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Suicide, Sociology of

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Abstract

Suicide, the act of deliberately killing oneself, is shaped by a confluence of biological, psychological, social, economic, and cultural factors. When attempting to explain suicide, psychologists emphasize individual-level factors that are partly determined by biology, such as a history of mental illness or substance abuse. In contrast, sociologists emphasize the importance of social aspects of suicide, focusing on variations in suicide rates across geographic areas and time. Numerous cross-sectional and longitudinal studies provide support for the Durkheimian perspective that social integration and regulation, proxied by religious and demographic composition, family structure, and economic conditions, are associated with suicide rates. Contagion and access to means also play a role. A multidisciplinary approach to understanding suicide is required, integrating the micro and macro, social and psychological, and quantitative and qualitative approaches.

Definition and Measurement of Suicide

Suicide derives from the Latin word sui (of oneself) and cide (killing) and is defined by the World Health Organization as the act of deliberately killing oneself or intentional self-harm resulting in death. Historical accounting of suicide is fragmented but reveals substantial variation in our attitudes and beliefs about the act. Some in ancient Greece believed fervently in the right of an individual to choose the means and timing of death, and Eskimo and Norse cultures encouraged altruistic suicide among the elderly and sick. Yet Aristotle viewed suicide as an act of cowardice and a form of treason, the Romans prohibited suicide, and major religions imposed strong sanctions and prohibitions against the act (Jamison, 1999). Today, virtually all Western societies have decriminalized suicide, most recently Ireland in 1993, but attempted suicide remains a punishable offense in some countries and is an issue of debate among the US military (Dishneau, AP April 30, 2013). Although public understanding of the phenomenon has improved, considerable misinformation and stigma still surround the act.

Researchers often distinguish between completed suicide in which a death has occurred and other forms of suicidal behavior, such as attempts, suicidal ideation, and other types of self-harm such as excessive alcohol or drug use, promiscuity, or reckless driving. Completed suicides are widely believed to be underreported with estimates of the underreporting ranging from 10 to 50%. Underreporting is common largely because it can be difficult to ascertain intent since the majority of suicides do not leave notes or have witness reports. Measurement is also complicated by the fact that different areas may have varying legal and administrative procedures to report suicide. Moreover, relatives may apply pressure on coroners to avoid the stigma of suicide, although studies suggest the influence of this is marginal (Timmermans, 2005). Most researchers have concluded that suicide underreporting is randomly distributed and that official statistics can reasonably be used (Pescosolido and Mendelsohn, 1986). Still, caution should be used when making comparisons over geographic area and time due to potential differences in reporting practices.

Schools of Thought on the Etiology of Suicide

Historically, suicide was believed to be caused by supernatural forces or by an insufficient embrace of religion; by the 1500–1600s, the notion of insanity as a cause of suicide emerged. It is clear from current research that the etiology of suicide is complex, shaped by a confluence of biological, psychological, social, economic, and cultural factors that operate at both the individual and societal levels. Thus, the topic of suicide lies at the intersection of multiple disciplines, among them sociology, psychology, psychiatry, biology, public health, genetics, neuroscience, and philosophy.

Psychological and Biological Approaches to Understanding Suicide

Not surprisingly, psychological theories of suicide emphasize psychological pain as the root cause of suicide. The early psychiatrists, Sigmund Freud and Karl Menninger, asserted that three emotions – hate, depression, and guilt – characterize suicide and that these feelings give rise to an excessively critical superego and a wish to die. In the contemporary period, Edwin Shneidman’s prominent 10-point definition of suicide emphasizes the intense ‘psychache’ experienced by suicide victims that leads them to view suicide as the only solution to their problems. Shneidman, the founder of the American Association of Suicidology, suggests that all suicides share 10 common characteristics, among them the need for a solution, unbearable psychological pain, hopelessness and helplessness, and a lifelong pattern of self-destruction (Maris et al., 2000).

As a result of this general theoretical framework, research coming out of the psychiatry/psychology fields focuses on the role of individual-level risk factors that are partly determined by biology, such as a history of mental illness or substance abuse. Using psychological autopsies in which data are collected through interviews and other sources about persons who have completed suicide, some studies indicate that close to 90% of individuals completing suicide suffered from some severe depressive disorder at the time of death. Twin and family studies show a strong genetic component to depression and
Suicide, with current research estimating the genetic contribution to suicidal behavior somewhere between 30 and 50\% (Joiner et al., 2005). Neurobiological work suggests that there are important serotonergic differences in depressed and suicidal individuals compared with others (see work by John Mann and colleagues), and some studies have linked the development and increased use of new antidepressants (selective serotonin reuptake inhibitors) to declines in suicide rates during the 1990s and early 2000s, particularly among the elderly (e.g., Gibbons et al., 2005). However, despite the clear significance of mental disorders in contributing to suicidal behavior, it remains the case that the vast majority of individuals who suffer from some mental illness do not commit suicide, suggesting the importance of other factors.

Individual-level analyses also reveal that a loss or lack of connection to others is an important underlying risk factor for suicide. Hopelessness has been identified as a significant correlate of suicide, along with other psychosocial factors such as burdensomeness, impulsivity and aggression, and ineffectiveness. These psychosocial factors may explain the strong links found at the individual level between changes in marital or employment status, physical or mental health problems, and substance abuse and the risk for suicide (Joiner et al., 2005; Maris et al., 2000). Psychologist Thomas Joiner interweaves these components in his influential interpersonal theory of suicide to identify conditions under which suicides are more likely to occur. According to Joiner’s theory, suicides are more common when both the desire for suicide, spurred by feelings of social alienation and burdensomeness, and the ability to suicide, a fearlessness regarding death whereby one is capable of suicide due to prior exposure to life-threatening accidents or self-injurious behavior, coexist (Joiner, 2007).

Yet the psychological approach cannot effectively account for group-level differences in suicide risk, be they across geographic areas or different demographic groups. Nor can the individual-level approach explain other social aspects of suicide, such as contagion and the fact that suicide rates, a collective measure, may operate on a different explanatory level from individual suicides due to the effect of social interaction.

**Sociological Approaches to Understanding Suicide**

To address some of these limitations to psychiatric and psychological perspectives on suicide, sociological approaches tend to study suicide at the aggregate level to understand variation across groups. Sociologists’ work on suicide is heavily influenced by Émile Durkheim, a founding father of sociology who argued that, although suicide is seemingly an individualistic act, it is also very much a function of a society’s social structure – what he termed a ‘social fact.’ Thus, societal level characteristics, such as marriage rates, religious composition, and economic conditions, may produce variation in suicide rates, and a vast number of studies have tested Durkheim’s ideas using data from a variety of countries and time periods. More recently, sociologists have introduced the notion of contagion in producing suicide as well as the role of networks. All these sociological approaches imply that social interaction is critical in affecting the well-being of societies and their members.

**Durkheim’s Original Thesis**

In his book entitled *Suicide*, Durkheim examined patterns of suicide in nineteenth-century Europe, finding that some societies displayed higher suicide rates than others and that a country’s suicide rate tended to correlate with other social characteristics. In explaining these patterns, he identified four types of suicide, which relate to levels of social integration and regulation within a society, as illustrated by Figure 1. Low levels of social integration within a society lead to instability and lack of cohesion, producing excessive individualism and high rates of *egoistic suicide*. Conversely, extreme levels of social integration can overwhelm individual needs, leading to *altruistic suicide*. A lack of social regulation produces anomie, an absence of norms and an inability of society to meet the population’s needs and expectations, and corresponds to high rates of *anomic suicide*. Too much social regulation, on the other hand, in which individuals may feel oppressed, may produce *fatalistic suicide*, although Durkheim asserted that this is a rare form of suicide (Durkheim, 1951). Using this framework, Durkheim was able to explain why Protestant societies exhibited higher suicide rates than their Catholic counterparts and higher proportions of married persons are associated with lower suicide rate. He used the theory to predict that suicide rates would rise during periods of economic depression and boom as a result of rising anomie.

**Critiques and Extensions of Durkheim**

Durkheim’s treatise has been criticized on a few grounds, most notably that he may have committed the ecological fallacy by drawing conclusions about individual behavior based on group-level statistics. Subsequent studies have found that differential recording practices across religious groups rather than differing levels of social integration and regulation may have accounted for some of the observed patterns (van Poppel and Day, 1996; but see van Tubergen et al., 2005). Others have
noted that some typologies of suicide, namely, fatalistic and altruistic suicide, are not fully developed and that the distinction between anomie and egoism may be false (Johnson, 1965).

Jack Douglas (1967) in particular was highly critical of the Durkheimian approach in his book The Social Meanings of Suicide. His critique rests largely on the argument that suicide does not have a tidy definition – rather, it is a multidimensional and complex phenomenon. As a result, official statistics like death records or death certificates cannot reliably indicate the extent of suicide, as evidenced by the fact that coroners and medical examiners tend to underreport suicide and apply varying criteria to make the determination. Without a well-measured dependent variable, Douglas argues that quantitative approaches to suicide and their attempts to link the phenomenon to measures of social isolation or regulation should be abandoned. Instead, researchers should consider the subjective meaning of suicide by applying an ethnethodological approach that focuses on the first-person accounts of actual suicidal individuals, namely, those who have made a prior serious attempt at suicide. Despite this criticism, it remains the case that the vast amount of sociological work on suicide is quantitative in nature.

Half a century after the publication of Durkheim’s Suicide, Henry and Short (1954) revisited Durkheian themes by examining how anomie and frustration can produce different types of aggressive responses. Like Durkheim, Henry and Short recognized the importance of external restraints (such as religion and particularly the economy) on suicide rates, but they introduced the notion of internal restraints (psychological components such as a strong conscience or propensity toward guilt) and the ways in which they may interact with varying levels of external restraints to produce different forms of aggression. Those experiencing weak external restraints (e.g., high social status and/or social isolation) and strong internal restraints (a well-developed superego) are more likely to take responsibility for frustration and internalize aggression (suicide) while those with strong external restraints and weak internal restraints are more likely to blame others for frustration and externalize their aggression (homicide). Although the theory is among the first to document the ways in which business cycles may affect social status and in turn levels of frustration and aggression, it has been criticized on empirical grounds since suicide rates tend to be higher among those of lower socioeconomic status; it cannot explain within-group variation in suicide/homicide rates and focuses primarily on level rather than change in status.

Gibbs and Martin (1964) expanded Durkheim’s conceptualization of social integration by introducing the notion of status integration to explain societal-level variation in suicide rates. Individual behavior is largely governed by one’s social identification or status, which carries with it a set of demands and expectations. An individual may occupy multiple social roles or statuses in the realm of family, work, community, and elsewhere. Status integration is determined by the degree to which the demands associated with one status are at odds with those dictated by another status; when roles are incompatible, social relationships are disrupted. Gibbs and Martin predicted that when a large proportion of the population faces a conflict in roles or lack of status integration, suicide rates rise. The authors pay close attention to the operationalization and advocate empirical testing of these concepts. Studies find support for the role of both occupational and marital integration in affecting levels of suicide (e.g., Gibbs, 2000).

Empirical Tests of the Durkheimian Perspective

Since Durkheim’s original formulation, a large number of empirical studies have been conducted to determine the extent to which his theoretical framework is supported. Perhaps the earliest application to the United States following Durkheim emanated from the Chicago School of Sociology. Faris (1955) showed that socially disorganized neighborhoods in Chicago during the 1930s exhibited higher levels of social problems, including suicide and mental illness. These types of studies have proliferated in recent decades with the advent of large data sets and increased computer capabilities. The studies adopt both cross-sectional approaches, examining variation in suicide rates across countries or smaller geographic areas such as states or counties, and longitudinal designs, exploring factors that can explain variation in suicide rates over time within a given locale. Taken as a whole, the studies provide substantial support from many of the ideas put forward by Durkheim.

The Role of Religion

The role of religion in affecting suicide rates was central in Durkheim’s argument. He presented evidence that Catholic societies exhibit lower suicide rates than their Protestant counterparts and attributed the difference to the degree of social integration and regulation present within the two Churches. While the Catholic Church is more communal and steeped in rituals with strong prohibitions against suicide, the Protestant Church, although prohibiting suicide, is more individualistic in orientation and places the responsibility for salvation on individual members. This tenet of Durkheim’s Suicide – the idea that Catholics are more socially integrated and regulated and present lower suicide rates as a result – was once viewed as so infallible as to be coined sociology’s ‘one law’ (Pope and Danigelis, 1981).

Recent research adds greater nuance to this finding, showing important differentiation by denomination. At the aggregate level, studies reveal that a greater proportion of more conservative Protestant faiths (such as Evangelical and Fundamental Christians) tend to protect against suicide while a greater prevalence of more liberal Protestant faiths (such as Mainline or Institutional Protestant churches) seem to raise suicide rates. The proportion of those adhering to Judaism tends to fall in between, having a small but protective effect (Pescosolido and Georgianna, 1989). A recent analysis of suicide rates across US states and over time between 1976 and 2000 showed that states with rising numbers of Catholics and greater declines in Episcopalians exhibited larger declines in suicide rates over the period (Phillips, 2013).

Contemporary work also offers insight into the mechanisms by which religious composition may affect suicide rates. The degree of religious heterogeneity appears to matter – an analysis of almost 300 metropolitan areas (MSAs) in the United States in 1979–81 revealed that MSAs with more homogeneous religious composition exhibit lower suicide rates, particularly in the Northeast and the South (Ellison et al., 1997).
Pescosolido (1990) attributes these differences to the strength of social networks – the more coadherents there are in an individual's direct environment, the more strongly involved and the greater support that individual will receive from the religious community, which in turn will lower the risk for suicide rate. van Tubergen et al. (2005) tested competing hypotheses about how and why religious communities (i.e., those with a high level of religious involvement) may be associated with lower suicide rates. Is the protective effect due to the fact that more religious communities and their social networks enhance the social and emotional support that their members experience, as Pescosolido (1990, 1994) proposes? Or do more religious communities impose stronger prohibitions against suicide than secular communities? Their study employs a rare multilevel analysis of suicide rates in the Netherlands to show that religious communities have a more general protective effect against suicide. As the proportion of religious individuals within a municipality increases, the risk of suicide declines within that municipality, regardless of an individual's own denomination and for non-Church members as well. These findings are consistent with the idea that a shared religious norm prohibiting suicide extends to all within the community and lowers the suicide risk, rather than the idea that social support from homogeneous others protects people from suicide.

The Role of Family Structure

Marital status and family are known to be among the strongest protective factors against suicide at both the individual and aggregate levels. Just as Durkheim observed in nineteenth-century Europe and explained using the idea of social integration, widowed and divorced individuals, men in particular, exhibit among the highest suicide rates while married individuals (over age 20 years) with children present the lowest rates. Of course, family relations are protective against suicide only when they are positive and strong. Evidence shows, not surprisingly, that family tension and conflict can elevate the risk of suicide at the individual level (Gibbs, 2000; Maris et al., 2000). For example, the risk of suicidal attempts among adolescents was reduced in families with higher levels of emotional and material support (forms of social integration) and with firm boundaries and greater parental supervision (Thorlindsson and Bjarnason, 1998).

At the aggregate level, research typically confirms that the higher the rate of divorce, the higher the rate of suicide, on average. This is particularly true for cross-sectional studies that examine variation across nations, states, and/or cities, but longitudinal studies that explore how changes in divorce over time are associated with changes in suicide rates often show a link as well. For example, Phillips (2013) found that US states with higher percentages of divorced persons exhibited higher firearm and nonfirearm suicide rates between 1976 and 2000, but that changes over the time period in the percentage divorced were positively associated only with nonfirearm suicide rates. Lester (1995) demonstrated that the divorce rate of a place is associated not only with the suicide rate of divorced people but also with those of the married, widowed, and single populations, suggesting that the divorce rate is a general indicator of the vitality of marriage as an institution and perhaps societal well-being.

The Role of the Economy

Durkheim hypothesized that suicide rates would rise during periods of economic depression and economic boom because both extremes can be viewed as indicators of anomie. With rapidly changing economic prospects in either direction, a society may be unable to adapt quickly enough to sufficiently meet its members’ needs and expectations, weakening social regulation. Furthermore, the rise in unemployment during periods of economic recession has implications for social integration. Social integration may be undermined directly as unemployed individuals have more limited access to social support systems and indirectly because unemployment can produce relationship problems and or financial difficulties that create stress, as well as harmful coping mechanisms, such as increased alcohol consumption. Studies show, for instance, an increase in excessive alcohol consumption during periods of economic downturn (Popovici and French, 2013). To test these assertions, research has adopted multiple measures of the economy, including unemployment rates, gross domestic product, real income, and sales, to determine its association with suicide rates.

Although cross-sectional analyses typically find limited support for a connection between economic conditions and suicide rates, longitudinal studies generally do find an association, supporting the more intuitive notion suggested by the Henry and Short model that suicide rates rise only during periods of economic recession (Stack, 2000a,b). One of the most comprehensive studies by Luo et al. (2011) examined business cycles and suicide rates in the United States between 1928 and 2007, showing that the total suicide rate tends to rise during periods of economic recession and fall during expansions. The study found some variation in the relationship by age group, with this association observed for those between the ages of 25 and 64 years, but no such relationship for those aged 15–24 years and over age 65 years. We might anticipate this variation by age, as those between the ages of 25 and 64 years are likely to be family breadwinners and supporting dependents and thus face greater hardship during periods of economic recession while the young and elderly are less likely to be in the labor force and often have the support of family and in the case of the elderly, social security. Although this analysis does not include the period of the 2009–10 Great Recession in the United States, US suicide rates have risen for those between the ages of 35 and 64 years during this period. A leading explanation for the recent spike among this particular age group relates to economic factors.

Studies using individual-level data confirm a powerful link between unemployment status and suicide risk (Maris et al., 2000). This relationship is particularly strong for men, who, historically at least, have been the family breadwinner with closer ties to work and careers than women and thus may experience more stress and feelings of failure when faced with unemployment. However, the pathways linking employment status to suicide at the individual level are less clear. While unemployment may increase suicide risk by creating financial strain, feelings of worthlessness, and relationship difficulties, it is also possible that those who possess a risk for suicide (e.g., through depression or substance abuse) may be more likely to become unemployed.
**The Role of Social Stratification**

Durkheim was relatively silent about the effect of social and economic stratification on suicide. He hypothesized that the poor would exhibit relatively low levels of suicide – essentially because he viewed poverty as a form of social regulation that protects against anomie during periods of recession. Henry and Short (1954) argued that the poor possessed strong familial and community relations but a disadvantaged social status, leading them to blame external factors for their difficulties. As a result, the poor were predicted to exhibit high homicide rates but low suicide rates. In reality, these predictions are not borne out by empirical data. The poor exhibit higher death rates from both homicide and suicide. Research on the effects of income inequality on suicide is limited and results are mixed, but scholars have explored race, gender, and life course disparities in suicide.

**Race**

Suicide rates are highest for Native Americans and whites and relatively low for Hispanics and blacks. Whites have rates three to four times those of blacks, a pattern that has remained remarkably stable over time. Scholars have put forward a number of explanations for the relatively low rates of suicide among blacks and Hispanics despite their economic disadvantage relative to whites. Some stress factors of social integration, such as the strong extended family networks and religious involvement within certain minority communities. Others note that suicide is highly stigmatized among the black community and viewed as ‘a white thing’ (Gibbs, 1997).

At the aggregate level, Kubrin et al. (2006) found that disadvantage (measured by factors such as male joblessness, poverty, educational attainment, and household structure) is associated positively with suicide for both young black and white men, but that industrial employment levels and changes therein as a result of deindustrialization are significant predictors of black male suicide rates only across US cities. Among Hispanics, higher levels of income inequality (relative to whites) are positively associated with suicide rates for the native-born but for foreign-born Hispanics, higher levels of black–Hispanic economic inequality are tied to lower suicide rates (Wadsworth and Kubrin, 2007).

**Gender**

With regard to gender, males are three to four times more likely to die by suicide than are females. Women, however, attempt suicide at higher rates but tend to use less lethal means such as poisoning, which are less likely to result in death. In terms of a sociological understanding of this differential, Durkheim, writing at the turn of the twentieth century, explained women’s lower risk of death by suicide by suggesting that women are ‘simpler social beings’ with ‘a less developed mental life.’ As a result, women possess weaker ties to the collective and their behavior is not so heavily influenced by the social structure. Durkheim’s arguments are now dismissed, and scholars today note that women may be protected from suicide because they tend to possess stronger and more frequent ties with family, friends, and community than do men and exhibit lower rates of alcohol abuse and higher rates of help seeking, among other explanations.

As women’s status has changed over time, with increases in female labor force participation and divorce rates, one may expect to see changes in the sex suicide differential. Using data on 18 nations over a 40-year period, Pampel (1998) found that male and female suicide rates start to converge as changes in labor force participation and marital stability emerge. However, as women become increasingly involved in the labor force and institutions adjust, the female advantage in suicide reappears as their rates fall relative to men’s, a pattern that occurs more quickly in collectivist societies. These findings are consistent with the conjectures of Gibbs and Martin, who argued that as status configurations (e.g., a married woman with children in the labor force) become more common, those in them may experience less role conflict and stress and lower suicide risk as a result.

**Birth Cohorts**

Demographers have focused attention on variation in suicide risk across birth cohorts or social generations. Cohort members share not only common contemporaneous but also historical sociocultural contexts that can influence behavior. Unlike prior work on suicide that tends to be divided along biological and social lines, the concept of a birth cohort implicitly connects biology and social structure by recognizing that the implications of a particular social or historical event can be distinct depending on the stage of life course at which that event occurs, with events during adolescence generally believed to be most formative in shaping attitudes and beliefs.

Most well known is Richard Easterlin’s theory of relative cohort size in explaining variation in cohort behavior, which suggests that members of relatively large birth cohorts experience a number of social and economic disadvantages that persist throughout the life course (Easterlin, 1987). In childhood and adolescence, social integration and regulation are reduced due to factors such as large classroom size and reduced parental attention due to bigger average family size; in adulthood, members of large birth cohorts face greater competition in college and in the labor market. Age-period-cohort analyses of suicide rates find support for this theory, with cohorts of larger relative size and with a greater proportion of nonmarital births exhibiting higher suicide rates, net of age and period effects (Stockard and O’Brien, 2002a,b). Others have noted the possibility of a cohort-based argument for the unusual and marked increase in suicide rates between 1999 and 2010 in the United States among middle-aged baby boomers (Phillips et al., 2010).

**The Theory of Contagion and Suicide Clusters**

A contemporary of Emile Durkheim, Gabriel Tarde (1903 [1895]) introduced an alternative perspective on suicide in a book entitled *Laus of Imitation*, in which he proposed that individuals will imitate those behaviors and attitudes to which they are exposed in their social environment. The closer the proximity to those behaviors and the more frequent the exposure, the greater the likelihood of imitation. Although Durkheim largely dismissed the notion of imitation, historical and contemporary analyses of suicide rates over time or space reveal that suicides can occur more frequently or cluster in close temporal or geographic proximity. More contemporary versions of imitation theory or suicide contagion are known as the
'Werther effect,' named for the rise in suicides in 1774 following the publication of Goethe’s novel about copycat suicides, whereby suicide rates may increase in the wake of well-publicized individual suicide cases. Simple awareness of a suicide act raises the possibility in the public’s mind, akin to Joiner’s notion of fearlessness. These ideas have been important in affecting guidelines for media reporting of suicide, which specify that details on method and location should not be included in public reports.

The sociologist David Phillips has been most influential in the recent period in promoting these ideas. Phillips (1974) demonstrated that coverage of celebrated suicides (such as Marilyn Monroe) on the front page of the New York Times newspaper was associated with a statistically significant increase in the national suicide rate 7–10 days after the publicity. The increase in suicide was greater the more extensive the front-page coverage and in geographic areas where the story ran. In another compelling study, Phillips (1982) tracked the association between the airing on television soap operas of fictional suicides and the actual suicide rate over a 10-year period, finding that the actual suicide rate spiked in the days following exposure to a soap opera suicide. Although the studies are suggestive of contagion, the ecological nature of the studies with minimal statistical controls limits our conclusions. However, research that includes more extensive controls for factors like unemployment shows more convincingly that contagion producing suicide clusters is more likely among teens and when the suicide involves a celebrity.

**Suicide Prevention**

While sociologists and psychologists have focused primarily on understanding the causes of suicide, public health practitioners are more likely to consider effective means of suicide prevention and postvention efforts. Historically, suicide prevention efforts rely on psychological approaches to understanding suicide and target those who possess well-known individual-level risk factors for suicide, such as a prior attempt or history of depression. Wray et al. (2011) lament the absence of sociological theories and explanations in suicide prevention research and call for a more active role moving forward, particularly in light of the expansion of community-based approaches to suicide prevention.

Perhaps the one exception to this individualistic approach to suicide prevention is the focus among public health scholars on the ways in which reducing access to lethal means of suicide can be a powerful prevention tool. This is most famously illustrated by the British Coal Gas story (Kreitman, 1976). During the 1950s, the British government began to move away from coal gas, which contained large quantities of carbon monoxide, and toward natural gas for domestic purposes. In the 10 years following this conversion, the national suicide rate declined markedly for all age–sex subgroups, sometimes by as much as one-third. The leading means of killing oneself – poisoning by gas inhalation – had been removed and suicides by other means increased only slightly, leading to an overall decline in suicide rates, particularly among females.

In the United States, Matthew Miller and colleagues at the Harvard School of Public Health have been most vocal recently in promoting the important role that means reduction must play in any comprehensive suicide prevention program (http://www.hsph.harvard.edu/means-matter). Research shows that a substantial number of suicide attempts are impulsive, that access to a lethal means, such as a firearm, is an important risk factor for suicide, and that individuals do not necessarily substitute an alternative method if access to a firearm is removed. For example, ecological studies show that for both sexes and all age groups in the United States, states with higher rates of household firearm ownership have higher suicide rates by firearm and overall, yet rates of nonfirearm suicide are not associated with gun ownership rates, indicating that displacement (from one method to another) does not occur (Miller et al., 2007). In sum, research shows importantly that any mechanism to slow down an action, whether requiring trigger locks on guns, placing barriers on bridges, or packaging pills individually, can be an effective way to prevent suicide.

**Conclusion**

A recent report by the Institute for Health Metrics and Evaluation on the Global Burden of Disease is a grim reminder of the importance of the topic. Worldwide, suicide was responsible in 2010 for more deaths than war, homicide, and natural disasters combined, and it was identified as the leading cause of death for those aged 15 to 49 years. Thousands of articles have been published on the topic of suicide, appearing in a wide variety of journals across multiple disciplines and underscoring both the complexity of and the continued interest in the mystery of suicide. Sociology has played a critical role in the understanding of the phenomenon, reminding us that even the most individualistic and intimate behaviors are products of the society we inhabit. Yet, as Wray et al. (2011) note in the Annual Review of Sociology, scholars are increasingly recognizing that a multidisciplinary approach to understanding suicide is required. Achieving that goal means that moving forward, sociologists must make concerted efforts to integrate the micro and the macro, the social and the psychological, and to employ both quantitative and qualitative methods in their quest to understand and ultimately prevent suicide (Wray et al., 2011).

See also: Adult Mortality in Industrialized Societies; Anomie; Gene–Environment Interplay; Inequality, Social; Life Course: Sociological Aspects; Medical Sociology; Mortality, Epidemiological, and Health Transitions; Social Relationships in Adulthood.

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