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Editorial

Suicide in a global perspective

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Since the early 1950s the World Health Organization (WHO) has collaborated with its member states for obtaining and analysing data on mortality and morbidity. The actual numbers "Death from all causes" was reported and transformed into rates. Mortality associated with suicide was also part of the WHO data bank (WHO, 1999). Although reliable data on suicide rates are not available for some regions of the world like most of the African countries, it is evident that between 1950 and 1995 the global suicide rates increased for approximately 49% in males and 33% in females (Figure 1).

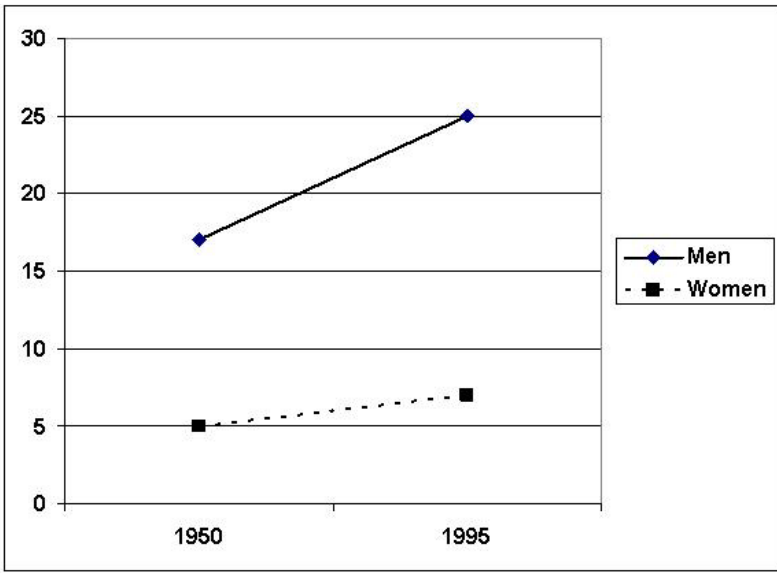

Figure 1 - Evolution of global suicide rates between 1950 and 1955 (per 100.000)

In a recent analysis of international data, De Leo and Evans (2004) reported high rates of suicide in Eastern Europe, intermediate rates in other regions like North America and the Pacific, and low rates in Latin America, some South-East Asian countries and Middle East. Although the global burden of suicide behavior has increased over the last 50 years, the culture-specific suicide rates have remained stable overtime. In a comparison of suicide rates for 14 European countries, Lester

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(2002) found a correlation between the longitudinal suicide rates for these countries to be 0.42 over a 100-year period between 1875 and 1975.
Figure 1 also demonstrates the relatively constant increased male to female suicide rate at: 3.2 : 1 in 1950 and 3.6 : 1 in 1995. China is the only known exception, where suicide rates in females have remained consistently higher than suicide rates in males (Phillips, Li, Zhang, 2002).
Additionally there is also a clear tendency for suicide rates to increase with age. Compared with a global suicide rate of 26.9 deaths per 100.000 for men in 1998, the age specific rates start at 1.2 at 5-14 years of age and gradually increase up to 55.7 over the age of 75 years. The same positive relationship between age and suicide rates were observed in relation to suicide rates in females too. However, compared to 1950 currently more suicides (55%) are committed by people aged 5-44 years than by people aged 45 years and older (Figure 2).

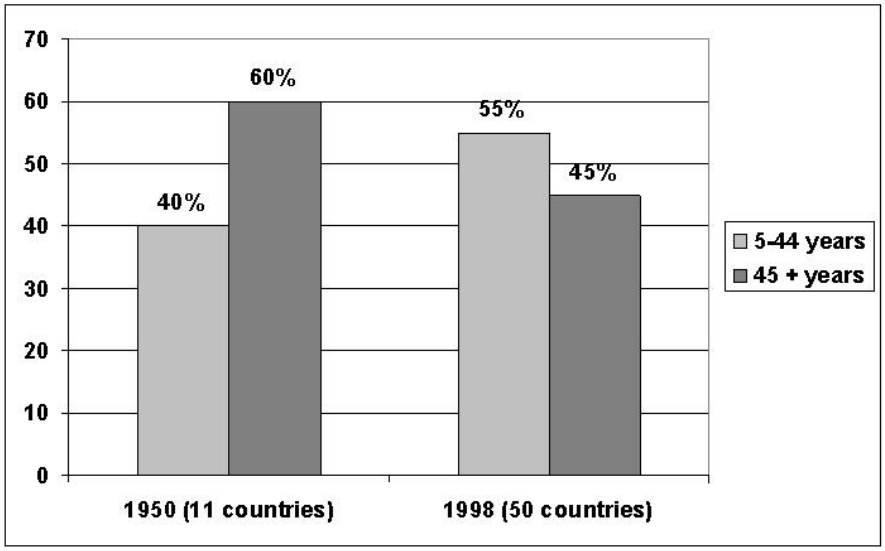

Figure 2 - Changes in the age distribution of cases of suicide between 1950 and 1998

The specific reasons for the national differences in suicide rates are speculated divergently. In this issue of the WCPRR we have published two papers on this issue. David Lester, one of the world's most outstanding researchers in the field of suicidology, presents a comprehensive overview on the current knowledge of the impact of culture on suicide rates. He has evaluated not only the official WHO data, as well as other sources like the Human Area File in order to cover tribal ethnics. The second paper (Ritter et al.) is the first evaluation of data from an international study comparing the acceptance of suicide motives in the general population across cultures. This survey was part of the research program of the Vienna Research Group in Transcultural Psychiatry. Until now Ritter and colleagues have included more than 600 healthy participants from six countries in the study (Austria, Poland, Lithuania, Georgia, Nigeria, and Pakistan). The survey aimed to establish a global map of culture specific attitudes towards suicide-motives in order to explore the influence of these value-systems on the national suicide-rates. I conclude this editorial by extending an invitation on behalf of Ritter et al, to the members of WCPA, TS-Section and all others who are interested in transcultural issues or suicidology, to participate in this survey.

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