Editorial

Seven Steps to Integrating Suicidology

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Tragically, Andrej Marušič died on 1 June 2008. An obituary appears on page 117 of this issue. He wrote this editorial in early 2008, his illness prompting him to reflect on how the field of suicidology needs to become integrated, at various levels and in different ways, in order to make progress in suicide research and prevention.

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To integrate or not to integrate, that is the question – or is it? If we do not integrate now, I believe we will sink in a sea of knowledge about suicide risk factors that are in danger of drowning out the real context of suicidal risk. There are many levels of suicidology, currently subdivided into many separate topics, which need to be integrated.

Step 1

The first and most obvious step required is the integration of *biologically, psychologically*, and *socially* orientated suicidology. We may not wish to admit it, but if we are honest, most of us are tempted to attend only the parallel sessions of suicidology meetings that focus on the aspects of suicidal ideation and behavior that we are familiar with, i.e., brain scientists attend biological sessions while psychodynamically oriented suicidologists attend psychotherapy-related research sessions. While the introductory and conclusive slides of each and every session stress the importance of understanding suicide as a complex phenomenon, inevitably these slides are given a different focus, based on the author's own point of view. Examining, investigating, and presenting only in the context of our own background science does not really help promote an understanding of suicide as a complex phenomenon. In fact, it just serves to reinforce the self-perpetuating ideas and images obtained from a single perspective, rather than an understanding of the multidimensional shape of the real world we all live in. Suicidologists who attend only those sessions that relate to their own specialty need to broaden their horizons if they wish to be taken seriously. Changing the current sessional divisions in suicidology congresses, conferences, and meetings would benefit everyone. The biological, psychological, and social aspects of *every* session dealing with the suicidal process or vulnerability of developing suicidal behavior or any other integrated part of suicidology must be covered. An ideal goal for the not too distant future would be to ensure that everyone attends all accepted presentations. There was an attempt to do at the 11th European Symposium on Suicide and Suicidal Behviour, which had had its own benefits (Marušič, Roskar, Zorko, & Sveticic, 2006).

Step 2

The second step would be the integration of *genetic* and *environmental* aspects of suicide. While this might, on the surface, appear to be just a part of the previous step outlined above, in fact it is not. Contrary to popular belief, not all genetic aspects of suicide are biological in origin, and not every environmental aspect of suicide is necessarily psychosocial in origin. Risk factors historically assumed to be psychosocial in origin, such as marital problems and divorce, are now known to have at least some genetic influence (Kendler et al., 1993), and according to Goldney (2000), our antenatal environment appears to exert its own influence on our biological ability to deal with stressors at a later age. In other words, our biological status at birth also depends on our stressful antenatal environment (as occurred, for example, with the bombardment of Berlin in 1945 during pregnancy). Investigating the potential genetic risk factors for suicidal ideation and behavior while ignoring environmental factors does not lead to any remarkable

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findings in the field of genetic suicidology. While most contemporary geneticists in our field try to include environmental risk factors in their studies, we need to question whether they are sufficiently informed to make such judgments, and whether their knowledge of environmental risk factors suffices. These two questions go hand in hand with the question: "Has a bridge been built between environmental suicidology experts and geneticists?" I doubt it has. Environmental suicidology experts tend to be quite suspicious about the genetics of suicidology and even more suspicious about the future genetic findings geneticists will bring forth. Each set of experts would benefit from sharing their knowledge and doubts with others in order to convey their knowledge and clarify their reservations to the "opposite side." If so, and only then, will a promising paper on gene-environment interaction like the one by Caspi et al. (2003) appear in our field.

Step 3

The third step would be the integration of our knowledge about development of suicidal *risk across the lifespan*. We study suicide risk in youth, suicide risk in adulthood, and suicide risk in the elderly, but do we know enough about the development of suicidal risk from one generation to another or from one age group to another? The development of intrapersonal suicide risk during aging still needs to be thoroughly investigated. Data on longitudinal observation of suicidal risk are dangerously scarce in our field, and this prevents us from understanding suicide risk throughout a person's lifespan. At present, the work by Neeleman, Wessely, and Wadsworth (1998) and Neeleman (2001) are rare attempts to overcome this shortcoming in suicidology.

Step 4

The fourth step would be the integration of suicidology in the *developed world* and suicidology in the *developing world*. We are all aware of the important steps that have been made in this direction by IASP, holding congresses in Asia and Africa and their future plans for South America, bringing together suicidology expertise from the developed and the developing world. However, 4 days every 2 years is not enough for a continuous and productive exchange of knowledge between these two worlds. One way forward would be to establish funds that would allow gifted suicidologists to visit centers of excellence in the developed world. A fund like this already exists in the field of mental health, in psychiatry, in public health, and other disciplines. We need to ask whether we have done enough for IASP to establish a similar fund of its own, to help gather and promote suicidologists to act independently as key people in undeveloped or developing countries all around the world. Another way forward would be for established suicidologists to gather together in locations around the world where suicide rates are increasing. A group of suicidologists, mainly IASP members, recently visited Kosovo to help local experts start a national prevention strategy. "Invite and visit" and "give and receive" are probably the best ways to achieve this step of integration. Finally, suicidologists from the developed world should not disregard high-quality publications from the developing world (e.g., Khan, 2007) as many characteristics of suicidal behavior in the developing world are brought to the developed one with migration.

Step 5

The fifth step of integration is between *suicidology research* and the *prevention of suicide*. What is the point of investigating suicide risk factors and the development of suicidal ideation and behavior if these results are not subsequently used in prevention strategies around the world? The one should not be able to exist without the other. We all know suicide prevention without a sound research base can occur, although it can be very difficult to prevent suicide without evidence-based strategies. Suicidology researchers are asked to conclude their papers with public-health values from the results they have obtained, but they often only do this because they have to. Conferences and congresses that attempt to bring research and practice together are to be commended, but they must go further. Regular meetings between top suicidology researchers and influential policymakers in the field of mental health – specifically suicide prevention – are essential. Suicidologists must be made aware of what is feasible in the real world of suicide prevention. Policymakers must be provided with the most applicable data that is easy to translate into practice. The only bridge between these two groups is at suicidology meetings, which must become common practice if we are to open up a two way channel of information.

Step 6

The sixth step is the integration of *local* and *global* prevention of suicide. We are all aware of the attempts to reduce suicidal rates in isolated samples over a short timespan, some of which prove more effective than others; and how some, but not many, of these samples become extended into regional, perhaps national or even international projects, such as the successful Nuremberg Project, which evolved into the European Alliance Against Depression (EAAD) (Hegerl & Schafer, 2007). All future projects need to be provided with a broader launch and financial sustainability across the whole timespan if they are to be effective and produce positive results. Without such changes there will be no improvement in global suicides rates. In fact, we have

recently been faced with reliable evidence of continued rise in global suicide rates all across the world.

Step 7

The seventh and last step is arguably the toughest to achieve: the integration among all persons involved in suicide prevention – *researchers* whose ambition it is to investigate what lies behind suicide; *field-workers* (clinicians and social workers) whose ambition it is to prevent the loss of life caused by self-aggressive behaviors; *policymakers* whose aim it is to decrease national suicide rates; *relatives and friends* whose simple ambition it is to keep those they love safe; and *survivors* whose strong ambition it is to understand why they have been left behind. This integration has to cope with the pure cognitive aims on the one side (e.g., decreasing national suicide rates and/or understanding behavior of serotonergic system during suicide behavior) and the sincere, emotionally colored behavior on the other (e.g., to be as long as possible with those who attempted or to miss those who completed suicide among their relatives). Who dares integrate them? Perhaps the ingredients for the recipe are outlined above. We all need to meet and exchange our opinions about the aims and strategies of our work. "Out of sight, out of mind" is not the way forward.

Conclusion

In conclusion, integration of suicidology may need more than the proposed seven steps outlined above, which might just be important stop gaps on the evolving journey toward a unified strategy. Suicidologists, and indeed everyone involved in suicide research and suicide prevention, should be keen to merge their knowledge, aims, and strategies, because increasing the speed of suicidology prevention will provide us all with a more satisfying outcome to our work.

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About the author

Andrej Marušič was a suicidologist. At the time of his death he was Head of the Health Research Center at the University of Primorska in Koper in Slovenia. He authored several articles and book chapters that addressed suicidology issues in an innovative way. He was also a clinician, and established an outpatient clinic for resistant suicidal patients in Slovenia. He worked strenuously to address suicide as a public health problem, in collaboration with policy makers in the European Union and in Slovenia. An obituary written by his friend and colleague Dr. Murad Khan is on page 117 of this issue.

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