experienced HCPs and in those HCPs that have received more education and training in mental health and suicide prevention (Anderson, 1997; Herron et al., 2001; McCann et al., 2006; Samuelsson et al., 1997; Saunders et al., 2012). There are also differences between HCP groups, with mental health professionals having more positive attitudes than non-mental health professionals in some (Herron et al., 2001; Samuelsson et al., 1997) but not all studies (Anderson, 1997) and between doctors, who were more able to identify suicide motives, and nurses who were more sympathetic and accepting (Ramon et al., 1975). For emergency ward staff, greater contact with psychiatrists is associated with more positive attitudes (Suominen et al., 2007).

General practitioner (GP) or primary care provider (PCP) attitudes towards suicide prevention are influenced by multiple factors but most consistently knowledge about depression and suicide (Duberstein et al., 1995; Fanello et al., 2002; Herron et al., 2001). An investigation to ascertain PCP characteristics associated with the exploration of suicide risk in patients with depressive symptoms reported that suicidality was explored in 36% of encounters (Feldman et al., 2007). While the type of depression and whether the patient requested antidepressant medication were associated with PCP exploration of suicidality, there was a lack of consistency in their approach (Feldman et al., 2007). In an online survey of 195 PCPs in the United States, those who perceived themselves as competent to work with suicidal patients were more willing to assess and treat suicidal patients, with the perception of competency fully explaining the relationship between training and willingness to treat (Graham et al., 2011). Female PCPs had lower self-perceived competence and having in-house access to professional mental health consultation increased self-perceived competency (Graham et al., 2011).

Education about depression and suicide is frequently identified as being one way to improve GP attitudes and confidence about management of depression and suicide risk (Fanello et al., 2002; Öncü et al., 2008).

Few studies have examined attitudes towards suicide prevention across primary care, hospital and mental health settings. One study of GPs, accident and emergency nurses, psychiatry trainees, and community psychiatric nurses found that attitudes toward suicide prevention differed significantly between professional groups. More positive attitudes were associated with mental health professionals, working in the community, and previous training in suicide risk assessment (Herron et al., 2001).

In this study we aimed to examine attitudes towards suicide and health care interventions to prevent suicide in mental health (psychiatrists, psychologists and mental health nurses) and other health care professionals, particularly GPs and medical specialists. We hypothesised that GPs and medical specialists would have more negative attitudes towards suicide prevention than mental health professionals. We also hypothesised that attitudes would be influenced by the age, experience, gender and training of the HCP.

Method

Participants

The sample was obtained from two separate study cohorts. The first cohort derived from a controlled psychological autopsy study of suicide in persons aged 35 years and over which aimed to examine the last clinical contact subjects who died by suicide had with HCPs, in order to determine whether this contact offers the opportunity for suicide prevention (De Leo et al., 2013a). The present study involved HCPs who were identified through interviews with the next of kin of persons who died by suicide or sudden death between 2006 and 2008, by other HCPs involved with the deceased person, from coroners' files and other medical records. HCPs were included only if the deceased had contact with them during the six months before death. A case-control study design was applied using sudden death victims as controls. The sudden death group included heart attacks, road traffic accidents (RTA), and other accidents; it excluded accidental overdoses, homicides, and single vehicle RTAs. Health care professionals were either interviewed face-to-face or by telephone (De Leo et al., 2013b).

The second cohort was obtained from an anonymous online survey by email invitation to approximately 260 (125 nurses, 80 allied health and 55 psychiatrists and psychiatry trainees – the precise size of the workforce during the survey is not known)

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clinicians in the Eastern Sydney Mental Health Service in spring 2005 with a reminder email in summer 2006. The email contained a link to a secure online survey.

This cohort was added to this study to augment the number of HCPs in the sample working in mental health and in public practice.

Data

Demographic data obtained from both cohorts included gender, age (under/over 50), type of health profession, years in practice, private or public setting, the number of suicides encountered in practice and in personal life. In addition, HCPs who were not mental health professionals provided information concerning whether they had 'any training in suicide prevention or depression management'. Attitudes towards suicide and suicide prevention were measured by the 10-item questionnaire developed by Michel & Valach (1992) for GPs, adapted for this study by changing the focus to HCPs and by the addition of an extra five items (the bottom five items in Table 2). Respondents were asked to rate each item on a 4-point scale – agree, tend to agree, tend to disagree, and disagree. These were scored (possible minimum score = 15 and maximum score = 60) with higher scores indicating more positive attitudes towards health care interventions to prevent suicide and how to do it.

Ethics

The psychological autopsy study was approved by the Griffith University Human Research Ethics Committee (HREC), South Eastern Sydney HREC and University of NSW HREC, while the online survey was approved by the South Eastern Sydney HREC and University of NSW HREC.

Statistical Analysis

Descriptive statistics were used to characterize the study population. Cronbach's alpha was calculated to assess the reliability of the original (10-item) (Michel & Valach, 1992) and the modified (15-item and 14-item) attitude scale and item-total statistics, including corrected item-total correlation

and Cronbach's alpha if item deleted, were examined. Exploratory Principal Component Analysis (PCA) was conducted in order to further explore the structure of the scale. Based on the literature regarding multidimensionality of attitudes towards suicide (Kodaka et al., 2011), a correlation between factors was assumed and direct oblimin method was chosen for factor rotation.

The chi-square test for independence was used to test differences between categorical variables. Independent t-test and one-way between-groups ANOVA with post-hoc comparisons were used to analyse differences in the scores on the attitude scale between subgroups (e.g., gender, age, years in practice, occupation). Given the differences in the sample sizes in the ANOVA analyses, the Hochberg GT2 test was chosen for post hoc comparisons (Field, 2009). Where the homogeneity of variance assumption for ANOVA was broken, i.e., $p < 0.05$ for the Levene test of homogeneity of variance, the Welch's F test and the Games-Howell procedure was used. In addition, effect sizes were calculated for t-test (Cohen's d), X^2 test (Cramer's V) and ANOVA (Eta squared or adjusted omega squared, where appropriate). The analyses were performed with SPSS (Version 22).

Results

The sample comprised 362 HCPs, 301 from the psychological autopsy (PA) investigation (210 from suicide cases and 91 from sudden death cases) and 61 from the online sample. The response rate for the online survey was approximately 25%. Demographic and professional practice details of the two samples are presented in Table 1.

Table 1. Demographic and Professional Practice Features of the Psychological Autopsy and Online Samples and scores on the attitude scale (N=362)

	PA Sample (N = 301) n (%)	Online Sample (N = 61) n (%)	Together (N=362) N (%)	Attitude Scale score M (SD)
Sex (N = 362)				
Male	218 (72.4)	22 (36.1)	240 (66.3)	43.76 (4.64)
Female	83 (27.6)	39 (63.9)	122 (33.7)	42.56 (5.13)
Age (N = 347)*				
< 50 years	138 (45.8)	31 (50.8)	169 (46.7)	43.91 (4.38)
≥ 50 years	162 (53.8)	16 (26.2)	178 (49.2)	42.02 (5.44)
Occupation (N = 362)				
General Practitioners	172 (57.1)	0 (0)	172 (47.5)	42.41 (4.65)
Psychiatrists & Trainee	50 (16.6)	17 (27.9)	67 (18.5)	46.16 (3.76)
Psychiatrists				
Psychologists	17 (5.6)	11 (18.0)	28 (7.7)	45.50 (4.18)
Mental Health Nurses	13 (4.3)	23 (37.7)	36 (9.9)	43.12 (4.58)
Medical Specialists	26 (8.6)	0 (0)	26 (7.2)	38.16 (5.51)
Other	23 (7.6)	10 (16.4)	33 (9.1)	41.35 (5.49)
Professional Practice (N = 360)**				
1-10 years	64 (21.3)	34 (55.7)	98 (27.0)	44.08 (4,36)
11-20 years	80 (26.6)	11 (18.0)	91 (25.1)	43.58 (4,49)
21-30 years	91 (30.2)	10 (16.4)	101 (27.9)	42.39 (5,04)
>30 years	64 (21.3)	6 (9.8)	70 (19.3)	41.54 (5,89)
Practice Location (N = 362)				
Private	225 (74.8)	0 (0)	225 (62.2)	42.28 (4.91)
Public	67 (22.2)	55 (90.2)	122 (33.7)	44.00 (4.62)
Both	9 (3.0)	6 (9.8)	15 (4.1)	45.00 (4.99)
Suicide in Practice (N =356)***				
0	33 (11.1)	24 (41.4)	57 (16.0)	42.26 (3,98)
1	92 (30.9)	12 (20.7)	104 (29.2)	43.03 (5,63)
>1	173 (58.1)	22 (37.9)	195 (54.8)	43.17 (4,89)
Suicide in Personal Life (N= =301)****				
Yes	94 (31.2)	n/a	94 (31.2)	42.87 (5,27)
No	207 (68.8)	n/a	207 (68.8)	42.76 (4,86)

* 15 missing, 14 in online sample

** 2 missing (both in PA sample)

*** 6 missing, 3 in online sample

**** Data available for PA sample only

We examined the psychometric properties of the original 10-item attitudes towards suicide prevention scale (Michel & Valach, 1992) and our extended 15-item version. Cronbach's alpha for the 10-item version was 0.444 which increased to 0.601 for the 15-item version. The examination of inter-item statistics for the 15-item scale indicated that Cronbach's alpha increased to 0.652 with the exclusion of the item 'a suicidal person belongs in the

hands of a psychiatrist'. This item had also a negative correlation with the total score (-0.109). Consequently, we excluded this item from the scale and further analyses were conducted on the 14-item version of the scale. The inconsistency in responses to this item were largely driven by the discrepancy in the views of the occupational groups: 'general medical' HCPs (i.e., GPs and medical specialists) tended to agree with this statement (69.9%)

significantly more than 'mental health' HCPs (i.e., psychologists, psychiatrists, mental health nurses) (59.5%) and 'other' HCPs, including social workers, counsellors allied health professionals (50%) ($\chi^2(2, N=359) = 6.822, p=0.033$).

An exploratory factor analysis (PCA with direct oblimin rotation) was performed on the 14-item scale resulting in 5 components with eigenvalues higher than 1 and explaining 56.31% of total variance. The numbers of items with loadings higher than 0.3 on each component varied from 4 to 1 and three items had loadings greater than 0.3 on more than one component. As no interpretable subscales could be ascertained, we decided to use the total score of the 14-item scale in the further analyses. Scores ranged from 23 to 53 on the 14 item version and overall the mean score obtained on the attitudes scale for the total sample was 42.97 (SD=4.99). The 14-item version of the attitudes towards suicide prevention per item is listed in Table 2.

Female HCPs had more positive attitudes towards suicide prevention than male HCPs ($t(334) = -2.094, p=0.037$) and younger HCPs (under the age of 50) had more positive attitudes than the older professionals (50+) ($t(314.301) = 3.467, p=0.001$); nonetheless the effect sizes were small (Cohen's $d = 0.23$ and 0.39 ; respectively). HCPs in the public sector

had more positive attitudes than professionals working in private practice ($F(2,333) = 5.695, p=0.004, \text{Eta squared}=0.033$), although post hoc comparisons using the Hochberg GT2 test showed no differences between these two groups and professionals working in both settings. Since the assumption of homogeneity of variance was not met for data regarding attitude scores for the four groups based on the variable 'years in professional practice', the Welch's adjusted F ratio was used. This analysis showed significant differences between the groups (Welch's $F(3, 174.470) = 3.978, p = 0.009$; adjusted omega squared=0.026). Post hoc analysis (Games-Howell test) indicated that professionals in practice longer than 30 years had more negative attitudes than HCP working less than 10 years, with no statistically significant differences among the other groups. Attitudes were not significantly related to the number of suicides encountered in practice (Welch's $F(2,132.749) = 0.911, p=0.405$) or personal life ($t(282) = 0.172, p=0.863$) (the latter data available for PA sample only). For the group of 'general medical' HCPs, no statistically significant differences were found for respondents with any training in depression or suicide prevention ($n=81$) and those without any training ($n=117$) ($t(184) = 1.454, p=0.148$).

Table 2. Health Care Professionals Attitudes Towards Suicide Prevention

	Agree N (%)	Tend to Agree N (%)	Tend to Disagree N (%)	Disagree N (%)
Each individual has the right to kill her/himself (N = 358)	53 (14.8)	85 (23.7)	97 (27.1)	123 (34.4)
It is questionable to interfere with the decision of a person to kill her/himself (N = 361)	10 (2.8)	16 (4.4)	54 (15.0)	281 (77.8)
If a person wants to kill her/himself, he/she will hide it even from their professional carer (N= 359)	85 (23.5)	131 (36.5)	86 (24.0)	57 (15.9)
Suicide is always the expression of a mental disorder (N = 359)	58 (16.2)	72 (20.1)	88 (24.5)	141 (39.3)
If somebody really wants to kill her/himself, she/he will do it even under optimal medical care (N = 362)	138 (38.1)	127 (35.1)	66 (18.2)	31 (8.6)
Health care professionals can often prevent suicide (N = 359)	172 (47.9)	147 (40.9)	29 (8.1)	11 (3.1)
Suicide is not of any importance in my practice (N = 359)	9 (2.5)	8 (2.2)	32 (8.9)	310 (86.4)
I think I would recognise a suicide risk in my patients (N = 357)	98 (27.5)	202 (56.6)	48 (13.4)	9 (2.5)
I feel competent in the management of suicidal patients (N = 356)	105 (29.5)	150 (42.1)	63 (17.7)	38 (10.7)

A suicide happens without warning (N = 360)	30 (8.3)	80 (22.2)	170 (47.2)	80 (22.2)
Once a person is intent on suicide there is no way of stopping them (N = 361)	14 (3.9)	43 (11.9)	146 (40.4)	158 (43.8)
People who threaten suicide are just seeking attention (N = 360)	7 (1.9)	36 (10.0)	104 (28.9)	213 (59.2)
Talking about suicide or asking someone if they feel suicidal will encourage suicide attempts (N = 361)	3 (0.8)	5 (1.4)	56 (15.5)	297 (82.3)
The suicidal person wants to die and there is nothing anyone, including the physician, can do (n = 362)	12 (3.3)	21 (5.8)	99 (27.3)	230 (63.5)

Further, differences in attitudes between HCP occupational groups were explored. Given its heterogeneity (social workers, counsellors, allied health professionals, general nurses, and dentists), the 'other' category was excluded from the analysis, leaving 329 participants. There were significant differences in the overall attitudes between the five occupations ($F(4, 300)=17.530$, $p<0.001$; $\eta^2=0.189$). Post hoc analyses using the Hochberg GT2 test showed that medical specialists ($M=38.16$, $SD=5.51$) had significantly more negative attitudes towards suicide than each of the other HCP groups: psychiatrists ($M=46.16$, $SD=3.76$), psychologists ($M=45.0$, $SD=4.18$), mental health nurses ($M=43.12$, $SD=4.58$), and GPs ($M=42.41$, $SD=4.65$). GPs had significantly more negative suicide attitudes than psychiatrists and psychologists. Within the category of mental health professionals, mental health nurses had more negative attitudes than psychiatrists and there were no significant differences between psychologists and psychiatrists.

On the item-level analysis, the attitude differences between the three categories of mental health professionals were mainly noted on two statements. On the statement 'each individual has the right to kill him/herself', more than half of psychologists (53.5%) agreed/tended to agree with the proposition, while only a minority of mental health nurses (38.9%) and psychiatrists (24.6%) agreed/tended to agree ($\chi^2(2, N=129) = 7.576$, $p=0.023$; Cramer's $V=0.242$). Although each of the professional groups agreed/tended to agree that 'if somebody really wants to kill him/herself he will do it even under optimal medical care', mental health nurses (86.1%) held significantly stronger views than psychiatrists (61.2%) or psychologists (60.7%) ($\chi^2(2, N=131) = 7.528$, $p=0.023$; Cramer's $V=0.240$).

In addition, psychiatrists, psychologists and mental health nurses were compared together as a group of 'mental health professionals' ($n=131$) with the 'general medical' group (i.e., GPs and medical

specialists) ($n=198$). There were statistically significant differences between these two groups ($t(303)=6.073$; $p<0.001$) with a relatively large effect size (Cohen's $d=0.69$). Mental health professionals had more positive attitudes towards suicide prevention and felt more competent about identifying and managing suicidal patients ($M=45.16$, $SD=4.12$) than the general medical groups ($M=41.84$, $SD=4.97$). Of interest, mental health professionals were significantly less likely to believe that suicide is always an expression of a mental disorder (27.5%) than GPs and medical specialists (45.6%) ($\chi^2(1, N=326)=10.931$; $p=0.001$; Cramer's $V=0.183$).

Discussion

This study provides further evidence that attitudes towards suicide prevention differ between HCP groups. As hypothesised, mental health professionals had more positive attitudes towards health care interventions to prevent suicide than non-mental health professionals. There were, however, some attitudinal differences between psychologists, psychiatrists and mental health nurses as well. The importance of these attitudinal differences resides in their potential to influence decisions in patient care and to be a barrier to cohesive teamwork (Morgan & Evans, 1994). The different professional groups involved in identification and care of suicidal individuals have varying specific training needs (Gibb et al., 2010).

Many of the attitudinal differences between mental health and non-mental health professionals may relate to perceived competence in assessing and managing suicidal patients (Saunders et al., 2012). But it is the negative attitudes towards being able to prevent suicide that are of most concern as they could impact upon management plans including referral for mental health review. HCPs without mental health training were significantly more likely than mental health professionals to believe that suicide was always an expression of mental illness.

The apparent paradox whereby HCPs without mental health training are more likely than mental health professionals to believe that suicide is an expression of mental illness but have more negative views about suicide prevention, may reflect their lack of confidence about the effectiveness of treatments of mental disorders.

Our finding that medical specialists, especially over the age of 50, had the most negative views about suicide prevention are important in the context that more older people are likely to be under their care due to their physical health comorbidities (Juurlink et al., 2004). These views seem to reflect a mix of poor knowledge about suicide and lack of skills in managing suicidal patients. How this might influence the treatment that they provide is unclear as such deficiencies might not be problematic so long as they are able to identify patients that are 'at risk' and facilitate appropriate mental health assessment. But the concern is that a significant number of these medical specialists and GPs indicated a lack of confidence in being able to identify such patients. GPs can play a significant role in identification, treatment and referral of suicidal patients (Mann et al., 2005).

Provision of education and training in suicide prevention can increase the knowledge and skills of GPs and increase their professional confidence in management of 'at risk' patients (Michel & Valach, 1992; Paxton et al., 2001). There are mixed findings about the best way to deliver education and training with one study finding that the seminar approach was more effective in improving knowledge and attitudes than written material (Michel & Valach, 1992). A facilitator-led educational intervention on assessment and management of suicide risk for 167 frontline staff including GPs, mental health staff and emergency ward staff produced positive outcomes in staff skills in assessment and management of suicide risk (Appleby et al., 2000). A recent clustered randomised controlled trial involving practice audit and targeted written education for 188 GPs reduced the two year prevalence of depression and self harm behaviour in older patients in their practices by 10 per cent compared with those managed by 184 control GPs (Almeida et al., 2012).

Although mental health professionals had more positive attitudes than non-mental health professionals, there were also some differences in attitudes between psychiatrists, psychologists and

mental health nurses that might have some impact on patient management. Given patients can die by suicide in acute in-patient settings while under intensive nursing care (e.g., Carlén & Bengtsson, 2007), it is not surprising that mental health nurses are more likely to endorse that suicides can occur 'even under optimal medical care' than psychologists and psychiatrists. Psychologists favoured individual autonomy more than psychiatrists or mental health nurses did on the attitude about an individual's right to kill him/herself. The extent to which these differing views might impact upon mental health teamwork is unclear (e.g., Betz et al., 2013), but it is perhaps important to note that psychiatrists and mental health nurses tend to have more involvement than psychologists in implementing involuntary treatment under mental health legislation in the state in which most participants lived (Mental Health Drug and Alcohol Office, 2010).

There are a number of limitations to this study. Most importantly this is a convenience sample recruited from two sources and it is unclear how representative it is for each of the professional groups. Combining two samples had the advantage of increasing representation from different professional groups but the disadvantage of utilising a different methodology in obtaining participants. The online sample were younger, less experienced and less likely to have had a suicide in their professional practice. It is also unclear what impact recruitment in the context of a psychological autopsy study might have had on the attitudes of the HCPs involved. We do not know how many of the potential sample for the online survey accessed their email invitations during the sampling period. Further, the sample size for some of the professional groups is small. The 'attitudes to suicide' questionnaire was adapted for this study from the original version (Michel & Valach, 1992) and has not been validated elsewhere. The 14-item version used in these analyses showed more acceptable reliability than the original 10-item version and expanded 15-item versions. However an exploratory factor analysis yielded no interpretable factors.

In conclusion, attitudes towards suicide vary amongst HCP professional groups and are influenced by age, experience and gender. Such differences have the potential to affect patient care.

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Original Research
**Extreme Traumatization and Suicide Notes from Lithuania: A
Thematic Analysis**

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Abstract: Suicide is a global concern, especially in countries with high rates of suicide; yet, there is a paucity of cross-cultural study. Lithuania is the country with the world's highest rate of suicide. In study 1, a thematic or theoretical-conceptual analysis of 56 suicide notes drawn from Lithuania and the United States (U.S.), matched for age and sex, was undertaken based on Leenaars' evidence-based multidimensional model of suicide. The results suggested that there were culturally common factors; yet, the factors were more extreme in the Lithuanian sample. It was suggested that extreme traumatization might be an explanation. In study 2, an analysis of Lithuanian, U.S., and Korean martyrs, also a group showing extremism (Leenaars, Park, et al., 2010), was undertaken. The results showed that the Lithuanian notes and the martyr notes were more the same than different in comparison with the U.S. in terms of extremism, not in terms of the presence or absence of the major psychological factors or characteristics in suicide. A question raised is whether the findings are related to extreme traumatization, such as genocide.

Keywords: suicide, suicide notes, Lithuania, extreme traumatization, martyrs

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Lithuania has the highest registered suicide rate in the world (Gailienė, 2004; Gailienė, Domanskienė, & Keturakis, 1995; World Health

Organization [WHO], 2002). The knowledge of this fact is a few decades old. It was not until 1988 that it became a possibility to analyze suicide rates in Lithuania. Before that time, during the Soviet occupation, suicidologists and the public had no access to data on suicide, but also no access to data on violence, crime, drug and alcohol addiction, and related phenomena. Indeed, people were offered a proclamation, what turned out to be a complete myth, namely that the progressive Soviet society allegedly suffered from none of these.

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The number of suicides in pre-war independent Lithuania was reported to be low; in 1924, 123 people died by suicide (a rate of 5 per 100,000). The first available data in the period of Soviet occupation was 1962; 450 (15.8 per 100,000) died by suicide; the subsequent reported data show increasing trends. The rates (all rates are crude rates per 100,000) of a sample of years are as follows: 1974, 31.0; 1984, 35.8. With the start of political reform and democratization in the Soviet Union, Prestrojka, there was a sudden drop in the annual suicide rate in 1986, from 33.7 to 25.1. During the years 1987 to 1990 the rates remained relatively low, but began to rise in 1991. Between 1990 and 1996, suicide mortality rose 82.4%. The rates stabilized at a very high level between 1998 and 2002 at an average rate of 44.6. This would be an epidemic by any international comparison (WHO, 2002). The question posed here is why. (Table 1 presents a sample of rates for the period in question.)

Despite this epidemic level, there have been limited studies on suicide in Lithuania. There have been multiple factors suggested for the epidemic, however. The most common hypothesis of the incredible suicide spread in Lithuania lies in the long lasting effects of the Soviet/Nazi/Soviet occupation of the 1940's and the 50 years under the communist regime. This affected the ability of individuals and groups to manage psychosocial stress and environmental traumatisation (Gailienė, 2004, 2005). Draguns (1998) compared the occupation to a real life analogue of learned helplessness. The Soviet genocide destroyed many socially, politically, and economically active people and their families (Kuodytė, 2005; Leenaars, 2005). In the years of 1940 to 1953, 33% of the total population was killed, deported to Siberia, or immigrated to Western countries (Anušauskas, 1996). During the Soviet years and even after the liberation of Lithuania, the traumatisation continued (Kazlauskas, 2006); suicide prevention was poorly received (Salander-Renberg, et al., 2003); and even in the media, reflected inertia and not only helplessness but also hopelessness (Fekete, et al., 1998). There was a deep stigma and it was suicidogenic. Research fared no better; the study of suicide and its prevention has been limited, with little support of policy makers and politicians (Gailienė, 2004; Salander-Renberg, et al., 2003); yet, the World Health Organization (2002) has called for such efforts, noting that it is imperative that the study of suicide occurs in the highest risk regions, such as Lithuania. This paper is one attempt to meet that challenge. We address the question: Why is suicide an epidemic? We will attempt an answer to the question raised with two studies. In the first

study, we ask, do suicide notes from Lithuania differ from American notes? In study 2, we attempt a first step at an evidence-based answer.

Study 1

Many researchers from around the world have used different methods to study suicide. Shneidman and Farberow (1957), Maris (1981), and others have suggested the following avenues: national mortality statistics, third party interviews (often called psychological autopsies), the study of nonfatal suicide attempts, and the analysis of documents (such as suicide notes). All of them have their limitations and there are problems in obtaining them in many countries, including Lithuania. Yet, each of these methods has been shown to extend our understanding of suicide and suicidal behaviour (Hawton & vanHeeringen, 2000; Leenaars, et al., 1997).

One of these methods, suicide note analysis, is the focus of this study. A suicide note is often the closest that we can get to a suicidal mind (Leenaars 1988; Leenaars, deWilde, Wenckstern, & Kral, 2001; Leenaars & Lester, 1991; Shneidman, 1985). Although there has been considerable debate around determining the utility of suicide note analysis within the field of suicidology (see Shneidman, 1985), it is now generally agreed, among other methods, that this inclusion remains integral to the understanding of this complex phenomena. Furthermore, a task force established by the International Academy for Suicide Research (IASR) supported the use of suicide notes (Leenaars et al., 1997).

To date, there has been no study of suicide notes in Lithuania in the professional literature. Early research (e.g., de Boismont, 1856; Wolff, 1931) on suicide notes largely used an anecdotal approach that incorporated descriptive information (Frederick, 1969). Using Frederick's scheme for methods of analysis (1969), subsequent methods have used content analysis, classification analysis and, although rarely, theoretical-conceptual analysis. Each of these approaches has had utility, although Frederick suggested that simple content analysis has limitations, whereas theoretical-conceptual analysis would be most revealing. Content analysis focuses on the actual presence or absence of emotional, verbal, and/or motivational aspects (see, for example, Ogilvie, Stone, & Shneidman, 1969). Classification schemes use data such as age, sex, marital status, mental disorder (see, for example, Ho, Yip, Chiu, & Halliday, 1998). A theoretical-conceptual analysis uses a schema (construct, theory) approach to understand the event, grounding the data in the foundation of science (Ayer, 1959; Carnap, 1959;

Table 1. Incidence and Rate of Suicide in Lithuania and the United States during 1996-2003

Year	Lithuania		United States	
	Total No. of Suicides	Rates of Suicide (per 100,000)	Total No. of Suicides	Rates of Suicide (per 100,000)
1996	1,723	47.0	30,903	11.6
1997	1,632	45.6	30,535	11.4
1998	1,554	43.8	30,575	11.3
1999	1,552	44.0	29,199	10.7
2000	1,631	46.6	29,350	10.7
2001	1,535	44.1	30,622	10.8
2002	1,551	44.7	31,655	11.0
2003	1,456	42.1	31,484	10.8

Cronbach & Meehl, 1955; Kuhn, 1962; Millon, 2010). Our method here is to use a thematic conceptual analysis of samples of suicide notes (see, for example, Leenaars, 1988, 1996).

Theoretical-conceptual analysis offers great promise (Frederich, 1969; Leenaars, 1988; Shneidman & Farberow, 1957). A theoretical approach, however, using only one theory about suicide, from an evidence-based basis (Kerlinger, 1964), seems limited and inadequate. For this reason, Leenaars (1988) developed a multidimensional model of suicide derived from the formulations of ten significant contributors in the suicidological history: A. Adler, L. Binswanger, S. Freud, C. G. Jung, K. A. Menninger, G. Kelly, H. A. Murray, E. S. Shneidman, H. S. Sullivan, and G. Zilboorg. In his model, Leenaars isolated 100 protocol sentences; ten each from the 10 theorists and reduced them to 35 sentences; 23 protocol sentences were found to be highly predictive (described) for the content of suicide notes (i.e., one standard deviation above the mean of observations) and 17 protocol sentences significantly discriminated genuine suicide notes from simulated notes (i.e., control data) (Leenaars & Balance, 1984; Leenaars, 1989). After a series of studies utilizing this model, using statistical techniques (Cluster Analysis, see Millon, 2010), the protocols were reduced to eight clusters, grouped in 5 intrapsychic and 3 interpersonal aspects: unbearable pain (UP), cognitive constriction (CC), indirect expressions (IE), inability to adjust (psychopathology) (IA), ego (vulnerability) (Ego), interpersonal relationships, rejection-aggression (RA), identification-egression (I-E) (Leenaars, 1996; Leenaars, 2004; Leenaars et al., 2001). (Table 4 presents a sample of protocol/theoretical-conceptual sentences in each cluster.)

Independent research on suicide notes (O'Connor, Sheehy & O'Connor, 1999), investigations

of suicidal Internet writings (Barak & Miran, 2005) and biographical studies of suicides (Lester, 1994) have supported the utility of the Leenaars' approach to note or any narrative analysis. Independent studies of inter-judge reliability (for example, O'Connor et al, 1999; Barak & Miran, 2005) and four decades of study by the senior author show that the percentage of inter-judge agreement has been satisfactory (> 85%; see Shaughnessy, Zechmeister, & Zechmeister, 2000; Siegel, 1956). Reliability has also been established in different countries and we will next highlight those studies.

Much of our understanding of suicide may be culture specific. Thus, caution is needed in the field. Shneidman (1985) noted that when making "cross-cultural comparisons, do not make the error of assuming that a suicide is a suicide" (p. 203). There is an increasing number of studies on suicide notes from different countries. Leenaars (1992) examined 56 suicide notes from Canada and the United States, whose writers were matched for age and sex (this was the first cross-cultural study of suicide notes). None of the intrapsychic or interpersonal aspects differed. Leenaars, Lester, Wenckstern and Heim (1994) examined 70 suicide notes from Germany and the United States, whose writers were matched for age and sex. None of the variables reached significance. Subsequently, studies from the United Kingdom (O'Connor & Leenaars, 2004), Hungary (Leenaars, Fekete, Wenckstern, & Osvath, 1998), Russia (Leenaars, Lester, Lopatin, Schustav, & Wenckstern, 2002), Mexico (Chavez, Leenaars, Chavez-de-Sanchez, & Leenaars, 2009), and Australia (Leenaars, Haines, Wenckstern, Williams, & Lester, 2003) supported this observation. On a different point, these countries are cultures of separateness (individualism). These cultures are assumed to differ

Table 2. Frequency of endorsement of protocol sentences, percentages, and significance in Lithuanian (n=28) and U.S. (n=28) notes

Cluster/ Protocol Sentence	Lithuania		United States		<i>p</i>
	<i>n</i>	%	<i>n</i>	%	
INTRAPSYCHIC					
I. Unbearable Psychological Pain	28	100.0	20	71.4	.002**
1) <i>Suicide as a relief</i>	28	100.0	16	57.1	.000***
2) <i>Suicide as a flight from trauma</i>	24	85.7	15	53.6	.009**
3) <i>Emotional states in suicidal trauma</i>	27	96.4	19	67.9	.005**
4) <i>Loss of interest to endure</i>	24	85.7	9	32.1	.000***
5) <i>Inability to meet life's challenges</i>	25	89.3	16	57.1	.007**
6) <i>State of heightened disturbance</i>	27	96.4	12	42.9	.000***
II. Cognitive Constriction	28	100.0	19	67.9	.000***
7) <i>A history of trauma</i>	24	85.7	13	46.4	.002**
8) <i>Overpowering emotions</i>	23	82.1	8	28.6	.000***
9) <i>Focus only on grief topics</i>	27	96.4	15	53.6	.000***
III. Indirect Expressions	22	78.6	19	67.9	.017*
10) <i>Ambivalence</i>	9	32.1	7	25.0	.554
11) <i>Aggression has turned inwards</i>	15	53.6	7	25.0	.029*
12) <i>Unconscious dynamics</i>	22	78.6	13	46.4	.013*
IV. Inability to Adjust	27	96.4	15	53.6	.000***
13) <i>Feels weak to overcome difficulties</i>	21	75.0	11	39.3	.007**
14) <i>Incompatible state of mind</i>	18	64.3	7	25.0	.003**
15) <i>Serious disorder in adjustment</i>	23	82.1	10	35.7	.000***
V. Ego	23	82.1	10	35.7	.002**
16) <i>Weakness in constructive tendencies</i>	19	67.9	6	21.4	.000***
17) <i>A "complex" or weakened ego</i>	20	71.4	6	21.4	.000***
18) <i>Harsh conscience</i>	13	46.4	6	21.4	.048*
INTERPERSONAL					
VI. Interpersonal Relations	26	92.8	17	60.7	.035*
19) <i>Problems determined by situations</i>	20	71.4	9	32.1	.003**
20) <i>Weakened by unresolved problems</i>	21	75.0	8	28.6	.001**
21) <i>Frustrated needs</i>	25	89.3	11	39.3	.000***
22) <i>Frustration to a traumatic degree</i>	12	42.9	9	32.1	.408
23) <i>Positive development not forthcoming</i>	9	32.1	6	21.4	.365
24) <i>Regressive, intimate relationships</i>	10	35.7	4	14.3	.064
VII. Rejection-Aggression	24	85.7	17	60.7	.294
25) <i>Report of a traumatic event</i>	21	75.0	9	32.1	.001**
26) <i>Narcissistic injury</i>	20	71.4	5	17.9	.000***
27) <i>Preoccupation with person</i>	9	32.1	7	25.0	.554
28) <i>Ambivalent feelings towards a person</i>	5	17.9	6	21.4	.737
29) <i>Aggression as self-directed</i>	9	32.1	6	21.4	.365
30) <i>Murderous impulse</i>	2	7.1	2	7.1	1.000
31) <i>Calculation of negative effect</i>	14	50.0	11	39.3	.420
32) <i>Revenge towards someone else</i>	12	42.9	11	39.3	.786
VIII. Identification-Egression	28	100.0	20	71.4	.000***
33) <i>Identification with person/ideal</i>	24	85.7	14	50.0	.004**
34) <i>Unwillingness to accept life</i>	24	85.7	8	28.6	.000***
35) <i>Suicide as escape</i>	28	100.0	18	64.3	.000***

*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Table 3. Frequency of endorsement of protocol sentences, percentages, and significance in Lithuanian (n=28), Altruistic (n=28) and U.S. (n=28) notes

Cluster/ Protocol Sentence	Lithuania		Altruistic		United States		p
	n	%	n	%	n	%	
INTRAPSYCHIC							
I. Unbearable Psychological Pain	28	100.0	28	100.0	20	71.4	0.000***
1) Suicide as a relief	28	100.0	28	100.0	16	57.1	0.000***
2) Suicide as a flight from trauma	24	85.7	27	96.4	15	53.6	0.000***
3) Emotional states in suicidal trauma	27	96.4	26	92.8	19	67.9	0.004**
4) Loss of interest to endure	24	85.7	25	89.3	9	32.1	0.000***
5) Inability to meet life's challenges	25	89.3	25	89.3	16	57.1	0.003**
6) State of heightened disturbance	27	96.4	25	89.3	12	42.9	0.000***
II. Cognitive Constriction	28	100.0	28	100.0	19	67.9	0.000***
7) A history of trauma	24	85.7	24	85.7	13	46.4	0.001**
8) Overpowering emotions	23	82.1	26	92.8	8	28.6	0.000***
9) Focus only on grief topics	27	96.4	27	96.4	15	53.6	0.000***
III. Indirect Expressions	22	78.6	28	100.0	19	67.9	0.000***
10) Ambivalence	9	32.1	2	7.1	7	25.0	0.063
11) Aggression has turned inwards	15	53.6	25	89.3	7	25.0	0.000***
12) Unconscious dynamics	22	78.6	26	92.8	13	46.4	0.000***
IV. Inability to Adjust	27	96.4	26	92.8	15	53.6	0.000***
13) Feels weak to overcome difficulties	21	75.0	20	71.4	11	39.3	0.010*
14) Incompatible state of mind	18	64.3	21	75.0	7	25.0	0.000***
15) Serious disorder in adjustment	23	82.1	25	89.3	10	35.7	0.000***
V. Ego	23	82.1	22	78.6	10	35.7	0.000***
16) Weakness in constructive tendencies	19	67.9	6	21.4	6	21.4	0.000***
17) A "complex" or weakened ego	20	71.4	21	75.0	6	21.4	0.000***
18) Harsh conscience	13	46.4	10	35.7	6	21.4	0.142
INTERPERSONAL							
VI. Interpersonal Relations	26	92.8	26	92.8	17	60.7	0.000***
19) Problems determined by situations	20	71.4	26	92.8	9	32.1	0.000***
20) Weakened by unresolved problems	21	75.0	26	92.8	8	28.6	0.000***
21) Frustrated needs	25	89.3	26	92.8	11	39.3	0.000***
22) Frustration to a traumatic degree	12	42.9	25	89.3	9	32.1	0.000***
23) Positive developm. not forthcoming	9	32.1	25	89.3	6	21.4	0.000***
24) Regressive, intimate, relationships	10	35.7	25	89.3	4	14.3	0.000***
VII. Rejection-Aggression	24	85.7	28	100.0	17	60.7	0.000***
25) Report of a traumatic event	21	75.0	27	96.4	9	32.1	0.000***
26) Narcissistic injury	20	71.4	12	42.8	5	17.9	0.000***
27) Preoccupation with person	9	32.1	8	28.6	7	25.0	0.839
28) Ambivalent feelings tow. a person	5	17.9	0	0.0	6	21.4	0.039*
29) Aggression as self-directed	9	32.1	4	14.3	6	21.4	0.275
30) Murderous impulse	2	7.1	28	100.0	2	7.1	0.000***
31) Calculation of negative effect	14	50.0	28	100.0	11	39.3	0.000***
32) Revenge towards someone else	12	42.9	28	100.0	11	39.3	0.000***
VIII. Identification-Egression	28	100.0	27	96.4	20	71.4	0.000***
33) Identification with person/ideal	24	85.7	26	92.8	14	50.0	0.000***
34) Unwillingness to accept life	24	85.7	27	96.4	8	28.6	0.000***
35) Suicide as escape	28	100.0	27	96.4	18	64.3	0.000***

*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

from cultures of relatedness (collectivism) (Eskin, 2003; Triandis, 1995). In collectivistic cultures, say Turkey and India, interpersonal relations are of critical importance, versus individualistic cultures, wherein personal autonomy is valued. Leenaars, Sayin, et al. (2010) and Leenaars, Girdhar, et al. (2010) studied the suicide notes from Turkey and India respectively. Unlike previous findings, a consistent difference emerged in Turkish and Indian

notes expressing more indirect and veiled communications (indirect expression). It can be concluded that the theory of suicide, the most extensive studied across the world to date, can be applied to many countries, but also much greater study of cultural factors, such as individualism versus collectivism, needs to be undertaken. The question arises, what other cultural factors may be most salient? Maybe culture sometimes affects some

aspects of suicide more than intrapsychic issues of pain, psychopathology, and so on. There is, thus, some cross-cultural reliability for the theory; this is rare in suicidology. Yet, there are questions about how different the United States, Canada, and India are compared to cultural differences with Lithuania from this list. Only Lithuania would be described as a country exposed to extreme traumatisation (genocide). We simply do not know whether the suicide of the Lithuanian is the same or different than say of the American. This was a purpose here.

There have been no published comparisons between suicide in Lithuania and the United States. These countries have different suicide rates (see Table 1) and markedly different histories and cultures. Thus, the aim of this study was not only to describe the suicide notes from Lithuania, but also to determine whether any psychological differences (and similarities) were evident in the suicide notes drawn from Lithuania and the United States. Why are the rates and likely meanings so different? We know a priori that genocide, obviously extreme trauma by any definition, occurred in Lithuania (Gailienė, 2004; Leenaars, 2005). This is believed to be most relevant to the epidemic (Gailienė, 2004).

Method

A study of completed suicides was conducted at the Vilnius Coroners Office from January 1, 1999 to December 31, 1999. All suicide notes in that sample were identified and obtained, with consents. Thirty-four suicide notes were identified; however, this sample, due to limitations in the data set, was reduced to 28 for comparison with the U.S. notes.

The Lithuanian sample, ages 18 and above, was reviewed and matched to an adult ($n=60$) American sample (see Leenaars et al, 2001); this U.S. sample has been the basis for all previous cross-cultural comparisons to date. Fifty-six suicide notes (28 Lithuanian notes versus 28 United States notes) were matched for age (plus/minus 3 years) and sex. Previous research highlighted the importance of matching the age and sex criteria (Leenaars, 1988). The mean age of the Lithuanian notes was 51.75; the age range was 21-91. There were, however, many older adult notes; one was 91 and another 87. The

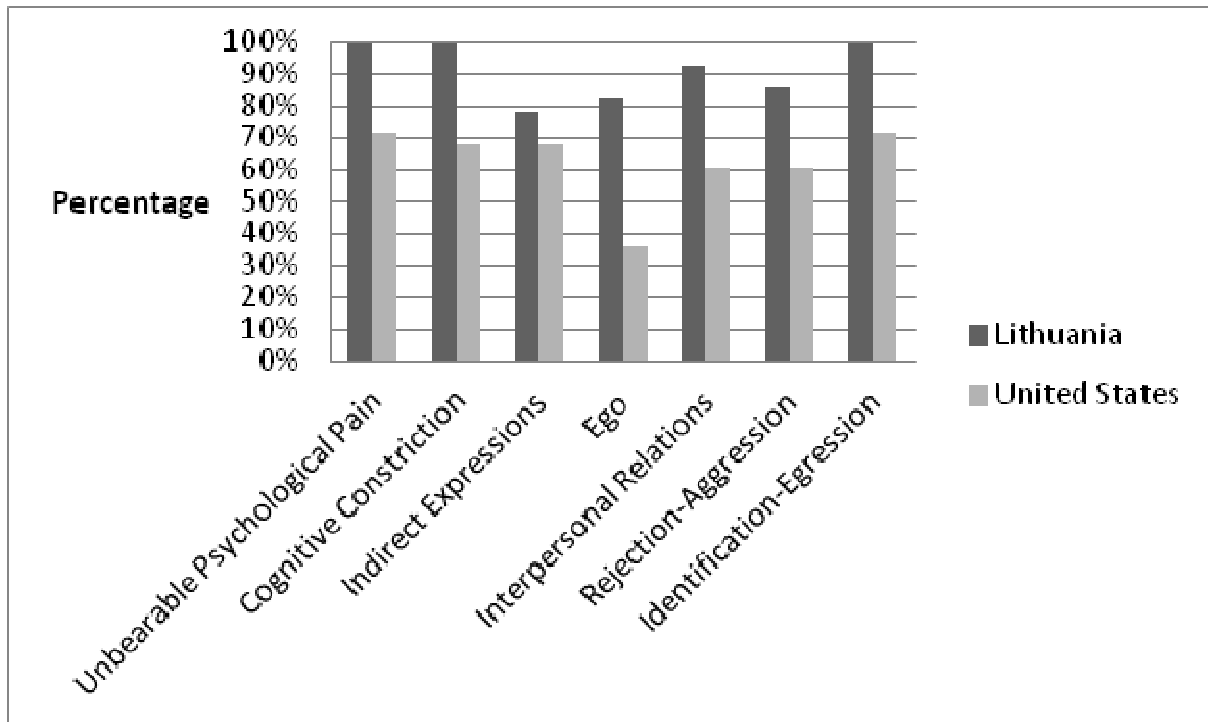
U.S. sample consisted of equal numbers ($n=20$) in young (18-25), middle (25-55), and mature (55 & >) adult groups, resulting in problems matching the notes from Lithuania. (During these years, the elderly were a high-risk group.) Thus, greater age differences were permitted in the older adults, simply to increase the n . Most of the Lithuanian notes were from middle adulthood, mainly males. The U.S. sampled an equal number of males and females; the complete 34 notes were from 22 males and 12 females. (This reflects the fact that males kill themselves 5 times more often than females in Lithuania.) No notes from teens were included. The mean age of the American notes was 50.20; the age range was 21-77. Thus, there were sampling issues.

Two raters (authors one and three) were trained in the system until agreement reached above 80%, as suggested by Leenaars (1988, 1996). Subsequently, the judges scored the notes independently. The inter-rater reliability for the raters was found to be Kappa = 0.66 ($p < 0.001$), thus indicating a substantial level of agreement (Landis & Koch, 1977).

The note analysis was done in two steps. At the first step, the meanings of 35 protocol sentences in Leenaars' method were discussed between two examiners who would analyze the notes, based on the literature of Leenaars' work (see Table 4 for Leenaars' schema and sample of protocol sentences). The examiners agreed before scoring that the target of the note might be other than a person; it could be an ideal, a group, or organization/government. A second step was then undertaken; two examiners analyzed all of the notes in this study independently. The notes were analyzed for the presence of the 35 protocol sentences.

After scoring inter-judge agreement, a reconciled rating was obtained. For subsequent calculations, each note was given a score for the number of matches with a protocol sentence of a given type. In order to determine whether suicide notes from the two samples differed significantly in the presence of 8 sub-clusters and 35 protocol sentences, chi-squares were performed, using SPSS for Windows.

Figure 1. Distribution of cluster themes evident in the suicide notes by country



Results

Similar to previous studies, there was substantial evidence for the presence of the protocol sentences and clusters in both samples of suicide notes (see Figure 1). Thus, one can conclude that the model is applicable to suicide notes of Lithuania. Yet, there were many differences between the Lithuanian and American notes.

As shown in Table 2, all clusters with the exception of Rejection-Aggression were significantly different, all more evident in the Lithuanian notes. The Chi-square results were as follows: UP ($CHI^2 = 21.18$, $df = 6$, $p = 0.002$), CC ($CHI^2 = 21.26$, $df = 3$, $p < 0.001$), IE ($CHI^2 = 10.17$, $df = 3$, $p = 0.017$), IA ($CHI^2 = 18.95$, $df = 3$, $p < 0.001$), Ego ($CHI^2 = 14.70$, $df = 3$, $p = 0.002$), IR ($CHI^2 = 13.57$, $df = 6$, $p = 0.035$), RA ($CHI^2 = 9.60$, $df = 8$, $p = 0.294$), and IEG ($CHI^2 = 20.13$, $df = 3$, $p < 0.001$).

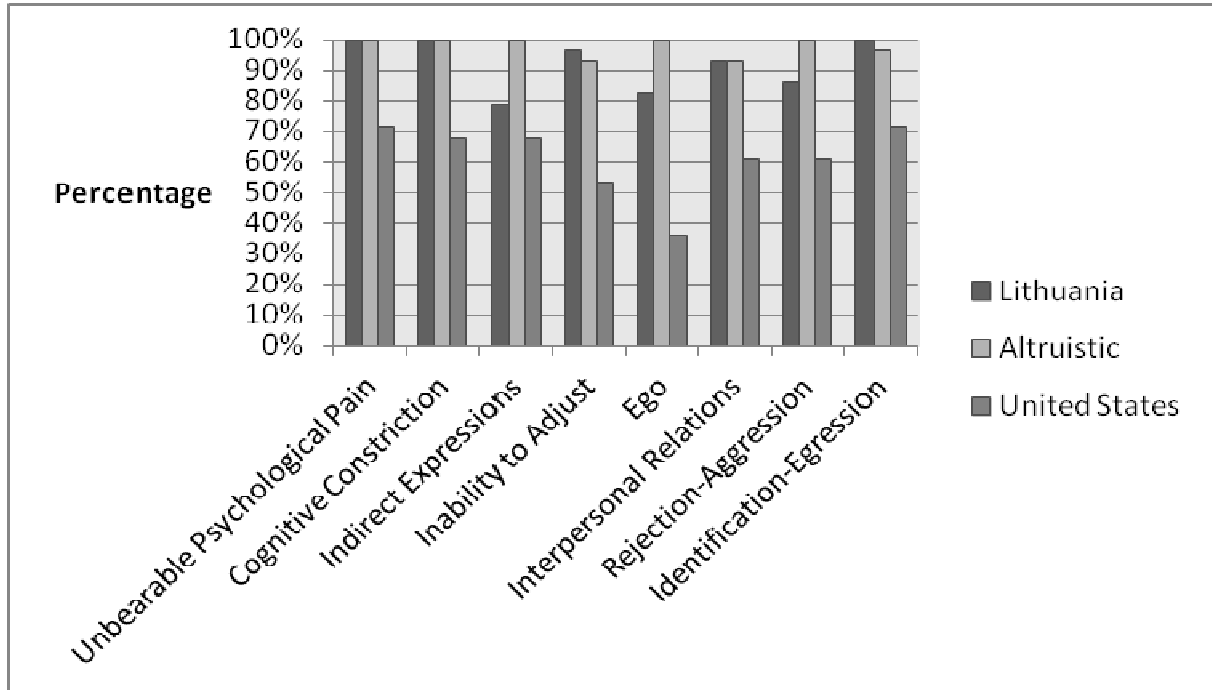
When one examines protocol sentences in each cluster, all but 11 sentences were statistically significant (see Table 2). For all significantly different protocol sentences, the sentences were more frequently cited in the Lithuanian notes. It is interesting to also note the most and least frequent protocol sentences for both samples. The most frequent in the Lithuanian notes was suicide as relief

(No. 1) and suicide as escape (No. 35), being observed in 100% of the notes. Similar to the Lithuanian notes, the most frequent protocol sentence for the U.S. notes was emotional states in suicidal trauma (No. 3), which was also within the Unbearable Psychological Pain cluster, and suicide as escape (No. 35), being observed in 67.9% and 64.3%, respectively. For both samples, the least cited protocol sentence was murderous impulse (No. 30) with this sentence observed in only 7.1% of both samples. The second least frequent sentence for the Lithuanian notes was ambivalent feelings towards a person (No. 28), being observed in only 17.9% of the notes. For the U.S. notes, the least frequent sentence was regressive, intimate relationships (No. 24), which was observed in only 14.3% of the sample.

Discussion

The findings provide further support for the multidimensional model proposed by Leenaars (1996, 2004, 2013). Once again, there is considerable evidence of both intrapsychic and interpersonal psychological correlates of suicide. This is as true in Lithuania as the United States sample. Similar to previous cross-cultural

Figure 2. Distribution of cluster themes evident in the suicide notes from Lithuania, martyrs and U.S.



studies, by virtue of our human quality, people have a number of important psychological characteristics in common. Pain is pain. Mental constriction is mental constriction. Psychopathology is psychopathology. The suicidal mind is the suicidal mind, whether in Lithuania or the United States. However, there is a striking observation, best described as extremism, in Lithuania. Thus, despite the value of looking at common factors, it is useful to group suicides under a cultural rubric. Of course, Lithuanians, Indians, Americans, Russians, Australians and so on die by suicide and it is useful to empirically examine such. The differences observed merit some comment, although, of course, further study is needed. This will be an aim of study 2.

As Gailienė (2004) strongly called for, further study of suicide in Lithuania is needed, including with suicide notes. We need to understand the high risk in this country, and by implication, in similar high-risk countries. Our findings described here, in fact, ought to be treated with caution. The sample size is small when compared to other countries studied. Yet, the question remains, why the extremes?

Study 2

Not only Lithuania, but also, other cultures have high rates of suicide, such as many Indigenous groups (Leenaars, 2005). One factor associated to high rates has been extreme traumatisation, such as occurred in Indigenous groups around the world (WHO, 2002). This may be true in Lithuania (Gailienė, 2005). The pain in this country is deep in the psyche. Leenaars (2005, 2013) has suggested that one may be

able to understand high rates of suicide by looking at trauma (e.g., among the military). The history of 20th century Europe, with its Nazi and communist regimes, is marked with repression, persecution, and human suffering (Gailienė, 2005). Millions of people were killed and millions of lives were affected. It only became possible to investigate the consequences of the two totalitarian regimes after they had collapsed. In this study, we examine whether long-lasting traumatisation may explain not only the epidemic of suicide in Lithuania, but also some of the meaning behind these events. How can we study this phenomenon?

Of course, what extreme traumatisation is, can be debated. Over a century ago, Emile Durkheim (1951/1897), published in his book, *Suicide: A study in sociology*, a typology of suicide that included “altruistic suicide”. Altruistic suicide refers to the person who is too integrated in his/her culture and sees their death as a duty or honor. This may include suicide terrorists, but also martyrs or war heroes (soldiers). There is little study on altruistic suicide; however, Leenaars, Park, et al. (2010) examined 33 letters of Korean self-immolators (martyrs), compared to 33 suicide notes of a matched sample of more common (American) suicides. An analysis of intrapsychic factors (suicide as unbearable pain, psychopathology) and interpersonal factors (suicide as murderous impulses, need to escape), as outlined in Leenaars’ theory, revealed that, although one can use the same psychological characteristics or dynamics to understand the deaths, the state of mind of martyrs is more extreme, such that the pain is

reported to be even more unbearable. Yet, there are differences, such as there was no ambivalence in the altruistic notes. It was concluded that intrapsychic and interpersonal characteristics are central in understanding altruistic suicide, probably equal to community or societal factors – see WHO’s ecological model (WHO, 2002). With the current study, what is obvious is that the findings of the altruistic suicides were strikingly similar to the Lithuanian notes. Thus, we examined the three groups together: Lithuanian, martyrs, and American (control).

Method

Subsequent to the first study, we pooled the data from study 1 and the martyrs’ study. The martyrs’ notes (n=33) were randomly reduced to match the sample of the available Lithuanian notes (n=28). The problem in the area of the study of martyrs is obtaining the very data themselves. There are problems in sampling, generalizability, etc. The suicide notes and other personal documents used in the Leenaars, Park, et al. (2010) study of martyr letters come from a variety of sources, including leaflets, newspapers, magazines and secondary publications. Thirty-three Korean self-immolators left behind the letters or notes. Many of the last letters left behind by Korean self-immolators came from an underground publication, *Everlasting Lives* (Sal ‘Aseo Ma’nra Rina’a), compiled by the Ad Hoc Committee for the Preparation of a Memorial Service for the Nation’s Martyrs and Victims of Democratization Movement (Leenaars, Park, et al., 2010). The notes from the Koreans were matched as well as possible, given the data set. The mean age of the martyr (or Altruistic) notes was 26.48; the age range was 20 to 58. Thus, there were notable age differences between the three samples in this study. Thus, greater caution is needed; yet, it is the only martyr sample available to date.

Results

Similar to previous studies, there was substantial evidence for the presence of the protocol sentences and clusters in all three samples of suicide notes (see Figure 2). Yet, there were many differences, especially when comparing Lithuania and the altruistic notes to the U.S. notes. As shown in Table 3, all clusters were significantly different when comparing the notes from Lithuania, the U.S. and the Altruistics. The Chi-Square results were as follows: UP ($\text{CHI}^2 = 35.77$, $\text{df} = 12$, $p < 0.001$), CC ($\text{CHI}^2 = 35.28$, $\text{df} = 6$, $p < 0.001$), IE ($\text{CHI}^2 = 38.10$, $\text{df} = 6$, $p < 0.001$), IA ($\text{CHI}^2 = 35.51$, $\text{df} = 6$, $p < 0.001$), Ego ($\text{CHI}^2 = 54.23$, $\text{df} = 6$, $p < 0.001$), IR ($\text{CHI}^2 = 58.40$, $\text{df} = 12$, $p < 0.001$), RA ($\text{CHI}^2 = 46.17$, $\text{df} = 16$, $p < 0.001$), IEG ($\text{CHI}^2 = 35.92$, $\text{df} = 6$, $p < 0.001$). In order to ascertain which groups of notes were significantly different from one another, two-

way Chi-Squares were run. When comparing the Lithuanian and U.S. notes, all clusters with the exception of Rejection-Aggression were statistically significant, all more evident in the Lithuanian notes. The Chi-Square results were as follows: UP ($\text{CHI}^2 = 21.18$, $\text{df} = 6$, $p = 0.002$), CC ($\text{CHI}^2 = 21.26$, $\text{df} = 3$, $p < 0.001$), IE ($\text{CHI}^2 = 10.17$, $\text{df} = 3$, $p = 0.017$), IA ($\text{CHI}^2 = 18.95$, $\text{df} = 3$, $p < 0.001$), Ego ($\text{CHI}^2 = 14.70$, $\text{df} = 3$, $p = 0.002$), IR ($\text{CHI}^2 = 13.57$, $\text{df} = 6$, $p = 0.035$), RA ($\text{CHI}^2 = 9.60$, $\text{df} = 8$, $p = 0.294$), IEG ($\text{CHI}^2 = 20.13$, $\text{df} = 3$, $p < 0.001$). When comparing the Lithuanian and Altruistic notes, the notes were not statistically significant for the UP, CC, IA, and IEG clusters. The notes were statistically different for the following clusters: IE ($\text{CHI}^2 = 16.71$, $\text{df} = 3$, $p = 0.001$), IR ($\text{CHI}^2 = 26.79$, $\text{df} = 6$, $p < 0.001$), and RA ($\text{CHI}^2 = 22.64$, $\text{df} = 8$, $p = 0.004$) more evident in the Altruistic notes; Ego ($\text{CHI}^2 = 24.92$, $\text{df} = 3$, $p < 0.001$) more evident in the Lithuanian notes. When comparing the U.S. to the Altruistic notes, all clusters were statistically significant, all more evident in the Altruistic notes. The Chi-Square results were as follows: UP ($\text{CHI}^2 = 22.34$, $\text{df} = 6$, $p = 0.001$), CC ($\text{CHI}^2 = 24.95$, $\text{df} = 3$, $p < 0.001$), IE ($\text{CHI}^2 = 27.04$, $\text{df} = 3$, $p < 0.001$), IA ($\text{CHI}^2 = 27.72$, $\text{df} = 3$, $p < 0.001$), Ego ($\text{CHI}^2 = 33.62$, $\text{df} = 3$, $p < 0.001$), IR ($\text{CHI}^2 = 38.62$, $\text{df} = 5$, $p < 0.001$), RA ($\text{CHI}^2 = 36.25$, $\text{df} = 7$, $p < 0.001$), IEG ($\text{CHI}^2 = 26.96$, $\text{df} = 3$, $p < 0.001$).

When one examines the protocol sentences in each cluster, all but four sentences were statistically significant (see Table 3). In order to ascertain which groups of notes were significantly different from one another, two-way Chi-Squares were run. When comparing the Lithuanian and U.S. notes, all sentences with the exception of sentences 10, 22, 23, 24, 27, 28, 29, 30, 31, and 32 were statistically significant (at a p value of 0.05 or less), all more evident in the Lithuanian notes. Similarly, when comparing the Altruistic and U.S. notes, all sentences with the exception of sentences 10, 16, 18, 27, 29 were statistically significant, all more evident in the Altruistic notes. The comparison of the Altruistic and Lithuanian notes was somewhat different with significant difference between sentences 10, 16, 26, and 28, which were more evident in the Lithuanian notes, and sentences 11, 19, 22, 23, 24, 25, 30, 31, 32, which were more evident in the Altruistic notes. It is interesting also to note the most and least frequent protocol sentences for both samples. The most frequent protocol sentences for the Lithuanian notes were suicide as relief (No. 1) and suicide as escape (No. 35), being observed in 100% of the notes. One of the most frequent sentences for the Altruistic notes was also sentence 1, as well as murderous impulse (No. 30), calculation of negative effect (No. 31), revenge towards someone else (No. 32), with 100% of the notes displaying these sentences. The most

frequent sentence for the U.S. notes was emotional states in suicidal trauma (No. 3). For both the Lithuanian and U.S. notes, the least cited sentence was murderous impulse (No. 30) at 7.1%. The differences between the Lithuanian (and American) notes and the Altruistic last letters should not be eschewed. The extreme observation (also significant at $p > .001$) on murderous impulses, for example, is a most important difference between not only the Lithuanian, but also the American notes, from the martyrs' notes. Maybe some suicidal martyrs intend not only self-murder, but are also bent on homicide(s)-suicide (Leenaars, 2010). It was also found that the least frequent (0%) sentence for the Altruistic notes was ambivalent feelings toward a person or ideal (No. 28).

Discussion

Although there are, of course, alternative possible explanations, we are struck by the similarity of the findings in the Lithuanian notes and the martyrs' notes. The question posed is, why? (And another question, why are some heavily traumatised suicidal people intent on murder and others, only on self-destruction?) Gailienė and Kazlauskas (2005) showed that severe and prolonged exposure to trauma has long-term effects that last decades after the trauma occurs. Many people in Lithuania suffered directly from political repression, while others lived for decades under communist regime. The effect of long-term historical trauma was hopelessness, despair, and a self-destructive adjustment style – such as alcohol consumption and suicidal behaviour. Our study showed that this might well be expressed in the narratives of the people who died by suicide, such as their suicide notes.

The findings provide further support for the multidimensional model proposed. There is considerable evidence of both intrapsychic and interpersonal correlates of suicide, whether altruistic or otherwise. This is true with Lithuania and martyrs. Similar to previous studies, there seem to be commonalities among suicides. By virtue of our human quality, people who are about to kill themselves have a number of important psychological characteristics in common. The suicidal mind is the suicidal mind; yet, significant differences emerged, not whether present or absent, but the intensity of the state. There can be extremism in the mind!

There are striking qualitative differences. The state of mind of the heavily traumatised suicidal person is extreme in such characteristics as pain, mental constriction, depression, and rage, to name a few. This difference is our most important finding. It is, we believe, useful to think of the suicide beyond the individual, and to place it within the socio-

political context. This is consistent not only with Durkheim's view, but also the WHO's ecological model (2002). We have to understand the community's and society's very meaning of the act. Not all suicides are the same. We should not assume a suicide is a suicide; Lithuanian suicides differ significantly.

A key question is why martyrdom emerged in South Korea (and elsewhere). Is it the same or different than issues in Lithuania? Was there extreme traumatisation in both cultures? On a community and societal level, the principal element common in Lithuania and Korea, with respect to the act of suicide, is that these acts grew out of intense political turbulence and widespread traumatisation, at least as one reads the last letters. Suicide, in Durkheim's sense, became a best solution. A factor linking many of these suicides is the combination of the need to respond to political conditions in one's country, and to communicate a strong message and example to others of the violence and it appears that suicide is only one, albeit especially powerful, form of response. It is an everlasting aftershock. The suicides' last letters in both countries are written as the penultimate spectacle of their pain. Of course, our findings do not negate that these two groups of people, Korean martyrs and Lithuanian suicides, are very different. Yet, they are the same in one aspect: extremism. Yet, they are also different from the more common, say American suicide; different in the sense that they show an extreme suicidal mind. The single most important finding is that people who died by suicide after extreme traumatisation, such as martyrs and Lithuanians, are more perturbed and suffering from intolerable pain or anguish; more mentally constricted on one and only one trauma; more unconscious of their individual dynamics; more emotionally disturbed (especially depressed or suffering from post traumatic stress disorder) about an external 'object', such as the government or a global enemy, the U.S. or Soviet Union; and more identifying with an ideal, seeing only suicide, as the solution. It is all, helpless!

Freud (1917/1974; 1920/1974; 1921/1974) hypothesized that intense identification with a lost or rejecting person or, as Zilboorg (1936) showed, with any lost ideal (e.g., employment, freedom) is crucial in understanding the suicidal person. The definition of identification is attachment (bond), attachment based upon an important emotional tie with another person(s) (Freud, 1920/1974) or any ideal, such as one's institutions. If this emotional need is not met, the (vulnerable) suicidal person experiences a deep pain (discomfort). This is especially so for an extremely traumatised person. There is an intense desperation and worthlessness, and the person wants to escape and to be gone from a world with no ideal,

hope, or help. The anguish must be stopped. The suicidal person wants to exit, escape, be elsewhere, and not be – anything but the abyss on earth. Suicide is then the only solution. The (extremely traumatised) person plunges into the death, whether it is for freedom, martyrdom, whatever. This was almost always written in their last letters.

Finally, it should be obvious that our sample of martyr letters is probably not representative of all altruistic self-immolators in Korea, let alone beyond Korea. This may be equally true for our extreme Lithuanian notes. Yet, these are the samples available for study. There are further sampling limitations in the sample size. Suicide notes are only one source of information and our study should be augmented by other sources of data; yet, further study, such as psychological autopsies, will likely not occur in Lithuania today (or in Korea for that matter). Not unlike the whole area of suicidology, we are left with

the limited sources of data available. We can speculate, we think, about other extremism and suicide, but with great caution. At best our study is exploratory, but also, we believe, a fascinating look into the mind of the Lithuanian person who died by suicide.

“Long times”, as Indigenous people would say, are needed for healing. Perhaps it describes the resilience of the people of Lithuania, as by right, they should have all fallen by the wayside. The long-lasting effects of political oppression should have terminated the people. They have survived some of the worst traumatisation imaginable. No wonder so may die by suicide. According to our categorisation, many Lithuanians’ who died by suicide suffered from (post-traumatic) traumatisation and weakened ego. This is true for many extremely traumatised people, like among the U.S. armed forces after the Iraq and Afghanistan wars (Leenaars, 2013). Suicide is escape!

Table 4. A Sample of Protocol Sentences Organized in Clusters on Intrapsychic and Interpersonal Aspects

Intrapsychic

I Unbearable Psychological Pain

- 1) Suicide has adjustive value and is functional because it stops painful tension and provides relief from intolerable psychological pain.
- 3) In the suicidal drama, certain emotional states are present, including pitiful forlornness, emotional deprivation, distress and/or grief.

II Cognitive Constriction

- 9) There is poverty of thought, exhibited by focusing only on permutations and combinations of grief and grief-provoking topics.

III Indirect Expressions

- 12) Unconscious dynamics can be concluded. There are likely more reasons to the suicide than the person is consciously aware.

IV Inability to Adjust

- 15) S exhibits a serious disorder in adjustment.
 - a) S’s reports are consistent with a manic-depressive disorder such as the down-phase; e.g., all-embracing negative statements, severe mood disturbances causing marked impairment.
 - b) S’s reports are consistent with schizophrenia; e.g., delusional thought, paranoid ideation.
 - c) S’s reports are consistent with anxiety disorder (such as obsessive-compulsive, post traumatic stress); e.g., feeling of losing control; recurrent and persistent thoughts, impulses or images.
 - d) S’s reports are consistent with antisocial personality (or conduct) disorder; e.g., deceitfulness, conning others.
 - e) S’s reports are consistent with borderline personality; e.g., frantic efforts to avoid real or imagined abandonment, unstable relationships.
 - f) S’s reports are consistent with depression; e.g., depressed mood, diminished interest, insomnia.
 - g) S’s reports are consistent with a disorder (or dysfunction) not otherwise specified. S is so paralyzed by pain that life, future, etc. is colorless and unattractive.

V Ego

- 16) There is a relative weakness in S’s capacity for developing constructive tendencies (e.g., attachment, love).

Interpersonal

VI Interpersonal Relations

- 20) S reports being weakened and/or defeated by unresolved problems in the interpersonal field (or some other ideal such as health, perfection).
- 23) A positive development in the disturbed relationship was seen as the only possible way to go on living, but such development was seen as not forthcoming.

VII Rejection-Aggression

- 28) S feels quite ambivalent, i.e., both affectionate and hostile towards the same (lost or rejecting) person.
- 30) S turns upon the self, murderous impulses that had previously been directed against someone else.
- 31) Although maybe not reported directly, S may have calculated the self-destructiveness to have a negative effect on someone else (e.g., a lost or rejecting person).

VIII Identification-Egression

- 35) S wants to egress (i.e., to escape, to depart, to flee, to be gone), to relieve the unbearable psychological pain.

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Original Research

The need for and barriers to professional help – a qualitative study of the bereaved in Sámi areas

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Abstract: In order to secure appropriate follow-up for the bereaved after traumatic death among indigenous groups in Norway, this study aims to acquire specific and local knowledge concerning their need for help and to examine whether they do in fact seek out and receive help from the healthcare system when needed. This paper is based on the analysis of 30 in-depth interviews with Sámi bereaved who had lost a close family member to suicide, murder, accident or sudden infant death, and it rests on a hermeneutic phenomenological approach. The findings indicate that most of the bereaved from Sámi areas were strongly affected by the traumatic death of a person close to them, but that they were met with barriers preventing the psychosocial follow-up that they needed. These barriers are discussed in relation to: a) the failure of traditional Sámi norms and support systems, b) shortcomings in majority (Norwegian) support systems, and c) knowledge and integration of new standards. Finally, the requirements for an optimal support service are outlined according to the needs of indigenous bereaved. The knowledge gained through the present study may be comparable and transferrable to other indigenous and minority groups.

Keywords: traumatic deaths, bereaved, indigenous Sámi, cultural competence, professional help

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Introduction

This paper elaborates on previous research to explore the need for and barriers to professional help after traumatic death in an indigenous context. From a minority perspective, the knowledge gained through the present study may be comparable and transferrable to other indigenous and minority groups. The data for this paper are taken from the North Norwegian Bereavement Study and it replicates a previous research project that was conducted on the main population of Norway from 1998-2003 (Dyregrov, 2002; 2003-2004; Dyregrov, Nordanger, & Dyregrov, 2003).

Traumatic bereavement

Previous research in the majority Norwegian context and many other Western societies has shown that those bereaved after 'unnatural' or 'violent' deaths (e.g., suicide, murder, accident, child deaths) exhibit different and more complex problems than those observed following a 'natural' death (Dyregrov et al., 2003; Jordan & McIntosh, 2011; Li, Precht, Mortensen, & Olsen, 2003). Studies report high levels of psychological distress, somatic symptoms, anxiety, insomnia, social dysfunction and severe depression; in the long-term, these are phenomena that could lead to a serious deterioration in the quality of life (Qin, Agerbo, & Mortensen, 2002). It seems, therefore, important to draw attention to sudden and traumatic deaths as a powerful risk factor for post-traumatic stress disorder (PTSD) and the subsequent development of complicated grief (CG) (Brent, Melhem, Donohoe, & Walker, 2009; De Leo, Cimitan, Dyregrov, Grad, & Adriessen, 2013; Mitchell, Kim, Prigerson, & Mortimer-Stephens (2004). The factors affecting the high prevalence of CG following violent death seem to be a lack of preparedness, difficulty in making sense of the death, a high level of negative appraisal about oneself and others, and various social stressors, such as exposure to the mass media, social stigma and legal procedures. The comorbidity of PTSD is particular considered to contribute to the development of CG (Nakajima, Ito, Akemi Shirai, & Konishi, 2012). Its increased impact is explained by the suddenness and unexpectedness of the death and the fact that the kind of death is beyond the ordinary, whereby the close bereaved lose control. In addition, sudden, unexpected and violent loss badly shake the basic beliefs, certainties and self-confidence of the close bereaved, often leading them to existential crises. Common patterns of thought and action (norms) may not work, and the brutal disruption of

the personal world puts a strain on the individual's ability to cope with what happened and to adjust to it mentally and emotionally (Dyregrov, Plyhn, & Dieserud, 2011; Janoff-Bulman, 1992). Finally, such events very often create long-lasting emotional, cognitive and behavioural challenges that will certainly require help and support (De Leo et al., 2013; Dyregrov, 2002; Dyregrov & Dyregrov, 2008; Wilson & Clark, 2005).

Although many bereaved receive extensive support from family, friends, work colleagues and neighbours, etc., especially in the first weeks following a loss, it is important to acknowledge that, wherever a network exists, its members will often display ineptitude as to how to encounter people in crisis. There is a lack of appropriate understanding concerning the time perspective in grief as well as how to deal with intrusive images of the dead or the death scene. Also, problems of a personal character and thoughts of guilt or shame often explain why social network support may be insufficient or else might be experienced as being unhelpful or even harmful (and thus contradictory to its purpose) (Brabant, Forsyth, & McFarlain, 1995; Dyregrov & Dyregrov, 2008; Wertheimer, 1999). Following from this, many traumatized bereaved report a need for professional assistance as a supplement to social network support (Dyregrov, 2002; Provini, Everett, & Pfeffer, 2000).

Help by professionals from a user perspective

Help by 'professionals' refers to help in broad terms, such as from local religious leaders, the police, doctors, psychologists, psychiatric nurses, funeral parlour agents, social workers and family welfare services. Professional help can include interventions, such as the local religious leader and police officer who communicate the news of the death, support counselling, medical or practical assistance or specific trauma-therapeutic treatment.

In a study of Norwegian parents who had lost young children to suicide, accident or SIDS during the period 1997-1998, the parents asked for early help, and help from trained personnel that was offered to them. Moreover, they asked for information about the event and reactions that might arise, the possibility to meet with others who had experienced the same or a similar situation, more help for surviving children, and help over time. Besides asking for psychological and medical help, they also emphasized the importance of practical and financial help and help with legal issues. However, frequently these groups of bereaved were not satisfied with the provisions made by community helpers. Despite the claim that Norway is a welfare state which takes care of citizens' health and which

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listens to its users' needs, the reason for the mismatch between needs and offers of help was judged to be due to a lack of evidence of what users ask for (Dyregrov, 2002), differing strategies for follow-up (Dyregrov, 2004a) and - probably - the fact that the traumatized bereaved represent a fairly new field. However, the crisis/trauma field has developed gradually over the years, and now yields increasingly better service to the bereaved after a traumatic death. Following the terror of July 22nd 2011 in Norway, where 77 people were shot dead in a massacre on an island and in a government building, the Health Directorate instructed the municipalities to provide outreach help, including most of what the traumatized bereaved have been asking for many years, to the closest family (Report IS-1984E). Furthermore, in recent years in Norway the requirement to listen to users (here: the bereaved) has been increasingly emphasized in public documents and guidelines regarding public healthcare. Under the Norwegian National Healthcare Plan 2011-2015, user involvement is defined by placing a strong emphasis on user needs, "in particular when the user uses public services, especially in health, social work and social security" (National Healthcare Plan (2011–2015)).

Sámi areas

In Norway, there are several Sámi areas with a multi-ethnic population with both indigenous Sámi, majority Norwegian and minority Kven (descendants of Finnish-speaking immigrants who emigrated to Northern Norway in the 18th and 19th centuries). The Sámi and Kven have their own language, history and culture, with their own traditions and norms that, in many respects, differ from the majority Norwegian culture. In these Sámi areas, the population traditionally included - and in many cases still consists of - a significant proportion of Sámi, and Sámi culture has characterized the inhabitants of different ways regardless of ethnicity. In line with indigenous people and minorities in other parts of the world, the Sámi and Kven have a long history of colonization, forced assimilation, stigmatization and discrimination (Minde, 2005; Hansen, Melhus, Høgmo & Lund, 2008). Today, these different ethnic groups have almost equal socio-economic status and a similar standard of living as the majority Norwegians. Furthermore, a high prevalence of sudden and unexpected death, especially suicides and accidents, is documented both among indigenous Sámi and among the Norwegian majority population in Northern Norway (Silviken, 2009; Kvåle Bakke, & Wisborg, 2006). Although the Norwegian authorities have set a target for the population in a Sámi context to have equal and equitable access to health and social services as that given to the general Norwegian

population (Health and Social Development, Plan of Action, 2001), there may be a danger that such help measures are adapted to the majority culture and that they may collide with minority norms.

The ability to be self-reliant and master the challenges that one encounters in nature and in life in general, *leš bierget* ('to be salvaged'), are values that are emphasized greatly in many Sámi communities. From ancient times, a lack of mental strength and autonomy has been described as a sign of weakness while avoiding asking for help from family and friends was perceived as a sign of mental strength (Bongo, 2012). As with most cultures, Sámi culture is changing, and it is important to develop understanding about how traditional norms and values still characterize the Sámi community and examine whether and how traditional rituals and/or coping strategies are used by the bereaved today.

In order to implement appropriate follow-up for the bereaved after a traumatic death in Sámi areas, the aim of the study is to explore the bereaved's need for professional help and what they consider to be barriers to their perceived need for help.

Method

The project was made in collaboration with the Centre for Sámi Health Research, the Norwegian Institute of Public Health, the Regional Resource Centre for Violence, Traumatic Stress and Suicide Prevention of Northern Norway, and the Sámi National Centre for Mental Health. It utilizes data from two samples: a population of individuals bereaved by sudden death and a sample of local communities providing help for the bereaved. Both self-administered questionnaires and in-depth interviews were used for the bereaved whereas the communities filled in questionnaires. This paper deals with the qualitative data of the bereaved and rests on a hermeneutic phenomenological approach (Kvale, 1996; Smith, Flowers, & Larkin, 2009). This means that the findings in the paper are presented as experienced and reported by the informants and, thereafter, are interpreted and discussed by the researchers.

Procedure

Chief municipal medical officers and crisis teams in all the local communities (n=88) of Norway were asked to identify any bereaved who satisfied the inclusion criteria of the project. In addition, the peer organizations for suicide (LEVE) and sudden child deaths (LUB) were invited to recruit members from their member lists. In the qualitative study, the inclusion criteria required that the informants: 1) be 18 years or older, 2) have lost a close person through unnatural death (accidents, sudden child death,

suicide or murder), 3) have lost that person a minimum of six months previously (up to a maximum of seven years), and 4) be resident in the selected Sámi areas. The different Sámi areas were preselected to cover the variation in the Sámi population of Norway (i.e., the Northern Sámi, Lule Sámi and Southern Sámi areas).

Sample

A total of 244 bereaved consented to participate in the main study and 204 (84%) volunteered to be interviewed in-depth. Based on the principle of breadth and variation as applied to the inclusion criteria, a theoretical interview sample of 34 bereaved was drawn from those who had accepted to be interviewed. Thus, those who were included for this paper lived in different Sámi areas, represented both genders, had high- and low-level educational backgrounds, and represented different age groups, different relationships with those lost and different lengths of time since their losses. Three of the invited participants did not participate due to different practical reasons at the time of the interview, and one transcription was partly damaged.

Thus, the sample for analysis consisted of 30 bereaved: 20 women and 10 men. The majority were between 35 and 55 years' old (mean age=46). Upon being asked, the bereaved classified themselves as Norwegians (n=10), indigenous Sámi (n=10), Norwegian/Sámi (8) or minority Kven (2). They lived mainly in rural areas, both coastal and inland, and in one urban area among the different Sámi areas in Norway. Eleven percent of the bereaved were educated to primary school level, 31% to secondary school level and 58% were educated to college or university level.

The majority of the informants had lost a child (18) whereas the others had lost a sibling (5), a parent (3) or a nephew/niece (4). Some of the deceased were represented by just one participant, and others by, e.g., both parents, two siblings or a parent and an aunt/uncle. The informants represented 19 deaths, due to suicide (8), accident (8), sudden child death (2) and homicide (1). The mean time since loss was three years and ranged between 1.5 years and 7 years.

Data collection and analysis

In order to explore different aspects the bereaved's need for help as experienced by the bereaved themselves, qualitative in-depth interviews were chosen as most appropriate. The method allowed the bereaved to explain in detail their experiences following the sudden loss of a loved one as seen from their own perspective in their own context. Data were collected from 2010-2011, and 30 interviews were conducted and analysed.

An interview guide based on the first study (Dyregrov, 2003) was further developed and adapted to the Sámi and northern Norwegian culture by the project group. In addition, based on a pilot interview, the guide was modified to include, e.g., questions about the use of alternative and traditional medicine and about their religiosity. The application of a thematic guide ensured that these subjects were addressed systematically in relation to the research focus: 1) What was their process of bereavement and for coping in their local context? 2) What help did they need, both shortly after the loss and over the long-term? 3) What kind of help did they receive from the public assistance scheme, both shortly after the loss and over the long-term? 4) What kind of support did they receive from their natural social networks? 5) What was most helpful in adjusting to such a dramatic loss? This paper will mainly analyse and describe the data from theme two, while touching upon findings from themes three and five. During the interviews, the questions were posed in as open a manner as possible and follow-up questions were considered to be important in order to facilitate any aspects that had not been thought of by the researchers.

Two researchers with clinical experience and knowledge of bereavement and Sámi culture (an anthropologist and a psychologist) conducted the interviews. As neither spoke Sámi fluently, the Sámi-speaking participants were offered an interpreter before the interviews. However, all refused the offer as they considered themselves bilingual and preferred to speak Norwegian instead of having a third person in the setting. Most of the interviews took place in the homes of the bereaved (24) and the rest took place in local public offices (6), based on the preferences of the informants. The mean time for each interview was two hours (range=1-4 h), although the researcher was present for longer for a debriefing conversation after the interview. Most interviews were completed coherently, except for one that was conducted in three parts as requested by the participant. In addition, three of the interviewees phoned after a few days with additional information that was recorded and added to the interviews.

All the interviews were audio-taped and transcribed verbatim by two trained transcribers, amounting to 845 pages (12 pt., single-spaced). To secure the anonymity of the participants, the transcripts were de-identified by giving pseudonyms to all the persons in the interviews. In addition, numbers coded the names of locations. Both the pseudonyms and the numbers were matched with the real information in a locked in/secured list.

The transcripts were analysed according to Kvale's (1996) stepwise analysis for qualitative data. The method begins with reading and re-reading so as

to acquire an overall impression and overview of the data. Thereafter, the opinions expressed in each interview dealing with the research focus are identified and condensed in order to select: a) basic units of meaning, b) categories, and c) the main themes in relation to the objectives of the study. After specifying the main themes, the analysed material was: d) interpreted in relation to relevant theory and previous research.

Ethical and methodological considerations

Approval to conduct the project was given by the Regional Research Ethics Committee of Northern Norway, and all the interviewees participated based on informed consent and a set of ethical considerations (Dyregrov, 2004b).

In line with the phenomenological and hermeneutical perspective of the study, we acknowledge the researchers' foreknowledge of the subject matter as important to the analysis and results (Kvale 1996; Smith et al., 2009). Therefore, to ensure that the analysis was not confined to one perspective, the interdisciplinary research group (a psychologist, an anthropologist and a sociologist) assessed, discussed and re-assessed the various themes and interpretations. In addition, the socio-historical knowledge of the Sámi areas was attended to and integrated into the findings by those in the team who possessed this knowledge.

Findings

As a context to the need for and barriers to professional help, the findings will briefly summarize the professional help received as reported by the bereaved. After presenting the experiences of the bereaved concerning the professional help that they had been offered, we describe their experiences of their actual need for help before presenting what barriers to help they perceived. Each of the superordinate themes regarding their needs and barriers will be described thoroughly and quotes are used in an anonymous manner to substantiate each of the superordinate themes.

Received help

In the questionnaires in another part of the study, the bereaved characterized the help variously as "very/fairly helpful" (about 1/3), "helpful to a certain degree" (about 1/3) or "not very helpful" (about 1/3). The main impression from the interviews was that professional help had been offered in an unsystematic way, and therefore was distributed differently for the bereaved and with varying content. It was difficult to determine any tendency such that the most vulnerable had received the best help. Rather, to some extent coincidences seemed to characterize the help provided. In addition, the

quality of the help appeared to be dependent on personal factors and knowledge of the helpers. Whereas some had been contacted by the helpers and offered help, most of the bereaved had to ask for help or else someone from their social networks had contacted, e.g., the community crisis team or the local doctor, for them. The psychosocial help consisted of information detailing what had happened, a physical presence during the funeral or inquest, family counselling, sick leave and medical prescriptions, grief group participation and psychotherapy from a psychologist or psychiatrist.

Needs for help

Although most of the bereaved stressed that support from family and friends had been of great importance, they claimed that it was not enough. They stated that help from public support systems was needed after the traumatic death of a close person to serve other needs than could be fulfilled by a network support. Public help was considered important in order to improve quality of life and prevent illness. Concerning such needs for help, three super-ordinate themes emerged from the interview data: 1) out-reach help, 2) initial help and help over time, and 3) competent and adapted help.

Outreach help. Most of the bereaved asked for "active outreach" from relevant helpers (i.e., that the helpers should initiate contact at an early stage and offer help). In order to come in contact with helpers and receive appropriate assistance, they claimed that this approach was needed due to the fact that they were often incapable of seeking it out themselves. Because of the enormous shock created by the sudden and often violent death "nothing functioned as before" and the bereaved "totally lacked energy" to mobilize help. A woman working in the healthcare system who had lost a parent to suicide explained why people, after such atrocities, would not contact for help:

...no, that will not be done, because you do not have the capacity and energy to do it; so it is better to be contacted with a message that "We'll call next week"... and then to somehow be offered a psychologist or something.

They claimed that the helpers should not expect the bereaved to contact the help system themselves, as would be the normal procedure for regular somatic health problems. On the contrary, the helpers should lower their demands and not expect the bereaved to identify their needs for help and know where to locate adequate help after such tragedies. A sibling who lost a sister to suicide

explained why she never got the help she needed: “I was told to contact those psychologists again, whose names I did not know, and barely knew where to locate. That became too... that became too troublesome. I did not manage it then.” A parent who had lost a teenager to suicide reacted very negatively to a well-meant offer from the crisis team:

When the crisis team tells you: “If you need something, just call!... At that time, I was not able to look-up a phone number and call... There are some words that support systems should be banned from saying... they should instead be at the door.

In addition, as was stressed by one bereaved who identified herself as a Sámi: “The Sámi people are very protective when it comes to feelings and such things. However, like other people in the world, they will also need help. However, they are too proud to ask for it.” A parent who lost a daughter in an accident explained why it might be harder to initiate contact with support services (especially psychologists) in a Sámi context than for ethnic Norwegians:

It's quite obvious that it is harder, in a Sámi context, to possibly consult a psychologist, right? Or to seek help if something happened - it's much harder in the Sámi areas than it is in the Norwegian communities. Why? That's because of Christianity, culture... because the Sámi people... have their pride... and the pride should not be cracked, one should instead suffer.

Because of traditional close ties within families and among relatives in Sámi areas, many of the bereaved had experienced that the extended family, which usually was there when bad things happened, were so affected by the loss that they lost their supporting capacity. Another reason for reduced social support resources was the fact that many of the deceased in our sample had died by suicide, which, especially for older family members, was considered to be sinful. A father who lost an adolescent to suicide said: “Well, the family broke. Everything and everybody that previously had been supportive was absent then. Truly, you had to fend for yourself...”

Therefore, they pledged the help system (in Norway, this would be a psychosocial crisis team/GP) “to dare to contact” the closest bereaved about their individual and familial needs for help. Through a home visit, the helpers were able to explore the functioning of these systems and offer help, and thereafter the individual members could accept or decline their help.

In order to reach every family member who would need help, it was not considered to be sufficient that the helpers should talk with only one member of the family, as he/she might turn down the offer (especially initially). Because it is easy to turn down offers of help when in shock, some bereaved emphasized the importance of leaving a business card if the bereaved turned down an initial offer of help. When the initial shock had subsided, it was their experience that they needed help after some time. A business card would also enable younger people (or their parents) to potentially access help later on without too much effort. The parents of bereaved siblings stressed the importance of outreach help repeating help offers for all the bereaved, but especially for young people who had to be “pushed a little” to accept help that often was needed.

Help initially and over time. Many of the bereaved asked for help initially when “everything had been turned upside-down”. Although they had fewer comments as to what kind of help they needed at an early stage, they knew that they needed someone “from outside” to be there (i.e., a professional who knew about their reactions, help needs and how to help, both at an individual and a familial level). Helpers should not wait until problems have become established, but rather try to prevent problems. Importantly, early contact with helpers would provide the opportunity for information and the posing of questions about the incident. Based on their negative experiences, some of the bereaved claimed that they needed someone to prevent the family system (often extending beyond the core family in Sámi areas) from breaking down by helping them relate to the new situation and facilitate open and honest communication within the extended family. In particular, this was an issue after a “sinful” suicide:

The difficult part was that one could not tell the whole story... as I remember it in earlier days, suicide was a sin, right? One would not say that it was suicide, so... it became so artificial between us when we (family and friends) met afterwards, because I could not explain what had happened and they did not get to ask about the things they had heard...

Early help should not end after a single meeting, but rather should start with a “crisis meeting” being held, preferably no later than, e.g., 14 days after the death. Afterwards, if needed, it should be followed-up by later contact. One bereaved parent appreciated one such meeting that was conducted with people from medical and psychiatric services and the extended family the day after the suicide of

the son. This meeting was connected to the memorial of the deceased.

Many of the bereaved had experienced long-lasting physical, grief and trauma reactions that had been frightening and strenuous. Those who had received help stressed the importance of stability and continuity of helpers as well as the need for help to continue over time. In addition, some pointed out that just when they thought that their situation had improved, so they would receive some new blow. Because of the experiences of ongoing and fluctuating grief processes, they stressed a need for the bereaved to have a person who would contact them and “convene control” occasionally over an extended time. A parent who lost a daughter in an accident elaborated upon the importance of having a long-term perspective in the follow-up:

Maybe it would be an idea to be called in by the family doctor after a while to be asked: “How are you doing?” right... when you have started to feel everyday life. Because it did not work well with me, I just have to admit that... it did not. I really think that when daily life starts coming, then you should be called on to check how you are doing, to alone.

Competent and adapted help. Some of the bereaved who had met with professionals called for more competent helpers who could understand their huge life-crisis and difficult grief processes. They felt that helpers should have more knowledge about the needs of the traumatized bereaved when exploring what the individual and the family might profit from. In particular, they proposed that a more integrated view of the interplay between “the body and the soul” was needed. A parent who lost a son in an accident explained that:

...when you start to feel that you are becoming... (sighs), well that... grief takes over, then the family doctor will be the first you will seek. However, when you feel that the GP does not understand I think something has to be done... the healthcare system has to change their professional perspective. In my case, it failed because he focused on the physical part, not the mental... they should be able to integrate several things they are focusing on at the same time; that is where the shoe pinches.

Both the bereaved who had received help and those who had not experienced a need for many types of help during the period following a traumatic death. In addition, they had learned that their needs for help varied with time. Therefore, they stressed the importance of not having any manualised follow-

up forced upon them but instead having it adapted to their actual problems and needs over time. Beyond counselling for communicational, psychological and medical challenges, they requested information about factual matters connected to the death and how to support children in the family. Moreover, they expressed the view that they needed help with existential issues and practical help with the organization of memorial gatherings and paperwork dealing with financial and legal matters. Some asked for advice via the Internet (e.g., how to connect with other bereaved or looking for a peer organization/grief-support group). Despite a certain resistance against psychologists, many of the bereaved asked for “psychological help or someone to talk to” and for advice concerning children and how to deal with the situation beyond the core family.

The informants had a very strong focus on the extended family, and pointed out the need to mobilize, stick together and facilitate communication within the greater family network. In order to release and optimize potential resources within the extended family, the helpers should get an overview of who they are and stimulate them to partake, even after stigmatized events (e.g., such as a suicide). As explained by one parent who had lost a daughter to suicide, a psycho-educative meeting led by professionals could mobilize and secure support from outside the core family:

I have kept on thinking that, in such a situation, those who are most important for the closest bereaved should have had the opportunity to partake in an extended group... How are you doing? How may we support you? What are your reactions to the event? Knowledge about this would have eased the situation for the closest bereaved, because I think that insecurity and ineptness underlie the difficulties of approaching bereaved populations... yes, I believe that... I think it is difficult being close... and I see for us as well, things that one should not expect to be difficult, proved hard.

Many parents were preoccupied with a focus on the well-being of their children. Parents stressed how professional helpers and the school should identify possible school-based problems and make arrangements for children and adolescents who have lost a sibling to a violent death. They told numerous stories about the difficulties involved in reaching out for them and suggested a need for low-threshold grief support for young people. This could be, e.g., an open door to the school nurse, teachers who understood how grief may influence schoolwork, or

the facilitation of the school day when disasters have struck a family. To reach both the youngest and oldest generations, some suggested campaigns and information to reduce the stigma connected to receiving help, and particularly to receiving psychological help.

Barriers to help

As indicated above, there exist barriers preventing the bereaved from receiving the necessary help after the sudden, traumatic death of a loved one. Three super-ordinate themes explain the barriers to professional help: 1) the extremeness of the experience, 2) inadequate help systems, and 3) prevailing norms.

The extremeness of the experience. Many of the bereaved elaborated in detail their extreme reactions following traumatic loss. They talked about the initial shock, the disbelief and numbness accompanied by very strong emotions, followed by sleeplessness and sick leave. Over time, a broad variety of problems arose, such as yearning and pain, self-reproach and feelings of guilt over the loss, reliving the fatal incident, irritation and anger, anxiety and vulnerability, sleep disturbances, concentration and memory problems, and physical ailments. Many explained how they felt helpless and estranged because of hitherto unknown reactions in themselves. A bereaved father explained his own frightening experiences:

You are in a bubble and you go on at full speed, you wobble away on an edge... it is like you become scared of yourself, right? It is almost as if you get obsessive thoughts or something. You try to push them away, but then they return even stronger. It is really frightening.

Several of the bereaved could not put into words what kind of help they needed or else described how they lacked the energy to contact help. Some, who had the power to ask for help, did not know where to turn to in order to elicit help, whereas others did not understand that they needed professional help until "it was too late." A sibling who had lost a brother to suicide described how the very symptoms that express the need for help become an actual barrier to seeking it out:

... At a certain time, I think I reflected that: "Ok, I must go and see a psychologist or something." I think I am going crazy... Therefore, I think that someone needs to be brought in, as you do not really recognize this for yourself.

Inadequate help systems. Whereas some had been contacted by the help services and subsequently offered help over time, most of the bereaved had not, or else help had been offered only initially. Some had been instructed to "please contact us if you need help," but had lacked the initiative to do so. Many of the bereaved perceived the expectation that the crisis stricken should seek assistance as a lack of an understanding of their extreme and vulnerable situation. Thus, they considered the absence of an outreach approach and passive helpers to be the most important barriers to adequate help.

In addition, other barriers to professional help were pointed out. One that seems to apply to many of the bereaved was rooted in the geography and demography of the majority of the Sámi areas. Because the communities consisted of large land areas with few people, the helpers would often be someone who the bereaved knew already (e.g., a neighbour, a friend, or a family member). A mixture of roles due to too tight and multiplex relations could cause the bereaved to decline help because they do not want to disclose personal reactions or vulnerabilities to their family members or end up comforting a very badly affected neighbour helper. In some communities, this barrier has been removed by the instigation of inter-municipal psychosocial follow-up.

Another barrier that was elaborated upon by the bereaved was a lack of confidence that the support system had the necessary expertise to help them following a traumatic death. They had been in contact with GPs, psychologists and psychiatric nurses, who were kind and pleasant to talk to but who could only help them up to a certain point. Moreover, the bereaved gave several examples of a failure to distinguish between normal and pathological grief and trauma reactions as compared to the diagnosis of anxiety and depression, as well as of an inability to determine how to approach the one as opposed to the other.

Finally, an important barrier to getting (more) help was the experience - either prior or after the actual death or previously - of arrogant or "power-hungry" helpers. The bereaved came up with examples ranging from ambulance personnel, priests, lawyers and health personnel, among others, whom they had met with after the death. For many of the bereaved in Sámi areas, such disrespect would revive old harassment by mainstream society and leave them with an inborn sense of inferiority. Indeed, for some it would be intolerable to be assisted by a disrespectful helper and, for some, to be helped at all. A well-educated Sámi father pointed out: "We have been harassed... I've pointed it out before. However, I will state it very briefly: We have learned that we are born inferior, we are genetically

inferior..." As a result, many expressed a strong need to be treated with genuine respect by professionals. It seemed particularly important that helpers should understand the history of Norwegian policies as well as the local practices, worldviews and beliefs of the Sámi people, so that those who had strong roots in Sámi spiritual culture or other traditions would not be ridiculed but rather taken seriously.

Prevailing norms. Three strong prevailing norms seemed to prevent the bereaved from seeking and/or using assistance after the traumatic death of someone close to them.

As reported by many of the bereaved, the prejudices, stigma and condemnation associated with getting help for psychological problems can act as a barrier to accessing help - even though they might feel that they need it. A woman who had experienced two sudden losses of close persons explained the need for an altered view regarding psychologists:

There should be [psychological] resources for each individual, and especially in a Sámi community there should be one or two persons working in a service so that you would have the possibility to ask: "May I come over and talk to you tomorrow or today? May I have a word with you today?" ...one should not think that if you go to a psychologist, then you are an idiot... but one should know of the option and where to go. Now it is very hard, very difficult to take the step over there.

The taboo of seeing a psychologist/psychiatrist appeared to have strong links to another prevailing norm, namely that of *leš bierget*. Given reality of decades of stigmatization as a minority indigenous population within Norway, the bereaved with Sámi ancestors had been socialised to the tradition of fending for themselves in every respect. Thus, a lack of mental strength and autonomy has been described as a sign of weakness from ancient times. In addition, the challenges related to geography, whereby the harsh climate in the circumpolar areas forced people to be self-reliant to master any encountered challenges up until modern infrastructure and welfare systems were secured for all areas of Norway. They had great pride in this tradition of self-sufficiency, and so would refuse any contact with mental health services unless imperative. A bereaved mother who worked within the public health system explained this norm of independence from others:

...this is the way we are all brought up by everyone: "We shall overcome, right... this is how it is and how it should be." I see it in my

job as well. One should prefer not to contact the help system, right... One should preferably fend for oneself.

A third norm linking to the former that also prevented the bereaved from getting the necessary help was that only the closest or the extended family should be let in to help following a tragedy. Strangers should not get access to the grief and vulnerability of those who were in need of help. One should not accept help "from outside." However, as experienced by the informants, help from the extended family would only infrequently deal with psychological vulnerabilities and have a short-term perspective.

Discussion

The findings indicate that many bereaved in Sámi areas are strongly affected by the traumatic death of a loved one, but that they meet with barriers preventing the psychosocial follow-up that they need. These findings will be discussed in relation to: a) the failure of traditional Sámi norms and support systems, b) shortcomings in majority (Norwegian) support systems, and c) the knowledge and integration of new standards. Finally, the requirements of an optimal support service will be outlined in line with the needs of the traumatized bereaved.

Needs for help – universal tendencies?

The literature demonstrates how sudden and dramatic deaths contribute to the particular vulnerability of the closest family members (De Leo et al., 2013). Although the sample in this study came from the Sámi areas of Norway, they reported severe problems and a need for help as previously found among majority Norwegians. As the bereaved in a former study, they asked for early, outreached, adapted and respectful help and help that continued over time (Dyregrov, 2002; Dyregrov & Dyregrov, 2008). Similar needs for assistance have been reported in other parts of the world (McMenamy, Jordan, & Mitchell, 2008; Wilson & Clark, 2005). Thus, there seems to be a tendency towards universal needs following traumatic deaths that transcend cultural diversities. Probably, the commonalities may be explained by the extremeness of such events. The shattering of common belief systems, and what we take for granted in daily life no longer apply, and the brutal upheaval involved imposes enormous demands with respect to adjusting to what has happened, at both the intellectual and emotional levels (Janoff-Bulman, 1992).

The failure of traditional Sámi norms and common support systems

In the context of our study (i.e., Sámi areas in Norway), many of the bereaved had a concept of an extended family which meant that the potentially traumatizing deaths struck far beyond the core family.

Consequently, the strong reactions manifested in the wake of traumatic deaths left such extended families without the resources usually offered to each other when such deaths happen. Even though they had been socialized to the Sámi norm *leš bierget* (Bongo, 2012), they felt that after a traumatic death they did not master the challenges themselves - the norm was violated. Standards for what one should manage within the family were violated because the traumatic death was beyond the limit of normal events and what the individual bereaved were accustomed to dealing with, alone or together with the core/extended family - "the family broke." In addition, for some of the bereaved the stigma and condemnation associated with receiving help for psychological problems or after suicide acted as a barrier to accessing help, both within and outside the family. Both close as well as more distant bereaved experienced the disappointment of not "weathering it out" - one should preferably do without the support system. Parts of their cultural meaning systems were challenged (D'Andrade, 1984). Due to this, and because help was not provided for them, some of the bereaved waited too long before they finally accessed professional help. When they finally did, some were reluctant to inform the extended family so as not to insinuate that they were not self-sufficient (and thereby risking harming their relationship with them).

Shortcomings in majority support systems

Although the bereaved in our study evinced all the signs of shock and existential crisis after their worlds had been turned upside-down, the public support system generally assumed that they would take the initiative to access help. Inherent in this practice is the expectation that a person is aware of what kind of help is available, what type of help he/she/the family needs at different times and, most of all, that the person is able to seek help. In addition, the local helper themselves may have internalized the cultural norm *leš bierget*, which can completely reinforce such expectations and subsequent practices (Silviken, Berntsen, & Dyregrov, 2014). Nonetheless, parts of the medical patient-physician "expert model" still seem to be normative as to how contact between support services and the 'patient' should be established (Måseide, 1991). The client/patient identifies a problem, contacts the support system and asks for help - the support system is not a 'provider'.

Still, whereas the 'expert model' has historically underscored medical praxis and health services, the 'cooperation model' has gradually become more integrated in Norwegian medical ideals together with the user perspective (National Healthcare Plan, 2010-2015). This recent shift implies that, in Norway, community services at large are listening more to user needs following crises and catastrophes in the community (Guidelines for psychosocial interventions in crises, accidents and disasters, 2011). Although many professionals still lack knowledge about traumatic death and its consequences, as well as how to deal with it, the field has gained increased focus and status, and especially promising is the prioritization given from the health authorities.

Knowledge and integration of new standards

Most notably after the terror at Utøya, 22nd July 2011, when 69 young people were killed, there was a shift in the psychosocial follow-up offered for the bereaved and survivors of the killings. An outreach model for follow-up was implemented, systematically fitting the needs of the bereaved based on previous Norwegian and international studies (Dyregrov, 2002; Murray, Terry, Vance, Battistutta, & Connolly, 2000; Wilson & Clark, 2005).

It seems likely that the needs and expectations of the bereaved in Sámi areas are also connected to their knowledge of the changed follow-up systems that had been practiced to different degrees around Norway, indicating that norms, knowledge and values can be replaced by new ones if the circumstances warrant it. In other words, the bereaved in the Sámi areas acted differently depending upon the special circumstances and challenges that they faced - not rigidly or stereotypically. Importantly, the potential for the bereaved to be helped by professionals and according to their needs will depend upon their capacity and opportunity for flexibility in relation to their cultural rules and norms. However, successful help will also depend upon the helpers' integration of new professional standards and knowledge as offered to the bereaved in a respectful and culturally sensitive manner. The latter is extremely important, as the history of past abuses and violations against the indigenous Sámi people has provided for a basic sense of inferiority and fear of the authorities. This may complicate the possibility of accepting help, especially from helpers whom they identify with the "perpetrators." Helpers need to understand the effect of the history of violations and the norms that have governed support processes in Sámi culture. Therefore, it will be of great importance that, when people are in utmost need and break their own norms to accept help from professionals, such help should be optimally adapted. Successful adaptation

would also contribute to fulfilling the goal of the Norwegian authorities of equalizing health and social services for the Sámi populations (Health and Social Development, Plan of Action, 2001).

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Essay
Oppression and Suicide
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Abstract: Of the four types of suicide described by Durkheim in his classic book on suicide, suicidologists have neglected fatalistic suicide, which Durkheim himself relegated to a single footnote in his book. This essay explores this neglected type of suicide. It discusses the role of oppression in suicide, ranging from the self-immolation of Tibetan monks protesting the oppression of Tibetans by China, suicides in slaves in early America, suicide in oppressed women around the world, suicide in homosexuals and other stigmatized groups (such as Gypsies), to oppression by peers and family members. Suicide prevention strategies should include political action, freeing individuals and groups from over-regulation and helping empower the oppressed.

Keywords: Suicide, oppression

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In Durkheim's (1897) classic sociological theory of suicide, fatalistic suicide is relegated to a single footnote, where he defines it as the type of suicide committed by those overly regulated by society, that is, "those whose futures are pitilessly blocked and passions violently choked by oppressive discipline" (Durkheim, 1951, p. 276). Later, Johnson (1965) claimed that fatalistic suicide was so rare in modern society that it could be ignored.

This paper is about that footnote.


Fatalistic Suicide

Durkheim argued that the social suicide rate was determined by two broad social characteristics: the degree of social integration (that is, the extent to which the members of the society are bound together in social networks) and the degree of social

regulation (that is, the degree to which the emotions, desires and behaviors of people are governed by the norms and customs of the society). Suicide rates will be higher when the level of social integration is too high (leading to altruistic suicide) or too low (leading to egoistic suicide) and when the level of social regulation is too high (leading to fatalistic suicide) or too low (leading to anomic suicide).

Van Hoesel (1983) gave the following an example of fatalistic suicide. A 27-year-old black male was found hanging from the top of his cell door in a state penitentiary. A week before his death he had received a 40-year sentence for his involvement in several armed robberies. According to Van Hoesel, this man was in a situation where he had very little free choice. He was "choked by oppressive discipline" and had no freedom.

The word fatalistic indicates that people are overwhelmed by their fate and suggests, therefore, either that a socially-determined fate requires their suicide or that suicide is an escape from too severe social regulation. The first type might be illustrated by the mass suicides of Americans in Guyana who were

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followers of Jim Jones (Kilduff & Javers, 1979) while the second type might be illustrated by the Jews in Austria who killed themselves rather than be sent away by the Nazis to concentration camps (Kwiet, 1984).

Protest by Self-Immolation

Recently, Tibetan monks and lay people have protested the treatment of Tibetans and Tibet by the Chinese government with a spate, almost an epidemic, of self-immolations. The October 13th, 2012, issue of *The Economist* reported 54 self-immolations in Tibet "since last year." The name of Jamphel Yeshe, who set fire to himself on March 26, 2012, and died in Delhi, India, to protest the persecution of Tibetans, may not be remembered, but the picture of his death, published worldwide, will live on in our memories.¹

Protesting tyranny has a long history, but modern protests begin with that of Thich Quang Duc, a Buddhist monk who set fire to himself in South Vietnam on June 11, 1963, at the age of 66, to protest the persecution of Buddhists by the President, Ngo Dinh Diem. Another notable protest self-immolation is that of Norman Morrison, 31 years old, on November 2, 1965, outside the Pentagon office of Robert McNamara (Secretary of Defense) to protest the Vietnam War. Morrison took his one-year old daughter, Emily, with him, and gave her to a bystander (or set her down) before he set fire to himself. Jan Palach, a 20 year-old Czech student, set fire to himself in Prague on January 16 1969, to protest the Soviet invasion of Czechoslovakia.

These self-immolations stirred the world but had no immediate impact. In contrast, the self-immolation of Mohamed Bouazizi on December 17, 2010, in Ben Arous, a town in Tunisia, to protest his harassment by the local government as he tried to support himself as a vendor on the streets, had a tremendous impact. Protests began within hours, and the President of Tunisia, Ben Ali, fled on January 14, 2011, the first victory of the *Arab Spring*, which led people in many Arab nations to rise up and attempt to overthrow their governments, some successfully.

Park and Lester (2009) studied protest suicides by people in South Korea and found that they fell into two groups: workers protesting the repression of workers and their unions by companies, and students protesting the government's policies in cooperating with the United States in their

confrontation with North Korea.² These acts were not impulsive since the suicides often wrote suicide notes several days in advance of their action. They showed a great deal of reflection and soul-searching, and the individuals did not appear to have psychiatric disorders. Park (2004) felt that these suicides were altruistic in nature since the people were trying to change the society.

It is the oppressed who protest in this way, of course – not the oppressors – and, if we wanted to stop these suicides, then we need to engage in their political struggles. The oppressors typically murder scores of people, but many of the oppressed also kill themselves. A few do so in a public manner as a protest, but many simply desire to escape the oppression.

Suicide in Slaves

The one example that Durkheim gave of fatalistic suicide was in slaves. The National Civil Rights Museum in Memphis, Tennessee, noted in the exhibit for 1619 that, "Many African Americans fought against bondage by stealing from their owners, escape, arson, even homicide. They broke tools, injured work animals, and pretended to be ill in the field or on the auction block. As a last resort, some committed suicide."

Lester (1998) explored suicide in slaves, and documented cases in those newly arrived and those on the plantations, and discovered examples of slaves committing suicide after being brutally punished by slave owners and after attempts at organized rebellion. Accurate data for the early years is, of course, impossible to obtain, but Lester found data from the 1850 United States Census from which he was able to calculate suicide rates for that year: whites 2.37 per 100,000 per year, slaves 0.72, and free slaves 1.15. However, Lester noted that slave owners often branded slaves who killed themselves as criminals, and they tried to convince slaves that committing suicide would mean that they would never be able to return home to Africa after death. Suicides by slaves were often covered up and labeled as accidents so as to prevent imitation by other slaves.

Suicide in the Concentration Camps

Lester (2005) endeavored to collect information on suicide in Jews in Germany and German-controlled Europe before and during the Second World War. There were mass suicides as the Germans, Austrians, and other national groups rounded up Jews in order to deport them to the concentration camps, but accurate counts are

¹ Many protesters around the world die by self-immolation, including those in Telangana in India agitating for an independent state (Anon, 2013) and, since the year 2000, in countries ranging from Algeria, Australia, Bulgaria, China, Ethiopia, Greece, Israel, Mauritania, Mexico, South Korea to the United Kingdom (en.wikipedia.org/wiki/List_of_political_self-immolations).

² These suicides used several other methods besides self-immolation.

impossible to obtain. For many years, however, it was always claimed that suicide was rare in the concentration camps (e.g., Bronisch, 1996), and commentators provided explanations for this seemingly odd “fact” (e.g., Lester, 1997).

Later, Krynska and Lester (2002; Lester, 2005) were able to calculate the suicide rate in the Lodz ghetto in Poland from 1941-1944 when the ghetto was closed and the inmates sent to the extermination camps. The inmates carried out accurate counts and wrote the results in records which were buried and recovered after the war ended. The rate was 44.3 per 100,000 per year, much higher than the suicide rates prior to persecution of Jews. (Lester found an estimated suicide rate for Jews in Lodz in 1927 of 13.)

Lester (2005) used reports of inmates of the concentration camps to estimate suicide rates and reported rates as high as 25,000 per 100,000 per year. For example, in the extermination camp at Treblinka, with about 1,000 inmates, one survivor (Arad, 1987) noted that they found that *at least* one inmate had hung himself every morning when they awoke, and that suicide was a daily occurrence. At one suicide per day, the suicide rate is, therefore, 36,500 per 100,000 per year.

Lester concluded that when some survivors of the concentration camps concluded that suicide was rare, they were not using the word *rare* in the dictionary sense of the word. Rather they were saying that it was surprising that even more inmates did not commit suicide.

Suicide and the Cultural Oppression of Women

Suicides by women are often given explanations by men in their culture that provide a “rational” view of the acts. Here I will cast them as the results of oppression by the society and, more explicitly, by men, focusing on sati and female suicide bombers. Detailed case studies of such suicides are rare and not carried out by unbiased expert suicidologists. Therefore, this section relies on detailed discussions of two cases provided by journalists.

Sati in India

Sheth (1994) and Vijayakumar (2009) have both noted that suicide committed as a personal act motivated by emotions such as pride, frustration and anger is censured in Hinduism. In contrast, other forms of voluntary self-termination of life are not considered to be suicide and, therefore, not condemned. Self-sacrifice for the general good is admired, as is self-sacrifice to expiate sins (such as incest). Ascetics are allowed to choose death by voluntary starvation, committed deliberately and without passion. For example, *mahaprasthan* (great journey) involves the individual going on a continuous

walk after giving up all attachments and possessions and subsisting only on air and water. *Sati* is also a form of suicide that permitted. As Weinberger-Thomas (1999) pointed out, *sati* refers to the woman who commits this act and signifies “a chaste and faithful virtuous wife (p. 20), but the term is typically used, erroneously, to refer to the act itself.

It should be noted that the sacrifice (voluntarily or otherwise) of survivors of a deceased individual was not uncommon in India and other countries in historical times. It was thought in many cultures that a deceased emperor or warrior would need to have the same kinds of possessions and services in the after-life, and so possessions were buried along with the deceased and, sometimes, servants were also sacrificed. Sati is one of the few cultural customs where a survivor of a low-ranking individual was expected to sacrifice herself.

Sati³, which means *virtuous woman* in Sanskrit, has a long history. Although best documented in India, it occurred in China, Mesopotamia, and Iran. It was practiced by kings, whose queens were expected to die with them. Rajput queens in India sometimes committed suicide by self-immolation even when their husbands were killed in battle far away. The first memorial to sati was found in Madhya Pradesh in India in 510 AD (Baig, 1988), but the earliest historical instance is of the wife of General Keteus who died in 316 B.C. (Vijayakumar, 2004). Sati is named after Sati, the consort of the god Shiva. Shiva and Sati’s father (Daksha) had an argument, and Sati was so angry at her father that the fire of her anger destroyed her. Shiva retaliated by sending a monster to destroy Daksha’s head but later relented and allowed Daksha to be fitted with a goat’s head. The higher castes (Brahmans, Kshatriyas and Vaishyas) have interpreted this myth as indicating the way a widow should join her dead husband on his death – by immolating herself (Freed & Freed, 1989).

The *Vedas*, the most important of the Hindu texts, does not demand that women commit sati, although there is disagreement over one word. Some argue that it is the word for “go forth” while others argue that it is the word for “to the fire” (Yang, 1989). Most now think the *Vedas* encourages widows to get on with their lives and even remarry.⁴ The British banned sati in 1829 (Mehta, 1966), but about forty cases have been documented since independence in 1947, the majority in the region of Rajasthan (Weinberger-Thomas, 1999).

There are two types of sati. *Sahamarana* (or *sahagamana*) is where the widow ascends the funeral pyre and is burnt along with the body of her dead

³ Sati is also spelled as suttee and suttu

⁴ Lower castes see marriage with the deceased husband’s younger brother as quite acceptable (Weinberger-Thomas, 1999).

husband. In *Anumarana* the widow commits suicide (usually on a funeral pyre, after the cremation of her husband (Yang, 1989), usually with his ashes or some memento of him, such as a piece of his clothing. Stein (1978) noted cases in the 18th and 19th Centuries in which women died on the funeral pyre of an important person, mothers died on a son's funeral pyre, and sisters died on their brother's funeral pyre. Weinberger-Thomas (1999) noted that pregnant women, women with infants, adulterous wives, pre-pubertal girls, women who were menstruating, women who had amenorrhea, and "disobedient" wives were not allowed to commit sati since they were considered to be impure at this stage.

A debate has raged over whether widows went voluntarily or were forced (at knife point, sometimes bound and gagged) or drugged. To prevent widows changing their minds and trying to escape from the fire, exits from the fire were sometimes blocked, and roofs of wood were designed to collapse on the widow's head (Stein, 1978). This debate continues today in discussions of modern cases of sati. Daly (1978) observed that Indian men sometimes married children under the age of ten,⁵ and Narasimhan (1994) noted that eyewitnesses in the 19th Century reported that child widows aged eight and ten were sometimes forced onto the funeral pyre, bound hand and foot if they tried to escape. Some widows were drugged with opium. On the other hand, some widows asked to be bound and to be thrown on the pyre to prevent them fleeing and escaping their duty (Vijayakumar, 2004).

One case has become extraordinarily famous, the sati of Roop Kanwar who committed sati in Deorala, Rajasthan, on September 4, 1987 (Ali, 1987). Thousands watched her sati, yet the "facts" of the case are far from clear (Hawley, 1994). Roop Kanwar was a well-educated 18 year-old woman from the Rajput caste who was married for only eight months. Her 24 year-old husband died from gastro-enteritis, appendicitis or a suicidal overdose. He had recently failed an exam required for entry into medical school. Dressed in bridal finery, she was watched by a crowd of about 4,000 as she died (Narasimhan, 1994). Although the government tried to prevent a celebration of this, some 250,00 people came to the village for a glorification ceremony. Money (estimates were as high as \$250,000) was donated to build a temple in her memory. Roop Kanwar's brother-in-law and father-in-law were arrested but released without charges being filed. Roop Kanwar became a *sati-mata*, a deified woman with miraculous powers to grant favors (Narasimhan, 1994).

There were rumors that she was forced into sati and may have been drugged (Kumar, 1995). She was escorted to the pyre by young men carrying swords who might well have stabbed her had she tried to flee (Narasimhan, 1994). She may have fallen from the pyre and needed assistance in mounting it (Hawley, 1994). Observers saw her flail her hands in the air as the flames touched her (Narasimhan, 1994), but one official claimed that she was blessing the crowd by this action. Others claimed that she cried out to her father for help (Hawley, 1994). There were rumors that she had had been unfaithful (Hawley, 1994). As a result of this sati, Parilla (1999) noted that both women and men in Rajasthan rallied to support the right to commit sati, while other groups fought to ban it (Kumar, 1995).⁶ Although there are other modern cases of sati, the case of Roop Kanwar has become the focus of much of the discussion. Hawley (1994) edited a book in which the only modern case discussed at length is that of Roop Kanwar.

There is an economic rationale for sati. Under the law of inheritance in Bengal (*dayabhaga*), widows inherit their husband's estate, over-ruling the claims of his relatives. Sati, therefore, keeps the man's assets in his family. Vijayakumar (2004) noted that sati is rare in Kerala where matriarchy prevails, unlike Bengal where wives are entitled to half of their husbands' property, leaving his relatives eager to be rid of them. Abraham (2005) noted that the women in Rajasthan (where sati has been common) are extremely subjugated. Their illiteracy rate is among the highest in India.

Women are oppressed throughout the world. As Johnson and Johnson (2001) have noted: "*Today, in every corner of the globe, some women are denied basic human rights, beaten, raped, and killed by men*" (p. 1051). It has been noted that women have particularly low status in India where female feticide (the selective abortion of female fetuses), female infanticide, murder, dowry murder and suicide are forces that decrease the female population relative to the male population (Freed & Freed, 1989)⁷. Freed and Freed quote a man in the village in which they stayed in 1958: "You have been here long enough to know that it is a small thing to kill a woman in an Indian village (pp. 144-145).

Dowry deaths are those of women within seven years of their marriage who are murdered or driven to suicide by harassment and torture by their husband and his family in an effort to extort an increased dowry. Mohanty, Sen and Sahu (2013)

⁵ A practice that in the West would be viewed as pedophilia.

⁶ The role of pressure is illustrated by the case of Gayatri in 1983 where the village elders refused to cremate her husband unless she agreed to become a sati. The police watched her death along with thousands on onlookers (Narasimhan, 1990).

⁷ Supplemented by maternal mortality as a result of unhygienic lying-in and postpartum conditions.

studied 140 women who were the victims of dowry deaths in India. They were aged between 18 and 26 (83%), childless (66%), illiterate (74%) and from rural regions (88%). The most common methods were hanging (31%), burning (30%) and poisoning (29%). The deaths were classified as suicide (57%) and murder (43%). Pridmore and Walter (2013) have documented suicides in Asia in women after a forced marriage.

In some countries, abandoned woman are social outcasts. In India, widows are treated very harshly. An article in *The Economist* (Anon, 2007) described 1,300 widows at an ashram in Vrindavan in Uttar Pradesh, who pray for three hours each day in return for a token which they can exchange for three rupees (seven cents) and a handful of uncooked lentils and rice. They are entitled to a state pension of \$3.70 a month and the food ration that is given to poor Indians, but only about one quarter of the widows receive these. The article noted that widows are "unwanted baggage." In the past they were encouraged to die on their husband's funeral pyre, and those who did not were forbidden to remarry. Today, the law gives them better protection, but remarriage is still discouraged. Two-fifths of the widows were married before they were twelve years old and a third were widowed by the age of 24. Those widows interviewed said that they preferred to live in the ashram than go home where their treatment would be even worse. In some places, widows are permitted only one meal a day, sometimes no fish (because fish are a symbol of fertility) and must shave their heads.

Daly (1978) has documented the oppression and *gynocide* of women throughout the centuries and across cultures, including sati, Chinese foot-binding, genital mutilation, witch burnings, and even gynecological practices. She noted several components to what she called these *sado-rituals*: (1) an obsession with female purity, (2) a total erasure of responsibility on the part of the men for the atrocities performed in these rituals, (3) the tendency of the gynocidal rituals to catch on and spread, (4) the use of women as scapegoats and token torturers (such as blaming mothers-in-law for the widows' suffering), (5) a compulsive orderliness, obsessive repetitiveness and fixation on minute details to divert attention from the horror, (6) behavior unacceptable in other contexts becoming acceptable and normative as a result of conditioning, and (7) legitimization of the ritual by "objective" scholarship, especially by stressing the role of cultural norms and customs in order to "understand" the ritual.

The Case of Roop Kanwar

What of Roop Kanwar, the case mentioned above, the 18-year-old widow of Mala Singh whose

sati on September 4, 1987, caused such a great debate in India? Only one journalist seems to have made an effort to find out some "facts" about the case. Mala Sen (2002), an Indian working in London, England, traveled on several occasions to India and, during her visits, became friends with Roop Kanwar's father-in-law, Sumer Singh. She also tracked down the first police officer to arrive at Deorala and who interviewed people in the village. What did she find out?⁸

The marriage had been arranged when Roop Kanwar was about five or six and Maal Singh was nine or ten. The contract was finalized in 1981, and they were married on January 17, 1987, in Jaipur. She was a city girl, and her father-in-law said that she was homesick in Deorala and so spent most of the marriage back in Jaipur with her parents. Her husband was studying for his exams at this time. The low caste servants in the village who were, therefore, afraid to talk of the sati for fear of upsetting their employers, did tell Mala Sen's taxi driver that there was crying and shouting in the house during the time Roop Kanwar returned to her in-laws a few days prior to Maal Singh's death.

When the police officer, Ram Rathi, arrived on the scene, only the remains of the pyre were left. He visited the village several times afterwards and spoke both to the rich and the poor in the village. He found out that Roop Kanwar had not loved her husband. In fact, she had a childhood sweetheart whom she was not allowed to marry⁹, and she had been having an affair with him after her marriage in her home town of Jaipur, to which her lover had moved from Ranchi. When her parents found out, they were horrified and ordered her to return to her husband. She had become pregnant as a result of affair, but hid this from her parents. On returning to her husband, she tried to persuade her husband that the child was his. However, their marriage had never been consummated because her husband was impotent and had "mental problems," as did his mother.¹⁰ Although he had a B.Sc. degree, Maal Singh was unemployed. Roop Kanwar had lived with her husband for only three weeks of their seven month marriage, a brief period after the marriage ceremony and a for a few days before his death. After Roop Kanwar came back to him, he tried to kill himself by swallowing a large quantity of fertilizer. His family tried to cover up his suicide attempt, and a doctor took him to a distant hospital where he died on

⁸ One element, modeling, seems to be ruled out. Roop Kanwar's father-in-law said that there were no previous sats in his or his daughter-in-law's family.

⁹ He was from a different caste

¹⁰ Her husband told Mala Sen that his wife suffered from depression.

September 4, 1987.¹¹ His body was rushed back to Deorala for a quick cremation in order to prevent an autopsy.

The police officer was of the opinion that Roop Kanwar was “encouraged” to commit suicide. Although myths quickly grew surrounding her death (that her eyes glowed red and her body generated an immense heat as she walked to her death), the children in the village told Ram Rathi that she seemed unsteady on her feet, as if drunk or drugged, and stumbled several times on the way to the funeral pyre. She was surrounded by several youths armed with swords, and her eldest brother-in-law (who was fourteen years old) lit the funeral pyre.¹² Reports that she waved her arms as she burned and called out have been interpreted as agony and pain, but supporters of sati argue that it was joy being expressed.

Wives are thought in this region of India to be responsible for illnesses and events that befall their husbands. If the husband dies or is killed, then she is responsible. In this case, the wife had been unfaithful to her husband and conceived a child by another man. In many families, Roop Kanwar would have been murdered for these behaviors. Whereas there are occasional modern cases where the parents of the bride saved her from committing sati, Roop Kanwar’s parents disapproved of her true love and had moved from Ranchi to Jaipur to put an end to the affair, to no avail. They, like her in-laws, celebrated her sati because now they were the parents of a new goddess and not simply business people who ran trucks between Ranchi and Jaipur.¹³

A Chechnyan Female Suicide Bomber: Zarema Muzhikhoyeva

There have been many suicide bombers in recent years, but they have rarely been studied intensively by psychologists. Journalists, on the whole, provide the only information about these individuals. For the men, journalists have focused on the training process but, for female suicide bombers, journalists have, on rare occasions, ferreted out and reported some of the details of their lives. The best such report is from Bullough (2010) – the case of Zarema Muzhikhoyeva - a potential suicide bomber, who lost the will to die and surrendered, deliberately botching her attempt to blow herself up at a café in Moscow in July, 2003.

According to articles in the *New York Times* (Myers, 2003, 2004), Zarema Muzhikhoyeva (aged 22) said that she had been recruited to terrorism out of shame and debt. Her husband had been murdered in a business dispute in one account and in a car accident in another account. She may have had an infant daughter. On the day of the bombing, she was given orange juice that made her dizzy and disoriented. The information given in article in the *New York Times* is limited and apparently false.

Bullough (2010) has written a book about the Caucasus region in Russia, and he uncovered details of the life of Zarema Muzhikhoyeva. According to Bullough, Zarema was 23 when she was sent to Moscow to blow herself up. Her mother abandoned her when she was ten months old, and her father died while working as a laborer in Siberia, seven years later. She lived with her father’s parents. She had a loveless childhood, followed by a loveless marriage (in 1999) to a man who kidnapped her from her home, the tradition in Chechnya, and who was twenty years older than she was. She quickly became pregnant, but two months later her husband was shot, leaving her with his family whom she hardly knew. Burdened with this daughter-in-law, her in-laws gave her daughter to one of their other sons, and sent Zarema back to her grandparents, again a common practice in Chechnya.

Zarema visited her daughter from time to time, bringing toys and clothes, but her daughter called her adopted parents “Mommy” and “Daddy,” and this broke her heart. She stole some jewelry from her grandmother and sold it with the plan of buying plane tickets and kidnapping her daughter. She reached the airport with her daughter, but she had left a note for her grandmother telling her about the plan, and her aunts stopped her at the airport. She was taken home, and her daughter was sent back to her adoptive parents.

Zarema was beaten by her grandparents, both for the theft and for bringing disgrace to the family. Her aunts told her that they wished she was dead. Eventually they refused even to acknowledge her. She felt completely worthless. She then volunteered to become a suicide bomber, thinking that to do so would obtain \$1,000 for her relatives, a way of paying back the debt from the theft. She was sent on one mission, but her nerve failed her. She lied about the reasons for her failure, but she felt more disgraced. Then she was sent on the mission to Moscow where she surrendered.

Lester (2008, 2010; Lester, et al., 2004), using reports from the Internet, suggested several factors that are common in female suicide bombers. First, it seems likely that the women have post-traumatic stress disorder after experiencing severe trauma. In war zones (Chechnya, Iraq and Palestine),

¹¹ After the sati, the doctor, Magan Singh, fled and was not found for many months. After he was found and charged, he was no longer allowed to practice medicine.

¹² Her father-in-law claimed to have been in a hospital many miles from Deorala after collapsing and becoming unconscious when his son, Mala Singh, was brought to Deorala.

¹³ Other reports say that Roop Kanwar’s father was a school teacher.

all of the citizens have witnessed brutality and death from childhood on, not only at the hands of the dominant power's military, but also from their own ethnic group. For example, in Chechnya, the kidnapping and rape of women by fellow Chechnyans is common and tolerated by the women's family (Bullough, 2010). In Iraq, the Muslim militias often tortured and executed those fellow Iraqis whom they believed had cooperated with the American military.

Lester also noted the development of feelings of burdensomeness in some female suicide bombers. Divorced or thrown out by their husbands, they become a burden to their families who have to take them in, with little prospect of finding a new husband, especially if part of the reason for the divorce was a failure to bear children. Burdensomeness has been proposed as a common component in the decision to commit suicide in the theory of suicide proposed by Joiner (2005)

The result is that some women in these countries develop feelings of depression, hopelessness and purposelessness in life. Suicide is seen as a way of escape from this psychological pain, and dying as a martyr is not only an escape, but also as a way of transforming their image. The acts of martyrdom often make the female suicide bombers heroines in their community.

Discussion

Sati is often cast as a noble sacrifice by a loving wife who cannot bear to survive after the death of her husband. Suicide bombers are often portrayed as heroic individuals who sacrifice themselves for a political cause. I have endeavored to show that this is only a superficial façade for these cases of suicide. It is extremely hard to find detailed biographies of the women involved in these acts, and none by expert suicidologists. But the two examples discussed in this essay (which are based on the only detailed accounts available to date) clearly indicate that these women have been severely traumatized and see no other way out of their horrendous circumstances. Roop Kanwar had a choice of being murdered or of committing sati – which is really no choice at all, except that the latter served to transform her image in the community. Zarema Muzhikhoyeva was beaten by her family, had lost her husband and had her children taken away from her. Her life had become unbearable. She felt worthless and ashamed. She became a suicide bomber to escape the pain imposed upon her by her society and to redeem herself a little by earning a reward to pay her debts, hoping to change her image in her family.

We need to ignore the superficial descriptions and explanations of these acts presented in news reports and seek the real reasons for and causes of these acts by oppressed women. In these

societies, the vast majority of women do not commit sati or become suicide bombers. It is likely that the few who do engage in these behaviors are suffering from extreme oppression and enormous distress.

Driven to Suicide: Suicide and the McCarthy Hearings

A lawyer by training, Joseph McCarthy¹⁴ served in the Marine Corps during World War II and was elected from Wisconsin to the United States Senate in 1946. In 1950, he claimed that he had a list of communists who were employed in the State Department, the Voice of America, President Truman's administration and the Army. In 1954, he led a series of hearings in the Senate known as the Army-McCarthy hearings. He was never able to substantiate his claims, and late in 1954 the Senate voted to censure him. He died in 1957 at the age of 48 from hepatitis brought on by alcoholism. There are still those who admire McCarthy (e.g., www.senatormccarthy.com) and who see him as driven by persecution to "alcoholic suicide."

The careers of many individuals from all walks of life were destroyed, some temporarily and some permanently, by being called to testify before McCarthy's committee. Some writers and actors working in the movie industry were blacklisted, while others cooperated with the committee to besmirch the names of their colleagues and friends.¹⁵ There have been rumors of individuals driven to suicide by this unjustified persecution. It is not easy to track down these suicides.

When McCarthy ran for the Senate, he defeated Senator Robert La Follette in the primary for the Republican candidate. Six years later, La Follette committed suicide, convinced he was about to be caught up in the McCarthy hearings. La Follette's biographer, Patrick Maney, has changed his mind several times about the veracity of this, but, in his latest opinion, McCarthy was planning to subpoena La Follette over the possibility that La Follette's Senate aides had communist ties.¹⁶ La Follette had a history of depression and anxiety and this stress may have led to his decision.

In 1953, Reed Harris, an administrator at the Voice of America (VOA), was harassed during days of testimony before McCarthy's committee. On the last day of Harris's testimony (March 5th, 1953), Raymond Kaplan, an engineer at VOA, threw himself under a truck in Boston rather than face questioning (Scates, 2006). He left a suicide note which read,

¹⁴ Born November 14, 1908; died May 2, 1957.

¹⁵ When Elia Kazan was awarded an Oscar in 2008 for his life-time achievements as a movie director, many in the audience refused to applaud because he had collaborated with the committee.

¹⁶ Steve Schultz: La Follette suicide linked to fear of McCarthy, *Milwaukee Journal-Sentinel*, May 17, 2003.

I have not done anything in my job which I did not think was in the best interest of the country, or of which I am ashamed. And the interest of my country is to fight Communism hard. I am much too upset to go into the details of the decision which led to the selection of the Washington [State] and North Carolina sites [for VOA transmitters]....My deepest love to all. (Scates, 2006, p. 75)

McCarthy thought the placing of the transmitters at sites which some claimed were not the best for transmitting to communist nations was a deliberate plot to sabotage their usefulness.¹⁷

Scates (2006) also relates an incident in 1954 when the son of Senator Lester Hunt, the senator from Wyoming, was arrested for soliciting a homosexual act from an undercover police officer. Hunt received word that, if he promised not seek re-election to the Senate, his son would not be prosecuted. Hunt decided to step down, but his son was found guilty and fined \$100. Hunt killed himself soon after, on June 19th 1954, in his Senate office with a rifle. McCarthy wanted to have a Republican senator elected in place of Hunt, a Democrat, to minimize the chances that he, McCarthy, would be censured. McCarthy also had accused Hunt of defrauding the Wyoming state government.

The Oppression of Homosexuals and Other Groups

Governments and individuals have long stigmatized and persecuted homosexual individuals. Alan Turing (1912-1954) was a brilliant and eccentric English mathematician. In the 1930s, Turing published a paper that proposed the hypothetical existence of computers. These machines were called *Turing Machines*, and he foresaw how they would work, even down to the binary input of data. During the Second World War, he worked on codes and ciphers and participated in the team that cracked the codes used by the Germans so that the British could be apprised of the German plans. After the war, Turing moved to the University of Manchester where he worked with the team that built one of the first actual computers.

Turing was gay, and a friend of his lover robbed Turing's house. When the police were called, they discovered that Turing was a homosexual, which at the time was illegal in England. They ignored the burglary and arrested Turing instead. He was found guilty and forced to undergo estrogen treatment. About a year after the treatment ended, Turing killed himself with cyanide. Homosexuality was de-

criminalized in England in 1967, too late for Alan Turing.

Unfortunately, gays and lesbians are still today the subject of prejudice and violence. In 2010, Tyler Clementi, a gay student at Rutgers University, New Jersey, had a sexual interaction with a lover in his dormitory room which, unbeknownst to him, was recorded on a webcam by his roommate, Dharun Ravi, and shown to others. Three days later Clementi jumped to his death from the George Washington Bridge connecting New York and New Jersey. Several similar incidents occurred around this time of high school students killing themselves after being taunted and bullied for their homosexuality.

There are other groups, religious, ethnic or chosen life-style, who are also oppressed and who sometimes have high suicide rates such as gypsies and other nomadic groups (Lester, 2014). For example, Walker (2008) has documented a high rate of suicide among Travellers in Ireland, a nomadic group that is persecuted by local governments who dislike their encampments. For the period 2000-2006, she calculated their suicide rate to be 37 per 100,000 per year, three times the Irish national suicide rate of 12.

Van Bergen, Smit, van Balkom and Saharso (2009) discussed the plight of young immigrant women of South Asian, Turkish and Moroccan descent living in the Netherlands. These women lack self-autonomy, and their behavior is over-regulated. They become suicidal in reaction to being forced into unwanted marriages, prostitution, abortions, and giving up their education. Any threat to living a chaste life and maintaining their reputation can result in them being made outcasts. Van Bergen and her colleagues concluded that traditional risk factors for suicidal behavior (such as psychiatric disorders) do not apply to these young women, but rather their suicidal behavior is fatalistic, a reaction to the oppression from their families.

Oppression in the Workplace and Suicide

The impact of oppression in the workplace has been illustrated by two recent examples. The first involved suicides at the Foxconn factories in Shenzhen, China, where nine workers committed suicide. There was an outcry, and the companies that had their products assembled there, including Apple, Hewlett Packard, Dell and Nokia, launched investigations into the conditions of the workers there. Chris Satullo, in an editorial on WHYY (National Public Radio) on January 23, 2012, accused Apple of using "abusive sweatshops" in China, resulting in a moral dilemma for him since he loved his Mac.¹⁸

¹⁷ Supporters of McCarthy claim that Kaplan's death was an accident (www.renewamerica.com).

¹⁸ www.newsworks.org/index.php/blogs/centre-square/item/32968-of-iphones-predators-poultry-and-evil

Conditions were improved: more time off was allowed, a 24-hour hotline was set up, some efforts were made to improve the social life, and wages were increased. One result, however, as reported by the *Financial Times*, was that some companies, including Apple, moved their production to Foxconn factories elsewhere in China where the salaries (and, therefore, the costs) remained low.¹⁹ Conditions remain poor at Foxconn factories. In Wuhan in 2012, workers at the Foxconn factory making Microsoft's Xbox game systems threatened a mass suicide.²⁰ In January 2012, a petition circulated urging Apple to treat the workers in China better.²¹

In the second case, more than 24 suicides (and perhaps as many as 40) occurred among workers of France Télécom beginning in 2008, a company that employs about 100,000 workers in France. The suicides and attempted suicides were attributed to work-related problems.²² As a result, the company halted involuntary transfers and permitted working from home. Many of the suicides occurred at home or in public places (such as a bridge over a highway), often leaving suicide notes blaming the company, but others jumped from the company building itself. There were demands for a parliamentary inquiry, and the deputy chief executive, Louis-Pierre Wenes, the architect of a drive to modernize the former state monopoly, resigned on October 2009.²³

Mercy Killings and Assisted Suicide

There has often been concern that mercy killings and assisted suicide are not simply choices made by individuals who wish to die, but rather that more subtle sexist forces are operating. Canetto and Hollenshead (1999-2000) noted that, of 75 individuals who Kevorkian assisted to die, 72% were women. Canetto and Hollenshead noted that Kevorkian's cases may not be representative of physician-assisted suicides in general, and there are no data on the persons who requested Kevorkian's help but whom he turned down. Perhaps women are more likely to have the conditions that are common in Kevorkian's cases (that is, chronic, incurable and debilitating diseases). It is possible that women are more likely to face their own deaths and that they are more concerned about self-determination in death. It may be that women's choices for care are limited by their disadvantaged social and economic conditions; that

women more often view their selves as undeserving of care and as having a duty to be altruistic and not burden others; that women's lives are devalued; that assisted suicide may be perceived as a more feminine choice (as compared to killing oneself which is seen as a masculine behavior); or that this is a case of a male "physician" and female patients acting out "gender scripts of subordination and domination" (Canetto & Hollenshead, 1999-2000, p. 192).

The sex difference in Kevorkian's cases parallel data on mercy killings. Canetto and Hollenshead (2000-2001) reported on 112 cases of mercy killings in the United States between 1960 and 1993. The majority involved men (usually husbands) killing physically-ill older women.²⁴

Oppression in the Home by Husbands

Couple suicide pacts are not very common. For example, according to a survey conducted in Dade County, Florida (Fishbain and Aldrich, 1985) suicide pacts constitute only 0.007 percent of the suicides. The most common pacts involved married couples, with young lovers next most common. Based on a survey of the United States from 1980 to 1987, Wickett (1989) documented 97 couples involving the suicide of one or both partners. Two-thirds of these cases involved mercy killings followed by suicide, while one-third were double suicides. In the typical case, the wife or both partners were ill, and the husband initiated the plan. The couple often left evidence indicating that they felt exhausted and hopeless, and they feared parting or being institutionalized. In the mercy killing cases, the husband could not bear his wife's suffering or life without her.

Rosenbaum (1983) studied cases of double suicide in which one partner survived. The instigator, usually a man with a history of attempted suicide, did not survive the suicidal action. The surviving partner was typically a woman who did not appear to be emotionally disturbed or to have a history of non-fatal suicidal behavior. The instigators had characteristics similar to those of murderers and murder-suicides.

For double suicides (rather than mercy killings), these studies suggest the role of a domineering and dominating husband who decides that both partners must commit suicide. Insight into double suicide maybe obtained from the biographies of famous double suicides. Two famous incidences involve Stefan Zweig and his wife Lotte (Allday, 1972; Prater, 1972) and Arthur Koestler and his wife Cynthia (Levene, 1984).

¹⁹ www.ft.com/cms/s/2/2429f498-82fd-11df-8b15-00144feabdco.html accessed 1/12/2012

²⁰ www.cnn.com/2012/2/01/11/world/asia/china-microsoft-factory/index.html accessed 1/12/2012

²¹ www.change.org/petitions

²² www.nytimes.com/2010/04/10/business/global/10ftel.html, accessed 1/18/2012

²³

[www.telegraph.co.uk/finance/newsbysector/mediatechnologyandtelecoms/6262591/...](http://www.telegraph.co.uk/finance/newsbysector/mediatechnologyandtelecoms/6262591/) accessed 1/24/2012

²⁴ Canetto and Hollenshead found that, in cases of a parent killing a child, women predominated as the killer.

Charlotte Altman and Stefan Zweig

Stefan Zweig's family was upper middle class, Jewish and Viennese, with successful industrialists, bankers, and professional men among his relatives (Allday, 1972; Prater, 1972). Stefan's father had established a large successful weaving mill in Czechoslovakia. His mother was from Italy and also Jewish. Stefan was born the second and last child on November 28th 1881. As a child, he wanted for nothing. He was spoiled by his family, relatives and servants, but also severely disciplined. He was less obedient than his older brother, given to temper tantrums and often in conflict with his mother.

His older brother was expected to go into the father's business and agreed to do so. This left Stefan free to pursue his own interests, and Stefan chose an academic life. After eight grim years in a Gymnasium (a rigorous version of an extended American high school), he attended the University of Vienna and very quickly found that his interests lay in theater and literature. He had poems published when he was 16, and he was soon writing for some of the best periodicals in Vienna. Almost everything he wrote was published, his first book when he was 19.

Despite his success, Stefan did not think highly of his writing. Thus, he decided to translate famous foreign authors rather than concentrate on his original composition. One of the first poets that Stefan translated was the Emile Vehaeren, a Belgian, and this early translation work prepared Stefan for the role he played in European literature, the interpreter and introducer of foreign writers and their work to German audiences.

After his first marriage ended, Zweig took up with his assistant, Charlotte Altman. The growing anti-Semitism in Germany and Austria affected him profoundly.²⁵ Unlike many Jews in those nations, Stefan accurately forecast the outcome. He knew that he had to escape, and so he began to spend longer amounts of time outside of Austria and eventually moved to England in 1938 after the German occupation of Austria. Charlotte Altman became his secretary in 1933. Lotte was physically frail and suffered from asthma. Stefan's biographers suggest that his sexual relationship with her was probably unsatisfactory. Friends of Stefan remarked that one hardly noticed Lotte. She seemed non-existent. Certainly Stefan's biographers have little to say of her. Yet her passionate devotion to Stefan is clear in her decision to commit suicide with him.

Stefan and Lotte bought a house in Bath, England, where Stefan managed to continue his

productive work. After his divorce, they were married in September 1939, three days after Chamberlain's declaration of war with Germany. Stefan was 57, Lotte 31. Stefan was convinced that England would fall to Hitler. By June of 1940. Denmark and Norway had fallen, followed by Belgium, the Netherlands and France. Stefan received invitations to lecture in the United States and South America, and he took this opportunity to escape from what he saw as the certain defeat of England. Stefan and Lotte went first to the United States and then to Brazil.

He and Lotte leased a house outside of Rio in Petropolis, where he completed his autobiography and wrote his last works of fiction. His reception in Brazil was cool, in contrast to the adulation on his tours there in the 1930s and, once they were installed in their home, few friends visited. Although he had complained of never having time to himself for his work, he now had all the time he needed but felt acutely isolated. The solace he had sought oppressed him.

He went to Rio for the Carnival, but on Shrove Tuesday (February 17th) the news arrived of the fall of Singapore to the Japanese. Stefan immediately left with Lotte for Petropolis. The decision was made. Stefan spent the rest of the week writing letters and making final arrangements. He called friends, and on Saturday evening invited a neighboring couple to dinner. On Sunday afternoon, he and Lotte both took massive doses of veronal and died.

Stefan's suicide note spoke only of his lack of desire to begin completely afresh in his 60th year. He spoke of being exhausted by long years of homeless wandering and his desire to avoid my future humiliation from loss of freedom and an inability to continue his intellectual work.

It remains a puzzle why Lotte died with him. He most certainly urged her to do so. But we learn so little about her from his biographers that we do not know why she submitted to such a suggestion. Clearly, Zweig's first wife, Friderike, did not and would not have died with him. Friderike was a writer too, had two children by her first husband and had learnt to live apart from Stefan since he traveled so extensively during their marriage. After the war, Friderike became an academic, one of the scholarly experts on Stefan Zweig. Lotte died with Stefan; Friderike built a career on him.

Cynthia Jeffries and Arthur Koestler

Arthur Koestler was born on September 5th, 1905, in Budapest, the only child of Henrik and Adela Koestler. After studying science and engineering, he worked as a newspaper correspondent, in Palestine, and then in Germany and France. He joined the Communist Party, made three trips to Spain during

²⁵ Of course, many suicides have occurred as a result of anti-semitism, most notably during the oppression and genocide of Jews by the Germans and other Europeans during World War Two. For documentation of suicides during the Holocaust, see Lester (2005).

the Civil War and was arrested as a spy and imprisoned for three months by Franco's Nationalists. He was sentenced to death but freed after British protests. Disillusioned now with Communism, he resigned from the Communist Party. He was detained and imprisoned in both England and France, but after the publication of his novel, "Darkness at Noon," was released and worked for the Ministry of Information in England during the war. After the war, the cause of Zionism again captured his attention, and he traveled to the Middle East and both reported on events and wrote novels around his experiences. He settled in England in 1952 and became a British citizen, and he continued to work for and write about political issues. His writings, including novels, essays and biographies, always exploring the important social issues of the times, and his work has been compared to that of George Orwell's in its impact on the times.

His third and final marriage was to Cynthia Jeffries in 1965, his secretary since 1950. Cynthia Jeffries was 22 when she started working for Koestler. She was from South Africa and moved to Paris with the aim of working for a writer. There had been stress in her life – her father committed suicide when she was 13 and there was a brief, unsuccessful marriage. From the time that she joined him, her life was rarely distinct from his. One of the causes for which Koestler worked was euthanasia. As he grew older, he developed Parkinson's disease and then leukemia. When the effects of these illnesses worsened, he decided to commit suicide, and Cynthia decided that she could not live without him.

Interestingly, all his wives remained in some way attached and, for some, devoted to and dependent on him. Dorothy Asher helped free Koestler from prison in Spain. Mamaine Paget, who suffered from his drunken rages, wrote that she would do anything, even leave him, if it were necessary to help him fulfill his destiny. Cynthia went further. On March 3rd 1983, she committed suicide with him in their London home.

There was some outcry after the double suicide of the Koestlers. Mikes (1984) noted that Arthur Koestler treated Cynthia abominably. She had to be on duty to serve Arthur 24 hours a day, and she had to be perfect in everything she did. She was secretary, lover, wife, nurse, housekeeper, cook, mother, daughter and inseparable companion. Mikes gives an example of Arthur criticizing Cynthia's cooking early in their relationship and sending her to cooking school to improve. In the 1970s, Arthur became Cynthia's prisoner, and she seemed more relaxed, and she teased Arthur more.

Blue (1983) argued that Cynthia should not have killed herself. She was in good health, energetic and able. She had a home, many friends and financial security. But Cynthia had come to live entirely for

Arthur and through him. As she added to Arthur's suicide note, 'I cannot face life without Arthur.' As Arthur sickened, Cynthia's attachment to him became less pathological but no less intense. His sickness, by making him more dependent upon her, gave her a little more power. But he obviously made no effort to prepare her for his death by encouraging her to have interests outside of his life by encouraging her independence.

Although the deaths of Charlotte Zweig and Cynthia Koestler were technically suicides, their deaths have the quality of murder, murder by self-centered, power-seeking husbands who gave little or no thought for the quality of life for their wives.

Suicide in Indigenous Women

Suicide in indigenous women is often a result of oppression, and the suicide functions as a political act (affecting power relationships) or as an escape. In her account of suicide among females in Papua-New Guinea, Counts (1980) has illustrated the way in which female suicide can be a culturally-recognized way of imposing social sanctions. Suicide holds political implications for the surviving kin and for those held responsible for the events leading women to commit suicide. In one such instance, the suicide of a rejected fiancée led to sanctions being imposed on the family which had rejected her. Counts described this woman's suicide as a political act which symbolically transformed her from a position of powerlessness to one of power.

Meng (2002) reported the case of Fang who killed herself by drowning at the age of 32 in a rural area of China.. Her marriage was a love marriage which is the basis of only about 13% of marriages in rural China, and her parents-in-law never accepted her. Although Fang was the wife of a first-born son, her parents-in-law gave preference to the wife of a younger son. Fang tried but failed to please her parents-in-law. After the birth of two sons, the couple moved to their own house in the family compound, and Fang became more hostile and confronted her parents-in-law more often. Fang's husband supported his parents and hit and punished Fang for insulting his parents. Fang was socially isolated in the village, having come from a distant village, and she remained an outsider. Fang coped by seeking spiritual assistance, making friends outside of the family, converting to Christianity and running away. After one last fight with her parents-in-law and punishment from her husband, Fang slipped away and killed herself.

The precipitating events for this suicide were quarrels with her in-laws and domestic violence. Fang's in-laws viewed her suicide as " a foolish act" for it cost the family a great deal in terms of cost and reputation. Fang's parents saw Fang's suicide as a

“forced decision.” They blamed Fang’s in-laws, destroyed furniture in the in-laws’ house and demanded a very expensive funeral and headstone for Fang in her in-laws burial plot. The villagers gave Fang’s suicide a mystical interpretation, believing that she was taken by a ghost, which served to avoid blaming Fang or her in-laws and to escape from a sense of responsibility themselves for Fang’s suicide. Only Fang’s husband truly mourned his wife.

Meng, however, viewed Fang’s suicide as changing Fang’s social status in the community. After her suicide, Fang’s parents-in-law had to bow to her memory and mourn for her, that is, to accept her and treat her as they never had during her life. Thus, her suicide could be viewed as a form of symbolic revenge on her in-laws for their mistreatment of her.

Kizza, Knizek, Kinyanda and Hjelmeland (2012) discussed three cases of suicide in Acholi women in post-conflict northern Uganda which has endured 20 years of horrific war between the government and rebels. Two million people have been displaced and reside in “protected villages.” These camps are densely populated, and the people depend on humanitarian aid and fear rebel attacks. The violence, rapes, and other inhuman behavior have resulted in despair, depression and hopelessness in the people. The women are the only ones able to earn a little money from brewing alcohol and cultivating a few crops, while the men drink alcohol, gamble and have sexual affairs. Taking a second wife is an established cultural custom in the Acholi, and the men maintain control over the family finances despite the fact that they do not earn any money. Thus, the women are forced to give their hard-earned money to their husbands who then spend it on alcohol, gambling and other women. Mothers are supposed to take care of their daughter-in-laws, but in the camps, the first wife, often only in her 20s or 30s, has to take care of any co-wife and her children that her husband brings home. Compounding the problem was the high incidence of HIV and AIDS which wives feared their husbands would infect them with from their sexual affairs and co-wives.

Kizza et al. conducted a psychological autopsy studied of three women who died by suicide and identified two main themes: no control in life and no care. No control was present in the reversed roles of husbands and wives combined with the power still residing with the husbands. The wives had no right to fight and, in cases of disputes with co-wives, the elders always sided with the husbands. Rebellion by the wife was met with physical violence from the husband, and married life had become unbearable for the wives. No care was present from the infidelity and polygamy of their husbands and the breakdown in inter-generational care in the camps. Kizza et al.

entitled their article on these suicides “An escape from agony.”

Oppression by the Family and Peers

As we have seen, society can be oppressive, resulting in suicidal behavior in those oppressed. But oppression also occurs at the one-on-one level. Meerloo (1962) described the phenomenon of *psychic homicide*, in which an individual “murders” another by getting the person to commit suicide.

An engineer who had struggled all his life with a harsh, domineering and alcoholic father gave his father a bottle of barbiturates to “cure” his addiction. He was very well aware of what he expected his father to do. When two days later, the telegram came announcing the death of his father, he drove home at reckless speed, without however, killing himself. (p. 94).

Richman (1986) documented hostile behavior by parents toward their children who had just attempted suicide, words that were said in front of the attending psychiatrist.

One mother’s first statement after seeing here 24-year-old son in the hospital was, “Next time pick a higher bridge.” A depressed man in his seventies said to his wife, “If I had a gun I’d shoot myself.” She replied, “I’ll buy you a gun”.....A mother said to her 29-year-old daughter, “I’ll do anything to show my love for you; I’ll open the window so you can jump.” (p. 80)

More generally, the association between the experience of physical and sexual abuse and of bullying with subsequent suicidal behavior has been well-documented (Klomet, Sourand & Gould, 2010; Maniglio, 2011). For example, Fisher, Moffitt, Houts, Belsky, Arseneault and Caspi (2012) interviewed a sample of over 2,000 British children when they were aged 7, 10 and 12 years old. The mothers reported that 16.5% of the children had been bullied before age 10, and 11.2% of the children reported themselves as having been bullied a lot before age 12. Self-harm or attempted suicide by the child was 3.53 times more likely if the mothers reported bullying and 3.33 times more likely if the child reported bullying. This increased risk of self-harm was found even after controls for maltreatment of the child by the parents,²⁶ pre-morbid mental health problems, and intelligence. This study was of twins and, therefore, the impact of the general home environment could be ruled out. Of the 162 twin pairs discordant for bullying, the bullied twin was 4.3 times more likely to self-harm than the non-bullied twin.

²⁶ Bullying plus maltreatment by parents increased the risk of self-harm even more.

It has been argued that, regardless of maltreatment by parents and bullying by peers, even parental pressure can lead to suicide in their children. Vicki Abeles, a former Wall Street lawyer, has made a documentary about the pressures placed on adolescents by their parents and the American educational system to excel, a documentary prompted by the suicide of a high achieving teenager in her community (Katz, 2012).

Comment

The people described in this essay who took their own lives do not typically have a psychiatric disorder, and they do not have need of a prescribed psychotropic medication. They need freedom from oppression, and they need empowerment. That requires a political movement and, for the rest of us, support for their struggles against the oppression.

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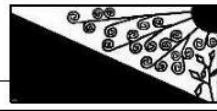
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The EPA Section of Suicidology and Suicide Prevention is one of the nineteen sections of the European Psychiatric Association.

The Section aims at improving research in this field and translating research findings into clinical practice. In this sense it adheres to a bio-psycho-social perspective and involves an international and multidisciplinary network of researchers and clinicians.

The objectives of the EPA Section of Suicidology and Suicide Prevention are:

- Raising awareness about suicide as important public health issue and fighting the stigma surrounding it;
- Improving understanding of risk and protective factors;
- Sharing experience and knowledge on suicide prevention;
- Disseminating best practices on management and treatment of the suicidal patients.

ACTIVITIES

The EPA Section of Suicidology and Suicide Prevention organises symposia and workshops during major scientific events, such as the annual congress of the European Psychiatric Association or the European Symposium on Suicide and Suicidal Behaviour.

The Section organizes Itinerant CME courses in collaboration with National Psychiatric Associations and other organizations.

MEMBERSHIP

The EPA Section of Suicidology and Suicide Prevention comprises 60 members from more than 15 countries. Besides psychiatrists, the Section includes experts in several scientific areas, such as genetics, psychology, anthropology and public health.

To apply for membership, please send your request to the Section Chair (marco.sarchiapone@me.com).

FURTHER INFORMATION

For further information, please visit our website www.suicidology.net/epa.