WHY WOMEN KILL THEMSELVES

Edited by

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The sex difference in suicide (males complete suicide at a higher rate than females while females attempt suicide at a higher rate than males) is one of the most pervasive and persistent phenomenon in suicidology. This book explores the reasons for this phenomenon and examines suicidal behavior from a variety of perspectives—anthropological, physiological, psychological, and sociological. Contributors discuss such topics as work patterns, the thinking style of suicidal women, suicide notes, social relationships, suicide and the menstrual cycle, and physiological differences between men and women and their relevance to suicidal behavior. Two detailed case studies are also presented.

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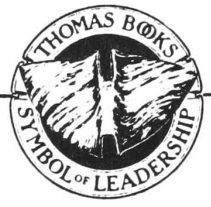

CHARLES C THOMAS • PUBLISHER
Springfield • Illinois • U.S.A.

Published and Distributed Throughout the World by

CHARLES C THOMAS • PUBLISHER
2600 South First Street
Springfield, Illinois 62794-9265

ISBN 0-398-05508-4

Library of Congress Catalog Card Number: 88-16018

Printed in the United States of America
Q-R-3

Library of Congress Cataloging in Publication Data

Why women kill themselves / edited by David Lester.
p. cm.
Includes bibliographies and index.
ISBN 0-398-05508-4
1. Suicide. 2. Women--Suicidal behavior. I. Lester, David, 1942-
[DNLM: 1. Suicide--psychology. 2. Women--psychology. HV 6546 W629]
RC569.W48 1988
616.85'8445'0088--dc19
DNLM/DLC
for Library of Congress 88-16018
CIP

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For Carol Ammons
for her encouragement

PREFACE

MANY RESEARCH findings in the study of suicide are hard to replicate. One published study may find a particular phenomenon, while another may fail to find the same phemonenon or may produce results that qualifies the earlier conclusion.

One of the clearest phenomenon in suicidal behavior is the difference in the suicidal behavior of the sexes. Males complete suicide at a higher rate than females while females attempt suicide at a higher rate than males. This difference has been known for centuries and has been consistently reported. An early explanation was that women used less lethal methods for suicide than men, but this is easily shown not to be the sole answer for, within any one method, men die more and women survive more.

Since the roles of the two sexes differ greatly in most societies and since men and women differ in many psychological characteristics, it is of interest also to inquire whether the meaning of suicide for women and the motivation for suicide differ from those of men.

The present book focuses upon these interesting and important issues. The editor and the contributing authors have examined suicidal behavior in women from a variety of perspectives—anthropological, physiological, psychological, and sociological. We cannot tie the conclusions of each chapter together into a neat theoretical package, but we can illustrate the diversity of the possible answers to the problem of why women kill themselves.

In addition, to illustrate the more academic discussions of suicidal behavior in women, we have included two case studies—Virginia Woolf who killed herself and Dorothy Parker who early in her life attempted suicide. Obviously, two women, even these two women, cannot be representative of all or even most women. However, these two women have interested people, and detailed biographies have appeared on them,

enabling us to examine their lives in much greater detail than the average woman. These two biographical essays are offered simply to give readers two detailed case studies for examination and for testing their hypotheses about the causes of suicide in women.

David Lester

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WHY WOMEN KILL THEMSELVES

CHAPTER 1

SUICIDE IN WOMEN: AN OVERVIEW[1]

DAVID LESTER

ONE OF THE most consistent findings from research into suicidal behavior is that males kill themselves more than females. In contrast, females attempt suicide more than males. This sex difference has been found in almost all nations, in almost all eras, and in almost all subgroups of the population of a given nation (for example, in white and black Americans, in the single, widowed, married, and divorced, and in all age groups).

It is very difficult to trace all completed and attempted suicides in a community, but three efforts have been made to do this. Farberow and Shneidman (1961) in Los Angeles in 1957 found 540 men but only 228 women who completed suicide. In contrast, they located 1824 women but only 828 men who had attempted suicide. Yap (1958) studied Hong Kong, whose population is mainly Chinese. He located 145 men but only 118 women who had completed suicide, whereas he located 508 women but only 386 men who had attempted suicide. In the Netherlands, de Graaf and Kruyt (1976) located 731 male and 478 female completed suicides as compared to 1562 male and 2551 female attempted suicides.

Completed Suicide

Data for completed suicides are more easily obtained since these deaths are officially recorded with reasonable accuracy. Looking at mortality statistics, there is an excess of male suicides both across the United States and across the world. The ratio of the male suicide rate for the

1. This chapter is based on Lester (1984)

female suicide ranged from 2.5 in Delaware to 5.6 in Vermont during 1949-51 (Gibbs and Martin, 1964) and from 1.5 in Japan to 7.4 in El Salvador (Gibbs and Martin, 1964) (The ratio for the U.S. was 3.6.). The ratio of the male suicide rate to the female suicide rate for the United States in 1964 ranged from 2.1 for those aged 35-44 to 14.5 for those aged 85 and older (Lester, 1979).

Although the male-female ratio of completed suicides in the United States remained fairly stable over the last twenty years (see Lester, 1979), the female suicide rate has been increasing recently at a proportionately higher rate than for males, though the female suicide rate remains only about one-third of the male suicide rate.

Burvill (1972) looked at nine nations and found that the female suicide rate had increased in all of them from 1955 to 1965, thereby causing the male-female ratio to decrease. It appears, therefore, that modern society is leading to more suicidogenic stress for females while having no ameliorative effect for males. Gove (1972) also has noted this phenomenon. From 1952-53 to 1962-63, the suicide rate for white males in the United States rose 10 percent, whereas the suicide rate for white females rose 49 percent. (The corresponding increases for black males and black females were 33 percent and 80 percent, respectively.) For nine western industrialized nations, the female suicide rate rose 18 percent, while the male suicide rate rose 2 percent.

This relatively higher increase in the female suicide rate is not, however, found in all age groups. Data reported by Metropolitan Life (1976) and presented in Table 1 show that suicide rates from 1963 to 1973 rose relatively more in females aged 35 and older, and in younger males aged 15 to 34.

Completed Suicide in Professional Women

Among professionals, the sex difference in suicide is much less. In some recent studies, females have been found to have a higher suicide rate than males. For example, female physicians have a higher suicide rate than male physicians (Ross, 1973). In other occupations, such as nurses, chemists, and psychologists, the female suicide rate is greater than for the general female population, though still less than the male suicide rate for those occupations.

This increased suicide rate among female professionals may be caused in part by the role conflicts created for females when they work.

Table 1

MORTALITY FROM SUICIDE 1963-64 to 1973-74
FOR THE U.S. WHITE POPULATION*

	Death rate per 100,000					
	1963-64		1973-74		Percent change	
Age	Male	Female	Male	Female	Male	Female
All ages	17.4	6.2	18.8	7.1	8.0	14.5
15-24	9.2	3.0	17.6	4.5	91.3	50.0
25-34	16.7	7.2	22.6	8.6	35.3	19.4
35-44	22.4	10.7	23.3	12.1	4.0	13.1
45-54	31.8	12.5	28.3	13.9	−11.0	11.2
55-64	38.6	11.0	32.3	11.5	−16.3	4.5
65-74	38.9	9.7	35.9	8.8	−7.7	−9.3
75 and over	52.4	6.7	47.1	6.8	−10.1	1.5

*Source: Metropolitan Life (1976).

Furthermore, professional females may experience greater stress in their work (as a result of sexism) than do males. It also appears that stresses from a career may be more suicidogenic than stresses from other sources.

Attempted Suicide

For attempted suicide, Kessler and McRae (1983) reviewed forty-five studies of attempted suicides from 1940 to 1980 and found that the female/male ratio increased up to 1970, where it peaked, and decreased thereafter.

MARITAL STATUS AND SUICIDAL BEHAVIOR

Gove (1972, 1979) has explored in detail the relationship between marital status and completed suicide for males and females. Since World War II, females have had higher rates of mental illness in the United States, and, in particular, married women have higher rates of mental illness than married men. In contrast, never-married men have higher rates of mental illness than never-married women. Gove concluded that marriage reduces psychiatric stress for males but increases psychiatric stress for females. Marriage is more advantageous for men than for women.

Gove examined the ratio of the suicide rate for never-married/suicide rate for married, an index called by Durkheim (1951) the coefficient of preservation. If Gove's hypothesis is correct, this ratio should be higher for males than for females. For the U.S. for 1959-61 the ratio for males aged 26-64 years of age was 2.0 and for females it was 1.5. Single males were 97 percent more likely to complete suicide than married males, while single females were 47 percent more likely to complete suicide than married females. (Divorce and widowhood also seem to be more disadvantageous for males than for females.) Gove also presented data to show that this same pattern appeared when rates of threatened and attempted suicide were examined. Durkheim's coefficient or preservation was consistently higher for males than for females. According to Gove, "there have been changes in the women's role that have been detrimental to (married) women and that, as marital roles are presently constituted in our society, marriage is more advantageous to men than to women while being single (widowed, divorced) is more disadvantageous" (Gove, 1972, pp. 211-212).

Related to this, Bock and Webber (1972) have noted the extremely high suicide rate of the elderly widower as compared to the elderly widow. They attributed this to a greater social isolation (including more frequent absence of kin and of organizational memberships) among the widowers as compared to the widows, and they documented this with a survey of the elderly in a Florida county. The high incidence of suicide among widowers is very likely to be related to the changes in their roles associated with retirement, whereas there may be more continuity in the roles of the women as they age.

Herman (1977) felt that suicide among divorced women was likely to be common because of their dependency role learned from their past life experiences and the difficulty in learning new roles as an adult, both of which would lead to feelings of helplessness.

CHARACTERISTICS OF SUICIDAL INDIVIDUALS

Studies of suicidal individuals have found them to be less active in their social lives and to have poorer relationships with peers and superiors. Suicidal individuals have been found to resent those upon whom they depend, which inhibits straightforward discussions of personal and interpersonal problems and unfulfilled needs. They are also found to

have less confidence in their ability to control their future, especially in interpersonal relationships, and to have less ability to use mature interpersonal strategies (Lester, 1972).

Seriously suicidal individuals have been found to have a lifelong inability to maintain warm and mutually interdependent relationships and to be interpersonally isolated and disengaged (even if married). They tended to make more efforts to change their role prior to their suicidal action than low-risk individuals and to communicate more to their significant others (Lester, 1972).

Clinical impressions of suicidal individuals have focused on difficulties in communicating to significant others just what they want from a relationship and on manipulative intent in the suicidal actions, coupled with frequent rejection from the spouse. It has been hypothesized that suicidal actions can result in part from conscious death wishes on the part of the significant other toward the suicidal partner. Suicidal individuals have been described as taking a demanding, passive-aggressive, and clinging role with their partner (Lester, 1972).

A study of married suicidal individuals (Hattem, 1964) concluded that these individuals were more emotionally unstable, more hypersensitive to rejection, and more critical of the world than their nonsuicidal spouse. They felt weak, dependent, and inferior. In contrast, the spouses felt more self-oriented, exploitive, and competitive, and recognized their need to have relationships with weak others. Hattem described these marriages as submissive-exploitive.

Are the characteristics described above more appropriate to the traditional female role or to the traditional male role? Perhaps females have felt less in control of their future than males, have been more likely to take a demanding, passive-aggressive clinging role, and have felt weaker, more dependent, and more inferior than males.

Wold (1971) proposed 10 types of suicidal individuals, based upon his experience with patients at the Los Angeles Suicide Prevention Center. Two types were characteristic only of women.

1. Discarded women had experienced repeated rejection by men and by their parents. They felt that they were failures as women, but assumed a facade of femininity and had hysterical personalities.
2. Harlequin women eroticized death, seeing death as peaceful and pleasurable. They were masochists and alienated, with a poor self-image and a facade of femininity.

Four other types were primarily women.

3. The chaotic type was psychotic, impulsive, and confused.
4. Middle-age depression characterized another type.
5. The "I can't live without you" type had a passive-dependent but stable life-style. She/he became suicidal in response to a rift in a symbiotic relationship.
6. The "I can't live with you" type was typically involved in a relationship with a person of the same type. Both partners were suicidal and harbored destructive wishes for the other.

Two types are found equally often among men and women.

7. Adolescents with problems in communication with their parents, and identity and dependency problems, often became suicidal. It was not unusual for the parents to have death wishes for their children.
8. The old-and-alone type was typically depressed, was in poor physical health, and had given up on life.

The final two types were characteristic of men.

9. The down-and-out type was a drug and alcohol abuser with a downwardly mobile life course. His self-esteem was low, his health poor, and his interpersonal relationships superficial.
10. The violent type experienced episodes of rage. He drank a lot but was able to hold a steady job and was rarely living alone. However, his rage often led to assaultive and self-destructive behavior.

Several studies have identified consistent differences between male and female suicides. Suicidal women tend to be diagnosed more often as neurotic and with affective disorders rather than as schizophrenic or psychopathic (Davis, 1968). Women tend to be suicidal more often in response to interpersonal problems, whereas men tend to be suicidal more often in response to intrapsychic conflicts and to commit suicide in response to job loss and legal problems (Beck, et al., 1973; Farberow, 1970).

EXPLANATIONS OF THE SEX DIFFERENCE

Methods for Suicide

Women use different methods for suicide than those used by men. Men prefer active methods such as hanging and shooting. Women

prefer passive methods such as drugs and poisons. More subtle differences exist. When suicide is committed by firearms, men are more likely to shoot themselves in the head. Lester (1969a) has speculated that women are more concerned with their physical appearance after death and so choose less disfiguring methods for suicide. Evidence exists for this notion in a study conducted by Diggory and Rothman (1961) on the consequences of death feared most. Women reported more concern with their physical appearance after death than did men.

Thus, one explanation for the sex difference in suicidal behavior is that women choose methods for suicide that are less likely to kill. For example, you are more likely to survive a shot in the body than one in the head, and you are more likely to survive a drug overdose than a bullet wound.

Lester (1969a) noted that this explanation, though possibly correct in part, was insufficient because within any method men die more often than women. For example, in Los Angeles in 1957, of 24 men who jumped to their death, 16 succeeded; whereas of 27 women who used jumping, only nine were successful.

Perhaps women choose less lethal methods for suicide because they are less intent on dying. However, choice of method may be affected by socialization. For example, Marks and Stokes (1976) surveyed male and female students and found that males had much more familiarity with firearms when growing up than did females. Southern students had more early experience with firearms than northern students, and this was reflected in the finding that suicide was committed most often using firearms in the South, for both males and females. Perhaps these differences in socialization experiences affect the choice of a method for suicide?

Physiological Explanations

Several studies have explored the relationship between the incidence of suicidal behavior and the phase of the menstrual cycle. It appears that the incidence of completed suicide does not vary significantly over the menstrual cycle, but that attempted suicide is more common during the premenstrual and menstrual phases (Lester, 1979; see Chapter 9). Thus, it is possible that the higher incidence of attempted suicide in women is due to an excess of attempts made during these two phases of the menstrual cycle. (However, we must remember that we do not know whether there is an excess during these two phases or a deficit at the other phases of the menstrual cycle.) This has led to the suggestion that the level of the circulating sex hormones affects the incidence of suicidal behavior.

Pregnant women have been found to have a low rate of suicide. One estimate of the suicide rate for pregnant women was .03 (per 100,000 per year) compared to a rate of about 6 for women in general (Barno, 1967). However, attempted suicide seems to be as common in pregnant women as in nonpregnant women (Whitlock and Edwards, 1968). Clearly, changes in the likelihood of suicide during pregnancy can have many causes. However, since pregnancy does involve changes in the levels of circulating hormones, hormone levels have been suggested as a possible source of the lowered incidence of suicidal behavior in pregnant women.

Along these same lines, Kane, Daly, Wallach, and Keeler (1966) reported using Enovid to treat a suicidal woman, and Lester (1969b) has suggested that women using the birth control pill might have a different suicide rate from other women. However, Vessey, et al. (1985) found that the attempted suicide rate in women on the pill did not differ from the rate of those using an intra-uterine device (though both of these groups had a higher suicide rate than women using a diaphragm). The length of time on the pill was not related to the rate of attempted suicide.

These reports by no means prove that the levels of circulating sex hormones affect the incidence of suicidal behavior in women. Psychological explanations of the associations can easily be provided. However, the reports do raise the possibility of a physiological influence on the suicidal behavior of women.

Psychosis and Mental Illness as an Explanation

Lester (1970) noted that psychotics have higher rates for completed suicide while neurotics have higher rates for attempted suicide. A review of community surveys revealed that males are more prone to psychosis, whereas females are more prone to neurosis. A community survey of a county in Tennessee (Roth and Luton, 1943) and one of a section of Baltimore (Lemkau, et al, 1942) both reported this sex difference. Lester suggested that the sex difference in suicide may be a result of this difference in the incidence of particular psychiatric disorders. Males are more likely to become psychotic and so may be more likely to complete suicide. Females are more likely to become neurotic and so may be more likely to attempt suicide. No adequate test of this hypothesis has yet appeared.

Societal Explanations

There is one explanation of the sex difference in suicidal behavior that has particular importance for a discussion of sex roles and suicidal behavior. Linehan (1973) felt that an important determinant of what happens

when a person is in crisis is what alternatives are socially acceptable. She felt that attempted suicide was seen in our society as a weak and feminine behavior, and less available to males. Males, therefore, may be less able to communicate mild levels of distress, suppressing their self-destructive impulses until they are so strong as to precipitate a lethal suicide action.

Linehan tested her ideas by presenting to undergraduate students case studies involving males and females in crisis and varying the characteristics of the patients so that some were portrayed as "masculine" while others were portrayed as "feminine." She found that the students predicted suicide as an outcome more often for males than for females, and also that suicide was the predicted outcome more often for masculine patients than for feminine patients. The students predicted suicide 71 percent of the time for the masculine males, 62 percent of the time for masculine females, 43 percent of the time for feminine males, and 22 percent of the time for feminine females.

This suggests that social sex role stereotypes, which are probably based in part on differences in the social roles and the behavior of males and females in the society, serve to perpetuate those stereotyped roles.

FEMALE SUPPRESSION AND SUICIDE

A discussion of sex roles and their influence on the suicide rate has to include the issue of female suppression in societies. Does the differential status of females in a society have any impact upon their suicide rate?

Stewart and Winter (1977) attempted to explore the characteristics of nations in which females were suppressed and discriminated against. They used a sample of all modern countries and identified 25 possible indices of female suppression and/or discrimination, including such variables as the relative amount of education given to females and the length of time for which females have been able to vote. They used a differential measure of the male-female suicide rate by simply subtracting the female suicide rate from the male suicide rate (rather than using a ratio index). Their results showed that the differential suicide rate between the sexes was *not* related to the indices of female suppression/discrimination.

(Incidentally, Stewart and Winter did find that the male suicide rate was relatively higher in countries where the divorce rate was higher, where there were a relatively high number of teenage females married, where there were fewer illegitimate births, where the life expectancies of both sexes were more similar, and where the differences in the male and female homicide rates were less.)

Related to the concept of female suppression is that of ascribed status. Typically, those individuals discriminated against and oppressed in a society have their status ascribed to them. They are what they are and do what they do because of the social roles and societal status prescribed for them. In contrast, the roles of the elite in a society are determined to a large extent by what they themselves accomplish and achieve.

People in ascribed roles have more external constraints on their behavior. Henry and Short (1954) argued that strong external constraints provide a clear external source to blame for one's misery and so facilitate homicidal behavior and inhibit suicidal behavior. In contrast, those in achieved roles have weak external constraints on their behavior. Their failures cannot be blamed so easily on external agents. They themselves must bear the burden of responsibility. Thus, suicidal behavior is facilitated and homicidal behavior is inhibited.

If we view the traditional female role as an ascribed one and the traditional male role as an achieved one, then suicidal behavior should be more common in males, whereas homicidal behavior should be more common in females. Only the first of these predictions can be confirmed. In the United States, males show both more suicidal behavior and more homicidal behavior.

The traditional roles change somewhat during time of war. In times of war, when males are drafted into the armed forces, females take over many of the traditional male roles in society. They thus become more able to achieve a role in the society. Lester (1972) reviewed information on suicide rates during time of war and found some evidence for a relatively higher female suicide rate.

Several studies have looked at the association between the extent to which women are in the labor force and the overall suicide rate of a region. Newman, et al. (1973) found in two U.S. cities (Atlanta and Chicago) that the suicide rate was higher in those census tracts with a higher proportion of females in the labor force. Although Lester (1973) failed to replicate this association using data from Buffalo, Stack (1978) replicated the association using a sample of 45 nations of the world.

The reasons for this association are far from clear, and none of the studies have tried to clarify them. It may be that more married and working females are committing suicide in areas where more females are in the labor force, possibly because of role strain. On the other hand, it may be that the participation of females in the labor force creates additional stress for men (both those in the labor force competing with the females and those married to the working females), thereby increasing

their suicide rate. Or it may be that the association is a spurious one, resulting from the importance of some other major sociological variable that is also associated with the percentage of females in the labor force (for example, industrialization).

Cumming, et al. (1975) reported that married women who were employed in British Columbia, Canada, had a lower suicide rate than those who were not employed. They concluded that there was no evidence for the existence of role strain in married working women. Incidentally, the suicide rates for single, widowed, and divorced women who were employed were also lower than those of the unemployed. Thus, employment is associated with a lowered suicide rate for all women, regardless of marital status.

Future studies are necessary to explore why geographic regions with many working females have a higher suicide rate.

FINAL COMMENTS

At a macroscopic level of analysis, there is some evidence for a relationship between sex roles and suicide. The effects of marital status on the suicide rates in males and females, the prediction by college students of suicide in masculine and feminine males and females, the sex difference in suicidal behavior, and the theoretical ideas of Henry and Short on ascribed versus achieved status all lend support to the notion that sex roles are related to suicidal behavior.

Sex roles also involve particular kinds of relationships between men and women. Two problems confront us here. What are the characteristics of the relationships between men and women, for example, between husbands and wives? What are the characteristics of the interpersonal relationships of those prone to suicide? Neither of these questions is easily answered.

Virtually no research has been conducted on the interpersonal relationships of those who complete suicide. Their death makes collection of data difficult. Interviews with the friends and relatives of the deceased person (often called psychological autopsies) yield some information, but it is generally unreliable. Informants often have a distorted perception of the deceased's behavior and personality, and their reports are not an adequate substitute for objective psychological test scores or the observations of expert clinicians. Thus, most of the information on the interpersonal relationships of suicidal individuals has been collected from

studies of those who attempt suicide, and many suicidologists have argued that the study of attempted suicide can tell us little that is relevant to completed suicides (Lester, 1972).

At a microscopic level of analysis, where we explore the relationship between actual behavioral roles and the frequency and kind of suicidal behavior in individual people, we find little systematic research. It is, of course, easier to study distal variables (such as marital status) than to study proximal variables (such as the nature of an individual's role). The data are more readily available and distal variables are operationally defined more easily than proximal variables.

The result is that we have some interesting possibilities as to how and why sex roles might be related to suicidal behavior. But we have little concrete evidence from studies of individuals that sex roles *per se* are (or are not) related to suicidal behavior.

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