

## Govus, Daniel

---

**From:** Cutts, David <David.Cutts@health.wa.gov.au>  
**Sent:** Monday, 9 February 2015 2:47 PM  
**To:** Govus, Daniel  
**Cc:** Keegan, Frances  
**Subject:** Re: EHSC FIFO trip to Karratha

Hi Again

Just following up on Mr Jacob's request for info on how many FIFO workers we see.

Dear Mr Jacobs

I'm emailing in response for your request for me to summarise, in writing, my comments regarding the low number of contacts our service has with FIFO workers. Please note that the numbers following are crude estimates only. We have no capacity to capture precise numbers using our clinical database.

I attend most of our Hedland/Inland team's daily intake meetings and keep rough notes. I am able to find the word "FIFO" in relation to only 4 individuals (all men) over the last 8 months. Allowing for missed meetings and assuming numbers have been roughly constant over the whole period, I estimate only about 8 – 10 FIFO workers were referred. If the rates in Karratha were similar (and I can't say they are but have been advised that the numbers are "low"), there may have been a total of 15 – 20 FIFO workers referred across the whole of the Pilbara in 12 months.

Of the 4 I refer to in my notes:

- 3 were seen in the context of suicidality - one after an overdose and two with suicidal ideation. The man who overdosed was quickly transferred to Perth for specialist mental health follow up and where his social supports/home are.
- 1 had a history of schizophrenia which was very well controlled. His principal MH care was delivered by a community mental health service in Perth but he required an occasional contact with our team so he could have his monthly depot antipsychotic injection.

With kind regards

Dr Dave Cutts  
Consultant Psychiatrist  
PMHDS  
NRCHS

---

**From:** Cutts, David  
**Sent:** Friday, 6 February 2015 10:55 AM  
**To:** [dgovus@parliament.wa.gov.au](mailto:dgovus@parliament.wa.gov.au)  
**Subject:** Re: Requested Articles

Hi again

Attached are two further articles. Neither of them as succinct and plain language as the editorial I sent yesterday.

The Pridmore article is perhaps at the extreme end of the spectrum of views... though I agree with the basic thrust of most of his arguments.

The other article takes a more balanced view of things... ie that suicide is multifactorial and, though addressing mental illness is important in suicide prevention, it's only one of a range of strategies.

There are a range of other articles on related issues in that same edition of the journal.

# Australian and New Zealand Journal of Psychiatry

<http://anp.sagepub.com/>

---

## **Problems with Suicide Risk Assessment**

Roger Mulder

*Aust N Z J Psychiatry* 2011 45: 605

DOI: 10.3109/00048674.2011.594786

The online version of this article can be found at:

<http://anp.sagepub.com/content/45/8/605>

---

Published by:



<http://www.sagepublications.com>

On behalf of:



[The Royal Australian and New Zealand College of Psychiatrists](http://www.ranzcp.org)

**Additional services and information for *Australian and New Zealand Journal of Psychiatry* can be found at:**

**Email Alerts:** <http://anp.sagepub.com/cgi/alerts>

**Subscriptions:** <http://anp.sagepub.com/subscriptions>

**Reprints:** <http://www.sagepub.com/journalsReprints.nav>

**Permissions:** <http://www.sagepub.com/journalsPermissions.nav>

>> [Version of Record](#) - Aug 1, 2011

[What is This?](#)

# Problems with suicide risk assessment

Roger Mulder

---

**Australian and New Zealand Journal of Psychiatry 2011; 45:605–607**

DOI:10.3109/00048674.2011.594786

There are a number of myths surrounding suicide risk assessment. The first is that certain risk factors can predict the likelihood of suicide in individual patients. The second is that people in high risk groups are likely to die by suicide. The third is that focusing resources on these high risk groups reduces the number of suicides. The fourth is that addressing and treating risk factors will result in a lower suicide rate.

These myths have led to the assumption that suicide could be reduced if increased risk assessments were more rigorously applied and appropriate treatment initiated. This assumption has led to expectations that clinicians routinely perform risk assessments on all patients. Such expectations have led patients, their relatives, their advocates and the coronial services to the belief that suicide is frequently the result of inadequate risk assessments within mental health services.

Large *et al.*'s paper [1] challenges these myths and expectations. They select a group of individuals with relatively high risk of suicide; patients discharged from a psychiatric hospital. They then perform a meta-analysis of controlled studies of suicide within a year of discharge. Their results are clear and emphatic. With regard to the myth that risk factors can predict the risk of suicide in individual patients they report 'No factor, or combination of factors, was strongly associated with suicide in the year after discharge.' This result is consistent with every study that has examined predictive risk factors in suicide. Beautrais [2] for example, after following up a cohort of individuals who had made a serious suicide attempt reported that only a very limited prediction of suicide was possible.

The second myth that people in high risk groups are likely to die by suicide is also refuted. Large *et al.* [1]

report that 97% of their high risk sample did not commit suicide. Again this is consistent with all similar research. Harriss *et al.* [3] examined a population of individuals who had overdosed and reported that they had a 97% overall survival rate. Even those with the three most important risk factors (alcohol, separated/widowed/divorced, age 55 plus) had a 95% survival rate. High risk groups are very unlikely to die by suicide and only slightly more likely to do so than low risk groups.

The third myth is that focusing on high risk groups reduces the number of suicides. It might do but not by very much. The problem, as Large *et al.* elegantly demonstrate, is that the majority of suicides occur in low risk groups. This finding arises because although low risk groups contain individuals at lower risk, they also contain many more members than high risk groups. While Large *et al.* report 60% of suicides are in the low risk group this figure is even higher in non-selected samples. According to the National Confidential Inquiry into Suicide and Homicide in People with Mental Illness, 86% of suicides are in the low risk groups [4,5]. This implies that even if we could accurately predict all high risk patients and had effective treatments to prevent them all committing suicide we would only reduce the suicide rate by 14%.

This leads on to the fourth myth, that treatment of risk factors has an impact on survival. Very few psychiatric interventions have been shown to reduce the incidence of suicide; perhaps clozapine in schizophrenia, lithium in bipolar disorder and possibly structured psychotherapies in borderline personality disorder [5]. Large *et al.* report that patients in receipt of less psychiatric follow up were less likely to commit suicide. While, as they point out, a plausible reason is that patients provided with more follow up were, as a group, more likely to commit suicide, the finding is hardly reassuring. More disturbingly, Kessler *et al.* [6] compared two general population cohorts for suicidal behaviours. They reported that despite a dramatic increase in treatment, no significant decrease

---

Roger Mulder, Professor and Head of Department

Department of Psychological Medicine, University of Otago, Christchurch, PO Box 4345, Christchurch Mail Centre Christchurch 8140, New Zealand. Email: roger.mulder@otago.ac.nz

occurred in suicidal thoughts, plans, gestures or attempts in the USA during the 1990s. A recent systematic review in young people reported no differences between treatment and control groups in reducing suicide risk except for one small study [7].

It seems sensible to conclude, as indeed Large *et al.* [1] do, that risk categorization is of very limited value in predicting which patients will commit suicide after discharge. It is worth emphasizing that no study has prospectively examined suicide among patients already categorized as high or low risk. As the authors point out a prospective high risk model is likely to perform even more poorly than the results from their meta-analysis, since different risk factors were significant in different studies.

However, Large *et al.* [1] go further, pointing out that preoccupation with risk assessment may be more than a waste of time: it may do harm. They note that 'erroneous beliefs about which patient characteristics are associated with post-discharge suicide could lead to needlessly more restrictive treatment for some patients wrongly labelled "high risk" and the misallocation of health care resources away from patients wrongly labelled "low risk".'

The 'risks of risk assessment', as Undrill [5] titled a recent article are only beginning to be discussed among clinicians. Three of the authors of the Large *et al.* paper wrote a recent article in *Australasian Psychiatry* outlining why clinical decisions in psychiatry should not be based on risk assessment [8]. They argue that risk assessments, particularly for rare and serious events, have little predictive value and are likely to expose some patients to adverse consequences. They suggest using capacity in preference to risk categorization as a base for involuntary treatment.

Undrill [5] goes further, positing that risk assessment is often an organizational attempt to tame anxiety rather than to improve patient care. He distinguishes primary and secondary risks arguing that the latter is clinicians becoming increasingly preoccupied with managing their own risk rather than the patient's risk. Patients may therefore be detained not for treatment needs but because not detaining them produces intolerable anxiety in the staff involved in the assessment. The influence of secondary risk management may have a corrosive effect on the doctor-patient relationship. Doctors construct patients as a source of threat to their professional standing and may not always act in their patients' interests [5].

Therefore our current preoccupation with risk assessment has the potential to harm patients, clinicians and the organizations in which they work. It has created a mythology with no evidence to support it, a

sense of unease among clinicians and a culture of blame when things go wrong. What can be done to change this?

First, we need to acknowledge the uncertainty of our knowledge base and that risk assessment is problematic and may carry its own risk. We need to re-educate the public that we are poor at predicting rare events like suicide and that mental illness models are neither necessary nor sufficient to explain suicidal behaviour.

Second, the best way to manage organizational risks is to improve core tasks of patient care. Risk should primarily, but not exclusively, be seen in terms of risk faced by the patient. The psychiatric interventions associated with reducing the risk of suicide such as clozapine, lithium and structured cognitive behaviour therapy are given because they are effective treatments, not for the purpose of reducing risk.

Third, organizations should take steps to protect their staff from the necessity of secondary risk management. Risk assessments should be used where appropriate and be a consensual process with the patient and clinician striving towards a realistic conceptualization of the risk then deciding how best to manage it. Detailed and complex risk assessments should be curtailed since they may amplify rather than reduce anxiety [5]. Accumulating more and more risk information of marginal utility is of little value in helping patients. Risk assessments of suicide are vulnerable professional decisions in the face of uncertainty. What is certain is that we will make both false negative and false positive judgements. While risk assessments are here to stay they should not form the basis of clinical decision making. The aim is to provide optimal care according to the psychiatric needs of each patient, regardless of the perceived risk of suicidal behaviours.

In summary, the current preoccupation with risk assessment is at variance with the evidence that such assessments are accurate. Because uncertainty is impossible to eliminate and an adverse outcome may carry hazards, clinicians often carry out risk assessments to minimize their anxiety in a rationally selfish way [5]. This leads to unintended negative consequences for patients, clinicians and health services. The challenge for clinicians is to return risk management to be a part, rather than focus of patient care.

## References

1. Large M, HSharma S, Cannon E, Ryan CE, Neilssen O. Risk factors for suicide within a year of discharge from psychiatric hospitals: A systematic meta-analysis. *Aust N Z J Psychiatry* 2011; 45:619-628.
2. Beautrais AL. Further suicidal behaviour amongst medically serious suicide attempters. *Suicide Life Threat Behav* 2004; 34:1-11.

3. Harriss L, Hawton K, Zahl D. Value of measuring suicidal intent in the assessment of people attending hospital following self-poisoning or self-injury. *Br J Psychiatry* 2005; 186:60–66.
4. Appleby L, Shaw I, Kapur N *et al*. Avoidable deaths: five year report by the national confidential inquiry into suicide and homicide by people with mental illness. In, 2006. University of Manchester. <http://www.medicine.manchester.ac.uk/mentalhealth/research/suicide/prevention/>
5. Undrill G. The risks of risk assessment. *Adv Psychiatr Treat* 2007; 13:291–297.
6. Kessler RC, Berglund P, Borges G, Nock M, Wang PS. Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990–1992 to 2001–2003. *JAMA* 2005; 293: 2487–2495.
7. Robinson J, Hetrick SE, Martin C. Preventing suicide in young people: systematic review. *Aust N Z J Psychiatry* 2011; 45: 3–26.
8. Ryan C, Nielssen O, Paton M, Large M. Clinical decisions in psychiatry should not be based on risk assessment. *Australas Psychiatry* 2010; 18:398–403.

# Suicide is a complex behaviour in which mental disorder usually plays a central role

Camilla Haw<sup>1,2</sup> and Keith Hawton<sup>1</sup>

Australian & New Zealand Journal of Psychiatry  
2015, Vol. 49(1) 13–15  
DOI: 10.1177/0004867414555419

© The Royal Australian and  
New Zealand College of Psychiatrists 2014  
Reprints and permissions:  
sagepub.co.uk/journalsPermissions.nav  
anp.sagepub.com



Pridmore, in his Viewpoint in this issue, asserts that experts in the field of suicidology and public health place undue emphasis on the role of mental disorder in the causation of suicide and that this leads to the majority of suicide prevention funding being spent on measures to improve the detection and treatment of mental disorder (Pridmore, 2015). But is this really so? Insel states that *'the presence of mental illness is a risk factor, but it is not universally present or identified in those who attempt suicide'* (Insel, 2014), a view with which others concur. Regarding funding for suicide prevention, consider the example of the UK where, although some suicide prevention funds have been directed towards reducing risk of suicide in certain high-risk groups, including patients with psychiatric disorders, and improving the detection and treatment of mental disorder in primary care, there has also been investment in other key areas; for example, in reducing access to lethal means, reducing inequalities in certain disadvantaged groups and increasing the availability of psychological therapies.

Systematic reviews have indeed demonstrated that the majority of people who die by suicide or engage in non-fatal self-harm have a mental disorder. The findings of studies examining the prevalence of psychiatric disorders in people dying by suicide in the non-Western world have varied widely, sometimes being lower than those conducted in the West and sometimes being comparable. Interestingly, in a meta-analysis of studies from around the world

of self-harm patients presenting to general hospitals, the reported prevalence of psychiatric disorders in non-Western countries was slightly lower than in the West but still high (71% vs 90%; Hawton et al., 2013b).

Regarding the risk of suicide in specific psychiatric disorders, in a recent meta-review of meta-analyses of suicide risk in mental disorders, particularly high rates of suicide were found in borderline personality disorder, where the risk was estimated at 45 times that of the general population, depression (20-fold risk), bipolar disorder (17-fold risk), opioid use (14-fold risk) and schizophrenia (13-fold risk), as well as in anorexia nervosa (31-fold risk) and alcohol misuse or dependence in females (16-fold risk) (Chesney et al., 2014). It is therefore undeniable that there is a strong association between suicide and psychiatric disorders.

So is it important to identify whether or not patients potentially at suicide risk, including those who have self-harmed, have an underlying psychiatric disorder? A primary aim of all mental health services is to alleviate suffering and enhance recovery. The UK government has adopted the slogan 'No health without mental health' for its strategy to improve well-being and services for people with mental health problems. Identification of specific psychiatric disorders in patients at risk should then lead to targeted evidence-based therapies aimed at preventing suicide and self-harm, as well as improving mental well-being. For example, there is evidence that a specific form of talking therapy, dialectical behavioural therapy, for people with

borderline personality disorder may reduce the frequency of self-harm and the amount of hospitalisation for suicidal ideation when compared with non-behavioural psychotherapy delivered by expert therapists. Regarding the effectiveness of pharmacotherapy in suicide prevention, it was initially thought that clozapine exerted a specific anti-suicidal for people with schizophrenia but in a more recent and large-scale study several other second-generation antipsychotics were found to exert a similar effect in reducing suicides compared to controls (odds ratio (OR), 0.29; 95% confidence intervals (CIs), 0.09, 0.97) (Reutfors et al., 2013). The use of lithium to reduce suicide in bipolar disorder now has a reasonably strong evidence-base. However, the potential role of antidepressants in diminishing the risk of suicide and of self-harm in patients with depression is not established. There is evidence, especially in young people, that initiating these drugs may in a few cases precipitate suicidal ideation, although current thinking is that the reaction of regulatory agencies to this finding may have caused more harm than good.

It is obvious that the majority of people with a psychiatric disorder do not engage in suicidal behaviour, so

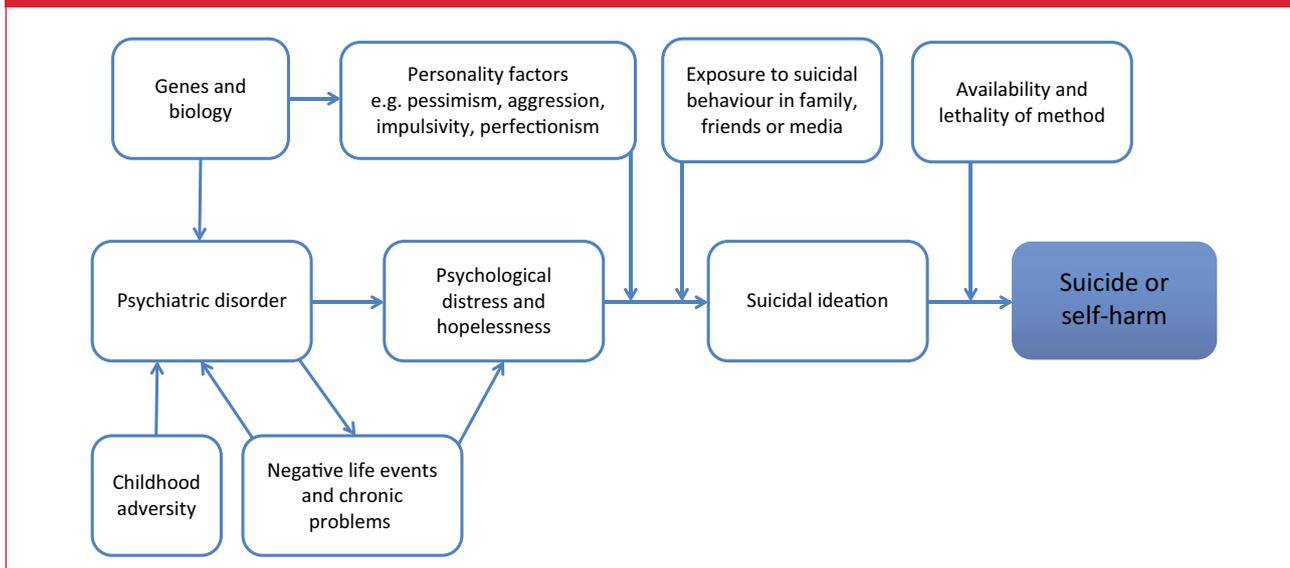
<sup>1</sup>Department of Psychiatry, Centre for Suicide Research, University of Oxford, Oxford, UK

<sup>2</sup>Academic Centre, St Andrew's, Northampton, UK

#### Corresponding author:

Camilla Haw, St Andrew's, Cliftonville, Northampton NNI 5DG, UK.  
Email: chaw@standrew.co.uk

**Figure 1.** Model of the interplay between psychiatric disorder and some of the bio-psycho-social factors leading to suicidal behaviour.



clearly other risk and protective factors are also in operation. A great deal of research in this field has focused upon identifying and understanding the multiple psychological factors, life events and chronic problems that contribute to suicidal behaviour. Pridmore (2015) rightly highlights the variation in suicide rates between countries and genders, but there are many other important social variables. These include age, ethnicity, employment status, childhood abuse and adversity, social disadvantage, occupation, smoking status and exposure to suicidal behaviour, both within the family and in friends and via the media. A further key risk factor is previous self-harm. In a systematic review and meta-analysis of risk factors for suicide in depression, a past history of self-harm was found to be the strongest predictor of subsequent suicide and substantially elevated the risk of subsequent suicide compared with controls (OR, 4.84; 95% CIs, 3.26, 7.20) (Hawton et al., 2013a). It has been suggested that an episode of self-harm brings about neurobiological, emotional and/or cognitive changes in an individual that directly increases his or her risk of further suicidal behaviour in a process known as 'kindling'. A similar

phenomenon of 'differential activation' of suicidal thought across depressive episodes in vulnerable individuals has been described. In older adults, physical illness, bereavement, loneliness and loss of independence are additional important factors.

Pridmore (2015) criticises psychological autopsy methodology and suggests that it is deeply flawed and that this approach should be abandoned. It is certainly true that psychological autopsy studies have some methodological limitations, but the detail, quality and consistency of information collected through interviews with relatives and other informants well acquainted with the deceased, together with details from coroners' and medical records, is substantially greater than in studies limited to examination of coroners' or medical records alone, where the information recorded is often selective and limited. Psychological autopsy studies have done much more than just determine whether or not a person who died by suicide was suffering from a mental disorder. They have provided valuable insights into the role that adverse life events, especially inter-personal difficulties, play in the pathway to suicide and have contributed important information that has assisted in the

development and testing of psychological factors and theories of suicidal behaviour.

The complex interplay of psychiatric disorders and personality factors with some of the more important psychological and social factors in the development of suicidal behaviour is illustrated in Figure 1. Gender is also an important variable, with suicide being more common in males than females in almost all countries. There are several possible explanations for this finding: males are more vulnerable to socio-economic adversity and to having drug and alcohol problems; they also tend to use more highly lethal and violent methods than females. Additionally, genetic and biological contributions to suicide risk are substantial. It is thought that about 50% of the risk of suicide due to diathesis is inherited and that this percentage may be higher in females than males. Environmental factors such as economic downturn are also important, particularly for males, and it is thought that the increased risk of suicide during economic recession is mediated mainly through the associated increases in unemployment, although threats to financial and work stability may be important in those who remain in employment.

In planning suicide prevention policies it is crucial that all these factors are addressed if the potential for prevention is to be maximised. To concentrate solely on psychiatric disorders will clearly be insufficient, but their effective treatment and prevention must be an essential component. It is indisputable, therefore, that this be included in all national suicide prevention strategies.

In summary, the causes of suicidal behaviour are complex. They are also not fully understood. Psychiatric disorders alone do not explain why people chose to end their lives but it is an established fact that in the majority of cases there is an underlying mental disorder and there is evidence this vulnerability interacts with multiple psychological and social factors which

leads some individuals to end their lives or try to do so. To neglect this is to do a disservice to the people whose deaths we are trying to prevent.

### Funding

This research received no specific grant from any funding agency in the public, commercial, and not-for-profit sectors. KH is a National Institute for Health Research Senior Investigator.

### Declaration of interest

KH is a member of the National Suicide Prevention Strategy for England Advisory Group.

### References

Chesney E, Goodwin GM and Fazel Z (2014) Risk of all-cause and suicide mortality in mental

disorders: a meta-review. *World Psychiatry* 13: 153–160.

Hawton K, Casañas Comabella C, Haw C, et al. (2013a) Risk factors for suicide in individuals with depression: a systematic review. *Journal of Affective Disorders* 147: 17–28.

Hawton K, Saunders K, Topiwala A, et al. (2013b) Psychiatric disorders in patients presenting to hospital following self-harm: A systematic review. *Journal of Affective Disorders* 151: 821–830.

Insel T (2014) Director's blog: a new research agenda for suicide prevention. Available at: [www.nimh.nih.gov/about/director/2014/a-new-research-agenda-for-suicide-prevention.shtml](http://www.nimh.nih.gov/about/director/2014/a-new-research-agenda-for-suicide-prevention.shtml) (accessed 23 July 2014).

Pridmore S (2015) Mental disorder and suicide: A faulty connection. *Australian and New Zealand Journal of Psychiatry* 49: 18–20.

Reutfors J, Bahmanyar S, Jönsson EG, et al. (2013) Medication and suicide risk in schizophrenia: a nested case-control study. *Schizophrenia Research* 150: 416–420.

# Mental disorder and suicide: A faulty connection

Saxby Pridmore

Australian & New Zealand Journal of Psychiatry  
2015, Vol. 49(1) 18–20  
DOI: 10.1177/0004867414548904

© The Royal Australian and  
New Zealand College of Psychiatrists 2014  
Reprints and permissions:  
sagepub.co.uk/journalsPermissions.nav  
anp.sagepub.com



Influential figures commonly state that suicide is always or almost always the consequence of mental disorder (Insel, 2013). This has become widely believed, and the majority of funds intended for suicide prevention are directed to medically orientated activities (and the community is comfortable, as all that can be done, is being done).

However, this belief is faulty; while mental disorder contributes to suicide rates, it is not 'the cause'. Should this counter claim be accepted, a broader view of suicide prevention would be necessary, lessening the role of doctors (as they cannot remedy many important factors), and increasing the responsibility of the wider community (the locale of many important factors) (Shahtahmasebi, 2013a).

## The psychological autopsy

This belief that suicide is always or almost always the consequence of mental disorder is based on the findings of psychological autopsy studies. A psychological autopsy is an exploration of the death of an individual by reconstructing what he/she thought, felt, and did before death, based on information gleaned from suicide notes, police, medical and coroner's records, and interviews with families, friends, and others. Scores of psychological autopsies over the last half century and many reviews have concluded that over 90% of those who complete suicide do so in response to mental disorder (or words to that effect).

Evidence indicates that psychological autopsies '*are flawed theoretically, methodologically and analytically*' (Shahtahmasebi, 2013b: 2). Difficulties in remaining objective and unbiased have been identified (Selkin and Loya, 1979). Methodology has not been standardized and consequently one study cannot be compared with another (Abondo et al., 2008). Validity and reliability are faulty (Ogloff and Otto, 1993). The vast majority have used ill-defined instruments, greatly reducing intended scientific value (Pouliot and De Leo, 2006) to the extent that a recent review concluded that psychological autopsies '*should now be abandoned*' (Hjelmeland et al., 2012: 622).

Recent psychological autopsies in China have found mental disorder in less than 50% of suicide completers, while in India mental disorder has been found in less than 40% of completers (Manoranjitham et al., 2010). This substantial difference in findings from the East and West may simply reflect the scientific shortcomings of the psychological autopsy method. However, important social and cultural factors have been identified as suicide triggers in the East, providing '*a challenge to the psychiatric model popular in the West*' (Zhang et al., 2010: 2003).

Another method for identifying factors associated with suicide is the examination of coroners' reports. While this approach lacks the 'sophistication' of psychological autopsies, it has the advantage of close consideration of relevant facts by a responsible

person outside the medical system. These studies generally report a history of mental disorder in less than 50% of cases. A recent thorough examination of records in Malaysia (Ali et al., 2014) found reports of mental disorder in only 22% of cases.

## National rates

National annual suicide rates are surprisingly stable (Insel, 2013), and the relative positions of nations (according to rate magnitude) remain much the same. Lithuania (around 40/100,000) usually has a suicide rate about three times higher than Australia (around 10/100,000), which usually has a rate about three times higher than Greece (around 3/100,000) (Varnik, 2012). For mental disorder to be the paramount factor in suicide, the people of Lithuania would need to have three times the psychopathology of the people of Australia, who would need to have three times the psychopathology of the people of Greece. This is not the case, and the initial premise is incorrect.

The argument might be made that the different suicide rates of different nations simply reflect different recording strategies. While local strategies doubtless play some role,

University of Tasmania, Hobart, Australia

### Corresponding author:

Saxby Pridmore, University of Tasmania,  
Private Bag 27, Hobart, TAS 7001, Australia.  
Email: S.Pridmore@utas.edu.au

counter arguments support the presence of real differences. First, the suicide rate in New Zealand is greater than that of Australia, which, in turn, is greater than that of the UK, and this relative relationship has remained constant over decades, even though these are well-resourced populations with comparable data collection systems and common historical roots. Second, immigrants take the suicide rate of their homeland to new domiciles, as demonstrated by French settling in Quebec, Indians settling in the UK and northern Europeans settling in Australia (Morrell et al., 1999). There are real differences (often substantial) between the suicide rates of different nations; these arise not through differences in the prevalence of psychopathology, but through socioconocultural differences.

### Gender ratio

Also against the primacy of the mental disorders theory is the gender ratio (male:female) of suicide. Globally, for the last five decades, it has been around 3:1. The ratios of individual countries differ somewhat from each other, USA being 3.3:1 and Korea 1.8:1, but everywhere (with the possible exception of parts of China) the male rate is greater than the female. There is no evidence of a significant difference in the overall rate of mental disorder between the genders. Some evidence indicates mood disorder is higher among females than males; if this discrepancy was to have an effect, it would be to push the female rate above the male (but the reverse is the case). The higher rate of suicide among men, worldwide, over decades, cannot be explained by mental disorder; culture and gender roles are responsible for this robust difference.

### Other disciplines

*‘For suicide is not simply a medical “problem”, or even a public health “problem” – it is a complex cultural and moral concern that is deeply embedded in social*

*and historical narratives and is unlikely to be greatly altered by any form of health intervention’* (Fitzpatrick and Kerridge, 2013: 470). These words from ethicists at Sydney University remind us that scholars outside medicine have relevant wisdom to offer. Some such scholars are scathing of the ‘mental disorder is the cause of all suicide’ belief (Weaver, 2014).

Durkheim (1951 [1897]), the first sociologist, conceptualized suicide as a social phenomenon. He proposed that individuals who are insufficiently ‘integrated’ into society are at risk of suicide, being less able to withstand the impact of unwelcome events. Insufficient integration can arise via one of two routes. The first is when society is breaking down (anomy), and no longer prescribing goals, rewards and limits, leaving the individual stranded without a life structure. The second is when society is healthy and functional, but the individual displays ‘excessive individualism’, is aloof or otherwise lacks the capacity to achieve sufficient integration.

Durkheim’s view on the role of mental disorder is often misunderstood. He does *not* completely reject mental disorder a ‘cause’ of suicide; he acknowledges a causal role for insanity (psychosis) in a small number of deaths. Also, in the terminology of the day he states: ‘*The temperament most predisposing man to kill himself is neurasthenia in all its forms*’ (p. 137) (neurasthenia representing mild mood and personality disorder). There is a connection between neurasthenia and insufficient integration. Durkheim argues that neurasthenia is not the cause of suicide, for the majority of those with neurasthenia do not kill themselves. Thus, the non-psychotic disorders predispose (rather than cause) the individual to suicide when ‘aggravation’ is encountered. For current purposes, Durkheim assures us that society is of profound importance, and alerts us to ‘cause’ and ‘predisposition’ being distinct designations.

Durkheim’s (1951 [1897]) theories have been challenged by fellow

sociologists on occasions, but he has strong current support from historians (Healy, 2006), who have taken low social integration to mean social isolation.

Philosophers have examined suicide since Classical Greek times, frequently focusing on the morality of the act. Plato condemned suicide (*Nicomachean Ethics* 1138a5–14), but listed extensive caveats to his embargo (*Laws* IX 854a3–5; 873c–d). Aristotle was not supportive, but nor was he strongly opposed. Socrates and Seneca both completed suicide. In the more recent past, Nietzsche famously wrote (*Beyond Good and Evil*): ‘*The thought of suicide is a great consolation: by means of it one gets through many a dark night*’. This enigmatic statement allows the possibility of suicide in response to difficult times. And, Camus famously wrote (*The Myth of Sisyphus*): ‘*There is but one truly serious philosophical problem, and that is suicide*’. He was introducing his philosophy of the absurd, and recommended that the way to deal with the world is to recognize and embrace life’s absurdity. However, if this formula failed, he considered suicide to be a balanced solution. Contemporary philosophers reject the ‘*uniform assumption that suicide is the causal product of mental illness*’ (Battin, 2005: 173).

### Conclusion

The current fashion of classifying the experiencing of negative emotions as depressive disorder has permeated the psychological autopsy setting (Zonda, 2005). It is probable that, preceding the act, those who complete suicide experience feelings of distress/misery (termed ‘psychache’ by Schneidman in 1993). Many authorities with an interest in suicide from outside of medicine (ethicists, sociologists, historians, philosophers and others), and some from within, contend that distress/misery may end in suicide. The dominant medical view (that at least 90% of suicide is the result of mental disorder) can only be

maintained by the surmise that adverse events lead to distress/misery, which in turn leads to a mental disorder, which then causes the act. But, not all 'depressive symptoms' evolve into depressive disorder, and Occam's razor encourages us to go, at least sometimes, with the least complicated explanation. Credible psychological models, such as the 'Cry of pain / Entrapment' model from Scotland and the 'Strain Theory of Suicide' from China, offer conceptualizations without recourse to the medical model.

Experience with people suffering psychotic depression proves to clinicians that mental disorder can be a sufficient cause of suicide. However, it is not necessary for suicide, as the deaths of Judas, Samson, Cleopatra, Dr Harold Shipman and many aging people in suicide pacts well demonstrate. Through the '90 percent of suicides are related to a mental disorder' message (Insel, 2013), the community has been taught and respectfully learned that mental disorder is necessary for suicide. Consequently, monies (and responsibilities) directed to suicide prevention are spent on medical activities (and any hopes of a comprehensive blueprint are abandoned).

A preferred message is that suicide may be the result of a mental disorder, or a single socioeconomic stressor (such as public disgrace), but more often it is the result of a number of stressors, one of which may be a mental disorder, with other possibilities including unemployment, relationship failure, drug and alcohol use, and painful emotions such as shame,

guilt and sadness. On suicide prevention, Professor John Werry (psychiatry) of Auckland University, New Zealand said, 'the thing that's most likely to have an effect in the long run is social policies which aim to give children, adolescents, and their families a fair break in life' (Weaver, 2014: 230). Suicide prevention needs to repair the faulty connection and develop a new plan, one which includes clinical people, but also a range of non-clinical people, working to improve awareness, practices and options.

### Keywords

Psychological autopsy, suicide, suicide prevention

### Funding

No monies or gratuities in any form were received from any individual or organization in connection with the preparation of this article.

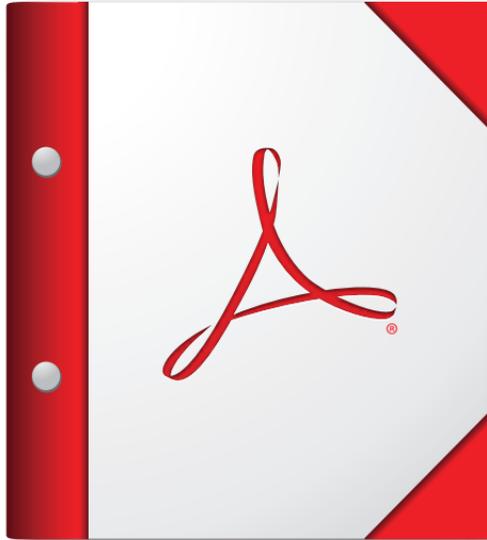
### Declaration of interest

The author reports no conflicts of interest. The author alone is responsible for the content and writing of the paper.

### References

- Abondo M, Masson M, Le Gueut M, et al. (2008) Psychiatric autopsy: its uses and limits in France. *L'Encéphale* 34: 343–346 [In French].
- Ali N, Zainun K, Haniff J, et al. (2014) Pattern of suicides in 2009: data from the National Suicide Registry Malaysia. *Asia Pacific Psychiatry* 6: 217–225.
- Battin M (2005) *Ending Life: Ethics and the Way We Die*. London: Oxford University Press.
- Durkheim E (1951) *Suicide: A Study in Sociology*. New York: Routledge Classics. (First published in French in 1897.)

- Fitzpatrick S and Kerridge I (2013) Challenges to a more open discussion of suicide. *Medical Journal of Australia* 198: 470–471.
- Healy R (2006) Suicide in early modern and modern Europe. *The Historical Journal* 49: 903–919.
- Hjelmeland H, Dieserud G, Knizek B, et al. (2012) Psychological autopsy studies as diagnostic tools: are they methodologically flawed? *Death Studies* 36: 605–626.
- Insel T (2013) Toward a new understanding of mental illness. Filmed January 2013 at TEDxCaltech. Available at: [www.ted.com/talks/thomas\\_insel\\_toward\\_a\\_new\\_understanding\\_of\\_mental\\_illness](http://www.ted.com/talks/thomas_insel_toward_a_new_understanding_of_mental_illness) (accessed 10 May 2014).
- Manoranjitham S, Rajkumar A, Thangadurai P, et al. (2010) Risk factors for suicide in rural south India. *British Journal of Psychiatry* 196: 26–30.
- Morrell S, Taylor R, Slaytor E, et al. (1999) Urban and rural suicide differentials in migrants and the Australian-born, New South Wales, Australia 1985–1994. *Social Science & Medicine* 49: 81–91.
- Ogloff J and Otto R (1993) Psychological autopsy: clinical and legal perspectives. *St Lewis University Law Journal* 37: 607–646.
- Pouliot L and De Leo D (2006) Critical issues in psychological autopsy studies. *Suicide and Life-Threatening Behaviour* 35: 491–510.
- Schneidman E (1993) Suicide as psychache. *The Journal of Nervous and Mental Disease* 181: 145–147.
- Selkin J and Loya F (1979) Issues in the psychological autopsy of a controversial public figure. *Professional Psychology* 19: 87–93.
- Shahtahmasebi S (2013a) De-politicizing youth suicide prevention. *Frontiers in Pediatrics* 1: 8.
- Shahtahmasebi S (2013b) Examining the claim that 80–90% of suicide cases had depression. *Frontiers in Public Health* 1: 62.
- Varnik P (2012) Suicide in the world. *International Journal of Environmental Research and Public Health* 9: 760–771.
- Weaver J (2014) *Sorrows of a Century: Interpreting Suicide in New Zealand, 1900–2000*. Montreal: McGill-Queen's University Press.
- Zhang J, Xiao S and Zhou L (2010) Mental disorders and suicide among young rural Chinese: a case-controlled psychological autopsy study. *American Journal of Psychiatry* 167: 773–781.
- Zonda T (2005) Depression and suicidal behaviour. *Crisis* 26: 34–35.



**For the best experience, open this PDF portfolio in  
Acrobat X or Adobe Reader X, or later.**

[Get Adobe Reader Now!](#)