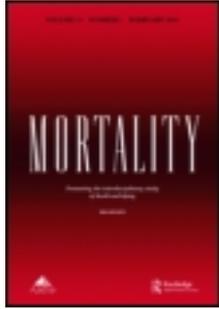


This article was downloaded by: [University of Glasgow]

On: 04 September 2013, At: 02:41

Publisher: Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Mortality: Promoting the interdisciplinary study of death and dying

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/cmrt20>

Suicide and gender

Rory C. O'Connor^a & Noel P. Sheehy^b

^a Department of Psychology, University of Strathclyde

^b Glasgow School of Psychology, Queen's University of Belfast

Published online: 19 Aug 2010.

To cite this article: Rory C. O'Connor & Noel P. Sheehy (1997) Suicide and gender, *Mortality: Promoting the interdisciplinary study of death and dying*, 2:3, 239-254, DOI: [10.1080/714892786](https://doi.org/10.1080/714892786)

To link to this article: <http://dx.doi.org/10.1080/714892786>

PLEASE SCROLL DOWN FOR ARTICLE

Taylor & Francis makes every effort to ensure the accuracy of all the information (the "Content") contained in the publications on our platform. However, Taylor & Francis, our agents, and our licensors make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content. Any opinions and views expressed in this publication are the opinions and views of the authors, and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content should not be relied upon and should be independently verified with primary sources of information. Taylor and Francis shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content.

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden. Terms & Conditions of access and use can be found at <http://www.tandfonline.com/page/terms-and-conditions>

Suicide and gender

RORY C. O'CONNOR¹ & NOEL P. SHEEHY²

¹Department of Psychology, University of Strathclyde, Glasgow & ²School of Psychology, Queen's University of Belfast

ABSTRACT *There has been an alarming increase in suicide, especially among the young. This study sought to profile suicide in Northern Ireland and investigate gender differences. It is argued that the identification of such differences is essential for more adequate intervention. Suicides (n = 142) drawn from catchment areas in Northern Ireland are described according to selected demographic, clinical and psychosocial factors. Females were significantly more likely to be living with a partner and suffering from health problems. There was a high incidence of mental illness, with females more often depressed. The importance of stressors as suicidal correlates is also supported. Almost 50% of the deceased had visited their GP in the 6 months prior to death and the role of the health care team in intervention is discussed. Suicide in Northern Ireland does not appear to be a special case and is very similar to that reported elsewhere. Gender differences in suicide should help identify more accurately those at risk.*

Introduction

There has been a steady increase in the incidence of suicide throughout the UK in recent decades. This trend is stronger for men than women and a particularly large increase has been recorded for young men (Charlton *et al.*, 1992). A similar pattern is emerging in Ireland, north and south (Kelleher, 1995; McCrea, 1996), Scotland (McLoone & Crombie, 1987) and England and Wales (Charlton *et al.*, 1993). In Northern Ireland, men account for over 70% of the annual number of suicides, and perhaps not surprisingly the vast majority of research has concentrated on men and neglected suicide in women. However, comparative analysis of suicide among men and women can elucidate a more complex picture. For example, it is already known that men are more likely to use particularly violent methods of suicide; this may partly explain why suicide attempts among men are more successful and why the suicide rate for men is three times that for women; however, further investigation is necessary. This study sought to profile suicides among men and women in Northern Ireland in order better to understand the nature of the differences.

Correspondence to: Rory C. O'Connor, Centre for Applied Social Psychology, The Graham Hills Building, 50 George Street, Glasgow G1 1QE, United Kingdom. Tel. 0141 548 4461; Fax 0141 552 1932. E-mail: rory.o-connor@Strath.ac.uk

Suicide risk factors

Those who are single, divorced or widowed are more likely to take their own lives and there is indicative evidence that a lack of social support may be an important precipitating variable in suicide risk (Kelleher & Daly, 1990). Measures of living arrangements have been used as simple indicators of social support (O'Connor & Sheehy, 1996) and it seems that individuals—especially men—living alone are at particular risk (Gallagher & Sheehy, 1994). How marital status *per se* mediates suicide is less clear. It may be that the combination of marital strife, break-up and so on pushes a particular person so far that he/she perceives suicide as the only option. Socio-economic status has not been considered in this study because it has not been consistently associated with suicide death, but unemployment is included because of its known relationship with suicide.

The use of official statistics for the analysis of suicide is plagued with methodological problems; a uniform method of classification is not used throughout the UK. An associated problem concerns the use of marital status as an indicator of living arrangements; it is commonly assumed that individuals classified as married are living with a partner. This excludes a large proportion who are either cohabiting or not living with a spouse. Hence, in this study living arrangements were ascertained from inquest papers rather than from official statistical records. Recent evidence in a small-scale study (O'Connor & Sheehy, 1995) has indicated quite a large discrepancy between the official classification (from Register General's Office for Northern Ireland) and the picture presented by inquest papers.

Depression and mental illness have long been considered predictors of suicidal risk: Maris *et al.* (1992) list depressive illness and mental disorder first in a table of common single predictors of suicide. The criteria used for evaluating evidence of depression are complex and this may lead to under-reporting because depression will not be recorded in the official reports unless there are supporting medical records of a clinical diagnosis. Consequently in this study, reports from friends and relatives were also taken as evidence for depression. Many clinicians now retrospectively assess the deceased's mental health from medical and hospital case notes as this seems to provide a more accurate incidence of depression among suicide victims. Many suicides suffer from alcoholism, schizophrenia, anxiety or personality disorder at time of death. The direction of the relationship between suicide and alcoholism is unclear: suicidal people may drink heavily as a way of coping or it might be that alcoholic individuals put themselves at risk through progressive reductions in the quality and quantity of their social relationships (which are thought to buffer against suicide). It has been estimated that between 9% and 13% of schizophrenics will eventually commit suicide (Meltzer & Fatemi, 1995), and young patients are 150 times more likely to take their own lives compared with peers in the general population (Mortensen, 1995). It is thought that an analysis of co-morbidity may provide a more beneficial insight into the relationship between suicide and mental health.

According to Blumenthal (1990) the interaction or overlap between the myriad risk factors is the key to understanding suicide. She represents the risk factors in five domains which include psychiatric, psychosocial, genetic and biological variables. This model posits that the degree of overlap between the respective domains determines suicide risk, but the degree to which each factor accentuates this risk is not known. There is a high incidence of mental illness among the suicide population, estimated by some at over 90% with 85% suffering from either depression or alcoholism (Barraclough *et al.*, 1974). The role of unemployment in suicide is also problematic and Platt (1984) believes that although it may not directly influence the suicide rate it is an important antecedent variable. It is unclear whether unemployment contributes to suicidal risk, or if those who are suicidal are less employable (Hawton, 1994). Other stressors have been implicated (Pritchard, 1992), including marital/relationship discord, financial difficulty, bereavement and personal problems. Those who abuse drugs, especially heroin, may be approximately 20 times more likely to take their own life than members of the general population (James, 1967). It is more beneficial to look at the relationship between these particular stressors and other psychosocial factors than to consider each in isolation.

Collecting suicide data

Three methods are used to investigate suicide: examination of official statistics, suicide note analysis and interviews with those who have attempted suicide. The former uses inquest papers and coroner's reports, the second covers a multitude of methods including content analysis, protocol and discourse analysis. The suicide note is considered the closest one can get to the 'suicidal mind' but the utility of suicide notes as a valid source of data has been questioned. Shneidman (1985), a pioneer in this area, has taken the view that suicide notes can provide a valuable insight into suicidal thinking when considered together with family history and medical records. Finally, interviews with parasuicidal individuals have proved essential to our understanding of suicidal behaviour. It is generally accepted that there is an overlap between those individuals who attempt (unsuccessfully) and those who complete and it is thought that identifying individuals who genuinely intended to take their own life but failed can help us better understand those who were successful. It is estimated that 'over their lifetimes about 10–15% of individuals making nonfatal suicide attempts eventually go on to kill themselves' (Roy & Linnoila, 1990). Moreover, suicidal history is one of the most accurate measures of completed suicide albeit that suicide is a rare event. The risk factors cited thus far are not exhaustive or differentially weighted but represent the common correlates and precipitates of suicide. One approach alone cannot yield a complete understanding of suicide; this study represents a strand of the research, which when integrated with others will further our understanding of suicide.

Suicide research is often riddled with inconsistencies which are due, in the main, to different methods of classification and the heterogeneity of data sources. Catchment area analysis—surveying trends in a particular behaviour in a given area over a period of time—has been used successfully (O'Dwyer *et al.*, 1992) to profile suicide in Ireland and elsewhere. This type of analysis is usually performed on small samples: O'Dwyer *et al.* (1992) reviewed 14 suicides in Waterford City & County (Ireland) gathering information from many sources including post-mortem records, local coroners and the police. Nevertheless, the trends obtained from such studies have yielded similar results to larger studies. In recent years similar research designs have been used in Dublin (McCarthy & Walsh, 1975), Galway (Clarke-Finnegan & Fahy, 1983) and Cork (Kelleher & Daly, 1990). This research strategy is not unique to the Republic of Ireland: in London Cattell (1988) surveyed 104 consecutive elderly suicides. He reviewed the coroner's inquest papers which provide details of demographic, psychosocial and clinical characteristics. Published studies in Northern Ireland have mostly been concerned with demographic profiles (Darragh, 1991) which of themselves have been shown to provide limited insights.

The present study sought to profile suicide by looking at a number of catchment areas. These were defined by the boundaries adhered to by HM Coroner for Greater Belfast. Access to coroner's inquest papers was obtained and demographic, clinical, psychological and psychosocial variables were investigated. The suicides were profiled to identify characteristics which may have been specific to Northern Ireland and to examine in greater detail the nature of gender differences in suicide.

Method

Suicides which came before the court of HM coroner for Greater Belfast in 1993 and 1994 were included in this study. There were 142 consecutive suicides (ICD codes E950–E959) during this time in Greater Belfast, South Antrim and North Down. One hundred and five men and 37 women are described. The coroner's inquest papers were scrutinized to determine clinical, demographic, psychological and psychosocial characteristics of the deceased. Inquest papers are substantial documents with records from both mental health professionals and relatives/friends of the deceased. They consist of:

- (1) Coroner's findings
- (2) Pathologist report
- (3) Depositions from family, friends etc.
- (4) Deposition from General Practitioner (GP)
- (5) Depositions from psychiatrist and other health care professionals (if relevant)
- (6) Suicide notes (if present)

TABLE 1. Basic demographic characteristics of the suicides

	Male (%)	Female (%)	Total (%)	¹ χ^2
Age				
Young (< = 33 yrs)	53.3	16.2	43.7	$p < 0.01$
Middle (34–55 yrs)	26.7	64.9	36.7	$p < 0.01$
Older (= > 56 yrs)	20.0	18.9	19.6	NS
Marital status				
Single	46.7	21.6	40.1	$p < 0.01$
Married	42.9	56.8	46.5	NS
Divorced	6.7	10.8	7.7	NS
Widowed	3.7	10.8	5.7	NS

¹Chi-square analysis between males and females only.

The development of a coding framework was informed by previous studies, reviewed earlier, which point to the importance of particular clinical, demographic, psychological and psychosocial variables.

Results

Demographic characteristics

Consistent with other countries, suicide among men is much more common than women; men are almost three times as likely to take their own lives (2.8:1.0). Younger (< = 33 yrs) individuals are also over-represented in this population, with older people (56 > = yrs) least likely to take their own lives (see Table 1). Among men, suicide victims tended to be younger ($p < 0.01$) while women were more likely to be middle-aged ($p < 0.01$). The individuals sampled in this study were mostly married (46.5%); however, men were significantly over-represented in the 'single' category ($p < 0.01$), whereas women tended to be married (56.8%).

Method of death

Poisoning was the most frequently-used method, with over 40% choosing this means of death (see Table 2). Men were more likely to hang themselves (35.2%), while women were more likely to use poison (56.7%). This is consistent with previous studies indicating that men tend to use methods that are more likely to be successful. A chi-square analysis revealed that men were significantly more likely ($p < 0.01$) to use a violent or more lethal method such as hanging, shooting, jumping or any other self-mutilating behaviours.

TABLE 2. The distribution of method across sex

	Poisoning	Hanging	Drowning	¹ Fire/Cut, etc.	Other
Total (%)	40.1	30.3	9.9	12.0	7.7
Male (%)	34.2	35.2	7.6	16.2	6.8
Female (%)	56.7	16.2	16.2	0	10.9

¹Fire/Cut, etc. includes firearms, cutting, piercing and any other self-mutilating acts.

Psychosocial variables

Individuals living alone (36%) accounted for the largest living arrangement classification, followed by living with partner (32%). More men (38%) than women (36%) were living alone at time of death (albeit not significantly) but women were significantly more likely ($p < 0.01$) to be living with a partner (see Table 3).

Individuals who were employed or engaged in full-time education or training schemes were classified as employed and retired people were classified as unemployed. Over 61% of the suicides were not employed at time of death. There were no gender differences. This is somewhat surprising given the higher level of participation of men in the work-force and implies that unemployment may be a more important precipitating factor for men than for women.

Stressors

We considered the prevalence of a range of stressors, including relationship strife and health problems. Marital/relationship problems were recorded most frequently (30%) both for the group as a whole and for men and women separately (see Figure 1); these ranged from minor arguments to infidelity. Women were significantly more likely ($p < 0.01$) to report health problems than men. There were no significant gender differences on any of the other stressors.

TABLE 3. Selected psychosocial variables

	Total (%)	Male (%)	Female (%)	¹ χ^2
Living arrangements				
Alone	35.9	38.1	29.7	NS
Partner	31.7	25.7	48.7	$p < 0.01$
Family	21.8	23.8	16.2	NS
Friend(s)	1.4	1.9	0	NS
Other	9.2	10.5	5.4	NS
Unemployed	61.3	60.0	64.9	NS

¹Chi-square analysis between male and females.

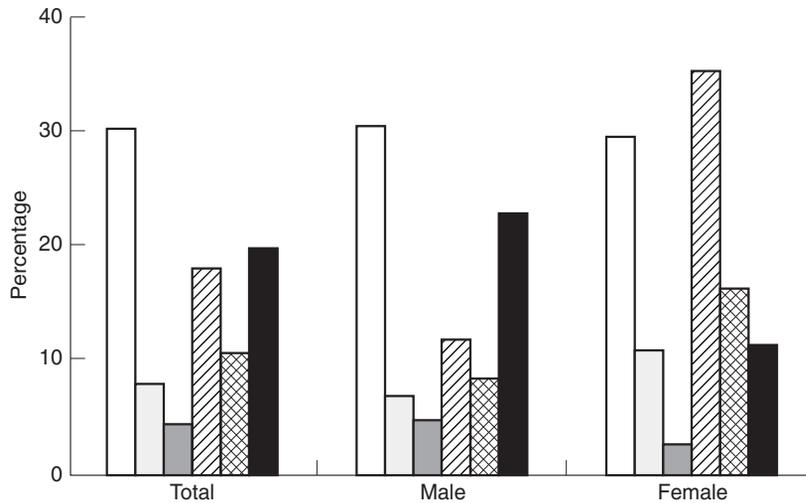


FIGURE 1. The prevalence of stressors. □ marital/partner; ▨ work; ▩ financial; ▪ health; ▤ bereaved; ■ other.

The observed relationships between stressors and suicide is consistent with previous studies.

Mental illness

Sixty-two per cent were suffering from depression or had a history of depression (Figure 2). A significantly ($p < 0.05$) greater number of women (78.4%) were more likely to be depressed than men (56.2%). Incidents of alcoholism, schizophrenia and epilepsy were recorded. Twenty-four per cent were either diagnosed as suffering from alcoholism or were described as very heavy drinkers. Approximately 5% were diagnosed with schizophrenia (5.6%) and less than 5% were epileptics but no other significant sex differences were noted.

Associated factors

Thirty-nine per cent had attempted to end their own lives at least once prior to death. Women were more likely to have a history of attempts, albeit not significantly different. Nonetheless, a t-test showed women to have made significantly more attempts per person than men ($p < 0.05$); they had a mean of 3.28 prior attempts compared with 2.30 for men. This is consistent with other findings indicating that when men attempt suicide they tend to use more lethal methods and are more likely to succeed. Verbalization of intention was also recorded if there was any indication that the individual gave any prior sign to either a mental health professional or family/friend. Thirty-six per cent verbalized their wish to die, with men being more likely to do so but not significantly

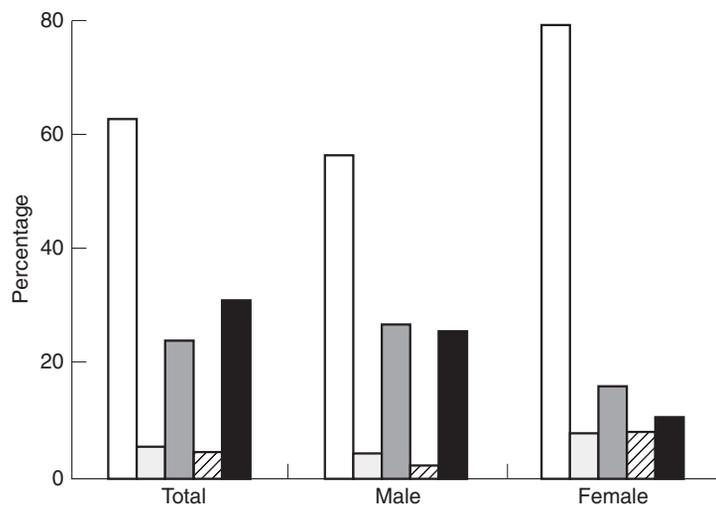


FIGURE 2. The incidence of stressors. □ depression; ▒ schizophrenia; ▒ alcoholism; ▒ epilepsy; ■ other.

so (Figure 3). Suicide notes were left by 38% of the deceased and men were significantly ($p < 0.01$) more likely to leave notes than women.

Contact with health care professionals

Three variables were included as gross indices of contact with health care officials. These were hospitalization in the year prior to death (general or

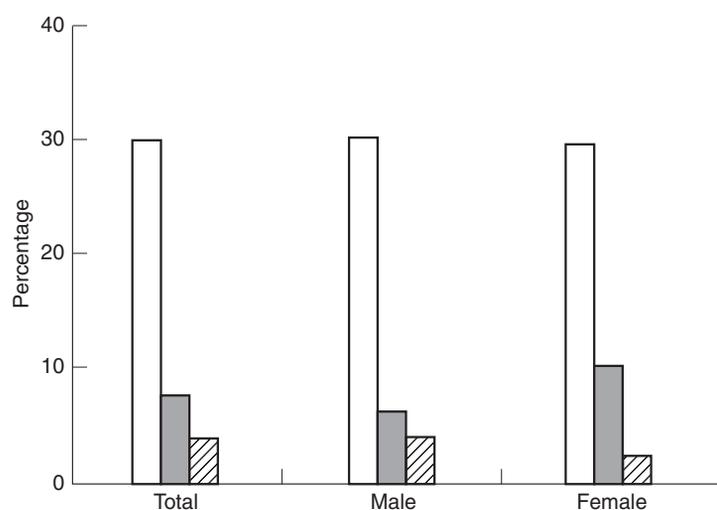


FIGURE 3. The distribution of associated factors. □ previous attempt; ▒ verbalization; ▒ suicide note.

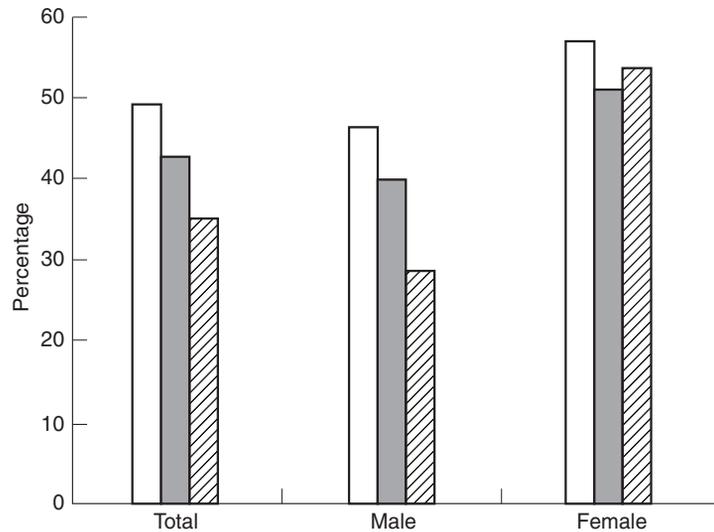


FIGURE 4. Contact with health care officials. □ GP contact; ■ psychiatric contact; ▨ hospitalization.

psychiatric), lifetime contact with any member of the psychiatric services and finally visits to the GP in the 6 months before death. Figure 4 shows that there was substantial contact with health workers—49.3% visited their GP within the 6 months before death. More women than men had visited health workers but this difference was not statistically significant. Forty-three per cent of all the deaths had contacted a psychiatric professional at least once in their lifetime but no significant sex differences were noted. Finally, more than a third (35.2%) had been hospitalized in the year prior to death and women were significantly over-represented ($p < 0.01$).

Discussion

The demographic, psychosocial and clinical characteristics of the sample reported here are consistent, in the main, with those reported in other studies in Ireland and the UK. Men accounted for the largest proportion (73.9%) of suicides, young men being most at risk and young women at least risk. Suicides among men were significantly more likely to involve younger men whereas among women the middle-aged were most at risk. Most of those in the sample were married, which would seem to contradict the popular view that suicides are carried out by single people. However, when one looks at the relationship between marital status and gender the picture is more complex than commonly thought: men were more often single and women more often married. This suggests that for women, being single may reduce suicide risk while being married may have the opposite effect. Poisoning was the most frequent means of suicide, followed by hanging. Men choose more violent or lethal methods. Darragh (1991) reported hanging as most prevalent among suicides in Northern

Ireland (1984–1989) but this was due to classification effects: he sub-divided incidents of poisoning according to substance but the summation of these returns poisoning as the most frequently-used method.

Marital status, as officially classified, is an inadequate measure of an individual's living arrangements, so in this study information about marital status was obtained directly from the inquest papers. A large percentage of men and women were living alone at the time of death but women 'living with a partner' were significantly over-represented: the role of marital status or social support in mediating suicide risk is probably more complex than was previously thought. This points to the importance of discriminating between 'intimate' social support represented by partners and 'casual' social support provided by family and close friends. The crude measures of social support which have been used thus far have not been successful in explaining the role of this significant social process mediating suicide risk.

We observed the frequently-reported association between suicide and unemployment. Platt (1984) argues that there is insufficient evidence to posit a direct causal link. McCrea (1996) accepted this view and indirectly implicated the civil violence in Northern Ireland, arguing that the 'troubles' reduced economic and social development which had knock-on effects on employment levels. Hence, it is not the 'troubles' *per se* but rather the socio-economic implications which in complex and indirect ways influence suicide rates. Crombie (1990) collected unemployment data and suicide rates in 16 developed countries over a decade and found inconsistent relationships between unemployment and suicide. The change in rates of unemployment could only explain a small percentage of the variation in suicide in many countries. Moreover in Germany 'a large increase in unemployment has been accompanied by a fall in suicide rates' (Crombie, 1990, p. 415). He did not find a consistent association between unemployment and suicide among women. In our study, however, there is an equally high incidence of unemployment among the men and women who killed themselves.

Many of those who killed themselves were enduring at least one stressor. Stressors ranged from marital/relationship strife to bankruptcy or health problems, and a high frequency of stressors was apparent in both men and women. Marital/relationship problems were the most frequently observed stressors and no sex differences were noted. This is interesting, as one might have expected an elevated frequency of these and related stressors in women since they were more often living with a partner at the time they took their lives. This suggests that it may not be the problems associated with living with a partner *per se* that are important here, but the dearth of social support which some partners provide.

There was a significantly higher occurrence of health problems in women, which included arthritis, back pains and raised blood pressure. Despite this difference in health problems the profile of stressors among men and women was broadly similar. Yet, we are all under stress at some time, so why is it that some people choose to end their lives and others do not? Rich *et al.* (1990)

identified the importance of distinguishing those stressors that precipitated suicide from those that did not. More recent evidence implicates intrapsychic and interpersonal aspects of suicide risk (Leenaars, 1996). It is not the presence or absence of stressors that is important in suicide risk but rather how stressors influence individual feelings and thoughts and how these interact with interpersonal relationships. Interviews with those who have genuinely attempted but failed to take their own lives could be very useful here and lead to a more informed awareness of signs associated with someone under 'suicide-mediating' stress.

Almost two-thirds of those who killed themselves were either depressed around the time of death or had a history of depressive treatment. Women were significantly more likely to be depressed and this may go some way to explaining why they complained more often about health problems: depression may predispose them both mentally and/or physically to ill-health. Alcoholism together with depression accounted for a large percentage of the mental illness recorded. Hence it is essential that co-morbidity be investigated to determine the role each form of mental illness plays in suicide risk, both individually and collectively. Studies which determine baseline levels of social support in alcoholics and non-alcoholics would help establish the direction of the relationship between alcoholism and suicide risk. The marked decrease in the quality and quantity of social interactions in alcoholics (compared with non-alcoholics) would suggest that one of the mediating factors may be social support. Unfortunately, due to the lack of control of many confounding variables, there is enormous difficulty in determining a causal relationship. Nevertheless, monitoring the levels and qualities of social interactions in reformed alcoholics together with other measures (including depression and self-esteem) should help considerably.

A history of self-harm was found to be a significant risk factor—it is known to be one of the best predictors of subsequent suicide death. Contrary to the traditional view it was not only women but we found that many men also attempted to kill themselves, but on average the latter have a history of fewer failed efforts. This difference may be due to the fact that women tend to use methods which are less violent or lethal. More than a third verbalized their intention to die and this supports contemporary arguments that every person who expresses any such desire should be taken seriously.

Contact with the health care services was measured somewhat crudely but was sufficient to illustrate the high levels of contact among suicidal people. These high levels show that, in some way, the health service is failing these people and it seems unlikely that the targeted reduction in suicides by the year 2000, as contained in the government's Health of the Nation white paper (Secretary of State for Health, 1992), will be achieved. More than 35% had been hospitalized in the year preceding their suicide. Psychiatric contact was comparatively common, with 43% having had at least one encounter with the psychiatric services during their lifetime. Women were significantly more likely to have been hospitalized in the previous year and this is not surprising as they

were more likely to be depressed or suffering from health problems. This high level of contact with primary health care teams is extremely worrying, as it indicates that both our assessment of risk is unreliable and the follow-up treatment for those shown to be at risk (i.e. those with suicidal history) is often not effective.

Almost half (49%) of this sample had visited their general practitioner (GP) during the 6 months preceding their suicide and there were no significant sex differences in this regard. Previous research (Vassilas & Morgan, 1993) has shown that young people (usually young men) are less likely than older people to visit their GP before suicide. Nevertheless, there are probably many more depressed individuals who do not present themselves to their GP and who possibly go on to take their own lives. A recent survey carried out in the United Kingdom found that members of the general public were 'disinclined to visit their general practitioner with a complaint about an emotional problem or depression' (Priest, 1994, p. 56). The Defeat Depression campaign has been launched by the Royal College of Psychiatrists and the Royal College of General Practitioners to address such issues, and will hopefully combat the embarrassment and the stigma associated with depression and other affective disorders.

This high level of health care contact is reassuring to a certain degree and would suggest that intervention at the level of the general practitioner can be effective and could go some way to reducing the suicide rate. It is important that GPs and other mental health professionals are aware of the risk factors associated with suicide. A recent study has shown that postgraduate training for GPs aimed at identifying and treating depressive disorders can reduce the frequency of suicide (Rutz *et al.*, 1989). Moreover, the clinician's attitude towards suicide is also central in prevention. Michel and Valach (1992) found that seminar-based training can make these care-givers more active in this area. Hence, both knowledge and attitudes have a substantial part to play in prevention. We found that almost 40% of people had attempted suicide at least once before succeeding, suggesting that post-attempt follow-ups ought to be modified so that these individuals do not become suicide statistics.

This paper has identified significant differences in the patterns of variables associated with suicide among men and women (see Table 4 for summary), indicating that suicidal behaviour is not a homogeneous psychological phenomenon and that men and women kill themselves for different reasons and adopt different methods with different rates of 'success'.

The purpose of this study was essentially twofold: first, to address the relatively neglected problem of suicide among women, and second, to determine gender differences in the profiles of suicidal people. Several differences have been noted and these may in time help clinicians identify gender-specific characteristics of at-risk individuals. Further research should address the dearth of information on suicide among women, since it cannot be concluded that men and women kill themselves for the same reasons. Suicide is a rare and complex behaviour and its prediction is plagued by 'false positives' and 'false negatives' (i.e. predicting suicide, and obtaining non-suicide; predicting non-suicide, and

TABLE 4. Summary characteristics

Females more often:	Males more often:
Middle-aged	Young
Married	Single
Living with partner	Living alone
Health problems	Violent methods
Depressed	
Hospitalized	

obtaining suicide respectively). Any research which identifies differences in suicide profiles should increase the efficacy of suicide prediction and can only be beneficial.

Only one stressor was significantly over-represented among women in this study—they tended to complain more frequently about health problems. Further research is needed to ascertain whether these health problems are manifestations of underlying suicidal correlates. It is generally agreed that the majority of suicidal individuals who present to a general practitioner in the weeks prior to death do not complain about feeling suicidal. Perhaps, for women at least, health problems are significant correlates or precursors to suicide. If this is the case it is important to identify the perceptions these women have about their health. Many people were depressed around the time of their death: the co-existence of depression and health-related problems if perceived in a particularly constricted manner may help provide us with a predictive framework. It is important to note that, despite the high incidence of depression in this sample, women were significantly more likely to be recorded as depressed than men. Is this because women are more likely to complain about affective disorders or is it the product of some underlying factor? For women, living with a partner does not appear to buffer against suicide; however, we are unsure as to why this may be the case. If marital/relationship discord were implicated one would expect to find a higher incidence among women—this was not the case. The nature of the role of alcoholism in suicide requires further attention too, since it is known that men are more likely to suffer from alcohol-related problems, and this may indirectly impact on suicide risk factors for them but less so for women. Demographic and psychosocial investigations alone are not sufficient to predict suicide with any accuracy. However, we believe that looking at the cognitive implications of psychosocial or clinical variables will significantly aid in the reduction of suicide. Any programme of intervention, if it is to be successful, should address both of these viewpoints. For many years it has been accepted that young, single men are at a heightened lifetime suicide risk: to intervene one must identify, for instance, the precipitating associated psychological variables which put someone living alone at risk. To answer such questions an integrated approach should be adopted to encompass psychological

(cognitions and perceptions) as well as environmental influences (unemployment and so on).

In the long term, government should address the social issues which are intrinsically and consistently associated with ill-health, not simply suicide death. For example, unemployment has a strong association with suicide, but its relationship is complex and problematic and it is agreed that policies implemented to reduce unemployment would have a parallel effect on general mental and physical health, but would not necessarily influence suicide rates in predictable ways (Crombie, 1990). It is important to consider the differential effects of unemployment on men and women. In the short term, better understanding of how unemployed individuals perceive themselves will increase our efficiency in spotting those unemployed people who are at risk. Concurrent macro and micro multi-disciplinary programmes can facilitate the identification of circumstances likely to place different kinds of people at different kinds of risk and in time improve our interventions. Research into group processes (nomothetic) alone is futile because suicide is a rare behaviour, but in conjunction with individualist methods (idiographic) it can be of considerable benefit.

Current research (O'Connor *et al.*, 1997) has further identified the somewhat heterogeneous nature of suicide and this should help identify those at risk more effectively and inform the development of more effective intervention programmes. In the meantime, it is incumbent on everyone concerned with health care to increase awareness of suicide risk factors, and perhaps this may at least help arrest and stabilize the increasing incidence of suicide, especially among the young.

REFERENCES

- BARRACLOUGH, B. *et al.* (1974). A hundred cases of suicide: clinical aspects. *British Journal of Psychiatry*, 125, 355–373.
- BLUMENTHAL, S.J. (1990). Youth suicide: Risk Factors, assessment, and treatment of adolescent and young adult suicidal patients. *Psychiatric Clinics of North America*, 13, 511–556.
- CATTELL, H.R. (1988). Elderly suicide in London: an analysis of coroners' inquests. *International Journal of Geriatric Psychiatry*, 125, 355–373.
- CHARLTON J. *et al.* (1992). Trends in suicide deaths in England and Wales. *Population Trends*, 69, 10–16.
- CHARLTON, J. *et al.* (1993). Suicide deaths in England and Wales: trends in factors associated with suicide deaths. *Population Trends*, 71, 34–42.
- CLARKE-FINNEGAN, M. & FAHY, T.J. (1983). Suicide rates in Ireland. *Psychological Bulletin*, 13, 385–391.
- CROMBIE, I. (1990). Can changes in the unemployment rates explain the recent changes in suicide rates in developed countries? *International Journal of Epidemiology*, 19, 412–416.
- DARRAGH, P.M. (1991). Epidemiology of suicides in Northern Ireland 1984–1989. *Irish Journal of Medical Science*, 160, 354–357.
- GALLAGHER, A.G. & SHEEHY, N.P. (1994). Suicide in rural communities. *Journal of Community and Applied Social Psychology*, 4, 145–155.

- HAWTON, K. (1994). Suicidal behaviours in young people: current issues. In M. J. KELLEHER (Ed.), *Divergent perspectives on suicidal behaviour*. Fifth European Symposium on Suicide, Cork, Ireland.
- JAMES, I.P. (1967). Suicide and mortality amongst heroin addicts in Britain. *British Journal of Addiction*, 62, 391–698.
- KELLEHER, M.J. (1995). *Young people and suicide*. Paper presented at Irish Youth Work Centre, Dublin, Ireland, 28 January.
- KELLEHER, M.J. & DALY M. (1990). Suicide in Cork and Ireland. *British Journal of Psychiatry*, 157, 533–538.
- LEENAARS, A.A. (1996). Suicide: a multidimensional malaise. *Suicide and Life-threatening Behaviour*, 26, 221–235.
- MCCARTHY, P.D. & WALSH D. (1975). The under-reporting of suicide and the consequences for national statistics. *British Journal of Psychiatry*, 126, 301–308.
- MCCREA, P.H. (1996). Trends in suicide in Northern Ireland 1922–1992. *Irish Journal of Psychological Medicine*, 13, 9–12.
- MCCLOONE, P. & CROMBIE, I.K. (1987). Trends in suicide in Scotland 1974–84: an increasing problem. *British Medical Journal*, 295, 629–631.
- MARIS R.W. *et al.* (Eds) (1992). *Assessment and prediction of suicide*. New York: Guilford Press.
- MELTZER, H.Y. & FATEMI, H. (1995). Suicide in schizophrenia. The effect of clozapine. *Clinical Neuropharmacology*, 18, 51–58.
- MICHEL, K. & VALACH, L. (1992). Suicide prevention: spreading the gospel to general practitioners. *British Journal of Psychiatry*, 160, 757–760.
- MORTENSEN, P.B. (1995). Suicide among schizophrenia patients—occurrence and risk factors. *Clinical Neuropharmacology*, 18, 1–58.
- O'CONNOR, R.C. & SHEEHY, N.P. (1995). *Suicide in Belfast: a preliminary analysis*. Paper presented at the 26th Annual Conference of The Psychological Society of Ireland. Bundoran, Ireland, 9–12 April.
- O'CONNOR, R.C. & SHEEHY, N.P. (1996). Suicide from a young male's perspective. *International Journal of Psychology*, 31, 231.
- O'CONNOR, R.C., SHEEHY, N.P. & MCGUINNESS, C. (1997). The utility of classification procedures and suicide prevention. *Proceedings of the British Psychological Society*, 5, 10.
- O'DWYER, A. *et al.* (1992). A catchment area study of suicides in Waterford in 1990. *Irish Journal of Psychological Medicine*, 9, 108–110.
- PLATT, S. (1984). Unemployment and suicidal behaviour: a review of the literature. *Social Science and Medicine*, 19, 93–115.
- PRIEST, R.G. (1994). The treatment of depression in general practice in the UK educational programme. *Focus on Depression and Anxiety*, 5, 56–60.
- PRITCHARD, C. (1992). Is there a link between suicide in young men and unemployment? *British Journal of Psychiatry*, 160, 750–756.
- RICH, C.L. *et al.* (1990). San Diego Study: the adolescents. *Adolescence*, 25(100), 855–865.
- ROY, A. & LINNOILA, M. (1990). Monamines & suicidal behaviour. In H. M. VAN PRAAG, R. PLUTCHIK & A. APTER (Eds), *Violence and suicidology: perspectives in clinical and psychological research*. New York: Brunner/Mazel.
- RUTZ, L., VON KNORRING, L. & WALINDER, J. (1989). Frequency of suicide on Gotland after systematic postgraduate education of general practitioners. *Acta Psychiatrica Scandinavica*, 80, 151–154.
- SECRETARY OF STATE FOR HEALTH (1992). *The health of the nation: a strategy for health in England*. London: HMSO.
- SHNEIDMAN, E.S. (1985). *Definition of suicide*. New York: Wiley.
- VASSILAS, C.A. & MORGAN, H.G. (1993). General practitioners' contact with victims of suicide. *British Medical Journal*, 307, 300–301.

Biographical notes

Rory O'Connor completed this work while doing his PhD at Queen's University Belfast. He has recently taken up a lectureship in Psychology at University of Strathclyde, Glasgow.

Noel Sheehy is Professor of Psychology at Queen's University Belfast. He is an applied social psychologist with particular interests in how people respond to seemingly intractable personal, social and environmental problems.