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Editorial

Is suicide prevention possible?

Suicide is not well understood - leading to unrealistic expectations about the prevention of this behaviour. We have failed to examine suicide across history and accept the ubiquity of suicide around the world. We have also failed to properly examine the influence of sociological, cultural and economic factors on self-killing. A major reconsideration is essential.

The belief that suicide was a sinful act was replaced in the early 19th century by the belief that suicide is always a response to a mental disorder (the mental disorder model of suicide). The WHO described this medical explanation as a 'myth'[1], but it persists. In the last decade, the Zero Suicide model has been described holding that appropriate medical/behavioural management will eliminate suicide[2]. There is no credible evidence to support such beliefs, and these cause damage.

In mythical Greece, Aegeus (Athenian) wrongly believed his son had been killed and threw himself in the sea, which was named in his honour. In Classical Greek times, Plato condemned suicide, but listed exceptions such as when the individual had committed inexcusable actions or was experiencing protracted suffering. In ancient Babylon, the lovers Pyramus and Thisbe died by suicide when each mistakenly thought the other had died. The Bible contains some 10 reports of suicide - Judas betrayed Jesus and then killed himself to relieve his guilt[3].

There are multiple recent examples in which mental disorder played no part. In 1780, Kuyili (an army officer in India) applied a flammable agent to her body, set herself alight and leapt into a British armory resulting in the defeat of her enemy. In 1917, during a particularly turbulent period of Russian history, Aleksandr Krymov (a military General) refused the order to send his troops into Saint Petersburg. Rather than stand trial, he shot himself. In 2004, in England, Dr Harold Shipman, a medical practitioner, who had killed at least two hundred of his patients, hanged himself in the Wakefield Prison. He had been convicted of murder and had exhausted the appeal process. He stated he would kill himself if he was not released. In 2018, in India, M. Jaishankar, an infamous Indian rapist and murderer, cut his throat and died in the Bangalore Central Prison. In 2019, in the USA, Jeffrey Epstein, a sex offender, hanged himself in a New York prison. He had been convicted once before and was facing further charges. All these men were in custody - they had been considered at risk of suicide and were under supervision and psychiatric care. That these men were able to kill themselves in spite of the best possible care proves that suicide is not always preventable. Other examples of suicide completed under the tightest security are the half dozen suicides which have been completed at the Guantánamo Bay detention camp[4]. When suicides occur in custody, various authorities who are ignorant of the difficulties of preventing suicide express anger and seek to blame and punish staff. It would be better if authorities gained a better understanding of these difficult events and expressed support rather than blamed the staff.

All these cases described above are on the public record. These are of special interest - the deceased often had high public profiles, and the outcome of their action impacted on others. In the lives of ordinary people, mundane events, broken relationships, bereavement and guilt may play a role. However, often, the effects of these precipitants are not expressed to others. If the cause is unknown, prevention is impossible.

In 1897, the great French sociologist, Durkheim[5] argued that suicide was largely a sociological problem, and that the majority of those who completed suicide

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lacked social and familial connections. He proposed that being part of a religious community was negatively correlated with suicide. To support his claims, he studied the suicide rate of different countries which (naturally) had different cultures (ways of responding to circumstances) - he found that different countries had different suicide rates. It is remarkable that the position of countries ranked according to their rates remains relatively stable[6].

The WHO reported that the suicide rate of Russia and Lithuania was always high (>25/100,000 p.a.) while that of India was moderately high (currently, 16.3). The USA rate (which is currently, 15.3) was higher than Australia (which is currently, 13.2) which was higher than the United Kingdom (which is currently 8.9). Greece, the Philippines and Indonesia always have low rates (currently around 3.2-5)[7].

In the West, for two thousand years, up until the mid-19th century, suicide was illegal. This meant the bodies of the deceased and attempters who survived were punished and their estates were confiscated by the State (so the heirs were also punished)[8]. Then, it was accepted that the suicide was the result of a mental disorder. This made suicide the responsibility of the medical profession, and prevention efforts were focused on the detection and treatment of this mental disorder.

Much suicide is unrelated to mental disorders[9]. Unfortunately, doctors are not good at advising on how to overcome huge cultural, social and political problems or prevent interpersonal problems or bad luck. In 1993, Shneidman[10] stated that suicide was universally underpinned by unbearable psychological pain - which he termed 'psychache'. Such unbearable pain could be caused by either mental disorder or simply by painful life circumstances.

Jacob[11] observed that India had a moderately high suicide rate. He proposed an enlightened approach to suicide prevention. He was critical of 'the medical, psychiatric and other strategies that target individuals' which hope to make a difference through the management of mental illness. Instead, he recommended 'improving general heath' by policies that would improve social justice, support vulnerable sections of society and address gender issues (however, a detailed method was not elucidated). Manoranjitham *et al*[12] studied suicide in India with important results. They compared 100 consecutive suicides and the same number of living controls and found that of those who died, only 37 per cent suffered a mental disorder. This dismantled the belief, inherited from the West, that all suicide was the result of mental disorder. They also found empirical support for the earlier speculative work of Jacob[11] including the frequent centrality of social factors, living alone, relationship problems and chronic pain.

In a systematic review, Rane and Nadkarni[13] warned that Indian estimates of suicide rates must be treated with caution. In comparison with high income countries, they found India had a larger rate of female suicides, and mental illness was less commonly present. Ramamurthy and Thilakan[14] looked at geographical and temporal rate variation across India in the decade 2006-2015. For the whole country, there was no variation in rate over time. However, there was a stable variation from one region to another. Six regions had very high rates (average, 32/100,000) and six had very low rates (average, 1.6/100,000). Of the lower rate regions, two had large Christian populations and another two had large Muslim populations, suggesting that a religious affiliation has a protective function[14].

Around the world, authorities started looking for the best way to prevent suicide before knowing whether the prevention of suicide was actually possible. They did not know whether the prevention of suicide was possible because they did not know what caused/triggered suicide.

Before the West, India found suicide was not always the result of mental disorder[12]. It is known that people with a serious mental disorder complete suicide more often than people without mental disorder suggesting that good treatment is important in suicide prevention (more suicides come from the group without mental disorder, because there are more people in that group). We remain uncertain about the best way to identify people who will commit suicide and how best to help them.

Suicide will not be eradicated in the short-term. Looking for a change in annual suicide rates is a waste of energy and demoralizing. This must be a long-term project.

Different countries have sustained differences in suicide rates - this is due to different cultures - the traditional ways the members of a particular group respond to circumstances.

Religious affiliation is a similar matter. In 1897, Durkheim[5] reported that a religious belief and affiliation

protected against suicide. More than a century later, Ramamurthy and Thilakan[14] made the same observation. It would not be appropriate for authorities to encourage religious participation as a means of protecting against suicide. Much of the benefit of religion is believed to be sense of 'belonging' to a group. Durkheim[5] advised membership of a well-integrated community provides support and common goals and interests. A few would doubt the value of such membership, however, how such communities can be created (and membership achieved) is uncertain. Also of concern is that while the new 'digital age' provides many advantages, it also threatens physical social/community life.

The eradication of suicide (the Zero Suicide Model) is a magnificent objective. It will not be possible in the short term (if ever). In addition to good mental health services, changes which reduce disappointment and disadvantage are required. Some change in culture will be necessary, but the timeline and methodology for such activities remain uncertain. If we are to have zero suicides, in addition to curing all mental disorders, we need to eradicate the causes which lead to suicidal thoughts.

***Conflicts of Interest*:** None.

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