Geschichte der Suizidprävention und aktuelle Situation

Univ.-Prof. Dr. Thomas Niederkrotenthaler, PhD MMSc
Zentrum für Public Health
Professur und Leiter, Abteilung für Public Mental Health

Enzyklopädie des Wiener Wissens
Band VI Krisenintervention

Gernot Sonneck, Helga Goll,
Thomas Kapitany, Claudius Stein,
Volker Strunz

KRISENINTERVENTION

Von den Anfängen der Suizidprävention bis zur Gegenwart

Verlag Bibliothek der Provinz *edition seidengasse*

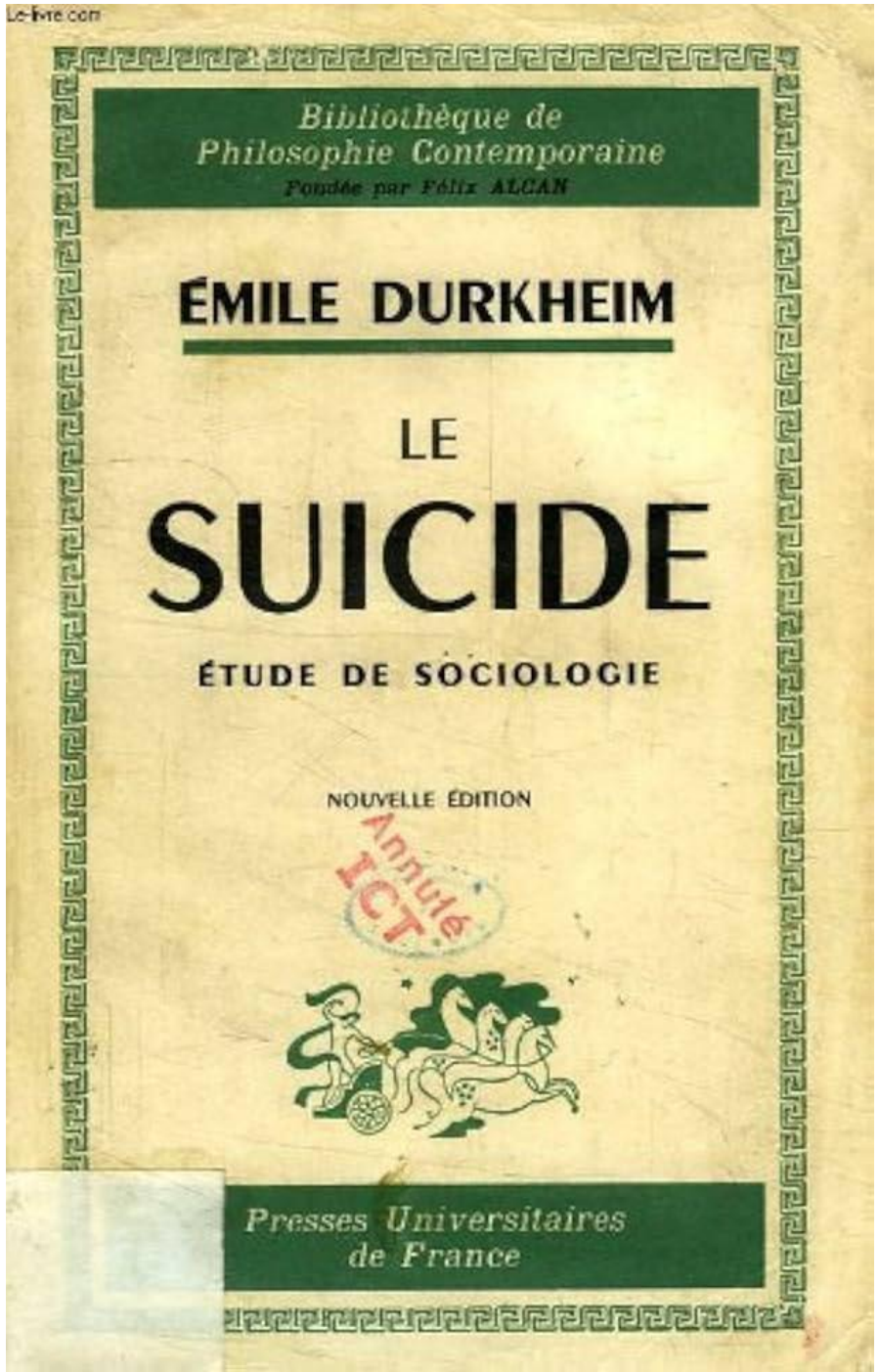
Die Leiden des jungen Werthers.

Erster Theil.

Jeder Jüngling sehnt sich so zu lieben,
Jedes Mädgen so geliebt zu seyn,
Ach, der heiligste von unsern Trieben,
Warum quillt aus ihm die grimme Pein?

Zweyte ächte Auflage.

Leipzig,
in der Weygandschen Buchhandlung.
1775.



4 Typen des Suizids basierend auf soziologischer Umstände

- **Egoistischer Suizid**
- Altruistischer Suizid
- **Anomischer Suizid**
- Fatalistischer Suizid

DISCUSSIONS OF THE VIENNA
PSYCHOANALYTIC SOCIETY—1910

ON SUICIDE

With Particular Reference to Suicide among Young Students

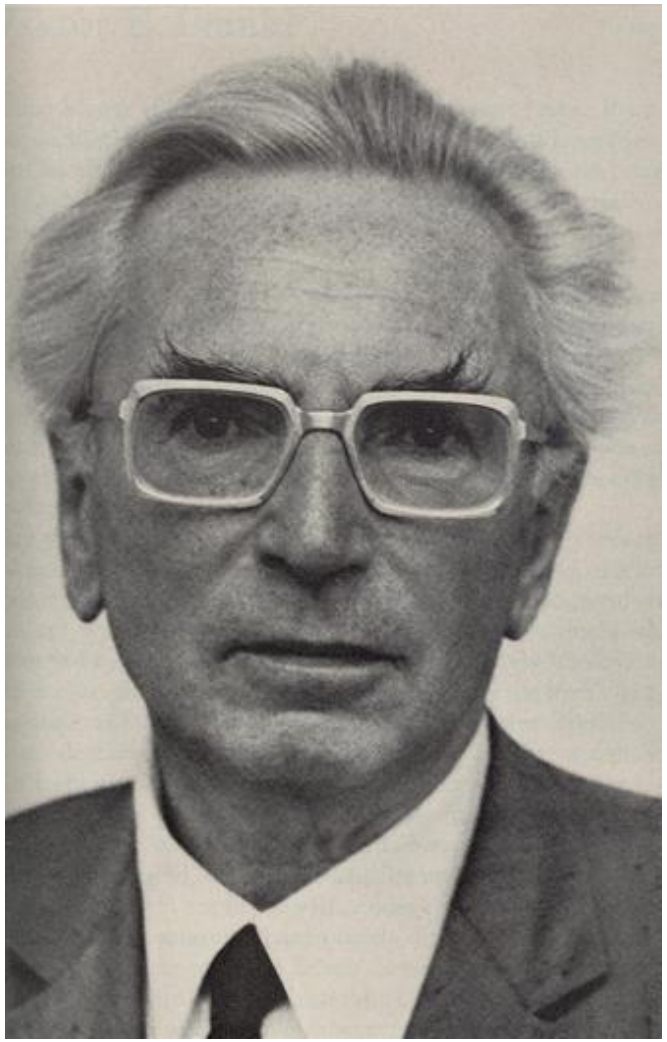
With contributions by

ALFRED ADLER, SIGMUND FREUD,
JOSEF K. FRIEDJUNG, KARL MOLITOR,
DAVID ERNST OPPENHEIM,
RUDOLF REITLER, J. [ISIDOR] SADGER,
WILHELM STEKEL

Edited by

PAUL FRIEDMAN, M.D., Ph.D.

INTERNATIONAL UNIVERSITIES PRESS, INC.
New York, 1967



Viktor Emil Frankl

Statistische Mitteilungen
der
Stadt Wien.

Herausgegeben von der Magistratsabteilung für Statistik.

Jahrgang 1927. 3. Sonderheft.

Selbstmorde
und
Selbstmordversuche in Wien
im Jahre 1926.

Von

Dr. R. M. Delannoy.

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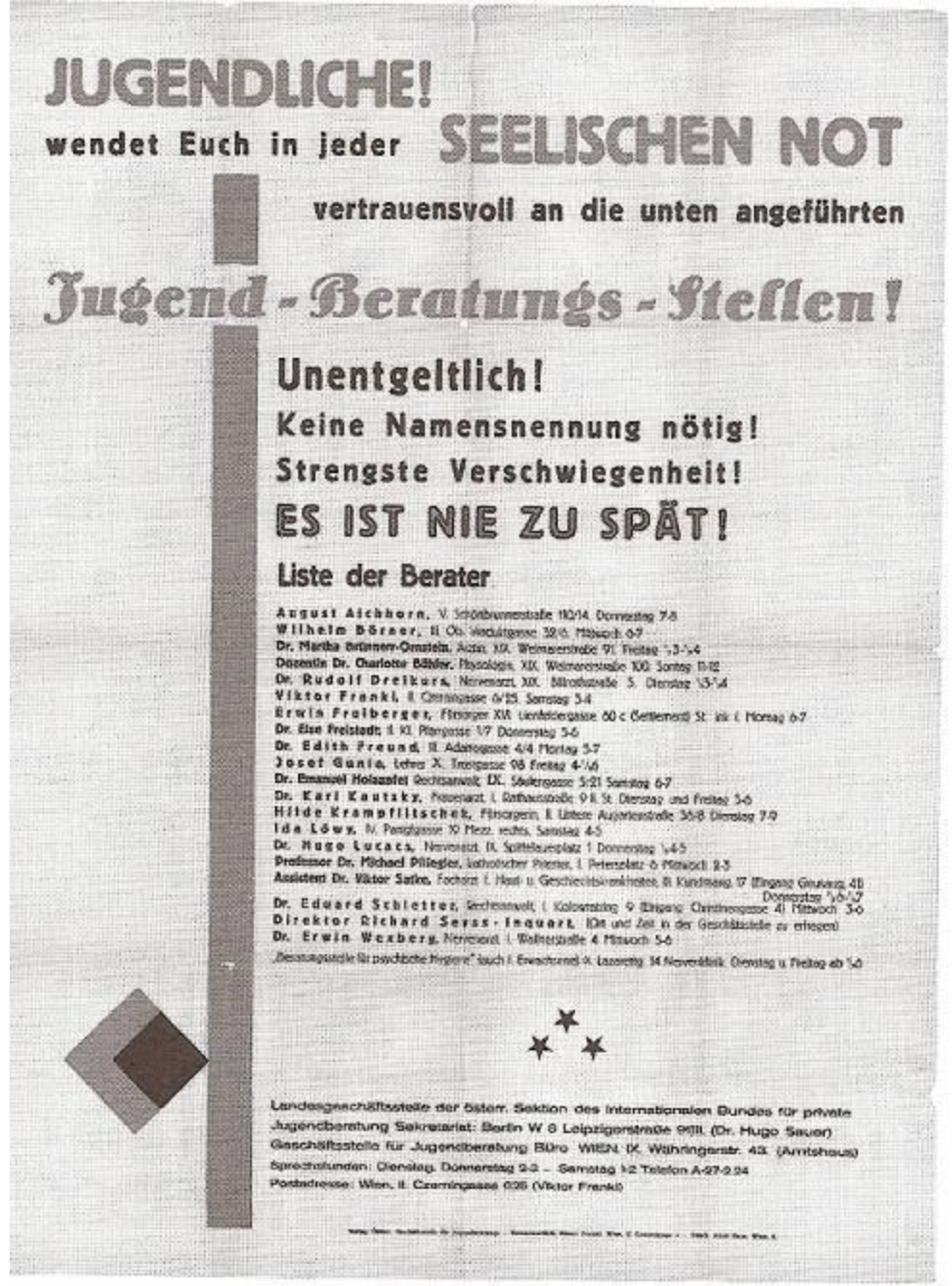

Abb. 7
Plakat der Jugendberatungsstellen (1928)

Wer war

Erwin Ringel?

Dokumente · Berichte · Analysen

Herausgegeben von Franz Richard Reiter

EPHELANT

Crisis Crisis Crisis

International Journal of Suicide- and Crisis-Studies
Internationale Zeitschrift für Selbstmord- und Krisen-Studien
Revue international pour l'étude du suicide et des états de crise

Published under the auspices of the International Association for Suicide Prevention (IASP)

Volume 1 No. 1 April 1980

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C. J. Hogrefe, Inc., Toronto/Canada

WIENER BEITRÄGE ZUR NEUROLOGIE UND PSYCHIATRIE
HERAUSGEGEBEN VON PROF. HANS HOFF UND PROF. OTTO PÖTZL
BAND III

DER SELBSTMORD

Abschluß einer krankhaften psychischen Entwicklung

(Eine Untersuchung an 745 geretteten Selbstmördern)

VON

Dr. ERWIN RINGEL
PSYCH.-NEUROL. UNIVERSITÄTS-KLINIK, PROF. DR. MED. HANS HOFF, WIEN

MIT TABELLEN

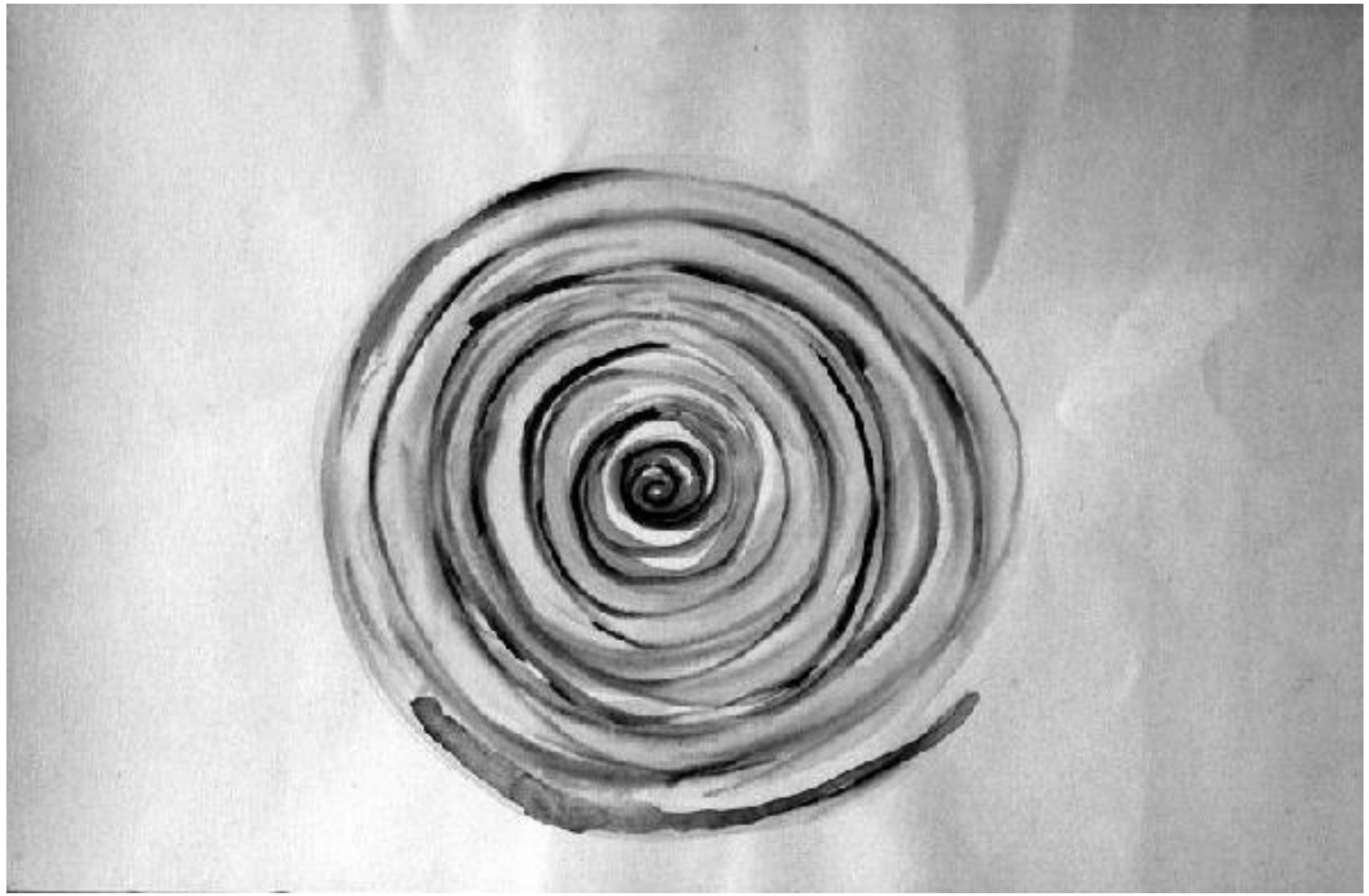
1953

VERLAG FÜR MEDIZINISCHE WISSENSCHAFTEN
WILHELM MAUDRICH / WIEN—DÜSSELDORF

1 ZUNEHMENDE EINENGUNG

2 GEHEMMTE AGGRESSION

3 SELBSTMORDPHANTASIEN



Gernot Sonneck

Archives of Suicide Research **4:** 67–74, 1998.

Article

Preventing suicide by in□uencing mass-media reporting. The Viennese experience 1980–1996

ELMAR ETZERSDORFER[1] and GERNOT SONNECK[2]
[1] *University Clinic for Psychoanalysis and Psychotherapy, University of Vienna, Austria;*
[2]*Institute for Medical Psychology, University of Vienna, Austria and Ludwig Boltzmann Institute for Social Psychiatry, Vienna, Austria*

Abstract. This paper reports a □eld experiment concerning mass-media and suicide. After the implementation of the subway system in Vienna in 1978, it became increasingly acceptable as means to commit suicide, with the suicide rates showing a sharp increase. This and the fact that the mass-media reported about these events in a very dramatic way, lead to the formation of a study-group of the Austrian Association for Suicide Prevention (ÖVSKK), which developed media guidelines and launched a media campaign in mid-1987. Subsequently, the media reports changed markedly and the number of subway-suicides and -attempts dropped more than 80% from the □rst to the second half of 1987, remaining at a rather low level since. Conclusions regarding the possible reduction of imitative suicidal behaviour by in□uencing mass-media-reports are drawn. Experiences from the media campaign are presented, as well as considerations about further research.

Key words: imitation, suicide, mass-media, prevention, Werther effect

Introduction

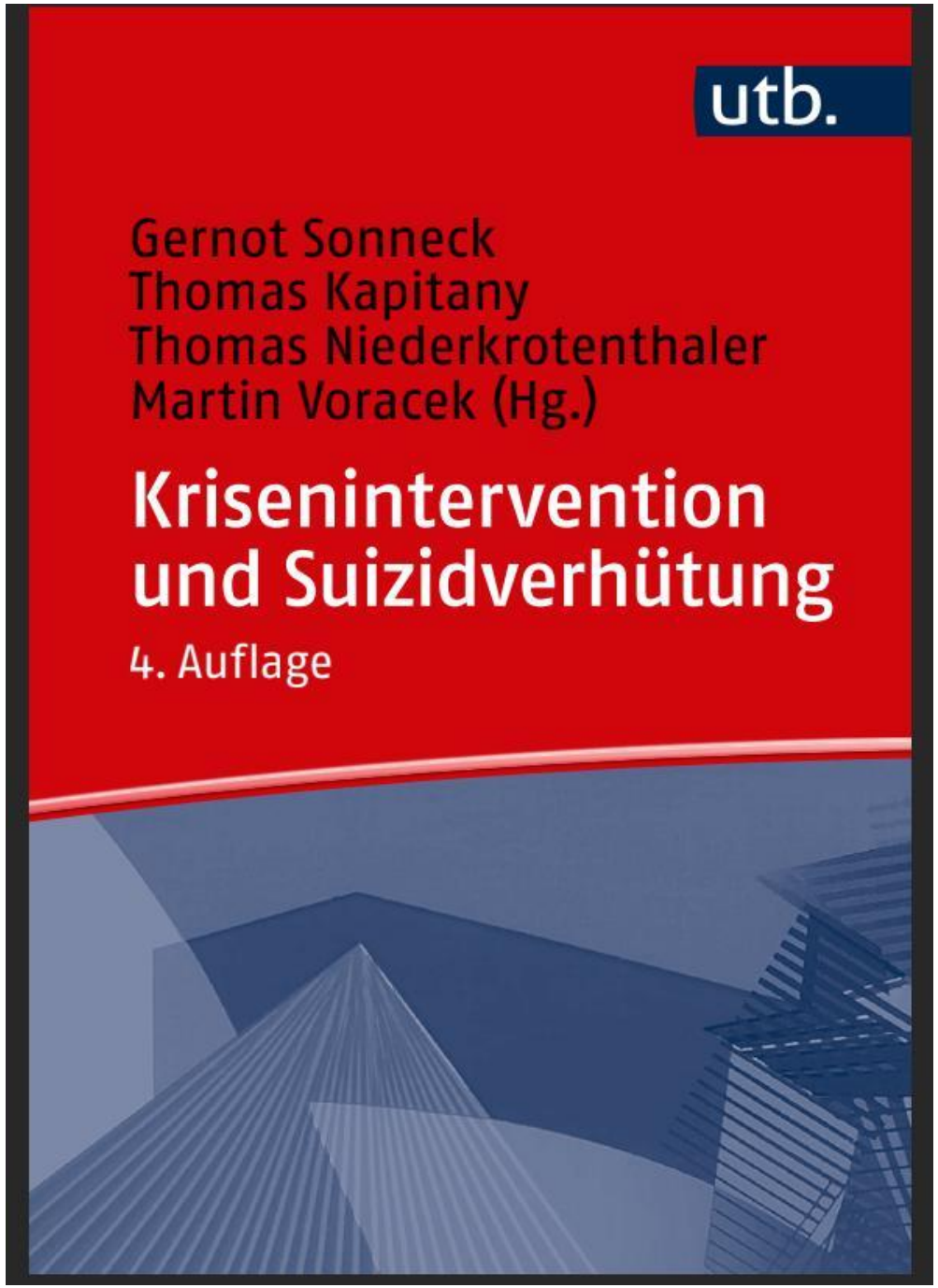
Since the beginning of suicide prevention very different strategies and approaches to prevent suicidal behaviour have been addressed. Apart from direct interventions with the individual (pairs, families or groups), approaches which focus on a broader level have been discussed but for a long time had a reputation of beeing unscienti□c or at least very dif□cult to evaluate. Concepts like primary prevention of suicidal behaviour are widely accepted as desirable, but whether it is really possible to be primarily preventive remained a different question. One area of research which investigates in□uences on suicidal behaviour on a macro-perspective is the possible in□uence of media reports on suicidal behaviour. Phillips (1974) used the term "Werther effect", which in the meantime has become widely used to describe imitative suicidal behaviour. It refers to Goethe's novel, which was blamed as having lead several young men to commit suicide in the same way as young Werther after the publication of the book.

Gernot Sonneck

Krisenintervention und Suizidverhütung

UTB
FÜR WISSEN SCHAFT

Facultas


utb.
Gernot Sonneck
Thomas Kapitany
Thomas Niederkrotenthaler
Martin Voracek (Hg.)
Krisenintervention
und Suizidverhütung
4. Auflage

Die Wiener Lebensmüdenfürsorge

1910 erste Initiativen in Wien: Wiener Rettungsgesellschaft

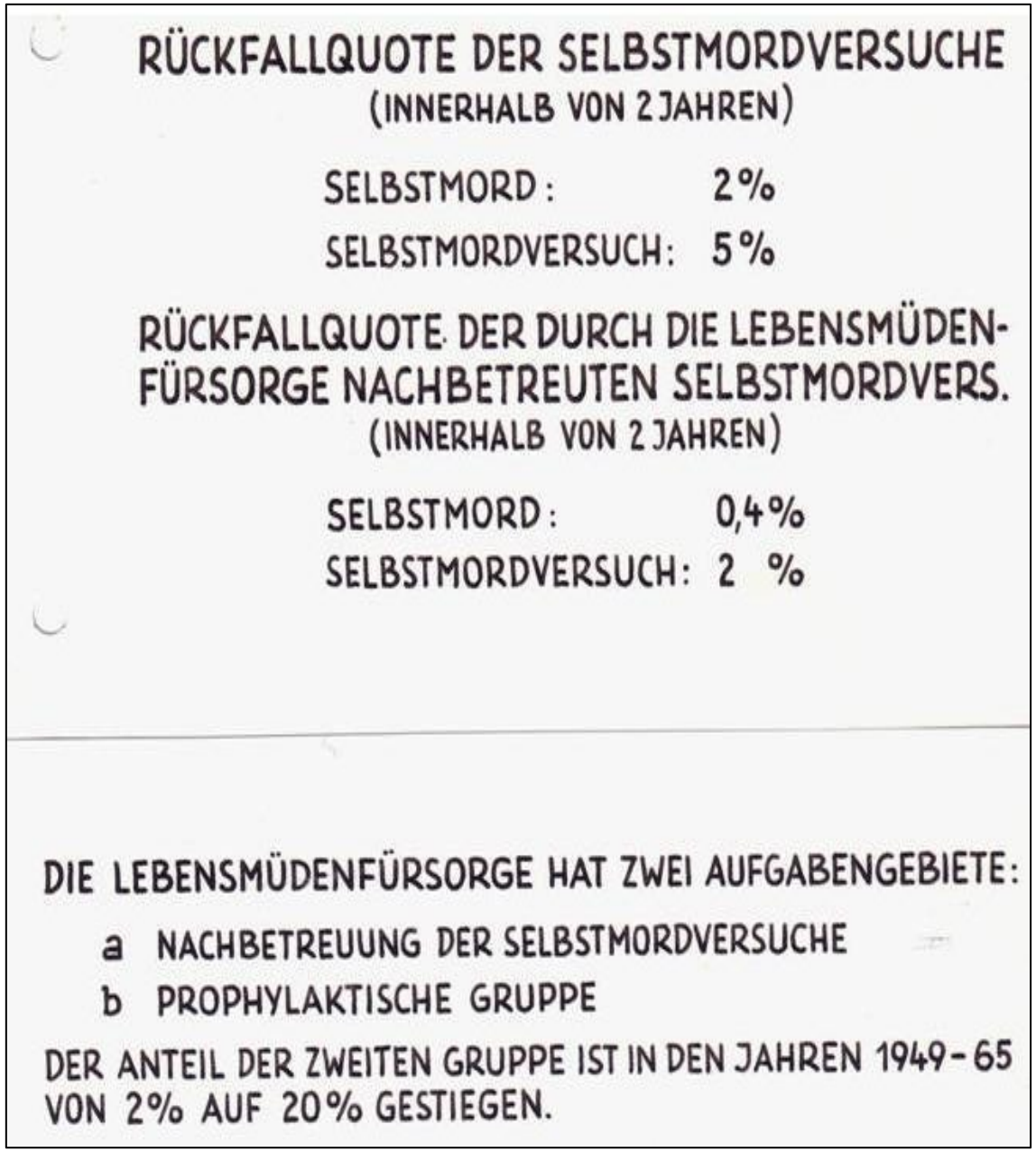
Ab 1918 in Zwischenkriegszeit zum Erliegen;

1926 bzw.1928 durch Wiener Rettungsgesellschaft wieder aufgenommen; 1938 auch Wiener Caritas

Ab 1939 zum Erliegen

1948 Wiederaufnahme durch Lebensmüdenfürsorge der Caritas

Seit 1977 Wiener Kriseninterventionszentrum



Die Telefonseelsorge

- 1953 (England): Notruf für Suizidgefährdete durch Baptistenpfarrer Chad Varah
- „Before you commit suicide, ring me up!“ [*Bevor Sie Suizid begehen, rufen Sie mich an!*]

- 1954: The Samaritans
- 1956: Telefonseelsorge Berlin
- 1966: Telefonseelsorge Linz; 1967: Wien

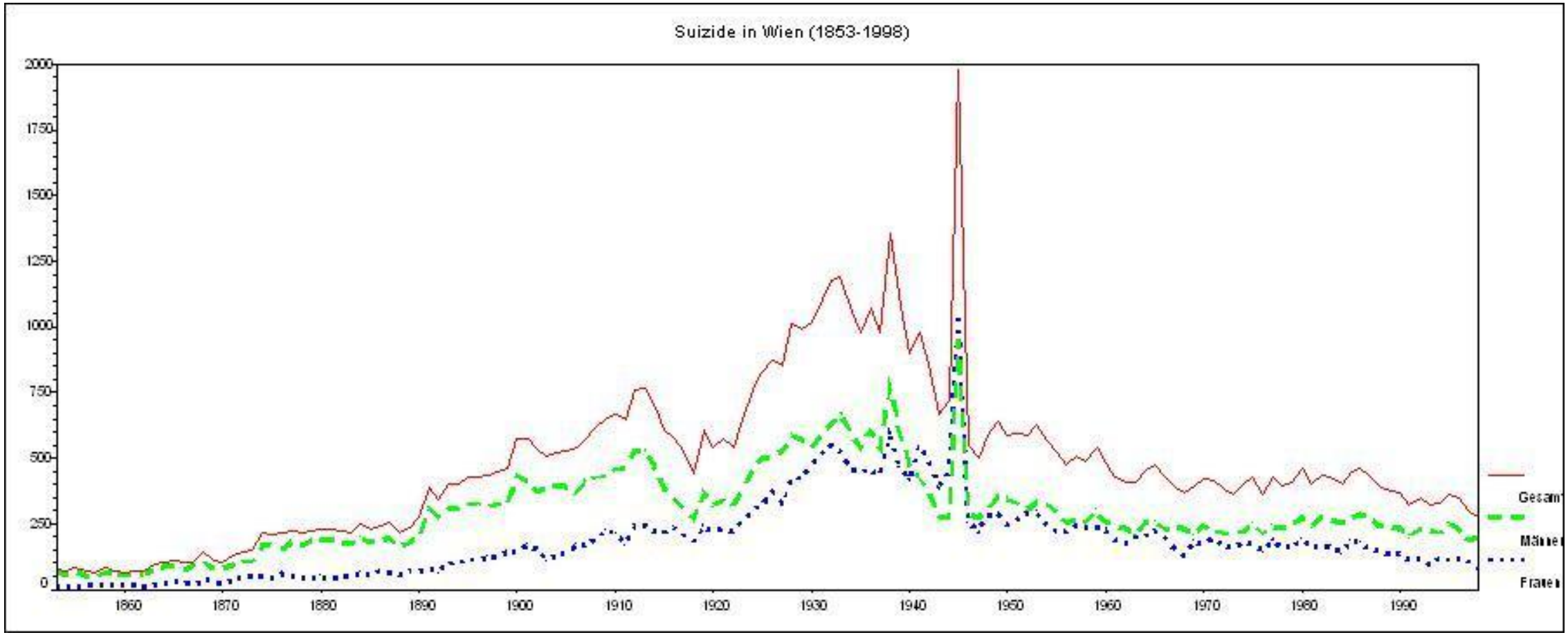
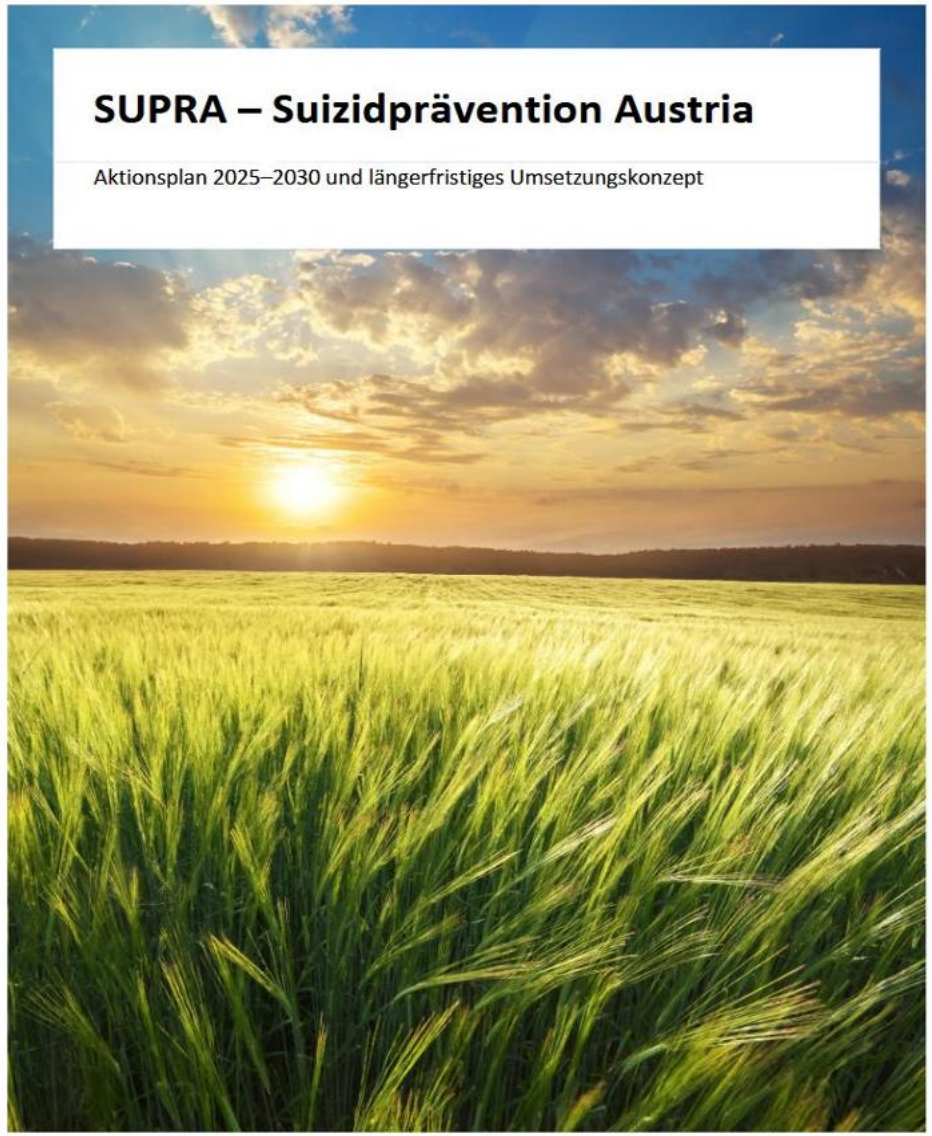


Abb. 1: Jährliche Zahl der Suizide in Wien (1853-1998)

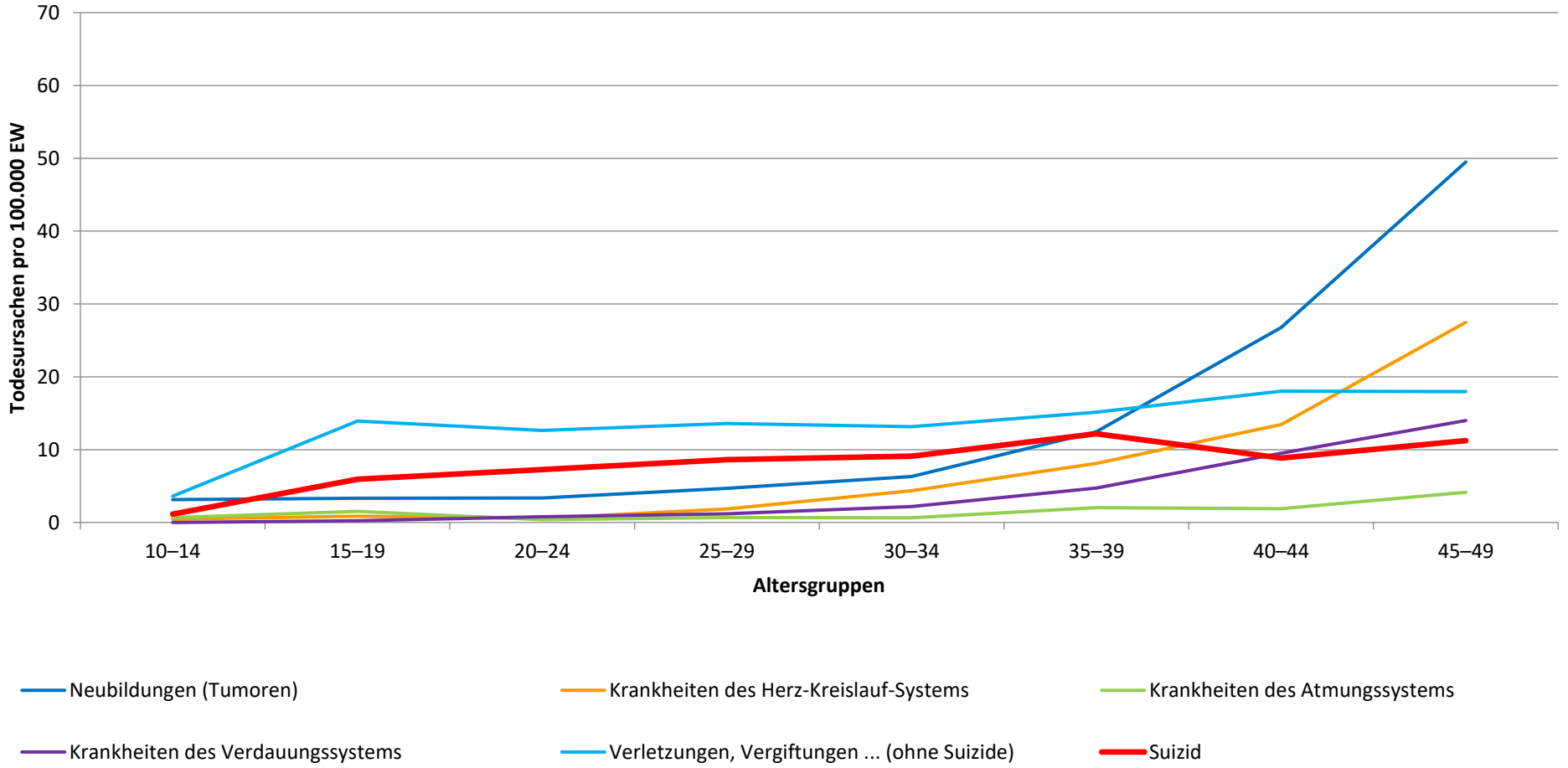
Bundesministerium
Soziales, Gesundheit, Pflege
und Konsumentenschutz



SUPRA – Suizidprävention Austria

Aktionsplan 2025–2030 und längerfristiges Umsetzungskonzept

Bis ins mittlere Alter eine der wichtigsten Todesursachen

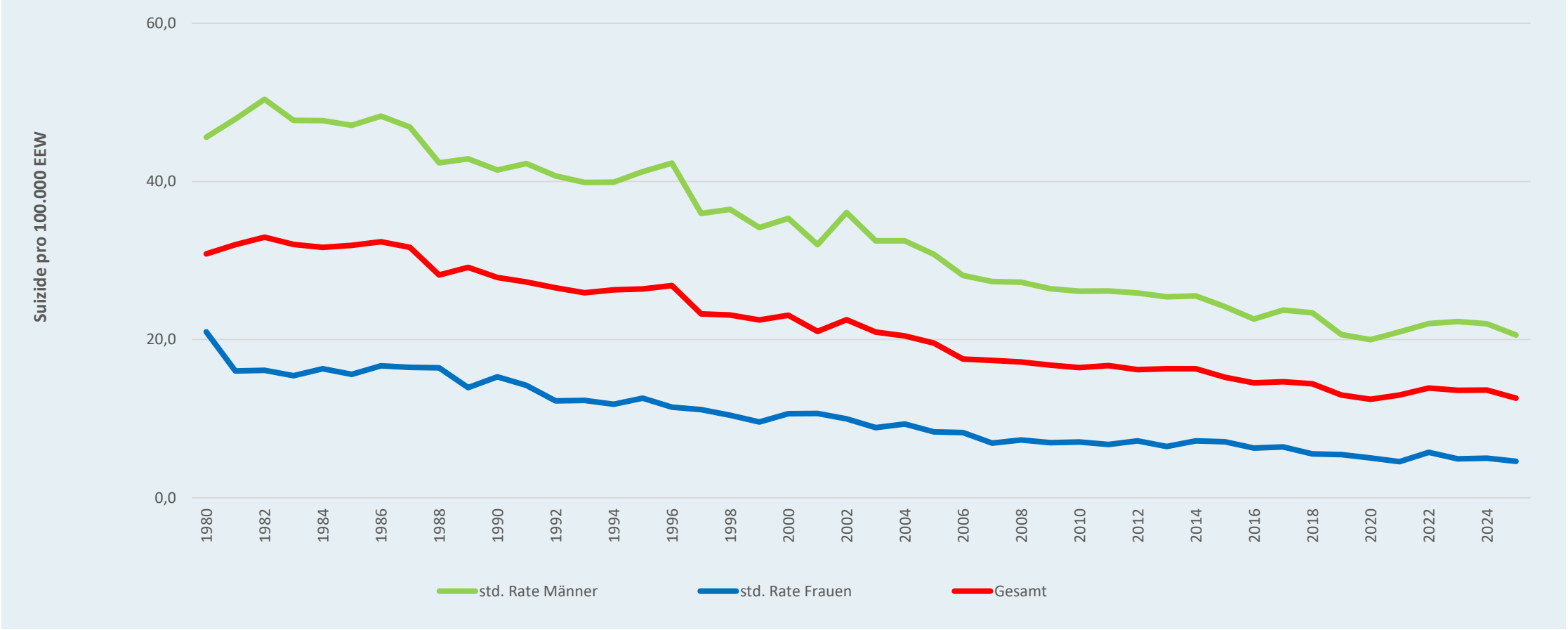


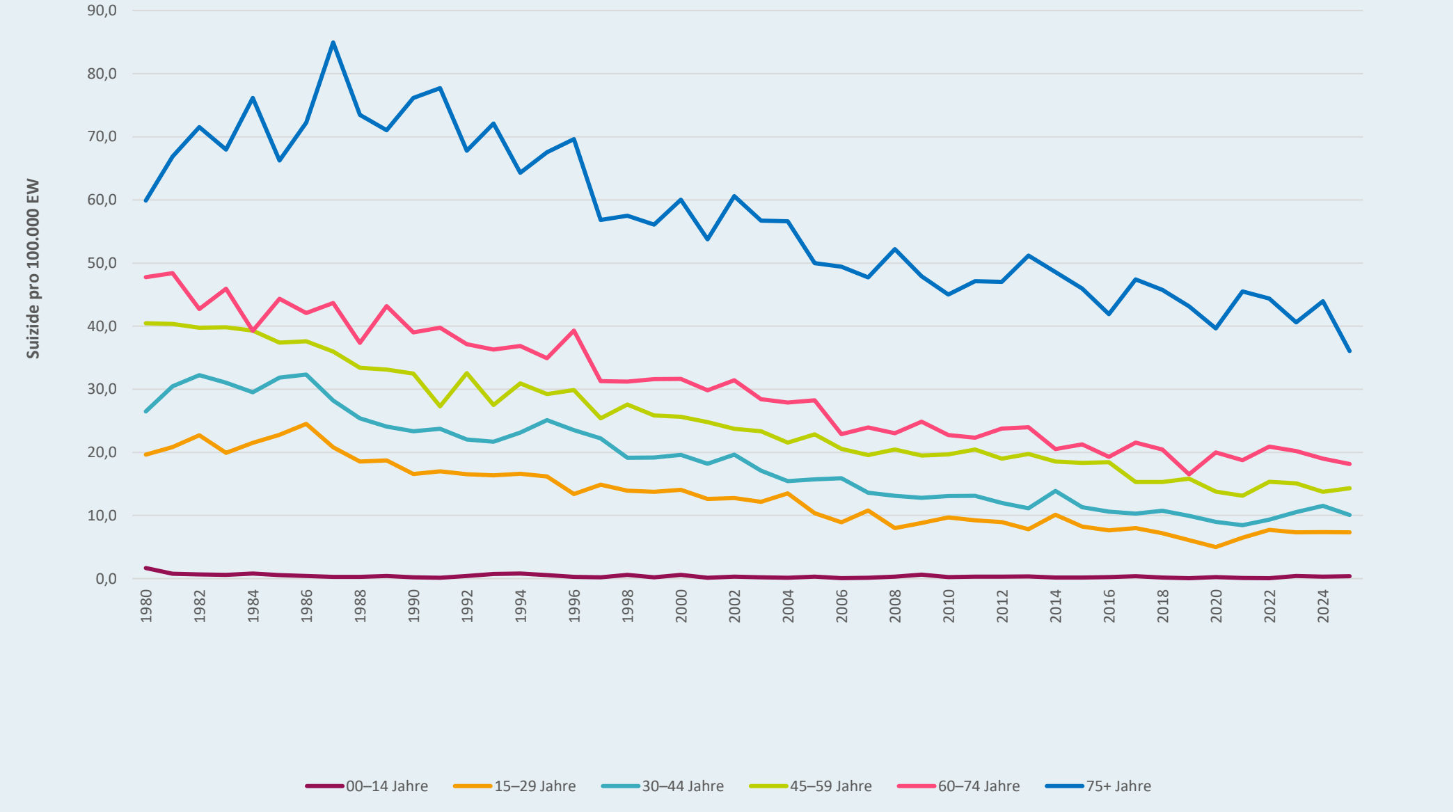
Rohdaten: Statistik Austria; Berechnung & Darstellung: GÖG

Suizidraten steigen mit Alter

Quelle: Suizidbericht, 2026

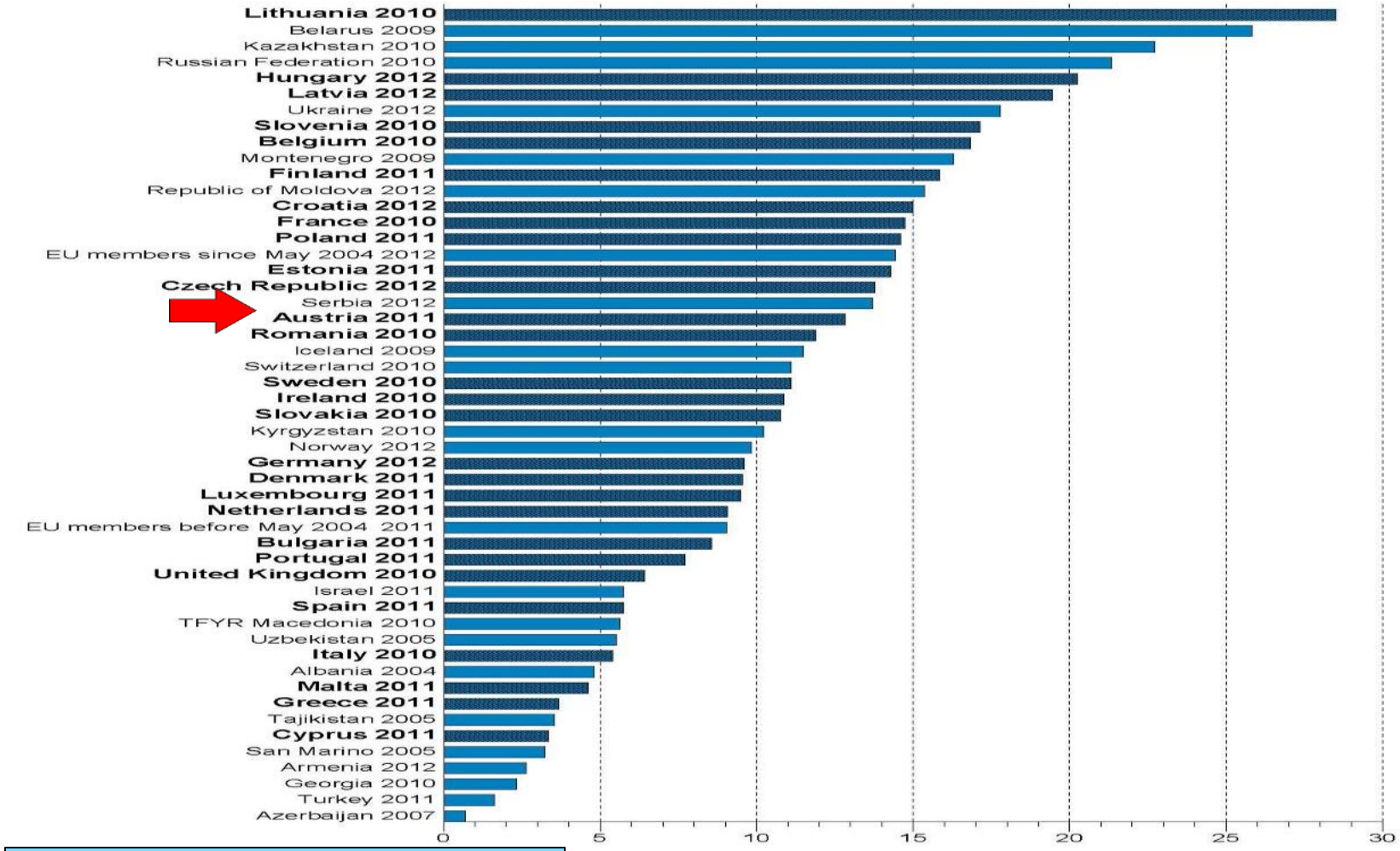
Suizidraten seit 1980-2025





Quelle/Rohdaten: Statistik Austria; Berechnung und Darstellung: GÖG (Standardbevölkerung Europa 2013)

Suizidraten im europäischen Mittelfeld



Source: WHO/Europe, European HFA Database, April 2014

Suizidraten in Europa

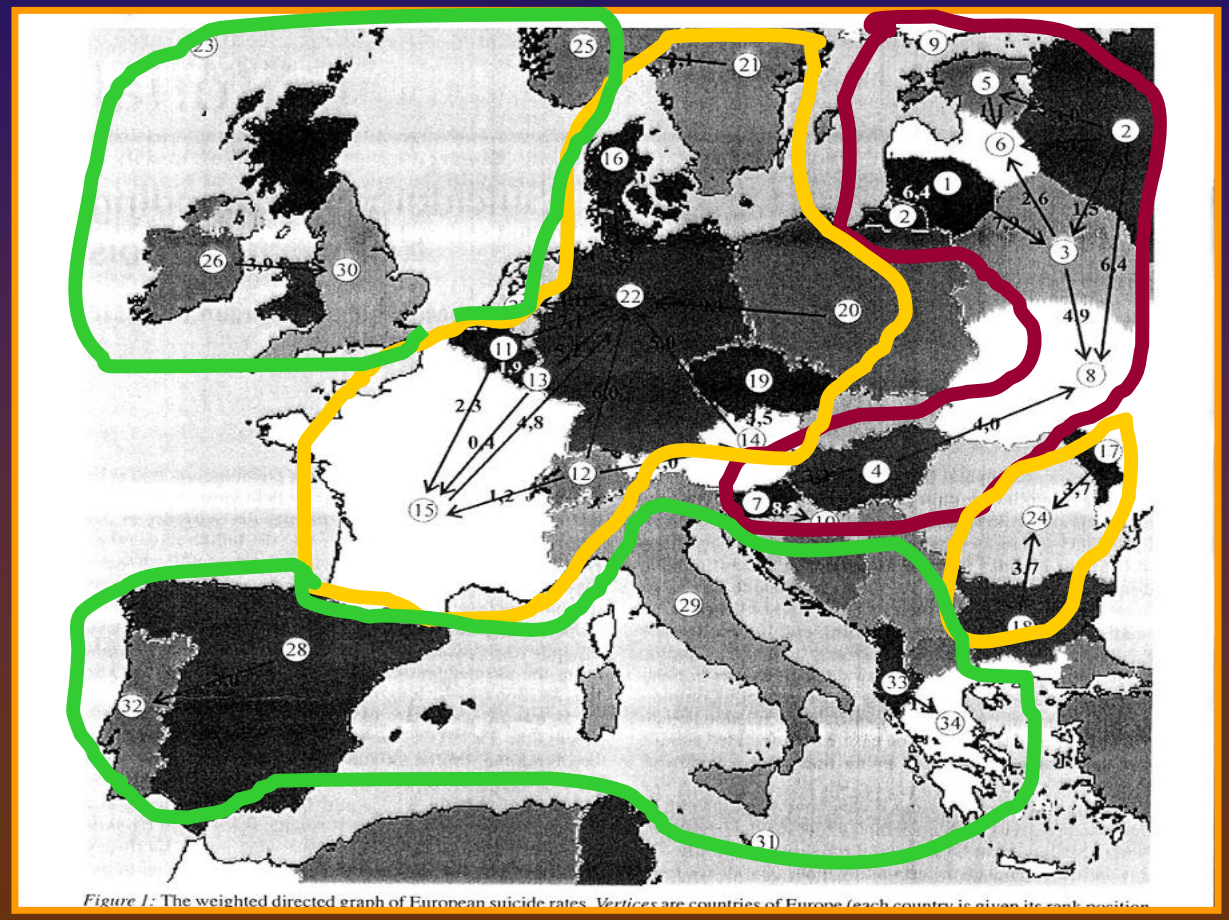
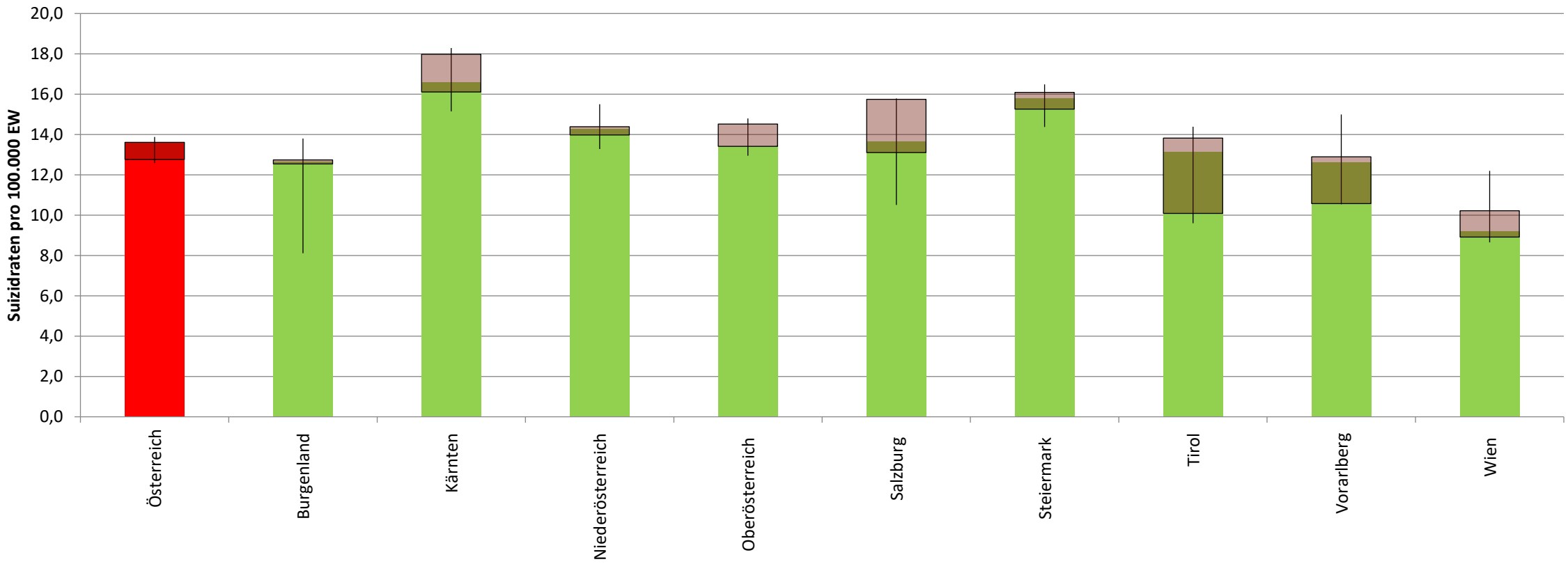


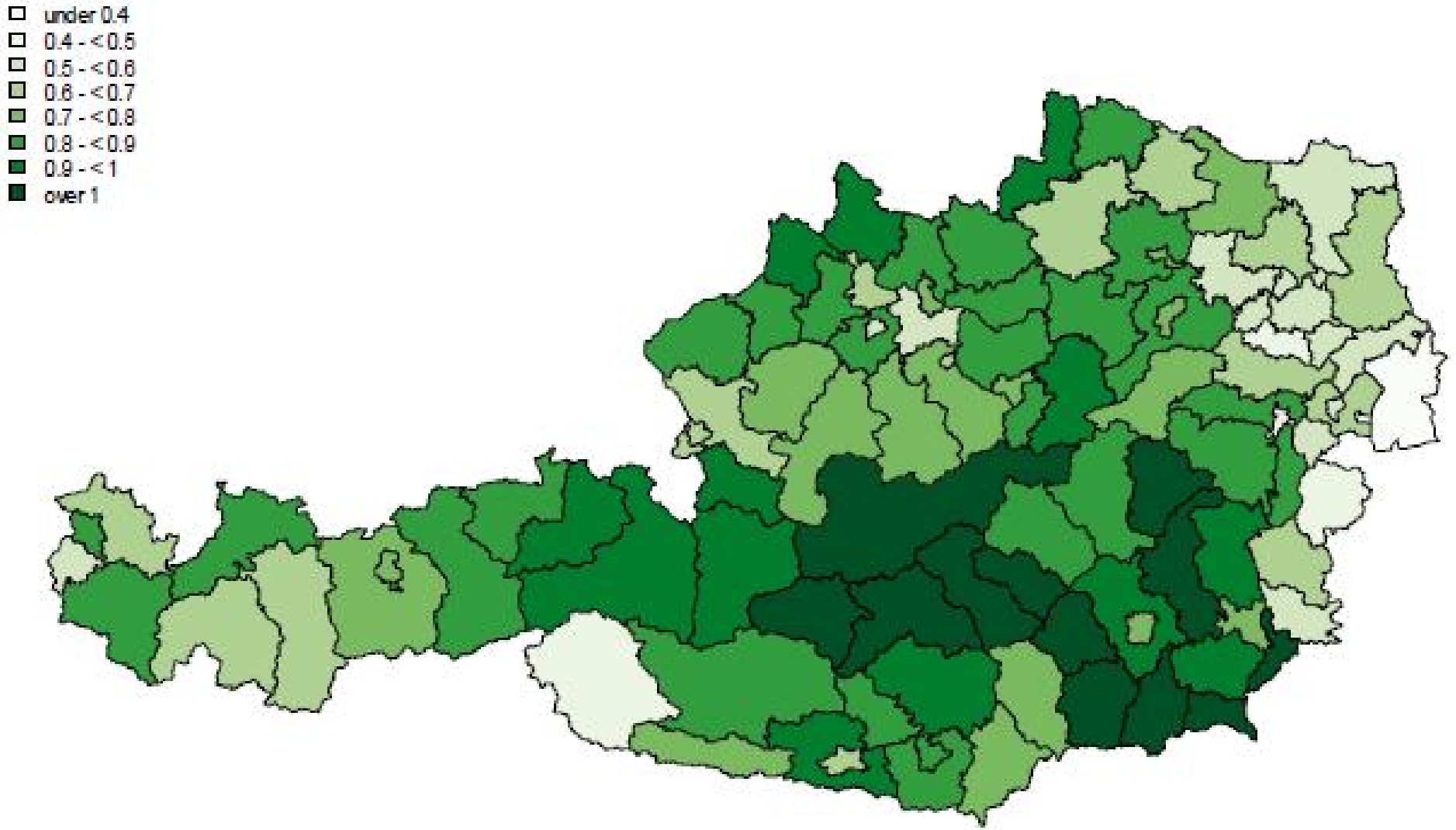
Figure 1: The weighted directed graph of European suicide rates. *Vertices* are countries of Europe (each country is given its rank position

Suizidraten Bundesländer, 2021 - 2025



Quelle: Österreichischer Suizidbericht, 2026

Standardisierte Suizidmortalitätsratios (SMR) auf politischer Bezirksebene



Grafik: Kapusta, 2012

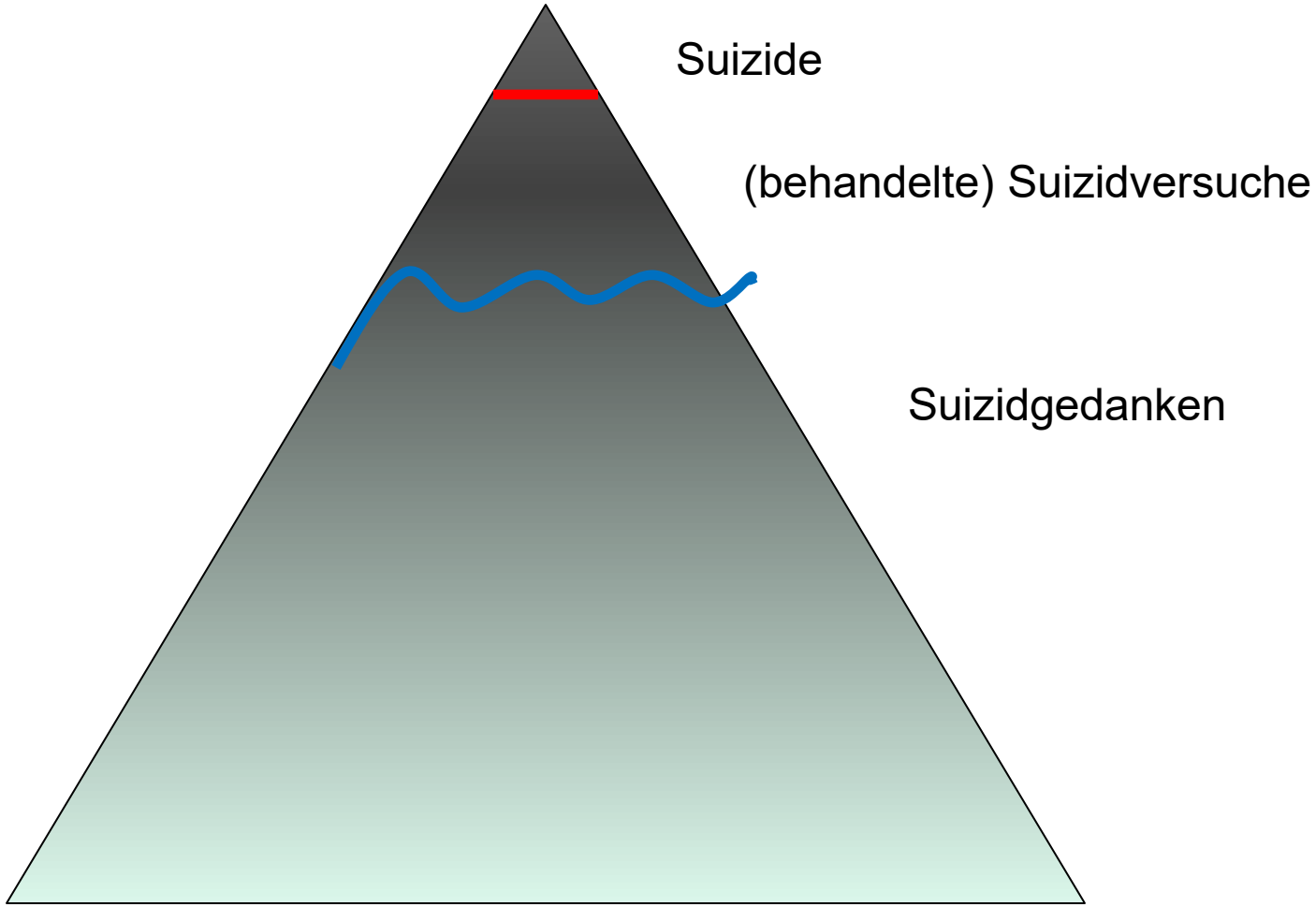
Gender & Suizid

Suizide Österreich (2025): Anzahl & Rate

Männer	**925**	**21**
Frauen	229	5

Frauen haben ca. 4 Mal mehr Suizidversuche als Männer

“Eisbergmodell” von Suizidalität



Papageno Medienpreis für suizidpräventive Berichterstattung

Blitzstein, 2019

SUPRA Suizidprävention Austria
Eine Initiative des Gesundheitsministeriums

Forschungsbereich assistierter Suizid

Diese Woche endet die kurze Begutachtungsfrist für das „Sterbeverfügungsgesetz“. Warum es aus suizidpräventiver Sicht hochproblematisch ist. Ein Gastkommentar.

Sich selbst überlassen?

Von Thomas Niederkrotenthaler und Thomas Kapitany

Foto: iStock / Mike Powell

Der vorliegende Entwurf eines „Sterbeverfügungsgesetzes“ birgt eine Reihe von Unklarheiten und Schwächen, die aus Sicht der Suizidprävention äußerst kritisch zu bewerten sind. Große Mängel bestehen etwa im Hinblick auf den Umgang mit Menschen mit psychischen Erkrankungen. Indem sich das Angebot des assistierten Suizids explizit an Personen richtet, die „an einer schweren, dauerhaften Krankheit mit anhaltenden Symptomen leide[n], deren Folgen die betroffene Person in ihrer gesamten Lebensführung dauerhaft beeinträchtigen“, sind diese Menschen klar angesprochen.

Suizidwünsche (N) entstehen häufig im Rahmen von psychischen Erkrankungen, zum Beispiel Depressionen – und klingen später wieder ab, wenn sich diese bessern, etwa durch Therapie. Somit ist davon auszugehen, dass auch Menschen mit behandelbaren psychischen Erkrankungen assistierten Suizid in Anspruch nehmen möchten. Das bleibt im Gesetzesentwurf aber weitgehend unberücksichtigt. Zwar

Hinzu kommt, dass die vorgesehene Wartezeit von zwölf Wochen nach einem womöglich innerhalb weniger Tage durchgeführten Begutachtungsverfahren viel zu kurz ist, um tatsächlich zu gewährleisten, dass in dieser Zeit bestehende Krisen oder psychische Krankheitsphasen erfolgreich behandelt werden können. Aufgrund der oft monatelangen Dauer von Krankheitsphasen wird in internationalen Empfehlungen ein Zeitraum von mindestens sechs bis zwölf Monaten empfohlen. Oftmals braucht es bei den gegebenen Engpässen der psychotherapeutischen, psychiatrischen und psychosozialen Versorgung der Bevölkerung schon Monate, bis ein Behandlungs-

Problematisch ist auch die Vermischung von Aufklärung beziehungsweise Beratung und Begutachtung im Gesetzesentwurf. Aufklärung und Bestätigung/Begutachtung sollten nicht in einer Hand liegen, weil das die Ergebnisoffenheit des Aufklärungsgesprächs beschädigt. Die betroffene Person kann nicht offen sprechen, um nicht das Ergebnis für sich negativ zu beeinflussen. Die Begründung für das vorgeschlagene Vorgehen inklusive Überlassung des Suizidmittels ist, dass „gewaltsame Suizide“ (eine Beschreibung, die bei Betroffenen und in der Prävention seit Langem sehr kritisch gesehen wird, da sie suggeriert, es gäbe „sanfte“ Suizide und man

- In Österreich ist Suizidassistenz seit 2022 möglich
- Österreichische Regelung hat zahlreiche Schwachstellen
  - Mangelndes Assessment der psychischen Gesundheit
  - Fehlende Trennung zwischen Beratung & Begutachtung
  - Fehlende Regeln zu Umgang mit Suizidmittel
- Forschungsbedarf bzgl. Epidemiologie, adäquater Prävention und Postvention im Kontext assistierter Suizid

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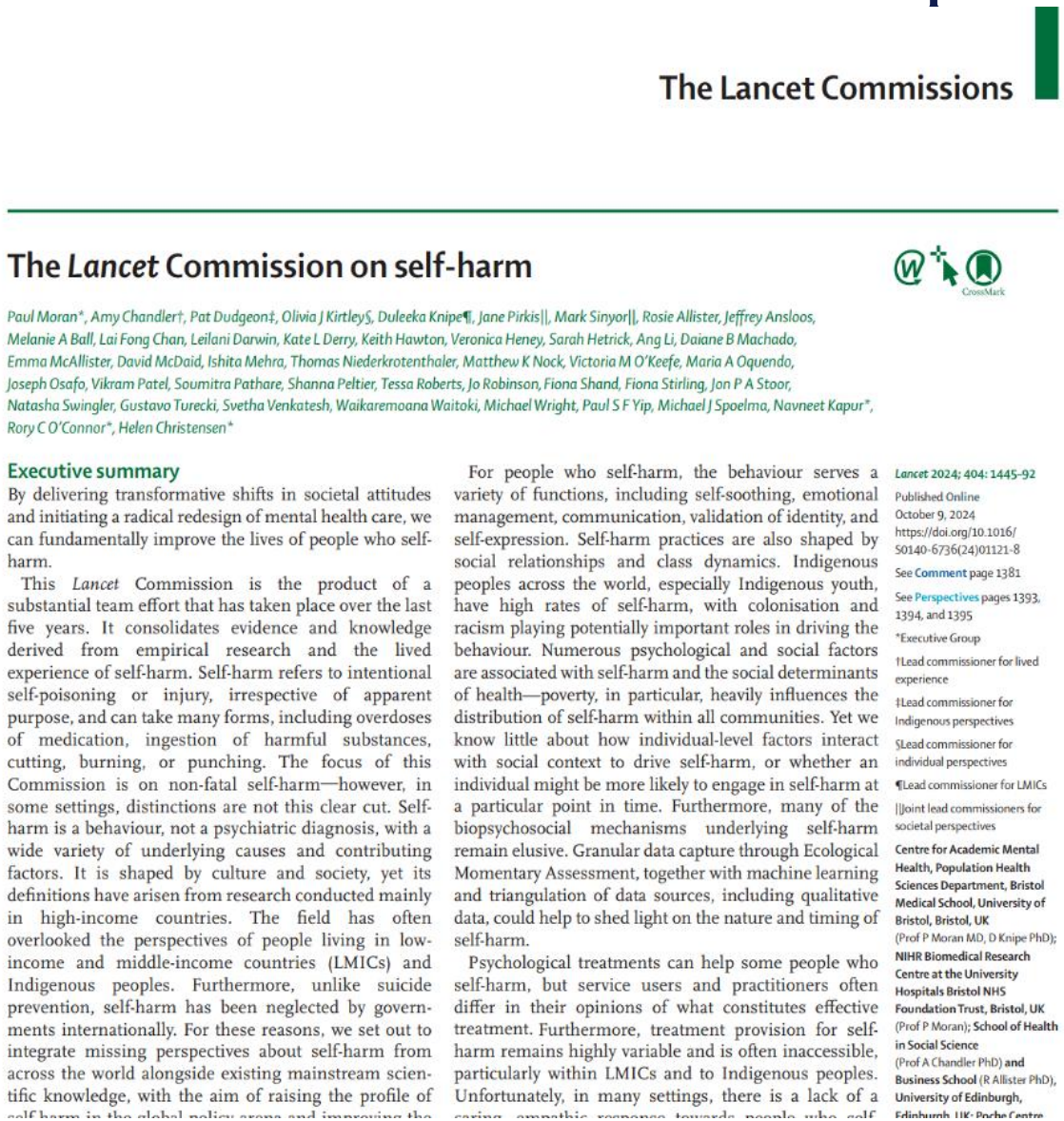
Darstellung: BMSGPK

Lancet Kommission Suizidprävention



The Lancet Commissions

The *Lancet* Commission on self-harm

Paul Moran*, Amy Chandler†, Pat Dudgeon‡, Olivia J Kirtley§, Duleeka Knipe¶, Jane Pirkis||, Mark Sinyor||, Rosie Allister, Jeffrey Ansloos, Melanie A Ball, Lai Fong Chan, Leilani Darwin, Kate L Derry, Keith Hawton, Veronica Heney, Sarah Hetrick, Ang Li, Daiane B Machado, Emma McAllister, David McDaid, Ishita Mehra, Thomas Niederkrotenthaler, Matthew K Nock, Victoria M O'Keefe, Maria A Oquendo, Joseph Osafo, Vikram Patel, Soumitra Pathare, Shanna Peltier, Tessa Roberts, Jo Robinson, Fiona Shand, Fiona Stirling, Jon P A Stoor, Natasha Swingler, Gustavo Turecki, Svetha Venkatesh, Waikaremoana Waitoki, Michael Wright, Paul S F Yip, Michael J Spoelma, Navneet Kapur*, Rory C O'Connor*, Helen Christensen*

Executive summary

By delivering transformative shifts in societal attitudes and initiating a radical redesign of mental health care, we can fundamentally improve the lives of people who self-harm.

This *Lancet* Commission is the product of a substantial team effort that has taken place over the last five years. It consolidates evidence and knowledge derived from empirical research and the lived experience of self-harm. Self-harm refers to intentional self-poisoning or injury, irrespective of apparent purpose, and can take many forms, including overdoses of medication, ingestion of harmful substances, cutting, burning, or punching. The focus of this Commission is on non-fatal self-harm—however, in some settings, distinctions are not this clear cut. Self-harm is a behaviour, not a psychiatric diagnosis, with a wide variety of underlying causes and contributing factors. It is shaped by culture and society, yet its definitions have arisen from research conducted mainly in high-income countries. The field has often overlooked the perspectives of people living in low-income and middle-income countries (LMICs) and Indigenous peoples. Furthermore, unlike suicide prevention, self-harm has been neglected by governments internationally. For these reasons, we set out to integrate missing perspectives about self-harm from across the world alongside existing mainstream scientific knowledge, with the aim of raising the profile of self-harm in the global policy arena and improving the

For people who self-harm, the behaviour serves a variety of functions, including self-soothing, emotional management, communication, validation of identity, and self-expression. Self-harm practices are also shaped by social relationships and class dynamics. Indigenous peoples across the world, especially Indigenous youth, have high rates of self-harm, with colonisation and racism playing potentially important roles in driving the behaviour. Numerous psychological and social factors are associated with self-harm and the social determinants of health—poverty, in particular, heavily influences the distribution of self-harm within all communities. Yet we know little about how individual-level factors interact with social context to drive self-harm, or whether an individual might be more likely to engage in self-harm at a particular point in time. Furthermore, many of the biopsychosocial mechanisms underlying self-harm remain elusive. Granular data capture through Ecological Momentary Assessment, together with machine learning and triangulation of data sources, including qualitative data, could help to shed light on the nature and timing of self-harm.

Psychological treatments can help some people who self-harm, but service users and practitioners often differ in their opinions of what constitutes effective treatment. Furthermore, treatment provision for self-harm remains highly variable and is often inaccessible, particularly within LMICs and to Indigenous peoples. Unfortunately, in many settings, there is a lack of a caring, empathic response towards people who self-

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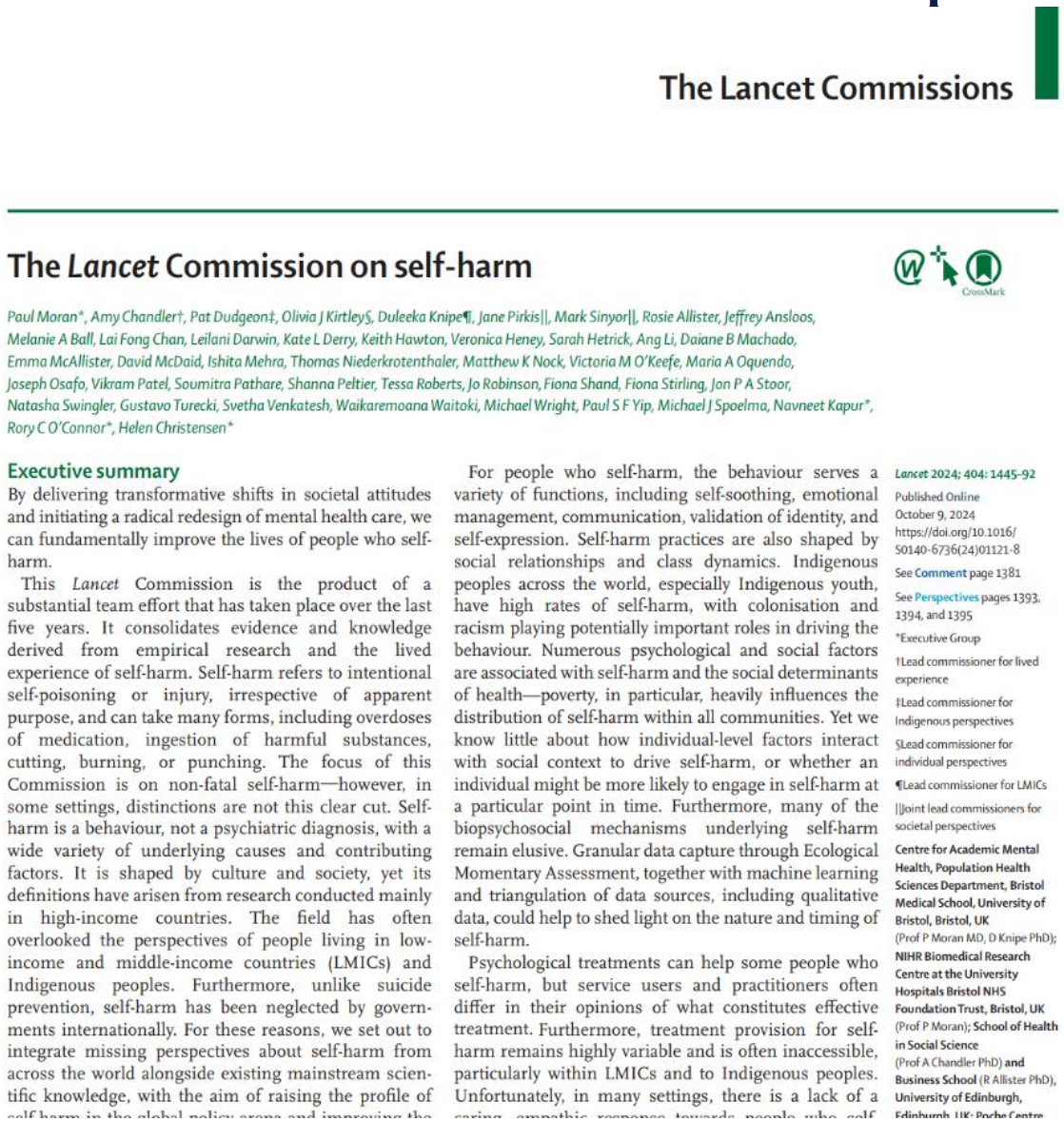
See Comment page 1381
See Perspectives pages 1393, 1394, and 1395

*Executive Group
†Lead commissioner for lived experience
‡Lead commissioner for Indigenous perspectives
§Lead commissioner for individual perspectives
¶Lead commissioner for LMICs
||Joint lead commissioners for societal perspectives

Centre for Academic Mental Health, Population Health Sciences Department, Bristol Medical School, University of Bristol, Bristol, UK (Prof P Moran MD, D Knipe PhD); **NIHR Biomedical Research Centre at the University Hospitals Bristol NHS Foundation Trust, Bristol, UK** (Prof P Moran); **School of Health in Social Science** (Prof A Chandler PhD) **and Business School** (R Allister PhD), **University of Edinburgh, Edinburgh, UK; Poche Centre**

- **Veränderung der Kommunikation über Suizid**
- Co-design mit Zielgruppe
- sektorenübergreifender Ansatz für Suizidprävention

Lancet Kommission Suizidprävention



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Psychological treatments can help some people who self-harm, but service users and practitioners often differ in their opinions of what constitutes effective treatment. Furthermore, treatment provision for self-harm remains highly variable and is often inaccessible, particularly within LMICs and to Indigenous peoples. Unfortunately, in many settings, there is a lack of a caring, empathic response towards people who self-

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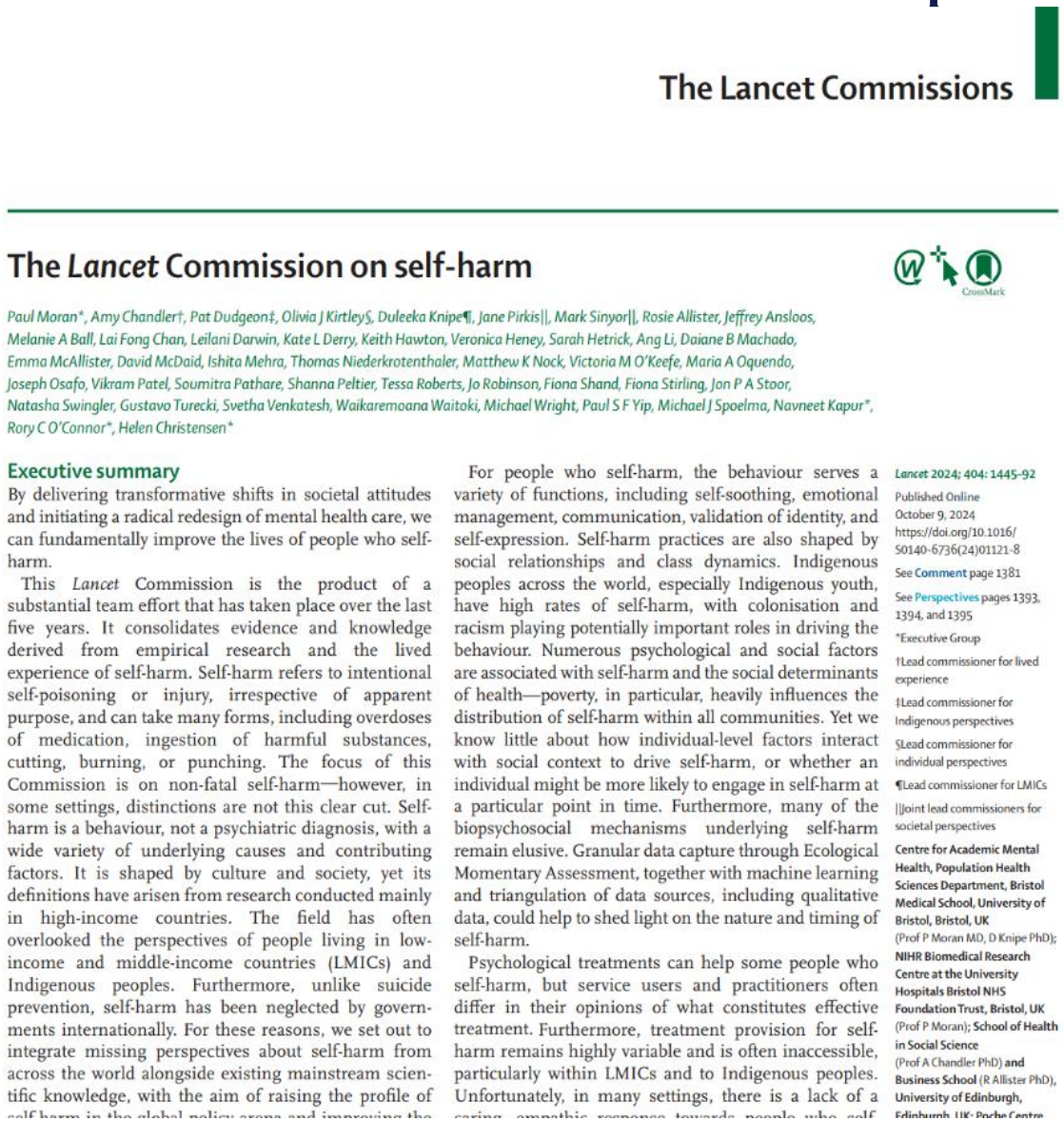
*Executive Group
†Lead commissioner for lived experience
‡Lead commissioner for Indigenous perspectives
§Lead commissioner for individual perspectives
¶Lead commissioner for LMICs
||Joint lead commissioners for societal perspectives

Centre for Academic Mental Health, Population Health Sciences Department, Bristol Medical School, University of Bristol, Bristol, UK (Prof P Moran MD, D Knipe PhD); **NIHR Biomedical Research Centre at the University Hospitals Bristol NHS Foundation Trust, Bristol, UK** (Prof P Moran); **School of Health in Social Science** (Prof A Chandler PhD) **and Business School** (R Allister PhD), **University of Edinburgh, Edinburgh, UK; Poche Centre**

- Veränderung der Kommunikation über Suizid
- **Co-design mit Zielgruppe**
- sektorenübergreifender Ansatz für Suizidprävention

Lancet Kommission Suizidprävention



The Lancet Commissions

The *Lancet* Commission on self-harm

Paul Moran, Amy Chandler†, Pat Dudgeon‡, Olivia J Kirtley§, Duleeka Knipe¶, Jane Pirkis||, Mark Sinyor||, Rosie Allister, Jeffrey Ansloos, Melanie A Ball, Lai Fong Chan, Leilani Darwin, Kate L Derry, Keith Hawton, Veronica Heney, Sarah Hetrick, Ang Li, Daiane B Machado, Emma McAllister, David McDaid, Ishita Mehra, Thomas Niederkrotenthaler, Matthew K Nock, Victoria M O'Keefe, Maria A Oquendo, Joseph Osafo, Vikram Patel, Soumitra Pathare, Shanna Peltier, Tessa Roberts, Jo Robinson, Fiona Shand, Fiona Stirling, Jon P A Stoor, Natasha Swingler, Gustavo Turecki, Svetha Venkatesh, Waikaremoana Waitoki, Michael Wright, Paul S F Yip, Michael J Spoelma, Navneet Kapur*, Rory C O'Connor*, Helen Christensen**

Executive summary

By delivering transformative shifts in societal attitudes and initiating a radical redesign of mental health care, we can fundamentally improve the lives of people who self-harm.

This *Lancet* Commission is the product of a substantial team effort that has taken place over the last five years. It consolidates evidence and knowledge derived from empirical research and the lived experience of self-harm. Self-harm refers to intentional self-poisoning or injury, irrespective of apparent purpose, and can take many forms, including overdoses of medication, ingestion of harmful substances, cutting, burning, or punching. The focus of this Commission is on non-fatal self-harm—however, in some settings, distinctions are not this clear cut. Self-harm is a behaviour, not a psychiatric diagnosis, with a wide variety of underlying causes and contributing factors. It is shaped by culture and society, yet its definitions have arisen from research conducted mainly in high-income countries. The field has often overlooked the perspectives of people living in low-income and middle-income countries (LMICs) and Indigenous peoples. Furthermore, unlike suicide prevention, self-harm has been neglected by governments internationally. For these reasons, we set out to integrate missing perspectives about self-harm from across the world alongside existing mainstream scientific knowledge, with the aim of raising the profile of self-harm in the global policy arena and improving the

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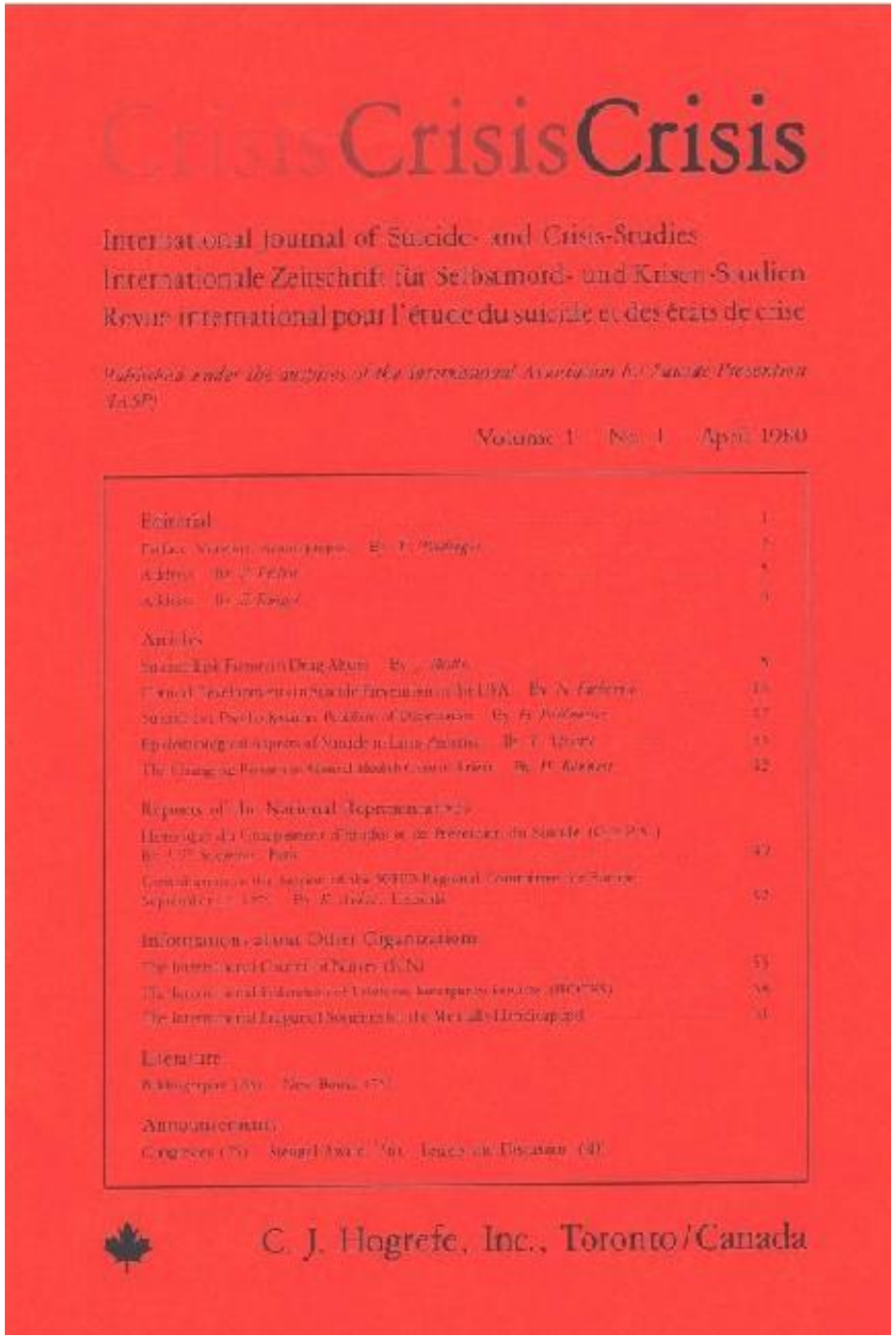
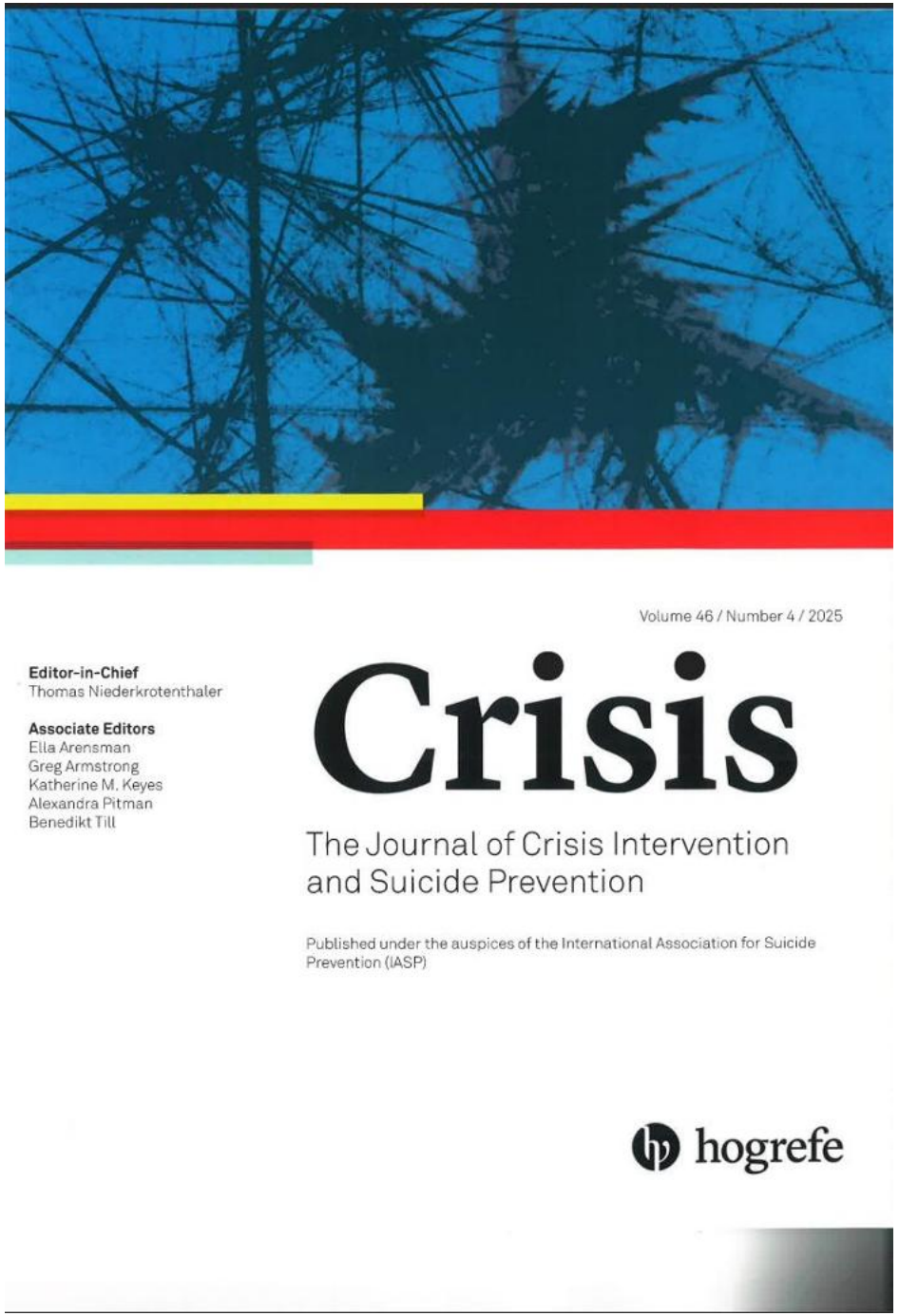

Crisis
International Journal of Suicide- and Crisis-Studies
Internationale Zeitschrift für Selbstmord- und Krisen-Studien
Revue internationale pour l'étude du suicide et des états de crise
Volume 1 No. 1 April 1980
Editorial
Articles
Reports of the National Representatives
Information about Other Organizations
Literature
Announcements
C. J. Hogrefe, Inc., Toronto/Canada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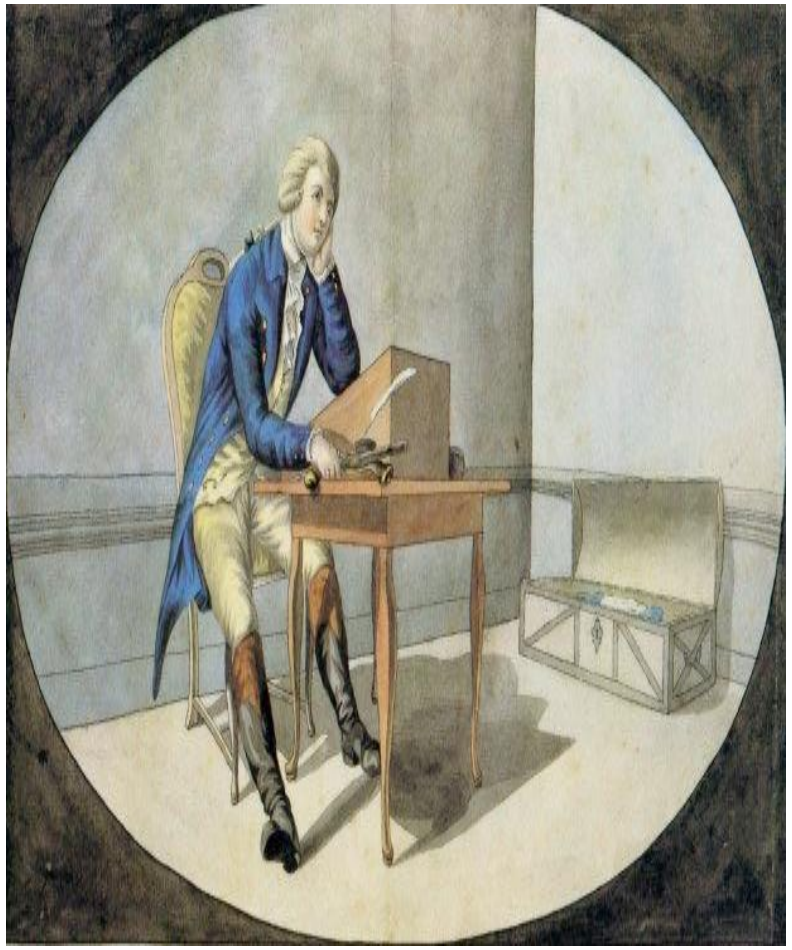
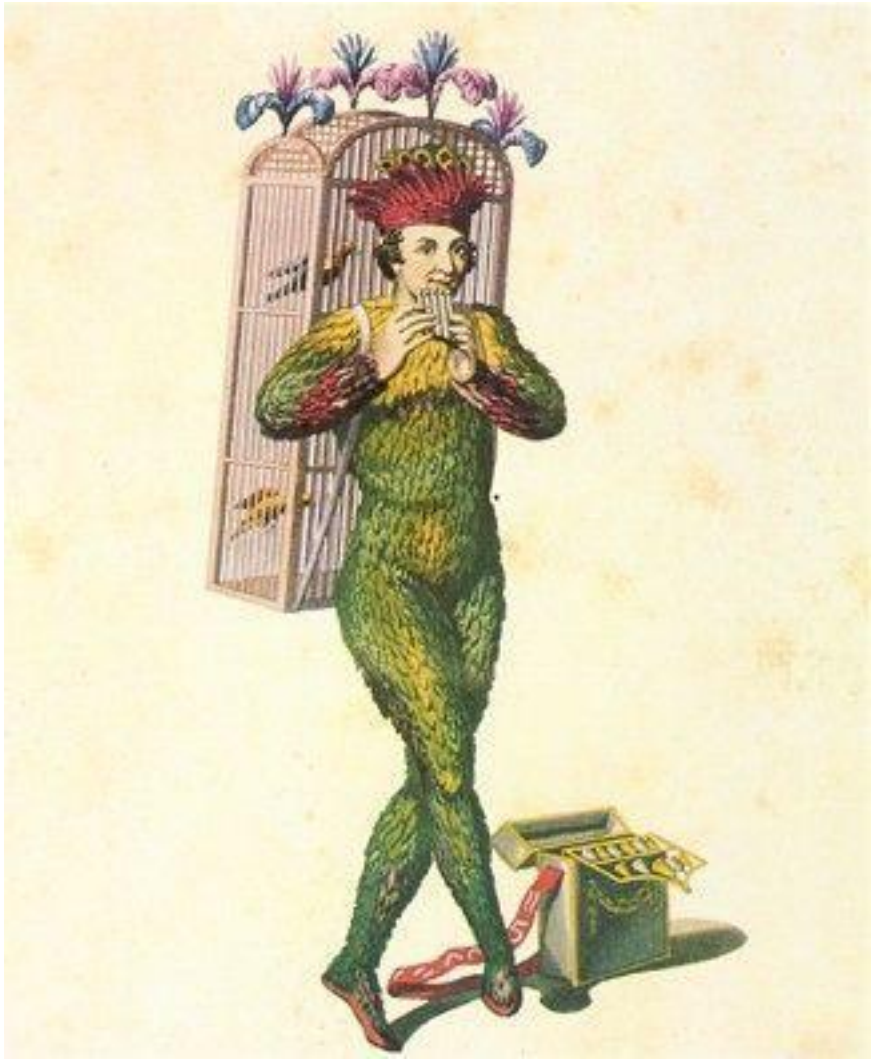
Slide 19



Chodowiecki, Berlin, 1775



Thiele, Vienna, 1816

Slide 23

Logic 1-800-273-8255 ft Alessia Cara, Khalid

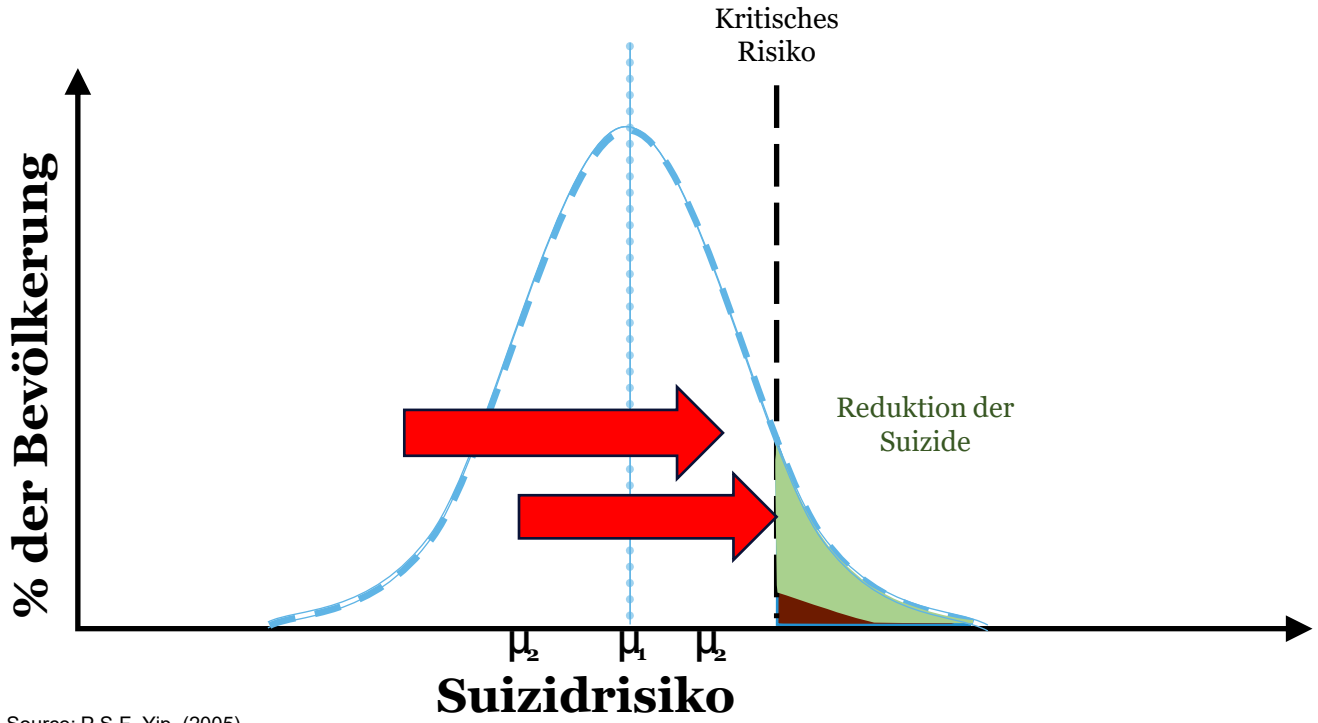
Evaluation:

Niederkrotenthaler T, Tran US, Gould M, Sinyor M, Sumner S, Strauss MJ, Voracek M, Till B, Murphy S, Gonzalez F, Spittal MJ, Draper J. Association of Logic's hip hop song "1-800-273-8255" with Lifeline calls and suicides in the United States: interrupted time series analysis. BMJ. 2021 Dec 13;375:e067726. doi: 10.1136/bmj-2021-067726.

„Shifting the Curve“ Präventionsparadox

Public Health Ansatz

Rose, G. (1985). Sick individuals and sick populations. International Journal of Epidemiology 1985(14), 32–38 427–432).



Source: P.S.F. Yip. (2005)

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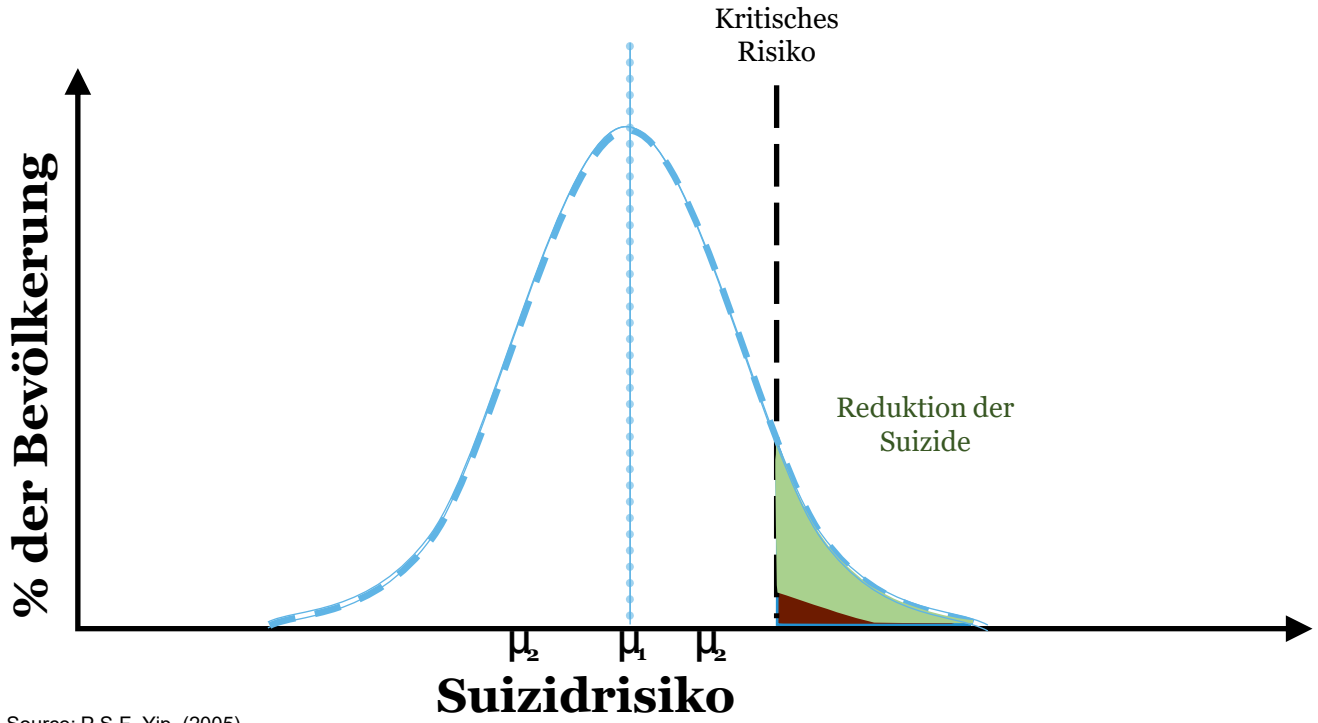

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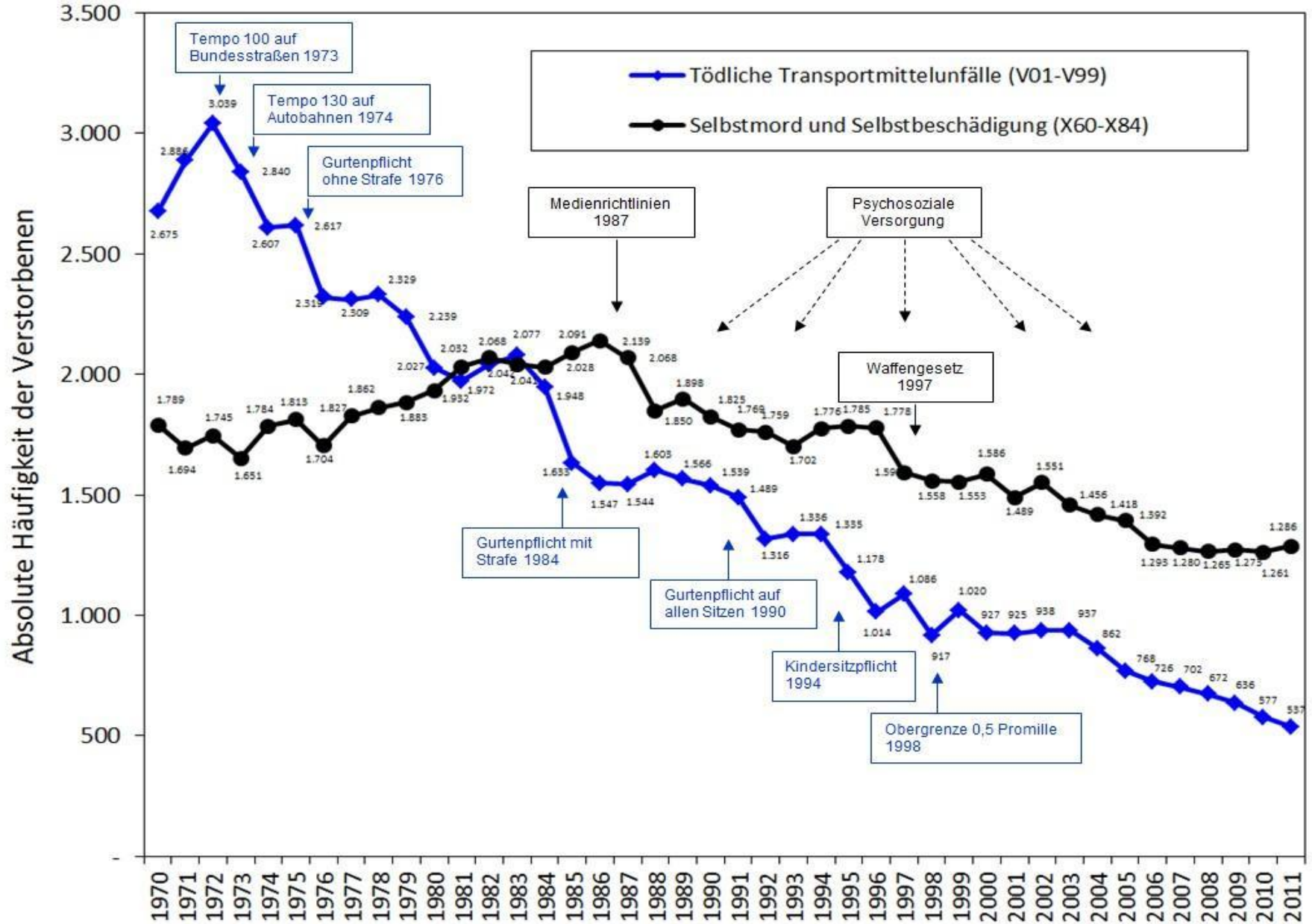
Partnerships for Life:
Österreich als Hub für europäische Suizidprävention


Absolute Häufigkeit der Verstorbenen
3.500
3.000
2.500
2.000
1.500
1.000
500
-
Tödliche Transportmittelunfälle (V01-V99)
Selbstmord und Selbstbeschädigung (X60-X84)
Tempo 100 auf Bundesstraßen 1973
Tempo 130 auf Autobahnen 1974
Gurtenpflicht ohne Strafe 1976
Medienrichtlinien 1987
Psychosoziale Versorgung
Waffengesetz 1997
Gurtenpflicht mit Strafe 1984
Gurtenpflicht auf allen Sitzen 1990
Kindersitzpflicht 1994
Obergrenze 0,5 Promille 1998
1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011

Erstfassung (1774)

{VORREDE}

Was ich von der Geschichte des armen Werthers nur habe auffinden können, habe ich mit Fleiß gesammlet, und leg es euch hier vor, und weis, daß ihr mir's danken werdet. Ihr könnt seinem Geist und seinem Charakter eure Bewunderung und Liebe, und seinem Schicksaale eure Thränen nicht versagen.

Und du gute Seele, die du eben den Drang fühlst wie er, schöpfe Trost aus seinem Leiden, und laß das Büchlein deinen Freund seyn, wenn du aus Geschick oder eigner Schuld keinen nähern finden kannst.

{In der zweiten Auflage der 'Werther'-Erstfassung - 1775 bei Weygand - fügte Goethe auf dem Titelblatt des ersten und zweiten Buches je eine vierzeilige Strophe hinzu, die er in der Endfassung wieder wegließ:}

Zueignung

Jeder Jüngling sehnt sich so zu lieben,
Jedes Mädgen so geliebt zu seyn,
Ach, der heiligste von unsern Trieben,
Warum quillt aus ihm die grimme Pein?

Du beweinst, du liebst ihn, liebe Seele,
Rettest sein Gedächtniss von der Schmach;
Sieh, dir winkt sein Geist aus seiner Höhle:
Sei ein Mann und folge mir nicht nach.

Niederkrotenthaler T, Herberth A, Sonneck G. The Werther-effect: Legende oder Realität? Neuropsychiatrie. 2007;21:284--290.