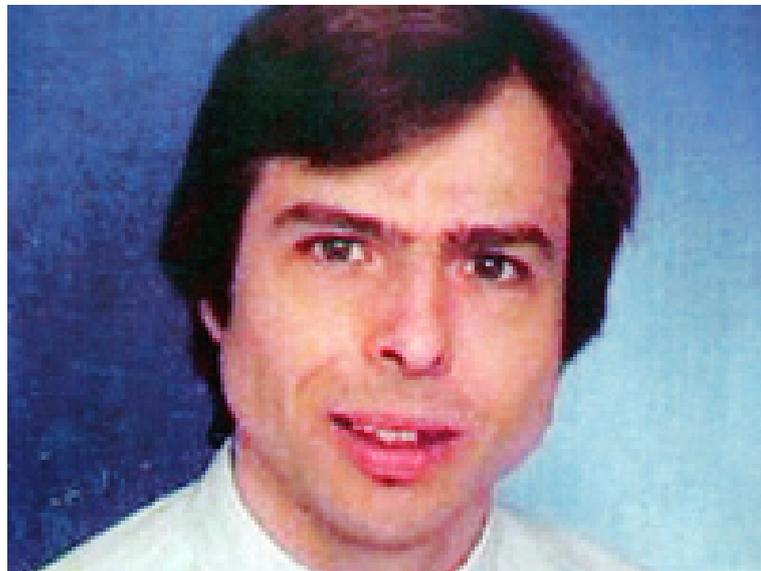


Chapter 31

SUICIDE: A BROAD VIEW

“Suicide is a very complex, multicausal human behavior with many ‘causes’ and several biological as well as psychosocial and cultural components”

Rihmer, 2007



Wolfgang Priklopil suicided in 2006. He had kidnapped Natasha Kampusch in Vienna, when she was 10 years of age. He imprisoned her for 8 years. When Natasha escaped, and the police were summoned, Priklopil threw himself under a train. He was a communications technician, who owned his own house and car (Kampusch, 2010). His death appears to have been motivated by fear of apprehension.

Conflict of interest/bias

For more than a century, many medical/psychiatric experts have believed that psychiatric disorder is the cause of all, or almost all, suicide.

The current author has opposed this view (Pridmore 2009; Pridmore 2014; Pridmore and Pridmore 2018). However, he accepts that suicide may be triggered by a mental disorder.

Recent developments

In 2014 the World Health Organization described the belief that all suicide was the result of mental illness as a myth. In 2018 the Centers for Disease Control stated the 54% of those who died by suicide did not have a mental health condition.

From possession to psychiatry

Suicide is known in all cultures and periods of history. It is known in all ethnic and religious groups and in all geographical regions (Lester, 2006).

In ancient Greek and Roman times suicide was completed by Pyramus and Thisbe, Aegeus, Hercules, Ajax, Stoics, and Anthony and Cleopatra.

The Bible provides accounts of suicide and suicidal thinking. Mathew 27: 5 details the actions of Judas when the priests refused to allow him to retract his betrayal of Jesus: “And he cast down the pieces of silver in the temple and departed and hanged himself.”

Other Biblical suicides include Samson (Judges 16:26-27), Abimelech (Judges 9:50-55), Saul (1 Samuel 31:3-5), Ahitophel (2 Samuel 17:23), Zimri (1 Kings 16:15-20). Insofar as Jesus took no steps to prevent his death he can also be considered to have suicided.

Revelations 9: 6 refers to a time when the air will be filled with smoke and flying scorpions: “And in these days shall men seek death and shall not find it, and shall desire to die, and death shall flee from them”. Thus, in particular circumstances, individuals may choose or at least consider suicide.

While the Bible does not contain a clear prohibition (Koch, 2005), the Christian church has considered suicide to be the result of satanic possession and refused to bury the body of the person who completes suicide with the usual religious rites. From pre-Christian times, in various countries, a stake was driven through the body, which was then buried at the crossroads. The stake was to pin the evil spirit to the ground and the cross roads were chosen so that the evil spirit would be confused by people going in different directions and not know which one to follow. This custom was last performed in Britain, in London, in 1823.

In the early 19th Century, suicide changed from being a moral/religious to a medical issue.

The psychiatric view

The psychiatric view is that suicide is primarily the result of psychiatric disorder and is therefore predictable and preventable (Mann et al, 2005).

It is the current author’s opinion that some statements supporting the psychiatric view are manifestly wrong – for example, a report (Nettelblatt et al, 2007) which claimed to have found evidence of psychiatric or alcohol disorder in 93 % of cases of completed suicide.

Placing the issue in context - the lifetime risk of suicide of people with major depression is 3.4% (Blair-West & Mellsop, 2001) – this is much higher than the risk for the general population – but, in no way supports the view that all suicide is the result of mental disorder.

Research groups dedicated to the understanding and prevention of suicide use “psychological autopsies” - they sift through all the information available regarding the events of the individual’s life. They report evidence of diagnosable mental disorder in 90% of those who suicide (Hawton and van Heringen, 2009) and argue that the remaining 10% probably suffered a mental disorder which it was not possible to detect (Ernst et al, 2004). However,

the “psychological autopsy” method has been discredited (Hjelmeland et al, 2012). Recent studies of this type in India (Manjoranjitham et al, 2010), China (Phillips, 2010) and Malaysia has found mental disorder in less than half those who completed suicide – strongly indicating the need for fresh thinking. Retrospective investigations are notoriously inaccurate, and bias can lead to distress being mistaken of psychiatric disorder.

The prevention strategy which is the natural consequence of the belief that all suicide is the result of mental disorder is “improved screening of depressed patients by primary care physicians and better treatment of major depression” (Mann et al, 2005). But, if mental disorder is not the cause of all suicide, this medical solution will have limited success.

It has been claimed that the introduction of antidepressants reduced the suicide rate in Sweden (Nettelbladt et al, 2007). However, in the USA and Brazil the use of antidepressants has been increasing for the last 20 years, and so too have national suicide rates.

Broader research indicates risk factors for suicide included mental disorder, past suicidal attempts, unemployment, low income, single and divorced marital status, painful physical illness, alcohol and drug problems, and a family history of suicide (Rihmer, 2007).



The psychiatric model of suicide – The Australian (national newspaper) – July 2018. An example of how this model dominates public discussion. The argument is made – give mental health services more money and the suicide rate will be reduced – well, it might be, but it hasn't been anywhere else in the world.

Genetics

Adoption (Schulsinger et al, 1979), family (Wender et al, 1986), and twin (Baldessarini and Hennen, 2004) studies have demonstrated that genes have a significant influence on suicide risk.

Heritability accounts of 30-55% of the risk for suicide (Voracek & Loibl, 2007). Gene/s for suicide are not proposed, rather this effect probably comes via genetic influences on the personality features of neuroticism/hopelessness and impulsivity/aggression, which underpin some suicidal behavior. (See Chapter 10, 'Personality' for more on these features.)

A recent study (Noroozi et al, 2018) suggested a single nucleotide polymorphism within the interleukin (IL-8) gene may play a role in suicidal behavior.

Acute and chronic risk

Suicide risk may increase rapidly (to critical level) because of sudden overpowering distress, or intoxication, in people both with and without mental disorder.

Wyder (2004) examined individuals who had survived a suicide attempt; 51% reported acting after thinking about their actions for 10 minutes or less. Of those who had been affected by alcohol, 93% had thought about their actions for 10 minutes or less. Impulsive acts make prevention problematic (WHO, 2014).

Dumais et al (2005) investigated cases in which suicide was completed during an episode of major depression. They found that impulsive-aggressive personality disorders and alcohol abuse/dependence were two important, independent predictors of suicide in major depression.

When acute suicide risk is the consequence of a mental disorder, appropriate psychiatric treatment should be administered without delay. Compulsory admission and treatment may be necessary.

Some individuals are at long term (chronic) risk of suicide. Chronic risk is a common feature of personality disorder, particularly borderline personality disorder. The personality disorders differ from conditions such as major depressive disorder, which manifest discrete episodes of difficulties. "Personality" refers to the characteristic (long-term) way the individual responds to the environment. Personality disorder is diagnosed when features of the personality lead to "distress and impairment". When the suicide risk is due to personality disorder, as personality disorder is a long-term (rather than episodic) disorder the suicide risk will be chronic.

Some types of personality disorder are more often associated with suicidal behavior than others. Borderline personality disorder, characterized by a pervasive pattern of instability of interpersonal relationships and mood, and marked impulsivity, has a 10% lifetime risk of suicide (Plakun et al, 1985).

While personality disorder is a chronic condition, there may be superimposed periods of more acute distress and acute risk of suicide. Impulsive suicide is usually triggered by adverse life events (Zouk et al, 2006).

The personality of people with personality disorder may mature and the distress these people experience may lessen over the years - particularly with the assistance of ongoing outpatient care. Lengthy inpatient periods in psychiatric facilities are at best useless and at worst, damaging; they remove individuals from the real world in which they need to learn to function, and delay the development of a sense of personal responsibility. However, brief hospitalization of individuals with personality disorder may be helpful during crisis periods (up to 72 hours) to allow the settling of acute distress. Wyder (2004) reports that of those who attempt suicide, in 79% the impulse has passed within 12 hours.

The management of patients with borderline personality disorder is legally perilous for doctors because of the lack of understanding in the community of the chronic risk of suicide and the principles of optimal care mentioned above (Gutheil, 1985). There are some informed jurisdictions, however, for example, the Ministry of Health (New Zealand) Guidelines (1998) state, "In order to achieve therapeutic gain, it is sometimes necessary to

take risks. A strategy of total risk avoidance could lead to excessively restricted management, which may in itself be damaging to the individual”.

Italy closed its psychiatric hospitals in 1978 and reduced psychiatric beds in general hospitals. The suicide rate fell from 7.1/100 000 in 1978 to 6.3/100 000 in 2012. Italy has the lowest number of acute-care psychiatric beds and the lowest suicide rate in the G7 (Barbui et al, 2018).

Distress

There is general agreement that those who perform suicide are emotionally distressed at the time. This probably includes those who suicide “for the greater good” of their community, such as political protesters, Kamikaze pilots and suicide bombers.



Thich Quang Duc burned himself to death in Saigon (Vietnam) in 1963. He was protesting the way the government was (in his view) oppressing the Buddhist religion.

We frequently learn of the suicide of people who are suffering intractable physical pain. Chronic pain doubles the risk of suicide (Tang & Crane, 2006)



Jo Shearer, a 56-year-old accomplished journalist who suffered intractable pain. She advised colleagues of her intention and ended her life.

Distress occurs in people who are facing legal charges. At the time of writing an early issue of this chapter, Steve Wright, the alleged Suffolk Ripper, was on ‘suicide watch’. The suicide of Wolfgang Priklopil in 2006 was mentioned on the first page of this chapter. Other examples of apparent distress leading to fatalities include the suicide in 1987 of Budd Dwyer a disgraced Pennsylvanian (USA) public figure, who shot himself in front of television cameras, the suicide in 1996 of Admiral Jeremy Boorda (USA) who was being investigated for wearing a medal to which he was not entitled, the suicide in 2000 of Wolfgang Huellen, the chief financial officer of the Christian Democratic Union (Germany) who was being investigated for embezzlement, and the suicide in 2003 of Dr David Kelly a British Ministry of Defense scientist who had been blamed for a political scandal relating to the Iraq War. In 2004 Dr Harold Shipman suicided because he did not wish to remain in goal and in 2013 Michael Martin took cyanide and died in a Phoenix (USA) court when he was found guilty of fraud and sentenced to 16 years goal.



Budd Dwyer shooting himself in front of television cameras (1987).

Under this heading (Distress) it is appropriate to mention ‘Psychache’ a term coined by Shneidman (1993) for ‘unbearable psychological pain’ which he described as precipitating suicide.

The sociological model

“Experience indicates that for effective suicide prevention, the appropriate treatment of people with mental disorders is just one of the main components. Actually, biological and psychological characteristics, and factors pertaining to the cultural, social and physical environment, although more difficult to approach in quantitative ways, should receive much more attention...”

Bertolote et al, 2004

In 1897, Emile Durkheim, a French sociologist, published “Suicide” (translated, 1951). He proposed that social factors were the setting and major cause of most suicide.

Durkheim made an enduring contribution to the field. He emphasized, 1) *social integration* (attachment to society providing a sense of purpose and meaning), and 2) *moral regulation* (the healthy society providing limits to the aspirations, behavior and thereby, the disappointments of the individual).

Social integration refers to shared beliefs and relationships between individuals. Integrated societies give both meaning to life and emotional support. When the individual becomes less attached to society there is an increased risk of suicide. Durkheim wrote of the dangers of “*excessive individualism*” and the associated loss of “*purpose and meaning*”. And, finally, when integration is inadequate, “*The individual yields to the slightest shock of circumstances because the state of society has made him a ready prey to suicide*”. This, he called, “*egoistic*” suicide. It is noted here that egoistic suicide may occur because of features in the individual, it is not necessarily the result of an unhealthy society, but simply that this individual does not well integrate (find meaning and support) with that society.

Moral regulation refers to the limitation and modulation of “*the passions*” (including aspirations). Durkheim used the term “*anomy*” to describe the situation when society provides inadequate regulation. He believed that in a state of anomy, society no longer provides regulation through shared values and beliefs, “*the passions*” are unregulated, and the consequent exhaustion (due to unquenchable aspirations) and dejection may lead to suicide. This is “*anomic*” suicide.

The “*anomy*” Durkheim had observed was a feature of the Industrial revolution. (Others have existed, more recently, with the decline in the centrality of communism in USSR.)

Durkheim believed that “*in the sphere of trade and industry*” (a field in which acquisition is the goal and there are no limits to profits) “*anomy*” is “*a chronic state*”.

For the sake of completeness, mention is made of “*excessive*” integration and excessive regulation. Excessive integration pertains when the individual is “*completely absorbed in the group*” and has no independent identity. Durkheim believed this could lead to “*altruistic*” suicide (such as the Kamikaze pilots, Thich Quang Duk, above; the opposite of egoistic suicide).

He also described ‘*fatalistic suicide*’ – where there is “*excessive*” regulation – in which “*futures pitilessly blocked and passions violently choked by oppressive discipline*” - observed among prisoners and the incurably sick.

“*Altruistic*” and “*fatalistic*” suicide are rare and of little importance from the quantitative perspective.

“*Anomic*” and “*egoistic*” suicide are more common – but, sadly, even these useful, Durkheimian concepts are rarely used.

Durkheim was the first to demonstrate the suicide rates of different nations were different, but relatively stable over time. This remains the case, for example the rate for Greece is around 6, Australia is around 10 and Lithuania is around 32 per 100 000 per year.

Current sociological studies of suicide continue to support Durkheim’s work (Bando et al, 2012). A major study by Zimmerman (2002) concluded, “Overall, the findings are consistent with the Durkheimian view that suicide is a statement about the characteristics of those institutions that normally function to bind individuals to each other and the larger society – marriage, community, workplace, social welfare – linking macro-level phenomena with the actions of individuals”. Qin et al (2003) found support for the Durkheimian theory that the protective effect of marriage is largely an effect of being a parent. Hsieh (2017) report support for Durkheim’s belief that religion protects against suicide.

The impact of social factors on suicide rates is well demonstrated in the North American Indians, who have the highest suicide rate of all ethnic groups in the United States (Olson & Wahab, 2006). This culture is under extreme pressure and family conflict, alcohol abuse and hopelessness are believed to be important factors leading to suicide (Strickland et al, 2006). The 2003 SARS epidemic in Hong Kong was associated with a marked increase in the suicide rate of the elderly, and biopsychosocial factors have been implicated (Chan et al, 2006). Psychosocial stresses have been associated with the suicidal behavior of adolescents in rural China (Liu et al, 2005) and Korea (Kim et al, 2010).

The importance of social factors in suicide in Australia was demonstrated by Page et al (2006), across the period 1979-2003; socioeconomic status being significantly inversely related to suicide rate.

The influence of changing levels of employment and affluence came strongly into focus recently, due to the Global Financial Crisis; predictably, suicide rising during periods of recession and falling during periods of growth (Luo et al, 2011). A complicating issue, included here for interest only, is that during the recent European recession, concurrent with the increase in the suicide rate (34.1%), there was a decrease in the all-cause-mortality rate (3.4%) (Toffolutti and Suhrcke, 2014).

With respect to religion/culture, evidence suggests a lower suicide rate among Muslims than other groups, although this may be a reporting problem (Shah & Chandia, 2010).

The relationship between perinatal circumstances and subsequent young adult suicide - (Riordan et al, 2006). A higher suicide risk was demonstrated for those who were, 1) the offspring of young parents, 2) the children of mothers of high parity, 3) the children of non-professional parents, and 4) of low birth weight. This study suggests that less than optimal perinatal circumstances impact on the individual, perhaps through personality development, limiting coping skills in later life.

Sociological factors have a profound effect on the rate of suicide. Changes in the suicide rate will require changes in educational, economic and employment opportunities, and illegal drug availability.

Prediction and prevention

Some authorities recommend psychological autopsies be continued so that a list of “**risk factors**” can be discovered which will enable us to identify those people at risk and prevent suicide (Sher, 2013).

In 1970, Stengel identified the important risk factors as being male, older, widowed, single or divorced, childless, high density population, residence in big towns, a high standard of living, economic crisis, alcohol consumption, broken home in childhood, mental disorder, and physical illness. While many of these findings still have relevance today, residence in the country has replaced “residence in big towns” and low socioeconomic status has replaced “a high standard of living”.

Lists of risk factors have been gathered for decades. They have high sensitivity but low specificity - suicide has a low base rate – using risk factors yields unmanageably large numbers of both false positives and false negatives.

An excellent examination of the validity and utility of categorizing inpatients with respect to risk of suicide (Large, et al, 2011) concludes, “Risk categorization of individual patients has little or no role to play in preventing suicide amongst psychiatric inpatients”.

A Sydney based group has authoritatively stated that risk categorization (using risk factors) plays little or no role in the prevention of suicide (Large and Ryan, 2014 a & b; Large et al, 2011 a & b). These authors recommend that patients with mental disorder and other suffering individuals should be closely examined and all possible treatment/assistance should be provided – it is the treatment/management of issues rather than the classification of risk which is helpful.

Studies have reported factors playing a stronger role than mental disorder. Almeida et al (2012) examined the suicidal thoughts of older people and found social disconnectedness and stress accounted for a larger proportion of cases than the mood disorders. Park et al (2014) have emphasized the importance of strained family relationships and a tolerant attitude to suicide. Schneider et al (2013) have emphasized the importance of obesity, smoking and living alone.

Some medically orientated groups make observations which encourage the belief that mental health professionals can prevent suicide. For example, a recent study (Beautrais, 2004) of people who had made a suicide attempt found that after 5 years, 6.7% had died by suicide. The paper concludes, “These findings imply the need for enhanced follow-up, treatment, and surveillance of all patients making serious suicide attempts”. This argument is logical, but impractical; most services are already doing their best and there is little evidence that any form of therapy is effective, also, maintaining intensive follow-up for 5 years would be impossible.

In another example (Burgess et al, 2000) - “Data on patient and treatment characteristics were examined by three experienced clinicians” and they found that “20% of the suicides were considered preventable.” The danger of retrospective studies aside, there is no proof in such statements that had the apparent shortcomings identified by experts been altered, suicide would have been prevented. An exemplary admission procedure does not stop the patient going out on leave getting drunk and being rejected by a lover.

Beck et al (1999) studied outpatients at high risk of suicide, people 100 times more likely to suicide than members of the general population. They found the suicide rate among this high-risk population was only 0.2% per annum. Thus, to save one life, even in this high-risk group, it would be necessary to provide infallible care, 24 hours per day to 500 people for one year. Also, the support offered would need to be in a form acceptable to everyone.

Powell et al (2000) studied psychiatric inpatient suicide. They compared those who had suicided as inpatients with a control group and identified risk factors. However, they concluded, “Although several factors were identified that were strongly associated with suicide, their clinical utility is limited by sensitivity and specificity, combined with the rarity of suicide, even in this high-risk group”.

Appleby et al (1999) conducted comprehensive analysis of 10 040 suicides. They found, "Most... (of the deceased)... were thought to have been at no or low immediate risk at the final contact".

Fahy et al (2004) asked 7 experienced mental health professionals to read the notes of 78 psychiatric patients and attempt to predict which 39 completed suicided. The readers considered all known suicide risk factors. These experienced clinicians did no better than chance. The authors state, "...these disappointing findings call into question the clinical utility of risk factor findings to date".

There have been several well resourced small studies, in which high risk groups have been given sustained attention with special counseling and additional support. In none of these was there a significant difference in outcome when the experimental was compared to a control group. Reviewing these studies, Gunnell and Frankel (1994) found, "No single intervention has been shown in a well conducted randomized controlled trial to reduce suicide". Similar conclusions have recently been made with respect of suicide among young people (Robinson et al, 2010).

To date, 5 men have completed suicide at Guantanamo prison camp. Even with the reputation of the most powerful nation in the world in the balance, in the most secure environment on the planet, and with all possible resources, suicide could not be indefinitely prevented.

Hospital admission

Not infrequently, following a suicide, there is criticism of mental health professionals and health systems for failing to admit people to hospital or, having admitted them, failing to provide some particular service/supervision. Most psychiatrists, however, have known closely supervised patients who have suicided. Powell et al (2000) described their experience, "...two inpatients were under continuous observation. One of these two jumped through a window and deliberately cut his neck with the broken glass, the other ran to a railway line and was hit by a train." Thus, admission to hospital and continuous observation is not a guarantee that suicide of an individual will be prevented.

With respect to community suicide rates, Garlow et al (2002) reported a natural experiment. In response to budgetary constraints, admissions to psychiatric hospital in Fulton County Georgia, USA, had to be reduced. Admissions were cut by 56%. Over the same period, the suicide rate of the county did not increase, but fell, from 12 to 10/100 000 (not statistically significant). Thus, ready admission to hospital does not improve the suicide rate of a general population.

Under the heading 'Acute and Chronic Risk' (see above) mention was made of the practice of admitting to hospital, for a brief time, people with personality disorder who are distressed and 'in crisis'. Another group admitted to hospital for their own safety are people with an episode of a disorder like major depressive disorder, who appear to be in some danger of suicide. The idea here is that hospital is a safe place where the mental disorder can be most efficiently treated.

The Sydney based researchers mentioned above have advanced a revolutionary idea - “Nosocomial Suicide” – the idea is that psychiatric admission may increase the risk of suicide (Large et al, 2014). For some individuals, adverse aspects of psychiatric ward admission may include stigmatization, a sense of abandonment and heightened vulnerability. For some individuals, Large et al (2014) state, “the protective benefits are outweighed by the additional ‘stress’ of hospitalization”.

The impact of suicide on others

Impact on relatives and friends. There is surprisingly little standardized data on the effect of relatives and friends of those who suicide – naturally, it may cause them much suffering. This may be greater when the relationship has been between the deceased and those who are left has been difficult. Some authors believe suicide can represent an aggressive act, an angry rejection and punishment of friends and relatives.

The Executive Director of the Alliance of Hope for Suicide Survivors (Walker, 2014) states that the unfounded popular media catch-cry “Suicide is Preventable” increases the “survivor guilt” of friends and relatives.

Impact on mental health professionals. For mental health professionals, suicide of patients is inevitable and has been designated an “occupational hazard” (Ruskin et al, 2004). The impact may be severe.

Ting et al (2006) described the impact of client suicide on mental health social workers, which in extreme cases included refusing to see further clients who appear to be at some risk, leaving the place of work and even the state.

Alexander et al (2000) studied psychiatrists and reported that following the suicide of a patient, a large proportion develop symptoms suggestive of depression, which last for at least a month, and 15% consider taking early retirement.

Dewar et al (2000) studied trainee psychiatrists and found 31% reported the suicide of a patient had an adverse impact on their personal lives. Following a completed suicide, trainees became “over cautious” in their management of patients, which disadvantaged some. 9% of trainees considered a change of career, and a small proportion decided not to pursue careers in general adult psychiatry, because of its higher risk of patient suicide.

Eagles et al (2001) state, “it seems probable that onerous expectations of prediction and prevention...contribute to the distress which suicides cause psychiatrists”. Such expectations of prediction are based on an incomplete understanding of the field and are unfair. There is a world-wide shortage of trained mental health professionals, and any process which further depletes this pool exposes rather than protects patients.

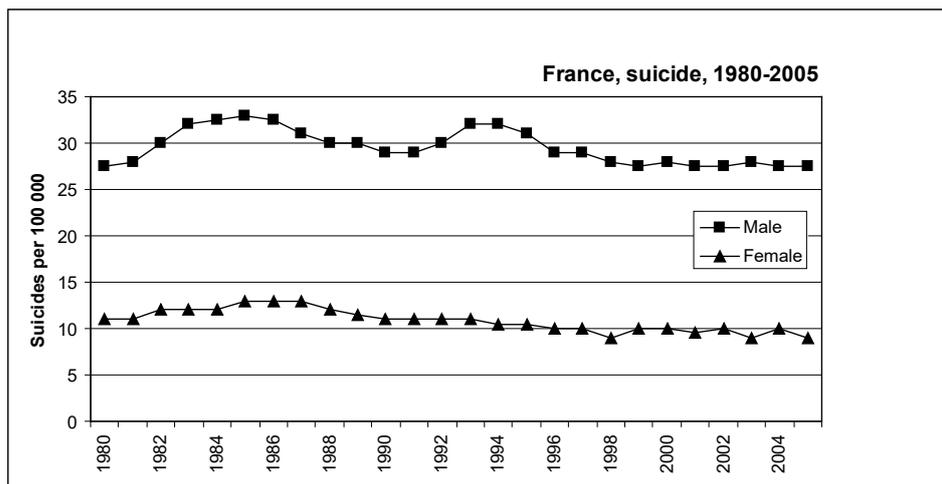
The impact of criticism on systems. Excessive criticism may be destructive. Critics of systems frequently suggest that additional steps need to be taken to protect patients. This results in the introduction of additional paper work, so that every aspect of patient care is fully documented, and staff are more, but not completely, legally protected. A problem which arises is that staff must spend so much time on defensive documentation that there is little left to spend with patients.

An additional consequence of post suicide criticism has been the locking of open wards. With the closing of the old psychiatric hospitals, new psychiatric wards were established in general hospitals. Initially these were open wards. Overtime many general hospital psychiatric wards have been converted into secure (locked) facilities. This is, at least in part, a response to criticisms made during the scrutiny of the suicide of unrestricted patients who have been able to leave wards and complete suicide. On balance, the closure of open wards to prevent the unpredictable is a retrograde step.

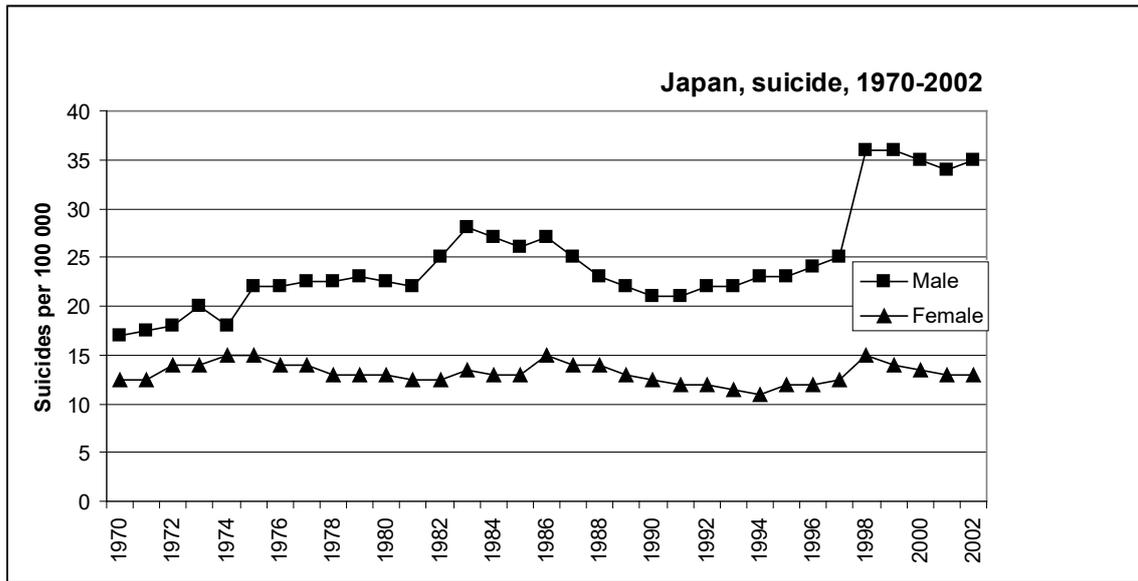
Patfield (2000) described “Creeping Custodialism”. He observed that, “Progressive removal of ‘hazards’ in order to prevent self harm, often in response to coronial inquests or law suits, is leading to inpatient units becoming stark and oppressive”. His view is that “The person who suicides in an inpatient setting is frightened, sad, lonely, disaffected, tired from sleepless nights and feels that life is hopeless and futile”. He believes that in the psychiatric ward there is a need to provide “warmth, human connection, reality and hope”. Finally, he stated that some strategies designed to “protect” patients serve to further isolate them and “paradoxically make suicide more likely”.

Rates of suicide

As Durkheim (1897) observed, the rates of suicide differ from one country to another, and they are relatively stable. While this difference may, to some extent, reflect different methods of “diagnosis” and different methods of collecting data, cultural factors are of overwhelming importance.



Suicide in France over a quarter of a century. An example of a relatively stable suicide rate.



Suicide in Japan over a 32-year period. A sharp rise in the suicide rate of men in the late 1990s reflects an economic downturn.

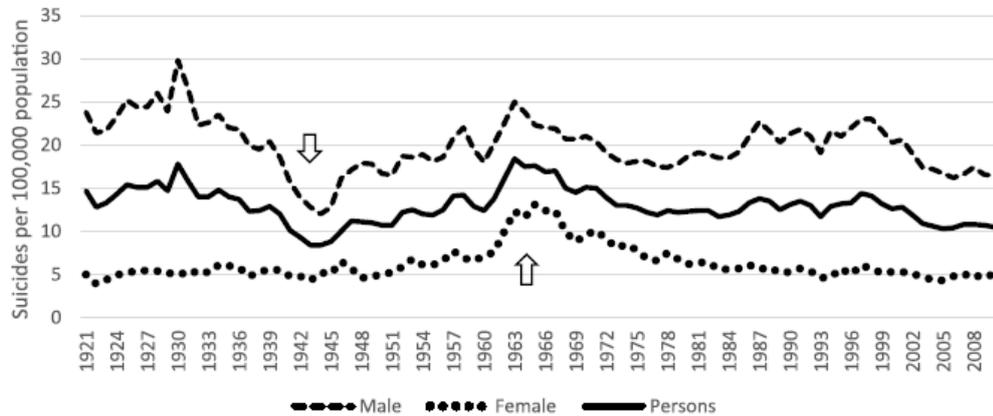


Figure 1. Suicide rates by sex, Australia 1921–2010. Reduction (downward arrow) during World War II; elevation (upward arrow) during the Vietnam War.

From Pridmore et al (2018).

Suicide in Australia over an 85-year period. Of interest - a fall in suicide rates from 1935 to 1945 - these are the years of the Second World War – reductions in suicide rates during wartime is the usually response - this is believed to be because the community draws together against a common enemy. However, also of interest is the increase in suicide rate from the early 1960s, lasting till the late 1960s. These were the years of the Vietnam War – this war divided the people of Australia, with public protests and great public unease, which may explain the anachronism.

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