

ORIGINS OF SUICIDALITY: COMPATIBILITY OF LAY AND EXPERT BELIEFS - QUALITATIVE STUDY

Tina Zadavec & Onja Grad

University Psychiatric Hospital Ljubljana, Ljubljana, Slovenia

received: 4.4.2012;

revised: 20.3.2013;

accepted: 21.4.2013

SUMMARY

Background: Today there exist different views on origins of suicidal behaviour, which can influence the help-seeking behaviour and the adherence to the treatment of suicidal people.

Subjects and methods: The beliefs lay people and patients have about the origins of suicidal behaviour as well as the compatibility of their beliefs with the views of the mental health personnel (general practitioners and psychiatrists) were assessed. 45 semi-structured interviews with the general population, suicide attempters, general practitioners and psychiatrists were conducted, audio typed, transcribed and a thematic analysis of the data was carried out.

Results: The results indicated the incompatibility of the views. The general population and the suicide attempters favoured psychological explanations of suicidal behaviour, whereas the general practitioners and psychiatrists promoted medical explanations. The only common theme was perception of the suicidal crisis as a crucial factor in suicidality.

Conclusions: Lay people and experts believe that suicidal crisis is the main origin of suicidal behaviour. The awareness of this common denominator and also of the differences in opinions between lay people and experts should be kept in mind when planning and implementing prevention and treatment programmes if we wish to promote help-seeking behaviour and attain good adherence to treatment.

Key words: suicide - public opinion - lay people - health personnel

* * * * *

INTRODUCTION

Attention to the beliefs which people hold about mental health is growing since these beliefs have been found to be one of the factors significantly influencing help-seeking behaviour and adherence to treatment (Caldwell & Jorm 2000, Goldney et al. 2002). In recent years several research groups have focused on the 'mental health literacy'¹ of both the general population and mental health professionals about mood disorders and schizophrenia (Goldney et al. 2002, Jorm & Griffiths 2008, Jorm et al. 1997, Matschinger & Angermeyer 1996, O'Reilly et al. 2010), two mental disorders closely related to suicidal behaviour (Marčinko et al. 2003, Marčinko & Vuksan-Ćusa 2009, Tanney 2000). There are some similar studies on suicidal behaviour (Eagles et al. 2003, Hjelmeland & Knizek 2004, Knizek et al. 2010, Owens et al. 2005, Tzeng & Lipton 2005, Zadavec et al. 2006) but the majority of studies focus on attitudes towards suicide, measuring predominantly normative evaluation of suicidal behaviour with only single items or factors referring to opinions about possible causes and treatment of suicidal behaviour (Diekstra & Kerkhof 1989, Domino et al. 1982, Salander Renberg &

Jacobson 2003). One of the reasons for the lack of such studies could be that the complexity and multidimensionality of suicidal behaviour results in many co-existing evidence-based theories on suicide. These theories vary in the individual or sociological factors they prioritise; for example medical, biological and genetic (Mann 2002), psychological or psychodynamic (Beck et al. 1974, Maltzberger 1992, Shneidman 1985, Williams & Pollock 2001), sociological factors (Durkheim 1951) and the treatment and prevention interventions they consequently favour. The concept 'mental health literacy' assumes the superiority of psychiatric knowledge that lay people and experts should follow and could devalue the subjective experience of the distressed people (Jorm 2000). Since none of the existing theories is recognized as revealing the complete explanation of suicidality we have used Moscovici's theory of social representations instead (Moscovici & Duveen 2000), which is popular in research on health psychology (Joffe 2002). Social representations are defined as complex entities of hierarchically and relationally arranged opinions, attitudes, stereotypes and explanation models about everyday phenomena including the understanding of the specific processes by which these contents are shaped as well. They enable individuals to orient themselves and facilitate communication among members of the community. These socially and culturally shared representations influence the perception and behaviour of the individual. The social representations of health and illness vary also according to personal experience

¹ 'Mental health literacy is a concept introduced by Jorm (2000) and is defined as 'Knowledge and beliefs about mental disorders which aide their recognition, management and prevention.'

and the familiarity people have with professional activity and as such are assumed to differ between the social groups. The effectiveness of the therapeutic process is not defined only by the content of representations about the problem but also by the compatibility between the views of the distressed people and experts (Krause 2002). The social representations are continuously transforming due to emerging scientific knowledge to which experts should have direct access; such knowledge however is disseminated to lay public by the mass media. The mass media does not present the scientific knowledge as it is, but simplifies it and saturates it with the core values and social norms of the culture. Lay people actively forge the transmitted knowledge and instead produce the common sense ideas that they follow. Similar concepts to social representations are explanatory models (Kleinman 1980) and patients' narratives (Frank 1995, Murray 2003). In order to assess the representations of suicidal behaviour in the relevant social groups we looked into the explanations of suicidal behaviour favoured by psychiatrists and general practitioners, both of whom are involved in treatment and in prevention of suicidal behaviour, and the compatibility of their views with the way that suicidal behaviour is conceptualized among the potential users of medical services, namely the general population and suicide attempters.

SUBJECTS AND METHODS

Subjects

Four groups of participants, namely from the general population, suicide attempters, general practitioners and psychiatrists were included in the study. They varied in degrees of (1) familiarity with the professional knowledge and (2) experiences with suicidality. The minimum number of participants per group was set at 10. All of the participants were informed about the purpose and risks of the research. They provided written consent for their participation. The research was approved by the National committee of ethics. The study was carried out in 2005.

The inclusion criteria for people from the general population were: (1) no suicide attempts in the past; (2) no suicide attempts or suicide in the immediate family; (3) no formal education on the subject of suicidality; and (4) no professional or voluntary work with people at risk of suicide. People of different gender, ages, education, employment status, household composition and civil status were recruited from among the acquaintances of the researchers or their friends. All of the 14 people invited agreed to take part in the research.

Suicide attempters were approached at the Crisis intervention unit and psychiatric intensive care unit of the University Psychiatric Hospital Ljubljana. The diagnosis of parasuicide was made by a psychiatrist according to the World Health Organization (1986) definition where parasuicide is 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 recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences'. The psychiatrists also examined the mental state of the patient but did not exclude any of the patients as all were mentally and intellectually able to participate. Three patients refused to take part in the study, one due to the taping of the interview and the other two due to a 'bad mood'. All together 10 patients were interviewed 1 to 7 days after the suicide attempt.

None of the 11 invited general practitioners refused to take part in the study. Some were approached via acquaintances and others because of their involvement in the teaching process of the next generations of general practitioners (faculty staff). The heterogeneity of the sample was ensured by differences in gender, age, private or public practice, urban or rural areas and users of the medical services (children and adolescents or adult population).

All but one of the psychiatrists in the sample worked at the University Psychiatric Hospital Ljubljana, which was at the time of the research the only teaching hospital for mental health personnel. The psychiatrists worked either on an inpatient or outpatient basis with patients of different age, gender and psychopathology. Only one psychiatrist declined the participation due to lack of time. All together 10 psychiatrists were interviewed.

Procedure

The semi-structured interviews were conducted in order to allow as free an expression of opinions as possible. Only the basic topics were determined in advance (origins, suicidal process, treatment, prevention, and stigmatization). No attempt was made to standardise the wording or the sequence of the questions. The interviews with people from the general population were conducted at the participant's home, a researcher's office or in a public place (a library). The interviews with patients took place at the hospital ward. The general practitioners and psychiatrists were interviewed at either their or a researcher's office. Interviews took from 30 to 110 minutes, with an average time of 45 minutes. None of the participants requested to end the interview prematurely or reported any distress at the end. The interviews were carried out by one of the principal researchers of this study. For the purpose of this study only the themes relevant to origins of suicidal behaviour are presented.

Data analysis

The interviews were audio taped and transcribed. As this is a comparative study, thematic analysis was carried out (Flick 2002). Paragraphs were used as the

unit of analysis. First open coding and then selective coding was applied aiming at developing the thematic structure. The thematic structure developed from the first case was modified and elaborated continuously for all further cases. The transcripts were reread and recoded during the process until no new themes and sub-themes emerged. The described process was carried out by two researchers, at first separately. After each researcher finished the process the themes and thematic structure were compared again and further process of elaboration and comparison was carried out until the two researchers agreed on the themes and sub-themes identified.

RESULTS

Description of the sample

All together 45 interviews were carried out. The socio-demographic characteristics of the sample are presented in Table 1. In keeping with the study design, the sample characteristics are diverse.

Seven suicide attempters had attempted suicide at least once before and 8 had already undergone psychiatric treatment. The general practitioners have worked in this field on average for 20 years (median). Seven general practitioners worked in the public health system and 4 in private practice. Eight general practitioners worked in a large city or its suburbs and 3 in smaller towns. One general practitioner worked predominantly with students, 3 with children and adolescents and the rest with adults. The psychiatrists have worked in this field on average for 10 years (median). Three psychiatrists worked with outpatients, 6 with inpatients and 1 was retired. Two psychiatrists worked with children and adolescents and 1 with geriatric patients. Two worked in the crisis intervention unit, 1 with alcohol addictions and 1 at the psychiatric intensive care unit. Two worked with the adult outpatient population.

Identified themes

The identified themes and sub-themes are shown in Table 2 in random order and are described below with few citations from participants added as examples.

Causes

All four groups referred to external adverse events as causes for suicidal behaviour at some point during the interview. Losses related to important relationships, financial situation or health problems were most often mentioned. Internal states as causes were mentioned less frequently. Six people from the general population claimed that suicidal behaviour may be a consequence of boredom, contemplating too much and a lack of life-goals. Only two suicide attempters stated that feelings of inner dissatisfaction, disappointment and insecurity about the future were the main motivators for suicidal

behaviour. The general practitioners stressed the combination of genetics, personality and circumstances. However during the actual interviews they spoke continuously about suicidal behaviour as a consequence or a part of mental illness, depression being the most often mentioned. Besides the external events the psychiatrists promoted mental illness as a possible cause for suicidal behaviour, especially illnesses that change the mental state of the person such as depression or psychosis (cit.1).

‘There could be external events like higher pressure than usual, more stress or there could be internal reasons, for example depression changing perspective.’ (cit 1; psychiatrist)

Table 1. Socio-demographic characteristics of the sample

Socio-demographic characteristics	P	SA	GP	PS
gender				
male	7	5	5	5
female	7	5	6	5
age (in years)				
18-19	2	0	0	0
20-29	2	2	0	0
30-39	2	4	3	4
40-49	2	1	4	3
50-59	2	3	4	1
60-69	2	0	0	2
70 or more	2	0	0	0
civil state				
single without partner	1	3	2	2
single with partner	2	1	1	1
married	6	2	7	4
divorced	1	2	0	2
widowed	2	1	0	0
cohabiting	2	1	1	1
household composition				
living alone	1	1	1	2
living with partner	3	1	1	3
living with partner and child(ren)	6	2	7	4
living with child(ren)	1	1	1	0
living with parents	3	2	1	1
living with other relatives or friends	0	3	0	0
education level				
unfinished primary school	2	0	0	0
primary school	0	1	0	0
secondary 3 year school	2	2	0	0
secondary 4 year school	7	5	0	0
higher education	3	1	11	10
employment status				
employed	6	5	11	9
unemployed	0	3	0	0
student	2	1	0	0
retired	6	1	0	1

Note: P=general population; SA=suicide attempters; GP=general practitioners; PS=psychiatrists

Table 2. Themes and sub-themes identified in the interviews

Main themes	General population	Suicide attempters	General practitioners	Psychiatrists
Causes	- external events - internal states	- external events - internal states	- external events - depression	- external events - mental illness
Personality (traits)	- weak - spoiled - ambitious - impulsiveness - poor problem solving - narrow-mindedness	- weak - poor problem solving	- different/special - weak - poor problem solving - introversion - aggression - self-destructiveness	- impulsiveness - aggression - poor coping with stress - pessimism - weak ego strength
Crisis	- negative affect - cognitive constriction - hopelessness	- negative affect - cognitive constriction - hopelessness	- crisis - depression	- negative affect - cognitive constriction - hopelessness - depression
Mental illness	<i>not important</i>	<i>not important</i>	- causally related	- present
Genetic	<i>not important</i>	<i>not important</i>	- causally related	- vulnerability
Family	- upbringing - adverse events - role model	- upbringing - adverse events - unfulfilled needs	- role model	- role model
Society	- values - disconnectedness - living conditions	<i>not important</i>	- values - disconnectedness - living conditions	<i>not important</i>

Personality

Personality is the most important concept in the general population's and suicide attempter's explanation of suicidal behaviour. In their opinion personality acts as a mediator between the individual and the environment and determines success in coping with problems. It is the source of chronic suicidality. Due to personality some people tend to overreact to everyday problems with suicidal behaviour. These people have a weak, overly sensitive and emotionally unstable personality. Spoiled and overly ambitious people are at risk for suicide as well. Spoiled people give up the first time they encounter a larger problem and are incapable of patiently following goals. Overly ambitious people try to surpass their capabilities and thus get into trouble. Some suicide attempters are impulsive and cannot control themselves. People who attempt suicide are poor problem solvers and are either too passive or too pessimistic. They might also be narrow-minded. Suicide attempters described themselves as generally weak personalities and also admitted to having poor problem solving skills (cit.2). Most general practitioners believed that the underlying tendency to suicide is some kind of personality trait or structure not visible on the outside. They suggested a variety of personality traits like weak personality, poor problem solving skills, general self-destructiveness, introversion, lack of assertiveness or aggression (cit.3). Psychiatrists believed that biologically based personality traits such as impulsiveness and aggression were strongly related to suicidal behaviour. They stressed poor coping or problem solving skills and pessimism as well. One mentioned weak ego strength.

'I don't know. Character. Basically personality itself. I'm not emotionally stable. I have intelligence,

ideas, good thinking, but I'm too sensitive.' (cit.2; suicide attempter)

'They do not have spine these people. Values. They have poor mental and physical capacity. They can not cope with suffering. They can't solve problems. They run, either into addictions, self-destructive, risky behaviours or illness and death.' (cit.3; general practitioner)

Crisis

By the opinion of the participants crisis is the ultimate reason for suicidal behaviour. The general population strongly believed that without crisis people would not commit suicide and were able to describe in detail the elements of suicidal crisis (cit.4). Most of the suicide attempters talked about the intolerable state of rumination, perturbation and a feeling of aloneness with the ensuing wish to end this state immediately (cit.5). Only one suicide attempter argued that his suicide attempt was rational, pre-contemplated and accompanied by a strong and lasting desire to die. The psychiatrists described the state of negative affect and cognitive constriction of the suicidal crisis as the final point of the suicidal process. Some psychiatrists mentioned that mental state, changed due to depression or psychosis, could lead to suicidal behaviour as well. The general practitioners mixed the elements of acute suicidal crisis and symptoms of depression. Depression was more accurately described and recognized. Psychiatrists and general practitioners argued that changed mental state impairs judgment and makes problems seem insolvable at that moment.

'An enormous crisis. Non-resolvable. Without solution.' (cit.4; general population)

'I want more willpower, not to have all this anxiety. I wish my head was empty, not like now, when it is full.

The same thoughts on a merry-go-round.’ (cit.5; suicide attempter)

Mental illness

The general population did not mention mental illness as being related to suicidality. The same opinion was shared by suicide attempters. Though they sometimes referred indirectly to anxiety disorders or alcohol addiction as an additional problem that had complicated their lives they did not use the term mental illness; nor did they see these problems as psychopathology (cit.6). The general practitioners perceived mental illness, especially depression causally related to suicidal behaviour, and acknowledged that their primary responsibility in suicide prevention was early recognition of depression. They were convinced that serious mental illness like depression or psychosis entails a predisposition to chronic suicidality. The psychiatrists believed that the symptoms of mental illness could be found in the majority of suicide attempters and that a psychiatric diagnosis could be made (cit.7). But they expressed that the mere presence of mental illness does not imply causal relations. Rather mental illness could be a risk factor for suicidal behaviour. The suicidal process might also be parallel to mental illness or could be a sad consequence of the losses that mental illness brings.

‘And also alcohol. An even bigger problem. There was no work, no money. When I got some money I drank. Then we fought at home even more. A disaster basically.’ (cit.6; suicide attempter)

‘Well, they are not completely healthy. Not necessarily mentally ill. They suffer from some disorders that psychiatry deals with. If somebody is in a crisis you can find enough symptoms to classify him in some psychiatric category. It could be cause; it could be parallel to suicidal behaviour. At least some personality traits that are dysfunctional.’ (cit.7; psychiatrist)

Genetic factors

The general population did not consider genetic factors significant. Neither did most suicide attempters. They interestingly claimed that genetic factors did not contribute to their own suicidal behaviour but were a principal predisposition to chronic suicidality in other people. Only one suicide attempter believed that the main cause for his suicide attempt were genetic factors. The general practitioners believed that suicidality runs in the family (cit.8). Two were convinced that genes play a major role in suicidal behaviour. Others suggested that only some subpopulations share suicidal genes. Two mentioned the influence of Ural genes in Slovenian people, the idea that stems from the Finno-Ugrian suicide hypothesis which assumes that the countries with the highest national suicide rates in Europe have similar genetic communalities. They border one another and form a J-shaped belt from Central to Northeastern Europe (Marušič 2005). The psychiatrists were familiar with the evidence-based research on a genetic basis for suicidal behaviour but did not find them useful in their everyday clinical work.

They thought that genes expressed themselves in the vulnerability to trait impulsiveness and aggression or vulnerability to mental illness.

‘I think suicidal behaviour is related to genetics. It is never only environment; it has to be something in the individual that goes in this direction.’ (cit.8; general practitioner)

Family

The general population and the suicide attempters argued that upbringing in the primary family determines deeply the lives of the children. Both groups agreed that very strict and punishing parents raise children with weak personalities. The general population pointed out that permissiveness results in spoiled or overly ambitious personalities. Adverse events like abuse of children, violence in the family, psychopathology of parents and divorce contribute to suicidal behaviour in adolescents or later in life. The life-stories of suicide attempters were filled with details of a sad and traumatic childhood (cit.9). Only one did not mention his family as important and one stated that her family was overly protective but pleasant to live in. Three suicide attempters recognised that they transferred the pathological relations from the primary family to the present family. They also tried to fulfil the needs for love from childhood in their present families which had proven to be too burdening for their partners. The general population, and even more so, the general practitioners and psychiatrists advocated that the parents’ pattern of problem solving, coping with stress or accepting suicidal behaviour as a solution to a problem presents a model from which children learned how to react when faced with troubles. Four psychiatrists mentioned that the idea of suicide as a possible solution is crucial for suicidal behaviour (cit.10). This idea could also be acquired outside the immediate family. Otherwise the general practitioners and psychiatrists rarely acknowledged the importance of family relationships.

‘They raised me in family like this. To be weak and quiet. If I said something, they beat me up. I was not wanted at home. My father was a chronic alcoholic, my parents fought all the time. Eventually they got divorced, I lived with my father. He tried to rape me. Then I went to live with my mother. She threw me on the street at 15.’ (cit.9; suicide attempter)

‘I imagine that he must have an idea of suicide as possible solution inside him from way back, when he was without problems. It must be somewhere, to get imprinted, whether he heard about someone, saw it in the family or he had thought about it before.’ (cit. 10; psychiatrist)

Society

Suicide attempters and psychiatrists did not find society to be relevant (cit. 11) whereas the general population and the general practitioners found the societal influence to be of great importance. The materialistic values of modern society were considered

especially detrimental because they promote success, productiveness and in this way put immense pressure on people (cit.12). The consequence of these values has been increasing disconnectedness among people and a growing lack of support. The sense of social security has lowered and more people live in poverty in and constant fear of losing their job.

‘If everybody else can live in this society, then it is not the society, it is me.’ (cit.11; suicide attempter)

‘The rhythm of the day changed a lot. All this competition, what will you achieve, materialism. If you see, that you have fallen behind, it is not pleasant.’ (cit.12; general practitioner)

DISCUSSION

From the themes identified we can notice that elements from various evidence-based perspectives (medical, biological or genetic, psychological and sociological) were represented. The themes were given different levels of importance in explanations of the origins of suicidality by the included groups. The general population and suicide attempters were similar in emphasising personality and crisis while ignoring mental illness and genetic factors. The latter two themes were stressed by the general practitioners and psychiatrists. Within a single group as well as within a single person different perspectives were usually combined in a more or less coherent system. Combining of the perspectives was expected since suicidal behaviour is multicausal and multidimensional.

The sample from the general population has shown rather homogenous concepts on the origins of suicidality, with personality being the mediator between adverse events and suicidal crisis. In the qualitative study of the Norwegian general population’s views on the causes of suicide (Hjelmeland & Knizek 2004) participants mentioned psychological causes most often, followed by experiences of loss in the interpersonal relationships and psychiatric illness or substance abuse. The first two categories were expressed in our study as well. Perhaps the awareness of the relationship between mental disorders and suicidality in the Norwegian population is the result of the implemented national action plan for suicide prevention as education and prevention programmes on suicidality have been proven to be efficient for suicide prevention (Titelman & Wasserman 2009). So far no national program on suicide prevention has been implemented in Slovenia but certain educational programmes for recognition of depression and suicide risk evaluation have proven to be beneficial (Roškar et al. 2010). In other studies on public opinion about the causes of mental disorders people emphasised psychosocial causes. Weak mental constitution, unstable personality or weakness of character was stressed as well (Jorm et al. 1997, Matschinger & Angermeyer 1996). Strength of character is of clinical importance in psychodynamic theories of suicidality but not given much attention in

the mainstream theories and research on suicidality (Maltzberger 1992, Marčinko et al. 2008). The general population believed that personality structure was developed in the primary family. The role of the primary family had been proven to be related to suicidal behaviour in various ways (Kolk et al. 1991, Yang & Clum 1996). While the general population believed that personality is hard to change, this concept gave a sense of hopelessness and permanent proneness to suicide in suicidal people. Weak personality was not automatically negatively evaluated except when lack of appropriate values was attributed to the individual person rather than to society as a whole. The role of society was also seen to be of great importance because society gives people the guidelines on how to live (that is, values) and provides basic living conditions. Without one or the other people are driven to crisis and weaker members are doomed to fail. The general population’s understanding of the subjective experiences of the suffering person in the moment of the crisis was surprisingly good and corresponded to Shneidman’s (1985) concept of psychache defined as intolerable emotional pain from which people try to escape by suicidal behaviour.

Suicide attempters’ views were similar to those of the general population, proving the immense influence of public opinion as well as sharing of the same social representations. Even though eight suicide attempters had already been psychiatrically treated they had not adopted the medical or biological views. Goldney et al. (2002) noticed that the subgroup of the general population that had professional contact because of depression and suicidal ideation did not show increased mental health literacy but Jorm et al. (2000) discovered that having sought help for depression was associated with beliefs closer to those of professionals. Suicide attempters stressed painful inner experiences (psychache), their sensitive personality and emotional instability as the main causes of their suicidality. Nearly half mentioned also unfulfilled needs for love and belonging as a consequence of adverse events and upbringing in the primary family. Unfulfilled psychological needs are the main source of psychache in Shneidman’s theory (1985). In the life-stories of older suicidal women, Haight & Hendrix (1998) found that dysfunctional families of origin, poor role models, a feeling of isolation and pessimistic outlook contributed to a suicidal career. Suicide attempters in our study explained suicidal behaviour on the individual, psychological level of mental pain, stating that society is not to be blamed and that social changes could not help them.

Half of the general population and most of the suicide attempters said they had never seen or read expert explanations on suicidal behaviour nor did they talk about suicide with other people except when somebody committed suicide; as a result of this explanations of suicidal behaviour were rather homogenous. In contrast the general practitioners had the most heterogeneous explanations of suicidal behaviour and

were the only group that mentioned all the themes identified. Their primary source of knowledge was their medical training and some experiences in working with suicidal people. The topics of suicidality and mental illnesses have been spreading in the last decade through formal education and certain prevention programs in Slovenia (Marušič et al. 2004, Roškar et al. 2010). The consequence of this process is the interesting mix of lay and expert theories of most general practitioners. For example one claimed that suicide attempters are weak personalities lacking basic human values. The society as a whole should change to stop them from committing suicide, but recognition of depression is the focus of the treatment. Most of the general practitioners concentrated on the role of mental illness (depression) in suicidality. They defined their primary responsibility at work as being able to recognize quickly the physical or mental illness of the patient. Perhaps this is the reason that they did not stress the subjective experiences of the suicidal people but emphasised the symptoms of depression. Though we could agree with Shneidman (1993) that depression and suicidal crisis are two distinct concepts, a quick screening of the people's mental state and referral to psychiatrists could be efficient enough for the majority of suicidal people. The general practitioners with preferences to work with psychological problems described the suicidal process and crisis well. As a group they also advocated the importance of society and living conditions as the major origins of stress on people. In general we could conclude that they favoured medical and sociological explanations.

Psychiatrists have in general adopted the current medical model of suicidality. They described adverse events and mental illness as triggers for the diathesis of suicidality in the form of impulsiveness and aggression as proposed by Mann (2002). They emphasised the idea of suicide, present in the family or in the wider environment that is transmitted to the individual or societal level through the social learning processes as in certain theories (Kral 1994). They strongly believed in prevention of suicidal behaviour by treatment of mental illness or resolving suicidal crisis, both of which only momentarily change the mental and physical state of the distressed persons.

In our quantitative study on expert and lay explanations of suicide behaviour (Zdravec et al. 2006) we got similar results. Lay people (general population and suicide attempters) favoured crisis, sociological and medical models whereas the experts (general practitioners and psychiatrists) shared the belief in the medical, genetic and crisis models. The personality model was the least accepted explanation in all groups. Again it was the crisis model that was the strongest common ground between the groups included.

Qualitative studies on lay and expert views on suicidal behaviour have thus far been rare (Haight & Hendrix 1998, Hjelmeland & Knizek 2004, Kenning et al. 2010, Knizek et al. 2008, Knizek et al. 2010, Owens

et al. 2005, Redley 2003). The results of our study could not be compared directly to the previous studies due to different design and data analysis. In a similar qualitative study on the views on suicide attempt in Taiwan, Tzeng & Lipson (2005) have also found differences between lay and expert views and suggested that the mental health professionals should bridge the gap between the two. In other countries with a lower suicide rate or already implemented national programs perhaps the differences between medical staff and lay population would be less pronounced. Evaluating the recruitment of the participants in our study we may argue that the included psychiatrists and general practitioners were probably more interested in suicidal behaviour and had a greater knowledge than the average. Although the main themes in this study were saturated, perhaps some new themes or sub-themes could emerge with further inclusion of different subjects or groups. It would be interesting as well to include some suicide attempters that had refused to accept psychiatric treatment or those who did not need inpatient care. An attempt was made to include also the significant others of the suicide attempters but the patients refused to involve their relatives or friends so as not to burden them. As this is a qualitative study, it was not the intention to quantify the knowledge and differences between the groups and to generalize them to other contexts.

CONCLUSIONS

First hand comparison of lay people's and experts' beliefs on suicidal behaviour clearly showed striking discrepancies that have been neglected up to now. The general population and suicide attempters shared similar views on origins of suicidal behaviour. Both stressed psychological factors (personality, suicidal crisis), while the general population mentioned sociological factors as well, but both groups ignored medical factors (mental illness, genetic factors). On the other hand medical staff, namely general practitioners and psychiatrists, emphasised medical factors and suicidal crisis. This discrepancy in beliefs between (potential) users of medical services and medical staff could be a cause for poor help-seeking and adherence to treatment by suicide attempters. It is advisable to identify the beliefs of the suicidal person and not simply impose a medical model from the expert position. A shared understanding of the patient's suicidality should be reached as some authors have already emphasised (Jobes 2010). A recommended starting point in the first contact between patient and the medical staff could be creating a narrative about the common theme identified in all four groups, namely, subjective experience of suicidal crisis. This shared understanding achieved through dialog is a prerequisite for establishing of a good therapeutic alliance which in the process of treatments enhances treatment adherence and with this better treatment outcome and prevention of further suicide behaviour.

Acknowledgements

The study was supported by Ministry of science, the project number V5-0577-0618-01, 'Samomorilnost in rodnost na Slovenskem' (Suicide and fertility in Slovenia).

Conflict of interest: None to declare.

References

1. Beck AT, Weissman A, Lester D, Trexler L: The measurement of pessimism: The hopelessness scale. *J Consult Clin Psychol* 1974; 42:861-65.
2. Caldwell TM, Jorm AF: Mental health nurses' beliefs about interventions for schizophrenia and depression: a comparison with psychiatrists and the public. *Aust N Z J Psychiatry* 2000; 34:602-11.
3. Diekstra RFW, Kerkhof AJFM: Attitudes towards suicide: The development of a suicide-attitude questionnaire (SUIATT). In RFW Diekstra, R Maris, S Platt, A Schimidtke & G Sonneck (eds): *Suicide and its prevention. The role of attitude and imitation*. E.J. Brill, 1989.
4. Domino G, Moore D, Westlake L, Gibson L: Attitudes towards suicide: A factor analytic approach. *J Clin Psychol* 1982; 38:257-62.
5. Durkheim E: *Suicide: A study in sociology*. Free Press, Glencoe, 1951.
6. Eagles JM, Carson DP, Begg A, Naji SA: Suicide prevention: a study of patients' views. *Br J Psychol* 2003; 182:261-65.
7. Flick U: *An introduction to qualitative research*. Sage, London, 2002.
8. Frank AW: *The wounded storyteller: Body, illness, and ethics*. University of Chicago Press, Chicago, 1995.
9. Goldney RD, Fisher LJ, Wilson DH, Cheok F: Mental health literacy of those with major depression and suicidal ideation: an impediment to help-seeking. *Suicide Life Threat Behav* 2002; 32:394-403.
10. Haight BK, Hendrix SA: Suicidal intent/life satisfaction: Comparing the life stories of older women. *Suicide Life Threat Behav* 1998; 28:272-84.
11. Hjelmeland H, Knizek BL: The general public's views on suicide and suicide prevention, and their perceptions of participating in a study on attitudes towards suicide. *Arch Suicide Res* 2004; 8:345-59.
12. Jobes DA: Suicidal patients, the therapeutic alliance and the collaborative assessment and management of suicidality. In Michel K & Jobes DA (eds): *Building a Therapeutic Alliance with the Suicidal Patient*, 205-229. American Psychological Association, 2010.
13. Joffe H: Social representations and health psychology. *Soc Sci Inf* 2002; 41:559-80.
14. Jorm AF: Mental health literacy. Public knowledge and beliefs about mental disorders. *Br J Psychiatry* 2000; 177:396-401.
15. Jorm AF, Korten AE, Jacomb PA, Christensen H, Rodgers B, Pollitt P: Public beliefs about causes and risk factors for depression and schizophrenia. *Soc Psychiatry Psychiatr Epidemiol* 1997; 32:143-8.
16. Jorm AF, Christensen H, Medway J, Korten AE, Jacomb PA, Rodgers B: Public belief systems about the helpfulness of interventions for depression: associations with history of depression and professional help-seeking. *Soc Psychiatry Psychiatr Epidemiol* 2000; 35:211-9.
17. Jorm AF, Griffiths KM: The public's stigmatizing attitudes towards people with mental disorders: How important are biomedical conceptualizations? *Acta Psychiatr Scand* 2008; 118:315-21.
18. Kenning C, Cooper J, Short V, Shaw J, Abel K, Chew-Graham C: Prison staff and women prisoner's views on self-harm; their implications for service delivery and development: A qualitative study. *Crim Behav Ment Health* 2010; 20:274-84.
19. Kleinmann AM: *Patients and healers in the context of culture*. University of California Press, Berkeley, 1980.
20. Knizek BL, Akotia CS, Hjelmeland H: A qualitative study of attitudes towards suicide and suicide prevention among psychology students in Ghana. *Omega* 2010; 62:169-86.
21. Knizek BL, Hjelmeland H, Skruibis P, Fartacek R, Fekete S, Gailiene D, Osvath P, Renberg ES, Rohrer RR: Country council politicians' attitudes toward suicide and suicide prevention – A qualitative cross-cultural study. *Crisis* 2008; 29:123-30.
22. Kral M: Suicide as social logic. *Suicide Life Threat Behav* 1994; 24:245-55.
23. Krause M: Social representations of psychological problems: contents and transformations. *Soc Sci Inf* 2002; 41:603-23.
24. Maltzberger JT: The psychodynamic formulation: an aid in assessing suicide risk. In Maris RW, Berman AL, Maltzberger JT & Yuffit RI (eds): *Assessment and prediction of suicide*, 25-49. The Guilford Press, 1992.
25. Mann JJ: A current perspective of suicide and attempted suicide. *Ann Intern Med* 2002; 136:302-11.
26. Marčinko D, Marčinko A, Kudumija Slijepčević M, Martinac M, Kudlek-Mikulić S, Karlović D: Suicide in schizophrenia: risk factors, therapy and preventive strategies. *Psychiatr Danub* 2003; 15:201-7.
27. Marčinko D, Skočić M, Šarić M, Popović-Knapić V, Tentor B, Rudan V: Countertransference in therapy of suicidal patients - an important part of integrative treatment. *Psychiatr Danub* 2008; 3:402-5.
28. Marčinko D, Vuksan-Čusa B: Borderline personality disorder and bipolar disorder comorbidity in suicidal patients: diagnostic and therapeutic challenges. *Psychiatr Danub* 2009; 3:386-90.
29. Marušič A: History and geography of suicide: Could genetic risk factors account for the variation in suicide rates? *Am J Med Genet* 2005; 133:43-7.
30. Marušič A, Roškar S, Dernovšek MZ, Groleger U, Janet E, Rupnik I, et al.: An attempt of suicide prevention: the Slovene Gotland Study. In *Final programme & abstract book: research - prevention - treatment and hope*, 77. ICS, 2004.
31. Matschinger H, Angermeyer MC: Lay beliefs about the causes of mental disorders: a new methodological approach. *Soc Psychiatry Psychiatr Epidemiol* 1996; 31:309-15.
32. Moscovici S, Duveen G: *Social representations. Explorations in social psychology*. Polity Press, Cambridge, 2000.
33. Murray M: *Narrative Psychology and Narrative Analysis*. In: Camic PM, Rhodes JE & Yardely J (eds): *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design*, 95-112. American Psychological Association, 2003.

34. O'Reilly CL, Bell JS, Chen TF: Pharmacists' belief about treatments and outcomes of mental disorders: a mental health literacy survey. *Aust N Z J Psychiatry* 2010; 44:1089-96.
35. Owens C, Lambert H, Donavan J, Lloyd KR: A qualitative study of help seeking and primary care consultation prior to suicide. *Br J Gen Pract* 2005; 55:503-509.
36. Redley M: Towards a new perspective on deliberate self-harm in an area of multiple deprivation. *Sociol Health Illn* 2003; 25:348-73.
37. Roškar S, Podlesek A, Zorko M, Tavčar R, Drnovšek M, Grolger U, Mirjanič M, Juričič-Konec N, Janet E, Marušič A: Effects of training program on recognition and management of depression and suicide risk evaluation for Slovenian primary-care physicians: Follow-up study. *Croat Med J* 2010; 51:192-7.
38. Salander Renberg E, Jacobsson L: Development of a Questionnaire on Attitudes towards Suicide (ATTS) and its application on a Swedish population. *Suicide Life Threat Behav* 2003; 33:52-64.
39. Shneidman ES: *The definition of suicide*. Wiley, New York, 1985.
40. Shneidman ES: Suicide as psychache. *J Nerv Ment Dis* 1993; 181:147-9.
41. Tanney BL: Psychiatric diagnosis and suicidal acts. In Maris RW & Silverman MM (eds). *Comprehensive textbook of suicidology*, 311-341. Guilford Press, 2000.
42. Titelman D, Wasserman D: Suicide prevention by education and moulding of attitudes. In Wasserman D & Wasserman C (eds): *Oxford textbook of Suicidology and Suicide Prevention*, 509-514. Oxford University Press, 2009.
43. Tzeng WC, Lipson JG: Health professionals' perspectives of suicide in Taiwan. *Issues Ment Health Nurs* 2005; 26:451-63.
44. Van der Kolk BA, Perry JC, Herman JL: Childhood origins of self-destructive behaviour. *Am J Psychiatry* 1991; 148:1665-71.
45. Zadravec T, Grad O, Sočan G: Expert and lay explanations of suicidal behaviour: comparison of the general population's, suicide attempters', general practitioners' and psychiatrists' views. *Int J Soc Psychiatry* 2006; 52:535-51.
46. Yang B, Clum GA: Effects of early negative life-experiences on cognitive functioning and risk for suicide: a review. *Clin Psychol Rev* 1996; 16:177-95.
47. Williams JMG, Pollock LR: Psychological aspects of the suicidal process. In Van Heeringen K (ed): *Understanding suicidal behaviour*, 76-93. Wiley, 2001.
48. World Health Organization Regional Office for Europe. Working group on preventive practices in suicide and attempted suicide: summary report (ICP/PSF 017 (S) 6526 V). WHO, Copenhagen, 1986.

Correspondence:

Tina Zadravec, PhD
University Psychiatric Hospital Ljubljana
Ljubljana, Slovenia
E-mail: tina.zadravec@psih-klinika.si