

such as this using well-designed RCTs that will inform clinical practice.

Declaration of interest

G.L. has received payments for lectures from the pharmaceutical industry.

Bell, A. J., Cole, A., Eccleston, D., et al (1993) Lithium neurotoxicity at normal therapeutic levels. *British Journal of Psychiatry*, **162**, 689–692.

G. Lewis Division of Psychiatry, University of Bristol, Cotham House, Cotham Hill, Bristol BS6 6JL, UK

N. Stimpson University of Wales College of Medicine, Cardiff, UK

N. Agrawal Chelsea and Westminster Hospital, London, UK

Getting closer to suicide prevention

We would like to offer a slightly different perspective from De Leo (2002) on the progress of suicide prevention. There is no argument against suicide representing a complex set of variables. The general method of science, however, is to analyse phenomena in order to find the most simple explanation – the principle formulated by William of Occam in the early 14th century. In the medical paradigm, death results from a disease process. Studying people with heart attacks led to the identification of atherosclerosis as the underlying disease process for the vast majority. Treating myocardial infarctions is important. The development of various approaches to prevention and treatment of atherosclerosis has, however, prevented more premature deaths from heart attacks. Why must one conclude that suicide is a more complicated medical problem than myocardial infarction?

A fundamental discovery was made in the late 1950s (Robins *et al*, 1959): the majority of suicides were committed by people with clinical depression. This finding has been replicated over and over again and we believe that many, like us, have concluded that this connection has been replicated enough to be proven. We have also presented evidence that suicides occur infrequently in people with depression taking antidepressant medication (Isacsson *et al*, 1994).

Thus, in spite of the ‘extreme complexity’ of the phenomenon of suicide, a simple and testable hypothesis can be stated: depression is a necessary cause of most suicides. Based on this proposition, it has

been suggested that effective suicide prevention must focus on improving identification and treatment of depression in the population (Isacsson, 2000). When we look at the declining suicide rates over the past decade or so, we see a great deal of support for that theory. Since the introduction of the new generation of antidepressants during the past 10–15 years, the use of antidepressants has increased up to 5-fold. Concurrently, suicide rates have decreased considerably in many Western countries (e.g. Joyce, 2001). It appears to us that we are getting closer to suicide prevention.

We believe that a lack of focus on depression as the basic disease leading to suicide is most likely the reason why the current decline in suicide rates ‘seems reasonably unrelated to the existence of any national plan’.

Declaration of interest

Both authors have delivered lectures at scientific meetings sponsored by pharmaceutical companies.

De Leo, D. (2002) Why are we not getting any closer to preventing suicide? *British Journal of Psychiatry*, **181**, 372–374.

Isacsson, G. (2000) Suicide prevention – a medical breakthrough? *Acta Psychiatrica Scandinavica*, **102**, 113–117.

—, **Bergman, U. & Rich, C. L. (1994)** Antidepressants, depression, and suicide: an analysis of the San Diego Study. *Journal of Affective Disorders*, **32**, 277–286.

Joyce, P. R. (2001) Improvements in the recognition and treatment of depression and decreasing suicide rates. *New Zealand Medical Journal*, **114**, 535–536.

Robins, E., Murphy, G. E., Wilkinson, R. H., et al (1959) Some clinical considerations in the prevention of suicide based on a study of 134 successful suicides. *American Journal of Public Health*, **49**, 888–899.

G. Isacsson Neurotec, Division of Psychiatry, Karolinska Institute, Huddinge University Hospital, S141 86 Stockholm, Sweden

C. L. Rich Department of Psychiatry, University of South Alabama, Mobile, Alabama, USA

Author’s reply: There is little doubt that depression has a major role in suicide, being identifiable in approximately 50% of cases (Andersen *et al*, 2001). For this reason, depression is a target in all the national plans that I am aware of.

The role of depression in suicide has been well known since antiquity (Van Hooff, 2000) and this understanding has been largely responsible for the decline in a punitive attitude towards those exhibiting

suicidal behaviour since the Enlightenment. Consequently, the ‘fundamental discovery’ at the end of the 1950s of the role of affective disorders in suicide was far from revolutionary. It is worth remembering that in the vast majority of cases, fortunately, depression does not culminate in suicide. The relative risk for suicide across the lifespan has been recently revised downwards (see, for example, Bostwick & Pankratz, 2000). In addition, a significant percentage of patients who die by suicide appear to have been adequately treated (25% in the experience of Andersen *et al*, 2001). A World Health Organization (1998) technical report has pointed out that optimal treatment of clinical depression would have little impact on global suicide rates, leaving the field open to speculations around more powerful factors in suicide prevention. In any case, the ‘medical paradigm’ is, in my view, only one of many possible perspectives, and needs to be integrated with other disciplines. Clearly, it is not the different prevalence of depression among countries that helps to explain the enormous diversity in rates of suicide that I mentioned in my editorial. Religious, cultural and social factors play very relevant roles in suicidal behaviour. It is in this light that the World Health Organization has correctly endorsed an ecological model, to help both understand and prevent/intervene in suicidal behaviours.

I am aware that Isacsson and Rich, through their research, strongly support the role of the newer antidepressants in preventing suicide. But others are a bit more hesitant in accepting this hypothesis (see, for example, Van Praag, 2002), and maybe lithium has shown more consistent (and convincing) effects, so far, on suicidal behaviour (Tondo *et al*, 2001).

With regard to the comments about a possible overemphasis on the complexities of suicidal behaviour, I am afraid that the philosopher Albert Camus, if he came back to life, would die again on hearing that!

Andersen, U. A., Andersen, M., Rosholm, J. U., et al (2001) Psychopharmacological treatment and psychiatric morbidity in 390 cases of suicide with special focus on affective disorders. *Acta Psychiatrica Scandinavica*, **104**, 458–465.

Bostwick, J. M. & Pankratz, V. S. (2000) Affective disorders and suicide risk: a re-examination. *American Journal of Psychiatry*, **157**, 1925–1932.

Tondo, L., Ghiani, C. & Albert, M. (2001) Pharmacologic intervention in suicide prevention. *Journal of Clinical Psychiatry*, **62** (suppl), 51–55.