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Suicide and Culture

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Abstract *The impact of culture on suicide, both at the aggregate level and the individual level, is discussed. The deleterious impact of a changing culture, especially for native and aboriginal groups, is noted, and the assumption of the cultural invariability of suicidal phenomena questioned. The implications of cultural differences for counselling the suicidal client are explored. Culture provides a set of rules and standards that are shared by members of a society. These rules and standards shape and determine the range of appropriate behavior. Culture influences the behavior of nationalities, ethnic groups and subgroups within a nation. The aim of this paper is to present an overview of some of the topics and issues which are present in the interaction of suicide and culture. A major dichotomy here, of course, is the level of analysis. The interaction can be explored for the aggregate suicide rate of a culture and also for the individual suicide living in a particular society or culture. Let us first look at the interaction at the aggregate level.*

Key words: Suicide, culture, society, ethnic groups

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SOCIETAL AND CULTURAL SUICIDE RATES It is an obvious fact that societal suicide rates differ widely. As shown in Table 1, male suicide rates in 2000 ranged from 80.4 per 100,000 per year in Lithuania to 0.1 in Egypt. For females, the suicide rates ranged from 16.9 in Lithuania to 0.0 in Egypt. Knowledge of worldwide trends in suicide are limited because many African, Middle East and Central and South American countries do not report their suicide rates to the World Health Organization.

For all the nations shown in Table 1, the male suicide rate is higher than the female suicide rate. The lone exception is China where women have a higher suicide rate than men[1]. However, China documents suicide fatalities for only a small percentage of the nation, and so the suicide rates are not accurate for the nation as a whole[2]. These differences in national suicide rates are large and generally stable over time. For example, in Table 2 the suicide rates for 16 nations in 1901, 1950 and 1990 are shown and, despite fluctuations, the rates in one year are positively associated with the rates in other years. Suicide rates also vary widely over the different geographic regions of a nation (for example, over American states and Canadian provinces, suicide rates increase toward the west [Lester, 1985]) and over the different social groups within a nation (for example, some groups of both native Americans and native Canadians have very high suicide rates [Lester, 1997a]). An obvious explanation of such variations in the aggregate suicide rate is that the reporting and counting of suicides in different nations and cultures differ greatly in accuracy (Douglas, 1967). Indeed, it has been easy to document serious official under-reporting of suicides, for example, in Newfoundland (Malla and Hoenig, 1983) and native Americans in Alaska (Hlady and Middaugh, 1988). Nevertheless, it is very unlikely that completely accurate reporting of

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suicides would eliminate the national and cultural differences. The suicide rates of immigrant groups both to the United States and to Australia are strongly associated with the suicide rates in the home nations from which they arrived (Sainsbury and Barraclough, 1968; Lester, 1972). For example, the Irish had a relatively low suicide rate in 1959, 2.5 per 100,000, and Irish immigrants to the United States in 1959, where they encountered the same medical examiners as other immigrant groups, also had the lowest suicide of all immigrants groups from European countries, only 9.8 (Dublin, 1963).

The distribution of suicide rates by age varies with the level of economic development of the nation (Girard, 1993). Male suicide rates increase with age in most nations of the world. For females, the distribution of suicide rates by age varies with the level of economic development of the nation. For the wealthy nations, such as the United States and Sweden, female suicide rates tend to peak in middle age. For poorer nations, such as Venezuela, suicide rates are higher for elderly women, while for the poorest nations, such as Thailand, the peak shifts to young women (Girard, 1993).

Explaining National Differences In Suicide The association of sociodemographic and economic variables with national suicides has been best analyzed using factor analysis. Conklin and Simpson (1987) identified two clusters of variables that appear to be associated with national suicide rates: one cluster had the highest loading from the Islam religion and the second cluster assessed economic development. Lower suicide rates were found for nations with less economic development and where Islam was the dominant religion.

In a similar study of cross-national suicide rates in 72 countries, Lester (1996) identified thirteen independent orthogonal factors for the social variables, only one of which was associated with suicide rates. This factor was economic development, with high loadings from such social variables as low population growth and high gross domestic product per capita.

Physiological Differences One possible explanation for differences in national suicide rates is that different nationalities differ in their physiology. For example, there are clear differences in the frequency of genes in the people from the different nations of Europe (Menozzi, Piazza & Cavalli-Sforza, 1978). Thus, different nations and cultures may differ in their genetic structure. Current research on identical twins and adopted children has shown that psychiatric disorders have a strong genetic basis. These differences in inherited psychiatric disorders, particularly affective disorders, or in brain concentrations of serotonin, the neurotransmitter believed to be responsible for depression, may be responsible for the differences in the suicide rates of nations and cultures. One study has attempted to demonstrate an association between physiological factors and suicide rates at the cross-national level. Lester (1987) found that the suicide rates of nations were associated with the proportion of people with Types O, A, B and AB blood – the higher the proportion of people in the nation with Type O blood, the lower the suicide rate. However, few studies have explored the role of physiological differences in accounting for national differences in suicide rates.

Psychological/Psychiatric Differences The major psychological factors found to be associated with suicidal behavior are depression, especially hopelessness, and psychological disturbance, such as neuroticism, anxiety, or emotional instability. Psychiatric disorder appears to increase the risk of suicide, with affective disorders and alcohol and drug abuse leading the list. Nations may differ in the prevalence of these conditions, and such differences could account for the differences in suicide rates. For example, nations certainly do differ in their consumption of alcohol (Adrian, 1984), as well as depression (Weissman and Klerman, 1977).

Social Composition Moksony (1990) noted that one simple explanation of national differences in suicide rates is that the national populations differ in the proportion of those at risk for suicide. For example, typically in developed nations, suicide rates are highest among the elderly, especially

elderly males. Therefore, nations with a higher proportion of elderly males will have a higher suicide rate.

Societal Differences The most popular explanation of the variation in national suicide rates focuses on social variables. These social variables may be viewed in two ways: (1) as direct causal agents of the suicidal behavior, or (2) as indices of broad social characteristics which differ between nations. Durkheim (1897) hypothesized that the suicide rate is related to the level of social integration (the degree to which the people are bound together in social networks) and the level of social regulation (the degree to which people's desires and emotions are regulated by societal norms and customs). According to Durkheim, egoistic and anomic suicides result from too little social integration and social regulation, respectively, while altruistic and fatalistic suicides result from too much social integration and social regulation, respectively. Later sociologists have argued that altruistic and fatalistic suicide are rare in modern societies. Therefore, suicide rarely results from excessive social integration or regulation. As a result, suicide in modern societies seems to increase as social integration and regulation decrease (e.g., Johnson, 1965).

Studies of samples of nations have found that suicide rates are associated with such variables as low church attendance, the amount of immigration and inter-regional migration, and divorce (e.g., Stack, 1983). Some investigators view these associations as suggesting a positive relationship between broken relationships and suicidal behavior. For example, divorce may be associated with suicide at the societal level because divorced people have a higher suicide rate than those with other marital statuses. A major issue here has been raised by Moksony (1990) and Taylor (1990) concerning whether specific social variables are directly related to social suicide rates or whether these specific social variables are measures of more basic, abstract and broad social characteristics which determine social suicide rates. Lester (2004) proposed that the strong associations between social variables argues for the importance of basic broad social characteristics. For example, in the United States, interstate migration, divorce, church non-attendance and alcohol consumption all inter-correlate highly, supporting the importance of a social characteristic, perhaps best called social disorganization, as a determinant of societal suicide rates. In this case, regions of the world with high rates of divorce would have high rates of suicide for those in all marital statuses. This is found for the United States where states with higher divorce rates have higher suicide rates among the single, the married, the divorced and the widowed (Lester, 1995a).

Comment: There is clearly much more research needed to compare and contrast these competing explanations for differences in national suicide rates.

Cultural Influences On The Motives For Suicidal Behavior Suicidal behavior is differently determined and has different meanings in different cultures, as demonstrated by Hendin's (1964) study of suicide in Scandinavian countries. In Denmark, Hendin noted that guilt arousal was the major disciplinary technique employed by Danish mothers to control aggression, resulting in strong dependency needs in their sons. This marked dependency was the root of depression and suicidality after adult experiences of loss or separation. Reunion fantasies with lost loved ones were common in those committing suicide.

In Sweden, a strong emphasis was placed by parents on performance and success, resulting in ambitious children for whom work was central to their lives. Suicide typically followed failure in performance and the resulting damage to the men's self-esteem. At the time Hendin conducted his study in Norway, the suicide rate was much lower than that found for Denmark. Although Hendin found strong dependency among the sons on their mothers in both countries, Norwegian children were less passive and more aggressive than Danish children. Alcohol abuse was more common among the Norwegians, and Norwegian men were more open about their feelings - able to laugh at themselves and cry more openly. Norwegian boys strove to please their mothers by causing no trouble, and they did not worry unduly about failure, typically blaming others for their personal failures and retreating into alcohol abuse.

In her account of suicide among females in Papua-New Guinea, Counts (1988) has illustrated the ways in which a culture can determine the meaning of the suicidal act. In Papua-New Guinea, female suicide is a culturally-recognized way of imposing social sanctions. Suicide also holds political implications for the surviving kin and for those held responsible for the events leading women to commit suicide. In one such instance, the suicide of a rejected fiancée led to sanctions being imposed on the family which had rejected her. Counts described this woman's suicide as a political act which symbolically transformed her from a position of powerlessness to one of power.

Cultures also differ in the degree in which suicide is condemned. It has been argued that one explanation for the low suicide rate in African-Americans is that suicide is a less acceptable behavior for African-Americans (Early, 1992). Murder rates are much higher in African-Americans, both as murderers and as victims, and a larger proportion of the murders involving African Americans are victim-precipitated, that is, the victim played some role, conscious or unconscious, in precipitating their own demise (Wolfgang, 1957). African-American culture appears to view a victim-precipitated murder as a more acceptable method of dying than suicide (Gibbs, 1988).

Choice Of Method For Suicide The methods chosen for suicide differ between cultures. De Catanzaro (1981) documented culturally unique methods for suicide, such as hanging by tying a noose around one's neck and running to another part of the house in Tikopia. Suttee, which is suicide by burning on the husband's funeral pyre, is a popular form in India, while seppuku, which is ritual disembowelment, is popular in Japan. These well-known examples of cultural influences on suicide methods also have culturally determined motives (grief and shame, respectively).

Firearms are the most common method for suicide in the United States and Canada presently, while in Switzerland, whose residents typically own firearms as part of their participation in the civilian militia, hanging is the most common method for suicide. A method may come to symbolize the act of suicide, as in England earlier this century when “to take the pipe” meant to commit suicide by inhaling toxic domestic gas since the gas was brought into houses by means of pipes and this was the most common method for suicide. (After the 1960s, domestic gas became less toxic as a result of the switch from coal gas to natural gas.) Burvill and his colleagues (1983) found that immigrants to Australia shifted over time from using the most common methods of suicide in their home nations to those most common in Australia. Research indicates that increased availability of a method for suicide is associated with an increase in its use for suicide (Carke and Lester, 1989). For example, Killias, van Kesteren and Rindlisbacher (2001) found that, in nations where a large proportion of the population owned guns, higher numbers of suicide were committed with guns. However, ownership of guns had no association with the total suicide rate. This suggests that, if guns are not freely available, people use guns less often for committing suicide but switch instead to other methods for suicide, such as poisons, hanging, stabbing, jumping and drowning. Related to this is the recent proposal for preventing suicide by limiting access to lethal methods for suicide (Clarke and Lester, 1989). Kreitman (1976) documented how detoxification of domestic gas in England and Wales led to a virtual elimination of domestic gas for suicide and a reduction in the overall suicide rate. Lester (1995b) studied this phenomenon in six other nations and found that detoxification of domestic gas reduced the use of domestic gas for suicide in all of the nations and, in those nations where suicide by domestic gas was more common, reduced the overall suicide rate as well.

Suicide In One Culture: The Chinese Studies by Lester (1994a, 1994b) on suicidal behavior in Chinese illustrates the role of culture, a culture of particular interest because the Chinese are native to many nations (such as mainland China and Hong Kong) and have emigrated in large numbers to nations such as America. The suicide rates of Asian Americans are relatively low compared to whites in the United States. For example, in 1980, the suicide rates were 13.3 per 100,000 per year for Native Americans, 13.2 for white Americans, 9.1 for Japanese Americans, 8.3

for Chinese Americans, 6.1 for African Americans and 3.5 for Filipino Americans (Lester, 1994c). Lester noted that the patterns of suicide also differed for these ethnic groups. The ratio of the male to female suicide rates was much larger for whites and African Americans than for Asian Americans for whom the suicide rates of men and women were more similar. In addition, suicide rates increased with age for Asian Americans, whereas the suicide rates peaked in young adulthood for African Americans and Native Americans. Asian Americans used hanging for suicide much more often than whites and African Americans, and they used firearms relatively less often. Lester concluded that the epidemiology of suicide in Asian Americans in America showed similarities to the results of epidemiological studies of suicide in their home nations, indicating that cultural factors have an important influence on the circumstances of suicidal behavior. Lester (1994a) then examined the epidemiology of suicide in Chinese in Hong Kong, Singapore, Taiwan, mainland China, Hawaii and the United States as a whole. A couple of examples here will illustrate the results. The ratio of the male to female suicide rates in 1980 were 1.2 for Chinese Americans, 1.2 for Hong Kong residents, 1.2 for Taiwanese residents and 1.2 for Singapore Chinese, identical gender ratios. Suicide rates peaked in the elderly in all the nations: for those 65 and older in Chinese Americans, 75 and older in Hong Kong and Taiwan and 70 and older in Singapore Chinese[3].

However, the methods used for suicide did differ for the different groups of Chinese: jumping was more common in the Chinese in Singapore and Hong Kong, hanging in Chinese Americans and poisons in Taiwan, probably a result of the difference between the nations in the availability of methods for suicide[4]. Furthermore, the suicide rates differed: in 1980 the suicide rates were 13.5 in Singapore and Hong Kong Chinese, 10.0 in Taiwan and 8.3 for Chinese Americans. Thus, the gender and age patterns in Chinese suicide seem to be affected strongly by culture, while the absolute suicide rates and methods used are affected by the nation in which the Chinese dwell[5].

Culture, Linguistics And Suicide As Douglas (1967) pointed out, a shared linguistic terminology for suicidal behavior is associated with shared meanings of the behavior, and there are also shared associated terms and phrases, such as despair, hopelessness, and "life isn't worth living." Douglas emphasized that these terms are not the phenomenon itself but rather are adopted by members of the culture (or subculture) to construct meanings for suicidal behavior. However, since the terms are rarely clearly defined or detailed and since there is often disagreement among commentators on their meaning, it follows that the meaning of suicide is ambiguous. Furthermore, since the terms are used to construct meanings for suicidal behavior, then estimates of the incidence and circumstances of suicidal behavior are in part a social construction.

For example, according to the Mohave, a Native American tribe in the southwest of the United States, a fetus which presents itself in the transverse position for birth, leading to its own death and that of its mother, is viewed as having intended to commit suicide and to murder its mother so that they can be together in the spirit world (Devereux, 1961). Medical examiners and coroners in the rest of the United States would not view such a still-born infant as a suicide.

Counts (1980), who has studied the suicidal behavior of women in the Kaliai district of Papua New Guinea, noted that in the past elderly widows sometimes immolated themselves on their husband's funeral pyre. The German and Australian colonial governors considered this behavior to be a form of ritual murder rather than suicide, and they outlawed it. Counts, however, saw neither term (suicide or murder) as appropriate for this custom since it differed so much from what North Americans and Europeans regard as either suicide or murder. Neither term describes the behavior, the interpersonal relationships involved, or the attitudes toward the widow and those assisting in her death, nor do they predict how the community will respond to her death.

Recently, some scholars, especially in Europe, have expressed doubts that people engaging in nonfatal suicidal behavior have self-destruction as their aim, and they have moved to calling the behavior "self-poisoning" or "self-injury" (e.g., Ramon, 1980). The semantic implication is that

nonfatal suicidal behavior is not "suicide." Since in most cultures women engage in more nonfatal suicidal actions than do men, this renaming of nonfatal suicidal behavior as self-injury makes "suicidal behavior" less common in women than it was hitherto.

Other suicidologists, on the other hand, include a wider range of behaviors under the rubric of "suicidal behavior." For example, Menninger (1938) classified behaviors such as alcoholism, drug abuse and anorexia as chronic suicide since the individuals were shortening their lives by their behaviors. Menninger also classified such behaviors such as polysurgery, self-castration, and self-mutilation as focal suicide, in which the self-destructive impulse is focused on one part of the body. These behaviors are often gender-linked. For example, anorexia is more common in women whereas illicit drug abuse is more common in men. Canetto (1991) has speculated that adolescents may respond differentially when under stress, with girls choosing nonfatal suicidal behavior more while boys choose drug abuse more. The use of Menninger's categories would change greatly the relative incidence of nonfatal suicidal behavior in women and men.

The Study Of Culture Can Challenge Myths Many theories of human behavior, including suicidal behavior, are based on physiological factors. Cultural anthropology helps challenge such theories by showing, for example, that behaviors which we consider gender-specific are not found in every culture. As we have noted above, in the United States and in European nations, nonfatal suicidal behavior appears to occur at a higher rate in women than in men; as a result it is has come to be viewed as a "feminine" behavior by the general public (Linehan, 1973) and by suicidologists as well. Other cultures, however, provide examples where nonfatal suicidal behavior, often carried out in front of others, is more common in men rather than women. The Nahane (or Kaska), a Native Canadian tribe located in British Columbia and the Yukon, provide a good example of this.

> [.....]observations and communications agree that attempted suicide by men is of frequent occurrence and very likely to appear during intoxication. There is a general pattern for such attempted self-destruction. In the two cases of the sort observed during field work, the weapon selected was a rifle. As he brandishes the weapon the would be suicide announces his intention in an emotional outburst. This becomes the signal for interference to block the deed. One or more men leap forward to wrest the gun from the intended suicide's possession and toss it out of sight. The would be victim is now usually emotionally overwhelmed by his behavior. This pattern is illustrated by Louis Maza's behavior during intoxication. Several times during the afternoon, Louis had manifested aggression toward himself, crying: "I don't care if I'm killed. I don't care my life." After several hours of such emotional outbursts interspersed with quarreling and aggression toward his companions, he seized his large caliber rifle and threatened to kill himself. Old Man threw himself on the gun and as the two men grappled for the weapon, Louis succeeded in firing one wild shot. John Kean and the ethnographer ran to the camp and together wrenched the gun from the drunken man. John fired the shells in the chamber and Old Man tossed the gun half-way down the cutbank. No punishment or other discrimination is reserved for attempted suicides. The individual is comforted and in the future, while intoxicated, he is watched lest he repeat the attempt. (Honigmann, 1949, p. 204)

Among the Washo, located in Nevada and California, nonfatal suicidal behavior seems to be equally common in men and women. In one case, a man had been having difficulty with his wife; she was interested in another man. The husband ate wild parsnip, but was saved. As a result his sons brought pressure on the wife and made her behave. The couple stayed together until the husband died.....Pete also says that men attempt suicide more than women, who just leave home when interpersonal difficulties arise. The destruction of the self is an ultimate, and the fact that men are more likely to invoke it than women indicates a lack of male authority in Washo culture. (D'Azevedo, et al., 1963, p. 50-51)

The Washo man is described as lacking authority and lacking in self-confidence, perhaps because the Washo man has had more difficulty adapting to the changing culture in this century than has

the Washo woman. Interestingly, the explanation provided by these Western anthropologists for the occurrence of nonfatal suicidal behavior among Washo men may be generalizable to societies where nonfatal suicidal behavior is more common in women. It may be that nonfatal suicidal behavior is not simply a "feminine" behavior, but rather a behavior found more commonly in those who are oppressed in a society, perhaps because the oppressed have fewer options for expressing their discontent.

The Impact Of Culture Conflict An issue that has become important in recent years is the impact of the pervasive Western culture on the suicidal behavior of those living in less modern cultures. The high suicide rates in some native American and Canadian groups and in some Micronesian islands has made this an issue of grave concern rather than mere academic debate.

Cultures often come into conflict. For example, the conflict between the traditional Native American culture and the dominant American culture has often been viewed as providing a major role in precipitating Native American suicide. May and Dizmang (1974) noted that there were three major sociological theories which have been proposed for explaining the Native American suicide rate. One theory focuses on social disorganization. The dominance of the Anglo-American culture has forced Native American culture to change and has eroded traditional cultural systems and values. This changes the level of social regulation and social integration, important causal factors for suicide in Durkheim's (1897) theory of suicide.

A second theory focuses on cultural conflict itself. The pressure from the educational system and mass media on Native Americans, especially the youth, to acculturate, a pressure which is opposed by their elders, leads to great stress for the youths.

A third theory focuses on the breakdown of the family in Native American tribes. Parents are often unemployed, substance abusers and in trouble with the law, and divorce and desertion of the family by one or more parents is common.

Acculturation occurs when a culture encounters a dominant alternative culture. The resulting pressure from the dominant culture leads to a variety of changes in the non-dominant culture (Berry, 1990): physical changes (such as type of housing, urbanization and increasing population density), biological changes (resulting from changing diet and exposure to new diseases), political changes (such as loss of autonomy for the non-dominant culture), economic changes (such as changes in type of employment), cultural changes (in language, religion, education and the arts), social relationships (both within the culture and between the two cultures), and psychological changes at the individual level (in behavior, values, attitudes and motives).

Berry noted that four possibilities are open to the non-dominant culture: integration-maintaining relations with the dominant culture while maintaining cultural identity; assimilation-maintaining relations with the dominant culture but not maintaining cultural identity; separation-not maintaining relations with the dominant culture but maintaining cultural identity; and marginalization-not maintaining relations with the dominant culture and not maintaining cultural identity.

It would be of great interest to categorize the different Native American tribes as to which strategy appears to have been chosen and to examine the different consequences for the society and for the individuals in the society.

Research On Acculturation Supportive results for the influence of acculturation on suicide in Native Americans comes from Van Winkle and May (1986) who examined suicide rates in three groups of Native Americans in New Mexico (the Apache, Navajo and Pueblo) and attempted to account for the differences in terms of the degree of acculturation. Overall, the crude suicide rates were 43.3 per 100,000 for the Apache, 27.8 for the Pueblo, and 12.0 for the Navajo.

The Jicarilla and Mescalero Apache of New Mexico were originally nomadic hunters and gatherers, organized into self-sufficient bands whose leaders held limited power. Their religion had no organized priesthood and was not a cohesive force in their lives. Individualism was a highly

valued characteristic. Today they live in homes scattered about the reservation or in border towns. They raise livestock, cut timber or work in tribally-owned businesses. Formal tribal governments have been established, but religion remains unimportant. Individualism is still valued. However, the raiding parties which formerly provided a some degree of social integration have been eliminated. The Apache appear, therefore, to have few integrating forces in their culture, and Van Winkle and May saw their high suicide rate as a direct result of this lack of integration. The Apache have been in close contact with whites. Their reservations are small and surrounded by white communities. Indeed many Apache live in mixed communities. Thus, the Apache have high acculturation in addition to their low social integration.

The Pueblo traditionally lived in compact towns and engaged in agriculture. Religion permeated their lives and was a strong integrating force. There was an organized priesthood and religious societies which took care of religious and civil matters. Individualism was discouraged and conformity valued. Thus, the Pueblo were the most integrated group, and Van Winkle and May found their intermediate suicide rate a puzzle. They tried to explain the Pueblo suicide rate using the role of acculturation. The Pueblo have had increasing contact with whites since 1959. Many of the Pueblos are near large cities such as Albuquerque and Santa Fe. Thus, they have high social integration and moderate but increasing acculturation. For the larger Pueblo tribes, Van Winkle and May compared the suicide rates of those tribes which had acculturated and those which had remained traditional and found a clear tendency for the acculturated and transitional tribes to have the higher suicide rates.

The Navajo, who have the lowest suicide rate, were nomadic hunters and gatherers who later settled down and turned to agriculture. They are organized into bands, but matrilineal clans exert a strong influence. Although religion is important in their lives, they have no organized priesthood. Individualism is valued but not as strongly as among the Apache. Thus, their social integration appears to be intermediate between that of the Apache and that of the Pueblo. However, the Navajo were the most geographically and socially isolated from whites of the three groups until the 1970s when mineral exploration increased on their reservations and some Navajo began to take wage-earning jobs.

Van Winkle and May's explanation of the suicide rates in the three groups can be summarized as follows:

	social acculturation / integration		suicide rate
Apache	low	high	high
Pueblo	high	moderate	moderate
Navajo	moderate	low	low

It can be seen that acculturation performed better than social integration an as explanation of the differing

In contrast, however, Bagley (1991) found in Alberta that it was those native Canadian reservations which were more isolated (and, incidentally, poorer) which had the higher suicide rates. In Taiwan also, Lee, Chang and Cheng (2002) found that the less assimilated aboriginal groups had higher suicides rates than those groups which were more assimilated in the mainstream culture.

These studies indicate that when different cultures encounter each other, the problems of acculturation can result in stress and its consequences, including increased rates of suicidal behavior, especially in the less dominant cultural group. But acculturation may not always lead to an increased incidence of suicide (and other disturbed behaviors). In the future, anthropologists may be able to identify which cultural characteristics enable some cultures to acculturate with few social and personal problems while other cultures develop many problems.

The Assumption Of Cultural Invariability Investigators often assume that a research finding found in one culture will apply to other cultures. It is, therefore, important to replicate research findings in cultures other than the one in which the results were first obtained to check on this assumption. For example, at the sociological level, Lester and Yang (1991) found that females in the labor force and the ratio of divorces to marriages predicted suicide rates in the United States and Australia from 1946 to 1984, but that the associations were in opposite directions for the two nations. While in the United States the ratio of divorces to marriages was positively associated with the suicide, the association was negative in Australia. Stack (1992) found that divorce had a deleterious effect on the suicide rate in Sweden and Denmark, but not in Japan. Stack offered four possible reasons; the divorce rate may be too low in Japan to affect the suicide rate, Japanese family support may be strong enough to counteract the loss of a spouse, ties between couples may be weak in Japan, and the cultural emphasis on conformity in Japan may suppress suicidal behavior. At the individual level, Lester, Castromayor and Icli (1991) found that an external locus of control was associated with a history of suicidal preoccupation in American, Philippine and Turkish students, but that the association was no longer found for American students once the level of depression was controlled. In a comparison of depression and suicide in mainland China and the United States, Chiles, et al. (1989) found that suicidal intent was predicted better by depression for Chinese psychiatric patients and better by hopelessness for American psychiatric patients. De Man and his associates (for example, De Man, et al., 1987) have published a number of studies of suicidal behavior in French-Canadians in order to explore the replicability of research findings originally identified for English-speaking cultures. It is important, therefore, for researchers to identify which findings have cross-cultural generality (and to which cultures) and which are specific to one culture.

Subcultures Wolfgang and Ferracuti (1967) examined the role that a subculture of violence plays in producing high murder and assault rates. For example, Gastil (1971) argued that such a subculture of violence pervaded the southern portion of the United States, and Marks and Stokes (1976) used this to account for the greater use of firearms for suicide in southern states as compared to the rest of America. Platt (1985) suggested that electoral wards in Edinburgh, Scotland differed in their rates of attempted suicide and had different norms for suicidal behavior, thereby differing in their subculture of suicide. Those living in wards with the highest rate had more intimate contact with suicidal individuals and had different values about life, such as having a greater expectation that married couples would quarrel and that men would fight in public. However, Platt was unable to find to his satisfaction that the wards differed in the proposed subculture of suicide.

Suicide Among Indigenous Peoples In some nations there has been a good deal of research on and speculation about suicidal behavior in indigenous peoples, sometimes called aborigines. A great deal of research has been conducted on Native Americans in the United States, and some on aborigines in Australia and Taiwan and on the Inuit in Canada and Greenland. What is noteworthy, however, is that many nations have indigenous peoples, yet we hear little about their suicidality and other self-destructive behaviors. For example, in Central and South America, almost every nation has an indigenous population: 71% in Bolivia, 66% in Guatemala, 47% in Peru, 38% in Ecuador, 14% in Mexico, 8% in Chile, 2% in Colombia, 1.5% in Paraguay, 1% in Venezuela, and 0.4% in Brazil (Anon, 2004). In recent years, these indigenous peoples have become organized politically. They have begun to protest against the governments of their nations, often toppling governments (as in Bolivia and Ecuador) and in rare cases assuming power (as in Peru).

Even in developed nations, the oldest inhabitants are often ignored. In suicide statistics from the United Kingdom, data from England and Wales are reported together. A recent report on suicide in Wales (Lester, 1994d) was rejected by reviewers for the British Journal of Psychiatry as being

of no interest![6] The United Kingdom has ethnic groups in Wales and the county of Cornwall who predate the Roman, Danish and French invaders and who have their own languages and ethnic identity. Yet their suicidal behavior has received no attention.

In Africa, the situation is odd in a different way. Setting aside the remnants of the European colonialists, all of the peoples there can be considered indigenous. Yet, when data on suicide are reported, they are reported for the artificial nations that the colonial rulers established with no regard for the tribal groups in each country. For example, suicide rates have been reported for Zimbabwe (Rittey & Castle, 1972; Lester & Wilson, 1988), yet Zimbabwe has two major ethic groups, the Shona (the dominant ethnic group) and the Ndebele. It would make much more sense to explore and compare suicide in these two ethnic groups. Some nations are only now beginning to organize their mortality-reporting procedures and structures. In many of these, it will be important to take into account the various indigenous groups in the country, such as China which has a multitude of ethnicities within its borders.

Comparisons Of Indigenous Peoples Within A Nation In a couple of nations, it has been possible to compare different ethnic groups within a nation. Lester (1997a) reviewed all of the studies on Native American suicide and summarized the suicide rates by tribe and by era (see Table 3). It can be seen that there was a slight tendency for the suicide rates to rise during the 20th Century and for the tribes to differ greatly in their suicide rate, ranging in the 1970s from 149 per 100,000 per year in the Kwakiutl and 73 in the Sioux to 7 in the Pima and 9 in the Lumbee. Cheng (1995, 1997) compared suicide in Taiwan in two aboriginal groups (the Atayal and the Ami) with suicide in the dominant Han Chinese. The Atayal had a suicide rate of 68.2 per 100,000 per year, the Ami 15.6 and the Han Chinese 18.0. The suicides in all three groups had a similarly high incidence of psychiatric disorder, and the high suicide rate in the Atayal was attributed to their high rate of alcoholism and earlier onset of major depressive disorders. We need many more studies comparing the different groups of indigenous peoples within a nation, not simply the crude suicide rates, but also the circumstances, motives and meanings of suicide in these different groups.

The Human Relations Area Files Anthropologists have typically studied historical societies or societies which have been relatively less influenced by modernization, often called preliterate, nonliterate or primitive societies, societies composed of whom we would now call indigenous peoples.

There is a superb source of data on indigenous peoples in the Human Relations Area Files (HRAF). The headquarters for this project are at Yale University, but microfiche copies of the results of the project are available at other major universities in the United States and around the world. The staff of the project have collected reports from visitors to these cultures as far back as they can and from all kinds of visitors (such as missionaries, colonial administrators and anthropologists). The content of the reports is coded for topic, and, for example, to see what has been written about suicide in these cultures, the code for suicide is ascertained from the codebook (it is 762), and then the section for 762 can be located for each culture in the HRAF. There are about 330 cultures represented in the HRAF. The files are now available on a CD-ROM, and there is a website for the HRAF (www.yale.edu/hraf/collections.htm). The files are updated and enlarged continually. To give some examples of the source material, in 1994, the Ainu in Japan had 1,573 text pages from 11 sources that had been coded, the Lapps in Finland 3,284 text pages from 16 sources, the Yoruba in Nigeria 1,637 text pages from 45 sources, and Delaware Indians in the United States 1,733 text pages from 15 sources. Several projects on suicide can be devised from the HRAF. First, some investigators have read the files on suicide for a sample of societies and tried to estimate the suicide rate for each society. Masumura (1977) had two judges rate 35 nations for the frequency of suicide by having them read the suicide entries in the HRAF, and his ratings are shown in Table 4[7]. From this group of cultures, it would appear that, among Native American groups, the Kwakiutl have a relatively high suicide rate and the Pomo a relatively low suicide

rate. In a research study on this sample, Masumura found that the estimated suicide rate was positively associated with a measure of social integration in opposition to a prediction from Durkheim's (1897) classic sociological theory of suicide. Ember and Ember (1992) drew attention to the fact that the materials on suicides in the HRAF come from very different time periods. Therefore, they urged that it was important to specify the year from which the data were derived. For example, they rated the Creek suicide rate as 1.74 (on a scale of 0-8) in 1800 and the Omaha as 1 in 1860.

Case Studies On occasions, anthropologists who have studied particular cultures write specifically on suicide. For example, Bohannan (1967) edited a book on suicide in Africa in which the contributors looked at suicidal behavior in several tribes from Uganda and Kenya.

Bohannan noted first that earlier investigators had differed greatly in whether they thought that suicide in primitive societies was rare (Cavan, 1928) or common (Steinmetz, 1894). It is more reasonable to conclude that the range for the incidence of suicide in primitive societies may be as great as in modern societies (Westermarck, 1908). Not only may the rate of suicide vary from one primitive society to another, but these differences may be stable even after emigration, forced as a result of slavery or free. For example, Bastide (1952) noted that Mina, Dahomeans and Yoruba slaves in Brazil tended more often to assault and kill their slave owners, whereas Fulani slaves and those from Gabon and Mozambique tended more often to kill themselves. As an anthropologist, Bohannan was not so much interested in the individual motives that people had for killing themselves in a society (he viewed what was in the mind of the suicide as unknowable), but rather he was interested in the causes ascribed to the suicide by members of the society. These popular ideas about suicide tell us something about the culture. For example, Fallers and Fallers (1967) examined suicide among the Busoga of south-eastern Uganda. The Busoga view suicide as an irresponsible and foolish act, probably impulsive. Thus, suicide, like homicide, is an act which must be punished. The body of a suicide is burnt, along with the tree or hut from which the person hung himself, and buried in waste land or at a crossroads. For the period from 1952 to 1954, the official suicide rate for the society was 7.0 per 100,000 per year, which the Fallers thought was a slight underestimate. Taking one hundred cases of suicide, the Fallers found that 86 percent hung themselves, in most cases impulsively. Sixty-nine percent were men. The most common motive was disease (31%) followed by quarrels with spouse, lover or kinsman (23%). Quarrels with a spouse were present in 48 percent of the homicides and 21 percent of the suicides, suggesting that marriage was full of conflict. The patrilineal nature of the society means that spouses have divided loyalties. The wife, in particular, feels drawn back to her family, and wives who feel oppressed by their husbands (which is not uncommon) often flee back to their father. The Fallers noted that the breaking down of the cultural traditions in recent times had decreased the incidence of suicide and homicide, probably as a result of the weakening of intergenerational family ties, which in turn has reduced marital conflicts.

In commenting on this and other reports, Bohannan (1967) noted that domestic institutions are responsible for the greatest number of the suicides. Women committed suicide as wives - they were unable to play the role of wife or mother because of husbands or fathers, co-wives or fate. Men, to a lesser extent, committed suicide as husbands, but impotence and loss of status played roles too. Suicide is consistently viewed as irresponsible and evil, and rituals involve destruction of the suicide's possessions and ritual cleaning. Bohannan felt that the suicide rates were moderate to low, though accurate estimates were mostly absent. It should be noted that historical studies of indigenous peoples may become more important as indigenous peoples cross-marry with the dominant cultures. For example, at the present time in New Zealand, there are no "pure" Maoris. All surviving Maoris have at least one white ancestor.

THEORIES OF SUICIDE There has been one theory of suicide, proposed by Naroll (1962, 1963, 1969) which was based on a study of these nonliterate societies and tested using data from the societies rather than data from modern nations, the basis for Durkheim's (1897) theory of suicide. Naroll proposed that suicide occurred in those who were socially disoriented, that in those who lack or lose basic social ties. But since all of those who are in this condition do not commit suicide, there must also be a psychological factor involved, that is, the individual's reaction to thwarting disorientation contexts. Thwarting disorientation contexts are those in which the individual's social ties are broken or weakened and those in which another person thwarts the individual and prevents him or her from achieving desired and expected satisfactions or in which they experience frustration. This thwarting must be interpersonal and not impersonal. Storm damage to one's dwelling is not thwarting but, when another person sets fire to it and destroys it, it is thwarting. The widow is not thwarted, but the divorced spouse is thwarted. Under the conditions of thwarting disorientation, individuals are more prone to commit suicide in such a way that it comes to public notice, that is, protest suicide. Naroll felt that this theory, better than other theories, explained suicide committed by indigenous peoples[8]. Jeffreys (1952) felt that Durkheim's (1897) categories of suicide, based on the concepts of social integration and social regulation, were not sufficient to explain cases of suicide he found in African tribes. He described suicide committed in order to revenge oneself on those one is angry at -- a type of suicide he called "Samsonic suicide" after the story of Samson in The Bible. Revenge can be obtained in two ways. In some societies, the belief is that one's ghost can return and harm those at whom one is angry, as among the Herero of South West Africa (Vedder, 1928). Alternatively, the societal laws demand that those who provoked a suicide must pay some penalty, usually a fine, but in some societies death. The payment of a heavy fine by the person who provoked a suicide is customary, for example, among the Bavenda (Stayt, 1931) and the Kassena (Cardinall, 1920). Lester (1997b) noted that the Mohave have a clearly specified theory of suicide - namely that suicide in their people is increasingly due to a breakdown in ties to the community and tribe as a whole and to an increasing dependence on a primary relationship with a lover or spouse. Lester tested this hypothesis that suicide would be common in nations with higher levels of individualism, and the results confirmed this hypothesis. It can be seen that examples of suicide behaviors, customs and attitudes in indigenous peoples can challenge traditional Western theories of suicide.

Comment: There has been a failure of suicidologists to study suicidal behavior in many indigenous peoples. On occasions they ignore indigenous peoples completely, such as the Welsh and Cornish peoples in the United Kingdom or the Basques in France and Spain. On other occasions, as in Africa, they study suicide in the artificially-created nations (created by the colonial rulers) rather than in the more meaningful ethnic groups. Occasionally, when suicide is studied in these nations, the investigators omit to mention the ethnic background of the people (e.g., Sefa-Dedeh & Canetto, 1992).

Second, this section has drawn attention to the Human Relations Area Files (HRAF) with its rich source of data on indigenous peoples, including suicide. Data from the HRAF were used to illustrate how suicide rates can be estimated and how the data can be used to test theories of suicide.

Finally, examples were given of theories of suicide which derive from studies of suicide in indigenous peoples rather than from studies of suicide in Western nations.

Psychotherapeutic Implications All of this scholarly discourse is important at the theoretical level, but it may be asked whether there are implications for counselling and psychotherapy. It is sometimes argued that only 'like' can counsel 'like', that is, that only homosexuals can counsel homosexuals, women counsel women, ex-addicts counsel addicts, and so on. Is the same true also for different cultures? The majority of counsellors and psychotherapists deny this, claiming that a good counsellor or psychotherapist can counsel any kind of patient.

However, to counsel someone very different in background from oneself may require that the counsellor learn about the background and culture from which the individual comes. Sue and Sue (1990) have addressed the issues that psychotherapists of one culture must confront when counselling clients from different cultures, such as racism and cultural differences in verbal and nonverbal communication styles. Zimmerman and Zayas (1995) have illustrated this point in their discussion of treating the suicidal adolescent Hispanic female. They noted that, in New York City, the values of the adolescent Latina often clash with those of her more traditional mother. Both mother and daughter experience problems in communication and a rupture in their relationship. Thus, the problem of acculturation exacerbates the normal adolescent turmoil. The Latina's mother wants her daughter to succeed in this new culture, yet she also wants her daughter to maintain traditional cultural attitudes and roles. The adolescent Latina feels overwhelmed by this conflict and, in extreme cases, makes a suicide attempt in an effort to reduce the tension felt in this conflict. After a suicide attempt, the psychotherapist must explain the conflict to the mother and daughter and help them find ways to re-establish mutual understanding and empathy. It is possible, of course, that psychotherapists could identify the nature of the problems confronting suicidal people and their families each time they encounter such a family, but the psychotherapeutic process is facilitated if psychotherapists have some notion of the cultural issues which they are likely to encounter.

Sue and Sue (1990) presented the case of Janet, a Chinese-American female college senior majoring in sociology, who came to the college counseling center complaining of depression, feelings of worthlessness and suicidal thoughts. She had difficulty identifying the causes of her depression, but she seemed quite hostile to the psychotherapist who was also Chinese-American. Discussion of this revealed that Janet resented being seen by a Chinese psychotherapist, feeling that she had been assigned to one because of her own race. Janet disliked everything Chinese, including Chinese men whom she found sexually unattractive. She dated only white men, which had upset her parents. However, her last romance had broken up partly because her boyfriend's parents objected to him dating a Chinese woman. Janet clearly had difficulties stemming from her continuing denial of her Chinese heritage. She was being forced to realize that she was Chinese for she was not fully accepted by white America. Initially she blamed the Chinese for her dilemma, but then she turned her hostility toward herself. Feeling alienated from her own culture and rejected by the white culture, she was experiencing an identity crisis with a resulting depression. The psychotherapist in such a case must deal with cultural racism and its effects on minorities. Positive acculturation must be distinguished from rejection of one's own cultural values, as well as typical adolescent rebellion from one's parents. Psychotherapists can work with such a client more effectively if they are conversant with the cultural history and experiences of Asian-Americans.

Does Cultural Conflict Cause Suicide? Although the problem of acculturation has been proposed as one of the major causes of depression and suicidal behavior among Native Americans, the majority of research reports on Native American individuals who attempt or complete suicide mention precipitating causes such as grief over loss and quarrels with relatives and friends. Rarely is cultural conflict listed among the precipitating causes. Of course, it may be that the problems of acculturation raise the stress level of individuals so much that stressors, which under ordinary circumstances would not precipitate suicide, now do so. A few brief case histories have been published which do illustrate the problems of acculturation and culture conflict. For example, Berlin (1986) described the case of a bright young Native American woman who completed undergraduate school and qualified as a teacher and who was admitted to graduate school. Her clan, however, told her that she was required to teach on the reservation. Her desire to go to graduate school was seen as striving to be better than her peers, and this was unacceptable and forbidden. The young woman had a psychiatric breakdown and was hospitalized. In a similar situation, the tribe and another family could not decide whether to let a young woman go to

graduate school for an MBA after she obtained her undergraduate degree and, during the long wait for a decision, she attempted suicide. In this latter case, the young woman, whom Berlin called Josie, had alcoholic parents who frequently sent her and her brothers and sisters to live with relatives while they went on drinking sprees. A teacher realized Josie's potential and received permission for Josie to live with her. With this teacher's help, her academic performance improved, and she went to college. Josie now resented that her parents, who had neglected her, were involved in decisions about her life. The clan leadership and tribal council were relatively enlightened about the issues and eventually gave permission for Josie to attend graduate school. While at graduate school, Josie underwent psychotherapy to deal with her depression and anger and other personal problems. After graduation, she returned to the tribe to manage their business office, marrying a young man who had fought a similar battle in order to obtain an MSW degree. Westermeyer (1979) provided cases of Native Americans seen at the University of Minnesota Hospitals for whom trying to live in the mainstream American culture had presented problems. Westermeyer felt that identity problems were perhaps no more common in Native Americans than in whites, but that Native Americans did show a unique type of identity problem, namely, ambivalent or negative feelings about their ethnic identity. Westermeyer presented cases of urban Native Americans who illustrate this problem. Five of the patients, ranging in age from 12 to 23, had identity crises -- they experienced conflict about their Native American identity and about what being "Indian" meant. All were students and economically dependent upon others. For example, one young girl, who was seen after a suicide attempt, had her Indian mother die two years earlier. She then lived with her white father and six siblings for a year. The father had trouble supporting them and sent the children to live with their Indian maternal grandmother. The patient began to use drugs and had problems with her white teachers at school. Eventually a white welfare worker sent her to a white foster home, at which point she attempted suicide. In the hospital, she said, "I'm the only Indian here and I hate everybody like they hate me." She had a recurrent dream in which she gave birth to baby girl with blue eyes which she loved but which she also wanted to injure. Five of the cases were judged to have a negative identity. These were older than the patients with identity crises, and all were male. They were estranged from their Indian family members, and they lived as lower class individuals on the periphery of the white society. One patient was admitted with hallucinations and paranoid delusions after a drinking binge. He had a record of multiple psychiatric admissions. Although he supported the idea of Indian activism, he felt estranged from Indians, had little respect for them and avoided them. He had joined a Jewish student activist group which he admired, and he wondered whether his Indian tribe might be a lost tribe of Israel. He identified himself as a Zionist.

CONCLUSIONS There are large cultural differences in the incidence of suicidal behavior, and culture influences also the methods used for committing suicide and the reasons for doing so. Although these cultural differences may be a result of physiological differences between the members of the different cultures, the more plausible explanations involve psychological and social variables, such as the abuse of alcohol and the level of social integration and regulation. When competing cultures interact, there may be increased stress (and, as a result, an increase in suicidality) in the less dominant culture.

It should be noted also that, in societies which are culturally heterogeneous, such as the United States, Canada and Australia, it cannot be assumed that suicides from the different cultural groups are similar in rate, method, motive and precipitating factors. Those working to prevent suicide in such societies must take these cultural influences into account (Sue and Sue, 1990; Zimmerman and Zayas ,1993).

This talk has attempted to raise and briefly discuss several of the issues involved in the interaction of culture and suicide. These issues should not be viewed as problems, but rather as

opportunities to plan and execute innovative and exciting research and to work more effectively with suicidal clients from diverse cultures.

NOTES

[1] Phillips, Liu and Zhang (1999) reported suicide rates of 33.6 per 100,000 per year versus 24.2 for the 1990-1994 period for women and men, respectively.
[2] Suicide rates for China in 200 were not available from the World Health Organization.
[3] The nations used different classifications by age.
[4] For example, Lester (1994c) showed that the used of jumping for suicide in Singapore was strongly associated with the development of high rise apartments.
[5] Within a nation, the different ethnic groups often differ in their suicide rates. Whites have higher suicide rates than blacks in the United States (13.0 per 100,000 per year versus 6.8 in 1992) and in African nations which report suicide rates such as Zimbabwe (17.6 versus 6.9 in 1983-1986) and South Africa (18.4 versus 3.0 in 1984) (Lester, 1998).
[6] It is no wonder that there is a Welsh liberation movement.
[7] Each judge rated the suicide rate of each society on a scale of 0-4, and their ratings were summed.
[8] Lester (1995c) has compared and contrasted Naroll's theory with those of Durkheim (1897) and Henry and Short (1954).

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