OPINION

'SUICIDE IS PREVENTABLE': AN UNSAFE CLAUSE

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Abstract

Objective: **To examine and determine the possible meaning/s and scientific basis of the clause "Suicide is preventable"** ***Methods:*** **We examined and compared a wide range of scientific literature, newspaper reports and electronic media publications.** ***Results:*** **When made without a statement of clarification, the meaning and scientific basis of this clause cannot be substantiated.** ***Conclusions:*** **When made without a statement of clarification, the clause "Suicide is preventable" has no meaning or scientific basis. It gives families, health professionals and the community wrong information and unrealistic expectations, and can lead to unjustified blaming of people who are attempting to help. Its continued use (in the absence of a clear statement of clarification) is discouraged.** ***ASEAN Journal of Psychiatry, Vol. 17 (1): January – June 2016: XX XX.***

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"Whatever words we utter should be chosen with care for people will hear them and be influenced by them for good or ill."
- Buddha

The "Suicide is preventable" (or similar) clause is promulgated on the websites of prominent authorities, including the World Health Organization, the National Institute of Mental Health, and the American Psychological Association. In the UK, it appears as a headline on a Liberal Democrat website, and in Australia it was in the title of a submission to a Senate inquiry into suicide. Not surprisingly, it has become the catch-cry of regional, state and national suicide prevention organizations.

The current authors contend this clause threatens harms. First, poor-quality information/knowledge threatens the general well-being of a community. Suicide and related matters are poorly understood by the public, and the distribution of misinformation should be avoided. Second, once introduced, this clause takes time and energy to debunk, distracting and delaying high-quality suicide research. Third, the judiciary has to accept this clause as accurate. It sits well with concepts of fault and duty of care, and places clinical and prison workers (who already receive criticism from this quarter) at increased risk (for suicide inevitably occurs) of criticism, and subsequent damage to reputation and mental health. Fourth, the relatives and friends of those who have completed suicide frequently experience 'guilt' at having 'failed' the deceased. 'Survivor guilt' is common among the relatives of suicide completers and should be mitigated rather than exacerbated.

This clause should not be accepted as a simple, harmless expression of good intentions or utopian desire. It has the appeal of positive attitudes, and is too easily accepted as an unexamined "given", becoming a cornerstone of policy and professional standards/performance.

Here we examine the possible meaning/s and scientific basis of this clause, and make comparisons with relevant research findings.

What could/does it mean?

Suggestions

What this clause is supposed to mean is nowhere explained. It could be intended to mean one or more of the following:

1a. Suicide can be eradicated from a state, a country, even the entire world.

2a. The suicide death of the individual who has expressed an intention to suicide in the near future, or of one who is considered by others to be in danger of suicide in the near future, can always be prevented, at least in the short term.

3a. The suicide death of an individual who has indicated an intention to suicide, or who is considered by others to be in danger of suicide death, can be permanently prevented.

Contrary evidence

When these possible meanings are examined against recent research findings, none are sustainable. Counter arguments include (but are by no means limited to):

1b. throughout history, there has never been a geographic region, ethnic, racial or religious group, which has been free of suicide. The factors associated with suicide are not only mental disorder, but a plethora of others so extensive and universal, that neutralizing them all, for every individual, at all times will be impossible [1].

2b. many psychiatric staffs have believed a particular individual to be in danger of suicide and provided all possible care, but in spite of their best efforts, the individual has succeeded in completing suicide. The case of the UK serial murderer Dr Harold Shipman is illustrative. When this man was gaoled and escape was impossible, he made clear that he intended to end his life. He was frequently examined by skilled clinicians and kept in a safe environment, nevertheless, he succeeded. It is not always possible to prevent the suicide of determined individuals, even in the short term.

The same applies to 7 Guantanamo Bay detainees who suicided under close supervision.

3b. It may be possible, in some cases, in the short term, to prevent the death of an individual who is considered to be in danger of suicide, or who has made a suicide attempt. The worlds/lives of some suicidal people have been described as "impossible" and "unliveable" [2].

Ariel Castro was convicted of 937 charges of kidnapping and rape of teenage females, in Ohio. He complained about his custodial conditions and expressed the desired to end his life, in which he soon succeeded. An independent enquiry into his death found, "his suicide was not surprising and perhaps inevitable" [3].

Thus, confidence that suicide can be prevented in the distant future is misplaced.

Possible Scientific Basis?

Suggestions

The scientific basis for making the claim that 'Suicide in preventable' is nowhere explained. However, it is probable that one or more of the following statements is/are believed by those who use the clause:

4a. At least 90% of those who complete suicide suffer a mental disorder.

5a. People who will complete suicide can be identified premorbidly by the use of 'risk factors'.

6a. Available treatments cure or eradicate the symptoms of mental disorders.

7a. Suicide prevention programs are designed to, and are effective in, reducing national suicide rates.

Contrary evidence

While some of these statements were originally based on research, none is sustainable in light of current knowledge.

4b. A recent review found the claim that 90% of suicide is the result of mental disorder to be inaccurate [4]. Flaws were identified in the psychological autopsy method (that used to 'establish' the presence of mental disorder), and attention was drawn to the great differences in national suicide rates and the gender ratios and that these differences cannot be attributed to mental disorder. Also, alternative perspectives to the 'mental disorder is the cause of all suicide' view were presented, taken from the fields of sociology, law/ethics, and philosophy. A recent review of the psychology of suicidal behaviour states that mental disorders "do not account for why people try to kill themselves" [5, p 74].

This contention has been discounted by the World Health Organization [6], and described as a "myth" [1, p 213]. Space limitations prevent the presentation of further material on this point.

5b. While 'risk assessment' remains fashionable, over the last 30 years, high-quality research has argued that risk assessment does not specify those at danger of suicide, or reduce suicide rates [7]. This arises from the facts that the known 'risk factors' are high in sensitivity and low in specificity, and with uncommon events, a large number of false positives are located. Added to this, different risk factor lists are favoured by different professional groups [8] – and discussion continues over which are the important central features [9].

6b. Psychiatric drugs, in general, have only modest efficacy. The antidepressants are perhaps the most relevant in a discussion of suicide. Many have found that the antidepressants are only slightly (if at all) more effective than placebo, and there is no evidence that the use of selective serotonin reuptake inhibitors reduces the suicide rate [10]. ECT, the most powerful treatment for depression, the most frequently cited as the psychiatric disorder causing suicide, brings remission in only 75% of cases [11]. Of course, there are no medical treatments for the thousands of Indian farmers who suicide during droughts – their predicament is not medical, but socioeconomic.

7b. Although designed and implemented with the best of intentions, suicide prevention policies have had no effect on national suicide rates [12]. Examining local initiatives, Gunnel and Frankel [13] found, "No single intervention has been shown in a well conducted randomized controlled trial to reduce suicide". In a very recent examination of two young persons' suicide prevention programs which are well established in North America, Wei et al [14] found one provided inconclusive results, and the other was ineffective. Thus, suicide prevention policies/strategies give no support to the notion/clause under consideration.

Conclusion

"Suicide is preventable" may have begun as an aspirational goal, a statement to inspire greater suicide prevention efforts. As such, it can be accepted, even applauded.

However, it has been uncritically embraced and regularly appearing in the media, as if has meaning. It appears at first glance to be scientifically based. However, as we have shown this clause lacks clear meaning and has no proper scientific basis. Without a clarifying note, stipulating when, why and how, it is nonsense. As a bald statement, "Suicide is preventable" promotes an unjustified belief that suicide is now understood and mastered. Nothing could be further from the truth. Suicide remains a leading cause of death among young people (second only to accident) and a major cause of death of the people of the world, in general.

"Suicide is preventable", stated without qualifications, suggests there is no longer uncertainty (a very comfortable state). With this new confidence comes the expectation that psychiatric and forensic services consumers will no longer know the behaviour known as suicide. And, because "suicide is preventable", should an event ever occur, it will (as it does, to a large extent, now) follow, that a clinical or prison worker has failed in his/her duty to provide proper service to one of their customers. This bright expression of unjustified optimism/confidence is misleading, retarding and damaging.

Suicide is a means of escape from unpleasant, unacceptable circumstances. A painful mental disorder which is untreated or unresponsive to treatment is a predicament which may lead to suicide. However, suicide is a vastly complex issue, and the world is packed with predicaments. Over two millennia ago, Judas hanged himself to end his guilt, very recently Ariel Castro hanged himself to escape his life in jail. Other triggers include drought in India and psychological strains in rural China [15]. Shame triggered the suicide of many unsuccessful Japanese businessmen, and Roh Moo-hyun, the disgraced former President of South Korea. Prevention in cases such as these will be very difficult.

The vastly different suicide rates between different countries (South Korea has about 30 suicides per 100 000 population per year, while the Philippines has around 3) indicate the importance of cultural contributions. The contributions to suicide of culture, poverty, unemployment, disadvantage and discrimination will require economic and political efforts (over generations). The notion that 'Suicide is 100% preventable' (a common variant) depends on the belief that suicide is a simple matter with a simple solution, such as the application of medication or a ready, concerned listener. This is an enthusiastic, but uninformed view.

In the mean time we should discourage the unqualified statement, 'Suicide is preventable' as it does not help those people contemplating suicide, and brings harm to grieving friends and relatives, and hard-working clinicians and prison officers.

References

1. Beattie D, Devitt P. Suicide: a modern Obsession. Dublin: Liberties Press; 2015.

2. Bunford N, Bergner R. Suicide and impossible worlds: an empirical investigation of worlds theory. Crisis 2012;33:335-343.

3. Hayes L, Cohen F. Report of recent high profile inmate suicides with the Ohio Department of Rehabilitation and Correction: Review and Legal Analysis. 22 November 2013. https://www.scribd.com/doc/189080462/Ohio-prison-suicide-report (accessed, 18 October 2015).

4. Pridmore S. Mental disorder and suicide: a faulty connection. Aust N Z J Psychiatry 2015;49,18-20.

5. O'Connor R, Nock M. The psychology of suicidal behaviour. Lancet Psychiatry 2014;1:73-85.

6. World Health Organization. Preventing suicide: A global imperative. Geneva: WHO; 2014.

7. Large M., Ryan C. Suicide risk assessment: myth and reality. Int J Clin Pract 2014;68:679-681.

8. Wang S, Hwang S, Yeon B, Choi K, Oh Y, Lee H, Kweon Y, Lee C, Lee K. Suicide risk assessments: which suicide risk factors psychiatric residents consider significant. Psychiatry Investig 2015;12:324-329.

9. Fisher L, Overholser J, Ridley J, Braden A, Rosoff C. From the outside looking in: sense of belonging, depression and suicide risk. Psychiatry 2015;78:29-41.

10. Safer D, Zito J. Do antidepressants reduce suicide rates? Public Health 2007;121:274-277.

11. Husain MM, Rush AJ, Fink M, Knapp R, Petrides G, Rummans T, Biggs M, et al. Speed of response and remission in major depressive disorder with acute electroconvulsive therapy (ECT): a consortium for research in ECT (CORE) report. J Clinical Psychiatry 2004;65:485–491.

12. De Leo, D., Evans, R. International suicide rates and prevention strategies. Gottingen, Germany: Hogrefe & Huber; 2004.

13. Gunnell D, Frankel S. Prevention of suicide: aspirations and evidence. BMJ 1994;308:1227-1233.

14. Wei Y, Kutcher S, LeBlanc J. Hot idea or hot air: a systematic review of evidence for two widely marketed youth suicide prevention programs and recommendations for Implementation. J Can Acad Child Adolesc Psychaitry 2014;24;5-16.

15. Zhang J, Lu J, Zhao S, Lamis DA, Li N, Kong Y, Jia C, Zhou L, Ma Z. Developing the Psychological Strain Scales (PSS): Reliability, Validity, and Preliminary Hypothesis Tests. Soc Indic Res 2014;115:337-361.

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