

CORRESPONDENCE

Suicide

TO THE EDITOR: In the review article on suicide by Fazel and Runeson (Jan. 16 issue),¹ the authors mention that placebo-controlled trials of antipsychotic medications “have shown reductions in suicide rates, but these results have been uncertain.” They omitted trials of clozapine from their discussion; clozapine is the only medication that is approved by the Food and Drug Administration for reducing the risk of recurrent suicidal behavior in persons with schizophrenia or schizoaffective disorder. This approval was based on the results of an 18-month, randomized, single-blind (trial staff who rated outcomes were unaware of the group assignments) clinical trial — the International Suicide Prevention Trial (InterSePT). The trial compared clozapine with olanzapine in 980 patients with schizophrenia or schizoaffective disorder who were at high risk for suicidality.² There was significantly less suicidality in the clozapine group than in the olanzapine group (hazard ratio, 0.76; 95% confidence interval, 0.58 to 0.97).

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TO THE EDITOR: In their review article on suicide, Fazel and Runeson state that “mental illnesses are estimated to be present in half of persons who have died by suicide.” Other studies suggest that approximately 90% of persons who have died by suicide have a mental disorder,¹⁻³ including affective disorders and substance-use disorders. In our experience with a project in Brazil on suicide prevention,⁴ we have come to believe that almost all persons who seriously attempt or complete suicide have a mental disorder.

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TO THE EDITOR: Fazel and Runeson have presented a thoughtful and comprehensive review of suicide, but we are concerned about their characterization of increases in suicide rates after the suicide of a celebrity as “small.” In a recent meta-analysis, we found that the reporting of the suicide of a celebrity was followed by a roughly 13% increase in the number of suicides across a population in the subsequent 4 weeks.¹ For example, in the 5 months after Robin Williams died by suicide, there were an estimated 1841 excess suicides in the United States, or 10% more than expected.² An increase of 16% was seen in Canada³ and 11% in Australia⁴ over the same time span.

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THE AUTHORS REPLY: Our review article focused on interventions to prevent the completion of suicide. This meant that some medication trials (such as InterSePT) that reported lower rates of self-harm and suicidal thoughts among patients who received clozapine than among those who received another antipsychotic drug were not directly relevant. The problem with relying on these proxy outcomes is that the risk factors for self-harm and suicidal thoughts are different from those for suicide, and the association of these factors with suicide is weak. In the general population, 0.2% of persons die by suicide within 12 months after expressing suicidal ideation,¹ and 1.6% die within 12 months after an act of self-harm. Moreover, a recent meta-analysis of placebo-controlled trials of clozapine reported no deaths.²

The accuracy of the statement that most persons who die by suicide have underlying mental disorders depends on the definition of mental disorders and the methods used for analysis. We estimated the prevalence of mental illness with the use of data from a meta-analysis of “psychological autopsy” studies (i.e., studies that use information from interviews with family members, relatives, or friends regarding persons who have died by suicide). The prevalence would be higher with the inclusion of substance use and personality disorders. However, these are not considered mental illnesses in most psychiatric taxonomies and reside in a broader category of mental disorders. In addition, diagnostic methods used to estimate the prevalence of mental disorders need to be considered. Psychological autopsy studies have shown that up to 90% of persons in high-income countries (and 60% in low- and middle-income countries) who die by suicide have a mental disorder. These estimates need to be interpreted in the context that, according to the psychological autopsy method, 35% of persons in control populations (i.e., persons who

have died from other causes, or matched living persons) have mental disorders. Despite heterogeneity in diagnostic methods, we think that most research is not consistent with the view that all persons who seriously attempt suicide have an associated mental disorder. A Swedish population-based study showed that 40 to 44% of persons who presented to a hospital with self-harm had no diagnosable mental disorder on admission or in the week before presentation,³ although it should be noted that registry-based studies are conservative in estimating psychiatric illness.

In our summary of risk factors, we investigated the strength of the association of each risk factor with suicide and the quality of evidence. To determine the influence of media on suicide rates, we used data from a 2012 meta-analysis of 10 studies,⁴ most of which were conducted in high-income countries, and estimated that the rate of death by suicide is higher by 0.26 per 100,000 persons in the month after a celebrity suicide. By comparison, a recent population-based study showed that among persons with neuropsychiatric disorders that we categorized as strong risk factors for suicide, the suicide rate was 88 per 100,000 persons in the 3 months after a person's discharge from psychiatric hospitalization.⁵

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Since publication of their article, the authors report no further potential conflict of interest.

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