



Original Paper

Suicide motives and culture

Degree of modernization, response behavior and acceptance

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Abstract Background: National suicide rates are relatively stable over long periods but differ considerably from one another. Considering that the acceptance of suicide motives in the general population might be associated with national suicide rates, a multi-centre survey on this topic was planned by the Vienna Research Group in Transcultural Psychiatry. **Method:** 610 healthy interviewees from Georgia, Lithuania, Nigeria, Austria, Pakistan and Poland completed a 46-Item questionnaire on attitudes towards and assessment of suicide-motives. **Results:** Subjects from European countries showed a highly distributed pattern of response with high acceptance of a few and almost total rejection of most other suicide motives. In contrast, subjects from Nigeria and Pakistan were indifferent towards most of the motives; however, in general the Nigerians expressed more understanding for suicide motives than the Pakistanis with their almost total rejection of suicide. Single suicide motives were unanimously highly accepted in all investigated societies; apart from that there are also culture-specific motives. **Conclusion:** The acceptance of suicide motives, mirrors the persistence of social value systems and their regulative mechanisms (e.g. shame-guilt), which seem to have some influence on national suicide rates.

Key words: Suicide motives, culture, acceptance, degree of modernization, religion

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INTRODUCTION Over the last decades suicide has become worldwide one of the main causes of death and occurs in nearly all known human communities. In most cultures it affects primarily old people and those between 15 and 34. In the latter group suicide globally is one of the prime three causes of death. Cross-sectional the national suicide rates vary to a large extent, while remaining relatively stable in the course of time (Lester, 2002).

Only in very few, usually isolated societies suicide is an unknown phenomenon, such as with the Zunis in the southern USA, the indigenous population of the Andamans and some Australian tribes (Pfeiffer, 1994). In many countries however the subject of suicide is still such a taboo that there are not even official numbers concerning that manner of death. This is the case with most African countries, large parts of Indonesia and some states in Asia and Latin America. One of

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possible reasons for the frequently conspicuous lack of interest of such states to raise data on suicides and attempted suicides is the strong social stigmatization of families concerned. Therefore there is a tendency to classify unexpected deaths as accidents rather than suicides, in order to preserve the reputation of the family concerned. In some African countries such as Nigeria a case of suicide often makes it impossible for a family to find husbands for its female members. In countries like Pakistan attempted suicide is punishable and usually entails fines or prison sentences. The background of such strong stigmatizations are concerns about mental disorders leading to suicide but also a tendency to regard suicide as a religious provocation, an evident rebellion against God's will, who alone is entitled to decide on an individual's life and death. With most religions, certainly with Islam, Judaism and the Christian faith suicide is a deliberate action against divine providence. Only Buddhism does not regard suicide as a rebellion against a higher order, but as a foolish deed, that only worsens one's karma, so that in the next life one shall have to confront the same problems again. Even in European countries, where suicide is usually associated with mental disorders, it remains a rather tabooed manner of death. In this case social notions of intact and socially acceptable families may trigger stigmatization. Within these families, something is bound to be wrong, causing feelings of helplessness, aggression and rejection with outside observers. Those left behind after a suicide also experience a variety of different feelings like aggression, guilt, shame and self-reproach but additionally a certain pressure to hide this event.

A lot of theories try to explain the considerable difference of worldwide suicide rates. There are studies on the connections between economic development and suicide rate, but also reflections on the dependence of suicide rates on various genetic dispositions of certain ethnic groups. David Lester (1987) found a positive correlation of national suicide rates and a high percentage of blood groups O. Low prevalence of blood group O and high percentages of A, B and AB went along with low suicide rates.

Psychological as well as sociological theories attempt to explain the enormous differences in the suicide rates of even neighboring countries and religions (Durkheim, 1997; Freud, 1999a, 1999b; Henseler et al., 1981; Henseler, 2000; Hillman, 1984). Suicide research however has already recognized that especially in the field of motivational research Western concepts of suicide do not fit for universal realities, concluding that culture-specific motives have also to be taken into considerations.

In our survey we try to investigate one further factor that might influence the prevalence of suicide cases in a certain country. It is well known that different cultures or periods adopt radically divergent moral attitudes towards the phenomenon suicide. While in traditional Japan in certain situations Harakiri was a question of honor and nearly a social obligation, suicide in Islam has always been charged with a severe taboo. We therefore proceed from the assumption that culture-specific attitudes and judgments on this issue may have considerable influence on the national suicide rates.

In the first part of the evaluation of our data we investigate:

1. whether subjects from the participating countries show different reply-tendencies,
2. whether there are generally accepted suicide motives, and
3. whether there are motives, that are either only permissible in traditional or only in modern and post-modern societies.

METHOD We studied psychically healthy subjects of various ethnic and national groups with different cultural backgrounds as to their acceptance and understanding of suicide motives within

their proper societies. The questionnaire developed for this study (“The Evaluation of Suicidal Motives”) consists of a brief explanatory introduction, a section on socio-demographic data (age, sex, occupation, religion, occupation of the father, nationality and marital status) and 46 closed questions on the conceivability of motives for suicide (with the alternative answers “not at all”, “under certain conditions” and “yes”). Basic for the conception of this questionnaire was the systematic comprehension of all motives for suicide, that could be found in the literature on that subject (e.g. Lester, 1995, 2002, 2004, 2006; Lester et al., 2003, 2005; Bhugra, 2004; Canetto, 2002; Farooqi, 2004). In particular we focused the diverse cultural aspects of suicide. After extensive research in the literature we elaborated the following crucial points as underlying motives for suicide: Guilt, shame/loss of honor, altruism, narcissistic mortification, revenge, impairment of physical integrity (illness, disfigurement, and torture), menace to economic existence, personal conflicts and religions reasons.

In addition to screening lay-subjects from different countries, we developed a semi-structured questionnaire with culture-specific questions on suicide, destined for psychiatrists as that profession, which is most concerned with suicidal persons. That way we hoped to procure the necessary country-specific and culture-specific information on suicide. The questionnaire consists of seven chapters for extensive statements on important issues associated with the local suicide behavior.

The healthy subjects were recruited by psychiatrists, belonging to the “Vienna Research Group on Transcultural Psychiatry”. All in all 610 participants from Georgia, Lithuania, Nigeria, Austria, Pakistan und Poland were included into our investigation.

For the definition of the degree of modernization of the participating countries the annually calculated Human Development Index (HDI) of the WHO was used (United Nations Development Programme, 2006). The HDI is composed of life expectancy at birth, the gross per capita and the degree of alphabetization of adults (Austria: 0,936; Poland: 0,858; Lithuania: 0,852; Georgia: 0,732; Nigeria: 0,527; Pakistan: 0,453).

RESULTS As already mentioned above, the differences in the suicide rates of the participating countries are quite remarkable (Figure 1).

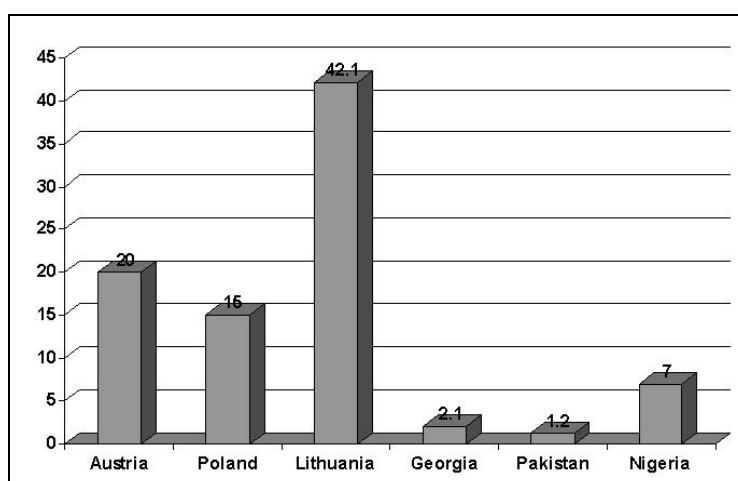


Figure 1 - Suicide-rates (N/100.000) in Austria, Poland, Lithuania, Georgia, Pakistan and Nigeria

Lithuania shows by for the highest suicide rate of the participating countries, followed by Austria and Poland. The other three countries have significantly lower rates. Figure 2 shows the country-specific responsive patterns. The medium value of items are arranged according to

importance of the item as an acceptable motive. It is striking that in the European countries roughly 10 motives exist, which can count on high understanding, between the 10th and the 15th rank curves tend to flatten.

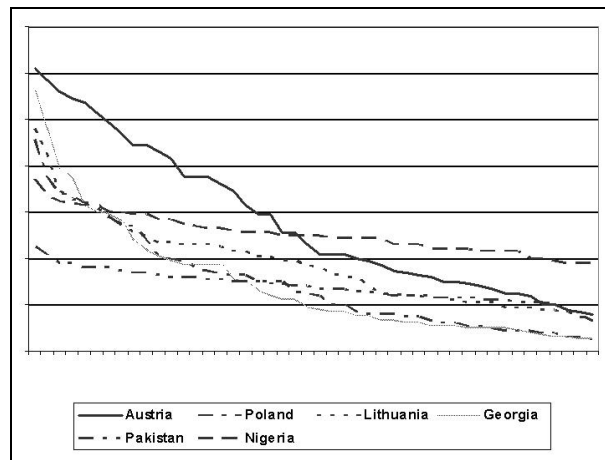


Figure 2 - Response behavior (mean by range) of the study-participants by country

In contrast Pakistanis and Nigerians show significantly flatter curves than the European samples. We also found substantial differences both within the European and the non-European group. In Europe the Austrians adopt a far more affirmative attitude towards the major motives, than the subjects from the three Eastern European States. In the two non-European countries the curves are similar but the Nigerians show a higher mean level of acceptance than the Pakistanis. In a next step we wanted to investigate, whether there are single motives, which can count or high acceptance in all 6 participating countries, and further, whether there are motives that are acceptable only for modern or only for traditional cultures. In order to classify a motive as globally accepted it had to rank among the first ten with both non-European and at least two European countries. Two motives are ranking among the ten most frequent with all 6 countries (Figure 3): massive impairment of the quality of life by chronic, non-treatable illness and the dependence on nursing, resulting from it.

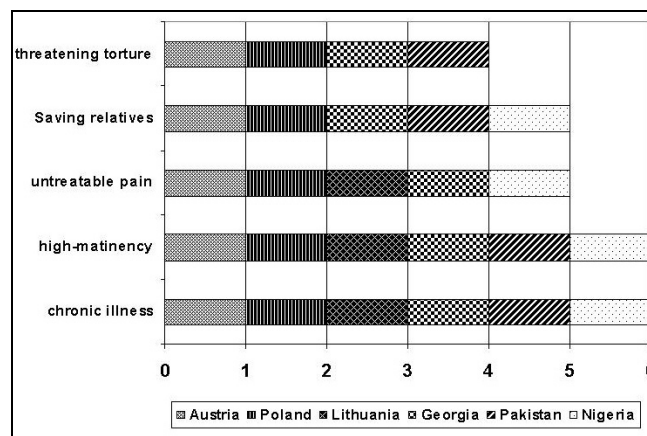


Figure 3 - The globally highest accepted suicide-motives

The experience of incurable pain can be classified in the same category. Whereas with the other motives the central focus is the Ego in its physical existence, the item “being able to save family members by one’s own death “belongs definitely to the category of altruistic suicide motive.

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Two of the items found among the first ten exclusively in European countries are directly related to guilt (Figure 4).

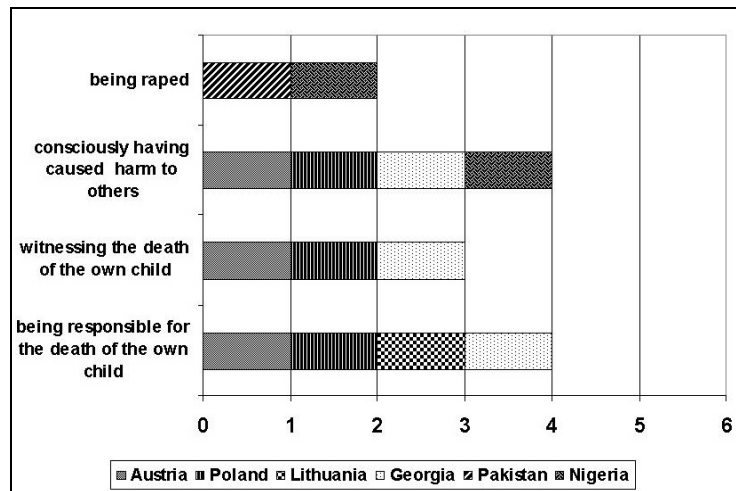


Figure 4 - Suicide-motives, either highly accepted in modern or in traditional cultures

To commit suicide for having culpably caused the death of one’s own child meets with a lot of acceptance in all four European countries. In both non-European countries typically a shame motive, suicide after rape, is classified among the first ten.

DISCUSSION The responsive attitude clearly reflects the degree of modernization of the different countries. Therefore it may be prudently deducted, that with the passage from segmented or hierarchically stratified to functionally differentiated societies, a process that usually entails the loss of leadership of religion as a guiding system of values, tolerance and an affirmative tendency towards individual motives of suicide tend to increase. The de-stigmatization of suicide has since progressed very far in European countries. The altitude, that one has the right to terminate one’s life is in turn a necessary precondition, that personal suicide ideas or fantasies do not have to be principally repulsed and that single suicide motives can acquire high degrees of acceptance.

While in Austria there are no official sanctions at all, in some Eastern European countries it is still official policy to deny suicides a Christian funeral. With the progress of functional differentiation (Luhmann, 1997), the influence of the Catholic Church in Austria decreased and was adjusted to general social attitudes. In some Eastern European Countries like Poland or Lithuania this process has not yet advanced so far and the original Christian position is still very influential. Local differences, which may be due to the various fates of the Christian churches under a communist regime that developed in different ways in the various states of the Warsaw Pact, however do exist (Tomka and Zulehner, 2000). In Georgia for example, where religion is least influential of the investigated countries (Inglehart, 1998), the attitude of the Orthodox Church circumvented and suicides are buried in the family graves.

The situation is altogether different in Nigeria and Pakistan. Caused by the central position of religion the strict rejection of suicide is still far more deeply entrenched in the individual than in Europe. Pakistan is a society in transition from hierarchical to functional differentiation with still, at least in rural areas, remnants of segmental social structures. In societies with hierarchical

differentiation usually religion dominates the other functional systems. In Pakistan Sunni Islam claims this central position. Law, politics, science, arts and other functional systems are at best in a preliminary phase of autonomy. In this concern Pakistan's position resembles the European social development between the 15th and the 18th century. The consequences of the attitude of the dominating dogmatic Islam towards suicide are a low suicide rate and contempt and division for those who survive suicide attempts and for family members of suicides.

Nigeria is a society in transition where elements of segmental, hierarchical and functional differentiation coexist side by side, too. The accent more markedly lies with segmental forms of differentiation. In most regions of Nigeria tribal structures and kinship still play a central role in socialization of the individual. In contrast to the dominating position of Sunni Islam in Pakistan, in Nigeria no religion can claim such a pronounced leadership. In the south one finds a multitude of Christian churches, many of them ecstatic in character such as the Pentecostals (Gifford, 2004). In the north Islam predominates, but both Islam and Christianity have incorporated substantial elements of tribal religions (Robinson, 2004). Officially only about 15% of the population acknowledge adherence to a tribal religion, unofficially however belief in the spirits of the ancestors is widely spread in all sections of the population (Witte, 1991). As in Pakistan the ban on suicide is to a substantial degree internalized through socialization, which leads to consequences similar to those in Pakistan. Nigeria also shows a low suicide rate (Figure 1) linked with a high degree of stigmatization. This might be one reason that there are no definitely supreme motives that may count on high rates of understanding in both countries (Figure 2).

In all investigated sites exposition to physical decay, loss of autonomy and quality of life and dependence on society are strongly imaginable suicide motives. With torture too the impotence of exposition and the futility to end this state by one's own will are added to pain. The fact that the death of one's own child as a suicide motive meets with less sympathy in Pakistan and Nigeria seems to be caused by high birth rates and high rates of infant mortality. Nigerian and Pakistani parents are more frequently confronted with the death of a child than Europeans, where such an experience has acquired an exceptionally traumatizing character.

Nigerians and Pakistanis emphasize motives related to loss of honor and humiliation, whereas in European countries nations of guilt and loss of economic foundation predominate. "Ethnic" feelings like shame and guilt arise in the consciousness when obligations towards oneself, the fellow citizens or a higher instance such as God cannot be fulfilled. Shame protects the integrity of the self and is essentially directed by the Ego-ideal (Wurmser, 1990). Guilt feelings on the other hand, protect the integrity of the other that is endangered by the undertaken or omitted activities of the subject. Guilt-feelings arise essentially through tensions between the "Id" and the "Superego". Whereas shame is usually linked with threatening loss of honour, guilt feelings point to a threat to the moral system of a society. The terms shame and guilt cultures were introduced to culture anthropology by Ruth Benedict's book "Crysanthenum and Sword" against the background of Japanese culture (Benedict, 1967). The division into shame and guilt cultures has meanwhile been applied to other cultures such as ancient Greece (Dodds, 1991), antique Judaism and China (Wurmser, 1990). Upon closer observation it is obvious that shame and guilt are regulatory mechanisms which can be found in every culture. There culture techniques such as control over the excretions of the body, which are exclusively regulated by shame, while, on the other hand in nearly all cultures obligation towards God or the gods are regulated by guilt. In between there exists a large field of ways of behavior that are either directed by guilt or by shame. An important example is sexual life. Violations of sexual norms in some cultures rather cause nations of shame in other cultures feelings of guilt predominate. Only for this non-determined field of human existence the terms shame and guilt culture are meaningful. It is however important noteworthy that culture is not once and for all times confined to one of those two qualities of feeling. Between the 12th and die 18th century Europe underwent a development from shame culture to guilt culture

(Elias, 1976, Gurjewitsch 1994, Bohn and Hahn, 1999). This process seems however to have passed its climax. In most Western societies one can meanwhile observe a decline in control of behavior by guilt, which begins to exercise some influence even on the psychopathology of psychoses (Stompe et al., 2003).

West African societies (Quack, 2006) and Pakistan (Frembgen, 1990) rest on totally different value systems. Reference to the social World forms a remarkable part of the human personality. The more an individual engages in mutual relations the more it becomes an honored person. In contrast to European culture traditional communities are socially centered. While the individual is not autonomous to the same degree as in the Occident, it nevertheless retains its status as a subject. But in no case the individual completely disappears in its community. However, whatever occurs to the individual is of concern to the whole group and whatever occurs to the group is of concern to the individual. This attitude entails a lot of social support. Community and loyalty are naturally owed to one's own family, then to one's kinship, whether biologically or taxonomically determined, and then to the neighborhood, which is at least partly also composed of relatives. In traditional societies suicide is more obviously directed against the whole social system, and is therefore regarded as an aggressive act against God and one's family. In western countries by contrast personal needs and advantages are regarded as accepted values. Therefore the decision for suicide is regarded as an exclusively personal matter, thus acquiring certain legitimacy.

In conclusion differences in moral attitudes appear in many details of our study and serve as an indicator that values and views of life can serve to explain many of the important difference in national suicide rates.

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