Suicide: A Worldwide Problem

By W. J. Poeldinger

ABSTRACT

The author tries to answer the question of how far can we speak of an increase in suicide and attempted suicide. The latest international comparison numbers made by WHO in Geneva show that the rate of suicide has increased tremendously in different countries especially since 1960. The reasons and motives of suicidal actions are examined. Depressions and disharmony in interpersonal communications are especially emphasized by the author. Management of the problem, including modern anti-depressives, telephone-emergency-services and crisis-intervention-centers, have been discussed.

The title of this article is the author's opinion right on one hand, because suicide and suicide attempts are worldwidely increasing and on the other hand we know nowadays that we can fight it. The discussion is not how to prevent suicide, but how to prevent it better.

First of all the question, how far we could speak of an increase of suicide and of suicide attempts. Although international examinations show, that the official suicide list of the different countries are only hard to compare, and not all members of WHO make the number of suicides known, we can say that the number of suicide is increasing. At the beginning of November the WHO in Geneva gave to me the latest international comparison numbers which can be seen in table I. The statistics in those countries go beyond 1975 or 1976. From that picture we can see that the number of suicides has inreased by a population of 100'000 adults. If we take an average of all those dates, so we see, that in all the named countries during the last 15 years (from 1951 — 1976) the suicidal rate, in a population of 100'000, has increased from 6,6 to 19,6. That is only the rates of suicide, while the rate of suicide at tempts is much higher, for the experts in that field think, that the relation between suicide and suicide -attempts must be betwen 1:5 or 1:10. As

far as those statistics are concerned, it is important to mention, that the rate of suicide has increased tremendously especially since 1960. If we turn to the detailed questions, Table II shows, that the suicidal rate by women increased extremely. When we compare the numbers of suicides by youth aged 15-24 years and women, it is impressing that the suicidal rate by women increased more than in the youth.

TABLE I

Suicide : Rates Per 100'000 Population

	1951	1960	1970	1974	1975	1976
Austria	—	7.6	24.2	23.7	24.1	22.7
Germany Fed. Rep.	—	6.2	21.5	21.0	20.9	21.7
Hungary	—	5.7	24.8	40.7	38.4	40.6
Japan	9.5	7.1	15.3	17.5	18.0	17.6
Netherland	3.8	2.4	8.1	9.2	8.9	9.4
Sweden	3.2	4.2	22.3	20.1	19.4	18.9
Switzerland	9.3	7.1	18.2	20.6	22.5	22.1
Thailand	—	3.9	4.1	4.8	4.7	4.5
USA	7.4	6.7	11.5	12.1	12.7	—
	6.6	5.6	16.5	18.8	18.8	19.6

TABLE II

Female Suicides : Rates Per 100'000 Population

	1960	1970	1975
Austria	2.9	14.2	13.9
Germany : Fed. Rep.	2.3	15.2	14.6
Hungary	2.3	19.8	22.1
Japan	2.9	13.3	14.6
Netherland	1.1	6.2	7.0
Sweden	1.5	13.2	11.2
Switzerland	4.0	10.1	12.9
Thailand	2.0	3.3	4.4
USA	3.8	6.5	6.8
	2.5	11.3	11.9

TABLE III

Age Group 15-24 : Rates Per 100'000 Population

	1960	1970	1975
Austria	6.9	16.5	15.6
Germany : Fed. Rep.	4.8	13.6	15.0
Hungary	5.2	18.8	16.6
Japan	5.1	13.0	16.0
Netherland	1.1	4.0	5.3
Sweden	1.9	13.3	13.5
Switzerland	5.5	14.1	20.7
Thailand	4.3	8.2	11.0
USA	3.5	8.8	11.8
	4.2	12.2	13.9

In Table IV we see the increase in per cent. It shows that the increase in the group of youth aged 15-24 years is in the average, while the increase by women 10% higher than the average. In that connection we organized a research in an international commitee for recognition and treatment of depression. An inquiry of 15'000 practising and specialized doctors in Europe, especially in German speaking countries, shows that depressions are increasing especially the so called masked depressions. That inquiry shows also, that 30-50% of all people who consult a doctor, mostly suffer from a psychiatric trouble. The knowing and the right treatment of depressions is a special task in the field of suicide prevention.

TABLE IV

Suicides : Rates Per 100000 Population

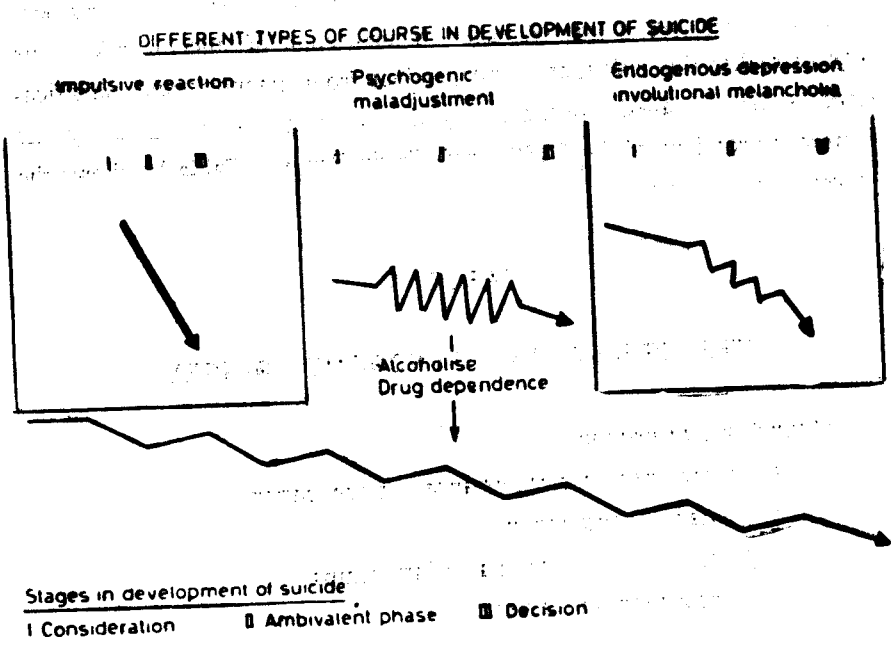
	1960	1975	Increase in %
Total	5.6	18.8	70.2
Female	2.5	11.9	78.9
Age Group 15-24	4.2	13.9	69.8

But if we ask for other groups of people, who are in danger to commit suicide, we can find depressive people, specially the drug-dependents and alcoholics. Asking for the reasons and motives of suicidal actions, we find and especially by women, that it is often the disharmony in interpersonal communication, which leads to suicide. I especially think of troubles in love and marriage and also of the problems caused by the generation-gap. This interpersonal familiar field of interactions is followed by the problems concerning profession and working place, then by the problems in connection with criminality.

The identification of the increase of suicidal actions and its reasons should lead to a better treatment of patients who have commited a suicide attempt, and if possible to completely prevent these attempts. Concerning the treatment of patients after suicidal attempts, we have learned that it is extremely important, that every patient who comes to a hospital after his suicidal action has to be seen by a psychiatrist who has to decide whether this patient has to be hospitalised in a psychiatric clinic, whether he can be treated as an outpatient or whether there is no need for a treatment at all.

A great number of patients who attempt suicide suffer from depressions, it is very importaont to give them an efficient antidepressive treatment. In this context I'd like to point out also the great importance of the modern anti-depressives. But it is still better to prevent those actions by recognising the suicidal ideas in time and by offering help. Figure 1 shows the dynamic course of a suicidal development. In a crisis the patient sees the suicide as a possibility to solve his problems, this stage is followed by a fight between self-destruction and self-preservation. It is this state, in which the patient often speaks about his suicidal ideas. Here it is very important to know that every suicide-threat has to be taken seriously and the old saying, that people who talk about suicide, will never commit it, is very wrong and had destroyed many precious lives. In this fight between self-destruction and sef-preservation it is possible to offer an anonymous help to the people in danger and it can be done in form of a telephone-emergency-service.

These emergency-services have been very helpful in the last decades and in many cities they have been introduced by different organisations.



The great advantage of these emergency calls is that they are anonymous and therefore everybody can call without mentioning his name and nobody has to be afraid of getting hospitalised by force. In these telephone-offices there are lay-helpers, who are specially trained in talking to people in stress-situations and who try to transform the anonymous contact into a personal one. Those emergency-call-offices can only help if the phone can be answered 24 hours a day. It is very pleasing that for instance the Swiss General Post Office has introduced an official short number for the whole country. By dialing 143 the Swiss can reach the telephone emergency service day and night.

Besides the telephone-emergency-service it is desirable to have a crisis-intervention-station or institution, that can not only offer help to outpatients but where patients can also be hospitalised for a short time and without all the formalities which have to be taken when a patient has to be forcebly hospitalised in a psychiatric clinic.

The first suicide prevention centers have been found in the United States and it is delightful, that they can be found in other places too. Especially important would be crisis-interventions centers in regional hospitals. Very important too is a safe prediction of suicidal risk. One way to realise this risk that is independent from diagnosis and classifications is the so-called presuicidal syndrome, that was invented by the honorary president of the IASP, prof. Erwin Ringel. Table V. shows the stages of this syndrome.

TABLE V

THE PRESUICIDAL SYNDROME (RINGEL)

1. **Mounting Constriction**
   a) in the specific circumstances of the patient
   b) Dynamic constriction
   c) Constriction in personal relationships
   d) Constriction in values.

2. **Mounting Aggression**

   which the patient is unable either to abreact or to cope with. Aggression becomes directed against the patient himself.

3. **Suicidal Fantasies**

   Freely willed in the beginning, and later on overwhelming the patient.

AUTHOR

Walter J. Poeldinger, M.D. President of the International Association for Suicide Prevention, Professor at the University of Basel Kantonale Psychiatrische Klinik CH 9500 Wil/St. Gallen/Switzerland.

الملـــوجز

الانتحار ـ مشكلة عالمية الانتشار

يحاول الباحث فى هذا المقال أن يوضح الزيادة المستمرة فى الانتحار ومحاولات الانتحار ، ويشير فى هذا الصدد الى آخر الاحصائيات المقـارنة التى أجرتها منظمة الصحة العالمية فى جنيف والتى تؤكد زيادة الانتحـــار المروعة فى أقطار العالم المختلفة وخصوصا منذ عام ١٩٦٠ ولقد قام الباحث بمحاولة استكشاف للأسباب والدوافع التى تكمن وراء هذه الزيادة ، وهذا يؤكد أهمية الدور الذى يلعبه الاكتئاب بأنواعه المختلفة وكذلك أهمية انعدام التناغم الحادث فى التواصل بين الأفراد · وأخيرا يناقش الباحث علاج هذه المشكلة مشيرا الى أهمية الأدوية الحديثة المضـــادة للاكتئاب ، والخدمات الطارئة عبر الاتصال التليفونى ، وكذلك مراكز التدخل أثناء الأزمات ·

ABSTRAIT

Le Suicide : Un Problème du Monde Entier

L'auteur a essayé de répondre à la question suivante : dans quelle mesure peut-on parler d'une augmentation de suicide et de tentatives de suicide. La dernière comparaison mondiale des chiffres donnés, dans ce contexte, par le WHO à Genève, a montré que le taux de suicide a épouvantablement augmenté à partir de 1962 dans les différents pays. Les raisons et les motifs de t'acte de suicide ont été étudiés. L'auteur envisage spécialement les depressions et le manque d'harmonie dans les communications interpersonnelles. Le traitement de ce problème comprenant les antidepressifs modernes, les services téléphones d'urgence et les centres établis pour interenir dans les crises, a été discuté.

Patterns and Issues in Multiaxial Psychiatric Diagnosis

by : JUANE. MEZZICH

Psychological Medicine, 9 : 125-137, 1979

There is a widespread and increasing interest in multiaxial models for psychiatric diagnosis which reflects a scientifically based challenge for the traditional single-label diagnostic model. The multiaxial model consists in the systematic formulation of a patient's condition according to seperate clinical variables or aspects. This innovative model promises to improve diagnostic reliability and validity and involves many methodological challenges. The present paper reiews several multiaxial systems and compares them in an attempt to detect and illustrate major patterns and issues in multiaxial development and implementation. The author discussed many points : conceptualization of axial content, number and organization of axes, dimentional v. typological scaling of axes, evaluation of axial reliability and validity, and further development of multiaxial systems.

The author concludes that we are at a very active point in the development of innovative diagnostic systems. Also he suggests that much alertness, creativity and hard work to assimilate appropriately new substantive research findings in psychiatry. Lastly, the author pointed to the importance of the apparent increase in interchange of ideas and proposals formulated in various parts of the world.

R. M.

Deciding How to Treat-The Relevance of Psychiatric Diagnosis

by : PAUL WILLIAMS

Psychological Medicine, 9 : 179-186, 1979

A distinction is drawn between "diagnostic decisions" and "management decisions". The author suggests a hierarchical model for the process