

SUICIDES IN POLAND AS A SOCIAL PROBLEM AND SOCIAL PHENOMENON

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Abstract. According to police statistics in 2013 in Poland there has been a sharp increase in the number of suicides among men, compared to previous years and to the number of suicides among women. Unfortunately, this trend continues to grow each year. Hence the idea of the article is to present problem and to shed some light on the phenomenon and try to characterise it, referencing the statistics and academic studies of suicides.

Keywords: Suicides in Poland, Social Problems, Social Work.

Introduction

According to police statistics, and warnings sounded by the media (eg. Matusiak & Kinasiewicz, 2014), in 2013 there has been a sharp increase in the number of suicides among men, compared to previous years and to the number of suicides among women. “In 1989, 3657 people in Poland took their own life; and in 2013 – 6097” (Matusiak & Kinasiewicz, 2014). This is 1394 more than in 2012, when there was a total of 4703 suicides (<http://statystyka.policja.pl>). In 2013 - 5193 of the six thousand suicides were committed by men; the rest (903 suicides) by women. In 2014 the number of suicides increased – 6165 Poles killed themselves (5 237 men and 928 women). Thus suicides among men comprised 85% of the overall number. In 2012, the proportion was different: suicides among men comprised 75% (4703 suicides overall, men 3569, women 1134). Referring to the statistics, one can easily conclude that, compared to 2012, in 2013 1 624 more men attempted to take their own life. The number of men who commit suicide is therefore on the rise, while the number of suicides among women decreases. This is an alarming trend, what grows each year what should not be disregarded or played down by social politicians, police forces and social services. Hence the idea presented itself to shed some light on the phenomenon and try to characterise it, referencing the statistics and academic studies of suicides. The article bases on police statistics over the last years (after social and political transformation in Poland) to underline the scale of the problem.

The phenomenon of suicides in a sociological and cultural perspective

Criminologists defining death distinguish between three types of the phenomenon (Bednarski & Urbanek, 2012: 17): (1) “Natural death” (i.e., physiological death) – is related to the natural exploitation of the supply forces of the human system. This process, the so-called senile dementia, is relatively rare, and does not entail evident organ or system disorder; (2) Death due to illness (spontaneous / idiopathic death) – is the result of a variety of pathological processes, whether inflammatory, degenerative, growth (cancerous) or others. This type of death is the main object of interest to medicine and doctors; the majority of such deaths occur after a prolonged illness; (3) Sudden death – the result of a variety of external factors that have led to a disruption in the functioning of crucial organs. These factors are differentiated according to the cause of death (mechanical injury, sudden strangling or suffocation, poisoning etc.

In the typology outlined above, suicide is therefore classified as the third type of death. In sociology, as well as social anthropology and cultural studies, death (including death by suicide) is a frequently addressed and investigated social problem. Works on that subject usually reference Émile Durkheim classic study, *Suicide* (2005). According to the French sociologist, “the term suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result” (Durkheim, 1976: 5, after: Hołyst, 2002: 33). In that context, one might ask what happens in societies where social control has weakened considerably; societies that have liberated themselves from the strict sectioning of every sphere of life, but do not generate in return any new institutions of control. Therefore, what is needed for interpreting the phenomenon of suicide is a multi-dimensional diagnosis, embedded in statistics and study results.

From a sociological perspective, suicide is an indication (of sorts) of social disintegration, rather than a manifestation of the suicide’s personality. This does not, however, preclude individual motivations that are not deterministic in nature. According to Brunon Hołyst: “Suicides are, after all, social phenomena, related to the structure of the population as a whole” (Hołyst, 2002: 438). What is more, “people’s behaviour and attitudes are not a manifestation of the pathological inclinations of isolated individuals; but rather the normal reaction of humans who find themselves in a particularly difficult situation or challenging environment” (Hołyst, 2002: 438). The same had previously been noted by Émile Durkheim, who, in his 1897 study *Le Suicide* claims that a suicidal individual does not fall into a specific psychological type; rather, it would be more fitting to discuss the characteristics of the social groups from which people who attempt suicide originate; and the conditions in which these

people live. In order to characterise suicidal individuals (who fit into a certain socio-psychological profile), it is therefore necessary to familiarise oneself with the social situation in which people live: “A predilection for self-destructing behaviour is therefore shown not by people who are physically or mentally ill, but by those who are more sensitive, less resilient, or who find themselves in a situation which is (objectively or subjectively) without a solution” (Hołyst, 2002: 438). Thus it would be wrong to claim that individual qualities, such as depression, stress, trauma or crisis, are completely irrelevant; nevertheless, there are certain common determinates of suicidal behaviour.

Since we are unable to answer the question concerning the motivations for committing suicide, we should perhaps learn more about the social circumstances in which suicide is likely to be committed. B. Hołyst identifies several “enhanced risk” groups, from which suicides originate (Hołyst, 2002: 44): (1) *People suffering from mental illness*: depressive individuals (original depressions; depressive states / episodes), individuals with an addiction (alcoholism, illegal drugs), schizophrenia (in the course of stationary treatment or rehabilitation), personality disorders; (2) *People with earlier suicide history*: announced intention to commit suicide (an ambivalent appeal for help), survivors of a previous suicide attempt (10% of re-offenders); (3) *People who are elderly, lonely, widowed; or chronically ill, in pain and of limited fitness*, (4) *Young adults, teenagers*: experiencing a developmental crisis or a crisis in interpersonal relations (an internal feeling of aloneness, questioning the purpose of life), with a drug problem, with family and school problems; (5) *People facing traumatic situations and crises related to changes in life*: relationship crisis, loss of a partner, loss of social, cultural, political living space, identification crises, chronic unemployment, criminality, above all road accidents (causing injury or death to another person), (6) *Individuals suffering from painful, chronic, limiting or injurious physical conditions; particularly conditions affecting the locomotor system and the central nervous system; individuals who are terminally ill, suffer from exhaustion and require a maximum of care*.

An overview of the suicide phenomenon in Poland

As has already been indicated, the number of suicides (particularly among men) rose sharply in 2013. This increase is represented in the table no. 1 showing the trend in the rises and falls in the number of suicide attempts since 1991:

Table 1 The number of suicides in Poland between 1991 and 2014
(all data from: <http://statystyka.policja.pl/st/wybrane-statystyki/samobojstwa>)

Year	Total	Men	Women	Year	Total	Men	Women	Year	Total	Men	Women
2014	6165	5.237	928	2006	4.090	3.444	646	1998	5.502	4.591	911
2013	6.101	5.196	904	2005	4.621	3.885	736	1997	5.614	4.622	992
2012	4.177	3.569	608	2004	4.893	4.104	789	1996	5.334	4.392	942
2011	3.839	3.294	545	2003	4.634	3.890	744	1995	5.485	4.465	1.020
2010	4.087	3.517	570	2002	5.100	4.215	885	1994	5.538	4.541	997
2009	4.384	3.739	645	2001	4.971	4.184	787	1993	5.569	4.519	1.050
2008	3.964	3.333	631	2000	4.947	4.090	857	1992	5.453	4.426	1.027
2007	3.530	2.924	606	1999	4.695	3.967	728	1991	4.159	3.388	771

Given that, since 2013, there has been a change to the way statistical data concerning suicide attempts are generated and stored, it should be noted that a total of 8579 suicide attempts have been made (including 7000 by men); 6097 of these ended in death. Previously, data were being entered into the system after the conducting and conclusion of preliminary or verifying proceedings (the latter according to Art. 308 of the Code of Criminal Procedure). Currently, data are being entered immediately after the event, if circumstances indicate the event had been a suicide attempt. The system allows for the modification of data if it emerges that the event had not been a suicide attempt (<http://statystyka.policja.pl/st/wybrane-statystyki/samobojstwa>).

Attempts were mostly made in: flats (3611 cases), outbuildings (1305), cellars and attics (861) and parks and forests (688). Methods of committing suicide vary greatly, the most frequently applied being hanging (5952 cases), followed by: throwing oneself from a height (647), other types of self-inflicted injury (400), taking barbiturates (313), damaging the blood system (226), throwing oneself under a vehicle (158), drowning (118), shooting oneself (83), gas poisoning (47), taking poison (41), and other methods (489). In 78 cases, the method of taking one's own life has not been determined. The majority of suicides were under the influence of alcohol (1858). The rest were sober (681), under the influence of psychotropic drugs (45) or other substances (66). In 5771 cases, the suicide's state of mind at the time of the deed had not been determined; in 209 cases, his or her state of mind had not been known.

What is more, police statistics provide information about the causes of suicide attempts (although, in 3663 cases, the motivation for the deed has not been determined). The causes are listed in the table no. 2.

Table 2 Motivation behind suicide attempts (data for 2013)

Causes of attempted suicide	Number of cases	Causes of attempted suicide	Number of cases
family discord	999	sudden loss of one's means of support	135
mental illness	797	committing an offence or crime	48
chronic illness	570	problems at school	27
disappointment in love	555	permanent disability	12
economic circumstances	484	unwanted pregnancy	8
death of a loved one	138	other	1463

Family does not necessarily provide the individual with a natural network of support: the majority of people who commit suicide are married (3231 cases). On the other hand, single people are next in line (2546). There follows a clear gap, as divorced people come third (637 cases), with widows and widowers in fourth place (456). Those who cohabit or are separated are least likely to commit suicide (289 and 60 cases, respectively). According to police reports, the marital status of 76 people was unknown, and, in 1266 cases, there was a shortage of reliable data. The suicides' marital status would seem to point to another fact, to do with their age. Is there a correlation between the two? Data related to the age of people who attempted to take their own life are provided in the table no. 3.

Table 3 The age of suicides (data for 2013)

Suicides' age	Number of attempts
9 or less	0
85 or more	130
age unknown	674

The table demonstrates that suicides are most frequent in two age groups: 25 or older, and 50 and older; in other words, among people who have either only just started their career (and / or a family) – or those who have been in a given situation for some time, and are in danger of being made redundant. This last issue is also linked to an individual's means of support: in 1570 cases, suicides were in employment. On the other hand, 1235 suicides supported themselves on a pension, allowance or alimony. 853 people did not have an income. The unemployed formed a relatively small group of suicides, with a total of 82 cases.

The phenomenon of suicide – a possible interpretation

Sociology, psychology, as well as related social sciences and the humanities attempt to explain why individuals carry out suicide attempts. An universal answer to this question does not exist, as no two suicides are alike: they are the result of different circumstances, and are motivated by unusual factors. Nonetheless, theories that aim to interpret the phenomenon with a view to understanding it, being able to provide help and acting preventively, continue to appear.

Scholars are seeking to determine what drives people to do the ultimate deed in a time of peace and social and physical security. “In literature, the dominant view is that during the war the number of suicides shows a tendency to decrease” (Hołyst, 2002: 450); and despite being in employment and having a family. To make sense of suicidal behaviour, some scholars have investigated the context of social norms, others – the context of the processes and phenomena taking place in society. And yet, theories tend to focus on a given aspect of the problem: this is, above all, the result of the research perspective one chooses to assume. Thus, in his analysis of societies and their norms, Émile Durkheim identified three types of suicide (after: Hołyst, 2002: 439): (1) Egoistic suicides; (2) Altruistic suicides, (3) Anomic suicides. In addition, Brunon Hołyst has identified a fourth type of suicide: fatalistic suicide, linked to an individual’s specific psychic and social situation: “What is meant here is the suicide of a person who has found him- or herself in a tragic situation, with no way out not only short-term, but also in the long run” (Hołyst, 2002: 439).

According to the concept of status integration, a theory formulated by James P. Gibbs and William T. Martin (1964), and closely related to Durkheim’s elucidations, what underlies deviant behaviour are contradictions in status, which ensue from conflicting roles played by individuals in society. As a result of that conflict, anger, aggression and self-aggression are triggered in individuals. This is why, in the social classes where instances of aggressive behaviour are numerous, there are few suicides on record, and vice versa.

Other scientific explanations take note of a suicide’s dwelling place. Maurice Halbwachs has argued that some of the factors identified by Durkheim are only ostensibly of importance. Thus, for instance, religion, family relationships, family model, education, social and professional structure, are the functions of lifestyle – whether urban or rural (Hołyst 2002: 440). Social mobility and other, related social processes (such as urbanisation, changes of consciousness, the ability to adapt, the process of learning new behaviours and norms, which often run against those acquired in one’s own environment) all play a significant role. It would seem that changes and the ability to adapt to new social situations, (but also the urban network of support, i.e. institutions

offering social and psychological assistance) would result in the number of suicides in cities being lower than in the country. Nevertheless, scholars argue that the “rate of suicides among immigrants is higher than the national average” (Hołyst, 2002: 441).

The long-running study by Maria Jarosz stands out in the field of suicide research in Poland (e.g. Jarosz 1977, 1997). Jarosz cites the different factors related to one’s profession or trade as positively influencing the decision to take one’s own life (Jarosz 1980). In her nationwide study conducted in the 1970s, Jarosz distinguished between three groups of professionals (or tradespeople) which varied according to the number of suicide attempts. In the first group (which included holders of managerial posts in administration, specialists and office workers) the number of suicides was more or less the same as the national average. The highest rate of suicides was observed among farm and forest workers, industrial and construction workers and those employed in transport and communication services. There were fewest suicides among farmers. A division into three social “classes” – the intelligentsia, the working class and farmers – emerges from the conclusions to the study. Of the three, the working class is most at risk.

Redundancy or unemployment are key in arriving at the decision to commit suicide. Being out of work must be seen in a broader perspective, as a predestining factor that causes health deterioration and hypochondria; as well as contributing to behavioural changes, such as the self-destructing habits of smoking, drinking and bad dietary choices. Specialists in psycho-immunology cite the serious social problems that are caused by unemployment: social isolation, loss of personal dignity etc. Thus not only the economic, but also the psychological and emotional implications of unemployment become evident. A study conducted in Sweden is a case in point. A significant drop in lymphocyte reactivity was observed among a group of Swedish employees, nine months after they had been made redundant (Hołyst, 2002: 448); notwithstanding the fact that, according to Swedish law, employees who were made redundant, receive 90% of the remuneration they had been paid while in work. One can thus speak of the suicide-instigating aspects of loneliness (McGraw, 2010), which, according to John McGraw, are boosted by changes to certain norms, i.e., hyper-individualism, materialism and the cult of success. These changes may affect anyone, whether a city or country dweller, rich or poor, old or young, man or woman. “In order to keep pace with the world, we are constantly setting ourselves goals that push us to the limit. We must be better, and we are paying the highest price for it. Our resources of mental resilience and the capacity for responding to stress make us ill-adapted to the changes which take place around us. However, progress happens at the expense of our lives. Relationships with other people become more shallow and time-limited” (Heitzman, 2014).

Professor Janusz Heitzman continues his diagnosis of the situation in the following manner: “About 40% of young Poles require financial assistance from their parents. (...). Others will be paying off their mortgage until they retire” (Heitzman, 2014).

The growing number of suicides is recognised as a problem not only by scholars and academics, but also by journalists, who keep track of the scale of the phenomenon around the world. “According to a study published in September 2013 by the *British Medical Journal*, the 2008 crash, that had led to a significant growth in unemployment, already in 2009 translated itself into 5000 <<extra>> suicides in America and Europe. Scientists from universities in Oxford, Bristol and Hong Kong have compared the number of people who took their own lives prior to, and during, the crisis. They have based their study on data from 54 countries. A similar study had been conducted earlier, following the Asian financial crash of 1997. It had been estimated at the time that in Japan, Hong Kong and South Korea alone 10 000 more people committed suicide than in times of economic prosperity” (Matusiak & Kinasiewicz, 2014).

Suicide prevention

The problem of suicide has also been acknowledged by the World Health Organisation. According to the WHO, “almost a million people take their lives every year, and the death of each of them affects at least six others. Thus the implications of suicide have an impact on millions of people around the world” (Matusiak & Kinasiewicz, 2014). Preventative action against suicides is needed, given that “another important reason for preventing not so much suicides as pre-suicidal behaviour, is the necessity to take an interest in the fate of people who are often in the dark about the full scope of possibility as far as solving their problems is concerned, and thus they cannot be said to be making a fully informed choice” (Hołyst, 2002: 67).

What, then, needs to be done? Above all, one should “constantly broaden one’s knowledge of the processes that motivate self-destructing behaviour” (Hołyst, 2002: 67) with a view to learning how to recognise the pre-suicidal syndrome that leads to the degeneration and atrophy of defence mechanisms. Equally essential is the ability to diagnose potentially self-destructing states, which may lead to the undoing of not just individuals, but the whole social, economic and political structure. What also needs to be examined is how these self-destructive states influence the physical and mental condition; and the decision-making processes of individuals. A clean and healthy natural environment helps minimise the risk of succumbing to the diseases which are associated with the progress of civilisation; and which contribute to instigating mental crises and inspiring suicide attempts.

Referencing the model of five-tier preventative action, Maria Skawińska points to the significant role of social policy as a complex and patent system of aid-providing institutions. The task of these institutions is to prevent suicide and offer suicide therapy (Skawińska 2003: 92-93). Tier one is made up of 'influencing by education' that comes in all shapes and sizes and is directed to the society as a whole. The aim of the actions in this tier to shape attitudes that are affirmative and accepting of life, and orientated towards thinking positively about the future. Actions on tier two are directed at the group at risk of developing pre-suicidal attitudes. This is why social diagnosis in this sphere is of such tremendous importance. Tier three consists of variegated, complementary institutional and non-institutional ways of influencing people who are already pre-suicidal. Here, the activity focuses on working with individual cases, and on intense individual therapy. Tier four entails working with a "suicidal situation": in essence, what is meant by this are different forms of therapeutic influence following a suicide attempt. Tier five is concerned with providing immediate help to people and families who find themselves in a post-suicidal situation (Skawińska 2003: 92-93). One could therefore say that preventative action should be addressed to all social groups and institutions: individuals in crisis, families, the police, school, social and health services, etc.

By contrast, Marek Borowski and Anna Stromecka envisage preventative action on three, rather than five tiers (Borowski & Stromecka, 2010: 116-121). Prevention of the first order "is aimed at promoting health and prolonging human life; as well as preventing problems that arise from dysfunctional behaviour. Here, the focus is on the process of developing various skills of coping with the challenges of life" (Borowski & Stromecka, 2010: 116). People who are at risk of finding themselves in crisis need to be taught to accept loneliness, so that they can acquire a sense of independence and, crucially, a sense of reality. The second tier includes activities aimed towards identifying a problem or crisis early, which would allow for withdrawal from risky behaviour; and provide assistance in a crisis. What would be the indications that an individual is undergoing a crisis? The authors of the study enumerate the following symptoms (Borowski & Stromecka, 2010: 120-121): occurrence of an acute critical event or a chronic crisis; perceiving the situation as a loss, danger or challenge; individual, subjective experience of negative emotions; sense of insecurity of the future, feeling of loss of control; sudden breach of the daily rhythm, routine forms of behaviour and habits; prolonged state of emotional tension; necessity to change one's existing mode of functioning". Third-tier activities consist in emergency actions, which are taken once a dysfunction occurs. The aim of these actions is to prepare an individual for his or her return to society; and to a socially acceptable, pathology-free way of life. What is important here is to involve family and friends in these activities.

Conclusions

The article analyses the wide scale of the suicides in Poland over the last 20 years. This trend is very dangerous in each perspective: social, psychological, economical etc. Author of the article considered that suicides' prevention is the important task for social policy and social work institution. Traditionally this kind of social activity is seen behind/ outside of the system of help/ helpers, but it should be part of social work (among work with homeless people, unemployment, addictions, poverty).

Preventative action thus needs to include a range of activities which differ in scope and character. Educational, diagnostic, preventative, repair, research, therapeutic, informative actions should all be taken into account. Culture-producing activities are equally important: they should be pursued in a conscious, rational and systematic manner, taking into account the cultural changes of which we are part. It is necessary to shape a certain attitude towards death: an attitude founded on the assumption that, in a crisis, help can be obtained at any place and time; and receiving that help will provide an individual with a sense of social and psychological security.

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