COMMENTARY

Looking at the facts about suicide

Brendan D. Kelly

COMMENTARY ON… Rational and irrational suicide in Plato and modern psychiatry†

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SUMMARY

Most human actions, including suicide, are motivated by variable mixes of rational and irrational factors. Notwithstanding debates about rational suicide, the vast majority of people who die by suicide suffer deeply beforehand. Those who present to mental health services in suicidal crises do so in search of treatment, care and support. It is a privilege to try to provide it.

DECLARATION OF INTEREST

None.

KEYWORDS

Suicide; mental illness; philosophy; reason; rationality.

Suicide is in decline. Around the world, the age-standardised mortality rate for suicide decreased by one-third between 1990 and 2016, albeit with significant variations between countries (Naghavi 2019). Notwithstanding this global fall in suicide, however, more needs to be done to support people in suicidal crises. Psychiatrists and mental health teams are often involved in treating people with mental illness who have suicidal thoughts or behaviours and who are at high risk of dying by suicide. Between 50 and 70% of consultant psychiatrists, and between 40 and 50% of psychiatric trainees, report experiencing at least one patient suicide (Foley 2007). Patient suicide can have significant personal and professional effects on psychiatrists, including increased stress levels, social withdrawal, disruption to relationships, symptoms of post-traumatic stress disorder and consideration of early retirement.

Against this background, and especially in the context of the loss of life through suicide and the suffering of the bereaved, any article that seeks to better understand suicidal behaviour and offer reasonable and reasoned paths forward is greatly to be welcomed. Dinkelaar's article 'Rational and irrational suicide in Plato and modern psychiatry' revisits the extensively discussed theme of 'rational suicide' from one particular philosophical perspective (Dinkelaar 2020, this issue).

Perhaps the most immediately striking aspect of the article is the author's early statement that it 'aims to demonstrate a potential need [to] mollify the persisting concept of suicide as necessarily irrational, especially among patients with mental illness'. I am aware of no mental health professional who assumes either irrationality or rationality in people who attempt suicide, people who die by suicide or, indeed, anyone else. My experience is that psychiatrists and other mental health professionals have a deep appreciation that any given person's apparent desire to die has a rationality of its own that merits hearing, exploration and understanding in that person's own terms.

Rational/irrational: a false dichotomy

I find these kinds of theoretical discussions about suicide especially interesting when the idea of 'rationality' is treated in a binary fashion, as if a given human action is either rational or irrational, but never, it seems, a mixture of both. As a psychiatrist, I, perhaps inevitably, cannot see the world in such simple, dichotomous terms. Most human actions, including suicide, are based on variable mixes of 'rational' and 'irrational' factors, just as many human actions are performed without clear and committed intentions, but with fluid, often paradoxical mixtures of desire, ambivalence, impulsivity and even, on occasion, pre-emptive regret. In fact, it might not even be possible to split motivations into rational and irrational elements, as both coexist and interact in ways that make it challenging, if not impossible, to consider each separately.

It is scarcely necessary to point out this mix of motivations to anyone who is involved in the day-to-day delivery of mental healthcare, especially in the context of suicide or self-harm. As a result, psychiatry has a deep and nuanced awareness of partial desires to die or 'sub-intended' suicidal acts, such as when a person routinely uses illegal drugs despite knowing that they will most likely kill them some day. This behaviour reflects, at the very least, an ambivalence about living. Although there might be no single moment in which a clear desire to die is formulated, this is still partial or sub-intended suicidal behaviour. Such behaviour

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invariably reflects a complicated combination of 'rational' and 'irrational' factors, variably mixed with emotions, impulsivity and, in many cases, intoxicating chemicals such as alcohol or drugs.

To elucidate these matters further, there is a need for greater exploration of the precise meaning of 'rational' and 'irrational' in this context, strengths and limitations of the rational/irrational approach to this issue in the first place, and the tension between theoretical and practical approaches to suicide.

The enormous number of people who engage in serious self-harm without the intent of dying provide further examples of the ambivalence, complexity and, perhaps, 'irrationality' (if we are to use this concept) that underpin such behaviours. There are many shades of grey in this field and it is regrettable that this realisation goes essentially unacknowledged in much theoretical writing about suicide. Ideas of 'rationality' and 'irrationality' are, on their own, woefully incapable of capturing even a small part of the complexity of these very human processes. As Dinkelaar acknowledges, 'there are many more factors to be taken into account that have not been covered by our discussion of Plato'. Indeed.

Suicide in the real world

Against this background, although Dinkelaar's article is undoubtedly intellectually interesting in its own terms, it needs to be placed in context. It is important that abstract, theoretical or philosophical discussions of suicide are accompanied by key facts about suicide in the real world. For example, there is compelling evidence from multiple studies with varying methodologies that approximately 90% of people who die by suicide suffer from mental illness (Arsenault-Lapierre 2004; Bachmann 2018). That is not to suggest that psychiatrists (or anyone) can predict who will or will not die by suicide, or even that there is necessarily a benefit in labelling all of these people as 'mentally ill', but we must still recognise this very clear evidence that the vast majority of instances of suicide are, as Dinkelaar acknowledges, preceded by extreme human suffering, much of which can be alleviated.

Whether we should call this suffering 'mental illness' or something else may be debatable, but the existence of the suffering itself is not, and nor is the imperative to do all that we can to alleviate it. Many people who are in suicidal crisis recognise this themselves and choose to present to mental health services, often in a state of considerable personal disorganisation and profound distress. Regardless of the rationality or irrationality of such a person's behaviours, they come to us in search of treatment, care and support. It is a privilege to be able to try to provide it.

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