

Suicide prevention is far more than a psychiatric business

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Since suicide is the worst of all human tragedies, the desire to find solutions inevitably brings us to adopt unrealistic simplifications and unfruitful searches for unifying theories. Not surprisingly, the state of the art of suicide prevention currently shows very few evidence-based results. The most commonly cited reasons for this are inadequate sample sizes for randomised controlled studies, and programs of insufficient duration. Other biases include the use of suicide attempters as research participants (who minimally overlap suicide completers, and imply the hypothesis of a *continuum* between non-fatal and fatal suicidal behaviour), the fact that they are taken from hospital treated/recruited subjects (not truly representative of *all* suicide attempters), difficulties in creating clusters of subjects sharing similar problems, the use of retrospective evaluations, the lack or inadequacy of control groups, the lack of standardised procedures for psychological autopsies (with a large variability in the timeframe for the interview, the type and number of informants and their characteristics), the “over-psychiatrisation” of results obtained through the selective use of psychiatric instruments, etc. On the other hand, very little is known (because poorly investigated) about factors that are likely to protect against suicide, such as coping skills, problem solving capabilities, social support or degree of connectedness. Not to mention the importance of socio-cultural factors, which has finally been acknowledged by the World Health Organization (WHO), which is now promoting a study, the Suicide Prevention - Multi-site Intervention Study on Suicide

(SUPRE-MISS), with centres from five continents. This project includes the comparison of a number of standardised socio-cultural indicators, a randomised clinical intervention on suicide attempters, a study of suicidal ideation and behaviours in the community, and a biological investigation (on DNA and stress-related hormones) (1).

Today, a number of countries have in operation national strategies to prevent suicide. In general, these plans incorporate improved detection and treatment of mental illness as a core feature of the strategy, with a particular emphasis on depression. Reducing access to lethal means, improved reporting of suicide in the media, school-based programs, treatment of drug and alcohol misuse, enhanced access to mental health services, and training for professionals are components of all national suicide prevention programs. An analysis performed by the Australian Institute for Suicide Research and Prevention on four of these programs (Australia, Finland, Norway and Sweden) has demonstrated that so far they had little or no impact on reducing suicide rates among youth and, with the possible exception of Finland (which has terminated its plan), among the general population (2). Apart from the obvious limitations of this kind of study, one of the conceptual criticisms that it originated concerns the tailoring of the programs in a too psychiatrically-oriented way, which would allow affecting only a small segment of the population. On the other hand, despite dramatic improvements in the drug treatment of psychiatric disorders, there has been relatively little change in suicide rates over the last decades. The treatment of schizophrenia with clozapine (3) has provided unconvincing evidence, while the therapy of depressions with selective serotonin reuptake inhibitors has

recently induced a re-focussing of the attention towards the potential capacity of these substances of eliciting suicidal ideation and behaviours, particularly in children and adolescents (4).

Many researchers and policy makers have argued that improved diagnosis and treatment of depression is critical to the prevention of suicide (5). Several studies have noted that the majority of individuals who commit suicide were not receiving treatment for a psychological disorder at the time of the suicide (6), but there are also studies that have demonstrated the presence of an adequate antidepressant therapy at the time of suicide (7). Although antidepressants may be effective in the treatment of depressive symptoms, the current evidence does not suggest that they have an effect in reducing the risk of suicide attempts or completions. Antidepressants do not address the variety of psychosocial factors that are strongly related to suicide and depression. Improvement in psychosocial functioning is independent from and slower than improvement in depressive symptoms (8). Furthermore, individuals with depression show greater improvement in psychosocial functioning when pharmacotherapy is combined with psychotherapy than when pharmacotherapy is used alone. Van Praag (9) has recently suggested that “worrying”, more than depression, represents a precursor of suicide. In my view, shame – which is not a psychiatric construct – may be a threatening killer in many life circumstances, particularly in men. In many cultures, male individuals have to cope with social and environmental expectations that may represent too challenging life experiences, and end in feelings of inadequacy and defeat. In addition, a recent meta-analysis has indicated that if we applied the treatment effectiveness index indicated in the World Health Report 2001 to an average of 50% of people suffering from depression, schizophrenia and alcohol abuse (the psychiatric conditions mostly associated to suicide), this would reduce suicide rates from

a world average of 15.1/100,000 to 12/100,000. This would represent more than 150,000 lives saved; nevertheless it still leaves much to do (10). Suicide is much more than a psychiatric problem. Only a serious cooperation with other disciplines will permit more effective prevention practices.

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