Health & Place 48 (2017) 40–46

Contents lists available at ScienceDirect

Health & Place

journal homepage: www.elsevier.com/locate/healthplace

Community social support as a protective factor against suicide: A gender-specific ecological study of 75 regions of 23 European countries

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ARTICLE INFO

Keywords:
Suicide
Social support
Social factors
Gender differences

ABSTRACT

By studying differences in suicide rates among different geographical regions one may identify factors connected to suicidal behaviour on a regional level. Many studies have focused on risk factors, whereas less is known about protective factors, such as social support. Using suicide rates and data from the European Social Survey (ESS) we explore the association between regional level social support indicator and suicide rates in 23 European countries in 2012. Linear multiple regression analyses using region as the unit of analysis revealed inverse relationships between mean respondent valuing of social support and suicide rates for both genders, with some indication of a stronger relationship among men. Social support may have a protective effect against suicide on a regional level. Thus, increasing social support could be an effective focus of preventive activities, resulting in lowering suicide rates, with greater expected results among men.

1. Introduction

Suicide represents an important public health concern worldwide, including in Europe (WHO, 2014a, 2014b). In Europe as in most Western countries there is a consistent pattern of gender-difference in suicide rates, with many more men than women dying by suicide (Canetto and Sakinofsky, 1998; Schrijvers et al., 2012). Suicide rates vary widely across European countries and regions. For example, rates are generally higher in Northern and Eastern Europe, particularly in Baltic countries, and lower in Mediterranean countries (Marušič, 1999). Understanding the reasons for national or regional differences in suicide rates has potential value for prevention.

In addition to individual-level psychological characteristics, such as personality traits, depression, hopelessness, and anxiety, a variety of other inter- and intra-national or regional factors such as socio-economic conditions (Maris, 1997; Mann et al., 1999; Platt, 2011; Milner et al., 2013; Yur'yev et al., 2013) and regional variations in the prevalence of genetic influences (Marušič and Farmer, 2001) may interact to shape the risk for suicide. Durkheim (1897) was one of the first theorists to offer a sociological argument concerning the root causes of suicide. He posited that suicide was influenced by social context and was the result of a lack of social integration. According to Durkheim (1897), periods of economic, social, or political change result in a state of anomie or normlessness. Anomic periods lead to deregulation of desires and suffering. Durkheim hypothesized that, as an expression of suffering, societies and groups experience an increase in suicide rates. Today, social capital (Ferlander, 2007) is a similar concept which has become very popular and is often tracked back to the work of Durkheim (1897), who showed that social integration was inversely related to the suicide rates. Social capital on the other hand includes both a buffer function of the social environment on health, as well as potential negative effects arising from social inequality and exclusion (Ferlander, 2007).

Although there is an extensive literature on suicide risk factors (Brown et al., 2000; Maris, 2002), much less is known about protective factors (Silverman, 2011). However, in recent decades, suicidologists have started to recognize the importance of identifying and promoting factors that may have a protective function against suicide (Grad, 2001; O'Connor, 2011). Social capital (Ferlander, 2007) is a concept that includes both risk and protective social factors. One component of social capital is community social support—defined as anything that leads someone to believe that she or he is cared for, loved, respected, and a member of a network of mutual obligations (Cobb, 1976)—and it is thought to be a particularly promising protective factor against suicide (Wilcox et al., 2010; Kleiman et al., 2012; Christensen et al., 2014) that warrants further consideration.

Prior research has focused on the role that the social support an individual receives (and perceives) has for the same individual's suicide risk. Although this approach is highly valuable, it is typically constrained by the standard limitations of self-report methodologies –

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http://dx.doi.org/10.1016/j.healthplace.2017.09.004
Received 17 January 2017; Received in revised form 4 September 2017; Accepted 12 September 2017
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namely, reporting biases (e.g. depression causes distorted perceptions of social support and suicidal thoughts) and reverse causation (e.g., depression and other suicide risk factors are taxing to individuals' social support networks). Furthermore, studying differences in regional suicide rates can be a starting point for gaining insight into factors connected to suicidal behaviour on a national and regional level. Better understanding of ecologic predictors of suicidal behaviour may be relevant especially for the development of universal prevention activities. In the present study we therefore explore whether regional levels of social support indicators have implications for regional suicide rates. Previous research has already identified several national- or community-level psycho-social correlates of suicide rates, such as the interaction between alcohol use and genetics (Marušič and Farmer, 2001), stigma toward people with mental health problems (Schomerus et al., 2014), intelligence (Voracek, 2009), income inequality (Machado et al., 2015) and other economic variables (Fountoulakis et al., 2014), and indicators of mental health systems (Shah et al., 2010; Rajkumar et al., 2013). Our study focused on the possible protective function of community social support at the societal level.

The indicator we studied is the value citizens place on helping others and caring for their well-being (*value of giving social support*), which is reflected in the level of attributed importance of social support by the community members. Living in a community or culture that highly values providing social support to others may act as a protective factor since strong appreciation of this value affects the individual's decision to help in situations when altruistic behaviour is needed (Shumaker and Brownell, 1984). As a result, there may be more social support available in the community. This, in turn, may have a reciprocity effect. Gouldner (1960) and Cobb (1976) posit that a norm of reciprocity is that people usually return the benefits they receive from other since belonging to a network characterized by mutual obligations as a component of social support. Hence, people living in communities with high appreciation of the value of helping others are more likely to give and also receive social support, in comparison to communities in which this value is not considered to be as important.

Furthermore, studies have confirmed a positive connection between community social support and help-seeking behaviour for mental health problems in adults (Suka et al., 2015) and adolescents (Gulliver et al., 2010). However such studies have focused more on the existing social support available in the community as the core element of social capital (Ferlander, 2007) rather than on the value that community members place on social support. To our knowledge, social support values have not been examined in relation to suicide rates at the community level.

Community social support may act as a universal protective factor decreasing the risk for suicide regardless of individual risk factors, but it may also act as a moderating protective factor, mitigating the effect of other risk factors for suicide (Clum and Febbraro, 1994; Harrison et al., 2010). For instance, social support buffers the risk of suicide associated with depression (Cohen and Wills, 1985; Chioqueta and Stiles, 2007), negative events (Kleiman et al., 2014), post-traumatic stress disorder (Panagioti et al., 2014), drug use (You et al., 2011), and bully-victim problems in adolescents (Rigby and Slee, 1999), indicating that social support might contribute to psychological resilience when an individual is confronted with difficulties.

From a theoretical standpoint, the Interpersonal Theory of Suicide (Joiner, 2005) also is relevant. First, community social support relates to perceptions of interpersonal belongingness. In this sense, it might present a protective factor against suicidal thoughts, since lack of belongingness is one of the two conditions crucial for developing suicidal ideation (Joiner et al., 2009; Van Orden et al., 2010). Likewise, placing a high value on helping others relates to the risk construct of burdensomeness that has been posited as another perception that leads to suicidal ideation (Joiner et al., 2009). If a nation's citizens value social support more and are able to provide it more often, then burdensomeness in the population should be lower. Both of these constructs are described as being dynamic cognitive-affective states, influenced by intrapersonal and interpersonal factors (Van Orden et al., 2010), which emphasizes the interactive effect of individual intrapsychic processes with societal factors in shaping the perceptions of themselves.

Although the needs to give and receive social support may be universal, the level of need or the significance of certain aspects of social support may differ for men and women. In general, men have fewer close relationships than women (Scourfield and Evans, 2014) and it is usual that women play a critical role in connecting men socially and providing them with emotional support (Oliffe et al., 2011). Given that men receive important stability and support within marriage, a loss or divorce can be an important trigger for them because the lost social bond can isolate them (Wyder et al., 2009). Joiner (2011) further suggests that even when men have a number of social contacts, they may feel lonely if the quality of these relationships is poor. Men may not recognize this loneliness, but in difficult times (e.g. when marriage fails), they may be suddenly struck by the lack of meaningful social support (Joiner, 2011). On the contrary, women may not experience such a sense of loneliness following the loss or divorce as they are more likely to have developed supportive networks and meaningful friendships that can be sustained independently from their partner (Kposowa, 2000).

There is also a striking gender difference regarding help-seeking behaviour, with men being in general less likely to do so for psychiatric disorders such as anxiety, posttraumatic stress disorder (Bland et al., 1997), depressive symptoms and other emotional problems (Möller-Leimkühler, 2002). Normative male gender-role expectations may impose important barriers to seeking help. For example, fears of disclosing emotional vulnerability and perceptions that seeking help is an admission of incompetence may result in men's reluctance to discuss their problems with their close ones or to contact mental health professionals (Cleary, 2012; Schrijvers et al., 2012; Scourfield and Evans, 2014). In order for men in distress to overcome these barriers there is a need for influential facilitators of help-seeking; stronger value and provision of social support may play this important role. Further, suicide rates are generally higher among men than women in high-income countries and also low- and middle-income European countries (WHO, 2014b).

The aim of the present study is to investigate the relationship between a regions' suicide rates and indicator of social support levels in the community – value of giving social support—across 75 regions of 23 countries. We hypothesise that higher levels of social support are associated with lower suicide rates, even after controlling for other risk and protective factors. Considering the noted gender differences regarding the significance of social support and suicide rates, we examine the associations separately by gender, and expect that negative associations between social support and suicide rates are stronger among men than women.

2. Method

We conducted an ecological study – an empirical investigation involving the group as the unit of analysis (Morgenstern, 1982). This method typically combines data on large populations and is useful when dealing with data that summarize 'morbidity' in different regions, such as suicide rates.

We used data from the European Social Survey (ESS), an academically-driven survey, within which data on social indicators such as well-being, values and attitudes were collected on large samples from multiple countries using a uniform methodology (European Social Survey Round 6 Data, 2014). The full ESS data are available to researchers on an open-access basis on the web page www.europeansocialsurvey.org.

We used data from 75 regions of 23 European countries: Belgium, Bulgaria, Switzerland, Cyprus, Czech Republic, Germany, Denmark,

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