NATIONAL UNIVERSITY OF IRELAND, MAYNOOTH
CO. KILDARE.

PROBABLE SOCIOLOGICAL REASONS FOR THE INCREASE IN SUICIDE IN CONTEMPORARY IRELAND.

MARY BRADY.

RESEARCH ADVISOR: PROFESSOR LIAM RYAN.

PRESENTED TO THE DEPARTMENT OF SOCIOLOGY IN PARTIAL FULFILLMENT OF THE DEGREE OF MASTER OF ARTS.
(MODE 11)

July 2000

ACKNOWLEDGEMENTS

A number of people must be thanked in this sphere of scholarship, especially Professor Liam Ryan, whose care, kindness, inspiration, criticism, encouragement, support, and most of all patience appears to have no bounds. The help he has given to me in the preparation and writing of this thesis is invaluable.

A sincere thanks to Dr Mary Corcoran who offered very helpful advice about my academic progress. Dr. Corcoran's seminars fostered my interest in Urban Regeneration processes.

Mrs Maureen Redmond has always been of great assistance and help in several respects, for which I am very grateful.

Finally the example of all of the lecturers in the Sociology Department of the National University of Ireland, Maynooth, has taught me the importance of looking further into the extraordinary study of Social Science and the Humanities. Their help and kindness is deeply appreciated.

TABLE OF CONTENTS

INTRODUCTION.

Why would an individual want to kill himself or herself? This continues to be a difficult question to understand, not to mention answer. Why not seek help when support and care is available? Why? Is the question the bereaved of those who take their lives by suicide constantly ask. Why has the value of life completely lost its appeal for a small number of people who appear to be healthy, when the opportunity is there to change course, to enjoy life to the full and to look into the extraordinary abyss of how little we know?

There are people around us who may be perceived as having many reasons to kill themselves and yet do everything in the power to live, and there are those who may appear to have every reason for living and yet kill themselves. Such is the enigma of suicide.

Human wisdom depends on many things, among which human interaction and personal reflection are paramount. Why then do bright, intelligent, articulate and reflective people decide that they need to opt out of life, leaving family members, relatives, and those who know them bewildered and traumatised for the rest of their lives. We can only attempt to do everything in our power to keep them alive and to try to understand why suicide is a recurrent feature in modern life.

There was a time when suicide was neither considered nor discussed openly. It was hidden and shameful. There is still in fact stigma attached to mental illness and suicide. In Ireland, since decriminalisation in 1993 and improved research methods, it has become easier for coroners to classify unnatural deaths. However, improved statistics make an insufficient explanation for the overall increase in suicide deaths each year and the problem of suicide continues to be an issue of growing concern nationally and internationally. If help is to be made available to those at risk, it is essential for researchers to have access to reliable information on the occurrence of, and factors associated with suicide. It is important to try to understand the problem of suicide in a specific Irish context and to identify the reasons why so many of our young (15-24 years) and young elderly people (64-74 years) in particular seek to end their lives in this way.

Most suicides are lonely, hidden affairs occurring far away from the blaze of publicity. People who commit suicide are usually ill. "They are not psychotic". (M.J. Kelleher, Suicide and The Irish: 13). Yet, in dying, they throw away the miracle of individual existence that can never be repeated, no matter how many more billions of people are born. Often death is, to use a catchphrase, a permanent solution to a temporary problem.

In this thesis suicide figures for the years 1971 to 1998 will be included, as well as variations in suicide in the eight Health Board Areas of the Republic of Ireland. The years studied for the latter were 1976 (the first year that data were comprehensively available on computer) to 1995 the last available year. Suicides occur in all groups in society. However, a study of one 'at-risk' group, in this case, a study of people living in an area of disadvantage, some of whom attempted, and others who committed suicide will be examined. As with all ecological studies of suicide the relations of variables such as the loss of social status, feelings of inadequacy, unemployment, poverty as well as other socio-psychological variables will be examined.

The case study method was used on a very small scale, as an adjunct to the studies using official statistics in order to get more and better information on cases. (See qualitative research section of the thesis). Obtaining in-depth information concerning individual motivational factors is important if the problem of suicide is to be further understood in contemporary Ireland. All of the general theories of suicide however that have been proposed and tested by sociologists have relied almost exclusively on official statistics. The most important reasons for this is that the constancy of the official suicide statistics indicates that there are some lawful social phenomena that merit careful study, especially with regard to the motives for suicide. Sociologists, especially after Morselli and Durkheim, considered suicide to be largely the

result of general social phenomena that could be observed only by comparing the variations in suicide rates between many different societies and between different regions within countries. Primary research requires the statistical approach, not merely as a convenience, but rather as an essential aspect of the sociological approach to suicide. Since Durkheim published his book Suicide sociologists have had a strong preference for general theories of suicide over the more meticulous studies that could come from the use of the case study method.

A major problem in the definition of suicide is the determination of intention. Often researchers shy away from this concept on the grounds that one can never be certain of what another intends. Suicide is defined as "all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce the result." (Durkheim 1897). The establishment of intent is essential in making a formal judgement of suicide. Psychiatrists believe that many 'attempters' may be ambivalent about the outcome of the event, but set upon a course of action in the knowledge that death is the likely outcome.

With Parasuicide, the situation is different. By definition, this refers to "any act deliberately undertaken by an individual which mimics the act of suicide but does not result in death" (Kreitman, *British Journal of Psychiatry*, 1988:

792). From the research so far carried out it has been found that no one fully understands the true impact of parasuicidal behaviour. As well as the lasting trauma this inflicts on family members, relatives and friends, it is likely to be of great cost to the individual, the family, the caring services and society as a whole. According to researchers at the National Suicide Foundation the areas with the highest rate of parasuicides are socially deprived areas. "These areas are also characterized by heavy emergency demands on the social services and a majority of the population has minimum education". (M.J. Kelleher: Suicide and The Irish:54).

CHAPTER 1

PROBABLE CAUSES OF SUICIDE ASSOCIATED WITH CULTURAL AND ECONOMIC CHANGES IN IRELAND.

One of the reasons for carrying out research on this topic is because of an interest in finding out some of the probable causes of suicide associated with major cultural, economic and social changes in Ireland. With regard to changes in this country, Ireland has gone through a cultural, economic and social revolution. There have been profound changes in the fabric of society. Nowhere is this more obvious than in the area of religion, which Emile Durkheim regarded as a protective factor against suicide. In Suicide he linked his forms of egoistic, altruistic, anomic and fatalistic suicide to the degree of integration into, or regulation by society. Integration refers to the degree to which collective beliefs are shared. Altruistic suicide is associated with a high degree of integration and egoistic suicide with a low degree of integration. Regulation refers to the degree of external constraint on people. Fatalistic suicide is associated with high regulation , anomic suicide with low regulation. Durkheim quoted rates of suicide from different parts of the German-speaking world. Catholics invariably showed lower rates of suicide than Protestants. He then examined suicide in Switzerland and found that for both French and German speaking cantons, the suicide rate amongst

Protestants was approximately four times higher than the rate amongst Catholics.

Concerning religious changes in Ireland over the last four decades, Michael P. Hornsby-Smith, in a paper entitled "*Social and Religious Transformations in Ireland:* A Case of Secularisation?" first refers to Berger's claim that it was 'reasonable to assume that a high degree of secularisation is a cultural concomitant of modern industrial societies' (1971:30). In an earlier study he defined secularisation as 'the process by which sectors of society and culture are removed from the domination of religious institutions and symbols'(1973:13).

Such changes, according to researchers could foster the antecedence of suicide, namely, depression and other psychiatric illnesses. The paper discusses this secularisation thesis in depth while simultaneously referring to religious revitalisation. For instance "Seeds of a transformed Catholicism are to be found in the success and international recognition of the work of *Trocaire* , the main Irish development agency." Also "a growing number of groups are working in inner-city areas or with deprived groups and attempting to raise awareness of some of the social injustices associated uncontrolled forms of Western capitalism"(Kirby, 1984).

In the context of church-state relations in Ireland, and of relevance to this thesis, in which there is a search for stability and reality, which is sanity,

Whyte concluded that there were only sixteen measures out of about 1,800 statutes enacted by the Irish Parliament between 1923 and 1970 where there was clear evidence that one or more bishops had been consulted or made representations (1980: 363-4). This led him to reject any suggestion that Ireland was a theocratic state. He rejected an alternative view that the Catholic hierarchy was simply one interest group among many and, following the suggestion of Professor Liam Ryan (1979), concluded that 'the best model to use for the hierarchy's current role is to see it as seeking to be the *conscience of society'* (1980:416). In this role the hierarchy is seen less as the close collaborator of the state and more as 'a left-of-centre' social critic on behalf of the poor, deprived and those oppressed and vulnerable as a result of social and economic change. It is misleading to see such a transformation of social role as evidence of secularisation. Rather it is appropriate to regard the change as evidence of a slow process of revitalisation in Catholic thinking which commenced a century ago with the first modern social encyclical but which in recent years dates from the reforms of the Second Vatican Coucil.

In a review of the survey evidence discussed in this paper, Father Liam Ryan has suggested that 'a picture emerges of a people largely believing in God and in the Church, but in possession of a belief which increasingly has little impact, not just on the wider world of business and politics, but also in

many areas of private morality' (1983:6). "A new type has appeared among middle-class Catholics, similar to Greeley's 'communal Catholic' (1976), wanting a less authoritarian and more participative style of leadership and demanding that the leadership speak out more authoritatively on social morality but less on matters which affect his or her private life"(p.282).

Vulnerable people include the bereaved families of those who committed suicide. They belong to different social groups, and their turmoil is greatly abated with the help of spiritual direction, psychiatric care and counselling. Approximately thirty conversations took place and extracts from these will be presented in the qualitative research section of this thesis.

Concerning social and economic change in contemporary Ireland: Anthony Giddens argues that in 'high modernity' there are more choices in social and working life available for everyone. The individual, by continuous self-reflection, generates the self-understanding necessary to plan ahead and is enabled to construct a trajectory which agrees with the individual's inner wishes. This may be possible for those with few financial concerns. At the end of the 'socio-economic' scale however, choices are limited for people whose homes are for instance in flat complexes such as Fatima Mansions, which Dr Mary Corcoran examined. Drug and alcohol factors are thought to be important in suicide in adolescence (Hawton et al 1993) and have been

suggested as a major cause of the rise of suicide in the young (Neeleman & Farrell, 1997). Many parents living in these conditions, who at least experienced some predictability in the past must now helplessly observe their young destroying their lives as a result of the increasing availability of drugs.

With regard to economic conditions, as the economy faltered in Ireland in the 1980s, the frustration of expectations of higher living standards led to higher levels of anomic disturbance: crime, marital breakdown, drug abuse increased especially in disadvantaged areas (NicGhiolla Phádraig, 1998:208). The number of suicides increased from 296 in 1980 to 334 in 1990. The suicide figure for 1997-1998 is 504. (Central Statistics Office).

With reference to cultural changes, the most lucrative form of what Pierre Bourdieu calls cultural capital is a third level qualification. In Ireland a major social as well as cultural change relates to the proportion of young people continuing their education beyond the minimum school-leaving age of 15 years. 46% of 14 to 24 year-olds were still in school in 1991, compared with 28% in 1971. The number of third level places has increased from 31,000 to 103,000 in 20 years. In particular, the gender ratio of students has changed quite dramatically; 62% were male in the academic year 1975-1976 and this has fallen steadily, with 1995-1996 being the first year in the history of the state when the majority of third level students were female.

Access to third level education is dependent on the number of points achieved in the Leaving Certificate examination, and the entry requirements, especially for some of the science and technology courses has increased every year, making competition for places very intense. Although it is well recognized that the system is stressful to students, teachers and parents, it is so far unclear whether or not it has contributed to the rise in young suicides in Ireland. Investigating this problem, recent research into the association between suicide and education in Ireland has found that the incidence of suicides among students of leaving certificate age is not associated with the time of sitting or the release of results of state examinations. When student, employed and unemployed 15- 24 year-old males were examined over an 18-year period, (1976-1993) it was found that students actually had the lowest rate of suicide and the unemployed had the highest rate(National Suicide Foundation, 1998). Although the unemployment figure has fallen dramatically, especially in the middle to late 1990s the suicide figures continue on a gradual upward trend (C.S.O.).

Along with the above changes the institution of the family in this country has undergone considerable change. Although divorce was legalised in 1996, the number of legal separations has been increasing over the years. The number of births to single mothers has also increased. Of the 53,354 births registered in 1999, 16,461 were born outside of marriage. 3,165 were born to single

mothers under the age of 20, (the majority, 1,302 to mothers aged 19 years). 5,949 were registered to those under the age of 25 years, bringing the total number of births to single mothers of this age group to 9114. (Central Statistics Office).

If the changes in the nuclear family are important in disposing towards a rise in suicide, then an explanation must be offered as to why it is that young males have shown the rise and not young females. The overall trend seems to be towards the exclusion of males from the family unit. If there is a separation, it is usually the male parental figure that leaves the home. Therefore, male role models for adolescents may be perceived in a less permanent and more negative way today than they were 20 years ago.

There are many other changes in Irish society in recent years that have not yet been the subject of analaysis. These include increasing urbanisation, marked internal migration, widespread industrialisation, an explosion in communication and information technology, as well as advances in technology generally and other changes which has brought a great increase in the gross national product. Economically, the country is more competitive internally, with its European neighbours and internationally. Any of these factors could contribute to the increase in suicide. Researchers of the probable sociological causes of the increase in suicide rates emphasise that

the rise in young males suicide, simply reflects what is happening in many Western societies and it is unwise to seek a purely internal system of causation rather than a wider one shared with many other countries.

Cytological, psychiatric and sociological reasons for ending life in this way are complex and there is a concerted effort by medical and sociological researchers, religious congregations, relatives of the suicidal, those bereaved by suicide and others to tease out the underlying reasons in detail, so that more effective measures may be put in place with a view to reducing the numbers of these deaths. The National Task Force on Suicide continues to employ new methodologies likely to generate innovative responses to the problem of suicide. Methods of intervention are being researched further. To date, one of the most important advances in suicidology has been the development of psychological autopsy studies, that is, the study of more detailed social and psychological information about the victim, including assessment of the contributions made by various psychological stressors prior to death. (Report of the National Task Force on Suicide).

Suicide accounts for just over 1% if Irish deaths each year. At present the total population is 3.825.087. The Central Statistics Office reported 433 suicide deaths from June 1996-1997, an increase of 41 suicides, compared to the previous year. 504 suicide deaths were registered for the year 1997-1998,

an increase of 71 deaths in one year. The figure for the following years is still provisional. Trends in suicide rates have been studied extensively between the different decades and show that higher rates are associated with cultural, economic and social change, for instance, with rises in divorce, unemployment, in times of economic improvement and depression, with a higher proportion of women in the work place as well as in third level education and with other factors which support Durkheim's theory of anomie.

Finally the main reason for carrying out research on suicide is because of an acute awareness of the extent of the traumatic effects of suicidal behaviour on the individual and on the family. The 'completed' suicide, furthermore is one of the most devastating events to occur in a locality. Further details will be presented later in the thesis.

CHAPTER 2

THEORETICAL FRAMEWORK.

The theoretical framework on which this thesis is based is in part at the macro level, influenced by the structural functional model of society and also at the micro level influenced by reflexivity theories. Emile Durkheim was a functionalist who believed that society operated like a living organism. He was also a structuralist. According to Durkheim society operates through a sense of structures that are independent of the individual. People are forced to behave in a certain way. Society reveals itself to us through social facts. Social facts have three characteristics, They are external to us, they are outside our control, and everyone is subject to them.

Durkheim and later Structural Functionalists such as Parsons viewed social facts as things. Society for these theorists exists independently of particular individuals and according to Durkheim, for sociology to be a scientific discipline its objective existence must be studied. In his classic work on methodology, Durkheim distinguished between material and non material social facts. In *Suicide* he stated that "the social fact is sometimes materialized to become an element of the external world". In much of his work the emphasis is placed on non-material social facts. These social currents do not have material

existence. They exist only within the consciousness of individuals and between them, but they have a material effect, for example suicide rates. In *Suicide* Durkheim concentrated on examples of this kind of social fact. He related differences in suicide rates to differences in social currents. For example, when there are strong currents of anomie, high levels of anomic suicide are found. This final major form of suicide discussed by Durkheim applies to people who experience an extreme sense of 'normlessness'. The moral order collapses and adapting to change, cultural or economic may be distressing. Sometimes when the economy improves the moral code collapses. Concerning Ireland, this was referred to the introduction of the thesis.

According to Durkheim external constraints become slaves to people's passions and there is little control over them. Social currents like anomie, egoism and altruism do not have a material existence but they have a material effect by causing different rates of suicide. Durkheim wished to study suicide in order to show that sociology is a science like physics or mathematics, as well as to establish the objective reality of human sociology as revealed by social facts. He chose the academic 'project' of explaining suicide, which is the most private and personal act that one can commit. Suicide is a relatively concrete and specific phenomenon and good data was available. If he could show that sociology had a role to play in explaining such an individualistic act, he could

gain recognition for it as an academic discipline. Furthermore it would highlight how much easier it is to explain more concrete phenomena.

Durkheim, who was a Jew, regarded the Catholic religion as a protective factor against suicide. He believed that predominantly Catholic countries had lower suicide rates than predominantly Protestant ones. He found England to have an intermediate rate and he attributed this to the manner of worship with the Anglican Church, which he believed had retained many of the practices of the Catholic Religion. Durkheim saw the Protestant as a person who stood in a direct relationship with God. Whereas the Catholic, in his view, had many mediating factors, including a sacramental priesthood, communal worship and confession.

Recent work has shown that religious denomination, even if one is non-practising, does influence suicide rates. A study of suicide in Holland confirms that traditionally Catholic areas have lower rates of suicide than traditionally Protestant areas, even though church attendance by both Catholics and Protestants is minimal. (Kerhof & Kunst, *A European Perspective of Suicide:* 22-23).

Durkheim was not concerned with the study of why any individual committed suicide. He saw that as the work of psychologists. He was interested in why

one group of people had a higher or lower rate than another. If there is variation it is because of social currents. For Durkheim Sociology was not about what went on in individual's minds. As a structural functionalist he looked at the 'big picture' for a total explanation of society. Suicide is caused by people 'acting out' social facts that are caused by society. Changes in social facts according to Durkheim cause changes in suicide rates.

Durkheim's theory of suicide, and the structure of his sociological reasoning can be seen more clearly if his four types of suicide, are examined:

Egoistic Suicide. High rates of *egoistic suicide* are likely to be found in those societies, collectivities, or groups in which the individual is not well integrated into the larger social unit. This lack of integration leads to a sense of meaningless among individuals. Societies with a strong collective conscience and protective, enveloping social currents that flow from it are likely to prevent the widespread occurrence of egoistic suicide by, for instance, providing people with a sense of the broader meaning of their lives. When these social currents are weak, individuals are able to surmount the collective conscience and do as they wish. Such unrestrained egoism is likely to lead to considerable personal dissatisfaction, because all needs cannot be fulfilled, and those that are fulfilled lead to the generation of more and more needs and, ultimately, to dissatisfaction,

and for some even suicide. (Breault, 1986). However, strongly integrated families, religious groups, and polities act as agents of a strong collective conscience and discourage suicide. "Religion protects man against the desire for self-destruction....What constitutes religion is the existence of a certain number of beliefs and practices common to all the faithful, traditional and thus obligatory. The more numerous and strong these collective states of mind are, the stronger the integration of the religious community, also the greater its preservative value". (Durkheim, 1897/1951:170).

Altruistic Suicide is the second type of suicide discussed by Durkheim. Whereas egoistic suicide is more likely to occur when social integration is too weak *altruistic suicide* is more likely to occur when "social integration is too strong" (Durkheim, 1897/1951:217). The individual is literally forced into committing suicide. Those who commit altruistic suicide do so because they feel that it is their duty to do so. As was the case with egoistic suicide, the degree of integration, in this case a high degree is not the direct cause of altruistic suicide. Rather, different degrees of integration produce different social currents, and these different currents affect suicide rates. As with egoistic suicide, Durkheim saw melancholy social currents as the cause of high rates of altruistic suicide. Whereas higher rates of egoistic suicide stem from "incurable weariness and sad depression, the increased likelihood of altruistic suicide

springs from hope, for it depends on the belief in beautiful perspectives beyond this life" (Durkheim, 1897/1951:225).

Anomic suicide is the final major form of suicide discussed by Durkheim. *Anomic suicide* is more likely to occur when the regulative powers of society are disrupted. Such disruptions are likely to leave individuals dissatisfied because there is little control over their passions, which are free to run wild in an insatiable race for gratification. Rates of anomic suicide are likely to rise whether the nature of the disruption is positive (for example, an economic boom) or negative (an economic depression). Either type of disruption renders the collectivity temporarily incapable of exercising its authority over individuals. Such changes put people in new situations in which the old norms no longer apply but new ones have yet to develop. Periods of disruption unleash currents of anomie, that is moods of rootlessness and normlessness and these currents lead to an increase in rates of anomic suicide. This is relatively easy to envisage in the case of depression. The closing down of a company due to an economic depression may lead to loss of work. The individual may consequently feel cut off from the regulative effect that both the company and work may have had. Being cut off from these structures or others, for example from family, religion, state can leave the individual highly vulnerable to the

effects of currents of anomie. Concerning an economic boom, individuals may feel that sudden success leads them away from the traditional structure in which they are embedded. Economic success may lead an individual to change their career, move to a different district and experience all that that entails. All these changes disrupt the regulative effect of extant structures and leave the individual in boom periods vulnerable to anomic social currents. The increase in rates of anomic suicide during periods of deregulation of social life are consistent with Durkheim's views on the pernicious effect of individual passions when freed of external constraint. People thus freed will become slaves to their passions and as a result, in Durkheim's view, commit a wide range of destructive acts, including killing themselves in greater numbers than they ordinarily would.

Fatalistic suicide is discussed only in a footnote in *Suicide*. Whereas anomic suicide is more likely to occur in situations in which regulation is too weak *fatalistic suicide* is more likely to occur in situations when regulation is excessive. Some prison suicides could be viewed as fatalistic suicides. Durkheim described those who are more likely to commit fatalistic suicide as "persons with futures pitilessly blocked and passions violently choked by oppressive discipline" (1897/195:276). Too much regulation or oppression unleashes currents of melancholy that, in turn, cause a rise in the rate of fatalistic suicide.

Talcott Parsons argued that in *Suicide* Durkheim moved increasingly away from the idea that external factors such as degree of functional differentiation of a group, cause the suicide rate of a society and increasingly towards the idea that forces of a "collective consciousness" are the fundamental causes of the suicide rate. Parsons interpreted parts of *Suicide* as follows: Durkheim considered altruistic suicide to be largely the result of external forces of group structure, whereas egoistic suicide was seen more as the result of internal forces of the "collective conscience" and anomic suicide was seen as almost entirely the result of the internal forces of the "collective conscience". (*The Structure of Social Action:* 330-338). Although the French word *Conscience* translates into English both as conscience and consciousness, Durkheim was not talking about a group mind. He was describing the varying nature of moral obligations. "The 'conscience', he maintains has four dimensions, *volume*, or the extent to which individual conscience is wholly permeated by collective feelings and standards. *Intensity*, or the energy and sincerity with which individuals observe collective sentiments. *Rigidity*, or the relative sharpness or vagueness in collective moral ideas. *Content*, the actual nature of the moral ideas themselves". (Lee and Newby, p.217). There is a degree of vacillation over just what the fundamental theory is. In *Suicide* Durkheim tended to place the emphasis more on shared beliefs or shared meanings than behaviour as the ultimate cause of suicide. The self, however, of any given individual, while it is measured against social

structural systems is also spiritually, logically and empirically distinct from the many forces which attempt to weld separate lives into a collectivity. Failure to make this distinction may have caused Durkheim increasingly to violate the more unrelenting aspects of his *Rules of Sociological Method.*

Maurice Halbwach's extension of Durkheim's theory did not attempt to delineate any collective representations, such as egoism-altruism and anomie-fatalism, but there were two essential points on which his work was in disagreement with Durkheim. These were concerned with the relations of economic crises to suicide rates and at the 'micro level' between individual 'mental troubles' and suicide. With regard to the former, Halbwachs concluded from his study of German economic indexes and suicide rates that suicide varied inversely with respect to the indexes and not simply to economic crises. Briefly, Halbwachs argued that mental troubles should be considered to be the causes of suicide. Though Halbwachs argument could be considered to be quite tentative because of the need for more evidence, the general direction of his theory indicated by these two essential points of disagreement is in fundamental opposition to Durkheim's theory of suicide. (Maurice Halbwachs, *Les Causes du Suicide:* 3-15).

According to Jack Douglas,"Halbwachs assumed that the basic explanatory link between the socio-cultural level of analysis and the personality level of analysis is that of the 'probabalistic' situations caused by culture and society and he assumed that individual motives must be fundamental, partially independent categories in an adequate theory of suicide"(Jack D, Douglas, The Social Meanings of Suicide).

Halbwachs argued that whenever the usually attributed motives for suicide is considered, he finds that they involve a common element of social isolation, (which may not necessarily mean geographical isolation) which he believed gave these attributed motives most, but not all of their explanatory power (Ibid. pages, 419, 433, 434. Because of this argument which is one that emphasises the social causes and aspects of individual motives, which involves the often unexpressed assumption that societal and cultural factors must be considered to be the ultimate causes of motives, Halbwachs' acceptance of motives, as categories of his theory of suicide, is not so radically different from Durkheim's theory, as is Halbwachs' assumption that the socially generated 'situation' of an individual is a necessary category in an adequate scientific explanation of suicide rates. This is not in agreement with Durkheim's assumption that it is the operation of the whole society (or culture) that directly causes the suicide rate characteristic of a group and that a scientific explanation of this suicide rate can only be in terms of the whole social system compared to other social systems. It

was this basic assumption that led Durkheim to believe that studying individual causes (hence "situations") was of no value for a scientific explanation of suicide rates. He was not entirely consistent, since he strongly implied in at least one place in *Suicide* that his method of study was dictated primarily by a lack of data on individual cases of suicide. At the micro-level it was clear to the theorist, Ruth S. Cavan, as far back as 1932 that social disorganization could not be significant in the causation of suicide unless it resulted in personal disorganization. Halbwachs made the study of *Situations* and their associated concrete meanings a necessary part of any scientific approach to suicide, although, according to Jack Douglas, "situated motives are somewhat more social than the general interpretation of Halbwachs' theory". (The Social Meaning of Suicide p.130). What is important about Halbwachs' theory is that it has helped to prepare the way for a fundamental reorientation of social research and theory on suicide, without throwing away the basic insights of Durkheim. Many sociologists have overlooked Halbwachs' basic critique of Durkheim's work, which, according to Douglas, he had very carefully analysed (Ibid: 131).

With regard to the micro level, influenced by reflexivity theories, Anthony Giddens and Ulrich Beck agree that modern society has reached a point where established parameters for analysing social change should be revised in a radical way. In so far as reflexivity is institutionalised, every dimension of

contemporary society is being placed under relentless and intensely critical scrutiny by its own members. This is not the well-ordered teleological process of critical self reflection envisaged by Jurgen Habermas. We are in an experimental society. In late modernity there are more and more choices available to everyone. According to Giddens self-reflexivity leads to a consciousness of the process of knowledge creation, and by drawing on that knowledge the individual also reproduces it. This approach also has important ramifications for understanding the nature of social change and political transformation. Anthony Giddens suggests that social action, in so far as it entails reflexive monitoring is potentially transformative. The strength of this concept of reflexivity is that it seeks to rework "conceptions of human being and human doing, social reproduction and social transformation" 1984:xx). The individual, by continuous self-reflection generates the self-understanding necessary to plan ahead, and to chart a trajectory which agrees with the individual's inner wishes. This may be an ideal course to take for self-realisation. The psyche however is complex and consequently it is difficult to understand why the people in the case studies committed suicide. Lifestyle is influenced by many factors including socio-economic conditions. Because of the complexity of choices it would appear that individuals have numerous identities from which to choose. Individual self-identity, however, can never be repeated no matter how many billions continue to exist. We are all unique.

According to researchers, it would be wise to remind those, who feel compelled to commit suicide of this reality.

For Giddens, "history has no teleology" (1990:54). For Beck, we are placed in the position of having to make decisions for ourselves rather than rely on experts. The future is unprecedently open-ended. The impression is given that a personal anchoring place in a larger universe has vanished, whereas from experience individual self-identity is the spiritual self, taking away, not struggle, pain and other socio-psychological and emotional problems, but fear to a great extent. We may think the future is our project, but again from experience, far too many unexpected situations arise beyond the control of the individual, which may either be enabling or constraining, enforcing certain courses of action, independent of knowledge, degree of wealth, power or even self-reflexivity. Giddens acknowledges that self-reflexivity must be interpretativly organised by the person concerned in relation to individual problems. This may be important when faced with the harsh reality that change for the better may not be an option. With regard to financial insecurity, Dr Mary Corcoran gives the example of unfortunate people at the end of the socio-economic scale who have known little but depravity, many of whom are living in flat complexes, hopelessly observing their young destroying themselves by drug and or alcohol abuse. Stanaslaus Kennedy refers to the stark choices for more than 5,000 people who

are homeless and others whose "life's" chances are poor. Rhetoric about fairness and justice continues to waste time. The absence of a comfortable and warm place in which to live, the absence of confidants, the absence of religious beliefs, the absence of extended family, unemployment, the loss of a parent in childhood, are aspects of anomie and egoism as described by Durkheim. These and other difficulties predispose to depression and even to suicide.

The third component which Durkheim describes as altruistic suicide is the use of self-immolation to achieve an ideal, and classic examples of this are found even in the present day, for example, hunger striking, Kamikaze units. Such suicides are of sociological and not psychiatric importance since the victims are not psychiatrically ill in any recognised sense and prevention rests with society, as well as the individual, and not necessarily with the medical profession.

Self-reflexivity, particularly in ethnomethodology or symbolic interactionism may be defined as the idea that our everyday practical accounts are not only self referring but also socially constitutive of the situation to which they refer. This view refers to reflexivity as a feature of reflexive social accounts of all types. These accounts may also act to reproduce or to transform social situations. Self-reflexivity may be the very condition of effectively planning ahead, but this concept may not be valid where sets of circumstances inhibit diversity of

possibilities. Moreover, humankind appear to live in a continuous situation of doubt, and although for some people, there may be a diversity of possibilities from which to choose, all human 'agents' may not be as free, 'knowledgeable' or as skilled as Giddens appears to assume, to take 'informed risks'. During a working, as well as a day of rest from study, the best therapy is supplication, alone in a quiet place, such as a church, where a workable philosophy of life and a way forward can be thought through, before the ultimate quest for some peace of mind with a sense of hope may be made, a wish which is sometimes granted even before the onset of what may be called 'the wisdom of age'.

According to Giddens, in late modernity the 'traditional' family is dead. He does not appear to give much consideration to the lasting trauma for many couples and children who are the victims of marriage separation. Mouzelis criticises the overemphasis on the instrumental aspect of self-reflexivity in Giddens' work. Ulrich Beck's discussion of the instability in conditions of contemporary modernity could be taught to children, as it is in Japan, where, according to M.J. Kelleher in Suicide and the Irish (p. 19) there is a marked reduction in suicide rates.

Reference is made, in reflexivity theories to Arthur Imhof's respect for the Christian beliefs of our ancestors in uncertain times of simultaneous plague, famine and war. Risk societies have always existed in one form or another, and

Christian beliefs continue to give emotional stability to people, worldwide, which is not easily thrown off balance, even in the worst possible occurrences. This seems to be apparent in the families of those who died by suicide. It is important to attempt to understand the problem of suicide in a specific Irish context and to respond to assist the suicidal and the bereaved.

CHAPTER 3

REVIEW OF LITERATURE

The gradual changing approaches to suicide research is well documented in much of the ample literature examining variations in suicide in the eight Health Boards of the Republic of Ireland. While all have experienced a rise in male suicide, it has been much less pronounced in the Easter Health Board, which is somewhat surprising when Dublin's much publicised problems with homelessness and drug misuse is considered. (According to Teresa Mason, Eastern Health Board, new information regarding fatal road traffic accidents needs to be gained about the younger age groups, (17-30), as well as other factors and circumstances relating to each case of suicide, against the background of cultural, economic and social change. This will facilitate a better understanding of the causes of suicide and allow for a more appropriate prevention/reduction programme to be developed) Since the mid-eighties female rates have been somewhat higher in the Southern, Mid-Western and South-Eastern Health Boards. This variation may reflect a difficulty with contacting services for psychological distress in rural areas, either

because of stigma or simple practical problems associated with transport. The Chief Executive Officers of each health board has nominated a resource officer, with responsibilities in the broad field of suicide. Resource Officers act as a contact point with voluntary groups and facilitate research into all aspects of suicidal and parasuicidal behaviour, and their consequences in the health board area.

Tony Bates In Depression, The Common Sense Approach, (1999) offers support to those who are familiar with feelings of despair, or who believe that they can no longer face the future. He offers advice to those who care for, and about them. The first step is to seek professional help if there is talk of suicide. This book offers hope to those who recognise the symptoms and causes of depression, as well as advice on where to ask for help, and how to cope with isolation. Written with and endorsed by the Samaritans, Depression provides emotional support to those who are experiencing crises and at risk of suicide. The process of finding psychological and physical strength for recovery is discussed in order to enable the reader to bring about positive and constructive change for the future.

According to Dr. Patricia Casey Schizophrenia is not a single entity but a "group of disorders which include auditory hallucinations, delusions of persecution, delusional mood, perplexity of mood and disorders of the form of thought". As with depressive illness many schizophrenic episodes follow upon major socio-psychological trauma although the type of event has been shown to be nonspecific. The lifetime risk for developing schizophrenia is about 1% and there is a slight excess of men over women. One in ten schizophrenic patients end their lives by suicide and are more likely to do so when well. On the other hand "depressed patients are more likely to do so when ill" (*British Journal of Psychiatry,* 1994;164, pp.284-287). An important aspect of long-term treatment is the environment in which the sufferer of schizophrenia lives. A moderately stimulating milieu that includes occupational therapy is superior on the one hand, to an unstructured long-stay ward and, on the other, to more intense treatments of psychotherapy, which may provoke relapse. Those who are being rehabilitated need help with the basic skills of everyday life, including self-care, household management and social skills. This necessitates adequate occupational and resocialisation therapy, usually provided by occupational therapists. Retraining for work may be feasible for those whose illness is under control and who have satisfactory social and personal skills.

The increasing suicide trends both internationally and nationally is now a major public health problem. According to Dr. Patrick McKeon, Suicides in Ireland, a Global Perspective and a National Strategy, p.7). "Over 40% to 70% of suicide victims are found to have a mood disorder. Some 70% of those with schizophrenia who kill themselves are depressed at the time of death, and more often they are young, male, having frequent relapses and are socially isolated". (Drake, Gates, Whitaker et al. *Comprehensive Psychiatry, 26:90-100).*

With regard to the elderly, the link between suicide and physical illness may be due to several factors including pain, depression, substance abuse and difficulties coming to terms with the handicap of a debilitating or terminal illnesss. (British Journal of Psychiatry, 1999,:373).

Parasuicide, according to Dr Patricia Casey is a behaviour which predominates in women, in those under 35 and in the divorced, single or separated. The association with unemployment and low social classes is well recognised although the mechanism for this is not understood. The episode generally occurs in the context of a family or personal crisis. Rates vary with marital status, with the divorced being the most at risk. A peak in late spring/early summer and a trough in late

December/January have been shown for women and are probably related to the sense of purpose which is associated with the traditional role of women at Christmas.

The aetiology of parasuicide is complex. The most common risk factors include unemployment, and social disintegration, or in Durkheimian terms anomie (normlessness). Evidence for the importance of societal norms in controlling suicidal behaviour comes from the findings that it is higher in inner cities where the correlates of anomie (non-marital births, crime, unemployment and divorce) are prominent. The relationship to poverty, independent of these factors remain unproven. Messages other than a behavioural plea for assistance may also be conveyed by parasuicide and individuals who have poor verbal skills, who are devoid of close relationships and who have poor social skills may use this behaviour as a method of controlling or bringing about changes in their environment. The psychiatric assessment of parasuicides is considered under four headings:

Suicide ideation. The individual might say 'I wish I could go to sleep and not wake up', or 'I wish I were dead' but without any further elaboration. These are referred to as passive death wishes. Nevertheless

inquiry should be made about more serious active death wishes which include plans against discovery, detailed plans to execute the act and even final plans about saying goodbye. In the event of an act of suicide a full medical assessment of the act itself is made in order to identify those of high intent.

Suicide intent. The question 'is the individual currently suicidal'? May be answered by considering the degree of intent at the time of the act and assessment of the current suicidal ideation. Failure to ask may lead to missing the seriously suicidal individual. The presence of a suicide note, indications of final plans, such as a will, and careful execution of the attempt may alert one to a high intent to commit suicide. Violent methods are generally believed by psychiatrists and sociologists to be evidence of high intent, along with the absence of another person in the vicinity. In my qualitative research, the second interviewee died by carbon monoxide poisoning. He was alone in his car in an isolated area. The absence of any wish to live or any conflict between the desire to live or die may show itself as composure when talking about suicide and is equally serious. The person with high suicide intent must be hospitalised as a life-saving measure, irrespective or whether a psychiatric illness is deemed to be present or not.

Psychiatric illness is uncommon in parasuicide individuals, although any treatable underlying illness is assessed. Inevitably high intent is frequently associated with psychiatric illness, and this is ruled out by the usual questions relating to sleep, appetite, ongoing sadness etc. The importance of hopelessness has been discussed above. A competent relative must supervise medication if tricyclic antidepressants are prescribed.

Social problems: By far the largest component in the assessment by a psychiatric sociologist will be an evaluation of the social difficulties the individual is experiencing. Social problems include poor housing, unemployment, drug and alcohol abuse, marital disharmony and are frequent concomitants to parasuicide. Social isolation is of special significance since it suggests the absence of support at times of crisis. This does not mean geographical or physical isolation but refers to loneliness and is especially significant in the elderly and infirm. At particular risk are the divorced, widowed or single. Anthony Giddens, (reflexivity theories) in saying that the traditional marriage is dead, does not appear to give much consideration to the lasting trauma for many couples and children who are victims of marriage separation. Social

services and local voluntary organisations, with the support of a good general practitioner helps to bring about change to the individual's social environment in providing companionship to the lonely.

The Samaritans are the largest voluntary organisation in this country. They offer non-directive supportive counselling to the distressed and they can be contacted from anywhere in Ireland. Confidentiality is guaranteed and interviews can be arranged. They are widely and frequently used. About 20% of their calls are suicide related, the rest being from those seeking relief from distress or loneliness. Two documents produced by the Samaritans entitled '*Suicide - Fiction or fact*' and *'Signs of Suicide Intent'* are distributed to appropriate health service personnel and to each voluntary group concerned with suicide. The Samaritans are also involved in the training of personnel from various statutory and voluntary agencies in suicide awareness and listening skills.

Dr Patrick McKeon in: Coping With Depression and Elation describes sympathetically the causes, symptoms and treatment of depressive moods, how to recognise mood swings and why it is so important that a true depressive illness should be properly diagnosed and treated. There

is advice for suffers and their families to help them to cope from day to day, and essential new information about the related problem of Seasonal Affective Disorder. With regard to intervention more enhanced educational effort is required to improve people's personal resources and coping skills, parenting styles and preparing for retirement. Access to this enhanced education is recommended for areas of disadvantage, as well as reducing access to lethal methods used in executing suicide acts, such as guns and illicit drugs. Access to satisfactory housing obviously reduces suicide risk (See study of suicide in area of disadvantage in the quantitative research).

Prison Suicides

The National Task Force on Suicide is concerned about the level and organisation of mental health services provided within the prison system. From January to June 2000 there has been three prison suicides. There is a need to significantly augment the existing provision of what might be broadly considered the "caring" services within the prison environment, for example medical including psychiatric, and psychological services. The task force endorses the recommendations of the Report of the Advisory Group on Prison Deaths (published in August 1991). This Group collected and analysed prison data, examined the level of suicide

in Irish prisons and agreed that a more positive and intensive approach to suicide prevention is required. The Group made recommendations concerning the provision of medical, psychiatric, psychological, welfare and counselling services in prisons. In addition, a number of recommendations in relation to the physical design of prisons and cells were made.

The National Task Force on Suicide recommended that "the mentally ill in prison be given appropriate treatment; that in view of the marked association between drug abuse and both self-injury and death (including suicide) in prison, particular effort and resources be devoted, in conjunction with community strategies, towards addressing the drug dependency problems of prisoners; that the medical and caring services within prison be developed to a level which would ensure equivalence with similar community services; that prison officers receive appropriate training in the recognition and response to suicidal behaviour; that every effort be made to prevent access to illicit drugs in prisons". (p.33). Initial and ongoing monitoring of the mental health and suicide risk of prisoners has yet to be fully implemented..

Emile Durkheim wrote Suicide in 1897. This book has long been regarded by sociologists as a classic example of the union of theory and data, and has been the subject of a corresponding amount of appreciation and attention. Emile Durkheim was interested in explaining differences in suicide rates. He was interested in why one group had a higher rate of suicide than another. This book is a complex one, which looks at, inter alia the significance of dynamic density for differences in suicide rates. Differences in dynamic density and other material social facts have an effect on differences in nonmaterial social facts, and these differences have a direct effect on suicide rates. "The social suicide rate can be explained only sociologically" (Durkheim 1897/1951:299). Durkheim was making two related arguments. On the one hand, he was arguing that different collectivities have different collective consciences and collective representations. These in turn, produce different social currents, which have differential effects on suicide rates. One way to study suicide is to compare different societies or other types of collectivities. On the other hand, Durkheim was arguing that changes in the collective conscience lead to changes in social currents, which, in turn, lead to changes in suicide rates. This leads to the historical study of changes in suicide rates within a given collectivity. In either case, cross-culturally or historically, the logic of the argument is essentially the

same: differences or changes in the collective conscience lead to differences or changes in social currents, and these, in turn, lead to differences or changes in suicide rates. In other words, changes in suicide rates are due to changes in social facts, primarily social currents. Durkheim was quite clear on the crucial role played by social currents in the aetiology of suicide. (There is a detailed discussion in the Theoretical Review section of the thesis).

The Social Meaning of Suicide by Jack D. Douglas is an indepth sociological study and critique of the Durkheimien approach to the subject. The positive contribution of this book lies in the discussion of the situational or social meaning of suicide acts, and in the original insights, ideas and analysis of Durkheim's method of theoretical argument in *Suicide.*

Dr. Tom Fahy, Professor of Psychiatry in University College, Galway argues that suicide, in his experience, is due more to chronic lack of self-confidence, than to depression. This can be caused by dismissive parents, teachers, and peer groups. Childish remarks such as 'you'll be sorry when I'm dead' sometimes do not alarm preoccupied parents, but this kind of thinking may persist into adolescence in those with little

confidence. Dr Fahy found that ambivalence of young suicide victims concerning death as a determined event, is reflected in remarks, threats and notes which are often worded in such a way that may give the impression that the suicidal expect to be witness to the discovery of the body. Such individuals may look forward to the shock and distress when the body is discovered. Many children suffer the traumatic experience of being a 'shut out' member of the family. Education is needed regarding the consequences of such parental behaviour, as well as the behaviour of whoever is interacting with sensitive people, because of negative attitudes towards them.

Suicide and the Irish

The late Dr Michael J. Kelleher, who was Clinical Director with the Southern Health Board, a suicidologist and founder member of the Suicide Research Foundation worked assiduously in researching underlying reasons for the increase in suicide in the Republic of Ireland. In Chapter Three of this book, *'Suicide and Family Life'*, he discusses in depth the increasing instability of the nuclear family, which may have a more deleterious effect on the adolescent male than on the adolescent female. If the home breaks up it is usually the father who leaves. Dr Kelleher points out that most boys are overtly or covertly identified with

their fathers. Some may express this through reaction formation, by which they adopt poses and stances diametrically opposed to their father's outlook, although as age advances, many are surprised at how like their fathers they have become. At the time of break-up they may feel hostile, rejected, angry and depressed. The situation may be complicated further if another adult male is welcomed into the home. Anger turned outwards may be destructive of domestic relationships. If turned in upon the self, it may result in deliberate self-harm. The author was a member of the Department of Health National Task Force on Suicide. He had extensive experience in working and lecturing abroad and was researching suicide and parasuicide in Ireland for approximately seventeen years. Dr Kelleher emphasised the importance of understanding the tragic problem of suicide in a specific Irish context. In Suicide and The Irish he draws together many strands of research and clinical practice.

CHAPTER 4

SUICIDES IN IRELAND

At the end of this chapter tables and graphs are attached.

Classification of Suicide Deaths

It now takes more than fifteen months to classify deaths by suicide – the revised coroner's certificate seeks additional information since 1998 on:

1. Marital status
2. Domestic living arrangements
3. Employment situation
4. Drug/alcohol dependency
5. Known contributory factors
6. Name and address of the deceased general practitioner.

The Central Statistics Office grants the status of Officer of Statistics to a researcher appointed by the Suicide Research Group who assists with analysing the information collected, evaluates on an ongoing basis the procedures at the Central Statistics Office for classifying deaths as suicides and reports on these matters to the Suicide Research Group. (Report on the National Task Force on Suicide, Department of Health and Children, 1998). Official figures are based

on the criminal law concept that the suicide must be established beyond reasonable doubt. Since it is impossible to predict suicide with any reasonable accuracy, psychiatrists nation wide and medical personnel assigned to the Health Boards argue that figures based on the civil law concept of the balance of probabilities give the most accurate measure of suicide. (*Irish Journal of Psychological Medicine*, 1999). Some causes of unnatural deaths are more difficult than others to classify, for example, medicinal self-poisoning among the elderly, or when a person may have unwisely gone for a swim.

There is evidence that suicide has been under-reported in the past and may still be in some areas of the country (P. Kirwan, 'Suicide in a Rural Irish Population', *Irish Medical Journal, 1991:14-15).* Research carried out in Dublin just over thirty years ago indicated this (McCarthy & Walsh, 'Suicide in Dublin', *British Medical Journal, 1966:393-6).* A further study in Galway also discovered under reporting. (Clark-Finnegan & Fahy, 'Suicide Rates in Ireland' *'Journal of Psychological Medicine', 1983:385-391).* Under-reporting, however is not a uniquely Irish phenomenon. A study of railway suicides in London found that deaths, where the individual was seen clearly and purposefully stepping off the platform into the path of the oncoming train were subsequently adjudged as non-suicides in the Coroner's Court. (O'Donnell & Farmer, 'The Limitations of Official Suicide Statistics', *British Journal of*

Psychiatry, 1995-458-461). By statistical tradition all deaths are divided into those caused by illness (natural deaths) and those not caused directly by illness (unnatural deaths). Unnatural deaths are further sub-divided into a number of categories, including accidental poisoning, accidental drowning, road traffic accidents, accidental falls, suicide (where the individual is believed to have purposefully brought about his or her own death). Undetermined deaths. (C.S.O).

The number of suicides from 1971-1995 is overleaf. The available data are not as detailed as they are from 1998 onwards. The number of suicides from 1996/1997 and from 1997/1998 are also attached. Later suicide death numbers are provisional. The number of undetermined deaths and the number of suicides expressed as proportion of suicides plus undetermined is included in Table 1.2. This table illustrates, that, apart from the years 1977, 1984, 1987 and 1994 there is a steady rise in suicide numbers from 1971 to 1995.

The number of undetermined deaths was reduced from 119 in 1971 to 9 in 1995, an indication of the gradual improvement in research methodology.
A death can be legally registered up to one year after its occurrence (up to two years in cases where an inquest is held C.S.O.). See overleaf.

Table 1.2

Number of suicides each year since 1971, number of undetermined deaths and number of suicides expressed as proportion of suicides – plus – undetermined

Year	Suicides E950-959	Undetermined E980-989	Suicides as a % of (suicides-plus-undetermined)
1971	81	119	40.5
1972	90	68	57.0
1973	105	79	57.1
1974	118	73	61.8
1975	148	68	68.5
1976	183	79	64.9
1977	151	73	67.4
1978	163	94	63.4
1979	193	120	62.3
1980	216	84	72.0
1981	223	72	75.6
1982	241	67	78.2
1983	282	62	82.0
1984	232	67	77.6
1985	276	65	80.9
1986	283	83	77.3
1987	245	71	77.5
1988	266	71	79.6
1989	278	92	75.1
1990	334	48	87.4
1991	346	38	90.1
1992	363	22	94.3
1993	361	26	93.3
1994	353	12	96.7
1995	383	9	97.7

Note: 1971 to 1992 (inclusive) data are based on the number of suicides occurring in those years; 1993, 1994 and 1995 figures relate to suicides registered in those years. A death can be legally registered up to one year after its occurrence (up to two years in cases where an inquest is held).

Source: Central Statistics Office.

The number of suicides registered between the years 1996/1997 was 433 when the population in the Republic of Ireland was 3,626,047. There was an increase of 41 suicide deaths in one year compared with the previous year when 392 suicide deaths were registered. The figure for 1997-1998 was 504, a rise of 71 deaths in a population of 3,825,087. (Central Statistics Office). The numbers for the following years are provisional, mentioned earlier.

The Country is divided into eight Health Board Areas, namely, the Eastern, (Dublin, Wicklow, Kildare, population: 1,445,245); South-Eastern, (Carlow, Kilkenny, Tipperary South Riding, Waterford, Wexford, population:393,187); North-Western, (Donegal, Leitrim, Sligo, population: 208,154); North-Eastern, (Cavan, Louth, Meath, Monaghan, population: 300,172); Midland, (Laois, Longford, Offaly, Westmeath, population: 202,865); Western, (Galway, Mayo and Roscommon, population: 312,573); Mid-Western, (Clare, Limerick, Tipperary North Riding, population: 420,628); Southern, (Cork, Kerry, population: 542,263). (C.S.O.)

Between 1996 and 1997 the number of suicides was tabulated into five-year age groups for each sex, using data supplied by the Central Statistics Office, (See attached Suicide Deaths, 1997). Rates were calculated according to the nearest

previous census. The 20-24 year age group shows the highest rate, 70 suicide deaths, (61 male 9 female). The figure for the 25-29 age group was 51 (45 male 6 female). A total of 46 in the 35-39 age group (39 male 7 female). In the 40-44 age group there were 38 suicides, (30 male 8 female). 22 in the 55-59 age group (20 male 2 female), 19 in the 60-64 age group (15 male 4 female), 16 in the 65-69 (10 male 6 female), 9 in the 70-74 age group (5 male, 4 female) 13 in the 75-79 age group (11 male 2 female), 5 in the 80-84 age group (4 male 1 female). Adolescent figures show a total of 33 suicide deaths (26 male 7 female) and among the 10-14 year age group the total number was 8 male no female suicide deaths.

By a vast majority, men have the higher rates of suicide than women and in most counties in Ireland the male rate recorded is over four times the female rate. The rate of male suicides in all age groups illustrates a striking increase in recent years (C.S.O.). This is most marked in the younger age group. There are a number of possible explanations advanced for the gender difference in completed suicide rates among young people. For example there are substantial differences between male and female in their susceptibility to risk factors such as aggressive and anti-social behaviour, alcohol abuse and depression. Also the fact that young men have a higher rate of risk taking behaviour, leading them to greater familiarity with lethal techniques. For young men the most common method of suicide is hanging, (40%), and firearms (20%). Young women

generally use poisoning, (47%), and drowning 19%. (National Task Force on Suicide).

In the Eastern Health Board area, there was a total of 126 suicides, 103 male, 23 female. The majority 94 (75 male 19 female) were in Dublin. The figure in the South-Eastern Health Board was 61 (39 male 22 female). The majority 21 were in Wexford, (16 male 5 female). In North Western, 19 (12 male 7 female). The figure for the North Eastern Health Board Area was 38 (34 male 4 female). The highest number of suicides, 14 (12 male 2 female) was shown for Meath. The Midlands returned a figure of 19 deaths (15 male 4 female). There were 33 suicide deaths in the Western Health Board area (29 male 4 female). Midwestern 34 (26 male 8 female). The Southern Health Board Area showed the majority of suicides 70 (51 male 19 female).

According to psychiatrists the increase in the young male suicide rate may not be because of any factors peculiar to Ireland. Rather it was in line with international trends. (Suicide in Ireland: Dr Patrick McKeon.1998). Suicide is virtually unknown in childhood. There have been a few self-inflicted deaths in children under 10 years. (C.S.O.). The level of intention in this age group is very uncertain. Also death, its meaning and its finality may not be understood.

From the early teenage years, suicide, starting from a very low base begins to increase in frequency and accelerates during the late teenage years. This age-

determined rise is common in other cultures. Psychological illness and access to alcohol and drugs become increasingly important factors in late teenage suicides and thereafter. "Throughout the Western World there has been an increase in suicide in the 15 – 24 and 55 – 74 year age group. " (M.J. Kelleher, Suicide Research Foundation).

In the years 1976 to 1993 the mortality rate for cancer among those under 65 years of age fell. This was partly due to better prevention, earlier recognition and to better treatment, particularly in the case of leukaemia. During the same period youth suicide deaths increased from a position where they were as frequent as cancer deaths in 1976 to greatly exceeding cancer deaths in 1993 (Interim Report of the National Task Force on Suicide). The contrast with road traffic accidents is even more striking. These were eight times more common than suicide deaths in 1976. By 1993, they were only twice as common (Ibid: p.31). Above the age of 75 years the suicide rate falls steeply.

A total of 504 suicide deaths were registered for the year 1998-1999. 421 of these were male and 83 were female. For the year 1998-1999 the number of suicides was tabulated into ten year age groups for each sex. The county of residence of the deceased is also shown. (See attached figures). Again the majority, 138 were among the 15 to 24 year age group. 118 were in the 25-44 year age group. 94 were between ages 35 and 44. There were 74 suicide deaths

in the 45-54 year age group. 40 in the 55 and 64 year age group. 28 died by suicide between the ages of 65 and 74 years and 11 in the 75 and over age group.

Two graphs were examined illustrating variations in suicide rates between the eight Health Board areas for the years 1976 to 1995. (Source: National Suicide Research Foundation). It was found, that while all have experienced a rise in male suicide, it was less pronounced in the Eastern Health Board. This is somewhat surprising when Dublin's much publicised problems with homelessness and drug misuse is considered. Since the mid-eighties, female rates have been somewhat higher in the southern half of the country, comprising the Southern, Mid-Western and South-Eastern Health Boards. This variation may reflect a difficulty with contacting services for psychological distress in rural areas, either because of stigma or simple practical problems associated with transport services.

The rise in suicide has been shown to be a rural rather than an urban phenomenon, a male rather than a female phenomenon affecting the 15-24 and 55-75 year age group. Some counties have exhibited rates of suicide much higher than neighbouring counties which overall could not be explained by

variation in recording practices. (Kelleher, Keeley & Corcoran, *Irish Medical Journal*, 1997:262-264).

The reason for this study is to clarify whether the problem of suicide is of similar magnitude in the eight different Health Board areas. The years studied were 1976 (the first year that data were comprehensively available on computer) to 1995, the last available year. There were four National Population censuses taken during that time, in the years 1979, 1981, 1986 and 1991. (Central Statistics Office, National Census Report). According to the 1991 Census the Republic of Ireland had a population of 3,525,719. Again the country is divided into eight Health Board Areas, but with a population difference: The Eastern (Dublin, Wicklow and Kildare, population 1,245,225); The South-Eastern (Carlow, Kilkenny, Tipperary South Riding, Waterford, Wexford, population 383,188); North Western (Donegal, Leitrim. Sligo, population 208,174); The North-Eastern (Cavan, Louth, Meath, Monaghan, population 300,183); The Midland (Laois, Longford, Offaly, Westmeath, population 202,984); The Western (Galway, Mayo, Roscommon, population 342,974); Mid-Western (Clare, Limerick, Tipperary North Riding, population 310,728); The Southern (Cork and Kerry, population 532,263).

For each Health Board area, the annual number of suicides was tabulated into five-year age groups for each sex, using data supplied by the Central Statistics

Office. Because the numbers of suicides occasionally fluctuate widely from year to year, five-year moving averages of suicide rates were plotted.

Results:

Between 1976 and 1995, all eight Health Boards show a rise in male suicide, (Figure 1) the rise being least pronounced in the Eastern Health Board. At the end of the study period, the rate in the Eastern Health Board is 13.6 per 100,000, whereas the other seven range from 19.4 in the Mid-Western to 23.4 per 100,000 in the South-Eastern Health Board area.

The female rates are more volatile due to the smaller numbers of suicides but the rates have converged to some degree (Figure 2). Initially, the rates ranged from 1.5 to 5.1 per 100,000, whereas by the end of the study there are between 3.5 and 5.0 per 100,000. However, over the past 10 years female suicide in the Southern, South-Eastern and Mid-Western Health Boards has been consistently higher than in the other health boards.

Males in The Eastern Health Board, 80% of whom live in Dublin appear to be relatively protected against suicide. This goes against what would be expected when the extent of the problems of homelessness and drug misuse is considered. It may be that the services are better, more accessible and more user friendly. This would counter the frequent claims in the media that there is a shortage of psychiatric beds in the Dublin area. By contrast the services in other more rural

Health Boards appear to be remote and inaccessible. It was stated in the Combat Poverty Report, 1997 that "medical card holders in the West of Ireland are ten times more likely to be more than five miles distant from the nearest health care facility" (Curtin, Haase, Tovey, Poverty in Rural Ireland: A political economy perspective, quoted by Breda O'Brien in The Sunday Business Post, 25th January, 1998). In country areas, public transport is less frequent and perhaps, because of distance, more expensive for the individual. It is also possible that having psychiatric services in a community increases its exposure to the reality of the high incidence of mental illness. This could help to reduce the stigma and isolation that, otherwise sufferers might experience and thus make them more willing to contact such services when in difficulties. It is quite possible that rural male suicide cases were, and the suicidal are, much less likely to seek medical, care or counselling. The situation with women is not clear. Over the last ten years the southern half of the country, comprising the Southern, South-Eastern and Mid-Western Health Boards, has had the higher rate of suicide. These data clearly point to a need for the development of more acceptable and accessible services for those at risk of suicidal behaviour, especially in the less urbanised areas.

The quantitative research, includes the examination of one of the 'high risk groups', in an attempt to establish the sociological causes for the increase in suicide in Ireland. 'High risk' groups include drug addicts, ex-prisoners, people

living in 'areas of disadvantage', the Travelling community, homosexuals, people, with physical and mental handicap, people with AIDS., refugees and other groups. Negative attitudes towards these groups were examined in depth by Father Micheál MacGréil. (Prejudice in Ireland, 1977. Prejudice in Ireland Revisited, 1996). Sensitive people include those with low self esteem in all groups of society, because of negative attitudes towards them. Medics, and counsellors find that such people tend to develop symptoms of anomie, such as pessimism, mistrust, anxiety and a general lack of confidence in self or friends. This can lead to a sense of frustration, despondency, paranoia and even suicide.

While European money has helped to transform buildings in some city centres, the poor are more and more ghettoised. (Stanaslaus Kennedy, Focus Point). The general health of individuals living in deprived areas is below average.(National Suicide Foundation). Some of these areas are characterised by petty crime and street violence. Those who deliver essential services (teachers, doctors, police, etc.) are likely to live elsewhere and only to visit during duty hours. Churchmen and women may still be one exception to this general rule and they are likely to act as community leaders, but the numbers are small. A concerted effort is required by planners, financial organisations, educators and large numbers of people from all strata of society to improve the general welfare of marginal groups. Inclusion for all humanity is in everyone's interest. A comprehensive

study of 'high risk' groups living in areas of disadvantage, who attempted suicide is not available in Dublin. However, according to researchers in the National Suicide Foundation, one such study has been carried out among one marginal group in Cork City where 245 individuals attempted suicide. Most of these people came from a background of appalling childhood disadvantage (found in other cities in Ireland and around the world). It is not clear, therefore why this kind of research was not carried out elsewhere in Ireland. People in the above mentioned group were first examined in 1982 and a follow-up study was carried out eight to ten years later.

Of the 245 individuals involved in the initial study, 195 were successfully identified eight to ten years later and contacted. 99 of these were interviewed. A relative of 57 of the cases was interviewed, and hospital notes only were examined in the 39 remaining cases. (Kelleher, Daly, Keohane, Crowley, Deprivation and long term outcome of deliberate self-poisoning, in Kelleher, M.J. (Ed.), *Divergent Perspectives on Suicidal Behavaiour,* Proceedings of Fifth European Symposium on Suicide, Cork, 1994: 71-78).

Of the 111 women, 44% had a family history of alcoholism (Figure 7.1) In 6% of cases, suicidal behaviour had occurred in the parents. In a further 16%, suicidal behaviour had occurred among other relatives. Of the total, 9% had spent time in care and 15% were the subject of physical abuse. One in ten was a

victim of sexual abuse. Almost half of the respondents described their childhood as being unhappy. A similar proportion described other disadvantages, many relating to being 'cheated' out of childhood, for example, having to care for elderly relatives and siblings, or having to work in other ways when they should have been at school.

The men had suffered broadly similar hardship. Of the 84, 42% of the men had a family history of mental illness, while almost 40% had a family history of alcoholism (Figure 7.2). In 3% of cases, suicidal behaviour had occurred in the parents. For 19%, suicidal behaviour had occurred among other relatives. A total of 16% had spent time in care, 28% had been subjected to physical abuse and 6% to sexual abuse. As many as 85% had left school at the minimum age, if not earlier, while 9% lacked discipline and training. Over half described their childhood as unhappy and over a third described other significant disadvantages.

Contrary to the view that these individuals were self-indulgent and acting in response to trivial occurrences, most had major difficulties and disabilities at the time of overdose. Two-thirds of the women were psychiatrically ill and 45% had a history of previous psychiatric illness, with a similar proportion suffering a major personality deficiency (Figure 7.3). Over a quarter had current problems with alcohol and 14% had current addictions. Domestic violence occurred in 16% of cases and marital discord occurred in almost 60% of cases.

With regard to the men, the situation was hardly better (Figure 7.4). There was a major personality deficiency in two-thirds of the men, while approximately 60% of the sample were psychiatrically ill at the time of overdose. Almost half had a previous history of psychiatric illness and a similar figure had previously self-poisoned. Three-quarters of the men had current alcohol problems, while a similar number had previous alcohol problems. A third had addiction problems, mainly to benzodiazepines (drugs such as valium, librium and ativan). . Almost half were experiencing marital discord and four-fifths were unemployed. One-third of the sample had a history of criminality.

The results of the follow-up study, for both men and women were abysmal. Over 40% of the women had self-poisoned again during the ten year period, while 12% had engaged in other acts of deliberate self-harm (Figure 7.5). Some 6% had died. In the year of follow-up, a third were treated for a psychiatric illness, just over a third were treated for alcoholism and 13% treated for benzodiazepine dependence. Three-quarters of those available for employment were unemployed most of the time.

The situation with regard to the men was worse (Figure 7.6). Two-thirds had engaged in subsequent acts of self-poisoning and a third had engaged in other acts of deliberate self-harm. Some 13% had died, most of these being unnatural

deaths. Almost a third were treated for psychiatric illness in the follow-up year, while almost two-thirds were treated for alcoholism and over 40% treated for benzodiazepine dependency. Two-thirds of the men had been unemployed for most of the ten years and 11% had spent time in prison. Almost 50% were regarded as being at risk of repeating the self-injurious behaviour.

"Assessing risk is at best an inexact science" (U.K. Department of Health). Doctors' ability to accurately predict those who are likely to kill themselves, both among the population of suicide attempters and those with high risk demographic features and psychiatric illness is poor" (G. Murphy, 1984. The Prediction of suicide: why it is so difficult, *American Journal of Psychotherapy.* 3; 341-349). Those working at the 'coal-face' do not agree with this opinion. Measure of 'intent to die', are the best predictors of suicide in the short term but longer term predicting is problematic.

None of the above statistics make for uplifting reading. Furthermore according to the researchers who carried out this study, harm to the self is also tinctured with harm to others, for instance harm to the children that such disturbed parents may cause. The fact that the latter were, victims of physical, sexual and emotional abuse, does not bode well for their children.

On a more 'upbeat' note, not all cases had such poor outcomes, one female student who had taken an overdose, recovered and returned to university, where she subsequently received a PhD. Another individual who had taken an overdose also graduated and found work abroad. Unfortunately these are the exceptions.

According to Michael J. Kelleher, (Suicide and The Irish: 67) it is easy to be critical of these people, who absorb such a disproportionate amount of health care services. But they are by and large deprived and know nothing but deprivation. The long term alleviation of the problem may have more to do with public health, employment and education, rather than an emergency clinical response which is the 'sticking plaster approach' (Gunnell, Peters, Kammerling & Brooks. 'Relation between parasuide, suicide, psychiatric admissions and socio-eonomic deprivation', *British Medical Journal,* 1995, 311: 226-230). Prevention is always better than cure.

Suicide Death, 1997

Suicide Deaths	Sex		
	Male	Female	Total
	N	N	N
Age			
10 - 14	8	.	8
15 - 19	26	7	33
20 - 24	61	9	70
25 - 29	45	6	51
30 - 34	38	10	48
35 - 39	39	7	46
40 - 44	30	8	38
45 - 49	27	7	34
50 - 54	17	4	21
55 - 59	20	2	22
60 - 64	15	4	19
65 - 69	10	6	16
70 - 74	4	5	9
75 - 79	11	2	13
80 - 84	4	1	5
Total	355	78	433

Source: Central Statistics Office.

Suicide Death, 1997

Suicide Deaths by county	Sex		
	Male	Female	Total
	N	N	N
County of residence			
Dublin C.B.	47	11	58
Dublin Fingal	12	5	17
Dun Laoghaire Rathdown	8	1	9
Dublin Belgard	8	2	10
Wicklow	12	.	12
Carlow	12	.	12
Kildare	16	4	20
Kilkenny	5	.	5
Laois	3	.	3
Longford	5	.	5
Louth	10	.	10
Meath	12	2	14
Offaly	2	2	4
Westmeath	5	2	7
Wexford	16	5	21
Waterford County	8	2	10
Waterford C.B.	2	3	5
Clare	7	2	9
Cork C.B.	16	11	27
Cork County	35	8	43
Kerry	16	1	17
Limerick C.B.	6	1	7
Limerick County	6	4	10

Suicide Death, 1997

Suicide Deaths by county	Sex		
	Male	Female	Total
	N	N	N
County of residence			
Tipperary N.R.	5	.	5
Tipperary S.R.	7	1	8
Galway C.B.	5	2	7
Leitrim	4	.	4
Mayo	16	2	18
Roscommon	8	.	8
Sligo	2	2	4
Galway County	17	2	19
Cavan	6	.	6
Donegal	10	1	11
Monaghan	6	2	8
Total	355	78	433

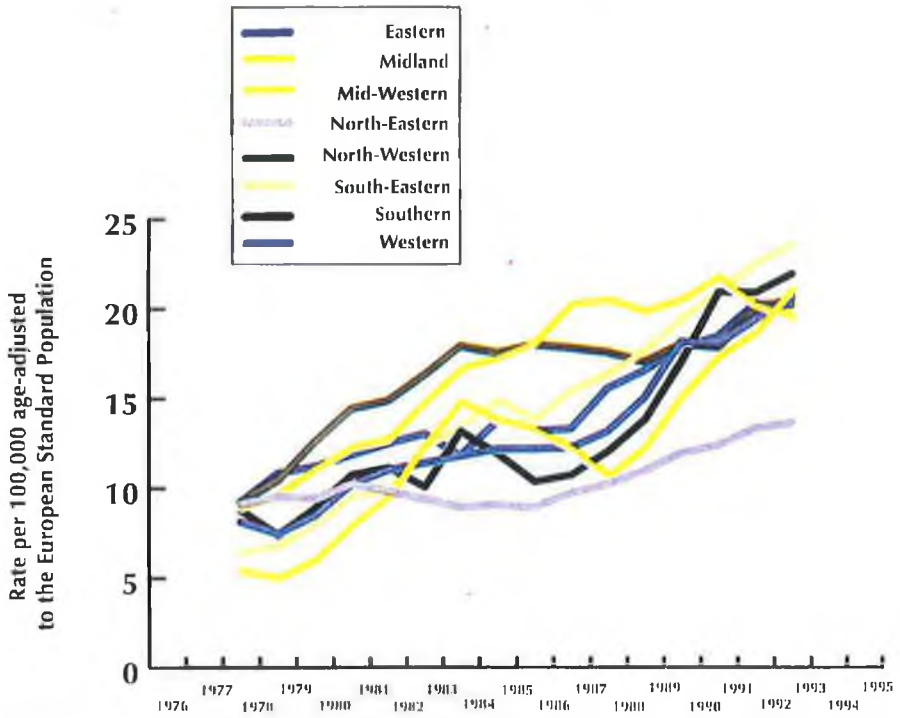
Source: Central Statistics Office.

Year of registration 98 Suicides

Province	County of residence	ALL	SEX		Age Group							
			1Male	2Female	05 - 14	15 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 and over
0 Leinster	Carlow	5	5	.	.	.	4	1	.	.	.	.
	Dublin Belgard	24	18	6	.	7	7	7	2	1	.	.
	Dublin C.B.	55	49	6	.	15	18	10	4	4	3	1
	Dublin Fingal	20	16	4	.	9	2	5	2	1	1	.
	Dun Lgh. Rdown	22	15	7	.	4	7	3	5	3	.	.
	Kildare	12	12	.	.	3	1	4	2	.	2	.
	Kilkenny	10	8	2	.	2	3	2	2	1	.	.
	Laois	12	10	2	.	3	3	3	1	2	.	.
	Longford	1	1	.	.	.	.	1	.	.	.	.
	Louth	14	9	5	.	1	2	3	4	1	3	.
	Meath	11	9	2	.	3	4	.	2	.	.	2
	Offaly	9	8	1	.	3	2	.	1	3	.	.
	Westmeath	11	9	2	.	2	3	3	2	1	.	.
	Wexford	14	9	5	.	1	2	5	2	2	1	1
	Wicklow	12	10	2	.	3	1	3	3	.	.	2
2 Munster	Clare	14	13	1	.	3	4	.	3	2	2	.
	Cork C.B.	32	28	4	.	5	8	7	6	3	3	.
	Cork Co.	48	39	9	.	11	11	8	10	5	.	3
	Kerry	29	24	5	1	11	9	2	3	.	3	.
	Limerick C.B.	9	9	.	.	.	4	4	.	.	1	.
	Limerick Co.	13	10	3	.	1	3	1	4	3	1	.
	Tipperary N.R.	8	7	1	.	5	2	.	1	.	.	.
	Tipperary S.R.	16	12	4	.	7	2	4	1	1	.	1
	Waterford C.B.	2	2	.	.	.	1	.	.	.	1	.
	Waterford Co.	7	7	.	.	.	3	1	1	1	1	.
3 Connacht	Galway C.B.	9	8	1	.	4	1	2	1	1	.	.
	Galway Co.	20	16	4	.	6	3	2	3	2	4	.
	Leitrim	5	4	1	.	.	.	1	3	.	1	.
	Mayo	9	8	1	.	7	.	2	.	.	.	.
	Roscommon	7	7	.	.	2	1	2	1	.	1	.
	Sligo	9	8	1	.	3	1	1	3	1	.	.
4 Ulster (part of)	Cavan	10	10	.	.	3	4	3	.	.	.	.
	Donegal	17	15	2	.	10	.	4	1	2	.	.
	Monaghan	8	6	2	.	4	2	.	1	.	.	1
ALL		504	421	83	1	138	118	94	74	40	28	11

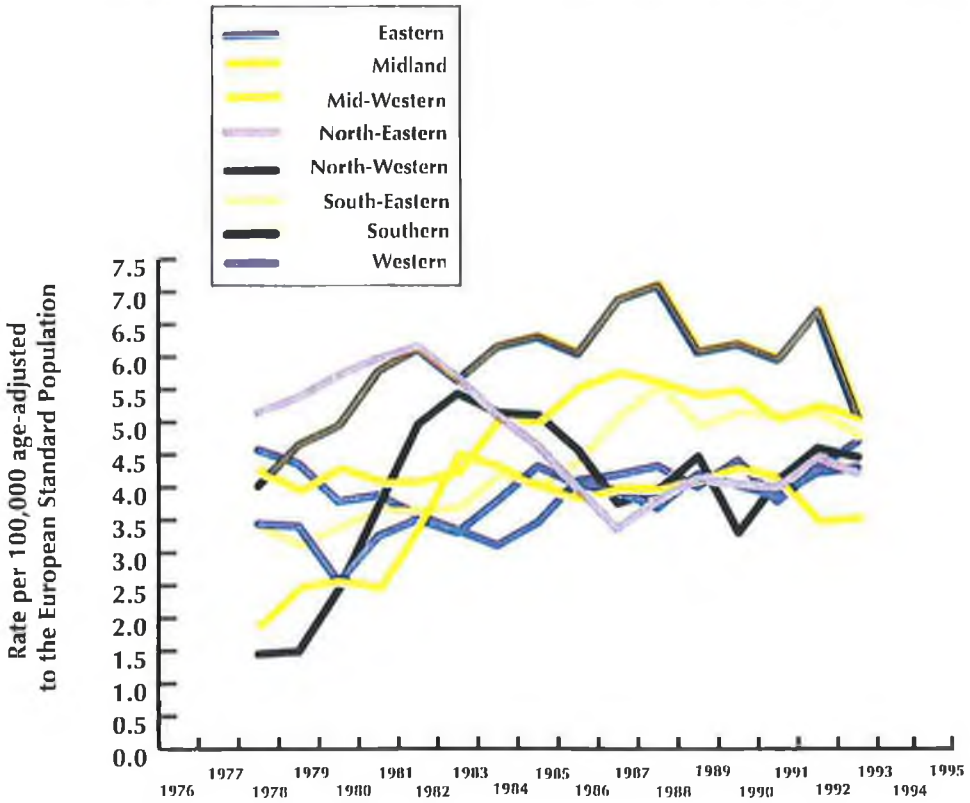
Source: Central Statistics Office.

Figure 1. Irish male suicide rate by Health Board, 1976-95.



Note: Five-year moving averages are plotted.

Figure 1. Irish female suicide rate by Health Board, 1976-95.



Note: Five-year moving averages are plotted.

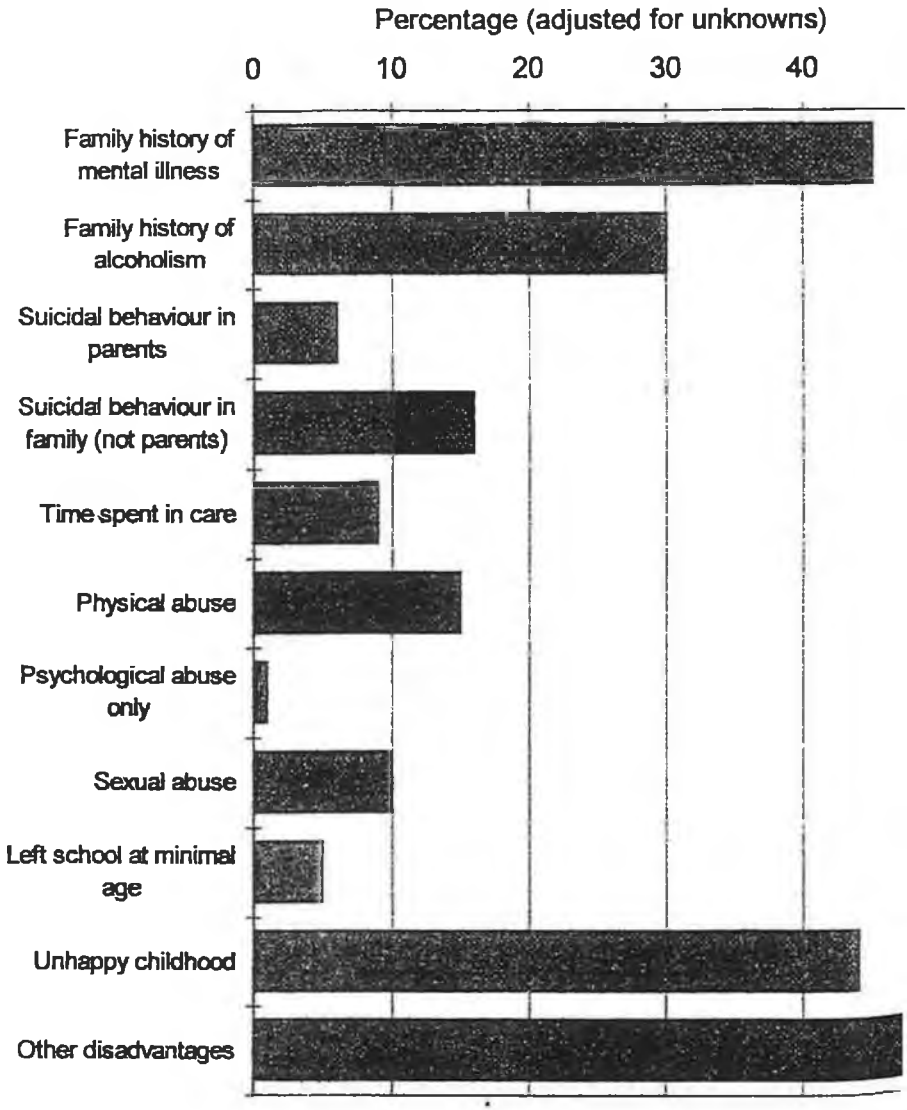


Figure 7.1. Childhood and family disadvantage – females.
[Source: Suicide Research Foundation, Cork]

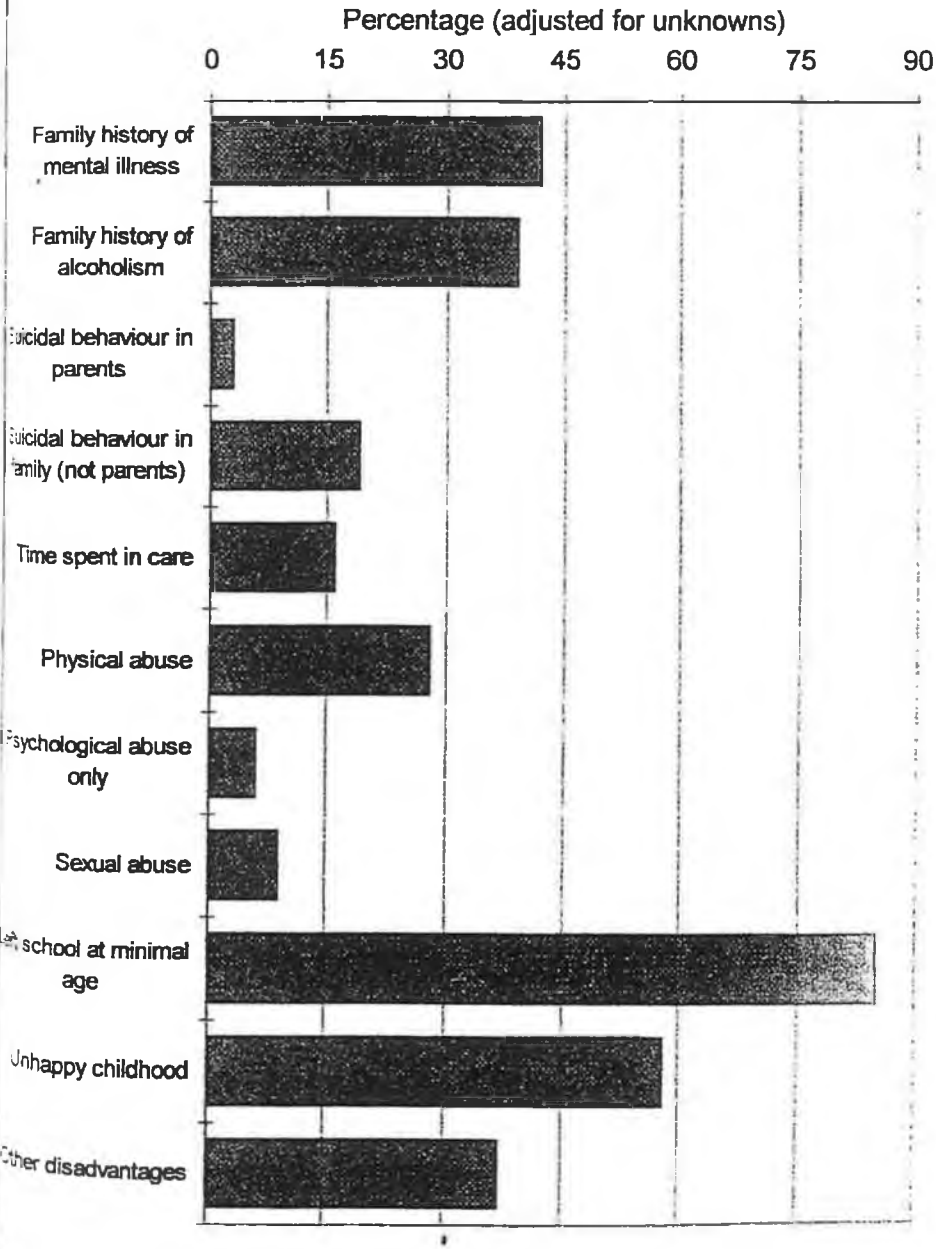


Figure 7.2. Childhood and family disadvantage – males.

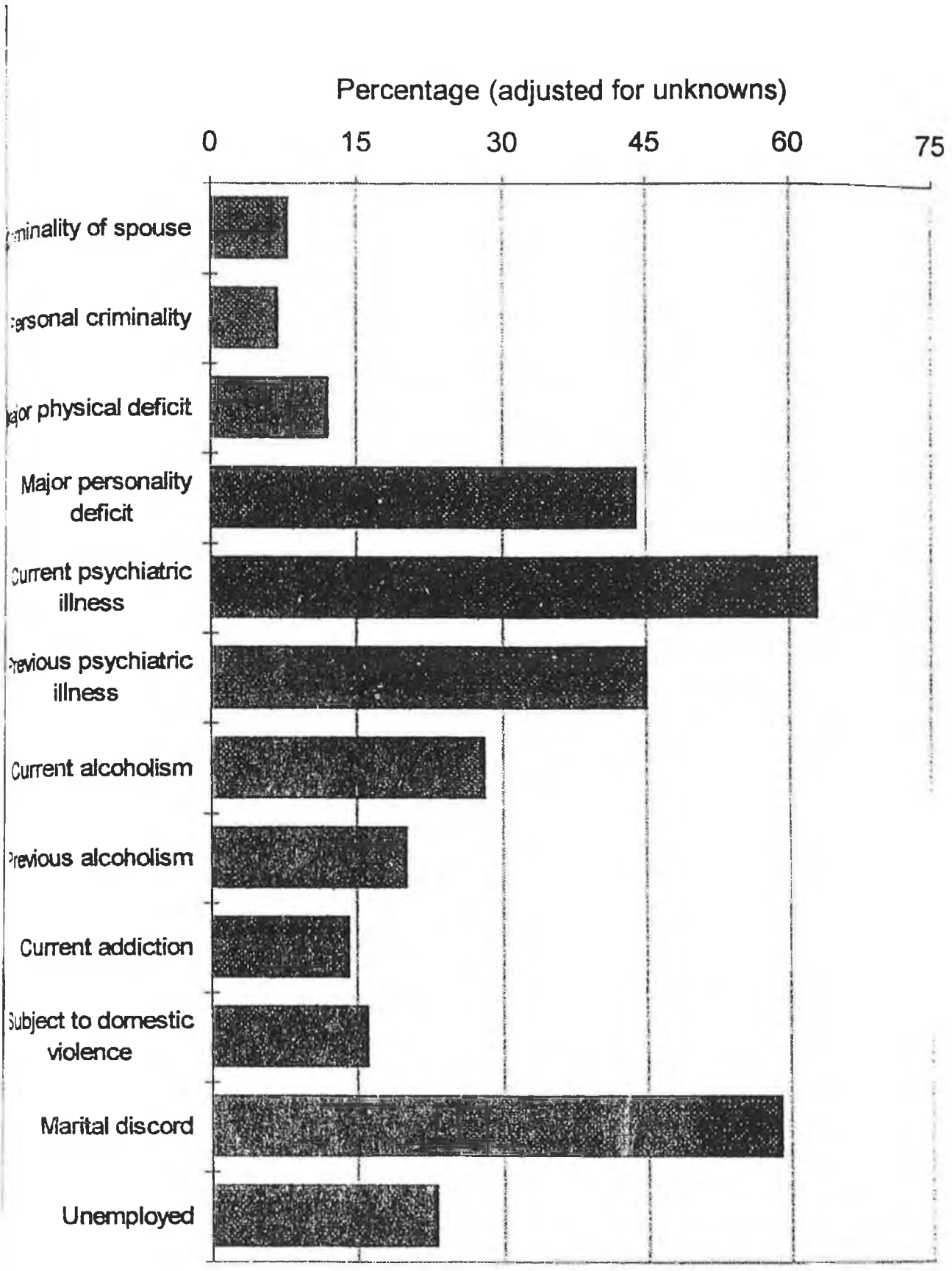


Figure 7.3. Social and personal deficit at time of overdose – females. [Source: Suicide Research Foundation, Cork]

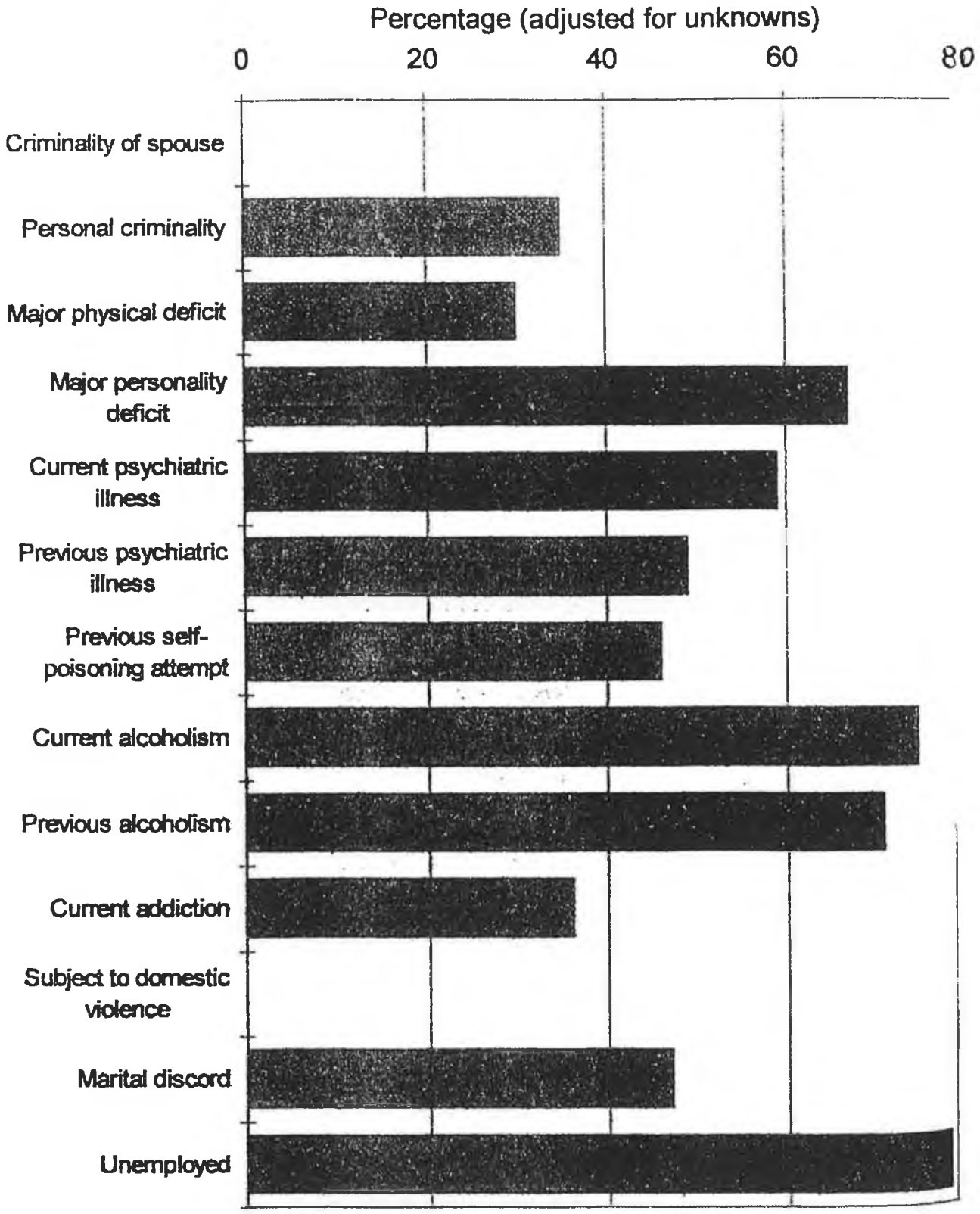


Figure 7.4. Social and personal deficit at time of overdose – males. [Source: Suicide Research Foundation, Cork]

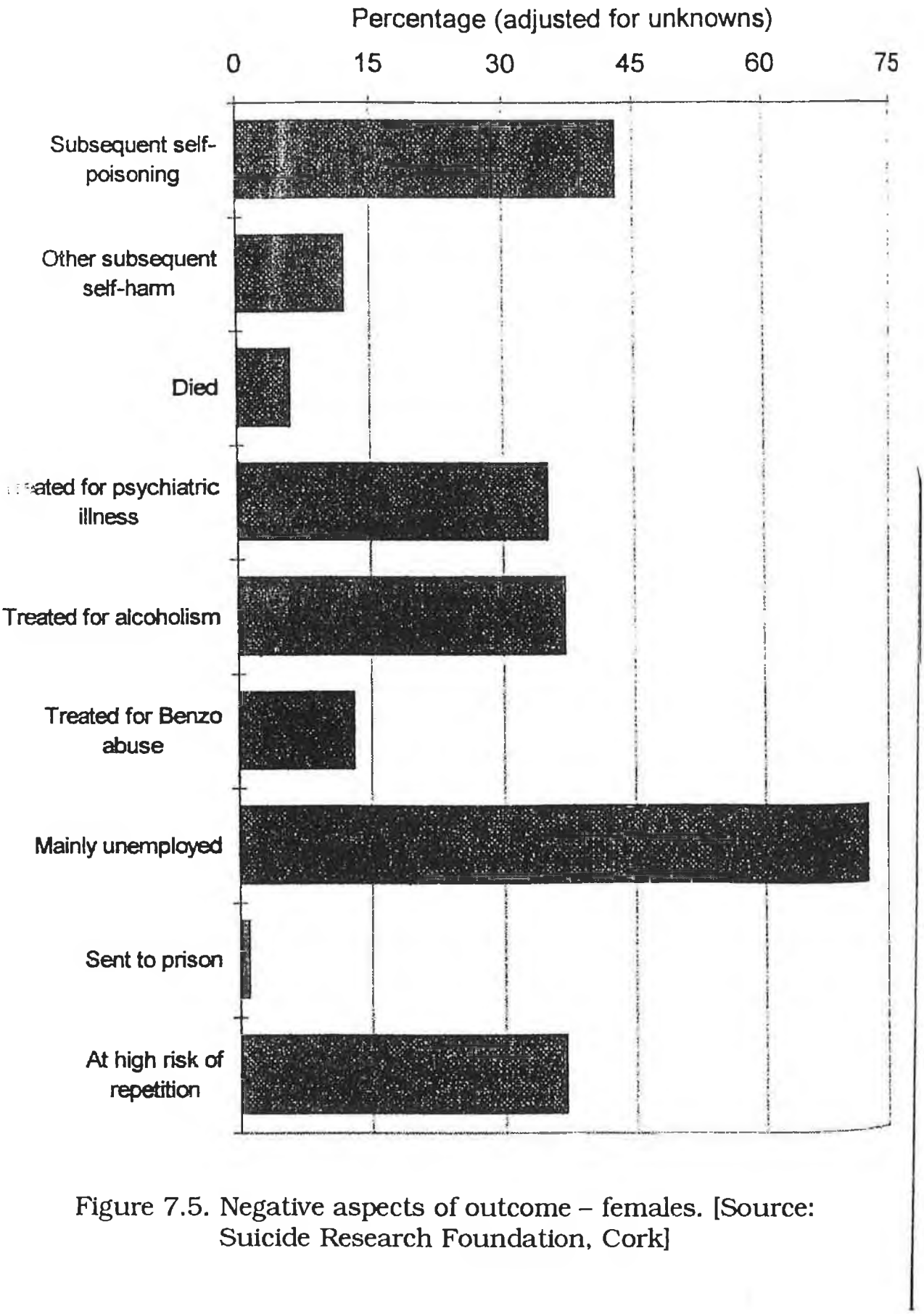


Figure 7.5. Negative aspects of outcome – females. [Source: Suicide Research Foundation, Cork]

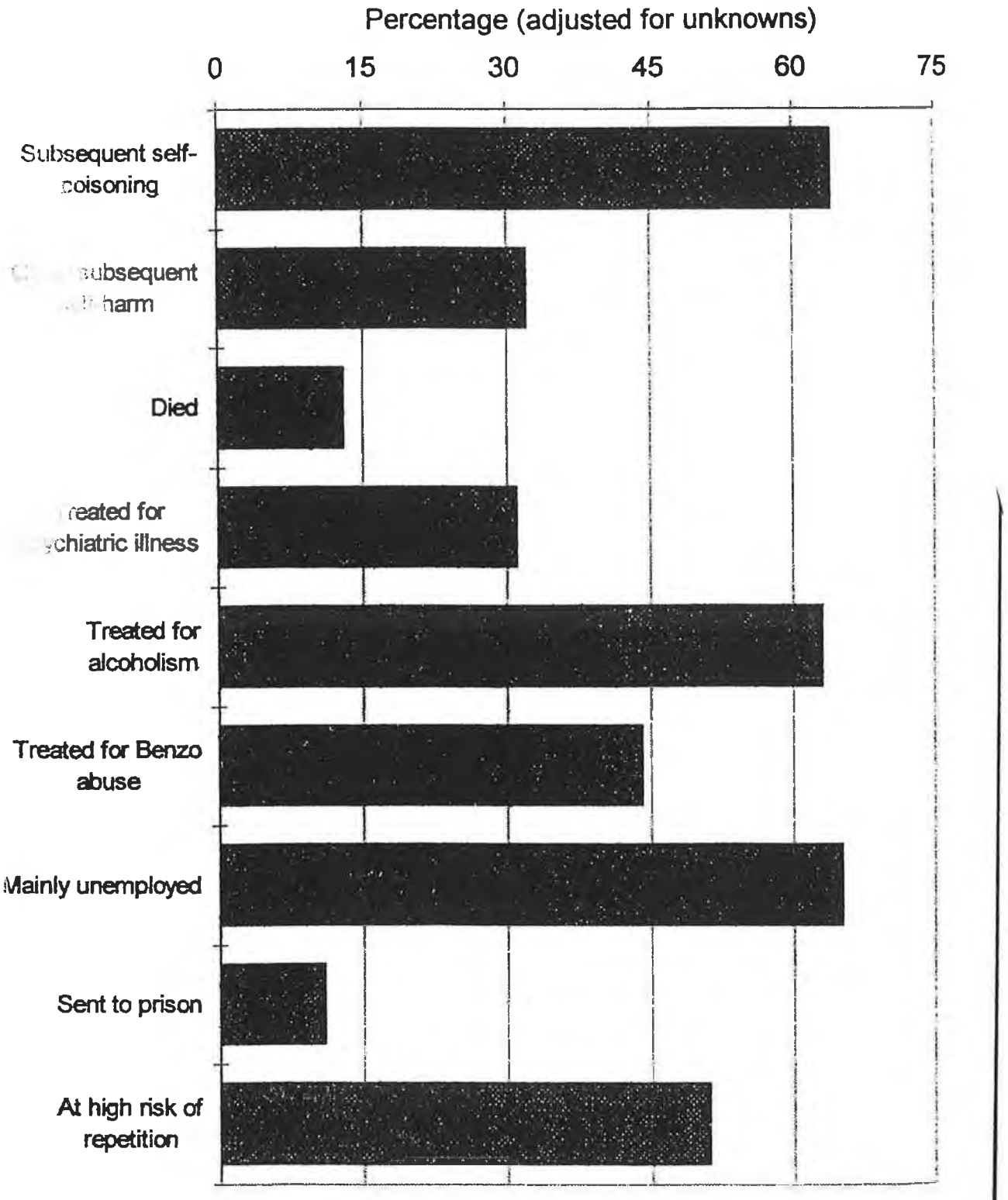


Figure 7.6. Negative aspects of outcome – males. [Source: Suicide Research Foundation, Cork]

CHAPTER 5

A COMPARISON OF SUICIDE IN TWO IRISH COUNTIES.

In 1998, sociological and psychiatric researchers, John F.Connolly, Anne Cullen, Dermot Walsh, Sheila McGauran and Darra Phelan examined and compared suicide trends between Kildare and Mayo. The years studied were 1988-1994. Kildare is approximately one quarter of the size of Mayo. According to the researchers, the density of the population of Mayo is one person for every five hectares and in Kildare, one person for every 1.4 hectares. Areas with a population of 1,500 or more are defined as towns, for the purposes of census taking. In Kildare 62% of the population live in communities of more than 1,500 people, compared to Mayo where the figure is 32%. In Kildare 33% of the population were employed while in Mayo 30% were employed.

Twenty eight per cent of the people studied in Mayo, and 52% in Kildare were in possession of a medical card. These figures are based on the 1991 census, which was taken at the midpoint of the study. In each county there was an equal number of single males, as well as an excess of males to females.

Methodology:

The researchers were divided into two teams. They examined the coroners' files for both counties for the years 1988-1994 and, with the help of information from general

practitioners they examined more closely cases "thought" to be suicide deaths. Suicide was defined as follows:

1. "Death should be self-inflicted"
2. "The self-inflicted action leading to death was intended to have that result." (Journal of Psychiatric Medicine, 1999. 16(4): 136-139).

Both groups assessed each case separately. As well as gaining access to information from general practitioners, they were also able to study hospital records. Official mortality data for each county were obtained from the Central Statistics Office. The number of deaths coded as suicide and undetermined was studied. With the help of data from the official census taken in the years 1986, 1991 and 1996, the researchers found that it was possible to estimate the populations for both counties for the years studied, and to calculate population changes. Suicide rates per 100,000 population for each county were calculated based on:

- Official suicide mortality data.
- Number of suicide deaths using clinical data.

Results:

Suicide rates per 100,000 of the population were based on data provided by the coroners, the Central Statistics Office, and what the researchers termed 'clinical criteria'. They estimated that in Mayo, the number of suicide deaths for the years 1988-1994 was 112, whereas official figures recorded only 81 suicide deaths. They concluded that there was

not as much under reporting in the years 1988-1994 as there was in the past, because of a gradual improvement in research methodology.

In Kildare the researchers estimated that 91 suicides occurred during the years studied, while the official figure was 76, a difference of 15 suicide deaths. It was found that the suicide figures fluctuate more in Mayo than in Kildare. Using a simple linear regression equation, they found that the total number of suicide deaths both in Kildare and Mayo is increasing at a rate of approximately four each year. In both counties the greatest number of male suicides occurred in the 15-44 year age group. Female suicides remained at a low baseline. Among female suicide deaths in Mayo, 47% were in the 34-54 year age group. In Kildare 63% were 55 years of age and over.

In Mayo it was found that drowning was the most common method used for committing suicide, (Males, 46%, females, 52%). 30% of the men and women hung themselves, and 14% of women 'self-poisoned' and 'overdosed'.

In Kildare, (35%) of the men hung themselves, whereas 72% of the women drowned. 23% of the men used firearms in Kildare. 8% used firearms in Mayo. In Kildare, 61% of those who shot themselves were military personnel. Those who used this method in Mayo were all civilians. 5% of the suicide deaths in Kildare overdosed.1% overdosed in Mayo.

Each day, 120 trains pass through Kildare, compared with seven through Mayo. The researchers did not give the number of 'railway suicides' for either county. The number of female suicides in this study was too small, to exhibit significant differences between the two counties.

Marital status:

In Mayo 70% of the males who committed suicide were single, compared to 48% in Kildare. 38% of the females in Mayo were married, compared to 18% in Kildare. The majority (52%) of females who committed suicide in Mayo were either married or widowed. In Kildare 55% of the females who committed suicide had never been married. It was found that the number of male suicide deaths was four times that of the female number of suicide deaths.

Employment:

In Mayo 57% of male suicides were employed at the time of their death. The researchers found that 'employment status' for males was difficult to evaluate, as many farmers were recorded as being in employment, although they we receiving welfare allowances. The reason for this was because their farms were small and unable to provide an adequate income. The majority of men and women in Kildare who committed suicide were employed. 67% of the males were employed at the time of their deaths.

Psychiatric illness:

It was recorded in the coroners' files that 46% of those who committed suicide in Kildare had a history of psychiatric illness. 47% of those who committed suicide in Mayo had a similar history.

Discussion:

At the time of the study the researchers found that "under-reporting of suicide remained a problem", (p.139) although "it is obvious", they said, "from the figures that official mortality data were beginning to reflect the real situation more accurately". According to the contributors to the Interim and Final Report of the National Task Force on Suicide, (1996 and 1998) the method of collecting data is as efficient as it could be. It would be difficult to collect further detailed information with regard to Irish Suicide mortality data, which are recorded in the statistics Department of the C.S.O. The fall in the number of deaths coded as undetermined is referred to in the 'Suicides in Ireland' section of this thesis. Ongoing studies at local level, such as the present one are needed, according to these researchers, to monitor research methodologies in the different counties, in order to ensure that under-reporting does to occur.

The average suicide rate in Mayo (14 per 100,000), for the years studied was higher than that in Kildare, (10 per 100,000). And higher than the national average. This is consistent, according to the researchers with the findings of other Irish and European studies, that is, that suicide rates are higher in rural areas than in urban areas.

In Mayo it was found that the most common method used by both male and female for committing suicide was drowning, reflecting the traditional method and access to means. Mayo is a coastal county with many rivers and lakes. Education and training and reducing access to means influences suicide rates. According to the above researchers, traditional attitudes to drowning and swimming need to be addressed in Mayo. It would be extremely difficult in coastal areas, however, to prevent suicidal people from taking their lives in this way, irrespective of attitudes or education. It was found that the males in Kildare are more likely to choose hanging or shooting as a method of suicide. Increased availability of firearms in Kildare, because of the presence of a large military establishment accounts for this.

The study of coroners' files revealed that in Kildare 47% and in Mayo 46% had a history of psychiatric illness. Psychological autopsy studies indicate that between 65% to 90% of those who die by suicide suffer from psychiatric illnesses, generally caused by sociological problems.

Establishing the true rates of suicide is important in monitoring suicide prevention programmes. According to the researchers, this is needed in small ecological areas, as national and international trends may not reflect specific methods used to commit suicide in different regions of the country. Such studies will alert the health services and researchers to the various choices of methods chosen, and will indicate the course of

action to be taken in addressing these. Difference in choice of methods and rates of suicide reflect the different traditions and access to means in each county. These, together with differences in demographic factors associated with suicide in the two counties indicate the importance of understanding detailed local studies before attempting to implement suicide prevention programmes.

In Ireland the availability of legally held firearms is very strictly controlled. Further restriction is unlikely to have any impact on the suicide rates. There may be a case however, according to these researchers, for careful psychological monitoring and support for those in occupations with easy access to firearms.

Government action is required, according to the researchers, so that appropriate infrastructure, including health care and educational facilities for small communities in some rural areas may be put in place.

CHAPTER 6

QUALITATIVE RESEARCH

The reason why I was able to carry qualitative research on a very small scale was because the families, relatives and friends of three people who took their lives in the last decade have been known to me (but not to each other) for a number of years. The limitations of carrying out such research include sensitivity and the lack of transcribed interviews with the victims, their relatives and friends. Reciprocal home visits continue to be periodical. While they were receiving professional help, the three people who attempted suicide described their experiences of the conflict between the wish to live or die. Important extracts from these conversations will be included in the thesis. According to their psychiatrists, had they persevered with therapy they would, more than likely have recovered, but all three discharged themselves from hospital shortly before their deaths. They were bright, intelligent, productive members of society before, they themselves detected that social and clinical advice was necessary. One of them, a 37-year-old father of four children was a civil engineer who died by suicide in 1987. In 1993 a relative of mine (22 years) was studying for a law degree and was in her second year at university. In 1995, a 45 year old air hostess, known to me died by suicide. She was participating in a promotional course to improve her career position. The events of all three suicide cases known to one person, whose deaths occurred in just over a decade

are rare in a lifetime. Because of these circumstances I decided to find out as much as possible about why it is that people die in this way.

The Qualitative research needed to be carried out in a sensitive and relaxed manner. I tried to help the respondents who were experiencing a conflict between the wish to live or die to have a greater sense of hope and will for the future. During the conversations, I learned that listening emphatically was more important than talking.

For the primary research there were approximately thirty recipocal home visits. Informal conversations took place with three people between the ages of twenty-two and forty-five years. They related their experiences of social problems and deep depression shortly before they died by suicide. Extracts of responses and experiences of the bereaved family members, relatives and friends who continue to receive professional help, spiritual care and counselling are included, as well as extracts of their opinions concerning the possible causes of these deaths. These conversations took place during informal reciprocal home visits.

Ms X, a twenty-two-year old student was studying for a law degree when she became depressed because of the volume of work she 'had to do'. Anorexia nervosa was diagnosed when she was fourteen years old and her parents, who are medical doctors referred her for professional help. She recovered and went

on to lead a normal life. Recently she returned to the psychiatric unit of a hospital when she experienced 'deep' depression and had insomnia. Shortly after leaving hospital she visited my home and related her experience. "At present I am deeply depressed. Next week I will have another consultation with the psychiatrist - the best in his field I am told". "Describe how you feel when you wake in the mornings, this morning for instance". "Part of me wants to continue to live, the other part is unable". "It must be a struggle to put into words your true feelings, but you identify the problem and seem to know immediately how to go about finding solutions". "Not before putting everybody around me through the mill. Sometimes there are dreadful scenes. I feel frustrated, angry, confused. Frustrated because I am unable to finish studies so that I could do what I set out to do in life. I was first admitted to hospital last year after an unsuccessful attempt to take my life. I recovered for a while but I am deeply depressed again. Parents are devastated. I lacked energy about two years before anorexia nervosa was diagnosed. At first they thought I was lazy, not depressed". "You look better now. With treatment do you feel hopeful that the depression will lift in time"? "I feel depressed, angry and confused because parents tried to instill a sense of purpose, and commitment into all of us. The others (she is third in a family of four) are making and sister has made a success of her life, I haven't". "Was the atmosphere not relaxed at home"? "Oh yes, and we still enjoy time together. I felt unwell and lacked energy since I was

eleven years old! After a thorough investigation the consultant concluded that there was nothing physically wrong. I irritated everyone when I didn't feel like getting out of bed and facing the day. That deep depression lifts temporarily now but only when I take a course of anti-depressants". "Parents diagnosed anorexia nervosa when I was about 13 or 14 - before anyone else did". "You are amazing. You suffered so much for so long. Yet you negotiated the points system and succeeded in reaching the second year of studies with a view to receiving a law degree. Does the family give you credit for this achievement?" . "My mood swings and unsuccessful attempts to take my life have shocked and saddened everyone at home. They understand why I can't help feeling anger and frustration. After I loose total control and say the most hurtful things, I take a long walk, maybe sit in a church for a while and ask for some peace of mind. Then I return home, or to wherever they are and apologize. Sometimes they tell me that that isn't me behaving in that way. Of course they forgive, but they must be firm sometimes, they say. Some demonic force seems to take over at times, I think, mainly because of a chemical imbalance". "Do parents keep in constant touch with the psychiatrist"? "Yes and all concerned are participating in 'in-house' consultations". "You have so much going for you (name), intelligence, looks, sense of humor, a great athlete (etc). When you feel better maybe you will return to studies and the other activities". She became irritated. "I can't envisage returning to studies. Who

knows what will happen? I am ill. I was taught to recognize that I am ill, not lazy or incompetent. We all know for some time now that I am ill". The depression and suicidal tendencies have devastated the family. Uncle arranged for me to work in the office. When I don't turn up everyone tells me that they understand, when I explain that I am unwell and advise me to rest. The family check constantly to find out where I am. I moved to the apartment because I can see that mum and dad are exhausted. There are 'phone calls every night from one or other and sometimes the whole family. I am now being monitored from a distance". "Do you not visit each other"? "Yes, whenever there's some free time". Nephew (three years old) is great fun. We paint and I read to him. We have fun on the 'phone as well". "Would you like to marry and have children"? "Yes". "Will you explain something about the chemical imbalance and also about social factors. Do they contribute to the depression"? "First, the medical explanation in my case is complex (use of terminology I could not grasp) and a combination of social and psychological factors can apparently cause this deep depression. Low levels of brain serotonin have been shown to be associated with aggression, either towards myself or others. Progress is being closely monitored". "Do you take alcohol"? "Hardly ever - I don't particularly like it. An odd time I take a glass of wine when we eat, if I'm not on medication". "while we're talking how do you feel"? I am enjoying the conversation, but a dark depression can hit at any time. For the past few days I

feel very tired and depressed. Schizophrenic symptoms manifest themselves sometimes but the problem is more complex and goes deeper than schizophrenia. Perhaps there is a combination of social and psychological explanations for this -----enigmatic problem". "Cytology as well as sociological research continues, according to psychiatrists and sociologists at the National Suicide Research Foundation. Does awareness of this information give you some hope that the chemical imbalance may soon be put right?" "Yes, we have our researchers at the hospital as well, but who can understand the psyche? I read in the literature that the majority of mentally ill people do not take their lives. We all know that. I'm constantly trying to understand why life is a living hell. A psychiatrist wrote that in cases such as mine life is reduced to a fatal syllogism, the major premise of which is that death is preferable to the continuance of this dilemma. The minor premise states that the dilemma will continue and that self chosen death is the solution". "In what way does group therapy help?" "Group therapy helps different people in different ways but not me. The psyche is so complex - we are all completely different". "In what way did you try to take your own life"? "Four or five years ago I took too many sleeping pills. (Brother's name) found me and I was rushed to the hospital. While I was in hospital a year ago I discharged myself - compulsory confinement is not allowed. I wandered around for some time before deciding to throw myself under a car. Somebody suddenly, somehow pulled me back. A

garda drove me to the hospital. During recovery I felt drained and disappointed that I didn't succeed in ending it all". "Mary you are loved very much by all of us. Parents, the family must have been frantic. You are now doing everything right to prevent a recurrence and that should ease the sadness and turmoil they must be suffering. When you feel better will you enjoy finding a way forward and finding your own niche in life"? "I am not able to look that far forward. I'm just trying to cope from day to day"(cried). Mum listens carefully to everything I say and between us we are trying to find some way forward". "And your dad"? "He is heartbroken. He tries to understand me but hasn't the same kind of patience or understanding as mother has. It's easier to get through to her than it is to Dad". "Do you still enjoy the company of friends and vice versa?" "Not anymore. At first there were several visits to the hospital. There is an occasional 'phone call now and the visits are few and far between. They are getting on with their lives. Sometimes after a match I meet the group and try to be sociable. They are good friends - and when I was in hospital they told me that they will always be friends. I can't blame them for not keeping in touch as often as they did. These days I finish up by depressing everyone around me Somehow I don't care any more. I have lost interest in being with friends". "In your school days did you feel under pressure?" "School wasn't a problem. I liked most of my teachers and they me. For different reasons there is no such day as an easy day since I was about eleven years old. Parents,

brothers and sister, of course are very competitive. I was a useful hockey and tennis player and they were proud of that. They came to the matches and cheered the school and me from the sidelines. They are there when needed and there when they are not needed". I laughed. "that's the case with many parents". "Do you enjoy your time at University, and on a good day do you enjoy a social life?" "To an extent. Energy levels are low and I try to work extra hard. I realise now that I set impossible goals. It was always a struggle to be sociable. I seldom enjoy a good social life. There is a façade most of the time. Deep depression defies description. I feel a combination of fear, isolation and most of the time I'm in a dark world of my own. I experienced some of my best moments ever though, on holiday in Greece in the summer. It may be the last time that the whole family will be able to get together. That holiday was what's called 'a holiday of a lifetime'. We all relaxed, I felt well. We had a good tour guide and we visited some places of note". "Short breaks often help,do you agree?" "Short breaks often would help but that's not practicable. Family or friends would not be able to take off whenever I need to take a break (laughs). I need to recover sufficiently before I would consider travelling alone". "When feeling out of sorts, might it be good idea to look forward to going to some warm exotic place, where the sea water is clear, to regain some energy?" "That kind of fantasy has been put to me by therapists. Yes, I suppose that's something to think about". "If deep depression hits when in the apartment or elsewhere do

you 'phone the hospital or one of the family members or one of the relatives or friends?" "The family has tried just about everything to keep me going. Some time ago I listened to a psychiatrist answering some questions that Pat Kenny put to him. The following night on the Late Late Show Gay Byrne interviewed another psychiatrist about suicides and parasuicides. One of them said that the main change in the suicidal is a narrowing of the focus of the mind, that one by one the various protective lights go out - concern for family, friends, relationships...that would be an accurate description in my case". "Does spiritual, as well as psychological direction help?" "I have a good spiritual director. Another good friend was transferred from a parish near ours to somewhere else. When I come out of hospital I will try to seek him out". "Did you ever consider seeking help from voluntary support organizations"? "Yes, I have a list of the support organizations. I may try to find one that suits me. If deep depression hits who knows what I'll intend to do". "Do you try to think of something positive, or think of something that would give pleasure like listening to music, when depression hits?". "NEGATIVE feelings take over. Several times I have thought of ending my life to escape from a living hell". "I read recently that in ending life in such a sad way you throw away the miracle of individual existence that can never be recreated, no matter how many more billions of people are born. Often the death is, to use a catchphrase a permanent solution to a temporary problem. Would awareness of this and knowing that

research continues give you hope that the problem will be resolved?" "It certainly is taking a long time to resolve this temporary problem. I suppose more patience is needed. That's true though, life is a biography - and individual existence can never be recreated. If I end my own life my autobiography is unfinished" (laughs). "Thank you for sharing your experience with me etc".

She died, according to the train driver by "purposefully" stepping off the platform into the path of the oncoming train. The train driver (who is receiving counselling, as well as the family, some relatives and friends) told her parents that that was his third such experience within one year. He is now training for some other kind of work.

Mr Y., was a 37 year-old father of four children and a civil engineer. He died by carbon monoxide poisoning on the morning of a working day in 1987. He revealed that he had been having serious marital difficulties for some years and mentioned that life at home was becoming unbearable. They both sought help but according to his wife he became depressed and withdrew from his family and friends and lost interest in sport, preferring to spend his time alone. He once confided that "the reason why he is still here is because of his children". His wife tried to be supportive and at first he voluntarily sought professional help but he failed to respond to therapeutic doses of anti-depressants" and disappeared for some days on two occasions. He returned home, but his wife

could not tolerate the situation, especially when he would not communicate. Consequently her health began to deteriorate. He became anxious, irritable and the suicide threats began. He was unable to concentrate at work and was advised to rest. He suspected that he would be unsuited to his future post. He went for professional help to a different therapist after some persuasion, but left hospital during treatment. He returned to work, but continued to remain alone in a room in his home and refused to socialise with family or friends. Shortly afterwards he died by suicide.

Ms Z was a forty-five year old air hostess who was participating in a promotional course to improve her career position when she felt unwell, She tried to continue with the promotional course but when anxiety became "especially bad" she decided to seek professional help. She revealed that she was becoming like her twin sister who had a history of not coping with work, low self-esteem and anxiety. The family is wealthy. She said that they were not supportive and her twin sister lived a bohemian existence in another country. She was ambitious and had intended to return to university to study economics, with a view to acquiring one of the top positions in the airline business. She wanted to become materially affluent so that she would not need to depend on the family inheritance. She revealed that "this anxiety was the most crippling aspect of her problem". She said that a diagnosis of "atypical depression was

made and that MAOIs were prescribed". She recovered and remained symptom free until she returned to work and was asked to accept work "on the ground" until the supervisor felt that she was ready for "long-haul" flights. Shortly afterwards she left the airline, her health deteriorated and she returned for treatment. She left hospital voluntarily and went on to work in different places. She 'phoned occasionally and invited me to her home, but discovered when I arrived on the last occasion that she had just been taken to hospital in an ambulance after 'overdosing'. She subsequently became anorexic and some weeks later her body was found in a Dublin harbour.

According to the Dr Patricia Casey, Professor of Psychiatry, University College, Dublin, the separatist view of suicide holds that sociological and psychiatric explorations of the aetiology of suicide are conflicting and mutually exclusive. She does not subscribe to this analysis but believes the two to be complementary and that both improve our understanding of this behaviour. A sociological as well as pharmacological basis for depressive illness is well recognised by most psychiatrists and sociologists. Whilst the association between mental illness and suicide continues to the present day, there is debate about whether suicide can in fact be prevented by medical means, given the rarity of the event. Some have suggested that socio-political and moral considerations are likely to make a greater impact on prevention (Wilkinson 1994). The above people experienced

social problems such as trying to achieve impossible goals, drug abuse, and marital disharmony which was the major problem with Case 2.

With regard to reflexivity theories and therapy, in her book, Self Therapy Janette Rainwater maintains that while therapy with another person, a psychiatrist or counsellor may be important, frequently crucial and sometimes part of a process of self-realization, therapy can only be successful when it involves the individual's own reflexivity. The therapist is at most a catalyst who can accelerate what has to be a process of self therapy and can inform someone about possible modes and directions of self-change.

The following opinions have been expressed by the families, relatives and friends of the deceased. Typical comments would be I am not an 'expert' in surviving such a life crisis but it does enable me to offer you the opportunity of experiencing such a bereavement through the eyes of the bereaved.

"The news of Ms X's suicide was expected. Nevertheless the professional parents of this clever young student are receiving spiritual direction psychiatric care and counselling because of their distress and bewilderment. They said that she had intended to take her life, despite continual efforts by all concerned to prevent this. Her father talked about how well balanced the other members of

the family are and although grieving, he comforted his wife by saying that she is now free from what was for her "a living hell". Mother said that it was a great tragedy that her daughter did not share her experience with her husband. She expressed a combination of emotions from denial to anger and frustration, but was convinced that she would recover long before her husband. At the same time she said that "one can never be complacent about anything and I will be keeping a close eye on the others". "In time we will get on with and even enjoy life, I hope, since this is part of eternity". There is nothing more to be said or done. Other member of the family said that this trauma will last forever.

"The news of my husband's suicide was a shattering experience, despite having prepared myself to receive such news over a lengthy period of time. His suicide brought with it a great deal of mixed emotions for our very small children and for myself. He was only in his thirties and to the outside world it seemed as if he had everything to live for. He had his physical health, he had a wife and four beautiful children. He was shortly to be at the top of his profession and commanded a salary that ensured a very comfortable lifestyle. Yet, despite all of this, it was not enough for my husband's well being. Before this depression he was a high achiever, always strove for perfection. When his problem began he became frustrated, angry, impatient and intolerant when any sign of imperfection was detectable in anything or anyone, but especially in himself.

He could not contemplate the possibility of failure and continually set himself tasks and goals in order to test and prove his abilities.

Bill was a very complex man. He was highly intelligent but also emotionally immature and detached. This meant that he found the sharing of emotions and feelings very difficult indeed which was a great source of pain for me and also for our children. With hindsight I would like to think that he did love us, but was for whatever reason unable to show it. As time progressed his personality began to deteriorate at an alarming rate. He would not let anyone close enough to help him. He could be verbally very cruel and harsh and either couldn't or wouldn't accept the offers of help that came his way. He shut himself off from us. He couldn't bear any noise. The baby crying became intolerable and totally unacceptable for him. He began to consume alcohol in large amounts and spent days and evenings away from home. Without going into great detail, it's enough to say that my life became unbearable. I never expected to be pussyfooting around him, to avoid upsetting him. He would sometimes fly into a very frightening rage. Then the suicide threats began. I constantly wondered whether he was going to do something harmful to himself. But then I knew he loved the children before he became ill and felt that he couldn't take such an action. Life was very difficult. While trying to seek help for him I also had to protect, reassure and care for the children. Our conversations were a great help. I went

to several people for help, as you know. Psychiatrists and social workers said that unless husband wished for help then there was nothing to be done. I felt that events were out of my control and that disaster would come. He was not a believer. I am, and I prayed that God would guide and help me. When the news finally came that he had taken his life, my initial reaction was one of shock, disbelief, anger, horror and then of relief. It was over. He had found peace in death that he couldn't find in life. I can't find any words in the English language to adequately describe the depth of sadness and pain that a suicide brings".

Briefly, Relatives and friends agree that all three had set impossible goals for themselves, and when they could not be achieved none of them would, or were able to accept other options, either in their field of work or elsewhere. "He/she would not accept any help or directions from us to change course, as we would try to do, if necessary". "Before the problems began she/he was a good friend, interesting company, kind, had a great sense of humour, and was always prepared to help us to solve our problems". Comments, such as cousin/friend was "not able to accept what they thought was failure" applied to the three deceased. "They put themselves under far too much pressure". One relative added that he would never take himself seriously again. "We may need to make career changes, but then we are not at the top of our particular fields of work". Another respondent replied that, even if he had reached the pinnacle of his

specialized field, and found that there was too much stress involved he would try to change course. They all agreed that in view of what has happened to sister/husband/ relative/friend, that they would try to find something else in their field of work, or look for some other kind of work if they felt constantly under pressure. "The important thing is to be here, I am not going to worry about trivialities such as social standing anymore". I put forward some solutions that may help such as arranging to take short breaks often, which some said they could manage. "Who isn't feeling out of sorts sometimes or at a low ebb, but I can't understand the depth of depression they were experiencing. "It was frightening to observe the 22 and 45 year-old relative/friend some days before death - she had become so gaunt". "It has a profound effect on all of us". "Husband's appearance did not change before death. I am constantly trying to understand the depth of suffering that would cause him to die in this way." "We must do something to help, there are so many people out there who can't or who won't express emotions".

"First, will you come back with a list of what helps and what does not help during bereavement?"

What helped:

A certain amount of affection from family, relatives and. Friends; offers of help; those who prepared a meal or made tea; helpful explanations;

reassurance; spiritual inputs; knowing if I asked for help it would be given; a caring GP; being told that those who died by suicide did not suffer in death; being accepted for myself; invitations for meals or tea; keeping a light on; 'phone calls, listening to music; meditation; lighting candles; reading and learning; visiting the grave when I felt like doing that; talking to the children and reassuring them; allowing people to ask questions; people being patient with me; a warm smile; animals.

What did not help:

The legal papers; form filling; waiting for the post mortem to take place; visiting accountants, solicitors, etc; not having time for myself; feeling I should be recovering by now, but the bereavement process is sometimes a long one; people saying it is for the best; people saying that I am young and would heal; being told to do specific things; people saying that it was a good thing that the children were young; being told I am strong and brave; being told 'I know how you feel'; working; being forced to eat; well meaning friends insisting that I join them when I don't feel like being sociable; celebrations without my husband present.

The themes which recurred during these conversations were the following:

Excessive competition

Loss of social status

Depression

Mood swings

Feelings of inadequacy

Feelings of isolation

Hopeless/helplessness

Despair.

These recurring themes are subject to further analysis with a view to implementing reduction/prevention strategies.

CONCLUSION.

Having amassed and carefully studied a great deal of material on suicide statistics and sociological works on suicide, it remains difficult to understand why a small number of people from all socio-economic backgrounds kill themselves.

When many different conceptual treatments of suicide are considered, it becomes reasonably clear that there are fundamentally independent but related dimensions included in different combinations of the definitions of suicide. Frequently the most fundamental dimensions of descriptions and decision making are incorporated into a number of factors that include supposed causes, such as loss of a family member at an early age, unresolvable conflict, loss of social status, unemployment and so on, discussed throughout the thesis.

It may be concluded from the review of literature that those who die by suicide are not psychotic, but this can not be proven. Debate continues as to whether the person who commits suicide is conscious of the action at the time of death. Some researchers maintain that a small number are aware that death will be the outcome of their action. The individual is unable to see an alternative way out of, what Dr Patricia Casey calls a combination of sociological and pharmacological problems.

From the case study method, used on a very small scale, obviously because of the rarity of the event, it was clear from conversations with three suicidal people, who, prior to completing therapy, discharged themselves from hospital shortly

before their deaths by suicide, as well as from conversations with their bereaved families, that psychic distress begins to dominate the person's consciousness. Their thinking becomes increasingly constricted and they see fewer possible solutions for their feelings of hopelessness. They loose interest in considering the many ways of escaping pain. Some do not seek emotional and professional help and suicide occurs.

Probable causes of suicide associated with cultural, social and economic changes are discussed in Chapter One of the thesis.

With regard to religious changes over the past four decades, Michael P. Hornsby-Smith, in a paper entitled "*Social and Religious transformations in Ireland: A case of Secularisation*?" refers to Berger's claim that "it was reasonable to assume that a high degree of secularisation is a cultural concomitant of modern industrial societies".

The impression may be given in this claim that for some, an anchoring place in a wider world has vanished, which may foster what Durkheim calls 'anomic' disturbance and even suicide, whereas individual self-identity is the spiritual self, not always taking away pain, but fear to a great extent. This paper discusses in detail, revitalisation in Catholic thinking. Spiritual as well as social comfort may be drawn from the suggestion made by Professor Liam Ryan that: "A picture emerges of a people largely believing in God and in the Church, but in possession of a belief which increasingly has little impact, not just on the wider world of business and politics, but also in many areas of private

morality"(1983:6). "A new type has appeared among middle-class Catholics, similar to Greeley's 'communal Catholic' (1976), wanting a less authoritarian and more participative style of leadership, and demanding that the leadership speak out more authoritatively on social morality but less on matters which affect his or her private life"(P.282).

With regard to education, the most lucrative form of what Pierre Bourdieu calls cultural capital, is a third level education. There has been a marked increase in third level places and, in particular, in the gender ratio of students. For example, 62% were male in the academic year of 1975-1976, and this has fallen steadily, with 1995-1996 being the first year in the history of the State when the majority of third level students were female. Entry requirements for some third level courses, especially in science and technology has increased each year, making competition for places very intense. Although it is well recognised that the system is stressful to students, teachers and parents, it is so far unclear whether or not it has contributed to the rise in young suicides in Ireland.

Concerning economic changes, according to Emile Durkheim, suicide rates increase in times of both economic expansion and depresssion. Economic conditions in Ireland began to improve gradually from the late 1950s and early 1960s, and markedly from the 1990s. Simultaneously, the number of suicide deaths continue on an upward trend.

In 1999, 504 suicide deaths were recorded in the Republic of Ireland, compared to 433 in 1998 (Central Statistics Office). In one year there was an increase of 71 suicide deaths.

Several factors may be contributing to suicide deaths, and it would be unwise to associate suicide merely with cultural, economic and social changes in societies.

The theoretical framework on which this thesis is based is in part at the Macro level, influenced by the structural functional model of society and also at the micro level influenced by reflexivity theories. Emile Durkheim's theory of suicide, is discussed in Chapter Two. Maurice Halbachs, Jack Douglas' and other theorist's views are also examined. At the micro level the reflexivity theories of Anthony Giddens and Ulrich Beck's *Risk Society* is discussed.

Suicide statistics for the years 1971 to 1999 are included in Chapter Four, the quantitative research section of the thesis. ('Suicides in Ireland). These are accompanied by a number of tables and graphs. The manner of collecting and tabulating suicide statistics in Ireland has greatly improved in recent years. The best measure of this is the proportionate relationship between suicide deaths and 'undetermined' (as to whether accidentally or deliberately intended). The number of undetermined deaths in Ireland has reduced from 119 in 1971 to 5 in 1999.

The rise in suicide among the young in Ireland preceded the drug misuse epidemic according to Michael J. Kelleher, National Suicide Foundation. The areas of the country with the highest rates of drug misuse are among those with the lowest rates of suicide. This would seem to suggest that the suicide increase is occurring independently of drug misuse, even though some of these drugs can alter individuals in a way that could lead to suicide.

Researchers in the Eastern Health Board, in a comparative study of suicides in Kildare and Mayo, examined suicide data for both counties and in Chapter Five there is a discussion about the methods used in each county. The years studied were from 1988 to 1994.

Suicide accounts for just over 1% of Irish deaths each year. However for young men it makes up 20% of their deaths, twice the rate of cancer deaths. (Central Statistics Office). Both cancer deaths and road traffic deaths among the young are decreasing. There are many reasons for this, including improved research. The mentally ill, the suicidal and those bereaved by suicide are increasingly given major support in Ireland by voluntary support organisations, therapists, religious congregations, sociologists and other groups. Nevertheless, the problem of suicide will never be adequately addressed until the underlying reasons are teased out in detail by continued research endeavour.

APPENDIX.

The World Health Organisation (WHO) and the European Union (EU) have called for health for all by the year 2000, health defined as "a state of complete physical, mental and social well-being". In order to make progress towards this goal targets were set for member states. The target for mental health was as follows:

> **"By the year 2000 there should be a sustained and continuing reduction in prevalence of mental disorders, an improvement in the quality of life of all people with such disorders and a reversal of the rising trends in suicide."**

Since the publication of the working party report on the development of mental health services -*Planning for the Future* in 1984, there has been significant development of mental health services with a corresponding improvement in the quality of life of people with mental disorders. Mental health services are increasingly delivered to persons with least disruption where possible to their daily lives. For example in 1984 there were 32 hospital/day centres in operation, compared with 159 in 1995 and 121 community residence in 1984, as against 377 in 1995. The total number of admissions to psychiatric hospitals and units in 1984 was 28,330, compared with 22,221 in 1995.

The National Task Force on Suicide considered in great detail the appropriateness of setting specific targets as part of a suicide prevention strategy. The setting of targets, that is, stating what the level should be by a certain year does not

necessarily address, the real problem. Researchers continue to gather improved information and to use this in open discussion when planning responses into the future. The overall objective is to reduce suicides to the lowest possible level. Addressing social and cultural factors as well as improving education and training, and reducing access to means has the potential to influence the suicide rate. Members of the Task Force maintain that suicide rates should be susceptible to influence by a number of measures including general public health measures. Well managed and responsive health services which can recognize mental illness early and make timely interventions are recommended. Comprehensive community based services which are accessible, appropriate and reach out into the community to provide more sensitive care for mentally ill patients are being put in place, so that progress may be made towards the above goal targets.

Important research into suicide is currently underway in this country. The Chief Executive Officers of the eight health boards initiated a study on suicide which commenced in October, 1995. This study is ongoing and aims to address concerns expressed about the rising trends in suicide and the need to gain information on factors and circumstances relating to each case of suicide. This will facilitate a better understanding of the causes of suicide and allow for a more appropriate prevention/reduction programme to be developed. The aims of the study are first, to establish the incidence and associated factors of suicide nationally on a health board basis and inform the present knowledge base on suicides. Second, to

provide information in order to facilitate future planning for a suicide prevention/reduction programme.

The study involves Coroners, Directors of Public Health, The Gardai, General Practitioners, Pathologists, Psychiatrists, Sociologists and Specialists in Public Health Medicine. The Director of Public Health in the North-Eastern Health Board has been designated by the Chief Executive Officers of the health boards to co-ordinate the study nationally.

BIBLIOGRAPHY

1. BATES, Tony: Depression: The Common Sense Approach Gill & Macmillan, Dublin 1999.

2. BECK, Ulrich: Risk Society: Towards a new Modernity, Sage Publications, London, 1986.

3. BREEN, Richard HANNAN, Damian ROTTMAN, David B. WHELAN, Christopher T.: Understanding Contemporary Ireland, Gill & MacMillan, 1990.

4. CASEY, Patricia R.: A Guide To Psychiatry, Wrightson Biochemical Publishing Ltd., Hamphsire, 1997.

5. CAVAN, Ruth S.: Suicide, University of Chicago, 1928.

6. DOUGLAS, Jack D.: The Social Meanings of Suicide, Princeton University Press, 1973.

7. DURKHEIM, Emile: Suicide: A Study in Sociology, The Free Press, New York, 1951.

8. GIDDENS, Anthony: Sociology, Polity Press, Cambridge, 1993.

9. GIDDENS, Anthony and BECK, Ulrich: Social Theory and Modernity, Pollity Press, Cambridge, 1994.

10. HALBWACHS, Maurice: *Les Causes du Suicide.* Felix Alcan, Paris, 1930.3

11. FAHY, Tom: Suicide In Ireland: From Sin to Serotonin Gill and MacMillan, 1991.

12. HEIMLER, Eugene: Mental Illness and Social Work. Penguin Books, England, 1969.

13. KEANE, Colm: Mental Health In Ireland Gill and MacMillan, 1991.

14. KELLEHER, Michael J.: Suicide and The Irish. Mercier Press, Dublin, 1996.

15. KREITMAN, N.: '*Suicide and Parasuicide*' in Kendall R.E. And Zeally. *A Companion to Psychiatric Studies*. Churchill, Livingston 1993.

16. LEE, David and Newby, Paul: The Problem of Sociology. Unwin Hyman Ltd., London, 1983.

17. MAC GREIL, Micheál: Prejudice In Ireland Revisited. The Survey and Research Unit, The Department of Social Studies, St. Patrick's College, Maynooth, 1996.

18. McKEON, Patrick: Suicide In Ireland: A Global Perspective and A National Strategy, Aware Publications, Dublin, 1998.

19. MAY, Tim: Social Research. Open University Press, 1977.

20. Pope, Whitney: Durkheim's Suicide A Classic Analyzed, University of Chicago Press, 1976.

21. RITZER, George: Sociolgical Theory. McGraw-Hill, Singapore.

PUBLICATIONS.

British and Irish Journals of Psychiatry	*1989, 1991, 1993, 1995, 1997, 1999.*
Report on a Comparison of Suicide In Two Counties, (Kildare and Mayo).	Journal of Psychiatric Medicine, 1999. p.136.
Report of the National Task Force On Suicide.	Government Publications, Dublin, 1998.
Social and Religious Transformations In Ireland.	Michael P. Hornsby-Smith, 1980, 416.
Variation in Suicide Rates in the Republic of Ireland.	M.J. Kelleher, in Southern Health Board Publications.