

# The Limits of Social Capital: Durkheim, Suicide, and Social Cohesion

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Recent applications of social capital theories to population health often draw on classic sociological theories for validation of the protective features of social cohesion and social integration. Durkheim's work on suicide has been cited as evidence that modern life disrupts social cohesion and results in a greater risk of morbidity and mortality—including self-destructive behaviors and suicide.

We argue that a close reading of Durkheim's evidence supports the opposite conclusion and that the incidence of self-destructive behaviors such as suicide is often greatest among those with high levels of social integration. A reexamination of Durkheim's data on female suicide and suicide in the military suggests that we should be skeptical about recent studies connecting improved population health to social capital. (*Am J Public Health*. 2005; 95:1139–1143. doi:10.2105/AJPH.2004.053314)

## PUBLIC HEALTH SCHOLARSHIP

often cites classic social theorists to demonstrate the link between social capital—the collective civic value of social networks—and population health. Kunitz<sup>1</sup> showed that classic theory is most often cited to authenticate a current assertion rather than to test the validity of a public health maxim. As a result, the work of the same theorist is often used to support contradictory arguments.<sup>1,2</sup> We examined the extent to which Durkheim's claims about the link between social disintegration and suicide have lent support to current assumptions that social capital is a protective factor in population health.<sup>3,4</sup> Durkheim tied modern urban life to declining birth rates, increasing alienation, and exacerbated gender role tensions, which, he believed, had negative health consequences, evidenced by increased suicide rates.<sup>5–8</sup>

Durkheim distinguished between egoistic, anomic, altruistic, and fatalistic suicide, broad classifications that reflect then-prevailing theories of human behavior. Dismissing altruistic and fatalistic suicide as unimportant, he viewed egoistic suicide as a consequence of the deterioration of social and familial bonds and linked anomic suicide to disillusionment and disappointment.<sup>8</sup> His claims about suicide among women and suicide in the military are emblematic of his assertion that increasing modernization and urbanization led to the breakdown of social cohesion. He viewed social integration as a

protective strategy against these modernizing forces. However, as other studies have shown, Durkheim's conceptualization of suicide and the interpretation of the data were framed by his own biases and by those of his early 20th century contemporaries.<sup>9,10</sup>

Social capital advocates have made their debt to Durkheim explicit.<sup>11–16</sup> Although social capital has a variety of contested definitions,<sup>4,17,18</sup> there is general consensus that the required conditions for social capital include the existence of community networks, civic engagement, civic identity, reciprocity, and trust.<sup>19,20</sup> One of the most well known works, Putnam's *Bowling Alone*,<sup>20</sup> identifies social associations and networks, norms of reciprocity, and trust as 3 key components of social capital.

Social capital constructs have had a great impact on recent examinations of population health, particularly on studies concerned with health disparities.<sup>21</sup> As Kawachi et al. argued, citing Putnam, social capital is “the glue that holds society together.”<sup>14(p57)</sup> In this context, a growing body of public health investigators hypothesize that diminished social capital contributes to an increased risk for an array of illnesses, ranging from chronic heart disease and diabetes to depressive disorders and suicide.

Others have challenged this view, arguing that social capital theorists ignore class relations, assuming instead that “social cohesion rather than political change is the major determinant of popu-

lation health.”<sup>4(p59)</sup> Challengers warn that “an emphasis on social cohesion can be used to render communities responsible for their mortality and morbidity rates: a community-level version of ‘blaming the victim.’”<sup>4(p59)</sup> Recent research indicates that specific mortalities among working class populations, even in wealthy countries, show that increased social capital is unrelated to improved health.<sup>4,22</sup> In their evaluation, Muntaner et al.<sup>23</sup> demonstrated that social capital is much less important than economic and social status for predicting infant and coronary disease mortality. Despite ongoing critique, the number of studies claiming a relation between social capital and improved population health seems undiminished. In part, this reflects a wider pressure on US public health practitioners to downplay class in favor of culture. By contrast, studies that examine the role of class or institutional social capital have shown that it is a more powerful predictor of positive health outcomes than communitarian social capital.<sup>2,23</sup>

Drawing on Durkheim, Kawachi et al.<sup>14</sup> defined *social capital* as synonymous with *social cohesion* and linked it to health outcomes. Kawachi et al. cited Wolf and Bruhn,<sup>24</sup> who examined the impact of the decline of social cohesion on the 1600 residents of Roseto, Pennsylvania. In the 1950s, death rates in this small, close-knit Italian American community were lower than in neighboring communities even though there was no significant

difference in risk factors. However, as younger residents began exploring employment outside Roseto, social ties weakened. By the mid-1960s, “expensive automobiles began to appear in the streets . . . families had joined country clubs, [and] . . . occasional visits to Atlantic City were replaced by weekends in Las Vegas and luxury cruises.”<sup>24(p122)</sup> Wolf and Bruhn tied these behaviors to increases in heart disease in Roseto. By contrast, the examination by Lynch and Davey Smith<sup>25</sup> revealed that the original empirical results were weaker than often is claimed by social capital experts and also were open to more plausible alternative interpretations. They pointed out that the original investigators had rather conservative preconceptions of what constitutes the “right” way to live and what formed “healthy” individual, family, and community relationships. Others<sup>26</sup> have pointed out that improvements in health historically occurred independently of social capital.

“The notion that social cohesion is related to the health of a population,” Kawachi et al. wrote, “is hardly new. One-hundred years ago, Emile Durkheim demonstrated that suicide rates were higher in populations that were less cohesive”<sup>14(p57)</sup> For Durkheim, social cohesion, especially traditional family life, provided the best protection against self-destructive behavior.<sup>27,28</sup> Nevertheless, a reading of Durkheim’s evidence supports the opposite conclusion, that is, that the incidence of suicide is greatest among those most subsumed in social groups. Durkheim’s data revealed that the highest suicide rates were found among those who were most socially integrated.<sup>29</sup>

A review of his discussion on female suicide and military suicide shows the enormous distance that Durkheim traveled to reconcile his theory with his evidence. This has not been evident because most social scientists share 3 of Durkheim’s assumptions. The first is the belief that modernity breeds alienation and egocentrism. The second is the assumption that women, as most socially integrated in family life, are the most protected against suicide. Finally, social integration is assumed to be socially protective. The acceptance of these assumptions among scholars can partly be explained by their reliance on Durkheim’s definition and typology of suicide. In what follows we reexamine these assumptions through an exploration of 2 issues that Durkheim addressed—women’s suicide and suicide in the military—and 1 issue that he failed to take into account—attempted suicide. First, however, we must review how Durkheim constructed his definition and typology of suicide.

### DEFINITION AND TYPOLOGY

Durkheim defined suicide as “death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result.”<sup>8(p44)</sup> However, Durkheim’s analysis relied on official suicide statistics that were collected without regard to his definition. For instance, those who sacrificed their lives for others were never recorded in official statistics; those whose deaths resulted only “indirectly” from their acts generally did not appear in the statistics either.<sup>28,29</sup>

Durkheim wanted to demonstrate that the suicide rate pro-

vided a measure of social pathology. According to Durkheim, anomie and egoism resulted from the collapse of traditional restraints, and thus their incidence could be used as an index for social pathology. In his view, the rate of anomic suicide measured alienation, whereas the rate of egoistic suicide measured the decline of self-restraint. Altruistic suicide, on the other hand, reflected socially sanctioned self-sacrifice.<sup>8</sup> Although the construct of altruistic suicide makes theoretical sense, such acts (heroism) were never reported as suicides. There could be almost no fatalistic suicides because Durkheim claimed that “it has so little contemporary importance and examples are so hard to find . . . that it seems useless to dwell upon it.”<sup>8(p276)</sup> As a result, subsequent studies ignored fatalistic suicide.<sup>28</sup>

### DURKHEIM AND THE PUTATIVE IMMUNITY OF WOMEN

Durkheim’s definition and typology of suicide reinforced his claim that the breakdown of traditional social order was the reason for an increase in suicide. Durkheim pointed to the putative low rates of female suicides, which he tied to women’s greater social integration. In no case did Durkheim view women’s suicide itself as a category for systematic analysis.<sup>30</sup> Instead as we demonstrate later, Durkheim’s classificatory system contributed to and sustained an underreporting of women’s completed suicides.

Durkheim’s claim that social disintegration led to an increase in suicide, especially among women, was based on his belief that women, because of their role

in the family and the community, were more immune to suicide than men.<sup>8</sup> Yet Durkheim’s assertion of the immunity of women to suicide owed more to his assumptions about the socially integrative impact of urban life and modernity than it did to his data. Durkheim asserted that “mental illnesses go hand in hand with civilization” and that insanity was more common “in towns than the countryside, and in large rather than small towns.”<sup>7(p215)</sup>

In an 1888 essay entitled “*Suicide et natalité: étude de statistique morale*,” Durkheim linked low birth rates to increased suicide rates.<sup>5</sup> “A low birthrate led to the weakening of the family,”<sup>5(p462–463)</sup> and Durkheim claimed those areas with the least population growth experienced the highest rates of suicide.<sup>5</sup> Because, according to Durkheim, the health of society depended on the density of families, women were expected to be mothers of many children. By extension, he said, women were healthiest and least prone to suicide themselves to the extent that they were subsumed in traditional roles: “Woman is less concerned than man in the civilizing process,” Durkheim asserted in 1893, “she participates less in it and draws less benefit from it. She thus resembles certain characteristics found in primitive cultures.”<sup>7(p192)</sup> These presumptions alone go far in explaining why Durkheim assumed that women were “naturally” immune to suicide.

Durkheim’s assertion in *Le Suicide* that “in all the countries of the world, women commit suicide less than men,” was based not only on the statistical data of his predecessors, but also on their gendered assumptions.<sup>9(p471)</sup>

In explaining the immunity of women to suicide, Durkheim concluded that “being a more instinctive creature than man, woman has only to follow her instincts to find calmness and peace.”<sup>8(p272)</sup>

Durkheim’s definition of fatalism described the psychological and social condition of many women, perhaps the majority of women who inhabit the globe today. He chose instead to define women in traditional families as socially integrated, despite the fact that, by any measure, most women’s lives actually more closely fit his definition of fatalism, that is, an excessively regulated existence, “with futures pitilessly blocked and passions violently choked by oppressive discipline.”<sup>8(p276)</sup> Durkheim never questioned the supposition that those most subsumed in the family (women and children) would be most immune to suicide.<sup>5</sup> Given this paradigm, suicide and integrative (women’s) behavior—what Durkheim labeled *fatalism*—were opposites. Because social integration was alleged to be the cure for suicidal ideation, there was no way for Durkheim to suppose that suicide could be a female behavior. The category of fatalistic suicide was constructed mainly for purposes of symmetry (as contrasted with egoistic suicide) and because it would undercut his central claims about the role of modern urban life as increasing the incidence of suicide, Durkheim could never seriously examine the possibility that social integration could result in suicide.

Data available to Durkheim reveal what he failed to examine. Those most subsumed in traditional social institutions were at as great, if not greater, risk of suicidal behavior than those who

were less “socially integrated.” Even accepting the equivocal data that women *completed* suicide less frequently than men, the high rate of *attempted* suicide by women suggested that suicidal behavior was a common way for women to express their profound unhappiness.<sup>31–33</sup> The primary reason that female suicidal behaviors have been undervalued is that explanations of the causes of suicide are almost always based on completed suicides. Although Durkheim admitted that attempted suicide fit his definition of suicide as a behavior, he excluded it from his typology because attempted suicide fell “short of actual death.”<sup>8(p44)</sup> Estimates since the early 19th century have indicated that for every completed suicide there have been at least 6 to 8 attempts.<sup>29,34–36</sup>

Reliable data on an expanded definition of suicide were available to Durkheim. For instance, beginning in 1826 (until 1961) the French Criminal Justice Ministry published suicide statistics that made no distinction between attempted and successful suicides. In the 19th century these were published in the *Annales d’hygiène*, which recorded the incidence of suicide (including, but not separating out attempted suicides) by age and by sex. Although these statistics suffered from the same weaknesses as data on completed suicides, there was no “objective” reason why they could not have been considered.<sup>28,37</sup>

The decision to exclude attempted suicide from consideration was peculiar because the entire enterprise of the sociological study of suicide was aimed at describing social behavior. Certainly, attempting to kill oneself

must be considered suicidal behavior. Yet suicidologists since Durkheim have relied on statistics that, by defining only completed suicide as suicide, have effectively eliminated the majority of suicidal behavior from their analysis of suicidal behavior. Women attempt suicide at a rate approximately 2.3 times greater than that of men.<sup>29,34,35</sup> Had Durkheim included attempted suicides, women rather than men would have emerged as the group at greatest risk of self-destructive behavior. The data on attempted suicide could have been used to demonstrate that women were less content with their social roles than were men.

Thus, although suicidologists continue to refine their statistical methods, they rarely have questioned the assumption that only completed or successful suicides should constitute the database for suicidal behavior. Although various ex post facto explanations have been offered justifying the exclusion of attempted suicides from measures of suicidal behavior, none of these have any logical basis other than one of convenience—that is, completed suicides are readily available to researchers as part of national vital statistics on death rates. In retrospect, it seems curious that suicide attempts were excluded from all considerations of the incidence of suicide just as sophisticated statistical methodologies allowing the inclusion of suicide attempts became available.

The high rate of attempted suicide among women alerts us to the fact that submersion in the family provided women with no special protection from suicidal behavior.<sup>38</sup> Although his evidence was no more “value free” than Durkheim’s, Steinmetz<sup>39</sup>

found that women living in the most socially integrated societies had a greater incidence of suicide than men. Johnson<sup>40</sup> suggested that women most submerged in the family display the greatest female suicidal behavior. Her views have been affirmed by recent reports that the highest rates of suicide in the world are found among rural Chinese women.<sup>41–43</sup> Similarly, Hasegawa<sup>44</sup> found that improved population health—declining infection rates and rising life expectancy—in Japan today can be traced to broadening of access to social resources for Japanese women at the beginning of the 20th century. This reinforces the conclusion of historian Roger Lane,<sup>45</sup> who found that contrary to Durkheim’s assumptions, increases in suicide rates were linked to social integration. Lane found that as 19th-century Philadelphia urbanized, its suicide rate grew proportionally greater than its homicide rate. Lane reasoned that the increasing incidence of suicide in late-19th-century cities served as a barometer of social integration because suicide, unlike homicide, indicated internalization of social anger.<sup>45</sup> Kunitz’s study<sup>1</sup> on the effect of overintegration in the family among Navajos in the southwestern United States supports the views of Johnson and Lane. Social relations within extended Navajo families, Kunitz found, often resulted in negative health outcomes, including significantly higher rates of depression and self-destructive behaviors.

## SUICIDE IN THE MILITARY

The greatest challenge to the belief that social integration provides protection from suicide,

however, comes from Durkheim's own data. Official statistics consistently reported that the highest rates of suicide were in the military. "It is a general fact in all European countries," wrote Durkheim, "that the suicidal aptitude of soldiers is much higher than that of the civilian population of the same age."<sup>8(p228)</sup> Durkheim's definition of fatalistic suicide as resulting "from excessive regulation," whose "passions [were] violently choked by oppressive discipline,"<sup>8(p276)</sup> seemed to describe 19th-century military life perfectly. Durkheim's typological definitions should have led him to classify military suicide as fatalistic.

Durkheim, however, overlooked the obvious inconsistency that military suicide posed for his sociology by arbitrarily classifying military suicide as "altruistic," even though *reported* military suicides could not be attributed to self-sacrifice.<sup>8</sup> Given his familiarity with suicide statistics, Durkheim must have known that those who sacrificed their lives for their military comrades in battle were never categorized as suicides in any official statistics. Indeed, to be reported as a suicide, a military death would have to have occurred outside a combat situation. As Besnard<sup>30(p339)</sup> pointed out, "The only 'modern' example given [by Durkheim] of altruistic suicide is military suicide, which, nevertheless, could also be interpreted in terms of excessive regulation" that comes from "very strong social integration."

Given his assumption about the "nature of women" and the prophylactic impact of family life, Durkheim could not acknowledge the parallels between soldiers' and women's social situa-

tions. The point is not that women's and soldiers' socialization was the same. Rather, Durkheim's description and discussions of military suicide fit into his category of fatalism more clearly than they fit into the category of altruism. Durkheim could not admit this because his theory of the protective role of social integration rested on his assertion that modern urban life (anomy and egoism) were the killers. If military suicides were categorized as fatalistic, Durkheim would have had to question his basic assumptions. Because the high rate of military suicide could not be attributed to modernity, Durkheim labeled it altruistic, which effectively eliminated it from consideration. Because altruistic suicides were socially condoned forms of self-sacrifice, they were never recorded as suicides.

## CONCLUSIONS

Theoretical frameworks are essential for improving population health, but when adopted uncritically they can have unintended consequences. The recent enthusiasm for social capital is an example of a theory whose rhetoric is often more liberating than its application. The reason for this is in part the foundation on which this paradigm rests: a theory of social integration that relies on Durkheim's suicide typology. For Durkheim, suicide rates were a marker for decreasing social capital. The key conditions for social capital—community networks, civic engagement, civic identity, reciprocity, and trust—appear important to health. Hence, numerous studies have identified a positive association between social capital and population health.<sup>22</sup> Less attention has been given to

those scholars who challenge the relevance of social capital to population health.

In *Suicide*, Durkheim provided a symmetrical typology of suicide in which altruism was contrasted with egoism and fatalism with anomie.<sup>8</sup> The impetus for Durkheim's study, however, was a concern with what he perceived to be a breakdown in moral order, by which he meant what researchers today have labeled social capital. Thus, Durkheim focused on increases in egoistic and anomic suicides because they provided a statistically viable measure of the decline of social capital. In his work, altruistic suicide served mainly a rhetorical function. Fatalistic suicide served as a descriptor for suicides in traditional societies, because Durkheim was faced with the issue that even in societies with abundant social capital, individuals nevertheless killed themselves. But, as we have shown, the data that Durkheim used was not linked to his definition of what constituted a suicide or to the typology he constructed. Moreover, suicide attempts were excluded, even though they fit Durkheim's definition. Women's suicides were made to fit the typology by assuming that they resulted from modernity and gender role stress. Nevertheless, Durkheim can be read as demonstrating that social integration can have negative health consequences.

A critical reading of Durkheim's original text should make researchers suspicious of current claims that social capital is likely to result in a reduction in morbidity and mortality, especially among constituents of communities with little social and economic power. Because it seems to provide confirmation of the pro-

phylactic impact of social capital or social cohesion, public health investigators have been too accepting of Durkheim's typology. Much of the current enthusiasm for social capital as a core concept in suicide prevention rests on unexamined nostalgic and patriarchal assumptions, similar to those that informed Durkheim's *Suicide*. The lesson here is that we must remain skeptical about current claims that improved health outcomes and reduced mortality will result from increased submersion in community activity.<sup>4,22</sup> Communities, after all, are heterogeneous, and involvement alone may mean less than the meaning that any individual brings to an experience. The quality of relationships is always paramount, and participation alone does not necessarily translate into acceptance, trust, or reciprocity. Moreover, the current enthusiasm for the health benefits of social capital should not serve as an occasion to view it as a substitute for other forms of capital and status. Camouflaging the nostalgia that informs many of these claims with metaphors of "social capital," or "social cohesion" should not conceal the traditional assumptions and antiurban bias that may underpin such a project.

Although we are persuaded that significant contributions have been made by social capital scholars, we fear that a promiscuous application of this approach can be harmful. This may explain why studies on social capital and health have resulted in equivocal findings. Even advocates of a social capital approach point out that the concept has its limitations. For instance, participation in social activities may result in engaging in unhealthy behaviors, and the dynamics sur-

rounding reciprocity and trust may create power relations that allow some groups to gain from social capital while reducing access to resources for others. Contradictions and concerns as identified in this article warrant continued research on the application of social capital to population health as well as continued public policy. ■

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