# Editorial

## *Crisis* – Looking Back Down the Road

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In his editorial for the previous issue, Diego De Leo looked at the road ahead for *Crisis*. The change from the old to the new year (as I am writing this editorial) is a time for also looking at what we have achieved in the past year. Looking back now on the road we traveled in 2008, I was pleased to see that *Crisis* published papers from a total of 15 different countries during the year – a range that is appropriate to the journal's status as the scientific publication of the International Association of Suicide Prevention (IASP). The articles spanned a multitude of issues including bereavement after suicide, suicide in indigenous people and in immigrants, increasing rates of presentations to emergency departments for suicide attempts, an account of one community's attempts to interrupt and stall a suicide cluster, social modeling of suicidal behavior, and attitudes toward suicide bombing.

A series of papers focused on suicide attempts.

Increasing rates of suicide-related presentations to emergency departments (EDs) are being reported from many countries, likely reflecting changes in mental health care and health care policies. Larkin, Smith, and Beautrais (2008) reviewed decade trends in US EDs, showing that suicide-related visits to EDs increased 47% from 1992 to 2001 – twice the rate of mental health visits – while there was a reciprocal decrease in admissions for suicide attempts. The consequences of these changes are that the ED has become the default option for suicide-attempt patients and, at least in the United States, the only health care facility mandated to take all patients who present. Increased ED visit rates for suicide attempts and decreased admission rates suggest an increasingly important role for EDs for assessment, screening, and brief interventions for suicidal patients.

Similarities and differences between suicide attempters in the East (exemplified by Uganda) and West (Norway) were found when interview content with attempters was examined to consider attempts as communicative acts (Hjelmeland et al., 2008). While Norwegians separated emotional and regulative behavior of their attempts toward others, Ugandans did not draw this distinction. The authors argue that this finding supports the view that a simple translation of a model of suicidal behavior from an individualistic to a collectivist society is not possible. They suggest that culturally appropriate treatments are needed and warn against the use of treatments derived from Western models in developing countries.

A retrospective record based review of 98 suicide attempt patients who presented to the emergency department of a teaching hospital in Karachi, Pakistan, was conducted to explore costs of treatment (Shahid, Khan, Haqvi, & Razzak, 2008). Costs of treatment are important and high in Pakistan, where patients must meet their own treatment costs, and where suicide is still criminalized and stigmatized. After treatment in the ED, one-third of all patients were subsequently admitted to medical wards, while the majority were discharged or left against medical advice. As might be expected, the prime determinant of cost was length of hospital stay.

A further paper from Pakistan explored the characteristics and patterns of self-harm among 69 young people aged less than 18 admitted to hospital in Karachi, using retrospective review of medical notes (Syed & Khan, 2008). Two-thirds were female, the mean age was 16, the most common method was overdose of benzodiazepines, and family conflicts were reported as the major precipitant. While 98% were Muslim, a religion that strictly prohibits suicide, three out of four stated that they in fact had hoped to die. The authors suggest school-based suicide prevention programs might begin to address adolescent suicide attempt behavior.

Building on previous work from Karachi and using a similar approach of retrospective chart review, Zakiullah et al. (2008) examined the characteristics of 284 people admitted to hospital for self-harm. Females, overdose, and family and marital conflicts predominated – as in Western countries; however, in Karachi almost half of the overdoses



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involved benzodiazepines. The authors conclude that general improvements in mental health care and, specifically, the offer of problem-solving therapy and stress management might address the precipitants of suicide attempts, while restricting ready access to benzodiazepines by regulation might reduce the frequency with which this agent is used in overdose.

Danish investigators examined gender differences in method choice for suicide attempts and in intent in a population referred to a suicide prevention center for a 2-week inpatient treatment program (Nordentoft & Branner, 2008). A total of 351 patients who had made suicide attempts were interviewed: Compared to women, the men who made attempts were older, had higher self-esteem, were less often depressed, and had higher suicide intent scores, but were less likely to use violent methods. Neither use of a violent method nor dangerousness of the attempt reflected intent.

In Tehran, Iran, the most common method of suicide from 2000 to 2004 was hanging, as determined by interrogation of the local mortality database (Razaeian, Mohammadi, Akbari, & Maleki, 2008). Hanging accounted for 86% of suicide deaths. The authors suggest that the high use of hanging might be explained by personal choice of a readily available, culturally sanctioned method; or it might reflect ascertainment bias in which hanging is less likely to be misclassified as accidental or undetermined death. Given the ubiquity of the means of hanging, the authors suggest that the thrust of suicide prevention efforts should rest with minimizing the causal factors of suicide rather than with efforts to restrict access or reduce the acceptability of hanging.

A further series of papers addressed topical concerns in adolescent suicidal ideation and suicide attempts. The relationship between bullying and suicidal behavior has received increased attention in recent years. Young people who are in prison or juvenile detention form a population with multiple risk factors for suicide, and the experience of incarceration itself may further enhance suicide risk. In a survey of 152 randomly selected male offenders aged 16–21 years in the Scottish penal system's largest institution, Kiriakidis (2008) found that rates of reported suicide attempts were higher in this group than in the general population. Those most at risk of suicide were those with a history of residential care, psychologist or social worker care in the community, a family history of suicide attempts or alcohol abuse, being a violent offender, and being bullied in custody. Being bullied while in custody increased risk of suicide attempt almost 10-fold.

Patterns of suicidal ideation and suicide attempts in immigrants differ from place to place. In some countries immigrants may have a lower risk of suicide than the native inhabitants (Malenfant, 2004), while in other circumstances acculturative stress and depression may be associated with increased risks (Hovey, 2000). In The Netherlands, van Bergen and colleagues (van Bergen, Smit, van Balkom, van Ameijden, & Saharso, 2008) compared suicidal ideation in ethnic minority and majority adolescents and found rates of ideation were highest in young Turkish immigrants. Ethnic minority status, migration, and low socioeconomic status did not explain differences in ideation among the ethnic groups. The authors suggest that higher ideation rates in Turkish adolescents are likely explained by additional, elusive individual and family sociocultural factors.

Data about suicide in South America are sparse. Pritchard and Mean (2008) used World Health Organization (WHO) date to compare suicide rates in young people in 13 Latin-American countries with rates in the 10 major developed countries. In all 13 Latin-American countries, rates of undetermined deaths were higher than suicide rates, and in nine countries rates of undetermined deaths among young males exceeded suicide rates. The authors suggest that undetermined deaths may conceal suicides, with cultural attitudes both contributing toward concealment and hindering prevention efforts.

Attitudes toward suicide were also explored in several papers published in 2008.

One example was a study comparing attitudes among psychology students in Ghana, Uganda, and Norway (Hjelmeland et al., 2008). African students had more experience of suicide and were more willing to take a stand on suicide issues than their Norwegian peers. However, fewer differences emerged overall than were expected. Nevertheless, the authors argue for culturally sensitive research and prevention efforts.

Medical student researchers canvassed attitudes toward suicide bombings in Pakistan, a country which sees 1,000 deaths in a year from such bombings (Kazim et al., 2008). In a cross-sectional survey of 215 people, the students found that belonging to the Sunni Muslim sect and strong observance of religious values predicted support for suicide bombings. Overall, however, most people condemned bombings and believed such behavior was associated with religious fundamentalism. Most people were uncertain as to whether suicide bombers were likely to be psychiatrically ill.

Knowledge and attitudes about suicide and suicide prevention among local politicians are significant in determining choices and funding for suicide prevention initiatives. A qualitative study of county council politicians in five European countries revealed differences in the views of politicians from different countries that were dominated, however, by common deficits in their understanding of both the causes of suicide and the likely best investments for suicide prevention (Knizek et al., 2008).

Attitudes toward suicide were also the focus of a Turkish study comparing views of suicide among four professional groups – general practitioners, police officers, teachers, and medical students (Oncu, Soykan, Ozgurihan, & Sayil, 2008). General practitioners and medical students held more permissive attitudes. General practitioners were less prepared than the other groups to prevent suicide – a finding of concern given evidence for the positive contribution they can make in primary care-based suicide prevention programs.

As a consequence of the efforts of survivor groups and the development of national suicide prevention strategies that have all included an emphasis on providing support for bereaved families, there has been an increased focus on examining the impact of suicide on family members. Cerel and colleagues (Cerel, Jordan, & Duberstein, 2008) review and summarize our knowledge on this topic, identifying the relatively sparse research that has addressed the impact of suicide on family functioning and social networks, and the impact on children and the elderly in particular. Based on this review, the authors develop a research agenda to identify studies on the psychological, physical, social, and health consequences of suicide on children and the elderly, and attitudes toward help-seeking among the bereaved, as prime areas for further research.

Suicide clusters engender fear and concern among health, education, and allied professionals who, usually without prior experience or training, are expected to intervene to interrupt and prevent these events. While general commonsense guidelines developed by the Centers for Disease Control (CDC) have been widely disseminated, there have been relatively few accounts of efforts to intervene and curtail clusters. Hacker, Collins, Gross-Young, Almeida, and Burke (2008) provide an account of how one community in Massachusetts in the United States developed a coalition of health and community partners, with strong mayoral leadership, to address a cluster of suicide and drug overdose deaths. Components of the community response included case-finding efforts that identified common peer groups and drug use linking those who had died, a community trauma response team, developing relationships with the media, focus groups for the bereaved, and prevention training for community groups. Implementation of these activities was followed by a decrease in suicide and overdose deaths.

Another case study focused on one family's experience of multiple suicide deaths and suicide attempts within a relatively short time (Pompili et al., 2008). This case provided an opportunity to discuss ways of giving support to families after suicide deaths. The importance of not underestimating the need to intervene is emphasized.

Clustering of suicides in families raises questions about the relative contributions of heritability and modeling to such behavior. The extent to which social modeling contributes to suicidal behavior in peers was explored using data from four large studies (the WHO/EURO Multicenter Study, The WHO SUPRE-MISS study, the CASE study and the Queensland Suicide register in Australia) by De Leo and Heller (2008). Suicidal behavior among the subjects' social groups increased the overall risk of suicidal behavior, with higher rates of suicidal behavior reported among social than family associates. The authors argue that this source of influence has been underrecognized and suggest the need for suicide prevention efforts to include attempts to contain the dissemination of information about suicidal behaviors.

Yale University holds the Human Relations Area Files (HRAF), a rich database about indigenous peoples. Lester (2008) identifies these files as a potentially rich source of data for studying suicide, suggesting that they might be used to test theories of suicide, to explore the linguistics associated with suicide in different cultures, and to compare suicidal behaviors across cultures. These suggestions are relevant to the concerns expressed in many countries about high rates of suicide in indigenous peoples.

Despite a recent decrease in suicide rates, suicides in China remain a significant public health problem and contribute to at least one-third of all world deaths by suicide. Yip, Liu, and Law (2008) estimate the socioeconomic burden of suicide in China, reporting that rural suicide rates were three times higher than those in urban areas, and that rural women aged 25–39 contributed the largest share of years of life lost. The authors argue that these findings justify a targeted approach to suicide prevention with a specific focus on addressing suicide in rural women.

Specific risk factors for suicide and suicide attempts were explored in several studies.

A psychological autopsy study of 52 adults who had died by suicide scrutinized their last contacts with health care professionals before their deaths (Draper, Snowdon, & Wyder, 2008). Suicide risk was assessed by health care professionals in only a minority of cases, and family members in possession of information about the suicide risk of a relative failed to convey their concerns to health staff proactively and/or and were not consulted by staff.

Rasmussen, O'Connor, and Brodie (2008) explored associations between perfectionism, autobiographical memory, and psychological distress in 40 patients admitted to hospital after a self-harm episode. Perfectionism and overgeneral recall of autobiographical memory predicted suicidal ideation and depression. These findings are interpreted as providing support for the "cry of pain" model of suicidal behavior, wherein feelings of defeat (inability to achieve standards) coupled with feelings of entrapment (inability to generate escape solutions because of overgeneral recall) result in suicide attempts.

The elevated risk of suicidal behavior among individuals exposed to childhood sexual abuse is well recognized. Sfoggia, Pacheco, and Grassi-Oliveira (2008), using the Childhood Trauma Questionnaire (CTQ), showed that severity of childhood maltreatment predicted suicidal behavior in psychiatric inpatients.

The indiscreet dissemination of information about suicide via internet websites has become a source of increasing concern. Baker and Fortune (2008) interviewed young adults who engaged in self-harm and were users of suicide websites. These young people indicated that they viewed suicide websites as sources of empathy and understanding. The authors suggest that these positive views of suicide sites need to be recognized by health care professionals who tend to focus on the risks associated with such sites.

Gender differences in suicide and suicide attempt are striking, but remain an underresearched issue. Hawton and Harriss (Hawton & Harriss, 2008) examined gender differences in self-harm rates across the lifecycle, using a 10-

 

year database involving more than 3,500 patients. The ratio varied across the life cycle: 8 females for each male in 10–14-year-olds; 3.1:1 in 15–19-year-olds; 1.6:1 in 20–24-year-olds; 1.3:1 in 25–49-year-olds, and 0.8:1 in people aged 50 and older. These differences are obscured if the overall gender ratio of 1.5:1 is used. The differences are likely to reflect developmental differences in puberty and adolescence, age-related changes in motivation, and the closer similarities between suicide and attempted suicide with increasing age.

Rock and Hallmayer (2008) examined the seasonal risk of suicide by disaggregating place of birth and place of residence, arguing that these two factors had been confounded in previous studies. Their data showed that despite living in the same place, three birth groups – UK migrants, Australian-born non-Aboriginals, and Australian-born Aboriginals – had different seasonal patterns of self-harm. While Aboriginals had the highest risk of suicide, they showed no seasonal risk of suicide, compared to the seasonal risk of Australian non-Aboriginals and UK migrants, in whom seasonal risk was highest in the spring and summer. For UK migrants the seasonal risk was found for females only. Gender differences are interpreted as suggesting that predisposition to seasonal risk of suicide attempt is established early in life but expressed according to local conditions.

India and parts of the developing world have high rates of suicide and contribute to the world burden of suicide. Jacob (2008) argues that suicide prevention efforts have been inappropriate, focusing on individual psychiatric treatments and restricting access to sites or methods of suicide. He contends that population-based rather than individual-based strategies are needed to reduce population rates of suicide, and suggests that macroeconomic and macrosocial strategies that address gender and social inequities and injustices would be more likely to achieve significant reductions in suicide rates than individual psychiatric and medical treatment.

Australian researchers led by Robinson (Robinson et al., 2008) compared current suicide research efforts with priorities identified by stakeholders. Existing priorities were examined by reviewing grants and published literature, and stakeholders' views were canvassed by questionnaires to 231 individuals associated with suicide prevention. Published literature focused on descriptive etiology, grants funded interventions, and stakeholders also favored interventions with a focus on efforts to prevent both suicide and attempted suicide. The authors combine this information to generate a research agenda to address both stakeholder-identified priorities and gaps in the research literature.

Finally, after this brief journey through the findings published in *Crisis* during the past year, I wish to thank all the members of the Editorial Board and the additional invited reviewers for their willingness to review manuscripts during 2008. Time pressures increasingly impinge on the availability and willingness of researchers to review journal manuscripts, but scientific peer review remains an important and integral part of the research process. The editors rely heavily on the generosity of reviewers and we gratefully acknowledge the contributions made by all the reviewers.

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