

Why suicide eradication is hardly possible.

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Abstract: The case is made that contrary to popular belief, suicide is not almost always a response to mental disorder. The psychological autopsy method which spawned this belief is considered. Evidence is presented that the external predicament can trigger self-destruction. Recent work which finds risk factors of no use in the prediction of suicide is detailed. Culture have a profound effect on suicide rate. Impulsivity and the ingestion of alcohol add a further to the difficulty of prediction. People experience a vast array of unacceptable external predicaments which cannot be reversed by counselling or medication. Others suffer mental disorders (internal predicaments), and prediction of suicide is not possible. Thus, the eradication of suicide will be difficult. It will be necessary to change the culture of the world, which may not be impossible, but will take some time and more resources than those of Mental Health Services.

Key words: suicide, suicide prevention, public health

INTRODUCTION

The thought that individuals can be so distressed, or find life so unrewarding, that they complete suicide, is painful to observers. Thus calls for suicide prevention strategies are activated. However, in spite of the desirability of preventing suicide (the same applies to volcanic eruptions) currently, there is no effective means of doing so.

Suicide is piece of responsive behaviour - like coughing, which can be triggered by terminal illness, irritating fumes, embarrassment or the desire to be noticed. There is not a single trigger for suicide, thus, with our current level of knowledge and our ability to make social changes, suicide prevention is an aspiration for the future.

Naming the psychological pain

The psychological pain associated with suicide has been labelled 'psychache' (Shneidman, 1993), shame (Lester, 1997), a sense of being a burden to others (Joiner, 2005), misery (Jacob, 2008), and despair (Kizza et al, 2012), among others.

Triggers

It is important to be aware that suicide has been known throughout history, in all geographic regions and among all ethnic and religious groups. Monographs of the highest standard have described the history of suicide from classical times to the recent past (Minois, 1999).

The ancient Greco-Roman texts (Pridmore and Majeed, 2011), old Norse and Finnish folk tales (Pridmore et al, 2011) and medieval Italian satire (Pridmore and Walter, 2013a) lists a range of triggers from loss of a loved one, escape from the clutches of an enemy to disgrace.

Current science respects only massed data, and looks askance at naturalistic, historical observations. But, let us consider some well know examples. Cato the Younger (95-46 BCE) was in armed conflict with Caesar. When his forces were defeated Cato stabbed himself to

death, not out of fear, it is said, but “on a matter of principal”. Judas (d. circa 30 AD) betrayed Jesus for 30 pieces of silver. He then went to the priests in the hope of reversing the deal, but was rebuffed. He hung himself, motivated, it is believed, by shame. Following defeat at the Second World War, many senior military people suicided, including Korechika Anami and Hatazo Adachi (Japan) and Himmler, Goring and Gobbels (Germany). The triggers for these events would have been various, but would include shame, disappointment, and fear of consequences.

More recently, publicly reported suicides include Wolfgang Priklopil (Austria) who placed himself in the path of a train when a teenager he had held prisoner for 8 years escaped and police arrived, Bruce Ivins (USA) a microbiologist who took a fatal dose of medication when he was about to be charged with sending anthrax to various politicians, Roh Moo-hynn a former President of South Korea who jumped from a height when he was about to be charged with having accepted bribes while in office. In the UK Dr David Evans, a biological weapons expert was accused of leaking his reservations about the justification for the first Iraq invasion, he was interviewed on Television and next day died overdose and blood loss from lacerations. Also in the UK, Dr Harold Shipman a GP who was found guilty of killing 250 of his patients and sentenced to 15 life sentences; when there were no further avenues of appeal, hanged himself in his cell.

Our group has developed the notion of ‘Predicament suicide’ for suicide which occurs when the individual without a mental disorder is in unacceptable circumstances from which an alternative escape is not possible (Pridmore, 2009). In a systematic search for triggers we examined the public record which involves not only detailed newspaper accounts, but often, official reports and Coroners’ findings. We identified groups of individuals with no evidence of mental disorder who completed suicide triggered by financial loss (Pridmore and Reddy, 2012), being a publicly exposed paedophile (Walter and Pridmore, 2012), being an unwilling participant in forced marriage (Pridmore and Walter, 2012) and suffering tinnitus (Pridmore et al, 2012), among others. We also examined reports of suicide by couples and found that a large proportion were elderly people without mental disorder, but suffering physical difficulties and concerned about their deteriorating quality of life (Pridmore and Reddy, 2010).

The common man accepts that the triggers such as those listed above underpin much suicide. He/She finds plots in literature (Pridmore and Walter, 2013b) and opera (Pridmore et al, 2013) containing such element to be appropriate and believable.

Psychological autopsies

These studies are applied to extend knowledge of suicide. All the evidence which can be gathered about the thinking and behaviour of the deceased from records and witnesses is collected and considered by researchers and conclusions are reached about the presence or otherwise of pre-morbid mental disorder and other risk factors.

There are many scientific impediments to these retrospective studies. Space does not permit them all to be listed. Selkin and Loya (1979) warned of the difficulty avoiding bias, Biffel (1996) pointed to doubtful validity and reliability, Abondo et al, (2009) observed there were so many different types that one could not be compared to another, and Poulit and De Leo (2006) observed that “the vast majority have used ill-defined instruments. Shahtahmasebi (2013) found psychological autopsies to be “flawed theoretically, methodologically, and

analytically”, and in a most comprehensive study Hjelmeland et al (2012) stated that psychological autopsies “should now be abandoned”.

In spite of these damning criticisms, psychological autopsies continue to be the gold-standard suicide research tool, rejected only by a few suicidology fringe dwellers.

Role of mental disorder in suicide

The most important of the psychological autopsy study findings (which has held fast for half a century) is that 90-100% who complete suicide are responding to a mental disorder. The above evidence indicates that this finding is not credible, and some experts outside suicidology have expressed disbelief (Fitzpatrick and Kerridge, 2013; Shahtahmasebi, 2013; O'Connor and Nock, 2014).

Recent psychological autopsies in China (Phillips, 2010) and India (Manoranjitham et al, 2010) give the rate of mental disorder as less than 50%.

It would be convenient if 90-100% of suicide was due to mental disorder, because there are treatments for mental disorders and by making treatments widely available, suicide could be eradicated. This may bolster perpetuation of the myth.

Risk factors

Another function of psychological autopsies and similar investigations has been to identify risk factors, in the hope that this may make possible the identification of those most likely to die by suicide. Lists of risk factors have been collected over the last century, but because suicide is a rare event and risk factors have high sensitivity and low specificity they have been found to be of no value (Pokorny, 1983; Wand, 2012). Large and Ryan (2014) head-up a team which over a long series of publications have found no use in suicide classification, but they are quick to add that rather than waste time on risk assessments, the psychiatrist should spend time providing patients with the best possible care according to their needs.

They (Large, et al, 2014) have proposed the notion of ‘Nosocomial suicide’. They attribute at least some of the increased suicide rate among psychiatric inpatients, not to mental disorder, but to features of being admitted to a psychiatric ward (loss of autonomy, stigma, being in a frightening place). This is a notion which calls for further examination.

Impulsivity

The World Health Organization (2014) has recently, for the first time, published on suicide prevention. It emphasised there is a need for a multisectorial approach to suicide and the importance of impulsivity. Others (Cheah et al, 2008) have remarked on the unpredictability of impulsive behaviour, and the difficulty of preventing unpredictable behaviour.

State emergencies

State emergencies influence suicide rate. In war time the suicide rate drops, because the people are working together against a common enemy. Rane and Nadkarni (2014) report that in India suicide is “more closely associated with poverty and less associated with mental disorder”. The suicide rate increases during times of economic downturn. Rescuing a state economy may reduce the suicide rate but this may well be offset by an increase diseases of affluence. Toffolutti and Suhrcke (2014) studied the Great Recession across EU countries. They reported a 34% increase in suicide rate, but also, a 3.4% decrease in all-cause mortality.

A return to prosperity will likely reduce the suicide rate, but what this will mean for all-cause mortality is not clear.

Culture

The impact of culture on suicide rate is well established, but receives little attention. Different countries have different suicide rates. The relative positions of countries on a magnitude scale have remained much the same for as long as records have been collected. It has been argued this is because of differences in collecting and reporting data – but even between English speaking countries, which are well resourced and have similar collection methods, retain the same relative positions with respect to rate.

Lithuania has a suicide rate of 31/100 000 pa, which is three times the rate in Australia (10) which in turn is three time the rate in Greece (3.4).

These differences can be attributed to culture (the norms and values shared by a group of people living in a defined space) which includes customs (widely accepted ways of behaving). Customs are responses to circumstances and include suicide.

CONCLUSION

The desire to eradicate suicide is commendable but impractical. A number of names have been given to the psychological pain associated with suicide, including misery. Suicide is a means of escape from such pain (Pridmore, 2009). It has been claimed that this pain is always the result of mental disorder. The current author is strongly opposed to this notion. The World Health Organization (2014) states, “There is no single explanation of why people die by suicide”. Psychological autopsy is the method which led to the claim of ubiquitous mental disorder. In this paper the scientific basis of psychological autopsy has been discredited.

We have provided an extensive list of triggers, but more than one stressor may impact on the individual at the same time.

Also contrary to current wisdom, because suicide is a rare event and risk factors are of high sensitivity and low specificity, they are of no value in identifying individuals who will complete suicide.

Suicide cannot be eradicated at the present time because a large number of any society is experiencing psychological pain due to external predicament or mental disorder at any point of time. It is often impossible to identify those who will take their lives – in the real world friends and relatives of decedents inform there were absolutely no warning signs. Mental Health Services are recommended for cases of distress. But a recently bereaved spouse expects to experience distress, is facing a very real loss and may not accept counselling or medication. In spite of excellence a Mental Health Service cannot replace a lost fortune, restore a tarnished reputation or release and inmate from jail.

Impulsivity is a further complication, it is known from serious suicide attempts that the individual may consider their deadly behaviour for less than 10 minutes before taking action. Impulsivity is often associated with alcohol ingestion which further increases the chance of reckless behaviour. Impulsivity and alcohol ingestion greatly increase the difficulty of preventing suicide.

Custom is what the members of a particular culture do (prescribed ways of behaving) when faced with particular circumstances. While the Lithuanian is more likely to complete suicide than the Greek, no culture has ever been free of suicide. To eradicate suicide it will be necessary to alter culture. While this is not impossible (Fiji is no longer known as The Cannibal Islands) it will take a concerted effort over a long time and will involve more than the Mental Health Services.

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