WESTERN AND EASTERN SUICIDE: DOES IT KNOW THE POINTS OF THE COMPASS?

Petrović A., Zorko M., Marušič A.

For Correspondence:
Andrej Marusic, University of Primorska, Titov trg 4, 5000 Koper, Slovenia, andrej.marusic@upr.si

Are there only geographic differences between Western and Eastern Europe or is there more to it? We do not have to take the whole course on history, geography and sociology to realize that the answer to the question is much more complex. Western and Eastern Europe are distinguished by historical and cultural differences rather than only by their position on the geographical map. It has long been known that different populations differ in their health and well-being and the difference is most probably not only the result of different definitions of mental health indicators. Can the specific cultural differences also affect the well-being (and that in turn the suicidal rate) of the population? Without any doubts, cultures of societies are important determinants of their population health and well-being.
We should first remind ourselves of what a culture is? In general, the word *culture*, from the Latin colo, *-ere*, with its root meaning "to cultivate", generally refers to patterns of human activity and the symbolic structures that give such activity significance. This kind of patterns of human behaviour surly indicates the way we feel, think, behave and how healthy we are. Culture could be called "the way of life for an entire society." As such, it includes codes of manners, dress, language, religion, rituals, values, artefacts, norms of behaviour and systems of belief. If the culture defines the way we behave in our everyday lives, then the culture also to some extent defines the way we behave in stressful situations, the way we encounter problems and the way we deal with defeat. On the other hand also the values of other people define the way we behave. The culture with permissive attitudes towards suicide gives different perspective to this kind of life-ending than a culture with a history of prohibition of suicide. We can even go further: different life events may have different meaning in different cultures. If having a steady job and adequate socio-economic status in one country is greater value than in another, than losing a job in the first country influences one's well-being more. Historical aspects (wars, economic changes, history of the "culture of suicide"…) of course also define, directly and indirectly, mental health of the population.
Western and Eastern European countries markedly differ in national suicide rates. In general, suicide rate in Western Europe is between approximately 5 and 19 suicides per 100 000 and is rather lower than in Eastern Europe where suicide rate is placed between 12 and 41 suicides per 100 000 (HFA-MDB). Cantor (2002) reminded us suicidal rates in Eastern European countries increased in the period between 1987 and 1991-1992, while the male-female suicide ratio in these countries widened. Furthermore, we also found differences in the method of completed suicide: national shares of suicides by hanging are variable, being higher in Eastern (Lithuania 90 %, Hungary 68 %, Latvia 81 %, Slovenia 62 %) compared to Western countries (Ireland 48 %, Holland 43 %, Spain 37 %, England and Wales 51 %).
Question that occurs is: what accounts for such large differences? Schmidtke (1997) listed for this purpose several factors that may influence this variance level: socio-demographic factors, ethnic differences, religious beliefs and affiliations, attitudes towards suicide, legislation regarding suicide, coping strategies, prevention strategies and reliability and validity of death certification and reporting. The last factor seems to be relevant because recording the cause of death can be influenced by legal, moral and cultural taboos. Gunnell (2005) saw some additional factors, especially economic differences (suicide rates higher in countries experiencing economic

recession), differences in the availability and effective delivery of primary and secondary health-care services for mental illness, levels of particular risk or protective factors (alcohol abuse, divorce, unemployment) and genetic differences between population.
If we consider socioeconomic factors we can see that variation in suicide incidence is not sufficiently accounted for by them. For instance, in mid-1990s suicide rates in 34 European countries (Schmidtke et al, 1999) were not significantly related to per capita gross domestic product (United Nations Development Programme, 2000). Several authors have reviewed some socioeconomic aspects of suicide rates in the former Soviet Republics during the process of perestroika, however no study has analysed a spectrum of social and economic correlates for the whole 15-year period: from perestroika to stabilization of the economic and political stabilization (Rancans et al, 2001). On the other side, Marušič et al (2002) investigated gross domestic products in association with literacy rates and national suicide rates in 33 European countries. Results of this study showed that high literacy rates significantly predicted high suicide rates even when controlling for gross domestic product and age distribution. When gross domestic product per capita was added to the linear regression model, the latter improved considerably. More specific, on one country (Latvia) orientated longitudinally study (Rancans et al, 2001) pointed out that the sudden drop in gross domestic product, the rapid increase in first-time alcohol psychosis and the percentage of people unemployed did not correspond strictly with the dynamics of suicide rates.
The differences may also be accounted by the reliability of death reporting. Are suicide rates between countries comparable, knowing that reporting procedures differ? It may happen that what would be registered as a suicide in one country may not be in another country. Most of the researchers believe that these sources of variance across Europe are random (Sainsbury & Jenkins, 1982; Monk, 1987; O'Carroll, 1989; Diekstra, 1993; Moscicki, 1997).
If so, where should we seek other factors that may influence the variation in European suicide rates? One of the possible different points of view is presented through Finno-Ugrian suicide hypothesis. Kondrichin (1995) has put forward this hypothesis, noting that European regions with prevailing Finno-Ugrian ethnicities, languages or cultural influences have higher suicide rates compared to other European countries. According to Marušič and Farmer (2001) the European countries with the highest suicide rates constitute a contiguous J-shaped belt spanning from Finland to Slovenia. These countries are diverse in terms of recent history, political systems and socioeconomic factors. People living within the J-curve could share genes, therefore, which do not tolerate well excessive amounts of alcohol, the combination of which is more likely to end in suicidal behaviour. Voracek et al (2003) stress that up to now the Finno-Ugrian hypothesis has been investigated only on an ecologic level and more fine-grained ecologic analyses of these initial findings will be needed. Also more direct evidence on a genetic level will be necessary for further confirmation.
At the end: what can we learn from Eastern and Western suicide rates differences? Inter- and intra-national variations in suicide call for specific national programmes for suicidal prevention. The later should not rely only on universal known suicide risk factors but should also consider specifics of the country. Of course, a greater understanding of origins of suicide variation and the extent to which their causes are modifiable, offers great potential for suicide prevention.
Development and implementation of national policies on suicide prevention varies across countries. On one hand there are Western European countries with profound prevention strategies (e.g. Finland, United Kingdom, Ireland, Scotland) and on the other there are countries of Eastern Europe still lacking a national policy on suicide prevention (e.g. Slovenia, Croatia, Russian Federation). If we take a broader perspective we can see that also mental health literacy varies, in many eastern countries mental health promotion and prevention is still not on the

political agenda and no budget is allocated for mental health (e.g. Slovenia, Czech Republic, Hungary, Latvia and Lithuania).
Samomor, suicide, самоубийство, zelfmoord, kamikaze, Selbstmord, suicidio, suicídio, självmord - the language we use to discuss suicide and its impact surely does not matter for those bereaved. With suicide a life is lost and the way we name the act itself does not actually matter. What matters is to find its causes and effective ways of preventing suicide and promoting mental health and well-being. Hopefully East will learn from the West and vice versa in regards to raising awareness about the need for effective prevention, intervention and postvention strategies.

The 11th European Symposium on Suicide and Suicidal Behaviour was a great opportunity to bridge the west and the east, since the event has been organised bilingually, with English and Russian as two official languages. It was not only a meeting of most broadly spoken West and East languages, but also a great exchange of knowledge in the field of West and East suicidology.

References

CANTOR, C.H. (2002) Suicide in the Western World. In K. Hawton and K. van Heeringen: The International Handbook of Suicide and Attempted Suicide. Chichester: Wiley.
DIEKSTRA, R.F. (1993) The epidemiology of suicide and parasuicide. Acta Psychitraica Scandinavica, 371 (Suppl.), 9-20.
GUNNELL, D. (2005) Time trend and geographic differences in suicide: implications for prevention. In K. Hawton: Prevention and treatment of suicidal behaviour – from science to practice. Oxford: Oxford University Press.
KONDRICHIN, S.V. (1995) Suicide among Finno-Ugrians. Lancet, 346, 1632-1633. [Letter]
MARUŠIČ, A., KHAN, M., FARMER, A. (2002) Can the Interaction of Poverty and Literacy Explain Some Variability of Suicide Rates in Europe? European Journal of Psychiatry, 16 (2), 103-107.
MARUŠIČ, A. & FARMER, A. (2001) Genetic risk factors as possible causes of the variation in European suicide rates. British Journal of Psychiatry, 179, 194-196.
MONK, M. (1987) Epidemiology of suicide. Epidemiologic Reviews, 9, 51-69.
MOSCICKI, E.K. (1997) Identification of suicide risk factors using epidemiologic studies. Psychiatric Clinics of North America, 20, 499-517.
O´CARROLLL, P.W. (1989) A consideration of the validity and reliability of suicide mortality data. Suicide and Life-Threatening Behaviour, 19, 1-16.
RANCANS, E., SALANDER RENBERG, E., JACOBSSON, L. (2001) Major demographic, social and economic factors associated to suicide rates in Latvia 1980-98. Acta Psychiatrica Scandinavica, 103, 275-281.
SAINSBURY, P. & JENKINS, J.S. (1982) The accuracy of officially reported suicide statistics for purposes of epidemiological research. Journal of Epidemiology and Community Health, 36, 43-48.
SCHMIDTKE, A. (1997) Perspective: suicide in Europe. Suicide and Life-Threatening Behavior, 27, 127-136.
SCHMIDTKE, A., WEINACKER, B., APTER, A., BATT, A., BERMAN, A., BILLE-BRAHE, U., BOTSIS, A., DE LEO, D., DONEUX, A., GOLDNEY, R., GRAD, O., HARING, C., HAWTON, K., HJELMELAND, H., KELLEHER, M., KERKHOF, A., LEENAARS, A., LÖNNQVIST, J., MICHEL, K., OSTAMO, A., SALANDER-RENBERG, E., SAYIL, I., TAKAHASHI, Y., VAN HEERINGEN, C., VÄRNK, A., & WASSERMAN, D.

(1999) Suicide rates in the world: update. Archives of Suicide Research, 5, 81-89.
VORACEK, M., FISHER, M.L., MARUŠIČ, A. (2003) The Finno-Ugrian suicide hypothesis: variation in European suicide rates by latitude and longitude. Perceptual and Motor Skills, 97, 401-406.