Looking back and ahead. Suicidology and suicide prevention: do we have perspectives?

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The suicide prevention movement started more than half a century ago. Looking back, a great effort has been made to understand what is suicide and how to prevent it. Pioneers have been magnificent. This historical and classic taboo topic has been widely discussed but maybe insufficiently understood (1). Strategies of suicide prevention are regularly implemented and countries have set up national programs. A major impulse has been produced by the World Health Organization (WHO) with the SUicide PREvention (SUPRE) program and its six publications "Resources for preventing suicide" (2).

One could say that, with all those efforts, suicide rates should have diminished greatly. We all know that unfortunately this is not the case. Ringel, founder of the International Association for Suicide Prevention (IASP), wrote: "The aim of suicide prevention is not so much to reduce

the suicide rates (after all we know how unreliable the figures are anyway), but to help people...”(3).

Looking ahead is facing several “topical” issues in a realistic approach. Josè Bertolote writes: “Not always one finds clinicians, suicidologists and public health officers working hand in hand”. It may be, but there are many different situations where suicide is a risk. Besides, too many authors seem to be more scientists than practitioners in suicide prevention. Edwin Shneidman makes the difference by distinguishing “therapeutic suicidologists” from others (4). Up to this point, is there a difference or not between suicidology and suicide prevention?

At this time several issues remain unclear. There is no consensus on the definition of suicide and not even on the different levels of suicide prevention (5). Is suicide only a mental health problem or a public health problem? Probably the combination of the two. If suicide risk has been extremely well documented, very few authors have discussed and insisted on the fact that suicide prevention should start by studying the predictability of suicide and therefore reinforce the notion of protective factors. It may be then that the notion of predictability has been insufficiently explored (5). If it is admitted that a negative environment predicts the suicide risk, very seldom this notion is associated with the necessity of evaluating protective factors.

Hawkes, in a large study of predictability comparing risk factors to protective factors, writes: “The term protective factor is given to those characteristics that tend to protect an individual from following through with dangerous behavior. Therefore, a factor that positively influences an individual and decreases risk for harm is a protective factor”(6).

By all means, we know that risk and protective factors may differ according to the sites, institutions, psychological profile, profession, etc. But it seems that there is a list of common factors that can be examined. It goes from educational programs to community and family bonding, religions, insight capacities, psychological defenses and access to social and health care. However, protective factors will specifically be different in schools, jails and, needless to insist, within the medical system (7). In this brief paper, it is impossible to enumerate them all. This remark has been confirmed by the work of the WHO International Committee on Suicide Prevention and Research and its publications mentioned above.

Danuta Wasserman pointed out clearly: “What makes the difference between life and death however, is not only the presence of risk factors, but also access to protective factors that strengthen the suicidal person’s coping strategies” (8).

The figure 1 included by José Bertolote in his paper is certainly interesting. It corresponds to the proposals of the Task Force of the WPA Section on Preventive Psychiatry, approved by the WPA General Assembly at the 12th World Congress in 2002 (9). This needs some brief explanations: universal means information of the general public; selective refers to treatment of mental disorder and its related risk; indicated means high risk psychological disorder not identified as psychiatric. If this consensus statement is confirmed, it will certainly be important to adapt it to the prevention of suicide, which does not concern only mental disorders but is a matter of respect for the human being and for the value of human life (10).

Last but not least, it is important to decide how far we can go with the prevention of suicide. The dramatic issue of euthanasia, advanced death and the so-called assistance to suicide is now part of discussions during congresses and meetings on suicide prevention, as seen in September 2003 during the 22nd Congress of the IASP in Stockholm.

Therefore, looking ahead leads to several questions. Should we be surprised that the movement of suicide prevention, which started in the early fifties to help people in despair as well as to help society to clearly understand that suicide was not to be considered anymore as only a mental illness, has led now to philosophical and ethical issues such as the right or not to kill oneself for people seeking help not to live better but to die with comfort? Should all this be legalized? What are the perspectives? Have we reached the limits of suicide prevention? Is suicidology progressively reduced to a political issue? Let’s be hopeful, since we have now within the WPA a Section on Suicidology ready to collaborate with other scientific Sections.

References

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