Suicidal Behaviour in Europe

Results from the WHO/EURO Multicentre Study on Suicidal Behaviour
Suicidal Behaviour in Europe

Results from the WHO/EURO Multicentre Study on Suicidal Behaviour

Edited by
Armin Schmidtke
Unni Bille-Brahe
Diego DeLeo
Ad Kerkhof

Hogrefe & Huber
Suicide is probably the most personal act anyone can perform. There are few acts that have such deep roots in social and human conditions, or have such far reaching consequences. Suicide affects the single individual who takes his/her life, it affects those persons in his/her immediate circle and it affects the local community as well as the wider community. We know of no culture in which suicide does not occur.

Suicides have been registered in Europe since the beginning of the nineteenth century, in some countries even longer. However, definitions and measurements have differed very much between the countries, and even between different geographical areas within the same country. Suicidal attempts have not been registered on a national level.

A great step forward was made when the WHO/Euro Multicentre Study on Suicidal Behaviour was established. In the monitoring part of the project, 1989-1999 a total of 25 centres in 19 countries were or are participating (1989-1993: 16 centres in 13 European countries, 1995-1999: 20 centres in 16 European countries, as well as Israel and Turkey). The catchment areas comprise nearly 5.7 million inhabitants. Leading experts in European suicidology have taken part in this unique investigation, so systematically planned, performed and coordinated. The results are convincing. There are great differences between the countries, great changes have taken place both as to suicide and suicidal attempts – as great changes have taken place also in European communities, not least in Eastern Europe during the last decade.

However, this book is not only of statistical interest. It will be of great importance for establishing suicide prevention programs, which we hopefully will see established in most, if not all, European countries. Thus it gives hopes for saving many lives and prepares the ground for better lives for those surviving suicide attempts. Final conclusions are given as to National Suicide Prevention Strategies (an overview) and WHO Strategies, and the WHO/Euro Network on Suicide Prevention is presented.

This book is not only of a high scientific level, and should be read by professional suicidologists, researchers and clinicians, but also has important messages to the many interdisciplinary members of staff whose work involves dealing with people at risk of suicide. It is a unique example of European scientific cooperation. This book will be a milestone in the history of suicidology.

Nils Retterstøl
Professor emeritus, University of Oslo
Previous President of the International Association for Suicide Prevention (1989-1991)
## Table of Contents

**Foreword** ................................................................. v  
*N. Retterstøl*

**Table of Contents** ....................................................... vii

**Preface** ................................................................. xi  
*A. Schmidtke, U. Bille-Brahe, D. DeLeo & A. Kerkhof*

### Part I: Introduction

1. The Suicide Situation in Europe and Suicide Prevention Within the Framework of the WHO Programme “Health for all by the Year 2000” ........................................ 3  
*W. Rutz*

2. The WHO/EURO Multicentre Study on Suicidal Behaviour – History and Aims of the Study ................................................................. 7  
*A. Schmidtke, U. Bille-Brahe, D. DeLeo & A. Kerkhof*

3. Definitions and Terminology Used in the WHO/EURO Multicentre Study ................................................................. 11  
*U. Bille-Brahe, A. Kerkhof, D. DeLeo & A. Schmidtke*

4. Suicide and Suicide Attempts in Europe – An Overview ................................. 15  

5. Sociodemographic Characteristics of Suicide Attempters in Europe – Combined Results of the Monitoring Part of the WHO/EURO Multicentre Study on Suicidal Behaviour ................................................................. 29  
Part II: Results in the Individual Countries

Northern Europe

6. Suicidal Behaviour in Finland .................................................. 49
   A. Ostamo & J. Lönnqvist

7. Suicidal Behaviour in Norway .................................................. 57
   H. Hjelmeland

8. Suicidal Behaviour in Sweden .................................................. 69
   E. Salander Renberg, G.-X. Jiang, L. Olsson, J. Estari & D. Wasserman

9. Suicidal Behaviour in Denmark .................................................. 85
   U. Bille-Brahe & K. Andersen

Central Europe

10. Suicidal Behaviour in Ireland ................................................... 97
    P. Corcoran, U. Burke, S. Byrne, D. Chambers, C. Daly, A. M. Hennessy,
        H. S. Keeley, M. Kelleher, M. J. Kelleher, C. McAuliffe, J. McCarthy,
        M. McCarthy, M. Lawlor, S. Neilson, M. O’Sullivan, I. J. Perry
        & E. Williamson

11. Suicidal Behaviour in Belgium ............................................... 107
    C. van Heeringen, T. Meerschaert & N. Braeckman

12. Suicidal Behaviour in Austria ............................................... 113
    D. Dunkel, E. Antretter, R. Seibl & C. Haring

13. Suicidal Behaviour in England and Wales ................................ 123
    K. Hawton, L. Harriss, S. Simkin, E. Bale & A. Bond

14. Suicidal Behaviour in France ............................................... 133
    A. Batt, F. Eudier, A. Philippe & X. Pommereau

15. Suicidal Behaviour in The Netherlands ................................... 141
    E. Arensman, A. Kerkhof, M. W. Hengeveld, J. D. Mulder

16. Suicidal Behaviour in Germany ............................................. 147
    A. Schmidtke, B. Weinacker & C. Löhr

17. Suicidal Behaviour in Switzerland ........................................ 157
    A. Schmidtke, B. Weinacker, C. Löhr, K. Waeber & K. Michel
Eastern Europe

18. Suicidal Behaviour in Lithuania .................................................. 167
   D. Gailiené

19. Suicidal Behaviour in Slovenia .................................................. 171
   O. T. Grad, U. Groleger & A. Zavasnik

20. Suicidal Behaviour in the Federal Republic of Yugoslavia
    (Serbia & Montenegro) ........................................................... 177
    S. Selakovic-Bursic

21. Suicidal Behaviour in the Ukraine .............................................. 185
    A. Mokhovikov & V. Rozanov

22. Suicidal Behaviour in Hungary .................................................. 189
    S. Fekete, B. Temesváry & P. Osvath

23. Suicidal Behaviour in Estonia ................................................... 195
    A. Värnik, O. Küpersepp, T. Marandi & E. Palo

24. Suicidal Behaviour in Latvia ..................................................... 201
    S. Udrasa & J. Logins

Southern Europe

25. Suicidal Behaviour in Spain (Basque Country) ................................. 207
    I. Querejeta, J. Ballesteros, R. Benito, B. Alegría, A. Sánchez, M. Ruiz,
    S. Barrio & M. J. Alberdi

26. Suicidal Behaviour in Italy ........................................................ 211
    G. Meneghel, P. Scocco, E. Colucci, M. Marini, P. Marietta, W. Padoani,
    M. Dello Buono, D. De Leo

27. Suicidal Behaviour in Greece ..................................................... 219
    A. J. Botsis, A. Kapsali, N. Vaidakis & C. N. Stefanis

Other Participating Centres

28. Suicidal Behaviour in Turkey ..................................................... 225
    I. Sayil & H. Devrimci-Özguven

29. Suicidal Behaviour in Israel ........................................................ 233
    D. Stein, E. Lublinsky, D. Sobol-Havia, J. Asherov, L. Lazarevitch & A. Apter
Invited Papers

30. Suicidal Behaviour in Asturias (Spain) .................................................. 241
    J. Bobes, P. A. Sáiz, M. P. G-Portilla, M. T. Bascarán, S. Martínez,
    B. Paredes & M. Bousoño

31. Suicidal Behaviour in Poland .............................................................. 249
    M. Zaluski, B. Weinacker & A. Schmidtke

Part III: Future Perspectives

32. The WHO/EURO Network on Suicide Prevention ................................. 255
    A. Schmidtke, D. Wasserman, U. Bille-Brahe & W. Rutz

Appendices

Suicide Prevention Organisations in Europe ............................................. 275

Contributors .................................................................................................. 281
In the spring of 1985, a small group of five people (Dr. John Henderson, WHO Copenhagen, Denmark; Prof. Heinz Häfner and Dr. Armin Schmidtke, Central Institute for Mental Health Mannheim, Germany; Prof. René Diekstra, University of Leiden, The Netherlands; and Dr. Peter Kennedy, York, UK) met in the WHO building in Copenhagen and, in the days before a European conference on social psychiatry, discussed the possibilities of suicide prevention in the European region of WHO in the frame of target 12 of the European strategy “Health for All by the Year 2000”. Nobody in this group could imagine the long-lasting results of this discussion. Later in the year, on behalf of this group, a small working group in Leiden (comprising in addition Prof. Niels Juel-Nielsen, Odense, Denmark, and Dr. S. Platt, Edinburgh, UK) then prepared a meeting for a bigger European conference in York, UK, with the aim of discussing and preparing European suicide prevention research and strategies.

One of the outcomes of the meeting in York in 1986 was a common working definition of “suicide attempt” (then “parasuicide”) and the decision to start a WHO multicentre and multinational European study to get a “real” picture of the magnitude of suicidal behaviour in Europe, to obtain epidemiological data, and to identify groups at risk. In the following years, several meetings took place to prepare the material to describe and assess the various catchment areas in different countries, to develop the monitoring forms and the material for the interviews etc. (e.g. in Leiden, Edinburgh, Wuerzburg, and Copenhagen). Someone who has never participated in a multinational multicentre study cannot imagine the amount of work involved in preparing and performing an epidemiological multilingual study with the same research frame, time schedule and instruments, on the one hand taking into account the huge varieties of the individual centres and on the other hand not neglecting and forgetting the common goals.

The study officially started in January 1989 after some months of test runs with 15 centres from 12 countries. Some members of the Steering Group in the first years were more or less sales representatives for the project, presenting it to governments and local authorities in the various countries and in the catchment areas, helping the centres in getting funds and in performing the huge task of educating researchers, interviewers, and helping with the data analyses.

The study immediately became well-known in Europe, the first results were presented soon in congresses not only in Europe but also overseas and in many papers. The first comprehensive results were published in the so-called Wassenaar Book (Kerkhof, A. J. F. M., Schmidtke, A., Bille-Brahe, U., DeLeo, D. & Lönnqvist, J. (Eds.). Attempted suicide in Europe. Leiden: DSWO Press).

Due to the increasing fame of the study, other researchers became more and more interested in joining the study. Therefore, the original Steering Group was enlarged and the responsibilities split within it. Over the years, many new centres joined the study, some of course also left. Wuerzburg became responsible for the monitoring part of the study, the part which collected data on suicide attempts, and the common data collection and analyses.

In December 2001, the study became part of the WHO/European Network on Suici-
cide Research and Prevention. The monitoring part now comprises 36 centres from 27 countries (including Turkey and Israel). It is now one of the largest and longest continuing monitoring studies on a mental health problem in Europe. Other countries and states are sometimes envious of this long-term cooperation and the magnitude of data, whose value can hardly be estimated.

The study, however, also had some agreeable side effects. It not only collected data and a picture of suicidal individuals in Europe but also built a network of suicidologists in Europe. Many young researchers got an insight into international cooperation and research methods, were educated in epidemiological methodology and suicidology, and numerous master theses and dissertations resulted. During the study, many researchers became friends over the years and, therefore, also contributed to European cooperation.

The present book (internally called Wassenaar 2 Book) is the comprehensive publication of the results of the monitoring part of the study from the beginning up to now. It presents the results of data collection over 14 years. When we planned this work, we could not imagine the workload involved in preparing such a book, and the task of editing chapters with such a large amount of information and numerous figures. Of course, the book would not have been possible without the help and support of many people. From the beginning, the WHO staff (the regional advisors Dr. J. Henderson, Dr. J. Sampaio-Faria, and Prof. Dr. W. Rutz from the European WHO Region) always supported the study and helped to encourage people. The editors also have to thank many people, who helped in the common data analyses, the checking and the editing, as well as with the layout. First of all, our thanks go to the first secretary of the group, Prof. Dr. Stephen Platt, Edinburgh, UK, whose work and help was in the first years unpayable. Dr. Bettina Weinacker, Wuerzburg, Germany, was the driving force behind the data collection over a number of years, checking and analysing. Dr. Cordula Löhr and DP Katrin Benkelmann, both also from Wuerzburg, took over this task with the same enthusiasm. Prof. Dr. Diego DeLeo helped with the English editing of the chapters, Unni Bille-Brahe also assisted with the editing and the layout, as well as cand. psych. Wieser.

We also have to thank Robert Dimbleby from Hogrefe & Huber Publishers, Göttingen, for the possibility to publish the book in this prestigious publishing house, and for his patience with us since it was not possible to always keep the deadlines.

We hope that this book will be of interest for all European suicidologists as well as for other disciplines and will help to fulfil one of the originally planned tasks: “To achieve a sustained and continuing reduction of suicidal behaviour in Europe.”

A. Schmidtke, D. DeLeo, U. Bille-Brahe and A. Kerkhof
Part I

Introduction
The suicide situation in Europe is diverse. In some countries, suicide figures are decreasing – reflecting a stable social situation and economical well being. In other countries, suicidality is stable or even decreasing, in spite of continued social instability, unemployment and an increasing prevalence of depression. In the third category of countries, one can find high prevalence of both depression and suicidality, especially in the countries of Eastern Europe, over the previous decade or more, where dramatic societal transition and changes have taken place, and where mental health services are underdeveloped. The crucial and discriminating aspect of suicidality in European countries relates to a respectable and increasing improvement in the recognition of, and access to the treatment and monitoring of depression.

There have been many attempts – successfully in some research environments – to relate suicidality to unemployment, age, gender, social connectedness, family status and economic determinants of health. Even if findings were consistent and statistically significant in some countries, it is difficult to find a consistent pattern in a global or even European realm. For example, while unemployment in one country may lead to isolation, shame, loss of dignity and self-confidence, and contribute to and aggravate a suicidal process, this may not be the case in another society.

Family and social connectedness may mean more to women than to men in many societies. On the other hand, loss of social status, identity as family provider or other traditional roles may have a stronger effect on male individuals.

The inconsistent findings in this research highlight the complexity of factors leading to suicide: They show a multifactoriality where an interactive causation can be found in the social, psychological, existential and even the biological/genetical dimensions of human life.

Other consistent findings suggest that the vast majority of all suicides are not committed in a situation of free will or philosophical autonomy, but in a condition of psychiatric disorder, mostly depression and/or heavy alcohol abuse. What we have learned, is that the suicidal process often goes through a presuicidal phase of clinical depression, distorting in a depressive way the cognitive perception of reality and self-value. In most cases, depression may be caused by a multifactoriality of biological, psychosocial and existential variables, leading in interaction and mutual reinforcement to depression and later in many cases, if untreated, to suicide.
From this research we have to learn that suicide prevention should be multifaceted and comprehensive and that one of the feasible ways in most societies to prevent suicide is through improved social and professional recognition of depression, greater access to treatment and better monitoring of depression, including a long term follow up.

In suicidology, there no longer seems to be time for disputes between qualitative and quantitative researchers, between representatives of sociological, psychological, theological or biological reductionism or for getting stuck finding different cultural patterns behind suicidality and an incompatibility of theses patterns between countries.

Today it is time for comprehensive approaches and multidimensional process thinking, with respect to cultural peculiarities and spiritual differences. One of the groups which has made important contributions to the state of art and knowledge in suicidology today is the Network represented in the WHO/EURO Multicentre Study on Suicidal Behaviour, which has existed, worked, gathered information and produced scientifically significant evidence over many years and in many important publications.

One of the most important outcomes of this group’s work to date, is demonstrated through findings that show the suicidal diversity throughout Europe. As well as this, evidence points to some common factors underlying the process of suicidality and frequent presuicidal depression:

- A loss of identity, dignity and self respect due to transition and social changes;
- A loss of social connectedness and sense of coherence, to be seen by and to see others, to be involved in a network of social communication and reinforcement;
- A loss of feeling of being integrated in a meaningful social context;
- A loss of having control of what is happening in one’s own life and how to react to this – a loss of feeling of not being helpless (a feeling of hopelessness).

Depression and suicidality have to be seen against a background of biological vulnerabilities which may even be genetically and hereditarily expressed in the family background and the individual life history. Our knowledge about

- the multidimensional and multifactorial causal process behind the development of depression, suicidality and later committed suicide,
- the importance of social connectedness, sense of coherence, identity and helplessness as causative factors in the suicidal process,
- biological predetermination concerning suicide and depression

today provides us with the possibility to develop a variety of effective approaches to suicide prevention.

Most of the approaches have been founded upon scientific research and hardly any of them stand in contradiction to each other. It seems unrealistic to expect that further research looking at monocausally linked background factors of suicidality will deliver better scientific knowledge. What we need today is to go beyond the collecting of data and move towards the research linked to it; from a focus on monocausalties to comprehensive and integrative action. The evidence exists, but has to be disseminated and implemented. Comprehensive strategies have already been developed, but have to be improved, tested in pilot projects and disseminated to the countries of Europe where suicidality in many cases is still, and sometimes dramatically, an increasing problem.

This does not mean, however, that the collection of evidence and data has become superfluous. On the contrary, the knowledge existing today about the complexity and multifactoriality of suicidality and suicide prevention and the linkage of suicides to
transition and societal change, creates an unquestionable need to continuously and care-
fully monitor suicidality and suicide related causal factors in the societies of a chang-
ing Europe. At present we see dramatic transitions in the countries of Eastern Europe. We still expect more transitions in the countries accessing the European Union in a process which will come to demand adaptation especially in the rural areas and in subpopulations at risk. For example, farmers in England and Ireland, adolescents in France, Portugal and Spain and women in Scandinavia as well as elderly in Central Europe have already changed their life in a sometimes dramatic way.

This data analysis has to comprehend the analysis of not only noxic but also protective factors. For example, what makes males in Eastern Europe so exposed to suicidality and what protects women in the same situation? Male alexithymia and incapacity to show weakness and ask for help may play a negative role. Women's greater capacities to create and maintain social networks, to develop a feeling of social significance and to find meaning in life seem to be some of the protective factors which have to be investigated further. Maybe spiritual dimensions, still existing in some of the countries of Eastern Europe, can again help Western European cultures to fight anomia and feelings of existential emptiness. Probably suicidality is only one part of a more comprehensive complex of self-destructive and risk-taking behaviour. Continued research is needed.

To monitor data on this and to develop a comprehensive approach to suicide preven-
tion is a task of the WHO and its collaborating Network on Suicide Prevention.

In this context, the knowledge presented in this book as well as the partial restruc-
turing and reorientation of the WHO’s collaborative Network on Suicide Prevention in Europe is an important step in the WHO’s suicide preventative activities in a still dra-
matic European reality.

This book links to earlier WHO publications on suicidality in Europe and is the first one of two books, giving evidence, calling for action and pointing out feasible possi-
bilities for prevention. It is a part of WHO’s activities linked to the year 2001, dedicated by the United Nations and the World Health Organisation to Mental Health. Topics actualised during the World Mental Health day in April, the World Health Assembly in May and in the World Health Report in October 2001 include:

- The burden, the costs and the suffering related to mental disorder;
- The generality of mental ill health and death related to it;
- The stigma inhibiting people to ask for help in time and facilitate early interven-
tion; and
- The treatment gap between what is today possible to do and what really is done due to lack of resources but also stigma and discrimination.

In all these areas, suicide research as presented here and carried out by the WHO Network, has to make important contributions.

This book reflects the current state of knowledge in suicidology and contributes to developing evidence-based possibilities to prevent suicide. It will be followed up by all European member states of the World Health Organisation through activities in education, awareness rising and engaging all sectors of society to reverse high or rising suicide trends in many countries and many populations at risk in Europe.
Introduction

In many European countries, suicidal behaviour constitutes a major public and mental health problem and a considerable drain on resources in both primary and secondary health care settings (Schmidtke et al., 1993). Therefore, in implementing the WHO programme, “Health for All by the Year 2000 (HFA 2000)”, the European region of WHO identified prevention of suicidal behaviour as a main task (WHO, 1992). As part of the action in the implementation of target 12 of the WHO European strategy and to develop indicators for this target, comparative data on rates and trends in attempted suicide in European countries were required. However, due to cross-cultural differences in the medical treatment of suicide attempters and in research methodology, it has proven almost impossible to make valid comparisons about any aspect of suicidal behaviour between different European countries. In the absence of national data, researchers have been forced to rely on local surveys, which vary considerably in terms of their operational definitions of suicide attempts, the representativeness of the samples, the time span covered, the amount of information gathered, etc. In addition, local studies have not always been adequate from an epidemiological standpoint. Therefore, the WHO/EURO Multicentre Study on Parasuicide had a significant role in relation to the action plan to implement target 12 and in the development of indicators for this target.

History of the study

In 1985, a small group of five international experts (Dr. J. Henderson, WHO Copenhagen, Prof. Dr. H. Hafner and Dr. A. Schmidtke, Central Institute for Mental Health Mannheim, Germany, Prof. Dr. R. Diekstra, University of Leiden, The Netherlands, and Dr. P. Kennedy, York, UK) met in the WHO building in Copenhagen and discussed the possibilities of suicide prevention in the European region of WHO in the frame of target 12 of the European strategies. In 1985 a small working group in Leiden (with additionally Prof. Dr. N. Juel-Nielsen, Odense, Denmark, and Dr. S. Platt, Edinburgh, UK) then prepared on be-
half of WHO a meeting for a bigger European WHO conference in York, UK, with the aim of discussing and preparing common European suicide prevention research and strategies.

The meeting in York, UK, was organized by Dr. P. Kennedy and gathered all at this time leading researchers in suicidology in Europe. For the first time also participants from the former USSR and some other Eastern states were present. One of the outcomes of the meeting in York was the decision to start a multicentre and multinational European study to get a “real” picture of the magnitude of the problem in Europe and to generate epidemiological information about attempted suicide as well as to gather information about special groups at risk.

In order to avoid the errors made in previous studies as much as possible, a common working definition of “suicide attempt” was discussed and this common definition of suicidal behaviour had to be used by all participating centres. This definition was the proposed ICD-10 definition. Originally parasuicide (later changed to suicide attempt) was defined as “An act with nonfatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences”.

In York the structure of the study was also set up. The study was to be guided by a Steering Group (originally: Dr. J. Henderson, WHO, Prof. R. Diekstra, Leiden, Dr. A. Schmidtke, Wuerzburg, Dr. S. Platt, Edinburgh, and U. Bille-Brahe, replacing Prof. Juel-Nielsen). The background and the organization of the study have previously been described in detail by Platt et al. (1992), Bille-Brahe et al. (1993), Schmidtke (1989), Schmidtke et al. (1993) and Kerkhof et al. (1994).

In the coming years, several meetings took place to prepare the material to describe and assess the various possible catchment areas. The data collection was to be identical in all centres, using common methods of sampling and a common monitoring sheet. During these meetings the material for the other parts of the study (the material for the interviews, etc.) was also prepared, e.g. in Leiden, Edinburgh, Wuerzburg, and Copenhagen. The place of Prof. Diekstra in the Steering Group was taken over by Dr. Ad Kerkhof, University of Leiden, The Netherlands.

The study started officially in January 1989 after some months of test runs with fifteen centres from 12 countries (Sør-Trøndelag, Norway; Helsinki, Finland; Umea and Stockholm, Sweden; Odense, Denmark; Leiden, The Netherlands; Berne, Switzerland; Bordeaux and Cergy-Pointoise, France; Guipuzcoa, Spain; Wuerzburg, Germany; Innsbruck, Austria; Szeged, Hungary; Emilia-Romagna and Padua, Italy. Oxford, UK, joined later, as did another 11 centres located in Ireland, Belgium, Lithuania, Slovenia, Yugoslavia, the Ukraine, Estonia, Latvia, Greece, Turkey, and Israel. Some members of the Steering Group were in the first years more or less representatives for the project, presenting it to governments and local authorities in various countries and in the catchment areas and helping the centres in performing the huge task of educating researchers, interviewers, and with the data analyses.

The catchment areas for the monitoring part included at the beginning of the study in total nearly 6 million inhabitants (population 15+: nearly 4 million).

When the technical coordinator, Dr. S. Platt, Edinburgh, left the Steering Group, as new member Dr. De Leo, from Padua, Italy, was appointed, and Unni Bille-Brahe,
Odense, Denmark, took over the position of the technical coordinator. The centre in Wuerzburg became responsible for the Monitoring part of the study, the part which collected data on suicide attempts, and the common data collection and analyses, and the centre in Odense became responsible for the Repetition part.

The study immediately became well known in Europe, the first results were presented soon in congresses not only in Europe but also overseas and in many papers. The first comprehensive results were published in the so called Wassernaaar Book (Kerkhof, A., Schmidtke, A., Bille-Brahe, U., DeLeo, D. & Lönnqvist, J. (Eds.). Attempted suicide in Europe. Leiden: DSWO Press.

During the course of the study, some centres dropped out, mainly due to financial problems, and some dropped out of part of the study, either the Monitoring part or the Repetition part. Other centres – encouraged by the enormous spreading of the results of the study and its increasing fame - continuously applied to join. During these processes, the Steering Group, in collaboration with WHO, decided to enlarge the study.

However, one of the main problems for the new centres was, of course, to learn and to adapt very quickly to the level of knowledge which the old centres have. Here, WHO/EURO, the Steering Group, the centres which are responsible for the two parts of the study, and the WHO collaborating centres provided support in training and education.

Once a year, a so-called technical meeting, organized mainly by the Wuerzburg group, provided an occasion to learn about technical problems and to analyze methods. The centres were informed about new developments and new techniques of collecting and analyzing the data. During the meeting, an effort was made to solve problems which had arisen during the previous year. Also once a year, the main investigators met to decide on the political aspects within the study, mainly in connection with international congresses.

The WHO/EURO Multicentre Study on Suicidal Behaviour became part of the WHO/EURO Network on Suicide Prevention and Research in December 2001. At that point, the Monitoring Study comprised 27 centres from 24 countries, and it had been one of the most comprehensive and longest-running continuous monitoring studies of suicidal behaviour in Europe. This long-term cooperation and the amount of data are sometimes regarded with envy. The value of the data can hardly be estimated. Therefore, we also invite other researchers to use this data pool.

The WHO European Regional Office launched a new project, entitled the WHO/European Network on Suicide Prevention and Research, in December 2001. In this frame, the former WHO Multicentre Study now comprises the Monitoring and Evaluation Part. This now includes 37 centres in 27 countries (see chapter 32).

References


Mors voluntaris, self-killing or self-murder have been some of the words used to describe the cause-of-death when somebody has taken his own life. The word *suicida* (self-slayer) was used already by the end of the 11th century and later, during the 17th century, the word *suicide* (said to be derived from Latin *sui caedere*), was a commonly accepted term (van Hooff, 1990).

The word *suicide* does not, however, define the concept of suicide, and through the years scientists and clinicians have been discussing how to construct definitions fit for everyday work and for research. More than one hundred years ago, Émile Durkheim wrote that the word suicide refers to all deaths that directly or indirectly are the outcome of a positive or negative act carried out by the deceased, who knew that the act would have a fatal outcome (Durkheim, 1897/1951). Half a century later, Erwin Stengel (1967) in his work on differentiating between completed and attempted suicide, defined suicide as a conscious and deliberate act carried out by a person who wanted to harm himself and the self-harm was fatal. Retterstøl (1990, p.10) agreed to this definition, but added that suicide can also be defined as a self-inflicted life-threatening act resulting in death – a definition that is close to the one given in Encyclopaedia Britannica (1974): “Suicide is the human act of self-inflicted, self intentioned cessation.” Suicidologists working within a sociological framework argue that suicide is an activity comprising acts based on societal, concrete historical motives, the aim and the end being the individual’s own biological death (e.g. Hammerlin & Enerstedt, 1988). Finally, Shneidman (1994) concluded in his book ‘Definition of Suicide’ that “Suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution.”

All these definitions have the main important elements in common, namely that the self-destructive act has to be conscious and deliberate. However, the question whether motives, causes, or concepts such as ‘wishing to die’ should be part of the definition, is still in debate. In ‘Operational Criteria for the Determination of Suicide’ published by the US Centers for Disease Control (Rosenberg et al., 1988), three criteria have to be met: 1) death as the result of injury of some sort which is 2) self-inflicted and 3) intentionally inflicted. In their discussion on definitions of suicidal behaviour on the need for a new nomenclature, O’Carroll and co-workers argue that the nomenclature for suicide-related behaviour has to be based on terms of outcome and intent to die (O’Carroll et al., 1996).
The main argument against incorporating motives such as the wish to die, is that it may be difficult or in fact impossible posthumously to prove any reason or motive behind the act, or any presence or strength of the wish to die. Another problem is that, as a manner of death, suicide can be perceived both as a means and as a goal. Many researchers argue that in practically all suicides one will find elements of ambivalence, and that in most cases the motive was not a wish to die (i.e. death as a goal), but a wish to cease living – or more specifically, cessation of consciousness (i.e. death as a means).

In the definition of suicide worked out in 1986 by the Regional Office Working Group on Preventive Practices in Suicide and Attempted Suicide (WHO Regional Office for Europe, 1986) these points of view are taken into consideration:

“Suicide is an act with fatal outcome which the deceased, knowing or expecting a fatal outcome had initiated and carried out with the purpose of provoking the changes that he desired”.

It is important to note that the definition contains no criteria regarding suicidal intention, neither regarding the danger or fatality of the act. On the other hand, persons that for some reason are unable to understand the potential danger of the act (e.g. because they are psychotic or retarded) are excluded.

When trying to define non-fatal suicidal acts, the problems are even more complicated, the reason being that not all non-fatal suicidal acts are ‘unsuccessful’ suicides. In particular, this became evident in the decades after the 2nd World War, when the frequency of so-called ‘suicide attempts’ increased with an almost epidemic haste. Studies proved that these self-inflicted injuries not necessarily were motivated by a wish to die, but rather by a ‘wish to live’. In some cases, the person could see no other way out of his problems, but in other cases the intention was to provoke changes that would make life (again) worth living or at least tolerable, or simply to avoid negative conditions at least for a while. A suicide attempt, therefore, could also be seen as manipulation or ‘a cry for help’ (Stengel, 1967). Feuerlein (1971) suggested that suicidal acts could be classified according to the intent in three groups: ‘serious attempted suicide’, ‘suicidal gesture’ and ‘suicidal break (pause)’. But still, the term attempted suicide was felt inadequate because in most cases the suicide attempter in fact had no intention to die. The problem was then to work out a definition that would cover all deliberate, conscious non-fatal suicidal acts, whether the intention to die had been strong, ambivalent or non-existent. By the end of the 1960s, a confusing number of terms designed to cover these kind of suicidal acts was in use. In 1969, Kreitman and his co-workers, therefore, proposed the new term parasuicide to replace them all. Kreitman argued that suicidal acts can have various motives, varying from a wish to die to a cry for help or attention; they may be well planned or carried out impulsively; they may be potentially fatal or without any serious danger, and what was needed, therefore, was a term that could act as a kind of umbrella for all these types of non-fatal suicidal acts.

When initiating the WHO/Euro Multicentre Study, the working group agreed at the meeting in York in 1986 to adopt the term parasuicide for the study, and the following definition was worked out:

“... an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing...