SUICIDE IN HONG KONG 1981-1991: A SOCIAL AND SPATIAL ANALYSIS

by

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ABSTRACT

This thesis is a social and spatial study of suicide in Hong Kong's three subregions: Hong Kong Island, Kowloon, and the New Territories for the period 1981-1991. The primary data used are official suicide statistics; these are supplemented by descriptive newspaper accounts of suicide. Over time, the suicide rate for Hong Kong as a whole, as well as for each of these subregions, increased during this period. Over space, the rate was highest for Kowloon, a core urban area with the highest degree of social disorganization. The New Territories, a recently urbanized subregion, had the lowest but increasing rate. Moreover, it has been found that the suicide rates for all subregions increased lineally with age. It is hypothesized that the relatively high suicide rate for the older population is related to the inequitable social-wealth redistribution stemming from Hong Kong's *laissez-faire* economic policy, in particular, inadequate social services, inefficient public-sector medical services, and formal and informal suicide-intervention opportunities. It is also observed that Hong Kong's media provide most of its suicide coverage to the age group with the lowest suicide rate—school age people, while coverage given to elderly suicides is relatively rare and usually brief; this perpetuates public ignorance of elderly suicide as a problematic social issue. Increased equity in social-wealth redistribution and increased public awareness of depression and suicide are proposed as means of reducing suicide in Hong Kong.

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To mom (1921-1992) and dad (1911-1991)

CHAPTER ONE: INTRODUCTION

Suicide is a universal phenomenon (Stillion *et al.* 1989, 18), a phenomenon which is found in societies of all social and economic conditions. Suicide causation cannot be reduced to any one factor to the exclusion of other factors; it is not a mental illness or emotional disorder; it is a potential *outcome* of a self-destructive behaviour related to, or resulting from, depression and a number of other factors, such as biological, psychological, social, and environmental factors. This thesis is a spatial analysis of suicide in Hong Kong's three subregions of Hong Kong Island, Kowloon, and the New Territories, for the period 1981-1991. It focuses primarily on the relationship between the rate of suicide on the one hand, and the socio-spatial and environmental characteristics of these subregions on the other hand. Chapter Two of this thesis will begin with a brief review of suicide literature from a selected number of non-spatial and non-sociological research perspectives, such as psychology, biology and genetics, and medicine and psychiatry. This is to familiarize readers from social science disciplines who are not suicidologists with some of the established findings and current debates in suicidology.

One of these major findings is that the affective disorder called clinical depression, as it is known in the West, is thought to be present in a sizeable majority of people who complete suicide. Although many studies have revealed biochemical changes in the brain among the clinically depressed, clinical depression is not caused exclusively by biological, genetic, or psychological factors; these factors, as many have argued, can only predispose certain individuals to develop depression.

Since most of the people who suffer from clinical depression do not die by suicide, many suicidologists have focused on the roles of other additional factors in suicide causation. Some have argued that certain environmental and social factors can accelerate the onset of clinical depression among people predisposed to developing it (Stillion *et al.*, 57-58), while others have asserted that environmental and social stressors can increase the likelihood of suicide completion among people who are already clinically depressed (Stillion *et al.*, 57-58). This thesis supports the significance of both of these probable causal relationships.

The objective of this thesis is to identify, analyze, compare, and contrast environmental and sociological factors related to completed suicides in Hong Kong's subregions. A measure of the level of importance of suicide in Hong Kong is that more people died by suicide than by accident in Hong Kong in 1990. This made death by suicide the second largest cause of death—next to death by natural causes (Hong Kong Government

1990).[1] A total of 747 people died by suicide in Hong Kong in 1991, resulting in an aggregate suicide rate of 13.52 per 100,000. Although this is a relatively low rate compared to those in many Western nations and Japan (Figure 1), it represents, nevertheless, a 38 per cent increase from a rate of 9.82 per 100,000 for 1981; in absolute terms, the number of completed suicides in 1991 increased by 50 per cent from a total of 497 suicides recorded in 1981, while the population increased by 11 per cent from a total of 5,109,892 in 1981 to a total of 5,674,114 in 1991 (Census and Statistics Department 1992). It is also evident that a more balanced sex ratio exists in the rate for Hong Kong, as well as that for the largely ethnic-Chinese city-state of Singapore. Spatial variations in the suicide rate are evident between each of Hong Kong's three subregions of Hong Kong Island, Kowloon, and the New Territories. While the aggregate suicide rate for all of Hong Kong in 1991 was 13.52 per 100,000, the rate for each of these subregions was 14.33 per 100,000, 15.24 per 100,000, and 11.72 per 100,000, respectively.[2] These and other data will be presented in Chapter Three and analyzed in Chapter Four.

What are some of the factors which have lead to these spatial variations between the core urban area of Hong Kong Island, the core urban area of Kowloon, and the recently urbanized New Territories in this modernized and deindustrialized colonial city-state? After the research methodology has been presented in Chapter Three, the suicide statistics used in this study for the period of 1981-1991 for these three subregions will be presented. The penultimate section will compare and analyze the subregional differences between the suicide rates in terms of spatial variations in age and sex, and in terms of the social, economic, and environmental conditions of these subregions; the major factors identified in the literature review are applied to the findings on suicide in Hong Kong throughout this section. Further discussion, prospects for suicide prevention in Hong Kong, and concluding remarks will be offered in the last section.

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[1]Suicide incidence supplied by Hong Kong Coroner's Office. Rate derived from incidence and 1991 census.

[2]See Chapter 3 for the sources and method of calculation of these rates.

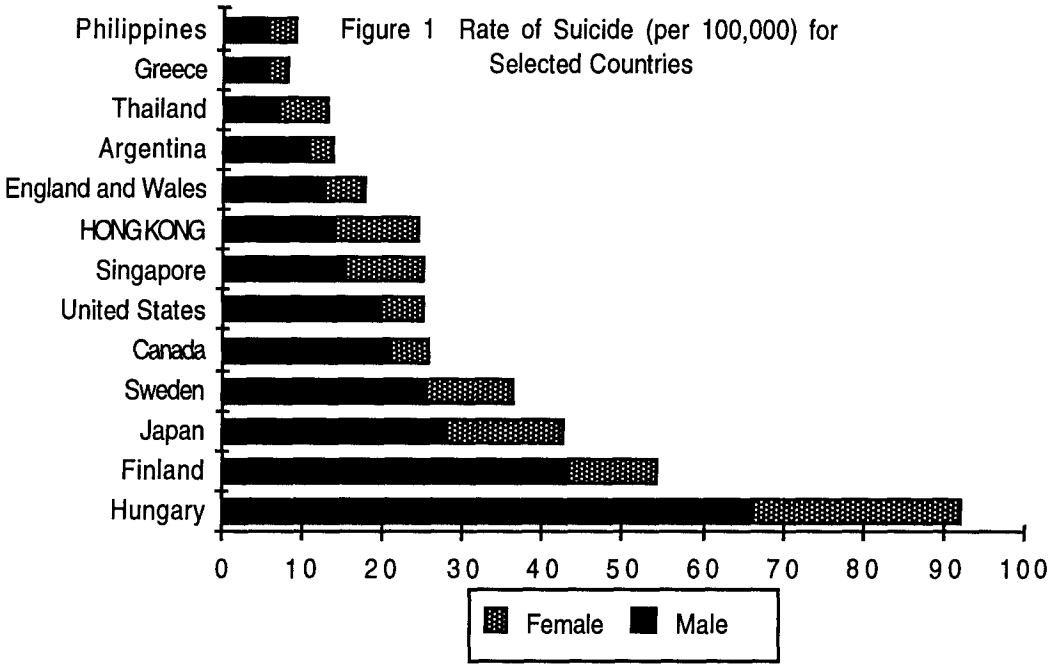

Figure 1 Rate of Suicide (per 100,000) for Selected Countries

Source: World health Organization Annual 1987.

CHAPTER TWO: LITERATURE REVIEW

Much debate has taken place among genetic-, biological-, medical-, and psychological-perspective suicidologists over the significance of genetic, biological, psychoanalytic, developmental, social learning, and psychopathological factors in the shaping of an individual's suicidal proneness. Although this thesis is not focused on these perspectives, the prevalence of depression and hopelessness among suicidal people almost universally renders it a necessity to understand more about depression; this is particularly true because the treatment of depression and alleviation of hopelessness are crucial to an *immediate* reduction of suicide lethality in suicidal individuals. This literature review will begin, therefore, with a selection of findings by these non-sociological researchers—findings which led to the recognition of clinical depression and hopelessness as two antecedents to suicide. Since ethnic-Chinese make up 98 per cent of Hong Kong's population, attempts will be made throughout the literature review chapter to apply Western suicide-research findings to suicide in Hong Kong, and to compare, contrast, and synthesize these Western findings with traditional Chinese concepts of health and illness.

The review of selected literature on the social, economic, and environmental causes of suicide which follows will examine factors external to the individual psyche that can affect the proneness of suicidal individuals to complete suicide: it is here that a section on the mobilization of social and economic resources for suicide prevention and intervention will also be presented.

Finally, the utility of each of these bodies of literature in enhancing the understanding of suicide causation and in increasing the effectiveness of suicide prevention will be evaluated at the end of this literature review chapter. It will be demonstrated throughout this chapter that although completed suicides are individually initiated acts, these sum total of these acts—the aggregate suicide statistics—for a given geographical area can reflect, and also be a result of, its social economic, and environmental characteristics. What will be discussed later in this review, then, are the relationship between depression and the emotional state of suicide ideation on the one hand, and 1) the psychosocial factors leading to the manifestation of one of the associated behaviours—a suicide attempt, and 2) the social, economic, and environmental factors leading to the completion of the attempt on the other hand. The suicide data for Hong Kong's three subregions for the period 1981-1991 will be introduced in the next chapter for the purpose of making spatial comparisons and analyses of completed suicides in those subregions. The following section begins with a review of the biological-perspective findings pertaining to suicide.

The Biological Perspective

The assertion that suicide has both organic and inherited causes was first made by the German psychiatrist Emil Kraeplin at the turn of the century (Kushner 1989, 80). Until the 1950s, depression and many other mental illnesses were thought of as purely psychological (Kushner 1989, 203). Today's biological research on suicide focuses on the *physical* or *physiological* composition or attributes, especially those of the brain, of humans capable of making them depressed and suicidal. Research in this perspective can be broken down into 1) genetics research and 2) biochemical research.

Genetics Research

For some time, genetic factors have been thought to be responsible for the transmission of affective disorder and suicidal tendencies, such that "a family history of suicide significantly increased the risk for a violent suicide attempt" (Roy 1990, 50). Blumenthal and Kupfer (1986) found that "suicidal behavior is higher in relatives of persons who exhibit suicidal behavior." Kallmann (1947) found "high concordance rates for schizophrenia and manic-depressive illness in monozygotic twins, [but] no concordance at all for suicide." Twenty years later, Haberlandt "found a significant number of concordant monozygotic twin pairs with suicide" (Haberlandt 1967). On the contrary, Kety found that "in no series [of studies] is the concordance rate as high [in suicide] as it is for depression or schizophrenia' (Kety 1986, 41).

Genetic research has not been able to adequately demonstrate that it is the genetic, rather than other factors—such the socialization-experience and environmental factors—that is accountable for this phenomenon. Research findings on purely or largely genetic factors in suicide remain inconclusive.

Research conducted for this thesis failed to reveal any genetic study of suicide among the Chinese.

Biochemical Research

An organic basis for the etiology of melancholia, as well as a somatic etiology of some suicides, were suggested in the nineteenth century (Kushner 1989, 80). Colt reported recently that more than three-fourths of suicides are by people who suffer from affective disorders and/or alcoholism" (Colt 1991, 202).

Modern biochemical research in depression and suicide is built on the basis that chemical changes at the synaptic junction in the brain between the transmitting and receiving neurons can affect the synaptic transmission processes, and that depression,

among other mental illnesses, results from the inhibition of normal synaptic transmission processes (Stillion *et al.* 1989, 54). This inhibition can be caused by psychological factors (such as the death of a close person), by natural biochemical changes due to senility, by physical trauma like a blow to the head, or by certain medication used to treat physical or other mental illnesses. In fact, it was one of the side effects of the drug Reserpine, used to control or treat high blood pressure, that led to the discovery of this relationship between the two neurons in the 1950s: a high percentage of patients on this drug reported depressive symptoms while on the drug (Stillion *et al.* 1989, 54).

By now, biochemical research in suicide has established a relationship between serotonin (as measured by one of its metabolic products called 5-HIAA) and dopamine deficiency in the brain on the one hand, and poor impulse control, aggressive behaviour, and *violent* suicide attempts on the other hand (Asberg, Nordstrom, and Traskman-Bendz 1986; Colt 1991, 203-04; De Leo 1988, 114; Korn *et al.* 1990, 57-70; Lester 1988a, 57; Roy 1990, 40-49; Stillion *et al.* 1989, 54-55). The use of psychoactive drugs, such as monoamine oxidase inhibitors (MAO) and tricyclic antidepressants, to correct chemical imbalances thought to cause depression can largely be attributed to biochemical research. No link, however, has been established *directly* between biochemical factors on the one hand, and suicidal proneness as well as the less violent suicides on the other hand.

Not all biochemical researchers dismiss the possibility that suicidal behaviour might be learned; many of them are aware that "the family member who has . . . [died by] suicide may serve as a role model to identify with when committing suicide enters one's mind as a possible solution to the alleviation of intolerable psychological pain" (Korn *et al.* 1990, 57; Roy 1990, 54-55). In fact, suicide as a learned behaviour will be presented in a subsequent section of this review. While many biochemical researchers have been criticized for their slighting of non-organic, such as social, causes of suicide (Colt 1991, 204-05; Conroy 1991, 80; Kushner 1989, 80), this following explanation by Akiskal and McKinney (1973) should help to demonstrate that not all biochemical researchers neglect the role of other factors in suicide causation:

> There is a "final common pathway" which results in the transformation of loss experiences and other negative life events into physiological functioning at the chemical level in the brain. Thus, regardless of the environmental cause of depression, whether the death of a loved one, a broken home, divorce, child abuse, or the negative self-concept and learned helplessness accumulated during a lifetime, at

> some point physiological changes occur in the brain. (Stillion *et al.* 1989, 56)

To examine the universality, if any, of this final common pathway, psychological and emotional disorders, as they are called in the West, tend to be somatized in traditional Chinese society. This is still evident in Hong Kong today, where a study on university students found that common health or mental health problems are described as "weakness and fatigue, tension and anxiety, difficulty in sleeping, 'hollow emptiness,' and headache" (Cheung, Lee, and Chan 1983). Symptoms such as these, as well as "lack of vital energy, lack of blood, . . . and *shen kui* (腎虧) [kidney deficiency]," often result in a diagnosis of neurasthenia by Western medical practitioners in Hong Kong (Cheung 1986, 179). This is a diagnosis which has been loosely applied by patients, their families, or professionals to refer to a variety of symptoms of both a somatic and psychological nature without incurring the stigma associated in Chinese society with being mentally ill (Cheung 1986, 179).

The few studies conducted on the correlation between Chinese psychopathology and physical and physiological attributes have revealed the following. Unusually quick electroencephalogram (EEG) reactions to external stimuli and delayed after-effect reactions were observed among neurasthenia patients (Kung 1963).

Ewing, Rouse, and Pellizzari (1974) found more face-flushing and higher heart rates among Asian students in the United States after consuming alcohol, and attempted to attribute these Asians' lower rates of alcohol abuse to their aversive physiological reaction to alcohol. A similar study was done by Sue and Nakamura (1984); these researchers concluded that socio-cultural, rather than biological, factors were responsible for differences in the rate of alcohol abuse.

Two Hong Kong studies found that compared with normal Chinese population, "Chinese schizophrenic and neurotic patients had smaller body size and higher linearity whereas, among affective patients, males had larger body size but females had smaller body size. The authors concluded that the correlation they obtained for these variables were similar to those reported for Caucasians" (Singer, Chang, and Hsu, 1972; Singer, Lieh-Mak, and Ng, 1976). No study can be found, however, on the biological or chemical characteristics of the Chinese to account for differences, if any, in the susceptibility to suicide between the Chinese and other populations.

Psychological Perspectives

Many people consider psychology the most appropriate field in which to study the causes of suicide. This is because suicide is generally seen as an exclusively human

behaviour (Asberg, Nordstrom, and Traskman-Bendz 1985, 47), and that psychology is often defined as the study of behaviour. Proponents of this view include psychoanalyst Alfred Adler, who argued that "suicide can be understood only individually, even if it has social preconditions and social consequences" (Colt 1991, 194), as well as Richman and Eyman, who expressed the view that psychology held the most promise in treating suicidal people:

> Suicide is the only form of death whose classification is determined by a psychological variable, that of the motivation or intent of the deceased. It therefore seems fitting to use psychological forms of treatment with suicidal patients. (Richman and Eyman 1990, 139)

The number of psychological works on suicide, however, is dwarfed by those coming from sociology (Lester 1988b, 3-4). This is in part because while sociological researchers can gain access to suicide and other social data with relative ease for the purposes of establishing numerical facts and making sociological inferences,[3] the standardized information on the psychological state of suicide attempters required by psychological researchers is rarely collected from suicide attempters by means of a standard questionnaire in the wake of suicide attempts. Asking direct questions about the psychological states of completed suicides becomes altogether impossible: the subjects are dead and not available to interviewers.

Another type of study method used from time to time in psychology is the longitudinal method. This type of study often tracks twins from the time of birth until well into adulthood; it has been used to determine, for instance, the role of the genes and the environment in the onset of disease, such as schizophrenia and alcoholism. But the statistical rarity of completed suicides, compared to the prevalence of schizophrenia and alcoholism, makes longitudinal studies of suicide extremely costly and next to impossible.

Yet another method, commonly used in experimental psychology, is to manipulate the emotional condition of experiment subjects in a controlled laboratory setting in

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[3]It must be stated that many suicides are masked, for example, as single motor-vehicle accidents and accidental drug overdoses, to the extent that the number of "real" suicides have been estimated to range between four to eight times the number of officially classified suicidal deaths worldwide. The continued reliance on and use of official suicide statistics by suicidologists is based on their confidence in the overall consistency of death-classification standard and practice over time *within* most jurisdictions. This consistency facilitates the comparison of changes over time in the suicide rate for an area—such as Hong Kong.

order to elicit a response or behaviour, such as an erection. Manipulating human subjects to the point of making them suicidal is certainly ethically unacceptable.

In spite of these limitations, psychology has contributed significantly to the understanding of the processes which lead to the presence of suicidal thoughts in a particular person's mind. This review now begins with Freud's psychoanalytic school of interpretation of suicide causation.

The Psychoanalytic (Freudian) Perspective

The psychoanalytic perspective, derived from classical Freudian and neo-Freudian theories, holds that each individual has a finite amount of psychic energy (*libido*). *Libido* is made up of the dichotomous entities of the life- and pleasure-seeking energy of *eros*, and the naturally occurring death-instinct energy of *thanatos*; suicide occurs when the amount of *thanatos* becomes so high that it becomes the dominant energy in the mind of a person. An excess of *thanatos* can be caused by factors such as "prolonged intrapsychic conflict, . . . regression or fixation at a particular psychosexual stage" and unconscious hostility (Stillion *et al.*, 35).

Freud's theory assumes that the mind of all individuals across time and space are developed and shaped in chronologically structured stages early in life. These stages—oral, anal, phallic, latency, and genital stages of development—last only up to about the age of 18. For fear of emotional pain, individuals instinctively store the unpleasant experiences (such as excessive beating, sexual abuse, and frequent neglect) which they received between birth and late adolescence in a "region" of their mind that is not identifiable physically, a region Freud called the unconscious, and by a process called repression. Repression, according to Freud, is an unconscious act people are capable of performing universally (T'ien 1985, 78). The higher the number of negative events experienced early in one's life, the more *libido* would be required to repress these events; this would result in an insufficient amount of *libido* left for normal development. Such deficit could then result in inadequate ego development, a condition which then generates an excess of desires and behaviours governed by the id (such as the need for frequent approval and those behaviour required to procure the approval), and to a pathologically strong superego, which can make an individual develop pathological perfectionism, or become obsessed with retaining independence, leadership, control over events and other people, etc. From a Freudian perspective, the suicide of Vincent J. Foster in July, 1993 in Washington, DC, can be seen as the result of a strong superego, which rendered him vulnerable to negative criticisms, perceived loss of control and failure.

The arrest of ego development, according to Freud, is also responsible for a host of psychological malaise, such as narcissism and self-directed anger. Suicide, in particular, is anger turned inward, which has been triggered by, say, the loss of, or rejection by, a significant and highly cathected object (i.e. a person) (Leenaars 1990, 159):

> Probably no one finds "the mental energy to kill himself unless, in the first place, in doing so he is at the same time killing an object with whom he has identified himself and, in the second place, is turning against himself a death wish which had been directed against someone else" (Freud 1920, 162; Leenaars 1990, 159).

The Freudian perspective asserts, then, that individuals who kill themselves do so out of anger which was initially directed externally (at the lost object), but was subsequently projected onto themselves.

It was not until the 1930s that Zilboorg—a "neo-Freudian"—added experiences acquired by one later on in life, such as a broken-home environment in one's teenage years, and an individual's suicidal proneness (Zilboorg 1937). Still later, Litman added the significance of emotional states, such as rage, guilt, anxiety, dependency, helplessness, and hopelessness to the suicidal process (Colt 1991, 201-02; Litman 1967, 70).

In spite of these modifications, the psychoanalytic theory of suicide is still ill-suited to the prevention of suicide (Stillion *et al.*, 35). This is because it attributes the causes of suicide—as an outcome (death) of a pathological behaviour (self-destruction)—to repressed and unconscious motives of an individual whose emotions were insufficiently developed, rather than, for instance, to depression induced by organic brain-disease or to social problems. Its high degree of reliance on the retrieval of repressed early experiences also necessitates lengthy and costly in-depth psychoanalysis, which rarely brings about a quick reduction in feelings of hopelessness or the severity of depression. This pessimistic view of the psychoanalytic approach was echoed by Conroy—a depression and suicidal-pain sufferer with over ten years of suicide-intervention experience. He attributed the popularity of the psychoanalytic model to a desire on the part of the mainstream members of American society to blame the suicidal person, instead of acknowledging "social complicity in the causation of suicidal pain" (Conroy 1991, 54).

A Freudian interpretation of suicide in Chinese culture might be focused on the role of shame or loss of face; these are some of the traditional means of moral- and

social-control mechanisms instilled into the Chinese at an age as young as Freud's first of three stages of development. Instead of being socialized to feel guilty of their immoral acts, Chinese children are taught to avoid bringing shame or causing a loss of face to the social unit to which they belong which, in Chinese society, is the family with the parents—especially the father—at its helm (King and Bond 1985, 37; Wu and Tseng 1985, 7). School-age individuals who receive demerit points for misconduct or failing grades in school, or breadwinners who lose their families' life savings in bad investments, might well be blamed by other family members for their academic failure or investment loss. This is because the poor academic performance or investment miscalculation, once leaked to people outside the family unit, can tarnish the image of, and incur shame to, the entire family unit (Lin and Lin 1981).

In the case of individuals whose emotional development prior to adulthood have been pathological, such set-backs can easily be construed as events causing the loss of love or approval of the significant other. This rejection, coupled with the typical ambivalence of people with inadequate emotional development, can lead to an ambivalent feeling of both affection and hostility toward their significant others. These individuals' pathological development also make them identify with the significant other. This is to say, then, that although they are angry or vengeful toward a significant other for their rejection, their identification with and their erroneous projection of the significant other compel them to act out to themselves as if they were acting toward the significant other. The anger and the murderous wishes initially targeted at the parents or at the spouse have now become anger turned inward. And when these individuals' overwhelming shame, harsh self-criticisms, and impaired personal-organization abilities compel them to destroy the "real" object of their hostility, they kill themselves. These might be one of the numerous processes, according to classical Freudian theories of suicide, for the failing Hong Kong student and financial risk-taker to commit "murder in the 180th degree."[4]

The Psychosocial Perspective

While Freud stressed only the childhood and adolescent experience of individuals, Erik Erikson, the founder of the psychosocial school of psychology, argued that the shaping of the human experience of individuals is not limited to the early years (Stillion *et al.*, 35-39). He asserted that individuals are continually modified by their

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[4]This application of the psychoanalytic approach to suicide in Chinese society is based on the 10 protocol sentences or aphorisms on the psychoanalytic approach to suicide as proposed by Leenaars 1990, p. 161.

experiences throughout their lives, and are capable of developing, maintaining, or increasing their sense of self-worth (as well as, for example, self-doubt, inferiority, and despair—feelings which could eventually lead to depression and suicide). From the standpoint of devising psychotherapy, the psychosocial school provides a more optimistic framework for the understanding and alleviation of psychological malaise and suicidal lethality compared to that of the psychoanalytic school. The psychosocial school asserts that negative self-image is a psychological state found in most suicidal people, and that the development and retention of personal integrity lessens the likelihood for one to form such a negative self-image. However, little research directly on suicide from this perspective has been produced.

Popular perception in the West, but also from within Chinese society, that the elderly in Chinese society are well looked after. Given that the elderly has the highest suicide rate in all the three subregions of Hong Kong, a high prevalence of despair among the the elderly population would be suggested by psychosocial theorists. This phenomenon will be examined in detail in Chapters Three and Four.

The Humanistic Perspective

The humanistic perspective believes that suicide occurs when individuals, having failed to discover meaning in their lives, begin to experience a sense of uselessness, hopelessness and, in the end, depression (Stillion *et al.*, 39-42). This type of condition, seen as pathological, has been described as "noogenic neurosis: . . . one of the most widespread illness of Western societies in the twentieth century" (Stillion *et al.*, 43-44). It is one of the psychological perspectives which acknowledges the presence of a relationship between social factors and depression. According to this theory, it is when individuals realize their unique potential—a process called "self-actualization"—that they then become capable of reaching the highest level of human attainment and, in turn, become less prone to suicide (Stillion *et al.*, 45). Applying this theory to Hong Kong, it might be hypothesized that the spatial or social area with the lowest suicide rate should be the least Westernized area, while the area with the highest rate should the most Westernized area.

The Behavioural Perspective

The behavioural, or learning, perspective discussed in this section and the cognitive perspective (discussed in the next section) are two of the psychological perspectives on suicide whose research and application have provided effective psychological therapy for suicide prevention (Clum and Lerner 1990). Behaviourists

believe that most observable behaviours—both the statistically normal and deviant types—can be *learned* by classical conditioning, operant conditioning or modeling (Lester 1988b, 23-27; Lester 1987 [throughout]; Stillion *et al.*, 39-42). The kind of conditioning, or *learning*, perhaps most well known is *classical conditioning*. The origin of this model is attributed to Pavlov at the turn of the century, when he conducted a series of experiments with dogs, in which the offer of food was always preceded by the ringing of a bell. After having repeatedly presented this pair of stimuli in the same sequence, the dogs learned to associate the bell-ringing to the imminent availability of food. By association, these dogs later *learned* (or were conditioned) to manifest the behaviour of salivating to the sound of the bell alone.

In a more recent experiment, heterosexual college males who were repeatedly shown pictures of boots, together with erotic pictures of attractive women, learned by association to exhibit sexual arousal when they were subsequently shown pictures of boots alone (Lester 1987a, 11; Rachman and Hodgson 1968). Similarly, behaviourists believe that most types of anxiety, such as claustrophobia, can be acquired by classical conditioning, for example, by frequent confinement to a tight space in early childhood (Stillion *et al.* 1989, 39), a process which leads to the mere association of confined space with anxiety. Unlike the psychoanalytic school, behaviourists hold the view that all pathological behaviours have demonstrable antecedents.

In addition to acquiring behaviour by mere association, behaviour can also be learned by reinforcement or rewarding—a learning process called *operant conditioning*. An example of operant conditioning is that hungry animals left alone in a controlled physical environment can *learn*, by trial and error, that food (a positive reward) can be made to appear whenever a certain lever is pushed (a behaviour); subsequently, these animals engaged in the same button-pushing behaviour whenever they wanted to be rewarded with food. Reinforcers (or rewards) can be positive or negative, as the following description of operant conditioning on a human being demonstrates:

> A baby is left alone in his crib, and the light turned out as his mother leaves his bedroom. He cries and, after a while, his mother returns and turns the light on to see if he is all right. The response of crying has been rewarded, both by the positive reinforcer of his mother's presence and attention, but also by the negative reinforcer of the ending of darkness and of being alone. His mother is teaching him to cry at night [by operant conditioning]. (Lester 1988b, 24)

According to the operant-conditioning model suicide can be seen as an act which provides a negative reinforcer: death provides an end to unbearable psychological pain, .

Another type of learning is called *social learning*. Unlike animals, humans have complex problem-solving abilities (such as piecing together a jigsaw puzzle) which enable them to learn by using solely internal thoughts:

> Thoughts can provide stimuli, responses can be imagined and reinforcers can be cognitions (such as self-praise). Thus, for example, a person can engage in trial-and-error problem solving tasks using solely internal thoughts, so that an observer would observe no stimuli, responses, or reinforcers. Social learning theory accepts too that humans can learn by watching others (by modeling). (Lester 1987, 12)

Modeling is a learning process whereby from observing others, one forms an idea of how certain new behaviours are performed, and that this coded information serves as a guide for action on later occasions (Bandura 1977, 22). Lester argued, for example, that the suicide of writer Ernest Hemingway could be explained from the standpoint of modeling. Hemingway had *learned*, from the numerous suicides by firearms in his family, to associate his own depression-induced emotional pain with the behaviour of suicide (Lester 1987, 105-118).

The timing, method, and location of suicide can also be *learned* by modeling. Some examples of modeling in suicide are as follows: suicides which take place on the anniversary of the suicide of a significant other (such as a parent, sibling or lover), suicides which occur in a cluster, for example, shortly after the suicide of a rock star or a charming and admired high-school group leader, and suicides at highly symbolic locations, such as the Eiffel Tower or the Golden Gate Bridge (Stillion *et al.* 1989, 40-41).

One sub-type of social learning theory—*learned helplessness*—is most pertinent to the understanding of depression and suicide (Stillion *et al.*, 41-42). This is when one has *learned* to believe in an *external locus of control*, rather than an *internal locus of control*, over events in one's life; it is a belief learned earlier in one's life that one's responding is independent of reinforcement (Seligman 1975, 93). In other words, it is a belief that one is unable to change the course of events in one's life regardless of what one tries to do.

From a behaviourist standpoint, this passive acceptance of an external locus of control over events in life results from a passive acceptance of painful stimuli (for instance, noxious, unpleasant, disturbing, or stressful stimuli) in one's life. The

founding of this theory of behaviour-learning can be credited to Seligman, who conducted an experiment on dogs restrained in harnesses. Seligman applied repeatedly, first, a tone, followed by an electric shock to these restrained dogs. As soon as the dogs *learned* to associate the tone with imminent pain, they attempted to break themselves free upon hearing the tone. However, once they have *learned* over a prolonged period of time that the shocks were inescapable, they ceased making any attempts at all to escape upon hearing the tone—even after their harnesses have been untied (Seligman 1975, 23-27; Stillion *et al.*, 41-42). Together with the findings of a series of experiments studies on humans, Seligman believes that unavoidable traumatic events suffered earlier in life can contribute to some types of depression found in suicidal individuals (Seligman 1975, 93-106; Stillion *et al.*, 41-42).

The effectiveness of behavioural therapy rests upon the behaviourists' optimistic view that most behaviours learned by classical conditioning, operant conditioning, or modeling can be *un-learned* by these same processes. In other words, the likelihood of suicide can be decreased by strengthening suicidal individuals' belief in an internal locus of control, and to develop "new and healthier ways of coping" (Stillion *et al.*, 42). This process—called behaviour modification—offers greater, and more immediate, therapeutic value than does the psychoanalytic approach in reducing the level of suicidal pain.

This kind of therapy, sometimes called "talk therapy," is rarely practiced in Hong Kong (Cheung 1984). The Chinese prefer discussing their psychological problems with friends and family members (Cheung 1984, Tsoi and Tam 1990, 211-12). The more serious affective disorders come to the attention of medical physicians as somatic complaints (Kleinman 1977; Marsella 1980; Tseng 1975); it is important, therefore, for professionals, friends, and family members to be aware of the potential affective problems often associated with somatic complaints. These findings indicate that one of the very few effective means of suicide prevention is not being used in Hong Kong (Cheung, Lau, and Wong 1984).

The Cognitive Perspective

The cognitive perspective on depression and suicide is most often associated with the research of Aaron Beck in the 1960s and 1970s (Leenaars 1990, 161-62). His research established the role of hopelessness, a cognitive state, as a variable between depression and suicide: a topic to be presented in the next section.

In contrast to the behavioural perspective's emphasis on observable behaviour, the cognitive perspective in suicide studies and attempts to modify the pathological

cognition—the thinking process and perceptions—of depressed or suicidal individuals, such as inexact labelling, selective abstraction and over-generalization (Stillion *et al.*, 50-51). Cognitive theories also try to integrate psychoanalytic, psychosocial and behavioural theories. They assert that it is the cognition that creates, in certain individuals, the often-erroneous perception of rejection or neglect by others; if these individuals can change their views they can improve their mental health (Stillion *et al.*, 45-51):

> From the point of view of suicidal patients, cognitive therapy offers hope that they can be taught to see the world in a more rational, less hopeless manner and that a change in worldview will result in a change in suicidal attitudes and behaviour. (Stillion *et al.*, 51)

In other words, cognitive therapy is focused on changing individuals' subjective—and negative—interpretation of their painful situations. The inclusion of behavioural views also enables cognitive therapy to aim at bringing relatively immediate changes to the behaviour of the suicidal.

Even when anti-depressant use is called for, a combined program of cognitive and behavioural therapy is most crucial in reducing suicidal pain during those initial weeks required for antidepressants to reach their minimum level of effective dosage. Continuation of cognition- and behaviour-modification therapy reduces the likelihood of recurrent negative views and destructive behaviours (Clum and Lerner 1990).

It was stated in the previous section that the emotionally disturbed in Hong Kong prefer informal peer counselling to formal therapy. Since cognition-modification calls for persuasion and reasoning, it is important that people who are called upon by their depressed friends to listen, to persuade, and to reason be well-informed of the symptoms of depression, and the important skills of listening, focusing, and mutual problem-solving.

Some studies have argued that the Chinese prefer to have an authority figure, such as a licensed medical doctor, instruct them on the means to get well; others have argued that authoritative instructions to get well psychologically work well only in the short term (Cheng and Wu 1977). The articles in the Appendices to this thesis provide examples of informal "counsellors" in Hong Kong attempting to moralize with the depressed about how wrong it is to feel suicidal, as in the case of the school principal who, following the suicidal death of one of his students, stressed the importance of "appreciating the preciousness of life" as a means to avoid feeling suicidal (Appendix 1). If *Ming Pao* can be considered a newspaper with an authoritative voice, its uncritical use

of popular Chinese idioms in reporting suicides can only prolong public ignorance of depression and suicide. For example, part of the headlines of a special column written to analyze the suicide of a 10-year-old student read "Inadequate Communications between Parents and Children Could Easily Make Children Do *Silly* Things" (*Ming Pao*, 17 May 1991, 2. Emphasis added). In Hong Kong as elsewhere, suggesting to depressed people that it is immoral for them to refuse to "snap out" of their depression, hopelessness, helplessness, and self-destructiveness can add to the depressed a sense of guilt, which can worsen their depression. Public education in depression is urgently needed in Hong Kong.

Summary of Psychological Theories of Suicide

Psychological theories of suicide stress the importance of the role of suicidal individuals in suicide causation, and attempt to change their views in order to produce in these *individuals* less pathological emotional conditions, which in turn reduce their likelihood of engaging in suicidal behaviours. Some schools within this perspective, such as the psychosocial and humanistic schools, are more theoretical in nature; they also provide some insight into the social causation of suicide ideation in individuals. The psychoanalytic, behavioural, and cognitive schools are more active in researching and preventing suicide. The psychoanalytic school, however, has produced few effective and immediate means of reducing the suicidal proneness of individuals; its therapy tends to be lengthy and costly. The behavioural and cognitive schools have provided more effective therapy in suicide prevention and intervention, through long-term behaviour-modification and cognitive therapy.

Before embarking on a review of suicide literature of the sociological perspective, the role of depression and hopelessness in suicide will be presented in the next section. While depression and hopelessness are not major perspectives by themselves, their near-universal presence among the suicidal are widely acknowledged by suicidologists. To recap, it is the research from medicine and psychiatry that established clinical depression as an affective disorder strongly related to suicide, while it is Beck's research in cognitive-behavioural psychology that established hopelessness as a pathological emotional state as a significant determinant in suicidal proneness among the clinically depressed.

Depression and Hopelessness in Suicide

Even though suicidologists from psychology, psychiatry, and medicine do not always agree on the origin of individuals' suicidal proneness, they agree that depression

plays a significant role in the causation of suicide. This section discusses and summarizes the role of depression and hopelessness in suicide, to which some references have already been made earlier.

Depression in Suicide

Depression is "something which is very different from [merely] sadness or unhappiness" (Sainsbury 1985, 73); it consists of not just one painful emotion, but "a host of painful emotions that painfully interact" (Conroy 1991, 85). The list of emotions, behaviours, and psychosomatic symptoms of a depressed person often includes some of the following: self-pity, shame, envy, grandiosity, anger, frustration, indecisiveness, submissiveness, social withdrawal, mental constriction (for example, cognitive distortion, dichotomous and rigid thinking), negative self-construing (for example, low self-esteem), changes in appetite (usually a reduction, which results in weight loss), changes in sleeping pattern (usually in the form of early-morning awakening), helplessness, and hopelessness (American Psychiatric Association 1987, 218-24; Conroy 1991, 83-114).

The latest manual used to diagnose psychiatric disorders in Western psychiatry—The *Diagnostic and Statistical Manual of Mental Disorders: DSM-III-R*, third edition, revised (*DSM-III-R*) states that "the most serious complication of a Major Depressive Episode is suicide" (American Psychiatric Association 1987, 221). Recent research has not only found that probably the majority of suicides suffered from an unequivocal and treatable depressive illness, but that most of them also contacted their doctors during the period immediately preceding their death (Robins *et al.* 1959; Sainsbury 1986, 73). Hagnell and Rorsman (1978) reported that a diagnosis of endogenous depression was found in half of the suicides. Furthermore, 64 of 100 suicides in a study conducted by Barraclough were found to have an uncomplicated primary depressive illness. This percentage is increased to 77 per cent when those suicides whose principal diagnoses was alcoholism, but who also had a severe depression, are included (Barraclough *et al.* 1974; Lester 1988b, 30; Sainsbury 1986, 75). The reluctance on the part of many depressed and suicidal people to seek professional help and the failure of professional caregivers to diagnose depression are probably why these estimated percentages are not even higher than they are.[5] Moreover, the standard *DSM-III* diagnostic procedure does not allow for a diagnosis of major depression when the

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[5]For a study and discussion of the failure of heath care professionals to detect depression and to ask patients whether or not they have suicidal thoughts (in the United States), see Coombs *et al.* 1992, and Maltsberger 1991 (in the West).

depression is complicated by something more severe, such as schizophrenia, or by organic factors, such as senile dementia; in either case, an official absence of depression does not automatically mean an actual absence of depression.

The majority of the people diagnosed as depressed, however, do not complete suicide; only a small proportion—15 per cent—of people diagnosed as such die by suicide (Lester 1988b, 30; Miles 1977; Sainsbury 1986, Table 5.1). Researchers and interventionists are faced, therefore, with the challenge of explaining why only a few depressed people complete suicide while the majority do not, and, more important, of trying to identify those depressed individuals who are at high risk for suicide. One of the many identification studies was conducted in 1971 in Sussex, England; these researchers reported that depressed suicides were "significantly more often male, older, separated, socially isolated, and recently bereaved" (Bunch, Barraclough, Nelson, and Sainsbury, 1971). Since the majority of the clinically depressed people in Sussex (as elsewhere) who fit this profile do not complete suicide, the major weakness in this type of retroactive studies of completed suicides is that they provide little in the way of predicting which depressed individual would complete suicide within, say, a period of one year. As a result of this drawback, it contributes little to increasing the efficiency in the use of suicide-intervention resources.

Hopelessness in Suicide

In the mid 1970s, Beck and his associates found that a high score on an objective scale-of-hopelessness test by the depressed was a stronger correlate of suicidal intention than a diagnosis of depression alone (Beck, Kovacs, and Weissman 1975). This suggests that even though it can take months or years to treat depression satisfactorily, a reduction in the perception of hopelessness by clinically depressed individuals (often achieved by informal social and emotional support, and by formal cognitive therapy) is crucial to the immediate reduction of their suicidal proneness.

Depression Causation

No consensus exists on the cause of depression. Its etiology, as discussed previously, has been attributed to the role of nature (for example, genetically-predisposed organic disease, which then results in brain-chemistry changes), the role of nurture (for example, neurochemical changes due to toxins in the physical environment, and depression as a learned behaviour, regardless of whether or not it is associated with neurochemical change), and to a combination of many bio-psychosocial and cultural factors.

Depression alleviation or treatment

There is more agreement, however, on the treatment of depression and suicidal pain. These include the use of psychoactive medication, cognitive therapy, and behavioural therapy where appropriate, and the provision of a socially-supportive environment. A glance at the number of predisposing factors to depression presented and described in the *DSM-III-R* should imply the importance of social support at all levels:

> Chronic physical illness and Psychoactive Substance Dependence, particularly Alcohol and Cocaine Dependence, apparently predispose to the development of a Major Depressive Episode. Frequently a Major Depressive Episode follows a psychosocial stressor, particularly death of a loved one, marital separation, or divorce. Childbirth sometimes precipitates a Major Depressive Episode. (American Psychiatric Association 1987, 221)

An increase in the level of public-education and social-service expenditure in the prevention and treatment of chronic illness, substance dependence, and—more important—in making available formal and informal social support after people in distress have received yet another psychosocial stressor, can be very instrumental to the prevention of a Major Depressive Episode and, hence, to reducing suicide.

In summary, research on depression and hopelessness vis-a-vis suicide indicates that clinical depression and hopelessness are present in most suicidal individuals. An immediate reduction in the sense of hopelessness by cognitive therapy, and long-term treatment of depression, often by a combination of cognitive, behavioural, and drug therapy, are essential to suicide prevention. In Hong Kong as elsewhere, the degree to which a depressed and suicidal person can access family, social, and medical resources for the alleviation of depression and hopelessness should be inversely related to that individual's likelihood of completing suicide. Since the level of family, social, and medical resource rests more in the hands of the society in which the suicidal individual is merely one small part, the understanding of suicide is not complete without an understanding of social factors—factors which are external to the psychological make-up of the individual. This review now turns to some of the major sociological research findings on suicide.

The Sociological Perspectives

While psychological theories of suicide stress the role of the mind of the individual in suicidal behaviour, sociological theories of suicide emphasize the role of

external social factors in determining the proportion of individuals in any given society who will engage in suicidal behaviour (Taylor 1990, 225, 228). These theories suggest that society can affect the prevalence of stress, depression, hopelessness, suicide ideation, and suicide completion. This is because the prevailing political ideology affects a country's domestic economic policy, which has a direct bearing on the generosity and efficiency of its social programs. The characteristics of these programs then determine the level of services available to support the depressed, as well as the extent to which the public is educated on recognizing depression in themselves and in significant others. Recognizing and acknowledging depression in others, as will be discussed later in this and other sections, is crucial to suicide prevention: the depressed, who are almost always confused, anxious, resigned, helpless, and guilt-ridden as well, are often unable to communicate their emotional state to others clearly. Since the sociological perspective deals with socially-shared and environmentally-sensitive factors—factors external to the individual, related to his or her immediate environment, and presumably varying over space and time—it lends itself to geographical analysis in a superior way. Beginning with Durkheim's *Suicide*, this section provides a review of the major sociological theories of suicide.

Durkheim's *Suicide*

It is only appropriate for a review of sociological theories of suicide to begin with Emile Durkheim and his *Suicide: a Study in Sociology*, originally published in 1897. Durkheim's use of statistics in examining a social phenomenon—suicide in western Europe—later made him one of the founders of modern sociology. In addition, his inter-regional suicide-rate comparisons rendered his method and findings valuable to subsequent spatial analyses of suicide.

One of Durkheim's main assertions in *Suicide* was that the incidence of suicide in a society was associated with the degree of social integration in that society (Durkheim 1951; Hassan 1983, 2). He stated, for example, that a society's suicide rate varied "inversely with the degree of integration of the social groups of which the individual forms a part" (Colt 1991, 194; Durkheim 1951, 209). This is to say that the more that people are integrated into, or the stronger that they feel a sense of attachment to, the society to which they belong, fewer people there would become detached or isolated enough to complete suicide; this process would lead to a relatively low suicide rate in that society. Durkheim did not explore the psychological or emotional condition of suicide-prone individuals vis-a-vis their degree of social integration.

Durkheim argued that different types of society generated different social causes of suicide; he classified these social causes into four major categories. The first was egoistic suicide. According to Durkheim, this type of suicide was found in societies with excessive individualism, a condition which led to the detachment of individuals from social life or communal activities. Mapping the suicide statistics that he collected, Durkheim demonstrated that the predominantly Protestant countries of western Europe had higher suicide rates than the predominantly Catholic countries. He argued that this was because the higher degree of social support provided by the Catholic Church to Catholic communities created more social integration. In contrast, Durkheim felt that the more individually orientated Protestant church provided a lower degree of social support, and achieved a lesser degree of social integration (Colt 1991, 191-92; Durkheim 1951). Durkheim then used this typology of egoistic suicide to account for the higher suicide rate in Protestant countries, which according to him had a larger number of socially isolated or emotionally isolated people. Conversely, he argued that Catholic countries had lower suicide rates because the strong social cohesion found in Catholic societies was beneficial to the psychological and moral health of the individual. (Colt 1991, 191-91; Durkheim 1951, 152-216; Hassan 1983, 5, 76; Shneidman 1985, 24; Stillion *et al.* 1989, 51-52; Taylor 1990, 226).

Durkheim also used egoistic suicide to account for the higher suicide rates he found in urban areas than in rural areas; he asserted that people who lived in cities were more socially detached (Durkheim 1951). However, Iga reported higher suicide rates for the Japanese countryside than the big cities in the early 1970s (Iga 1986, 19). This occurred at a time when many of the young in Japan migrated to urban areas for higher-paid employment in industries, leaving a large number of elderly people in rural villages with reduced financial and emotional support. Iga's finding suggests social attachment cannot be taken for granted in all rural areas in the world. According to this typology, given that Hong Kong society—apart from family or clan networks—is not highly cohesive to begin with (Lau and Kuan 1988), it might be expected—all things being equal—that if increased urbanization would break down family ties, the high urbanization rate of an area such as the New Territories would increase the degree of social detachment and the rate of suicide in that subregion.

Durkheim called the second social type of suicide altruistic suicide. While egoistic suicide was a result of inadequate social integration, Durkheim thought that altruistic suicide occurred because individuals were so excessively integrated into the norms, expectations, discipline and regulations of society, to the extent that they never received sufficient individuation (Colt 1991, 193). Examples of this type of behaviour

are those exhibited by the elite troops in the French military in Durkheim's time and, more recently, those by the *kamikaze* pilots in the Japanese air force during World War II (Durkheim 1951, 217-40; Hassan 1983, 3-4; Stillion *et al.* 1989, 52). According to this typology, Hong Kong's culture of economic individualism, as suggested by Lau and Kuan (1988) should result in such a low level of social cohesion that the prevalence of altruistic suicide should be keep to a minimum. On the other hand, excessive integration into the family by the Chinese of Hong Kong could result in more altruistic suicides in Hong Kong than in countries where familial cohesion is disintegrating. Nevertheless, if the cohesion of the traditional Chinese family unit in Hong Kong's New Territories have been weakened by the urbanization of that area in the 1970s and 1980s, it might be expected that this type of suicide would have decreased in that subregion.

Durkheim's third type of suicide was anomic suicide. This kind of suicide was thought to occur when individuals were confronted by changes in life fortunes too sudden and drastic for them to cope with (Colt 1991, 193; Durkheim 1951, 241-76; Hassan 1983, 5-6; Kushner 1989, 2-3; Stillion *et al.* 1989, 52). Suicide resulting from economic anomie was thought to occur when individuals suddenly became poor or wealthy, to the point that their lives became so de-regulated that their needs were no longer in harmony with their means (Durkheim 1951, 241-76, 403; Shneidman 1985, 24). According to this typology, the prevalence of financial speculation in the *laissez-faire* capitalistic society of Hong Kong would suggest that horse-race gamblers and stock-market speculators—people who are vulnerable to sudden financial gains and losses—are most susceptible to anomic suicide.

Durkheim's fourth type of suicide was fatalistic suicide. This type of suicide occurred, according to Durkheim, when people are driven to desperation and hopelessness, such as when soldiers in a losing battle realize that their destruction and torture by their enemies are imminent. It might be argued that Hong Kong's political structure might be increase the prevalence of fatalistic suicide among the poor, in that the Hong Kong Government has coopted a local merchant-class Chinese elite since the late 19th century primarily for its wealth, economic leadership, and political acquiescence, rather than for its espousal of any Chinese or Western moral values (Lau and Kuan 1988). Without an indigenous leadership acting in the interests of the poor, the poor have become passively tolerant of Hong Kong's economic inegalitarianism (Lau and Kuan 1988). They maintain this fatalism by rationalizing that they have become affluent *relative* to the friends whom they have left behind in China. The political acquiescence of the poor and the political apathy of the more affluent in Hong Kong have slowed the introduction of a fully representative government in Hong Kong. This has in turn slowed

the implementation of a more equitable wealth-redistribution policy.[6] Durkheim might have asserted, then, that the poor of Hong Kong who feel helpless, hopeless and desperate can be prone to fatalistic suicide.

Durkheim did not incorporate psychological factors into, for example, the suicides of people in anomic or de-regulated societies. The was done by "post-Durkheimian" researchers and, vice versa, by psychological scholars in the decades subsequent to the publication of Durkheim's *Suicide* . Advances in the collection and manipulation of statistics also enabled later researchers to operationalize Durkheim's theories.

Status Integration Theories of Suicide

Gibbs and Martin are two of many of these "post-Durkheim" scholars who attempted this operationalization Durkheim's theories. Their work was a theoretical extension of Durkheim's sociological theory of suicide (Gibbs and Martin 1958; Gibbs and Martin 1964). Using the concept of status integration, they operationalized Durkheim's theory into the following theorem:

> The suicide rate of a population varies inversely with the degree of status integration in that population. (Gibbs and Martin 1964, 27)

In order to measure the degree of status integration, Gibbs and Martin chose a number of officially created social classifications (such as the categories of being "married" and "divorced"). Like Durkheim, however, they did not relate the role of status integration to suicide precipitation.

According to this theory, it might be expected that the modernization and the capitalistic nature of Hong Kong society would increase the prevalence of role conflict, for example, as in the case of a married and employed middle-age woman occupying the roles of wife, mother, tutor, employee, and currency speculator. Each of these roles exerts competing demands and potentially conflicting duties from her, and increases the number of incompatible statuses occupied by her. Singer, for example, has suggested that "urbanization together with the ensuing housing problems, the increased value of the conjugal family and of individualism, and the greater independence of women, have

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[6]It can also be argued that this apathy has been cultivated deliberately by the Hong Kong government and condoned by the Chinese government, both of which believe that it is in their own political and economic interest that Hong Kong does not develop full democracy. See Benjamin K. P. Leung, "Political development: prospects and possibilities."

created more conflict in the family, particularly between children and parents, and mothers- and daughters-in-law" in Hong Kong (Singer 1976).

Pearson described another role of the Hong Kong mother not often prescribed to mothers elsewhere, that of preparing their children for Hong Kong's competitive standard examinations:

> [In Hong Kong], the major burden of supervising homework tends, in most households, to fall on the mother. Both she and her child are tired after a long day at work but homework fills the gap between the end of dinner and bedtime. In otherwise happy families this factor seems to cause more distress than any other. Even the difficult relationship with the mother-in-law may pale into second place beside it. (Pearson 1990, 128)

If the number of people in Hong Kong occupying incompatible statuses have, in fact, increased along with modernization, the theorem of Gibbs and Martin would suggest that the suicide rate should have increased at the same time.

Status and Anomie Theory of Suicide

Like Gibbs and Martin, Powell's status and anomie theory of suicide was also an attempt to operationalize Durkheim's theories (Douglas 1967, 93). According to Powell, individuals are simply more prone to suicide "when they cannot validate their 'selves' through the normally approved form of status activity" (Douglas 1967, 93). Powell, however, did not suggest any provisions for the testing of the relationship between this self-invalidation and the tendency to . . . suicide, or to account for any cognitive variations in the definition of social phenomena, such as "failure," by different individuals (Douglas 1967, 93). Nevertheless, Powell opened the door to later studies in the role of cognitive perception vis-a-vis depression and hopelessness within particular social settings. For instance, most of the people who fail school exams or lose half of their life savings in Hong Kong as elsewhere do not perceive themselves as complete failures in life and, as a result of it, become clinically depressed and suicidal. Two important research question raised, then, were these: In what ways might some of the social values which lend one to harsh self-invalidation be *learned* socially? And in what ways might psychological, such as cognitive, factors and perhaps even biochemical factors interact with socially *learned* self-invalidation to make one depressed and suicidal?

Status-Change Theories of Suicide

It was stated earlier that one of the fundamental components of Durkheim's theory of anomic suicide is that downward mobility leads to deregulation, which in turn increases the probability of suicide (Douglas 1967, 109). While status-change theorists assert that any change in the status of individuals can be a "burden badly tolerated" (Douglas 1967, 111), it is particularly downward change, that can induce sufficient stress to lead individuals to desperation and suicide (Douglas 1967, 111). For example, Sainsbury found in a study in London that poverty in itself did relatively little to render individuals more suicide-prone. Rather, it is when poverty befell those who were used to a better standard of living that it became a burden badly tolerated—especially among those in the upper occupational classes during economic depression—that made them more suicide-prone (Sainsbury 1955, 19).

Maris found that most male suicides in the United States had also experienced downward occupational mobility, as indicated by "developmental stagnation, unemployment, and erratic [recent] work histories (Maris 1981, 156). He also found that and one-fifth of [suicide] completers were disabled and retired (Maris 1981, 169). Similar findings have been made by Breed in New Orleans (Breed 1963). Platt (1984) also hypothesized that unemployment or loss of employment was "a principal causal agent of the current rise in suicide mortality" in the countries of Northwest and central Europe undergoing important socioeconomic development. Lo and Leung demonstrated in their recent study that while 4.1 per cent of Hong Kong's economically active male—suicidal and non-suicidal—population was unemployed, 36.6 per cent of male suicidal subjects between 20 and 65 years of age were unemployed (Lo and Leung 1985, 288). Unfortunately, neither Platt, nor Lo and Leung, provided data on how recently the suicidal individuals had become unemployed.

Rao's study in India also confirm that "poverty and unemployment are definite causes of suicide and suicidal attempts" among members of one occupational group who experienced the badly tolerated burden of downward status change (Rao 1975, 237):

> Often entire families have put an end to themselves by poisoning or by other means because of being unable to live in poverty. There was a wave of suicide a few years ago among the goldsmiths in India when they found themselves suddenly unemployed as a result of the promulgation of the Gold Control Order by the Government of India. (Rao 1975, 237)

Critics of status-change theories have questioned whether or not any additional event, such as the loss of a loved one, might have preceded the loss of status (which may

lead, for instance, to depression and job loss). Some have even suggested that the "discovery" of statistically significant relationships between social-status variables and suicide are not necessarily any more significant than the "discovery" of relationships between suicide and visits to the zoo (Douglas 1967, 119-20). These are valid criticisms, considering that the relationship between downward status change (or, "drift," as it is known today) and suicide completion usually contains many intervening variables. Indeed, the state of "desperation" that lies between unemployment and suicide completion certainly comprises those mental and emotional conditions described by psychological-perspective researchers as decreased self-esteem, helplessness, hopelessness, and depression. For instance, while Lo and Leung confirmed a correlation between suicide and unemployment in Hong Kong, they also indicated that a high proportion of the completed suicides in their study had suffered from a physical disability or psychiatric illness; they argued that it is the disability or illness rather than unemployment per se, that is, downward status change, that precipitated these suicidal acts (Lo and Leung 1985, 291).

In summary, while status-change theories of suicide facilitate the mapping and explaining of the suicide phenomenon—perhaps for the use of health-care policy planners, it is less useful to individual cases of suicide prevention and intervention against individual cases of suicide. A large majority of people who lose jobs or receive demotions do not complete suicide, and these theories alone do little to help the family members of a "clammed-up" unemployed breadwinner realize this person's suicide-proneness, let alone initiate an appropriate course of action.

Aggression in Suicide

According to Henry and Short, suicide—like homicide—is directly related to aggression (Douglas 1967, 132). The introduction of the element of aggression to a sociological theory of suicide made this the first major psychosocial theory of suicide. In general, the theory of Henry and Short is based on the following assumptions:

> 1. An increase in frustration will cause an increase in aggression, and a decrease in frustration will cause a decrease in aggression.
>
> 2. For a given population (especially a class group), an increase in aggression leads to an increase in homicide or an increase in suicide; and a decrease in aggression leads to a decrease in homicide or a decrease in suicide.

> 3. An increase in general economic gains will lead to a general decrease in frustration; and an increase in general economic losses will lead to an increase in frustration.
>
> 4. An individual will express (or direct) his aggression against (or toward) the object(s) to which he imputes generalized responsibility for his frustration.
>
> 5. The direction of the imputation of generalized responsibility is determined by the degree of external restraint on the actions of the individual, such that a high degree of external restraint will lead to the imputation of generalized responsibility to others and a low degree of external restraint will lead to the imputation of generalized responsibility to ego.
>
> 6. The degree of external restraint varies inversely with the social strata. (Douglas 1967, 133-40)

Henry and Short were recognized for their formulation of "a definite, hypothesized order of interdependency" between psychological and sociological variables which cause variations in the suicide rates (Douglas 1967, 132). They have been criticized, however, for having failed to consider that "the imputation of responsibility among people of a specific social stratum might well be the result of subculture differences" (Douglas 1967, 142). Douglas argued that instead of being restrained externally, upper-class individuals might shoulder more responsibility not because of their high status, but simply because upper-class parents, more then their lower-class counterparts, tend to teach their children that they are responsible for what happens to them (Douglas 1967, 142). Furthermore, Douglas criticized Henry and Short for their reliance on data from two dichotomous categories comprising the rich and the poor: they failed to notice a strong U-functional relation with respect to social class, in that the upper class and the lower class have roughly similar suicide rates and the middle class having a considerably lower rate (Douglas 1967, 143).

Hassan dismissed in his Singapore study this simplistic U-functional relationship—at least for suicide—by arguing that "not all high prestige occupations have high suicide rate and not all low prestige occupations have high suicide rate," and that *two* occupational factors were related to suicide: the level of external social constraint by one's employer and the public, and the level of social and economic reward from one's employer and the public (Hassan 1983, 73). According to Hassan, most prone to suicide are individuals whose occupations "have high regulations of social behaviour [but] with relatively low economic rewards and social prestige, such as working proprietors of catering and lodging establishments, hairdressers, bankers and beauticians; employees

such as domestic servants, caretakers, cleaners, cooks, waiters and bartenders, and policemen and other protective service workers" (Hassan 1983: 73). He added that this external-restraint stress factor can be moderated somewhat, however, by an increase in economic reward. For instance, Hassan thought that although administrative and managerial workers also have a high degree of external restraint, their tendency to suicide is lower than those who face both high external restraint and low income (Hassan 1983, 73). Hassan also stated that clerical workers, agricultural workers, and fishing people had only a low level of external restraint exerted upon them, and that they had the lowest suicide rates in Singapore (Hassan 1983, 73).

Yap reported only one case of suicide among what he called "farmers," and none among "fishermen" in an 18-month study period in Hong Kong in the mid 1950s (Yap 1958, 33). As in Hassan's Singapore study, the low suicide rates among people in the fishing and agricultural occupations could probably be attributed to their greater insulation from cultural change, and a less degree of external restraint and economic uncertainty. Among the urban population of Hong Kong, Yap found that the unemployed (under 60), the "unemployed over 60," entertainers (mostly low-paid female tea-house singers and "dancing-parlour girls"), shop assistants, coolies (streetside and dockside piecework labourers) and amahs (female live-in domestics)—occupations subject to a high degree of economic insecurity and uncertainty—had some of the highest suicide rates. The police had the lowest suicide rate among all of the occupational categories discussed by Yap (Yap 1958, 32-37, 77). This is probably because the police was largely a "top-down" policy-implementation instrument of the colonial government, and was mandated to control—rather than to be accountable to—the public. Most of the individuals who entered the police department had the assurance of something akin to lifetime employment, and were consequently relatively sheltered from economic stress than were individuals working in the private or, often, the informal sector. Newspapers in the 1980s and 1990s however, did report accounts of police-officer suicides (*Ming Pao*, 8 March 1991, 5; 30 September 1991, 4). Although these unquantified accounts cannot be used to argue for an increase in the suicide rate among the police, they do challenge Hassan's assertion that the external social constraint of the employer could be compensated by economic reward.

Others have simply argued that suicide is democratic:

> Suicide is . . . the one continuous, everyday, ever-present problem of living. It is a question of degree. I'd seen them in all varying stages of development and despair. The failed lawyer, the cynical doctor, the depressed housewife, the angry teenager . . . all of mankind engaged in the massive

> conspiracy against their own lives that is their daily activity. (Daniel Stern, in Hassan 1983, 53)

But since real or perceived failure, cynicism, and anger all are common symptoms of depression, Stern's finding might well be interpreted in a way which suggests that mental state, rather than occupation, is the more important factor affecting the suicidal proneness of these individuals.

In any case, while Hong Kong's aggregate suicide rate increased gradually almost linearly between 1981 and 1986, the aggregate homicide (labelled officially as "manslaughter") rate decreased gradually almost linearly as well, suggesting that there is *prima facie* evidence of an inverse relationship between the rate of homicide and suicide in Hong Kong. Before the aggression theory of Henry and Short can be fully tested for Hong Kong, however, it will be necessary to confirm the socio-economic status of all of the suicide completers and homicide perpetrators. Data on the latter can be difficult to obtain, considering that not all of the identities of homicide perpetrators are known to the police. Moreover, it should also be considered that, in Hong Kong as elsewhere, members of the upper class who take overdoses can also be more likely to have death resulting from "internally directed aggression" certified as accidental (Slaby 1992, 157-58). This process can cloud suicide statistics, as well as the attempts to analyze the imputation of blame and the role of economic reward in suicide.

It should also be added that acts of aggression, in Hong Kong as elsewhere, rarely become entries in suicide or crime statistics (Figure 2). Apart from the few relatively closely knit villages in the distant parts of the New Territories (mostly those on outlying islands such as Cheung Chau and Lantao), "legal" aggressive behaviour is the norm, rather than the exception, in Hong Kong. Aggressive behaviour—rationalized by those who express such behaviour as "something we all have to do to get anywhere"—can be observed in the way taxis are snatched, often by young and able-bodied men and women from the frail elderly or parcel-laden hailer. It can also be seen in the manner in which many young and able-bodied travellers run—like race horses do—for trains and immigration checkpoints at the border with China, and, with little fore-thought or after-thought, colliding against the baggage-laden, slow-moving elderly, and the child-carrying travellers. More of this type of anxiety induced aggressive behaviour in Hong Kong will be examined later in the section on the statistical analysis of suicide in Hong Kong between 1981 and 1991. Suffice to indicate for now that studies on the relationship between aggression on the one hand, and suicide or homicide on the other hand are inconclusive. Future studies will need to consider and perhaps even quantify

Figure 2 Legal aggression in Hong Kong: Disregard for the stranger.

Source: W.H. Kwan, 1992.

those aggressive behaviours which are culturally condoned, and not only the "pent-up" ones that culminate in suicide or homicide statistics.

Gold's Theory of Suicide

While Henry and Short "merely provided a juxtaposition of psychological and sociological variables [in suicide and homicide], rather than some kind of synthesis of the two . . ." (Douglas 1967, 145), Gold offered the following synthesis:

> 1. The socialization of aggression is the fundamental determinant of the preference for homicide or suicide.
>
> 2. The type of socialization normally associated with the outward expression of aggression is found more among lower-class individuals than among upper-class individuals, and the type of socialization normally associated with inward expression of aggression is found more among upper-class individuals than among lower-class individuals.
>
> 3. Therefore, lower-class individuals will show a preference for homicide over suicide and upper-class individuals will show a preference for suicide over homicide. (Douglas 1967, 145-46)

In spite of these refinements, Douglas suggested that Gold's attempt at synthesizing the numerous psychological and sociological variables fell short of taking into account the many . . . socially determined meanings of immediate situations" (Douglas 1967, 150-51). For instance, "Gold does not attempt to show that the social position of individuals has any causal effect on their socialization process, . . . [in the sense that] it is possible that individuals with a tendency to express aggression outwardly and to socialize their children to do so are lower class precisely because of this tendency, rather than that the tendency to express aggression outwardly is caused by their social-class position" (Douglas 1967, 146). Any attempt to test Gold's theory for Hong Kong will also require the type of approach and data suggested earlier for testing the aggression theory of suicide and homicide of Henry and Short.

Ecological Theories of Suicide

The ecological approach emphasizes largely the causal dependence of social action on the physical environment of society or social groups (Douglas 1967, 96-97). Using the social areas approach, Zorbaugh found that "the cold, unsociable atmosphere" of the rooming-house district of Seattle was related to the suicide rate there (see Schmid

1928, 20-21). Like many of his predecessors and contemporaries, Zorbaugh has been criticized for having relied on the homogeneity of a population contained in officially classified areal statistics.

Later ecological studies downplayed slightly the ecological aspects and endeavoured to make the ecological theory more determinate. Cavan, Schmid and Faris postulated the existence of predisposing factors which, in most Western societies, gave negative social meanings to suicide. According to these researchers, it is the acceptance of negative social meanings of suicide by certain individuals that render them, when faced with a crisis (a precipitating factor), more likely or less likely to "opt for" suicide as a way out (Douglas 1967, 108).

Hassan found in his Singapore study that the suicide rate was high in the central-city area with a high concentration of poor and single elderly people, and also in the physically and socially alienating environment of high-rise public housing areas (Hassan 1983, 161). Hassan further commented that the social anonymity and the architectural design and layout of the buildings reduce opportunities for social and cultural intervention after frustrated housewifes have "decided to kill themselves on the spur of the moment" (Hassan 1983, 65-66).

It will be stated in the next section of this review that suicide only appears to be a rational option in the confused and constricted state of mind of the clinically depressed person. Established well before the current knowledge of depression and hopelessness have been acquired, the line of reasoning used by many of these earlier ecological researchers run contrary to the assertions of suicide interventionists that most suicide attempts are cries for help. As for completed suicides, they are cries that went unheeded, in the sense that bio-psychosocial intervention was not available in the immediate environment of the completer. Analyzing the availability of such intervention opportunities is a useful approach and important research question for ecological studies of suicide. These studies, however, must be cautious of the pitfall of attributing suicides by the people of a certain social area to such rationalizations by the suicidal as "Society considers suicidal people as losers. Since I'm poor, unemployed, old, useless, miserable, and have become a loser already because of these factors, what other ways do I have to end my pain than killing myself?"

Any ecological studies of suicide in Hong Kong, as elsewhere, will require approaches to suicide and the geography of suicide that have rarely appeared in the suicide literature on Hong Kong. As Ferenc Moksony stated: "influences stemming from the local community have not only to be established; they have to be explained as well by developing causal theories about how the environment sets limits to the individuals

living in it, how people perceive those constraints, and how they respond to them." (Moksony 1990, 134). The importance of individual cognitive perceptions and behaviour in suicide is why socio-spatial studies of suicide must incorporate theories of suicide introduced by the cognitive school in psychology, and revelations of the cognitive state of suicidal people as reported by suicide interventionists, and by those who have recovered from depression and suicide ideation.

Summary of Sociological Theories of Suicide

Sociological theories of suicide began with Durkheim's observation and analysis of socio-spatial variations in suicide rates of different societies and geographical regions in western Europe about a century ago. The growth of psychology as an academic discipline in 20th century led to considerable cross-fertilization between psychological and sociological theories of suicide. This is evident in such examples as the imputation of personal aggression to certain members of a spatial unit or socio-economic category. The significance of sociology in the study of suicide can best be summed up as follows:

> The sociological view of suicide calls for a broader perspective than that found in most psychological approaches. It challenges people to look at conditions in their cultures at any given point in history as factors which can directly influence the suicide rate. In this way, sociologists provides a major service to students of suicide. An analogy that is useful in understanding the utility of this perspective is that of the ant hill. A child watching an individual ant busily wander back and forth across a path carrying a bit of sand can infer little meaning from the behavior. If, however, the child stands up and regard the broader scene, he or she may observe a nearly finished ant hill. While the individual behavior is not explainable, it becomes meaningful as a part of a larger picture. In just such a way, individual suicidal behavior may become more meaningful when examined against the social fabric of society. (Stillion *et al.* 1989, 53)

The study of suicide as a social phenomenon is less effective in preventing the suicide of specific individuals; it is more useful to the reduction of the total number of suicides in society, as long as the political will to do so and the necessary economic resources are present. The extent to which public suicide-intervention services are available in Hong Kong will be discussed briefly below after an introduction to the concept of suicide intervention.

The Prevention and Intervention Perspective

The following passage is perhaps a concise summary of the causes of suicide:

> Stressful environments change body chemistry. In susceptible people, increased stress can result in changes that increase the likelihood of depression. When these chemical changes occur, an increase in depression related cognitions . . . may result. Such negative cognitions may well increase the subjective impression of stress, which in turn will have a continuing effect on the chemistry of the brain. In short, personality, environment, biology, and cognitions may interact to produce a suicidal individual. (Stillion *et al.* 1989, 57-58)

This section will examine the role of the social mechanisms available to prevent the production of suicidal individuals and to prevent them from carrying out their suicidal acts. It includes an introduction to suicide prevention, and an account of my personal experience in suicide intervention in Canada. The purpose of this account is to demonstrate the importance of social support and easy access to the services of competent professional caregivers. Discussion of long-term comprehensive suicide prevention methods will be provided at the end of this section and, in the manner that they can be applied to Hong Kong, in the last chapter of this thesis.

Suicide Prevention

It needs little emphasis here that all of the literature reviewed so far, regardless of the perspective from which it was written, has one common purpose—to prevent suicide. Apart from humanitarian concerns, suicide prevention is important because the psychological effects of one's suicide on surviving family members can be devastating: the thought of using suicide as a means to escape intolerable pain can be *learned* more easily by those—especially the young—with a history of suicide among family members or peer groups than by those who do not have a family history of suicide.[1] In order to enhance social and economic stability, and to reduce the prevalence of suicides resulting from *learning* by today's survivors, it is clear that the significance of suicide prevention cannot be slighted.

Much has been done in biology and pharmacology to delay the onset of depression-inducing organic brain disease, and to control the symptoms of these disease by

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[1]For example, a young relative of an eight-year old girl who jumped to her death from a public housing building had done the same two years earlier. See appendix 6.

medication after their onset. Much has been discussed about the role of social, environmental, and economic factors in shaping the developmental process of individuals, which may lead to the development of pathological personalities and psychological disorders.

The number of developmental experiences which can make it easy for people to become depressed, hopeless, and helpless, etc. are infinite. These are but a few examples: people who grew up in a domestic environment in which they were required to act as mediators between warring parents; people who, for fear of parental rejection, were coerced to settle for course marks no less than 100 per cent, to diet or to exercise fervently in preparation to win the elusive Olympic Gold, or to conceal physical and sexual abuses done to them by family members. It goes without saying, then, that the task of suicide prevention begins with teaching parenting skills which include making only realistic expectations of *themselves* and their children, and not using children as commodities for the parents' own gains in prestige, status, and other superficial respectability in the name of "This is done for the good of all for 'us'—the family." The task continues with ensuring the availability of adequate social support for parents, whether they are single, common-law, or "married and intact" parents. These are only some of the numerous social changes which can help reduce the number of suicide-prone individuals; they are presented here merely to demonstrate how much more society need to do to prevent suicide and where society can begin to focus to prevent suicide.

One area of suicide prevention which has been researched frequently and applied more widely is the restriction of the means of suicide. For example, the detoxification of home gas in England in the 1970s resulted in a drastic reduction in suicides by gas poisoning in subsequent years—without incurring any significant increase in suicide by other means. Increased difficulty in access to potentially lethal drugs, such as tranquillizers and sleeping pills, has also made suicide completion by these drugs more difficult. These means alone, however, are no substitutes for social support for the suicidal.

Ultimately, social support can best be increased by a dedicated effort to educate the public about depression and suicide to the point that it knows what they are, and to the extent that these no longer remain taboo conversation topics. To say the least, this means that the public must be as aware of depression and suicide as the Western public is of the ways in which AIDS is transmitted and, more important, the ways in which AIDS is *not* transmitted.

The amount of popular television air time spent on the edcation of depression and suicide in Canada and the United States is, unfortunately, next to nil in the four years

since I began my research on this thesis. Many university counselling offices have copies of pamphlets on these topic stacked next to those on stress, dieting, weight problems, and perfectionism, etc. In this university, they are placed in the waiting room in the counselling office, which can hardly be considered a thorough effort in public education. Most suicide prevention pamphlets contain a "What to do" checklist and a "What not to do" checklist. They advise helpers, for example, not to tell suicidal friends to "snap out of it," or to say things like "Come on. Things can't be *that* bad!", or "Stop whining!". Instead, befrienders are advised to use both verbal and body language to listen, to reflect non-judgementally, to empathize, and to show support. Unfortunately, these pamphlets alone were far from being effective when they were put to test among many of my non-suicidal university friends, as the section following the next should amply indicate. In the meantime, this next section will introduce one of the most crucial component of suicide prevention—suicide intervention.

Suicide Intervention

Suicide intervention is another components of suicide prevention. Unlike prevention, suicide intervention mobilizes all available and necessary social and medical resources in an effort to stop individuals on the verge of attempting suicide from doing so. One type of social support in most modern countries comes from public suicide-intervention services. These are important because family members and relatives may be in the immediate vicinity of suicidal people to offer support. Moreover, "culturally approved" significant others can often be contributors to the emotional malaise of suicidal individuals.

Public phone-in and volunteer-staffed suicide intervention services is often said to have begun in the 1950s, with the founding of a crisis centre in Los Angeles in the United States and a similar one by the Samaritans in England (Lester 1990, 183). Since that time, such crisis hotlines have proliferated to the extent that they can be found in the telephone directory of almost every community in the West. The Samaritans have been providing their services in Hong Kong since the mid 1960s.

The effectiveness of these hotlines have often been questioned, especially by government fund-allocation agencies and by biomedical researchers in depression and suicide, who argue either that most of the calls received are merely for information, or that professional medical treatment are available to the suicidal. It is true that most hotline services provide information and referrals in order to demonstrate their utility to funding agencies. It is also true that referrals to the services of other providers, such as social-welfare, debt-counselling, and prenatal-care agencies, are often what is

needed to reduce the level of frustration, anxiety, or depression of the callers—whether or not they are suicidal. As stated earlier, it is also sadly true that most of the suicidal have made contact with the medical system in the weeks prior to suicide completion, but only to have physicians miss making the diagnosis of depression; it may also be that an event perceived to be catastrophic enough by callers to become a precipitating factor in suicide has occurred when their medical doctors are asleep or on vacation. In any case, no medication-use can, and should, replace the prevention of illness by maintaining physical and emotional health. This is especially true for suicide intervention, where it must be pointed out that in spite of advances in the development of psychoactive medications for the immediate alleviation of panic, anxiety, and schizophrenic hallucinations, biomedical and pharmaceutical research has not yet developed one single psychoactive medication that can control depression or reduce suicidal pain *immediately*. Until this kind of medication is developed, hotlines will remain the last and only source of round-the-clock emotional support available to the suicidal caller.

Most interventionists, whether they are hotline volunteers, clinic counsellors, or researchers, operate on the premise that peak-level suicide lethality in people lasts for only about a week or two, and it is during this period that maximum medical, psychological, and social resources must be mobilized for suicidal individuals in order to prevent their suicide. They argue that the cognitive state of severely depressed and highly suicidal individuals are constricted, and that the "decisions" they make to die are logical and rational only to people in such a psychological state. Rather than honouring individuals' irrational decisions to die, suicide interventionists interpret suicidal people's "rational decision to die " as a cry for help in seeking a solution to end intolerable psychological pain (Shneidman 1985, 3-5).

From the perspective of interventionists, even acknowledging the existence of "rational suicide" or manipulative motives (other than an instinctive motive of communicating intolerable psychological pain) is detrimental to raising the level of public support for suicide-intervention education. Instead of seeing suicidal people as angry, frustrated, and hopeless individuals formulating plans to punish themselves or others, interventionists suggest that suicide occurs simply because these individuals' aggregate level of psychological pain—intensified by an endless array of bio-social, cultural, and environment factors—has exceeded the aggregate level of their coping resources.

In order to alleviate suicidal lethality, interventionists argue that the aggregate level of suicidal pain—regardless of its antecedent—must be reduced by any available means (Conroy 1991; Shneidman 1985, 13-14). Typically, these include increasing

the level of formal and informal social support for suicidal people and treating their clinical depression of, during the critical week-long period. Longer-term goals include counselling and therapy for the suicidal, de-stigmatizing depression and expressions of suicidal feelings, as well as increasing public awareness of the signs of depression and suicide (Shneidman 1985, 15-16). The importance of these short- and long-term objectives cannot be overemphasized, considering that most completed suicides could have been prevented with timely social intervention.

A Personal Account in Intervention

Within a two-month period recently, two university-student friends of mine expressed suicide ideation to me. The first friend had already visited the student counselling office and a psychiatrist in the student health service on enough occasions to feel that the visits "were getting nowhere," and that he was given the "run-around." He informed me that he felt that his depressed state was not being completely understood by others, including the caregivers at student health services. He reminded me that he had been suffering from gastro-intestinal problems for several months, that he had been waking up late at night and unable to return to sleep, and that his inability to eat had brought significant weight loss. In retrospect, it became clear to me that his perception of the unresponsiveness of the professional caregivers resulted partly from the depression itself: uncomplicated unipolar depression has on its list of symptoms the loss of assertiveness, which in this case meant the lack of the very assertiveness needed in order for him to inform his medical practitioners of his suicide ideation and plan. His reluctance to volunteer his suicide plan also resulted from his faith in the ability of members of an reputable authority—medical practitioners—to "know enough" and to ask him.

The second of my two friends imparted to me one evening in a cocktail lounge that he felt sad, depressed, rejected, and misunderstood by the world, that he had been sleepless and losing weight for over a month. He had not made any attempt to contact student health services.

Up to that moment, I did not have any clinical experience in counselling or suicide intervention; my understanding about suicide was limited to about a year's preliminary reading of suicide research written from various perspectives found in the university library. It was from this literature that recalled the "motto" that asking whether a person was suicidal or not would not put the "wrong" idea in the head of a non-suicidal person; I also recalled that the degree of suicide lethality is positively related to the firmness of a suicide plan.

Upon asking, I was told by my first friend that he had a symbolic place in mind to cut his wrist, and by the other that he had a symbolic date planned on which to take an overdose of sleeping pills.

I was more than willing to take time off from research to support them emotionally. I was also most concerned that they get professional help immediately, which meant that they communicate their suicide plan to the caregivers like they did to me. This required several days of emotional support by me and another mutual friend, a student of medicine, before our first friend could be motivated sufficiently to do so.

My second friend, on the other hand, adamantly refused to approach the professionals for fear of being stigmatized as a "wacko"; he also insisted that there was no turning back from his suicide plan: it was the only means available to him to prove that he was not a "total loser." It became necessary for my supportive friend and me to de-stigmatize depression. This task took several days—and many sleepless nights wondering if we were going to see our friend again—before he approached the professional caregivers voluntarily.

My attempts to rally social support from other mutual friends were more problematic. Even after I have distributed the suicide prevention pamphlet from the counselling office to many of them, most of them displayed many of the behaviours itemized on the "What not to do" list. Some of them expressed to me that they had difficulties in applying abstract terms like "empathize," and "being non-judgemental," citing that it was because they had never taken a course in psychology! Some asked me if they were just looking for attention, and whether or not getting each of them a girlfriend might help. They found it difficult (and probably fearful) to take personalized approaches suited to the unique nature of their friendship; it appeared that some wished that there had been a script for them to rehearse and recite. Some even avoided facing the pressure altogether by avoiding our suicidal friends, citing they were fearful of the whole university becoming suicidal because these two cases had occurred within a month. Their avoidance, an act clearly indicated on most "What not to do list," could be interpreted as a disservice, rather than a positive contribution, to the emotional well-being of their depressed friends.

As a postscript, neither of them attempted suicide, nor are they suicidal now.

These reactions to depression and suicide are not isolated ones. The experiences derived from these two incidents are, indeed, that suicidal people need both social support and easy access to well-trained professional care. Social support can best be assured when society—the suicidal and their would-be supporters—are well educated in depression and suicide, so that they are not apprehensive in seeking treatment or

showing support. Access to professional help can best be ensured, to say the least, when it is not dependent on the ability of the suicidal to pay for such services. The quality of care for the suicidal can best be achieved by training all professionals to ask patients or clients with depressive symptoms whether or not they are suicidal.

The reluctance of the depressed to seek treatment and the difficulties they encounter in obtaining social and emotional support are, unfortunately, still the norm rather than the exception in Canada, in spite of its relatively generous socialized-medicine and public-health education spending. The following section will examine public understanding of suicide, and the availability and the quality of suicide prevention services in Hong Kong.

Social Support in Hong Kong

The findings in this section are based on observations made during my 15 years of residence in, and subsequent annual visits to, Hong Kong. The literature on the views of Hong Kong people toward strangers and mental illness in general will also be examined.

Hong Kong's culture of fervent materialistic pursuit and apathy toward strangers has been well documented:

> Individual and family interests are without exception ranked above societal or collective interests. In fact, society is seen as an arena where individual interests are pursued, and social interests are important to the extent that this arena has to be preserved for the sake of individual interests. (Lau and Kuan 1988, 54)

This view is supported by another student of Hong Kong:

> The ideology which can be found in Hong Kong . . . is characterized by the people's emphasis on economic pursuits and a general apathy toward . . . matters outside one's personal orbit. Hong Kong has often been described as a city where no one is concerned about the well-being of other people . . . People are only interested in what they can obtain and not in what they can give. (Chow 1986, 407)

To date, public education on mental illness has been scarce (Tsoi and Tam 1990, 209); on suicide, it is limited to superficial training for school teachers—in light of a few highly sensationalized student suicides. Otherwise, no systematic effort has been made to educate mental illness or mental health (Chen 1981). Where mental illness was included in the school curriculum, "mental illness was described as a 'sickness' and 'an

inability to solve life's problems and to overcome anxiety' without any attempt to synthesize the two" (Tsoi and Tam 1990, 209-10).

Chinese society has traditionally regarded mental illness as a misfortune befalling families in which one of its members must have done wrong in a previous life. In Hong Kong, for instance, "mental illness has often been associated with manslaughter, running amok or long-haired beggars" (Tsoi and Tam 1990, 213). It has been argued that depression tends to be somatized in Chinese culture (Cheung 1985); it is probably this type of stigma that forces depressed Chinese to report only physical symptoms: the sufferers reject their illness themselves (Ma 1974). Given these views of Hong Kong society toward the mentally ill, having a mentally ill family member can stigmatize the entire family; this can force the family to overprotect, collude, and conceal this "blemish" in the household, and reduce its access to non-judgemental social support in such times of crisis (Lin and Lin 1981). For example, a study conducted on families of schizophrenic patients in Hong Kong found that 60 per cent of them were not receiving help from relatives (Pan 1987); the immediate family members struggled on their own.

This is not to say that the Chinese are by nature less caring. In fact, Okenberg (1970) found in a study conducted on Hong Kong secondary-school students that those students who had received a relatively traditional Chinese education tended to be less Machiavellian than those students who had received a Western education. These findings led Yang (1986) to suggest "it appears that Westernization, in the Chinese context, will strengthen Machiavellian attitudes." Neither of these authors clarified if "Westernization in the Chinese context" was limited to Westernization in the context of Hong Kong's *laissez-faire* capitalism, its preoccupation with wealth (Lau 1981; Lee 1985, 199-208), and its relatively limited social-wealth redistribution. The ways in which this redistribution is manifested in the health-care and social-welfare systems, and the effectiveness of these system in treating depression and preventing suicide will be examined below.

Suicide Prevention in Hong Kong

The extent to which suicide intervention services are available and accessible, in Hong Kong as in other modernized societies, are dependent upon the funding priorities of a government; these are, in turn, dependent upon society's overall economic conditions, and the characteristics of the political ideology which shape social-wealth redistribution policies. In this section, we will first examine the role of Hong Kong's health care system in suicide prevention.

Hong Kong's health-care system can best be described as a two-dimensional system. One the one hand, Hong Kong has a public medical-care system which is nominally free for all; this publicly funded sector is poorly managed, resulting in bureaucratic rationing of outpatient-clinic services by means of service limitations and long waiting time (Hay 1992, xxiv/35). In 1991, a public hospital refused to perform the frequent and medically required cleaning of a patient's kidney, citing that limited funding by the government compelled it to refuse providing such a service to patients over 55 years of age. The hospital insisted that this was done to make more efficient use of its limited resources, in that money spent on treating younger patients could benefit more people; the husband of the patient was in no mood to consider this aggregate utilitarian argument. He reported the incident to the press, and explained that because his family could not afford to obtain the same treatment from private-sector providers, this public hospital was in fact committing premeditated murder (*Ming Pao*, 23 September 1991, 1).

Rationing policies can also make the public stay away from public-sector providers voluntarily. Since time—a "commodity" required to accumulate wealth—is highly precious in Hong Kong, even those who can just barely afford to pay for private consultations prefer spending a little money in order to make more money, rather than waste time and money—since time equals money—in the queues public clinics. Inpatient services at government hospitals are known for their high patient-to-doctor and staff ratio, the inadequate training of emergency-room doctors, the absence of the latest high-tech imaging technology, the poor morale of doctors and nurses, and the perpetual congestion of the wards whose halls are filled with camp beds (Hay 1992; Yuen 1992, 288-90). It has been argued that some aspects of Hong Kong's unique social structure render the people of Hong Kong quite tolerant of high-density living (Lee 1985, 196-99; Millar 1979). This tolerance between healthy Hong Kong urbanites, however, often diminishes among the sick in the congested hospital wards, where poorly attended patients often break into verbal and fist fights. These factors act as disincentive to prevent all but the poor and those requiring lengthy hospitalization to use government hospitals (Hay 1992, 35-36). Very little research data on the government's provision of heath services have been made public (Hay 1991). Judging by the overall quality of the public-sector heath care, however, public-sector health-care services for the clinically depressed and suicidal cannot but be as inadequate as those for the physically ill. Suicides by jumping out of hospital windows are not unheard of in Hong Kong (*Ming Pao*, 15 April 1991, 4); this suggests that the minimum precaution of restricting means of suicide is not observed by hospital administrators or staff.

On the other hand, the highly efficient health-care services provided by the private sector in Hong Kong have lured an increasing number of patients (Hay 1992, 41), such that 80 per cent of outpatient care in 1992 was delivered by the private sector (Yuen 1992, 287). Private out-patient medical practices are so numerous that residents in the congested areas of Hong Kong Island and Kowloon can usually find one within a five-minute walk from home. The waiting time is minimal, usually less than 10 minutes. These doctors are also licensed to dispense prescription drugs, so it is common for patients diagnosed with a flu to receive several little bags of drugs, such as painkillers, antihistamine, and a small bottle of cough syrup with codine after a one-minute check of the throat and the chest on the stethoscope. For those with sick-leave documents to be signed, it can even be done at a discounted rate without a medical examination.[8] This speedy and apparently personal service provided by private-sector doctors—at prices way below that charged for an office visit in the United States—attract all but the poor and the economically less-active to the private doctor. Since no centralized records on office visits are kept, no mechanism exists to prevent patients in search of lethal dosages of sleeping pills or tranquillizers from visiting as many doctors as they can afford to (Hay 1992, 44).

The same level of efficiency can be found in Hong Kong's private hospitals, along with sophisticated treatment technology (Hay 1992, 41-45). For most middle income people, a week-long stay in an eight-patient ward in a private hospital for the removal of a benign tumour or gall bladder is not financially threatening. A chronic or terminal illness requiring stays of several months, however, can lead to a financial crisis and severe psychological stress for most except the rich in Hong Kong. This has serious implications, of course, for the clinically depressed and suicidal. For instance, what is the best immediate course of action to take for suicidal people whose constricted thinking happens to be "telling" them that they are failures because they are poor (because they have only the "wrong" amount of $3,000,000 in savings, and not the "right" amount of $5,000,000)? Will the thought of having to spend $1,000 on whatever type of initial treatment to alleviate that constricted thinking become a precipitating factor in suicide? What if a suicidal person is feeling guilt-ridden and worthless for having already brought financial ruin to the family? Will more guilt arise if another $10,000 is spent on treating this highly stigmatized illness called depression, along with the extra

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[8]A 40-year-old doctor received a two-year suspended sentence for signing sickness certificates required by employers for four "customers" for a fee ranging from $20 to $30 (US $3-$4) each without even having examined the "customers." See *Ming Pao*, 21 February 1991.

pressure exerted on family members to lie to their friends in an attempt to conceal the patient's true whereabouts?

As for public health education in general, apart from posters and advertisement on the prevention of the spread of infectious disease, such as AIDS, tuberculosis, and cholera, public health education in Hong Kong is next to non-existent. Public ignorance of the nature of disease compel many to adhere zealously to the practice of refusing to sit down immediately after a seat on board a public conveyance has been vacated by a stranger, for fear of catching venereal disease. Ignorance of healthy eating patterns results in such erroneous beliefs in many people as "weight loss can be achieved by eating meat alone without any intake of cereal." When the significant others of post-stroke patients are called into the (public) hospital to attend a free one-hour lecture by a dietician on how to prepare low-sodium meals, it is often the first time they learn that the patients should have avoided such things as dim sum, roast duck, preserved duck eggs, and soya sauce for the previous 20 years or so (*Ming Pao*, 20 January 1991, 19).

It is not unlikely, then, that the first time that most people in Hong Kong are informed about clinical depression is after their significant others have survived a suicide attempt serious enough for them to be hospitalized for at least several days. Based on the information available on Hong Kong's medical and health services, their role in suicide prevention is insignificant and inadequate.

Welfare Services and Suicide Prevention in Hong Kong

Hong Kong has never been a welfare state (Chow 1993, 92). Recent figures on Hong Kong's income distribution indicate that while the richest 20 per cent of Hong Kong households claimed 49.3 per cent of Hong Kong's income in 1971, the share of the poorest 20 per cent of households amounted to only 6.2 per cent (Leung 1990d: 70). At that time, the common rationale cited by the government for its refusal to provide the kind of comprehensive welfare program found in many of the industrialized nations of the West was simply because such generous programs would add to the already large flow of refugees from China (Hodge 1981, 6-7).

Opposition to the introduction of generous welfare benefits have come largely from the business community, which denies the accusations that this is done for selfish motives. Instead, business asserts that the opposition comes from its far-sighted recognition that any increases in taxation for welfare funding would drive away business, which would then reduce trickle-down benefits (Hodge 1981, 12). Other members of the rich have voice opposition to any concept of giving away "free lunch" (Leung 1990c, 78). By 1991, the share of the richest 20 per cent in Hong Kong has

increased to 50.4 per cent, while that of the poorest 20 per cent has decreased to 4.6 per cent. In spite of such glowing inequities, the Governor has reaffirmed recently that Hong Kong still will not become a welfare state (Chow 1993, 92). In sum, Hong Kong's welfare policy is that of benign neglect, marketed in the rhetoric of stimulating self-help.

Government and business have repeatedly asserted that any generous welfare program would erode Hong Kong's diligent work ethic (Chow 1981, 120-21). It has also been argued, however, that it is the lack of a social safety net that forces the poor into low-wage labour with little job security and even dangerous working conditions for fear of economic hardship (Levin 1990, 94); it is their fervent struggle to survive that has created this work ethic. An example of this culture of struggle can be seen from a common Cantonese saying unique to Hong Kong: *kou ting shou ting* (口停手停)—the hand can only stop working if and when the mouth is willing to stop eating (Smart 1991, 129). Moreover, this kind of fervent struggle has led to or increased economic individualism, utilitarian familism, instrumental social relationships and a lack of concern for strangers (Lau and Kuan 1988; Figure 2).

The Hong Kong Government, meanwhile, follows socioeconomic policies which have been described by many as *laissez-faire*, but also by others as a total absence of any official ideology: the government merely "muddles through" by trial and error, being cautious at every step to prevent or contain unrest, so as to enable it tax base—business—to prosper (Wong 1980, 65). In order to ensure an adequate supply of labour for the smooth operation of business, the government has clearly been willing to redistribute some wealth in such areas as public housing, basic education, and basic health and medical service. This is to say, the, that the basic welfare needs of the able-bodied can be met, by and large, through the government's basic social expenditures.

It is when the needs of certain segments of the population exceed what the government considers to be basic that a woefully inadequate picture emerges. While Hong Kong does have a universal pension plan nominally, the amount of monthly benefit is barely enough for an elderly single recipient to pay for the rental of a bed space in a dormitory-type flat.[9] This kind of financial hardship forces many of Hong Kong's

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[9]In a *Ming Pao* (May 13, 1991, 4) news article on the killing of one old-age resident by another in a senior-citizen dormitory located in a resettlement-estate-turned-old-age home in the Sau Mau Ping District in northern Kowloon, it was revealed that both the victim and the assailant were unemployed. Each of them survived on $725 (US $93) of social assistance per month. The monthly charge for staying at the dormitory was $296 (US $38) in rent for those who were physically able to shop for their own groceries and cook their own meals, and $893 (US $114) for those who required full bed and board.

elderly to continue working. For example, in 1986, 35 per cent of the poor elderly between the ages of sixty and seventy surveyed in a study were working, mostly in low-wage jobs (Chow 1990).[10] Others work as self-employed scavengers in search of tin cans and cardboard boxes left on the street by hawkers in an attempt to get spending money, if not merely to stay alive.[11] In the event that such a person is physically or mentally handicapped, additional benefits in the form of a disability pension can just barely cover the extra rent charged for board by equally congested retirement or rest homes, many of which have waiting lists of up to three years (*Ming Pao*, 6 May 1991, 7). Thrust together among strangers in their old age many to a room, "unrests" break out in these poorly attended rest home just like they do in the congested and poorly attended public hospital wards. For example, a man in his 70s, probably suffering from some delusion, hacked a roommate with a cleaver without warning (Note 9; *Ming Pao*, 18 May 1991, 5). The staff, obviously insufficiently trained to deal with such emergencies, did not attempt to intervene. They stayed clear of the room in which the assault took place for the police to find the victim dead. In a similar incident a few days later, an argument between two old men in a similar type of "rest" home in the Kwun Tong District of Kowloon saw the victim seriously injured, and the assailant jump to his death after the attack. The idiomatic headline dismissed the social significance of this tragedy by stating that the attacker had jumped to his death "because he was afraid of [legal] retribution" (*Ming Pao*, 18 May 1991, 5). The condition of the poor elderly in Hong Kong can best be described by this observation by Chow:

> The elderly in Hong Kong today no longer hold a prestigious position in either the family or the society. In other words, filial piety, once regarded as the prime virtue in Chinese culture, now plays only a minor role in family life and society in general. (Chow 1990, 167)

The same study on the self-image of the elderly in Hong Kong from which the above analysis was derived also revealed that 24 per cent and 43 per cent of those surveyed "agreed strongly" and "agreed", respectively, that they were just "waiting for death to

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The 69-year-old assailant had unexpectedly become violent, and hacked the victim in his 70s—one of the assailant's four roommates in a cramped room—13 times with a Chinese cleaver. The assailant was also reported to have had a history of epilepsy but not mental illness, suggesting that a diagnosis of some form of psychosis might have been missed by public-sector health-care providers, or simply because the human resources required to take the assailant to a clinic for regular check-ups were unavailable.

[10]See Nelson Chow, "Ageing in Hong Kong" for the growing need for public intervention in caring for Hong Kong's increasing elderly population.

[11]See the budget of an unemployed elderly person presented in Note 9.

come (*dengsi* 等死)" (Appendix 2; Chow 1990, 168). Such a gloomy view of life and the overall deprivation of those dependent upon social services suggest that Hong Kong's social services have been negligent in suicide prevention efforts.

Summary of Prevention and Intervention Perspective

The suicide prevention and intervention perspective draws from the research of all other perspectives, as well as from experiences in current prevention and intervention efforts, in order to prevent suicide. One of the most important means of preventing suicide is to increase the level of public awareness of clinical depression and suicide among the public, medical practitioners, and social-service providers. The goals of researchers and practitioners in suicide prevention are to prevent clinical depression, suicide ideation, and suicide attempts, using all available social, psychological, and medical resources. The literature on suicide prevention in Hong Kong is almost non-existent. Based on the sparse amount of literature on the provision of medical services, the relative abundance of literature on social services, and personal observation made, on Hong Kong, it appears that Hong Kong lacks an adequate public and professional education program in depression and suicide.

Summary

The literature reviewed in this chapter indicates that suicide is a complex universal phenomenon which cannot be explained thoroughly by any one theory or any one type of study. Most psychological theories of suicide agree that clinical depression and hopelessness are the mental and emotional conditions common in most suicides, and that it is the difference in the ways in which individuals perceive their experiences that render some of them more prone to depression and suicide than others. Sociological theories of suicide emphasize the relationship between socially induced stress—such as unemployment, poverty, migration-induced loneliness, and rigidity of social roles—and the suicide rate of a society. Many of these research findings have contributed to another perspective in suicide research: suicide prevention and intervention. Researchers in this perspective attempt to reduce suicide by putting to practice various measures which make individuals less likely to make suicide attempts and to complete suicide. In particular, suicide interventionists attempt to find the most effective and immediate ways to alleviate suicidal pain—regardless of the causes of the pain. The findings from each approach are beneficial to the understanding of every aspect of suicide, whether it is causation, suicidal-proneness evaluation, or effective prevention and intervention. The understanding of suicide is enriched—and the prevention of suicide is made more

effective—by multi-disciplinary research. The data on suicide for Hong Kong will be presented in the following chapter; they will be analyzed using many of these multi-disciplinary research findings in Chapter Four.

This chapter begins with an introduction to the landscape of each of the three subregions of the British Territory of Hong Kong. It will be followed by an explanation of the manner in which these data were obtained, as well as their limitations; it is hoped that this information will ease data procurement by future researchers of suicide in Hong Kong. The first set of data to be introduced will be the suicide data for the Territory as a whole in order to provide an overall picture of suicide; these will be followed by the suicide data for each of Hong Kong's three subregions: Hong Kong Island, Kowloon, and the New Territories in order to facilitate a spatial analysis. An interpretation of these data of all of these data will be made after all data have been presented. An analysis of these data, as seen from many of the various perspectives on suicide presented in the literature review, will follow in the next chapter.

Hong Kong's Socio-Economic Landscape

In spite of Hong Kong's "miraculous" economic performance, the redistribution of social wealth is far from equitable. The ability of the poor in making this redistribution more equitable is hampered by their lack of political power. Forced to work hard just to subsist, members of this large workforce has helped create what has been presented in Chapter Two as the diligent work ethic of the Hong Kong people; their acquiescence have also helped maintain the economic, political and social status quo. Although social welfare programs do exist, the unemployed and the unemployable members of Hong Kong society cannot expect public assistance beyond the level of subsistence; those who cannot count on the additional financial support of family members are likely to be waiting for death to come to them in the midst of economic prosperity for others.

Hong Kong has a total land area of just over 1,000 square kilometres. (See Figure 3 for a map of Hong Kong.) This has result in a high overall population density of more than 5000 persons per square kilometre. Eighty per cent of this 1000 square kilometre of land is considered to be too steep or otherwise too costly for residential or commercial development. This uneven distribution of land suitable for residential development has resulted in a highly uneven spatial distribution of the population of the Territory. In 1981, 74 per cent of the Territory's population lived in the core urban area of Hong Kong Island and Kowloon. Furthermore, this core urban area population was not spread out evenly across Hong Kong Island and Kowloon; it was highly concentrated in areas on both sides of the harbour, whose total land area comprised only 12 per cent of the total land area of all of Hong Kong Island and Kowloon. Moreover, numerous pockets of extremely high population densities, some measuring more than

100,000 persons per square kilometre (including one in north-central Kowloon with 165,445 persons per square kilometre), could be found in the low-lying and poorer sections of this urban core (Figures 4 and 5). Juxtaposed against some of these poorer neighbourhoods on Hong Kong Island and in Kowloon are some of the Territory's most affluent residential areas. It should be stated, therefore, that substantial variations in economic conditions exist even within each of these two subregions.

Hong Kong Island

Until the end of the 1960s, more than 80 per cent of Hong Kong population lived in the core urban area on the north shore of Hong Kong Island and the southern tip of Kowloon Peninsula (Lo 1986). Today, most government, financial, and corporate offices are situated in the core business area on the north side of Hong Kong Island. On the rest of this thin strip of land on the north side of Hong Kong Island are a variety of low- to mid-income high-rise residential buildings, mostly in areas of extremely high population density. Some of the Territory's most expensive housing is located high on the north-facing hill slope above this coastal strip, as well as on south-facing slope of Hong Kong Island (Figures 6 and 7); both of these areas provide the kind of quieter and more spacious living environment not found along the busy streets by the waterfront.

A few public-housing estates were built in a few pockets of land within, and on both extremities of, this narrow strip in the 1960s and 1970s. Hong Kong's stringent immigration regulations in the 1980s have stemmed the flow of refugees and illegal immigrants from China. This reduction in population pressure and the limiting of most new social housing projects to the New Territories have relocated much of the territory's population of childbearing age to the New Territories. This reduced rate of population growth on Hong Kong Island enabled the government to rebuild, upgrade, or replace many of these old, high-density housing estates on Hong Kong Island. By 1991, relatively few low-income housing estates remain on Hong Kong Island, and an increasing number of privately developed (and higher-cost) housing complexes have been built. Coupled with a territory-wide declining birth rate throughout the 1980s, the population of Hong Kong Island has been reduced to a level which made it the lowest of all three subregions in 1991.

Figure 3 Map of Hong Kong

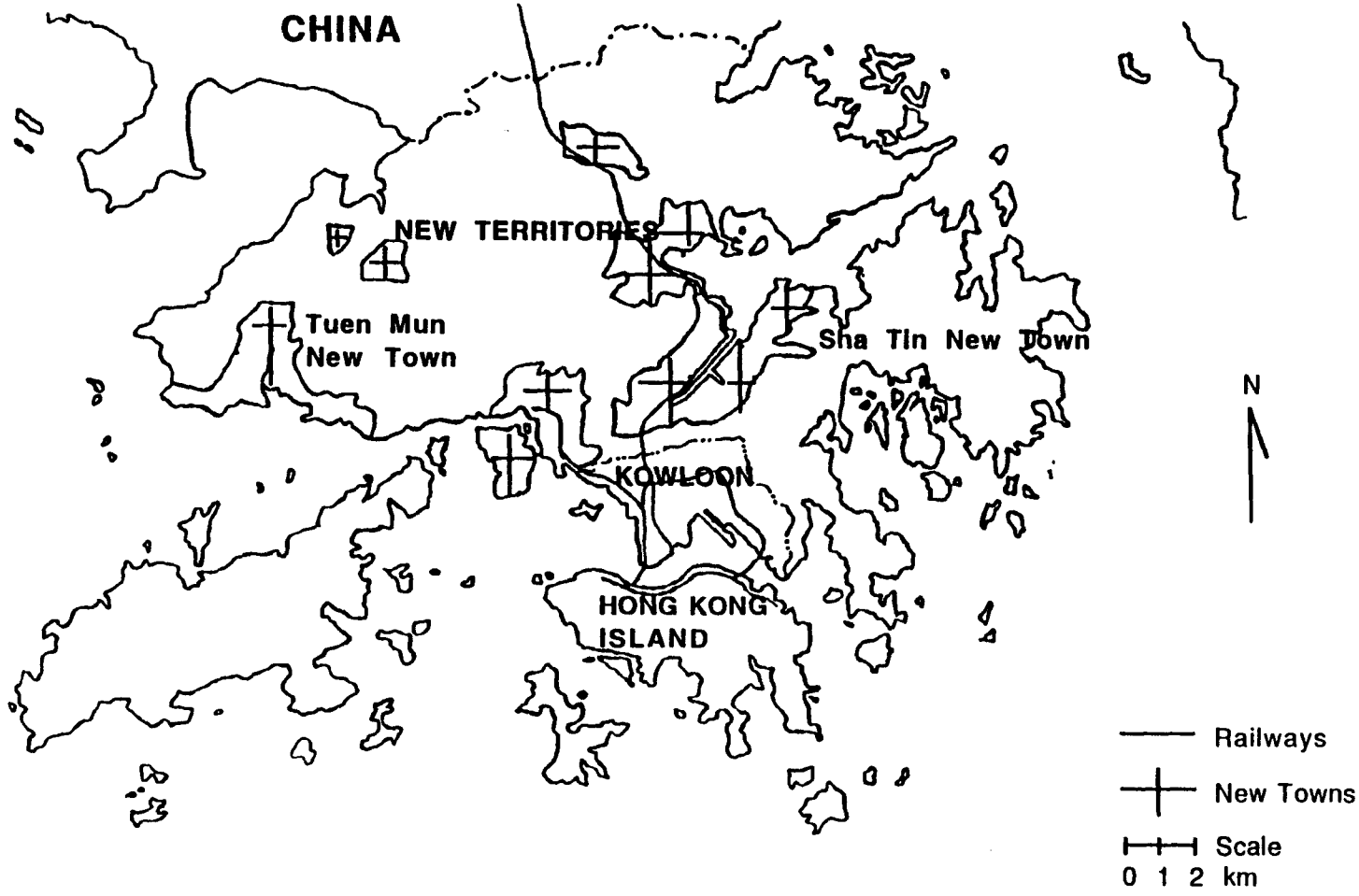
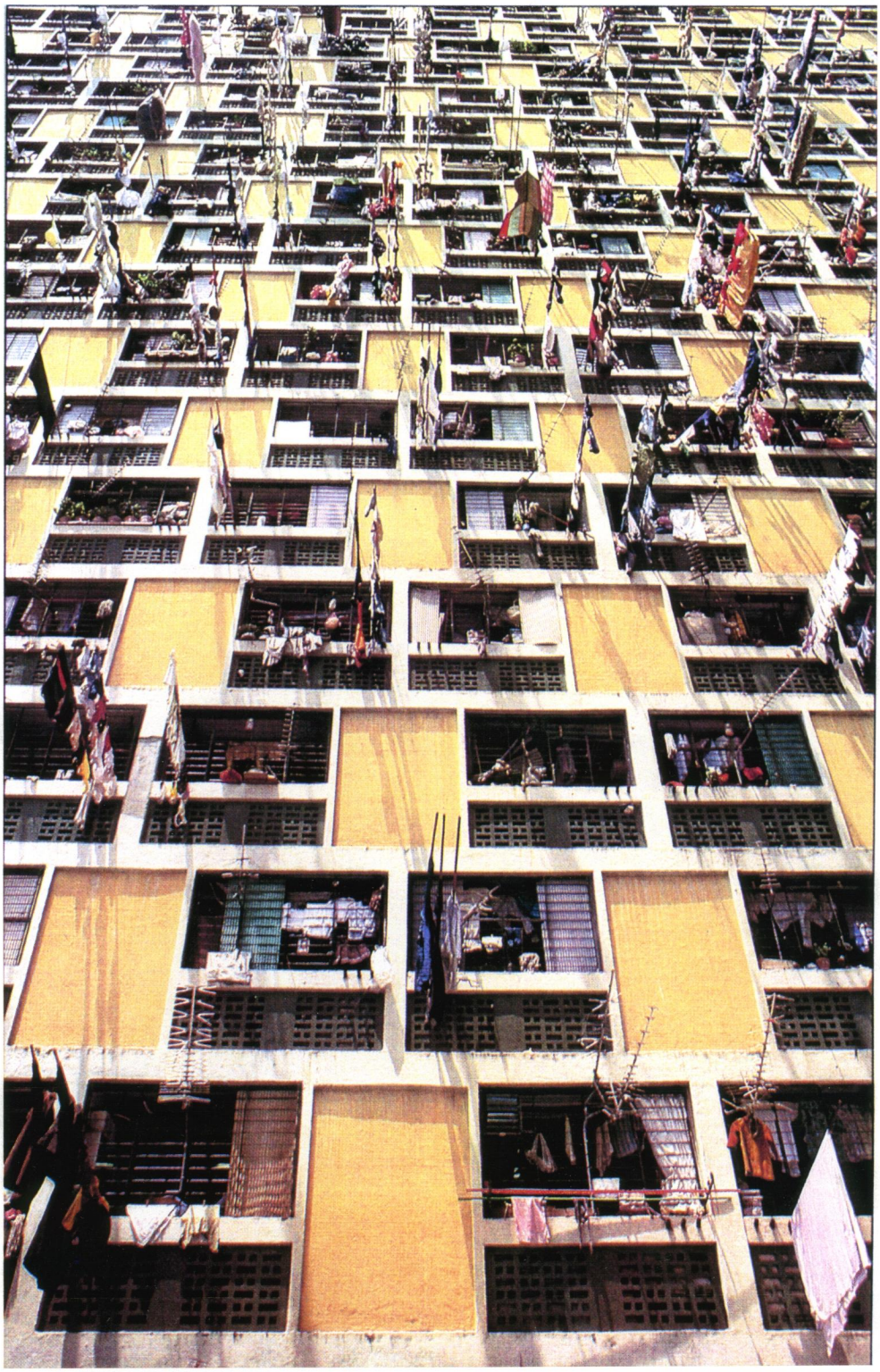


Figure 4 A typical lower-middle income apartment building in the core urban area of Hong Kond Island and Kowloon.

Source: Max Lawrence, n. d. (a)

Figure 5 A typical low-income public housing estate.



Source: Max Lawrence, n.d. (b)

Figure 6 Affluence: A role model for Hong Kong's diligent work ethic?

Source: R. Ian Lloyd, n.d. (a)

Figure 7 A not-so-private display of personal wealth

Source: R. Ian Lloyd, n. d. (b)

Kowloon

Most of the Territory's night life activities are found on the Kowloon Peninsula, where "world class" hotels for the entertainment of the affluent, British-style pubs for the ex-patroit community, sex-for-hire services mostly for heterosexual men, and open air "night clubs" comprising whole streets full of food vendors and export-unfit merchandise hawkers for those with low income are concentrated. Apart from the homeless, most of the poor live in crowded tenement flats on the upper floors of buildings in the vicinity of the open air "night clubs" in southern and central Kowloon, as well as in the densely populated public housing in northern Kowloon (also known as New Kowloon). Also found in northern Kowloon, however, is one small area with the Territory's highest-priced real estate called Kowloon Tong.

Most of the public housing in northern Kowloon comprised high-density resettlement housing estates built in the 1950s and 1960s for the resettlement of squatters. During the period 1981-1991, some of these seven-storey resettlement estates were also upgraded, much like their public-housing counterparts on Hong Kong Island. This usually meant that elevators were installed in these buildings, that the number of residential unit in each building was reduced, that private kitchens and bathrooms were installed in each individual unit, and that the amount of rent charged to each household has been increased to reflect the increased affluence of their former-refugee residents. This modest gentrification in Kowloon (as well as on Hong Kong Island) was also achieved by the promise of lower-density and higher-quality housing in the New Towns in the New Territories to the more economically productive population. The buildings which remained "as is" became the shared dwellings for some of the Territory's poorest members of society: single elderly people on social assistance and disability pension who have waited for years to be assigned one such shared flat in which to wait for death. Their less fortunate counterparts, on the other hand, await their deaths in the privately operated wired bedspace cages in other parts of northern Kowloon (Figures 8 and 9), while the least fortunate ones get by as street-sleepers.

Lo and Leung reported in the mid 1980s that northern Kowloon was an area characterized by social disorganization, an area whose suicide rate—21.7 per 100,000 among population aged 15 and over in 1985—was the highest in all of Hong Kong (Lo and Leung 1985, 291). In 1991, the size of Kowloon's population remained the higher of the two core urban areas. The density of the population in some of its districts remained the highest in the Territory. Its suicide rate has also stayed the highest of the three subregions.

Figure 8 Two cage "flats"

Source: C.W. Wong, 1992.

Figure 9 A "cage man"

Source: C.L. Cheng, 1992.

The New Territories

Until the 1960s, most of the plains and valleys of the New Territories were used for agriculture, handicraft and construction-material production, while the coastal areas on the New Territories provided moorage, trading facilities, and services for the fishing population. The physical, social, and economic landscape of the New Territories have changed drastically since the late 1960s and the early 1970s, after the government introduced a series of urban development programs designed to house Hong Kong's low- to mid-income residents in conditions less congested than those of the public housing built earlier in the core urban area (Hong Kong Government 1981).

This program called for the construction of high-rise residential apartments to house mainly nuclear families, industrial buildings, schools, and community centres, at the sites of a number of coastal and inland market towns (Bristow 1989). The designs of these new towns were derived, to a certain extent, from the planned and self-contained towns, called New Towns, which originated in post-War Britain (Bristow 1989; Leung 1986). The program called for the public sector to provide most of the housing initially, to be followed by private investment in industry, business, and additional housing, in the hope of attracting a variety of people to live and work in the New Territories (Bristow 1989; Leung 1986). The government had expected to disperse about half of Hong Kong's total population of up to six million to the New Territories by the early 1990s, so that the traffic, population density, and congestion in the core urban area could be reduced. It is obvious today that the goal of population dispersal was successful, and that the promise of less-congested living space has been fulfilled: the highest population density was only 31,575 persons per square kilometre in one of the recently developed New Towns (Lo 1986, 148). But the majority of the employed New Town residents, especially those in higher-paid information and white-collar service sector jobs, continue to work on Hong Kong Island and in Kowloon. This suggests that the goal of self-containment has not been achieved in the New Towns (Bristow 1989; Leung 1986).

In the meantime, the changing economic structures of Hong Kong and China and the increased trade between Hong Kong and China since the late 1970s have also changed the landscape of those areas of the New Territories outside New Town boundaries. The need for goods storage space has transformed most of the New Territories' crop land and fish ponds to warehouses and truck-trailer parking lots. It is true that the loss of the New Territories' young to the core urban areas and to emigration overseas is not a new phenomenon, but this accelerated modernization in the 1970s and 1980s has certainly quickened the pace of physical, demographic, and social changes in the New Territories.

The transformation of the New Territories from a close-knit agricultural and fishing society to a more individualistic and urbanized society also brought various types of pathogenic social conditions, such as social isolation, loneliness, and violence (Caritas 1986), and teenage alcohol and drug abuse (Furlong 1993); the New Territories' suicide rate of 8.7 per 100,000 in 1954 (Yap 1958, Table 2) increased to about 12 per 100,000 in 1991 (Figure 14).

Summary

With the highest population density still found in Kowloon, followed by Hong Kong Island, and then by the New Territories, the subregional rank order in terms of population density has remained unchanged between 1981 and 1991. The New Town Program has succeeded, however, in changing the spatial concentration and distribution of the Territory's population, such that the New Territories has become the subregion with the highest population in 1991, followed by Kowloon, and then by Hong Kong Island.

For the period 1981-1991, a large majority of the households in the New Territories comprised a relatively socio-economically homogeneous group of young, low- to mid-income urbanites in conjugal relationships, who were more likely to be commuting to work in Kowloon or on Hong Kong Island than working in their own New Towns. The inequity of Hong Kong's social-wealth redistribution is perhaps least visible in the New Territories. By comparison, more variations can be found in the socio-economic characteristics of the residents of Kowloon. They range from the few affluent ones in Kowloon Tong's garden villas, to the poor in dormitory cages nearby, and to the destitute street-sleepers in alleys and staircases between "world class" hotels. Dormitory cages and street-sleepers could also be found in the urban area adjacent to the harbour on Hong Kong Island, though the overall economic condition of the population on Hong Kong Island rendered it the most affluent of all three subregions. Many of those with middle income lived in relatively spacious flats in large, privately developed, apartment complexes, while the rich and senior government officials lived higher up on the hill slope above the central business district, and in luxurious resort-like apartment complexes, complete with uniformed security guards, on the south-facing slope of Hong Kong Island. Having provided this brief view of the socio-economic landscape of Hong Kong as a whole and by its three subregions, the following section will introduce and then examine the suicide data for the Territory as a whole, and those for each of these subregions.

Data Limitations

Four major types of data were used to compile the suicide rates used in this study:

1) The total number of cases of suicide for Hong Kong as a whole for each year between 1981 and 1991, inclusive, as provided by the Registrar of the Supreme Court in Hong Kong.
2) The total number of cases of suicide for each of Hong Kong's three subregions for the years 1981, 1986, and 1991, as provided by The Coroner of Hong Kong.
3) Census population data for each of the three subregions for the years 1981, 1986, and 1991.
4) Mid-year population estimates for Hong Kong as a whole for each year between 1981 and 1991.

Raw Suicide Data

Statistics on the number of suicides were obtained in the following manner. In 1991, two editions of Hong Kong Coroners Report—*Hong Kong Coroners Report for the Year 1989* and *Hong Kong Coroners Report for the Year 1990*—were found in the library of the University of Hong Kong. Each of these publications contains, for the corresponding year, four two-part tables of suicide data, one for all of Hong Kong, one for Hong Kong Island, one for Kowloon, and one for the New Territories. The top half of the sheet for each subregion lists the number of suicides between January 1 and December 31 by age group, sex, and method in that subregion; the bottom half of the same sheet lists the number of deaths resulting from "injury undetermined whether accidentally or purposely inflicted" between January 1 and December 31 by age, sex, and method in the corresponding subregion. In order to maintain consistency, only those deaths classified by the Coroner as suicide (and listed in the table at the top half of each of these pages) have been counted in this analysis.

Attempts were made to locate earlier editions of the *Hong Kong Coroners Report*, but it was learned that this publication did not exist prior to 1989. In December 1990, a phone call was then placed to the Coroner's office for the purpose of requesting suicide data for years prior to 1989. The staff there indicated that all public inquiries were handled only through the office of the Registrar of the Supreme Court. A phone call was then made to the Supreme Court Registrar's office, requesting suicide data for the three separate subregions "in a format similar or identical to that found in the *Hong Kong Coroners Report for the Year 1989* for as far back as possible." The staff there

indicated that something would be made available for pick up later that day. Upon examination of the content of the envelope picked up later that same day, it was discovered to contain only aggregate suicide data for Hong Kong as a whole for each of the years between 1981 and 1991. A verbal request for separate data for each of the three subregions was rejected due to "lack of manpower and undue expense to the public." At this time, it was also added that any additional requests be made in writing. A written request, which indicated a willingness to pay for overtime work at a "reasonable rate," was then made and delivered personally to Mr. Julian Betts, the Supreme Court Registrar. A written denial, signed by Mr. Betts, was received three days later, indicating that no further assistance could be expected from him. A phone call was then made to the Samaritans—Hong Kong's crisis-intervention and service referral centre. Staff members there did not know where spatial suicide data for each of the three subregions could be procured.

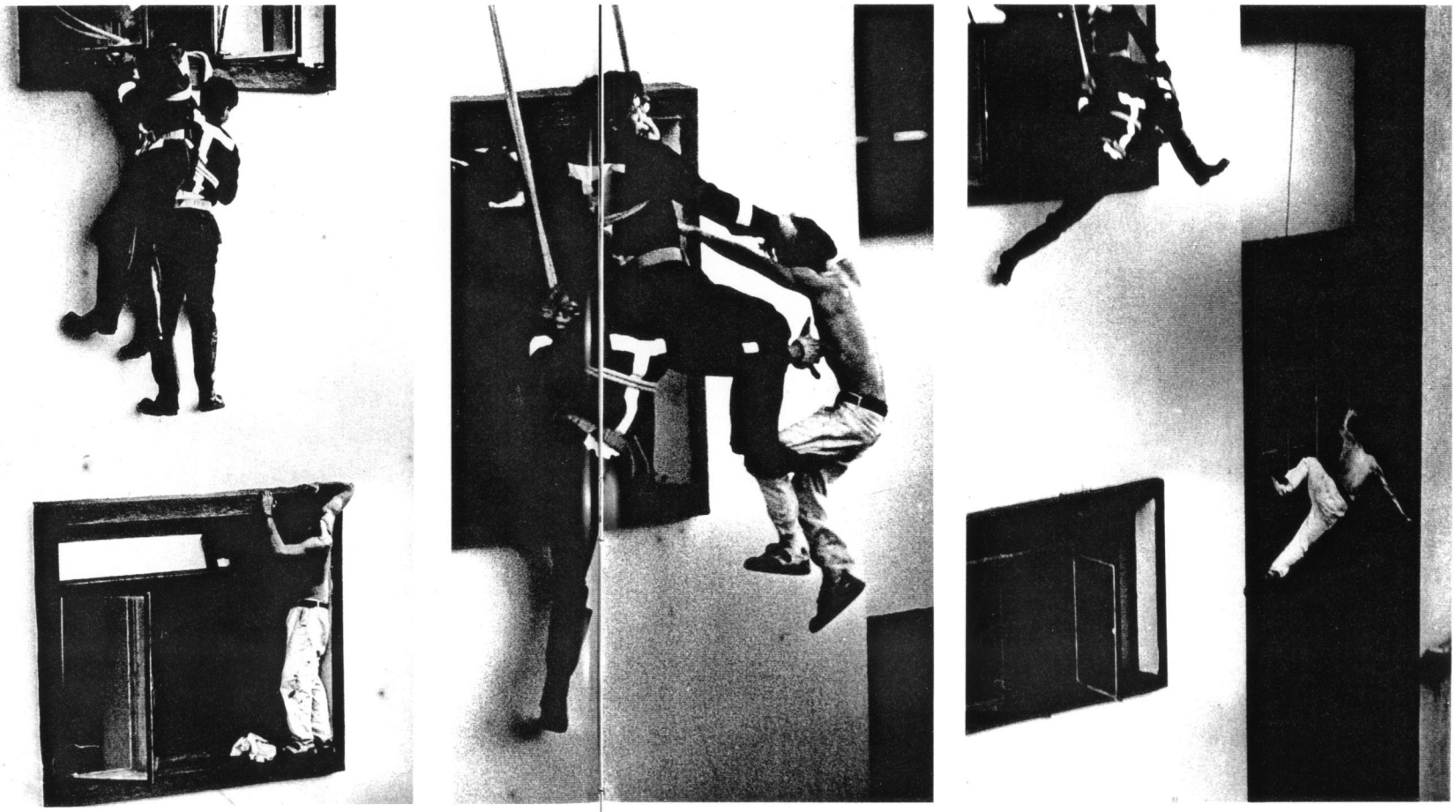
In order to determine whether or not the total number of cases of suicide reported in any daily newspaper matched the number of suicide published in the *Hong Kong Coroners Report*, several weeks were spent examining three of Hong Kong's daily newspapers for the year 1991. Only a handful of suicides were reported by the English-language daily *South China Morning Post*, and about a quarter of those published by the Coroner were reported in the Chinese-language daily *Ming Pao* : Hong Kong's daily read by academics.

Although the numerical discrepancy confirmed that these newspapers could not be used as a statistical source, the number of suicides reported and details on these suicides as mentioned in the newspaper reports led to some useful observations. For example, the majority of the cases reported by *Ming Pao* were completed and attempted suicides by the young. In addition, the amount of detail in each report tended to be related to the age of the suicide and the degree to which the attempt or completion was sensational: the younger an attempter or completer was, the larger the size of the story and the greater the depth of its coverage. This is most noticeable either when a young suicide attempter or completer had created news-worthy footages by holding suicide-intervention counsellors at bay from the edge of a roof for several hours (Figures 10 and 11), or when a fall from a great height provided a "picture-perfect" shot of mangled flesh and blood on the street. Conversely, elderly suicidal deaths were given very brief coverage, it at all (Appendix 3).

Figure 10 A camera-ready suicide.

Source: T.Y. Lo, n.d.

Figure 11 Another camera-ready suicide.



Source: W.K. Yu, 1987.

In March 1992, a thorough examination of the government telephone listings in the Hong Kong telephone directory revealed a potentially useful source listed as the "Senior Statistician of Social and Economic Statistics." A phone call was made to the switchboard there to verify its mailing address. A written request for spatial suicide data for the census or by-census years of 1971, 1976, 1981, 1986, and 1991 was addressed to the Senior Statistician of Social and Economic Statistics, who must have then forwarded it to the Coroner. A speedy reply from Mr. H. Y. Lam (Clerk to Coroners) was received. It contained spatial suicide data for the three subregions for 1981, 1986, and 1991; Mr. Lam apologized that "this sort of statistics" have been kept only since 1981, thus limiting this study to the period 1981-1991.

In sum, data on the number of suicides by age group, sex, and suicide method for each of the three subregions of Hong Kong Island, Kowloon, and the New Territories for 1981, 1986, and 1991 were provided through the assistance of Mr. H. Y. Lam in the Coroner's Court in early 1992, and through the referrals made by the Senior Statistician. In relative terms, the Supreme Court Registrar was less helpful in providing the spatial statistics needed for this study.

Population Data

Aggregate population data for the years 1981-1991 were obtained from the table "Estimated Mid-Year Population by Age Group by Sex" in various issues of the *Hong Kong Annual Digest of Statistics* published annually by the Census and Statistics Department in Hong Kong. Population data by age group, sex, and census area for the by-census year of 1986 and the census years of 1981 and 1991 were obtained from government census publications, whose titles are indicated at the bottom of each figure. Although the elderly population has been broken down into age groups of 60-64, 65-69, 70-74, and 75 and higher in the 1986 and 1991 census data, the elderly population data published in the 1981 census is available only as a single group of 60 and higher. In order to ensure consistency and comparability, the oldest age group presented in this study will be the age group of 60 and over.

Suicide Rate Computation

Suicide rates for each of the three areas of Hong Kong for 1981, 1986, and 1991 were computed using this formula:

> Number of suicides during the calendar year divided by
> census population and multiplied by 100,000

Aggregate suicide rates for all of Hong Kong for each year, 1981-1991, were computed using the formula:

Number of suicides during the calendar year divided by mid-year population estimates and multiplied by 100,000

Data Interpretation

Like coroners in many Western jurisdictions, Hong Kong's coroner's office classifies all deaths brought to its attention under the four major categories of deaths: 1) natural causes, 2) accident, 3) suicide, and 4) indeterminate causes. Information on the definition of suicide used by the Coroner in Hong Kong was not available for this study. However, the centralized processing of Cause-of-Death verdicts should ensure a high degree of uniformity in death certification among these areas.

The data analyzed first will be the aggregate data for all of Hong Kong as a whole. These will be followed by a spatial analysis of the data for Hong Kong Island, Kowloon, and the New Territories.

Suicide in Hong Kong—An Overview

Figure 12 indicates that the male suicide rate has remained consistently higher than the female rate, and that a gradual increasing trend for both sexes is evident for the period 1981-1991 for Hong Kong as a whole. More fluctuations can be observed in the male suicide rate than the female suicide rate over time. A substantial increase can be noted in the male suicide rate throughout the early and mid 1980s. This is followed by a sizeable decrease for two years, and then by a period of accelerated increase toward 1991. On the other hand, the rate for females also shows a sizeable increase during the early and mid 1980s, but has remained relatively stable since the mid 1980s. Overall, the suicide rate ranges from a low of just under 8 per 100,000 (for females in the early 1980s) to a high of slightly over 15 per 100,000 (for males in 1991). These data also indicate that the increase in the aggregate suicide rate in the period 1981-1991 resulted from a rise in both the male and female suicide rate.

Elsewhere, Stillion *et al.* reported that three times as many men complete suicide globally (Stillion *et al.*, 1989, 17). Lester reported a suicide rate of 19.3 per 100,000 for males and 5.1 per 100,000 in the United States for 1986 (Lester 1990, 182-83), and and Hassan reported a rate of 11.4 per 100,000 for males and 7.7 per 100,000 for females in Singapore in 1970 (Hassan 1983, 69). Yap reported a rate of 16.3 per 100,000 for males and 12.0 for females in Hong Kong in 1954 (Yap 1958,

9), a period when homelessness, unemployment, and starvation, that is, absolute deprivation, were more prevalent than in the 1980s. The higher rate found in males is a gender-specific characteristic also found in the suicide statistics reported by most countries to the World Health Organization (Figure 1).

Figure 13 reveals year-to-year fluctuations in the suicide rate for some of the age groups; it also clearly shows rate increases over time in each of the groups 20 years of age and over. Increases over time are especially pronounced for the older age groups, with the rate for the 60-69 rising from about 20 per 100,000 in 1981 to higher than 25 per 100,000 in 1991, and that for the group 70 and over increasing from just over 35 per 100,000 in 1981 to over 50 per 100,000 in 1991. Yap, Lo, and Leung also found that Hong Kong's suicide rate increased with age (Lo and Leung 1985, 288; Yap 1958, 13).

Elsewhere, Yampey stated that suicide among the elderly became more prevalent than among the young in Buenos Aires as the size of that city's elderly population increased in the 1960s (Yampey 1975, 61). Rao also reported an increase in the incidence of suicide among the elderly in India; Rao attributed it to an increase in the the size of the country's elderly population (Rao 1975, 237). McIntosh found that while the suicide rate among the 15 to 24 age group in the United States has increased in recent decades to 13.1 per 100,000 in 1986, a suicide rate of 21.5 for those 65 and over for the same year was almost 50 per cent higher than the rate for the 15 to 24 age group (McIntosh 1991, 60-63). Hassan found that elderly ethnic-Chinese and ethnic-Indian people 60 years of age and higher in Singapore are six times more prone to suicide than their counterparts 59 years of age and under (Hassan 1983, 61). Apart from a smaller peak in the suicide rate for those between the ages of 20 and 24, the suicide rate for Japan also peaked among those 70 years of age and over (Iga 1986, 13, 15; Iga and Tatai 1975, 255-56).

These findings and the characteristics indicated in Figure 13 are consistent with the finding that the rate of suicide completion increases with age in most countries (Durkheim 1951, 324-25; Hassan 1983, 60-62; Leenaars 1992, v; Lester 1991, 73-77; Miller 1979, 1; Osgood 1986, ix; Stillion *et al.* 1989, 159; Yampey 1975, 60; Yap 1958, 13). The elderly in Hong Kong not only have the highest suicide *rate*, those 60 and older—when classified as one single age group—also complete the highest *number* of suicides compared to all younger age groups. The elderly suicide rate did not decrease along with the modernization and increased economic prosperity of Hong Kong between the mid 1950s (the period covered by Yap's study) and the 1980s; it has, in fact, increased.

Figure 12 Rate of Suicide (by Sex) for Hong Kong 1981-1991

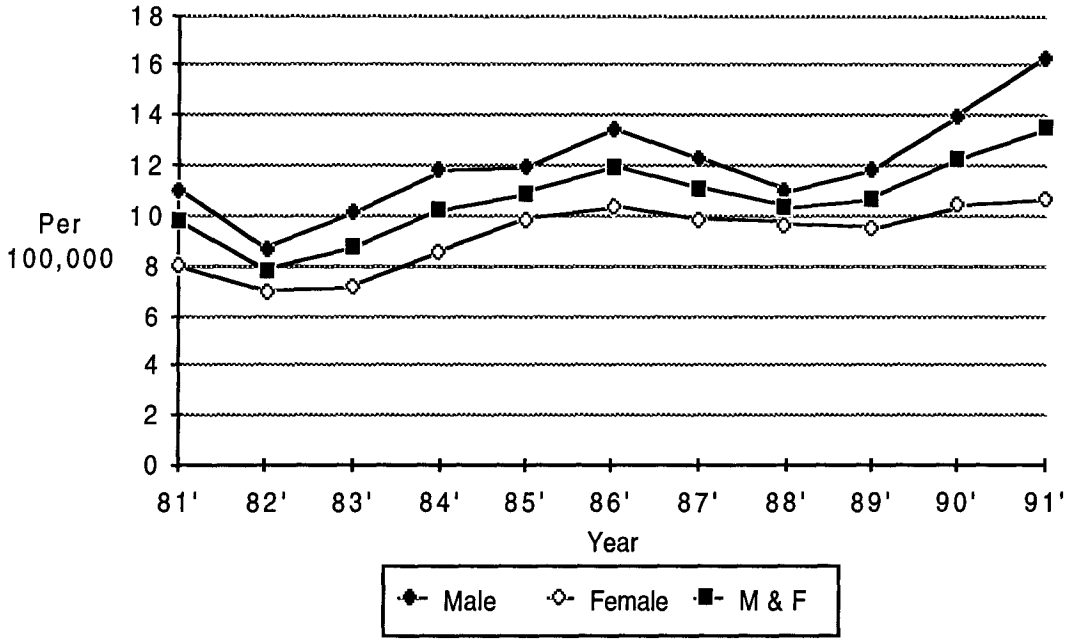
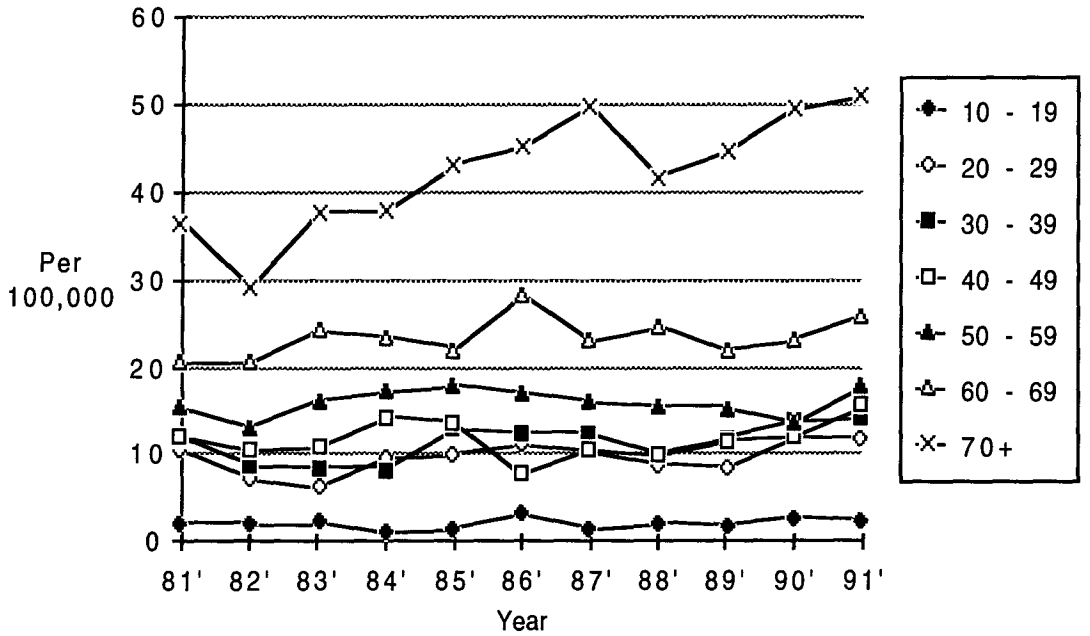


Figure 13 Rate of Suicide (by Age Group) for Hong Kong 1981-1991



Source for both figures: Raw suicide data provided by Hong Kong Coroner's Court, see Hong Kong Coroner's Court 1992. Population data from mid-year population estimates, Census and Statistics Department, *Hong Kong Annual Digest of Statistics* 1990 and 1992.

Spatial Variations Between the Three Subregions

Figure 14 provides a spatial breakdown of the overall suicide rate for Hong Kong Island, Kowloon, and the New Territories for the 1981, 1986, and 1991. It is evident that the suicide rate for all three areas has increased over time. The rate for Kowloon is the highest, followed by Hong Kong Island, and then by the New Territories; this ranking order is identical to that reported by Yap (1958, Table 2), and similar to that reported by Lo and Leung (1985, Table 1).[12].

Accounting for gender (Figures 15, 16, and 17), rate increases over time are still evident for all areas and both sexes. One exception is that the female suicide rate in Kowloon decreased slightly between 1986 and 1991, though the rate for 1991 is still higher when compared to that of 1981. These figures also reveal that males have higher suicide rates than females in all three subregions and time periods; they also indicate that the rate for females was consistently but only slightly lower than that for males for this period.

Figures 18 through 23 are then presented in an attempt to verify whether or not this general increase is spread across people of all ages; they show the rate of suicide by age group for each of the three areas of Hong Kong Island, Kowloon, and the New Territories for 1981, 1986, and 1991, respectively. A comparison of the value of the x-axis of these six figures reveals that the value generally increases with age; this indicates that the aggregate phenomenon noted earlier that suicide increases with age is applicable to all three areas.

More variations can be observed, however, in the ranking of the rates between the three subregions. For example, for the 10-19 age group, the suicide rate was highest in the New Territories in 1981 and 1991, while the rate for Hong Kong Island peaked in 1986, but decreased drastically to become the lowest of the three areas in 1991 (Figure 18). Meanwhile, the rate for Kowloon began at just below that for Hong Kong Island in 1981, increased to match that of the New Territories in 1986, but subsequently fell back to its 1981 level. For this age group, the high-to-low ranking order in 1991 was the New Territories, Kowloon, and Hong Kong Island (Figure 18).

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[12]Lo and Leung counted only incidence of suicide of those 15 years of age and above, and computed all of their rates using population figures of those 15 and over. Furthermore, spatial data were broken down into the four areas of Hong Kong Island (with a suicide rate of 17.6 per 100,000), Kowloon (10.4 per 100,000), New Kowloon (21.7 per 100,000), and the New Territories (18.4 per 100,000) (Lo and Leung 1985, Table 1)

Figure 14 Suicide Rate (per 100,000) for Hong Kong Island, Kowloon, and the New Territories (1981, 1986, 1991)

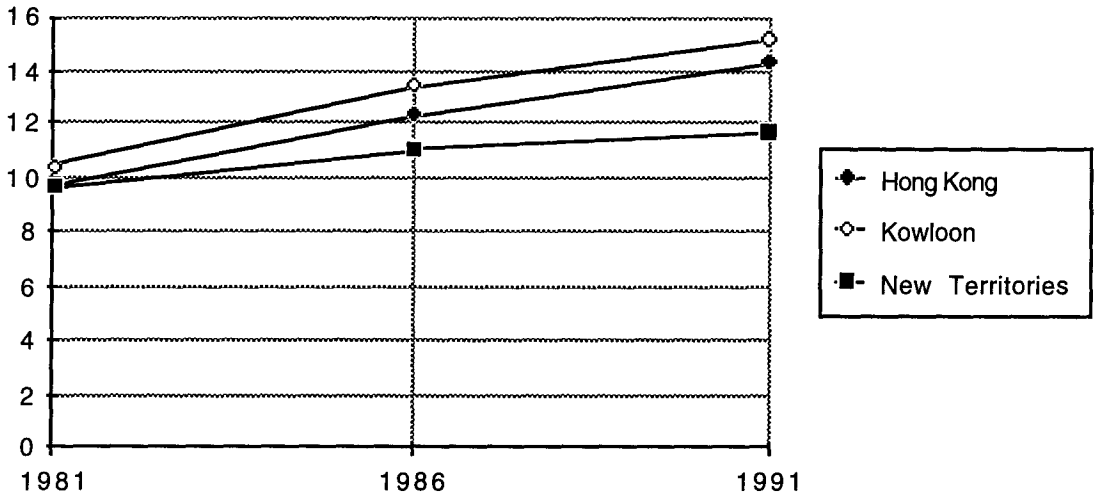
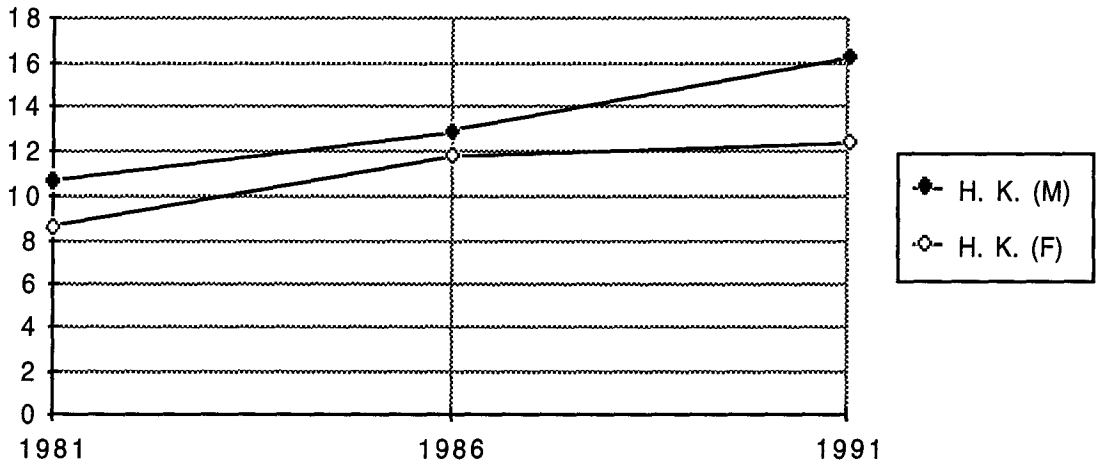


Figure 15 Suicide Rate (per 100,000) for Hong Kong Island by Sex (1981, 1986, 1991)



Source (for Figures 14-17): Raw suicide data from Hong Kong Coroner's Court 1992. Population data from the following publications by the Census and Statistics Department of Hong Kong. *Hong Kong 1981 Census: Basic Tables* (Table 1); *Hong Kong 1986 By-Census—District Board Constituency Area: Population by Age* (Area Tables for Hong Kong District Boards on p. 11, Kowloon District Boards on p. 12, and New Territories District Boards on p. 13); *Hong Kong 1991 Population Census—Tabulations for District Board Districts and Constituency Areas: Population by Age and Sex* (Summary Tables for Hong Kong Island on p. 28, Kowloon and New Kowloon on p. 29, and the New Territories on p. 30).

Figure 16 Suicide Rate (per 100,000) by Sex for Kowloon (1981, 1986, 1991)

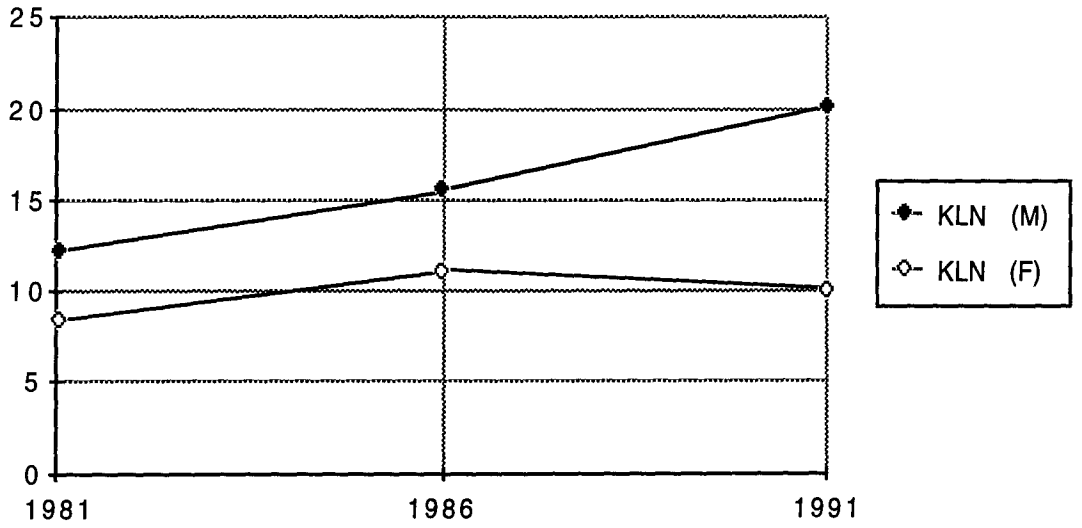


Figure 17 Suicide Rate (per 100,000) by Sex for the New Territories (1981, 1986, 1991)

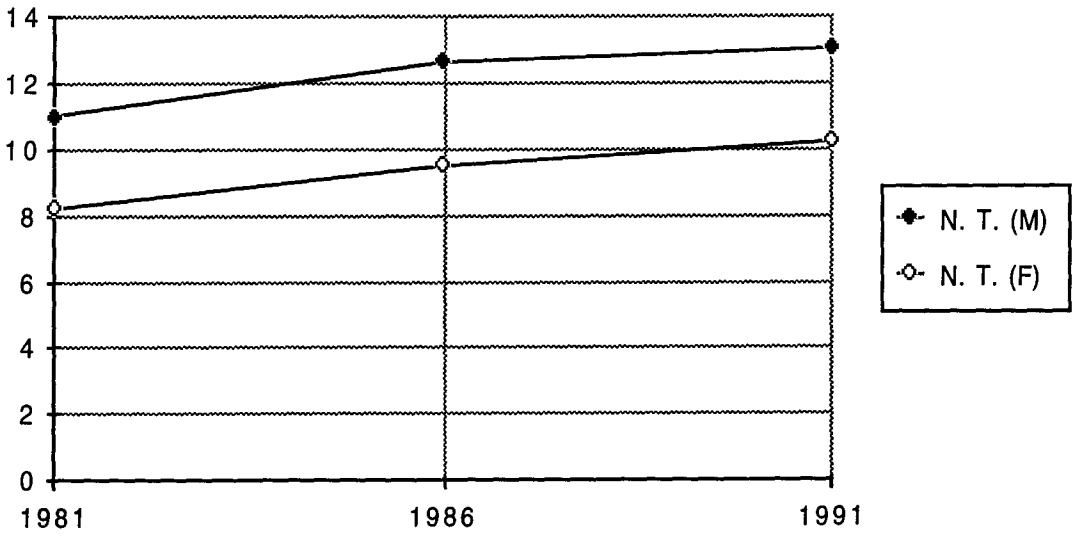


Figure 18 Suicide Rate (per 100,000) for the 10-19 Age Group for Hong Kong Island, Kowloon, and the New Territories

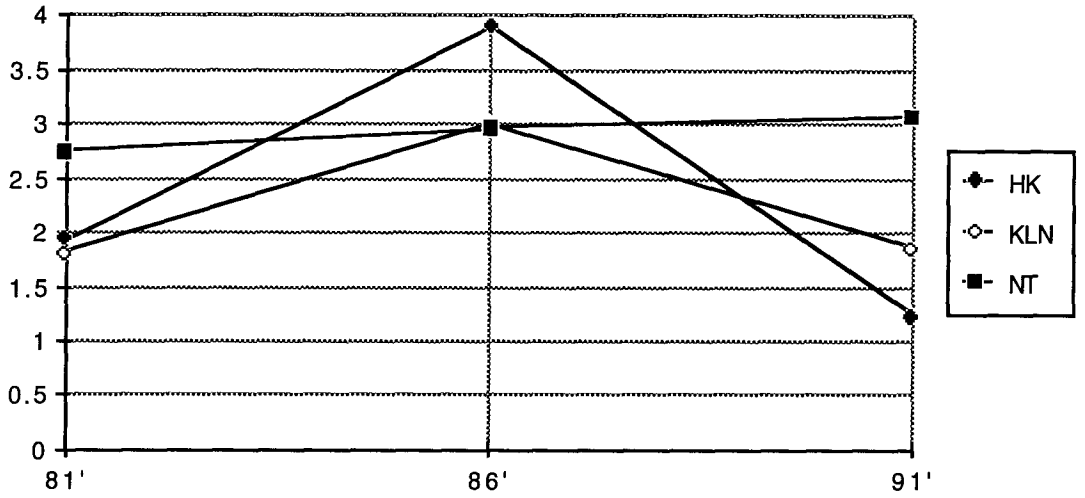
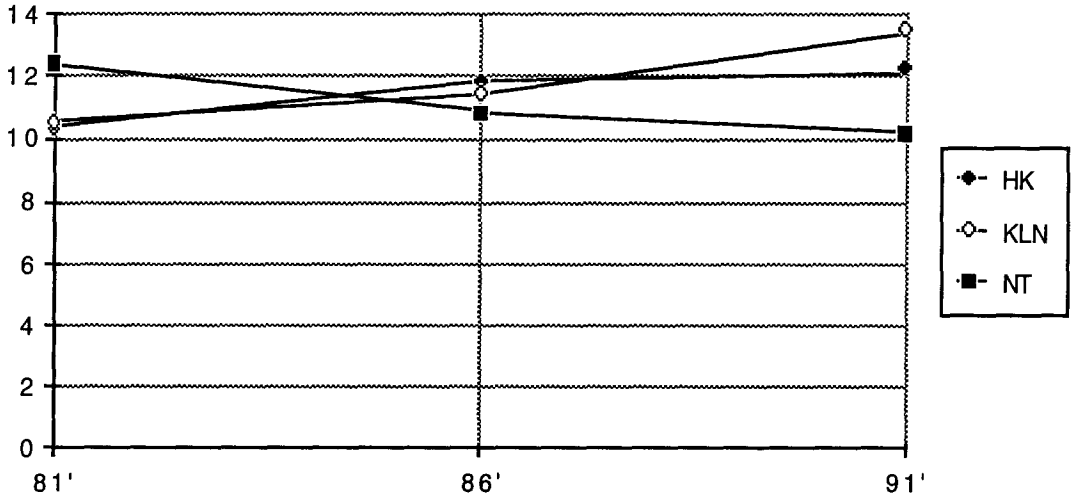


Figure 19 Suicide Rate (per 100,000) for the 20-29 Age Group for Hong Kong Island, Kowloon, and the New Territories



Source for Figures 18-23: Raw suicide data from Hong Kong Coroner's Court 1992. Population data from the following publications by the Census and Statistics Department of Hong Kong. *Hong Kong 1981 Census: Basic Tables* (Table 1); *Hong Kong 1986 By-Census—District Board Constituency Area: Population by Age* (Area Tables for Hong Kong District Boards on p. 11, Kowloon District Boards on p. 12, and New Territories District Boards on p. 13); *Hong Kong 1991 Population Census—Tabulations for District Board Districts and Constituency Areas: Population by Age and Sex* (Summary Tables for Hong Kong Island on p. 28, Kowloon and New Kowloon on p. 29, and the New Territories on p. 30).

Figure 20 Suicide Rate (per 100,000) for the 30-39 Age Group for Hong Kong Island, Kowloon, and the New Territories

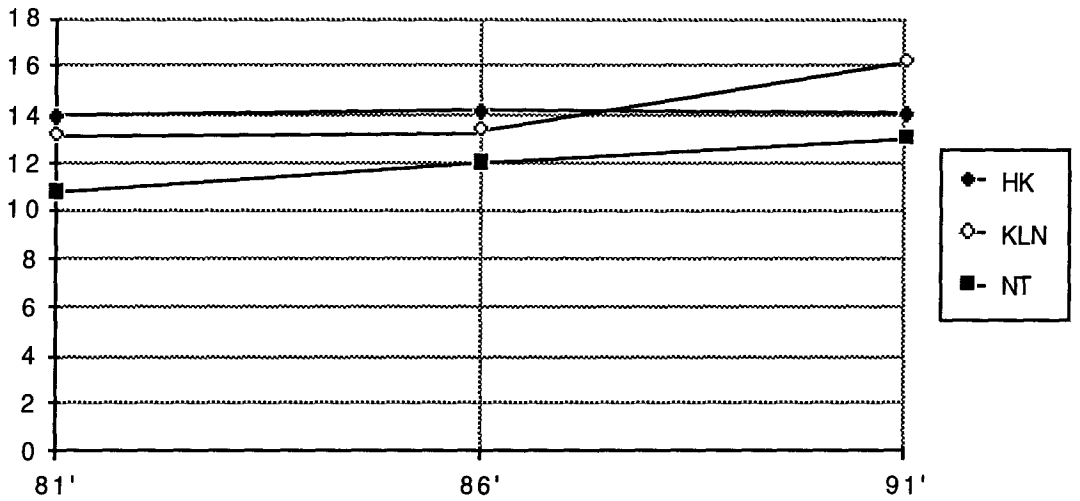


Figure 21 Suicide Rate (per 100,000) for the 40-49 Age Group for Hong Kong Island, Kowloon, and the New Territories

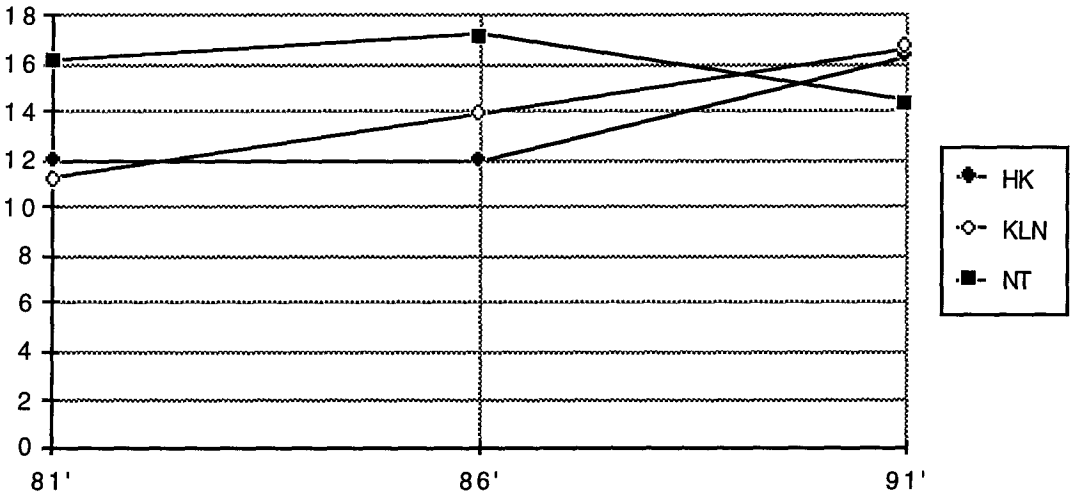


Figure 22 Suicide Rate (per 100,000) for the 50-59 Age Group for Hong Kong Island, Kowloon, and the New Territories

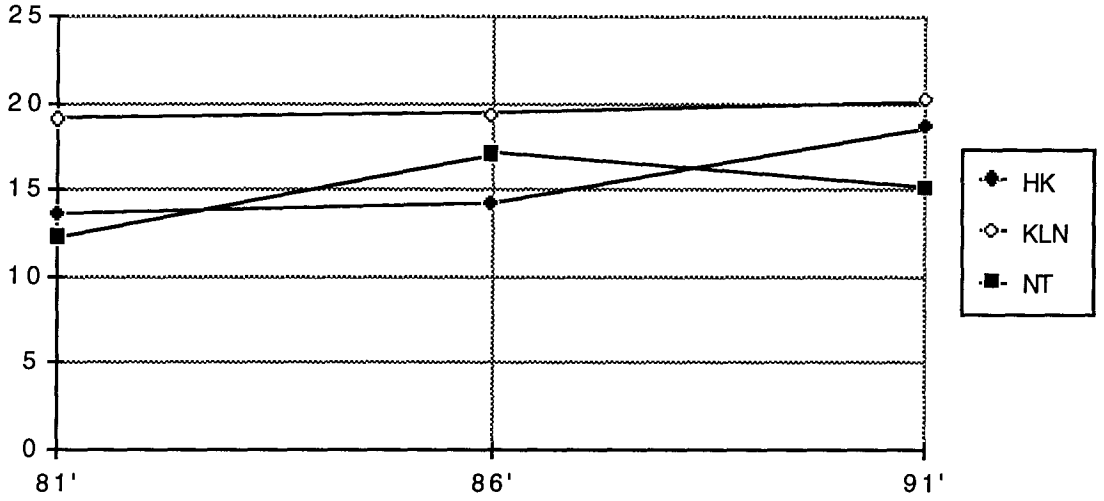
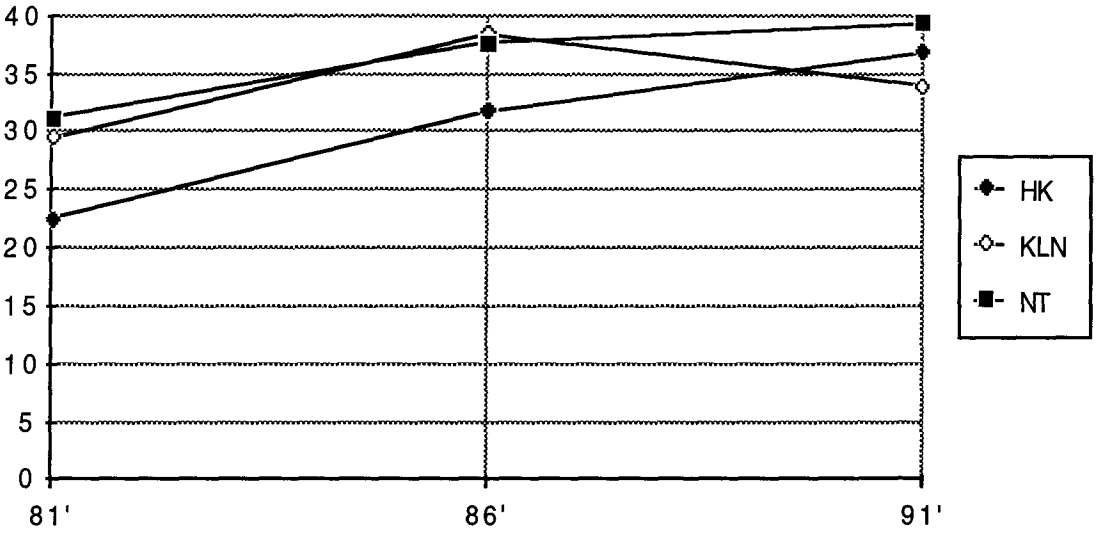


Figure 23 Suicide Rate (per 100,000) for the 60 and Over for Hong Kong Island, Kowloon, and the New Territories



The pattern in Figure 19 reveals that the suicide rate among the 20-29 age group was was the highest in the New Territories in 1981; it then decreased for 1986 and 1991, to the extent that the New Territories had the lowest suicide rate of all three subregions for both 1986 and 1991. The rates for Hong Kong Island and Kowloon for this age group were similar to each other in 1981 and were both lower than that for the New Territories, but both exceeded that for the New Territories in 1986 and 1991. The subregional rank order for this age group was, in 1991, Kowloon, Hong Kong, and the New Territories, which is identical to the aggregate picture.

Figure 20 indicates that the suicide rate for the young middle-age people 30 to 39 years of age in the New Territories was consistently the lowest. As for the two traditional urban areas of Hong Kong Island and Kowloon, the rate for Hong Kong Island was slightly higher than the rate for Kowloon for both 1981 and 1986. While the rate for Hong Kong Island remained stable for all the three time periods, it was exceeded by that for Kowloon for 1991. The increase in the rate for Kowloon between 1986 and 1991 brought, in 1991, a rank order for this age group identical to that of the aggregate pattern.

The pattern for the older middle-age group (40-49 years of age) is that the rate for the New Territories was the highest for both 1981 and 1986, but fell to the lowest of all three areas for 1991 (Figure 21). The rate for Kowloon was the lowest for 1981, but increased steadily to surpass that of Hong Kong Island in 1986, and those of both subregions for 1991. Again, the ranking of the suicide rate of the three subregions for 1991 conforms to the aggregate order.

Among those aged 50-59 years, the rate for Kowloon simply remained the highest for all three time periods (Figure 22). The rates for the other two subregions fluctuated somewhat, with the rate for Hong Kong Island being the lowest of the three subregions for 1981. This was exceeded in the 1986 by a substantial rise in the rate for the New Territories. Hong Kong's rate surpassed that of the New Territories again, however, as it began to rise while the rate for the New Territories fell between 1986 and 1991. Once more, the spatial rank order for this age group is identical to that of the aggregate for 1991.

Lastly, the suicide rate for those 60 years of age and higher was the lowest on Hong Kong Island for both 1981 and 1986 (Figure 23). It rose, however, to a level between those of the other two subregions in 1991. The rate for this old and the very-old age group in Kowloon was higher than that for Hong Kong Island in 1981 and 1986, but fell to become the lowest rate found in the three subregions for 1991. As for the New Territories, its rate began from being the highest of all three subregions in 1981,

which was exceeded slightly by Kowloon for 1986 because the increase for the latter was greater than that for the New Territories. Between 1986 and 1991, the rate for Kowloon fell slightly while that for the New Territories continued to increase. By 1991, the old and the very-old in the New Territories not only had the highest suicide rate of this age group in all three subregions, they had the highest suicide rate for any age group anywhere. Figure 23 also indicates that the high suicide rates among the elderly population demonstrated earlier in the aggregate data in Figure 13 is a result of high suicide rates among Hong Kong's elderly population in all three subregions.

Summary

To summarize, Hong Kong's aggregate suicide rate increased between 1981 and 1991. The aggregate suicide data reveal two patterns similar to those found in most countries: 1) the rate increases with age and 2) the rate for males is higher. Spatially, the suicide rate is the highest in Kowloon, followed by Hong Kong Island, and then by the New Territories—except for the young and the elderly populations, whose rates were highest in the New Territories. These statistical data will be examined further in the next chapter, where a socio-spatial analysis of suicide in each of these three subregions will be provided.

CHAPTER FOUR: ANALYSIS OF SUICIDE IN HONG KONG AND ITS THREE SUBREGIONS

This section will analyze the suicide data presented earlier. Attempts will be made to explain them in the context of the socio-economic environment of each of the three subregions.

Analysis of Suicide on Hong Kong Island

The Territory's social, demographic, and economic changes, especially those which have taken place on Hong Kong Island, have probably attributed to Hong Kong Island's relatively low suicide rate compared to that of Kowloon (Figure 14). In fact, the data in Figures 18 to 23 indicate that the suicide rate in 1991 for those 20 and older on Hong Kong Island remained at a level lower than that for Kowloon, and higher than that for the New Territories. Even though the presence of the wealth of the Territory's small handful of rich households is most evident in this subregion, the relative affluence of the majority of people on Hong Kong Island reduces the likelihood of psychological malaise resulting from a sense of gross self-inadequacy; this relative economic sufficiency and stability is probably a significant protection against suicide resulting from deprivation of basic material needs.

Compared to those 20 years of age and older, the number and the rate of suicides by those 10 to 19 years of age are both low. The small size of statistical sample for those of this age group reduces the representativeness of the changes in its suicide rate between 1981, 1986, and 1991. Namely, was 1986 an unusually high year and 1991 an unusually low year (Figure 18)? In any case, if the low rate for 1991 is typical of the early 1990s, it might be hypothesized that this rate also resulted from the general economic affluence of this subregion. In particular, most of the people in this age group are certainly to be students. The relative affluence of their elders increases the likelihood that they can afford to hire tutors and domestic help. This should decrease the workload and the level of stress and frustration on the part of the elders, who might otherwise have to struggle long hours every day to make ends meet. It should also increase their physical and emotional availability to their children, so that their children would more readily approach them to discuss their social and academic difficulties, rather than avoid them in guilt or shame for fear of parental rejection.

On the other hand, except for the relatively stable rate for the 30-39 age group, increases over time can be observed in every age group 20 and over. Moreover, the rate of increase itself tends to accelerate with increases in age. For instance, while the rate for those 20-29 increased by 15 per cent from about 10.5 per 100,000 in 1981 to

about 12.1 in 1991, the rate for the 60 and higher increased by 68 per cent from about 22 per 100,000 to about 37 per 100,000 during the same ten-year period. This high rate of increase among the elderly population of Hong Kong Island suggests either that the hypothesized economic protection against suicide available to the young was not extended to the elderly, or that the aggregate pain experienced by the elderly simply overwhelmed whatever economic protection that was available to them. No spatial data is available on the income of the elderly, but if the social and psychological condition of the elderly described in Appendix 2 is representative of the condition of the elderly on Hong Kong Island, it can only be concluded that they walk a financial tightrope in the midst of the affluence of others; their psychological state can best be described as feeling lonely, hopeless, useless, and disillusioned.

Analysis of Suicide in Kowloon

Except for the suicide rate among the 10-19 age group, the suicide rate in Kowloon has increased for every age group between 1981 and 1991. As in the case of Hong Kong Island, the rate for the school-age population peaked in 1986, and then decreased in 1991. In Kowloon's case, however, the decrease was not as substantial as that on Hong Kong Island: the rate only went down to its 1981 level. Again, it can only be hypothesized that a general Territory-wide increase in overall affluence and a decrease in the size of the households to which the young belong have reduced economically induced stress among the 10-19 age group of Kowloon.

This thesis of affluence, however, cannot be generalized to the middle-age population, since worldviews and their socially and cognitively constructed means of appraising their self-worth are more likely than not to differ from those of the 10-19 age group. In other words, different sets of environmental stressors, as well as their greater vulnerability to physical and mental illness, can generate more stress for the older individuals than for those of school age. The increase in the suicide rates for the middle age groups in Kowloon, like that for similar age groups in other subregions, might be a result of a realization in their adulthood the inability to reach the goal of accumulation which they had set for themselves, a relative lack of intervention opportunities in the single-person and public-housing home environments, and a greater reliance on the relatively inefficient public health providers to detect, diagnose, and treat mental problems.

Appendix 4, the account of an attempted suicide by a poor middle-age man in the "high-rise jungle" or urban Kowloon, provides an excellent example of cognitive rigidity, insufficient drug-addiction (and probably metal-illness) treatment (Figure

24), and inadequate early recognition of suicidal intentions by a good friend. The unwillingness to partake of Hong Kong's meagre welfare benefits by this suicide attempter and Tsui Chun as described in Appendix 2 probably resulted from their internalization of the prevalent view in Hong Kong society that to accept welfare is to acknowledge one's failure and uselessness. This is also because the government, in not having enshrined in legislation most of the social services it provides directly or through subventioned voluntary agencies, has created the public perception the social services are charity rather than rightful entitlement (Jones 1981, xiii).

The high suicide rate for the 60 and over in Kowloon, which increased from about 30 per 100,000 in 1981 to about 34 per 100,000 in 1991, might be attributed to the large number of poor single people of this age group in this subregion. Although some of the world's highest-priced real estate is located in a very small part of northern Kowloon (an area known as Kowloon Tong) with pseudo-English garden-city landscape, within a kilometre or two of it can also be found some of Hong Kong's highest concentration of Hong Kong's poor, single, childless, and unemployed.

Some of them went to Hong Kong from rural villages in nearby Guangdong Province several decades ago in their prime. Having severed their emotional ties to a China in political, social, and economic turmoil, they toiled as labourers or domestic servants in the Territory until they became too frail to work—never having earned enough money to establish a family. Many of these residents sleep in congested bed-space units in high-rise flats in the Tai Kok Tsui area in northwestern Kowloon and the Kowloon City area in north-central Kowloon. Each of these units is enclosed by mesh wires designed to prevent theft of their scarce personal belongings by other residents. Most of the tenants of these "cages" are single elderly men. This high-density living environment among strangers fosters tension and suspicion; it rarely creates goodwill and mutual support. The funds they use to pay for such accommodation come partly from Hong Kong's meagre universal pension, designed nominally to "thank" them for the decades of services which they provided to society in their prime, but often dispensed to them in a pitying manner that insults their dignity. For many, the funds also come partly from doing odd jobs or from scavenging.

Those who are too mentally ill or physically frail to supplement their pension income with their own labour, as well as those who have been evicted by the re-development of their bed-space buildings into higher-standard residential complexes, simply sleep under cardboard boxes in public areas. For the relatively healthy street-sleepers, the occasional near-freezing temperature experienced in Hong Kong during passages of cold fronts in the winter drives them to the warmth of community centres

Figure 24 "Just another druggie who refuses to make money like the rest of us." Graffiti at top reads "This way (left) to hell."

Source: K.M. Mak, 1991.

serving as temporary street-sleepers' quarters in cold weather; for those who are too frail or disorientated to find their way to a community centre, they become statistics of those frozen to death amidst the affluence of Hong Kong. In sum, poverty and illness in old age, as well as the absence of a socially supportive environment, are factors which foster or intensify the loneliness, depression, and hopelessness of the elderly in Kowloon. These are likely the social and environmental factors associated with Kowloon's high elderly suicide rate.

It can only be hoped that the slight reduction in their suicide rate between 1986 and 1991 was the beginning of a decreasing trend. If further studies can confirm this encouraging trend, the trend might be attributed to the positive effects of the Welfare Department's outreach programs, which have been found to be more effective and less demeaning to their users (Chow 1990). If this is indeed the case, it can only be clear to the government that more social service provided with dignity to the poor elderly population is required to enable them to live in more humane conditions.

Analysis of Suicide in the New Territories

Except for the youngest and the oldest age groups, the suicide rates for the New Territories were the lowest of the three subregions in 1991. Moreover, the rates for the 20-29 and 40-49 age groups have decreased between 1981 and 1991—a trend opposite to the trend for the Territory as a whole. The rate climbed for those in their 30s, though only by 18 per cent from about 11 per 100,000 in 1981 to about 13 per 100,000 in 1991.

Members of these 20 to 49 age groups in the New Territories die as tragically as those in the other subregions. An examination of the newspaper articles on suicide in the New Territories for 1991 also revealed suicides resulting from stress, helplessness, and hopelessness, which were in turn precipitated or aggravated by such events as failed romance or by threats of loss of face made by loan sharks,[13] as indicated by the tragedy of this family, originally from Kowloon, which had just been assigned a flat in a housing estate in Shatin New Town a year earlier (*Ming Pao,* 11 October 1991, 2). The wife and mother, a 35-year-old housewife addicted to gambling, lost money and then borrowed from loan sharks. When the creditor threatened her family for the non-payment of

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[13]The relative importance of saving face and avoiding shame (or maintaining a socially acceptable reputation) for the family or household in Chinese culture and Hong Kong society enables loan sharks to intimidate delinquent borrowers by threatening to post or spray-paint overdue notices on the doors of indebted households. It is hoped that the urge to avoid incurring shame would compel debtors to pay up.

several tens of thousands of dollars, a heated argument broke out between she and her husband. She was stabbed over 30 times to her death by her husband, a man whom neighbours thought of as civilized and gentle. He then jumped to 10 floors to his death from their high-rise housing-estate flat. Their two daughters subsequently complained of nightmares, and were likely to be emotionally scarred for life (*Ming Pao,* 12 October 1991, 4).

Following the suicidal death of a woman in Tuen Mun New Town, a warning was issued by the Tuen Mun District Board about the danger of lonely and friendless New Town residents falling prey to the unscrupulous practices of loan sharks (*Ming Pao*, 25 November 1991, 6). The Hong Kong Government, however, fell short of announcing any new social policies designed to enhance the social cohesion of New Towns. Nevertheless, the relatively low rates of suicide of these age groups probably are a reflection of the relative affluence and socio-economic homogeneity of the New Town environment. The New Territories did not have as high a proportion of the destitute and struggling poor as the core urban areas had in the period 1981-1991.

Two disturbing trends of increase, however, are evident in the New Territories for this period: the increase in the suicide rates for both the school-age and the elderly populations. They also reached levels which were the highest among the three subregions. The school curriculum is standardized throughout the Territory. It is likely for many students in New Territories schools, however, to have moved to that subregion in recent years. They have severed their social ties with former classmates and neigbourhood playmates, but have not yet established new ones. The relatively unsupportive school environment, when coupled with their small families and parents working outside the home for long hours on most days, reduce parent-child communication and intervention opportunities should social, academic, or emotional difficulties arise. The suicide reported in Appendix 1 is typical of a suicide by a 10-19 year-old in the New Territories.

As stated earlier, the slighting of elderly suicides by the press imposes a sizeable handicap to to the understanding of suicides by this age group in all of Hong Kong, but especially in the New Territories: none of the 92 suicides by those 60 and older in the New Territories were even reported at all by *Ming Pao.* Two hypotheses, however, can be provided for the time being. First, the high rate might be a result of the urbanization of areas which have become new towns; this process increased the number and proportion of elderly people who have been physically or emotionally neglected by children who were employed for long hours in Kowloon or on Hong Kong Island. The second might be that the en-masse conversion of agricultural village land into concrete-

filled shipping-container parking plots, the depopulation of the peripheral areas of the New Territories, and a large-scale emigration of the young contributed to the abandonment of the elderly long-time residents of the New Territories. It is likely, then, that these factors, along with the absence of younger family members to detect depressive symptoms, might have contributed to elderly suicides in the New Territories. Although the tragedy reported in Appendix 5 is not a suicide, it nevertheless provides a glimpse of the plight of one elderly couple in the New Territories. The scarcity of newspaper reports to account for the group with the highest suicide rate in the Territory suggests that this vacuum needs to be filled by case files from the Coroner.

Analysis of Suicide by Age Group

The statistical evidence presented so far indicates that suicide rates have increased for most age groups between 1981 and 1991 in all three subregions of Hong Kong. Judging by the suicide completers' home addresses and their suicide locations as reported in *Ming Pao* for 1991, it is clear that a large majority of them had low to lower-middle socio-economic backgrounds. Assuming that the newspaper reports were relatively representative of all of the suicides in Hong Kong that year, it can be tentatively concluded that economic stress in the household played a significant role in creating, increasing, or maintaining the overall level of psychological stress among the suicide completers in all three subregions.

Among older and poorer single adults, prolonged economic stress can directly increase their level of psychological stress, which makes them more vulnerable to feeling depressed, particularly if they are chronically ill or disabled, and are forced to depend on Hong Kong's meagre pension and welfare handout for their subsistence. Under these conditions of extreme relative economic deprivation, physical and financial helplessness, and the loss of hope that their condition would ever improve, one additional stressor—such as the death a close friend or the eviction from a familiar residential environment to make way for the profit of affluent investors—could lead to suicide ideation. Ideation develops into suicide attempt without adequate social and medical intervention. Based on the literature reviewed so far, it is clear that both types of intervention are kept to a minimum by the lack of concern for others in modern Hong Kong, by the unsupportive residential environments of cage flats and "rest" homes, and by the unintentional neglect on the part of the overworked personnel of Hong Kong's underfunded and inefficiently operated social and medical services. When this type of attempts become completions, they become contributions to statistics of what Durkheim called fatalistic suicide.

Among middle-age adults in Hong Kong, prolonged economically induced stress is less likely to result from severe financial deprivation. For those working as bus drivers, office clerks, or junior bureaucrats, wholesale internalization of Hong Kong's social norm of fervent accumulation can result in, or strengthen, an insatiable compulsion to measure self-worth in terms of the wealth accumulated. This can in turn lead to or strengthen a perpetual cognitive perception of imperfection or personal failure. The perennial urge to become successful by such measures can easily lead to such risky financial ventures as race-track gambling in Hong Kong, or pawning and losing one's return jetfoil ticket in the casinos and dog track of Macau. In an attempt to recover from the "bad Luck" or simply to procure the lost food and rent money for the following month, many such risk takers turn to borrow from loan sharks. Interest on these loans compounds quickly when repayment cannot be made quickly. When extended periods of non-payment results in the harassment of the debtors family members by loan sharks, tension and more stress develop among household members. The heated arguments which ensue, and the reluctance of newly and barely acquainted neighbours to meddle in the affairs of strangers, can often precipitate the suicide of individuals who already feel helpless and hopeless in ever recovering from their shame and failures. The suicide by these individuals—individuals unsure of the meaningful ways in which to measure their success or self-worth—results in what Durkheim called egoistic suicides. On the other hand, it might also be said that these are anomic suicides, in that they occur as a result of the badly tolerated burden of financial loss by people accustomed to a higher standard of living.

Among the school-age population of Hong Kong, prolonged economically induced stress on the part of their adult family members can also lead to psychological stress. The adults' struggle for basic material needs and for relative materialistic gains (for the enhancement of their own prestige) often requires them to be physically absent from home for long hours; this absence reduces their emotional availability to their children. This can lead to their children feeling distanced from and outright contempt for their parents, as well as feeling lonely, rejected, helpless and depressed. Being at a developmental stage in which peer approval is eagerly sought for and highly valued, a public scolding by a teacher for a missed assignment or humiliation by peer-group members in school can aggravate these negative feelings enough to produce suicide ideation. This can materialize into an attempt when overworked adults at home, ignorant of depression and suicide themselves, dismiss their children's wish to be dead as manipulative whining or downright trivial. It might be argued, from a classical

Freudian perspective, that these suicides occurred when the hatred felt by Hong Kong's emotionally abandoned children for their parents are turned in the 180th degree.

Summary

The statistical evidence available to this study indicates that suicide rates have increased between 1981 and 1991 for all age groups in Hong Kong as a whole, and for all age groups in each of Hong Kong's three subregions. Furthermore, this evidence also indicates that the level of the suicide rate for each subregion remained in the same rank relative to the other two subregions, with Kowloon having the highest rate during this period, followed by Hong Kong Island, and then by the New Territories. In other words, the same pattern of spatial variations in the suicide rates between the three subregions remained throughout the period 1981-1991.

While the rank among these three subregions did not change, it is important to stress that the steady increase in the New Territories' suicide rate during this period suggests that the kind of social organization structure which kept its suicide rate low—as hypothesized by Yap in the 1950s—was no longer in place in the modernized and urbanized New Territories of the 1980s. This is to say, then, that the New Territories provided a greater degree of protection against suicide for its population in the period 1981-1991 in relative, but not in absolute, terms. Based on these statistical data and the news reports in *Ming Pao*, it has been suggested that this relative degree of protection resulted from the relative economic sufficiency and socio-economic homogeneity of its population, and that the absolute increase in its suicide rate resulted from the increased anonymity and the decreased social support in the physical and social environment of an urbanized New Territories. As for the other two subregions, it has been hypothesized that their rates remained higher by comparison because they contained a higher proportion of the Territory's elderly poor population, many of whose members lived in an economically deprived, socially unsupportive, medically neglected, and psychologically stressful environment.

Furthermore, it has been argued that the economic factor was the most significant factor in directly causing or indirectly developing suicide ideation in individuals of all three subregions, and that certain socio-economic factors found throughout the three subregions for the period 1981-1991 significantly affected the availability of suicide intervention opportunities in all of Hong Kong. From a suicide prevention and intervention standpoint, these findings suggest that the causes of suicide in Hong Kong are more similar—rather than varied—across space: an economic policy which promotes the fervent accumulation of wealth for its own sake, a culture of

extreme selfishness, and a social policy which neglects and discards economically unproductive members of society.

CHAPTER FIVE: DISCUSSION AND CONCLUSION

It is assumed that all humane societies are willing to reduce the prevalence of suicide, and that all willing societies, as long as their basic needs of food and shelter are being met, are capable of reducing suicide. It is also argued here that an economically affluent society like Hong Kong can afford to modify the social, economic, and environmental conditions of society in order to reduce suicide. Even though depression and suicidal deaths can never be completely prevented in Hong Kong, a number of social actions can be undertaken to reduce suicide in Hong Kong. This section contains a summary of some of the causes of suicide in Hong Kong. It also includes some of the means by which suicide can be reduced in Hong Kong.

At present, the quality of the nominally "free" universal medical services does not reflect what an economically prosperous Hong Kong can afford to provide. The inefficient operation of outpatient clinics force them to ration consultations, thus requiring the sick to stand in line at dawn to "take a number." This practice discourages poor people without a visible life-threatening condition—which usually means a physical illness—from seeking medical aid; it can only be too effective in deterring those who are depressed and suicidal from seeking medical treatment. Even if contact is made with the medical system, the oversubscribed facilities keeps to a minimum the amount of interview time, and the low morale among the professionals reduce their sensitivities to the needs of the patient, both of which can easily result in a missed diagnosis of depression.

The underdiagnosis of clinical depression among the Chinese in Hong Kong is also caused in part by the absence of the concept of clinical depression in Chinese culture. It has been a long-standing policy of the colonial government to allow Chinese cultural characteristics and social institutions to co-exist with Western ones for as long as the former are not deemed to be detrimental to the interests of the government. One of the Chinese institutions which has been allowed to exist is the unregulated practice of Chinese medicine. It is not the intention here to argue that Western medicine is absolutely superior to Chinese medicine; it important, however, to point out that clinical depression is not recognized as such in Chinese medicine. The absence of its expression in popular Chinese language and the expression of its symptoms in psychosomatic terms enable the the Chinese in Hong Kong to avoid telling others openly that they have a "mental illness," which in Chinese culture can be attributed pejoratively to wrongdoings in the past lives of the sufferer or their ancestors. While the concealment of depression by psychosomatic terms allows the depressed and their family to keep their condition from being known by people outside the household, it

reinforces the stigma attached to depression, increases the misunderstanding of depression, and encourages public avoidance of the depressed. The negative attitude toward the depressed taxes heavily on the coping resources of families with a depressed member, which may in turn cause caregiving family members under stress to express anger and frustration at the depressed. Feeling unwanted by their family, avoided by the public, and rejected by doctors, the depressed are likely to internalize their suffering, resulting in a strengthening of their belief that they are indeed a useless burden to all, which is one of the major precipitating factors of suicide, especially among the elderly or the terminally ill.

It is reasonable to argue, then, that Hong Kong's public medical services—used mostly by those who cannot afford private-sector medical care—are inadequately equipped to detect depression among the poor. Changing Hong Kong's source-specific universal health-care system to allow a covered person access to any doctor should increase accessibility to medical care for more people. It should also increase the incentive for doctors to see, as well as get to know, their patients, thus increasing the likelihood of detecting depression and any potential suicide plans. Still, whether or not improvement in medical service occurs soon—as a revamping of the public health care service in 1992 was designed to achieve, a relatively low-cost way of reducing suicide, for the time being, is to increase the awareness of clinical depression among doctors and nurses, and to reduce any reluctance on their part to ask depressed patients specifically whether or not they are suicidal.

At the same time, it must be emphasized that health care comprises more than corrective medical care, and that the detection of depression and suicide plans must be thought of as a last line of defence in suicide prevention. Long before the elderly develop severe clinical depression, the sense of uselessness, and the feeling of hopelessness, steps should have been taken to prevent these negative conditions from having arisen in the first place. It is not that loneliness and widowhood in old age were unknown phenomena in Chinese society. Rather, they were probably perceived by many of today's elderly in Hong Kong as conditions associated with a poor China "in the bad old days," conditions which inspired them to move to Hong Kong in the first place. Having arrived in a capitalist and consumption-oriented Hong Kong at the prime of their life, most of them were able to work hard, and to enjoy a comparatively comfortable lifestyle the likes of which was beyond their imagination. They were probably unaware, however, that the same social and family social network on which most of the elderly in China had depended could not be transplanted to Hong Kong. Dazzled by the government's subtle civic-pride campaigns, such as its promotion of Hong Kong as the shoppers' paradise and

the culinary heaven, images of spending their old age alone—rather than among well-acquainted neighbours and respectful grandchildren—were probably beyond their most vivid imagination. It is therefore important that the social consequences of industrialization and de-industrialization, the emigration of the young, the prevalence of the nuclear family, the widespread use of technology in everyday living, must not only be recognized by today's planners, they must also be materialized in actions designed to alleviate the negative outcomes of what might be called the "obsolescence of the elderly."

To begin, the public must be taught that welfare is a right, not charity. The amount of pension paid to the elderly must then be increased from the current level, which is just a little more than what an elderly person pays in rent for a bedspace in a cage flat. This is because increasing the income of the elderly can reduce their feelings of being a burden, and increase their sense of independence, productivity, and self-worth. In addition, instead of inducing the elderly to search in vain for physical and emotional security from the ideal child instilled with Confucian "family values," a campaign which suggests to the elderly that living alone is the norm, rather than the exception, needs to be introduced to prepare the aging population against disappointment and psychological devastation. Of course, this campaign must be accompanied by increased social expenditures on the expansion of community, social, health, and recreational services for the elderly. This will enable more of Hong Kong's aging people to reduce their fear of losing face just because they are establishing a social network among strangers, rather than counting on the existence of the idealized version of the caring and respectful offspring. The cost of these programs will necessarily be shouldered by the young, especially the affluent young. Even if funding must come from tax increases instead of wealth redistribution, it is not difficult to market such as increase in *laissez-faire* capitalist Hong Kong. It needs only be suggested to the public that such an increase represents a shift of the costs of caring for the aged from the hands of the young and busy members of society, to an account designed to provide "world class" old-age care designed specifically to allow the elderly to live in dignity, and to free the young to accumulate more wealth or capital for themselves.

A social program like this one probably will not quell the zeal and anxiety among those middle age people who have already learned, through early social conditioning, to measure their self-worth and social status solely on the basis of their ability to increase their personal holding of capital and material wealth. The security provided by such a program for Hong Kong's senior citizens can, however, reduce the anxiety among the middle age people who, fearful of financial insecurity in their old age, are caught up in high-risk financial venture, or are simply over-exerting themselves to the detriment

of of their own and their family members' physical and emotional health. Having had some of their fears for the future alleviated, the middle age will be more physically and emotionally available to their aging parents. Increased face-to-face contact can in turn reduce the loneliness and helplessness experienced by the elderly, and the likelihood of developing depression among the elderly. The middle age will also have more time available to themselves, which can enable them to pursue less stressful, spiritually rewarding, and socially productive activities. This will reduce their own vulnerability to anger and the development of any pathological perception of failure and hopelessness. They will also have more emotionally constructive moments with their spouse and children. This will enable them to enhance the intimacy of their relationships among each other, be more accessible to those members who experience academic- or work-related stress, and be more readily available to those who might have become frustrated or depressed.

Lastly, the amount of pressure which they exert on their children to succeed vis-a-vis other children will also be reduced, thanks to the reduction of their own fears of having to depend on their children's financial and emotional support in later years. This will decrease the likelihood of their children developing pathological perfectionism, helplessness, and depression.

The factors which can improve the mental health of the people of all age groups in Hong Kong are as multi-dimensional as those which can worsen it sufficiently to intensify depression and to lead to suicide. Suicide results from an extensive culmination of social and psychological factors, and deconstructing these social and psychological conditions is a lengthy but not impossible task. Collectively, Hong Kong is a society affluent enough to enable all of its citizens to meet their basic needs. Whether or not they can meet their emotional needs, such as care, understanding, and dignity will, of course, be dependent upon the spending priorities of the present and the incoming government.

Appendix 1

A teenage suicide in a New Town in the New Territories

This report on the suicide of a 14-year-old student at her public-housing flat in a New Town in the New Territories reveals a moralizing and resigned editorial tone, implying that "its just too bad that another tragedy as sad, unpreventable, and unpredictable as this has happened again." The views expressed by the school principal is slightly more encouraging, though he did not appear to know that moralizing about the preciousness of life to depressed and suicidal cannot alleviate their depression and suicide ideation. His attitude of leaving all suicide prevention work to the experts indicates his ignorance of the crucial role of social support in suicide prevention. Note the extended absence of busy double-income nuclear-family parents, both struggling to make ends meet by working in relatively low-wage jobs. Also note suggestions of the suicide's pathological perfectionism, and the school's misinterpretation or missed interpretation of the suicide's decline from top rank to 15th place, which probably resulted from cognitive distortion, inability to concentrate, and interruption to regular sleeping pattern—all symptoms of clinical depression.

Dissatisfied With Declining School Grades
Female Form 3 Student Dies Tragically After Fall From Building

Numerous child suicide cases have taken place since the beginning of this month; this ill wind shows no sign of abating. Another such suicide happened this morning, this time to a female 14-year-old Form 3 student at Po Lam Estate in Junk Bay. The student died immediately after having fallen from building. No suicide note was found, but the death is thought to be related to academic problems. The school principal has indicated that guidelines set by the Education Department will be adhered to; namely, all students will be duly notified of the death, and timely counselling services will be provided.

Dead is Chan Fung Yee, aged 14. Chan lived with her family in Hong Lam Building in Po Lam Estate. Chan's parents are both employed in the restaurant business. Chan was the eldest of four children; Chan had two younger sisters and one younger brother. Chan was enrolled in Form 3 in a Protestant school in the Estate. As usual, she left home for school in her school uniform this morning at about 7:30. She was found shortly afterwards, however, lying in a seriously-injured condition on the ground floor of her building. Upon notification, police arrived to rush her to hospital, but her life could no longer be revived. Police believe she had fallen from a high place. While investigate along the staircase, police found the school bag of the deceased on the 21st floor. Afterwards, police contacted the family and the school of the deceased.

Based on information provided by Mr. Lau—the principal of the school attended by the deceased, Chan had maintaining herself as one the highest-ranking students ever since she enrolled in that school in Form 1. Although her academic performance had fallen somewhat during the current academic year, she still ranked about 15th among the 200 or so students of her grade. Chan had frequently expressed anxiety over her grades, so it is believed that this tragedy is related to this matter. The principal stated that ever since directives from the Education Department were received last month,the school has increased the amount of counselling to students, and has been emphasizing the preciousness of life in school assemblies. Accordingly, the school intends to notify all students of this incident, and will be providing the necessary guidance and counselling. Meanwhile, Chan's father blamed himself. He added that both he and his wife have been compelled to work long hours every day in order to make a living, and he feels that they must have neglected the duty of looking after their children.

Source: *Sing Tao Daily* (British Columbia ed.), 19 January 1993.

Appendix 2

Go kick the bucket, now! *Ni kuai dian-er si*! (你快點兒死!)

This special report on the social and economic conditions of Hong Kong's elderly people reveals some of the negative financial and psychological pressures experienced by one of Hong Kong's many single elderly women. In spite of the meagreness of the welfare support to which they are entitled, some tend to refuse it because they perceive it as charity rather than entitlement.

Cursed to Death by Her Vicious Tenant
Tsui Chun Really Wants to Die Soon

Ms. Tsui Chun is 87 years old. Other than one younger sister, the rest of her family members all died during the Japanese occupation of Hong Kong [between 1941 and 1945]. The two sisters have had only each other to lean on for almost thirty years, that is, until the sister also left this world. Tsui Chun lives alone in a residential unit in a private building of the old type [the dark and dingy type constructed before the War] in the Kennedy Town district on Hong Kong Island. That unit is partitioned into three rooms and eight bedspaces. She rents one of the three partitioned rooms, and ekes out a living by renting out, or subletting, two bedspaces to two tenants and by collecting pension subsidies.

Tsui Chun's financial condition is just sufficient for her to fill her mouth. She said, however, "I've eaten food that's been leftover [unrefrigerated] for as many as four days."

She said that she was not happy in the 20 or so years that she has lived there. In fact, she has often been abused by others.

She stated, for example, that administrative and maintenance charges for the building is collected on the 20th of every month. Once, one of her tenants went away from Hong Kong, and stayed away till after the 20th of that month. When she attempted to collect the overdue fees, the tenant insisted that it had been paid on the 20th. An argument ensued, and her opponent insisted that Tsui Chun kneel on the floor and swear in the name of her family honour before she would pay. And so Tsui Chun did it.

She said that the same tenant, when praying to Buddha, frequently cursed Tsui Chun, and urged god to take her back to the western heaven as soon as possible.

Tsui Chun rarely converses with her neighbours. She said, "If I had a bowl of congee, I can take it to my neighbours. But what do I have. If all I tell my neighbours every day is a bellyful of my anger, even if I don't think that's too troublesome, they will certainly get fed up with me!"

Tsui Chun rarely participates in senior citizen activities. She said that other seniors like to go there because they know that the activities there are free of charge. She wondered if they would keep on going if a charge is made for the activities! She said it is precisely because they are free that she refuses to participate."

When asked if Tsui Chun had a wish, she replied, "I'd like to die soon."

Translated from: *Ming Pao*, 16 December 1991. 3.

Appendix 3

The brevity of this report on two elderly suicides is typical of the length of reports on elderly suicides. Its tone implies that suicide resulting from chronic illness in old age is inevitable and unpreventable. It also fails to suggest that being tired of and depressed by a lack of social life and social support—rather than being tired of living—are more likely to be the causes of these suicides. For arguments and prevention against "rational" suicide by or euthanasia for the terminally ill, see Joseph Richman, "A rational approach to rational suicide."

Tired of Life Due to Illness
Two Old Men Over 70 Leap to Death

Fed up with life due to illness, two old men jumped to death in two separate incidents on Hong Kong Island yesterday morning.

One of the dead was 73-year-old Mr. To who, afflicted by kidney disease, had to enter hospital for treatment last month, where he stayed until four days ago. Having returned home to rest, it was suspected that he became tired of living. At 10:30 A.M. yesterday, he waited for the moment when his wife was not paying attention to leap out of the kitchen window at a residential unit on the 13th floor at 4 Park Road on Hong Kong Island. Residents nearby noticed the fall, and contacted police to have him rushed to hospital, at which time he was certified dead. When news of his death reached his wife, she was so shocked and saddened that she lost consciousness, and had to be sent to hospital for a check-up.

The second dead old man was 79-year-old Mr. Yung Yan Tak, who lived with family members in a flat on the 9th floor at 151 Jaffa Road in Wanchai on Hong Kong Island. It has been learned that he was ill. At about 11 A. M. yesterday, his 39-year-old daughter noticed that he jumped out of the back of their residence, and landed in the alley behind the apartment building. She immediately notified Mr. Man, the watchman of the building, who in turn contacted police. Mr. Yung was rushed to hospital, but unfortunately could not be revived. Family members were extremely saddened by the news of his death.

Translated from *Ming Pao*, 2 January 1991. 6.

Appendix 4

This man could easily have died and become another suicide statistic for Kowloon in 1991. As it was, social intervention came too late, and he was only saved by technology and the "precision" of his fall. There is hardly any evidence to suggest that he would receive sufficient social and medical assistance to prevent him from making another suicide attempt. He is another example of a Hong Kong residents who has internalized the social norm that receiving welfare is receiving charity and is, therefore, a confirmation that one is a "loser." His rejection of such a label and the inadequate help he receives made him one of the many street-sleepers amidst the open-air "night club" district of Kowloon.

Thought to Have Incurred Debt to Loan Sharks
Indebted Man Slightly Injured After Fall from 19th Floor

A 41-year-old man, suspected of owing large amounts to loan sharks and of robbery with violence, jumped from the roof on the 19th floor of Man Wai Building in the Jordan District [of southern Kowloon] yesterday. Before this, negotiation experts, reporters, and a good friend persuaded him to the point of exhaustion—to no avails—for four hours. Fortunately, the air mattresses placed on the ground by fire services enabled him to escape with only minor injuries.

While negotiation experts were in the process of persuading this man at Man Wai Building yesterday, he asked to meet with a news reporter, to whom he narrated a little story. He stated that he borrowed $2,000 [US $250] from a loan shark about three or four years ago at the request of a friend who needed money. But this friend did not have money to pay him back, so he ended up owing the loan shark $40,000 [US $5,000] in principle plus interest. He has also been beaten on numerous occasions, and has requested help from police, but police refused to handle the matter.

While on the roof, he also revealed to the negotiation experts and the police, that he robbed and hit the head of an old man in the pedestrian tunnel at the intersection of Ching Ping and Tung Kun Streets at about 10 A. M. yesterday.

After investigation, police confirmed that a 75-year-old man, Mr. Sun X Chuen was robbed in the pedestrian tunnel at the intersection of Ching Ping and Tung Kun Streets at about 10 A. M. yesterday; his head was hit and injured.[14] Subsequently, police believed that Mr. Lau Shek Chuen was involved in this robbery.

At about 10:30 A. M. yesterday, Lau Shek Chuen went to a restaurant on the ground floor of Man Ying Building in Jordan District to look for his good friend Mr. Lau Yiu Ho (38 years old). After having chatted harmoniously for a while with his good friend, he suddenly announced to Lau Yiu Ho, "Someone's cornering me, 'So what if I stumble on the street and die; it's no big deal for me to jump off a building and die.'"

At the time, Lau Yiu Ho did not give the matter any thought, and did not pay any attention. thereafter, he left his seat to get some dim sum.

When Lau Yiu Ho returned to his seat, Lau Shek Chuen had already left the restaurant, so Lau Yiu Ho went out of the restaurant to look for him. When Lau Yiu Ho reached Man Wai

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[14]"X" is a common device used by the Hong Kong's Chinese press to indicate that the full name or address of a victim, witness, or suspect has been omitted intentionally.

Building by way of Man Ying Building, he saw a large number of police and fire personnel racing to the scene. At the same time, he heard from bystanders that someone was trying to jump from the roof of Man Wai Building.

After checking with police at the scene, Lau Yiu Ho was able to confirm that the man attempting to jump from the roof was his good friend Lau Shek Chuen. Subsequently, he asked police for him to be allowed on the roof to persuade Lau Shek Chuen. But he was refused by police.

After a few detectives and non-Chinese police officials saw that Lau Shek Chuen was standing on a metal cover which extended beyond the concrete edge of the building on the roof, they deemed the situation extremely dangerous. They then immediate notified fire personnel to set up some inflated foam-cushions on the street, and negotiation experts to go there to persuade Lau Shek Chuen.

Three negotiation experts took turns in persuading Lau on the roof. At one point Lau asked to meet with a reporter, in order to pour out his bitter predicament. Simultaneously, he even at one point raced toward the edge of the roof, and wanted to jump right over. Witnessing this critical scene, the negotiation experts immediately uttered for him to stop. He finally obeyed, and returned to stand on the metal cover.

At 1:45 P. M., police arranged for a reporter to arrive on the roof, and allowed him to straddle one set of fences, in order to persuade Lau Shek Chuen to return to the roof. While the reporter was attempting to persuade him, he asked for the reporter's press card and business card to examine. While persuading him, the reporter even passed a cigarette to him.

At 2:45 P. M., Lau accepted the reporter's persuasion, and walked from the metal cover back towards the roof, but he wanted a certain distance be kept between them.

At the same moment, his good friend Lau Yiu Ho obtained permission from a fireman at the scene to go to the roof to try to persuade Lau Shek Chuen. When Lau Yiu Ho arrived on the roof to persuade Lau Shek Chuen, he asked to negotiate in private with Lau Yiu Ho. Police subsequently allowed Lau Yiu Ho to climb over the fence on the roof in order to converse with Lau Shek Chuen. Lau Yiu Ho first poured a glass of water and passed it to Lau Shek Chuen and, while preoccupied with drinking the water, jumped forward and grabbed both of his hands. Witnessing this opportunity, police took quick action, but it was too late. He shook off Lau Yiu Ho and jumped straight down. Fortunately, he fell right on the upper right-hand corner of the air cushion, and sustained only minor injuries.

The ambulance attendants and fire service personnel on alert on the street immediately took him down from the cushion and took him to hospital, where he was listed in satisfactory condition.

Lau Shek Chuen is a casual labourer in soldering and peeling off paint on board ships. But he has been unemployed for three weeks. His friend Lau Yiu Ho revealed that he has a stubborn character. Even when he has no money and no work, he still refuses to apply for public assistance. His parents, older and younger brothers, and grandmother all live in Hong Kong, but he has not been home for over 10 years. For years, he has been sleeping under the overpass at Ferry Street.

Lau Yiu Ho also indicated that at the time he met Lau Shek Chuen 10 years ago, Lau Shek Chuen was addicted to drugs [heroin], and has entered drug-rehabilitation centres on

numerous occasions. He has just recently left a rehabilitation centre, and has not been seen doing drugs since then.

Translated from: *Ming Pao*, 12 August 1991. 2.

Appendix 5

This article exemplifies the environment of pathological codependency which some, if not many, of Hong Kong's elderly couples live in. It indicates that even the "traditional" rural social structure of the New Territories has been significantly altered in recent years.

Afflicted by Stubborn illness
Mutually Dependent for Survival
Loyal to Each Other Till Death
Old Woman Falls, Hurt Head While Trying to Save Husband
Bled Till Unconscious and Too Late to Be Revived

A tragic accident happened at noon yesterday to a mutually dependent elderly couple in Ko Po Village in the Kam Tin area of the New Territories. After the husband lost his balance and fell on the ground, and when the old wife, in a panic, went up to try to lift him, she unfortunately also lost her balance and fell. Moreover, she even struck her head, began to bleed, and soon lost consciousness. In this state they remained—until the two old ones were discovered by their daughter, who just happened to have decided to pay them a visit. By the time police had been notified and the couple rushed to the hospital, then old woman had unfortunately died; the old husband was a satisfactory condition.

Dead is Wan Kwon Tai, aged 76. She lived with her husband, Ho Cheuk Sang, in a two-storey village-house in Ko Po Village in Kam Tin. They raised a son and a daughter, but they did not live with them in Ko Po Village; they only went back home to visit the two old ones occasionally.

According to their daughter, her father is afflicted with diabetes, and has difficulty walking, while the mother had high blood pressure for many years. The two had retired for many years, and had been mutually dependent on each other to survive. They relied on the children's financial support and the sale of their own home-grown vegetables to survive.

At about 3 P. M. yesterday, Ho's daughter took some groceries with her to visit her parents. The moment she stepped through the gate to the yard, she unexpectedly saw her mother lying in a mud pool by the fish pond outside the house. Her head was bleeding and her face had already turned dark, and her father was leaning against her. He wailed to his daughter to rush her to the hospital, so the daughter immediately notified police.

Translated from *Ming Pao*, 23 August 1991.

Appendix 6

A possible case of suicide as a learned behaviour: one of these two suicides lost a relative of about the same age to suicide two years earlier.

Two Girls Leap to Death on Same Day: Holiday School Assignment Turns Into Pressure Unexpectedly

Who can fathom the world of the inner hearts of children? Soon after the jump of an eight-year old girl from a building at Pak Tin Village at 9 AM yesterday, another jump took place at 12:45 PM. The second jump resulted in the suicidal death of an 11-year old girl.

Dying tragically from the fall is 11-year old female student Lau Ka Man. Preliminary investigation led to the belief that the wish to trivialize life arose from problems related to academic exercises due to be completed during the school holidays. It is also known, however, that one of the paternal elder male cousins of about the same age as the deceased also leaped to his death two years ago; it is thought that this event generated some negative influence in the small and tender heart and soul of Lau.

The deceased lived with her parents and a younger sister in Flat 1X5 in Leung Fat Building in Cheung Fat Estate.[15] Her father is a day shift taxi driver, who has to begin work every day at dawn. Her mother is a housewife who, in addition to looking after her two small daughters, has to accept at-home light-industrial assembly consignments in order to remedy the financial insufficiency of the household. It is known that Mr. and Mrs. Lau loved their daughters dearly. They rarely scolded their daughters; in sum, family relationships were very cordial. Moreover, neighbours also indicated that they have a very good impression of the family; many of them expressed shock and regret over news of the death.

Ka Man attended the afternoon section of Primary 6-C at the nearby Tsing Yi Island Lui Ming Choi Chinese Methodist Primary School. According to school principal Wong Kok Kong, that school has always emphasized the importance of its relationship to the students. Wong also added that the scarcity of homework given to its students can even be considered one of the notable features of that school.

Lau Ka Man's classes normally started at 12:45 PM. Yesterday was the first day of class after the Christmas and New Year holidays. After having had her hunch at home, Ka Man left her residence at Leung Fat Building with her school bag. In no more than ten minutes' time, however, residents in the neighbourhood saw a girl in white athletic outfit and a red school blazer falling from a high place. The body landed on the public square outside the main entrance to the building; blood splattered everywhere.

On the other hand, after having heard a loud thump coming from the street into her apartment, Lau's mother immediately went out to investigate. She first found her daughter's black school bag in the staircase on the 10th floor. She then rushed down the stairs in a panic and full of fear. After having confirmed that the fallen girl was her loved daughter, she became so grieved that she wished life would end. She embraced her fatally injured daughter and wailed, refusing to let go of her body. Witness at the scene found it hard to hold back their own tears. Afterwards, other residents in the neighbourhood notified police. Lau Ka Man was pronounced dead upon arrival at hospital.

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[15] A public housing estate in Tsing Yi New Town in the New Territories

According to police investigation, the mother of the deceased indicated that upon inquiring into the status of her daughter's holiday assignment, the deceased had replied that it was incomplete. She then urged her to hurry up and finish it. In addition, just prior to leaving home for school yesterday, the deceased had revealed to Mrs. Lau that her homework, though completed, had been misplaced. The deceased also added that she felt guilty over the matter. Mrs. Lau did not blame her daughter any more than usual. On the contrary, she even urged the deceased to to explain the situation to the teacher; she never even remotely anticipated that her daughter would jump to her death. Furthermore, it has also been revealed that the school has found a suicide note in the school bag of the deceased. The content of the note, however, has not been made public.

Source: *Sing Tao Daily* (British Columbia ed.), 5 January 1993. 10.

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