

Investigating the claim that bipolar increases the risk of suicide

Said Shahtahmasebi, PhD.

The Good Life Research Centre Trust. **Email:** radisolevoo@gmail.com

Key words: suicide; suicide prevention; public health; grassroots; depoliticising

Received: 2/2/2018; **modified:** 26/5/2018; **accepted:** 28/5/2018

Abstract

Psychiatric intervention as a suicide prevention strategy has failed. The biggest problem in psychiatry is poor grasp of statistical concept. For example, the use of the outcome suicide attempt as a predictor of suicide. If an attempt is made then prevention strategy has failed! In order to continue with the same strategy suicide in certain sub-groups (e.g. depression, bipolar, schizophrenia) have been highlighted. However, suicide rates follow a cyclic pattern, but cycles for each subgroup do not begin or end at the same time, or have the same duration, i.e. perpetual observation of rise in suicide numbers in one subgroup coinciding with decrease in other subgroups. The World Health Organisation (WHO) and Centers for Disease Control and Prevention (CDC) have finally declared that suicide is not a mental health problem. Psychiatrists can no longer justify the relevance of intervention to suicide prevention by claiming that only psychiatry can reduce suicide – the evidence is weighed heavily against them. About one-third of all suicide cases who receive psychiatric intervention go on to complete suicide. Let's put an end to sub-categorising and labelling suicidality and help this group to choose life instead of death and thus reduce the suicide rate by one-third almost immediately.

Introduction

In New Zealand, like many other countries, suicide prevention strategy is based on psychiatric intervention. The suicide literature is littered with the claim that mental illness or subgroups such as depression, bipolar, schizophrenia, are the cause of suicide. It is not surprising that globally the focus of suicide prevention strategies has been to tackle depression and mental illness. Despite the wealth of evidence disproving the mental illness link with suicide (CDC, 2018; Hjelmeland *et al.*, 2012; S. Pridmore, 2014; Shahtahmasebi, 2013, 2014; WHO, 2014), governments across the world still place suicide prevention policy under mental health.

This is nowhere more emphasised than in New Zealand. The 2006 suicide prevention strategy (Associate Minister for Health, 2006) allocated \$6 million to mental health services to combat depression, a practice which has continued since; more resources are promised to mental health services when suicide numbers rise (Shahtahmasebi, 2017). It is incomprehensible for the relevant ministers to sign off a prevention strategy that promised to shift the focus from mental illness to more social, economic and environmental issues but in practice diverts resources to mental health services.

Current evidence shows that the mental illness approach to suicide prevention does not work and is basically 'more of the same' policy year after year hardly affecting the increasing suicide trend (e.g. see (Shahtahmasebi, 2018)). Yet, governments/psychiatrists are reluctant

to admit defeat and sternly refuse to change course. The New Zealand government's own documents show that anti-depressant prescriptions had doubled between 1997 and 2005 (Ministry of Health, 2007). And doubled again in the period 2005-12 (Antidepressant use in New Zealand doubles, 2012). Since 1997 suicide in New Zealand followed an upward trend breaking records in 2014/15, and again in 2015/16, and then again in 2016/17; a record number of New Zealanders ending their lives three years in a row, and, each time the government allocated more resources to mental health services to reduce suicide.

The irony is that the latest suicide prevention strategy (Ministry of Health, 2017) is suspiciously a second take on the 2006 version with a shift from depression to 'stress'. In other words, we must now focus on identifying signs of stress and refer people who stressed to mental health services!

But, stress is all around us and is inevitable. The social structure of New Zealand society is such that one cannot escape negative stress, e.g. cases of bullying leading to suicide (https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12061835), chronic high levels of bullying in the legal profession (<https://www.newshub.co.nz/home/shows/2018/03/survey-reveals-shocking-extent-of-harassment-and-bullying-in-nz-legal-profession.html>), (also see (Shahtahmasebi, 2016))

The myths about suicide, e.g. 80-90% of suicides have mental illness, talking about suicide can lead to more suicides, are due to poor research methodology and inappropriate statistical methodology. These myths have been debunked (e.g. see (Hjelmeland et al., 2012; Shahtahmasebi, 2014; WHO, 2014)). Yet, the continued persistence for a medical model to prevent suicide is synonymous with the gambler's syndrome: willingly forgetting past failures whilst hoping that the medical model will be successful next time.

A recent addition to the above list is that people with bipolar have an increased risk of suicide. In this article I attempt to explore this claim.

Methods

It is beyond the scope of this paper to carry out an extensive literature review on bipolar and schizophrenia. For an initial exploration the methodology involved seeking and accessing data on the prevalence of bipolar, schizophrenia and other psychiatric diagnoses. A search of the internet and data centres such as NIMH, Ministry of Health NZ, Centers for Disease Control and Prevention (CDC) proved ineffective. Although, there were articles alluding to estimates of prevalence but data on the incidence and suicide of people with bipolar could not be found. Data on suicide by those diagnosed with schizophrenia from the confidential enquiry into suicide (Shahtahmasebi, 2003) was made available but unfortunately the confidential enquiry did not provide information on prevalence of bipolar or schizophrenia.

At the time of writing there was no data available to perform basic calculations, e.g. proportions of people with bipolar, schizophrenia, anxiety disorder, etc who had completed suicide over time.

In terms of evaluating increased risk, a proportion of suicide in each diagnosis category over time is needed. These are necessary in order to assess any change in the risk of suicide in a category (proportion who suicided) firstly over time, and secondly, to compare with other diagnostic categories.

Results and Discussion

In an earlier paper (Shahtahmasebi, 2003) suicide data from a mental health service provider in the UK was presented enabling a breakdown of data by diagnosis, see Table 1. One-third of this sample had no diagnosis, and the remaining two-thirds can be divided into a number of diagnosis categories. It can be seen that the proportion of suicide cases with schizophrenia is slightly lower than depressive disorders but higher than other diagnoses, and bipolar does not feature. This in itself does not indicate one group having a higher risk than other groups. We need data on the total population for each category.

Table 1. The Sample Distribution of Psychiatric Diagnosis

First Diagnosis	Frequency	Percentage
Depressive illness	8	16.7
Schizophrenia	6	12.5
Personality disorder	3	6.3
Alcoholism	4	8.3
Paranoid illness	2	4.2
Anxiety state	1	2.1
Other	8	16.7
No-diagnosis	1	2.1
Non-recorded	15	31.3
Total	48	100

We do know that estimates of depression in the population were quite high at the time this sample was taken (Blair-West *et al.*, 1997; Wattis, 1995) and rising (<http://www.everybody.co.nz/page-75c9ff3f-7aa4-4b07-b63d-eaf5d92b88bb.aspx>, (Ministry of Health, 2007). This means that the proportion of people with depression who committed suicide is very small. Similarly, number of people with bipolar in the population is estimated to be high. For example, 4.4% of U.S. adults experience bipolar disorder at some time in their lives and an estimated 2.8% of US adults had bipolar disorder in the past year (the National Institute of Mental Health: <https://www.nimh.nih.gov/health/statistics/bipolar-disorder.shtml>). Therefore, the proportion of cases with a bipolar disorder who commit suicide should be very small.

On the other hand there has been an increase in diagnosis of bipolar (Moreno *et al.*, 2007; Parker & Graham, 2017; Sara & Malhi, 2015). In other words, as the population with bipolar disorder grows, population outcomes (in this case suicide) are also expected to grow. However, given the size of the population with bipolar disorder (2.8% of US adults) which is also expanding, the increase in suicides will have very little impact on the suicide risk for this group.

Although, the proportion of suicide cases with bipolar appears very small, we are still none the wiser as to whether people with bipolar have an increased risk of suicide. But it is more likely that the reason why suicide may appear higher in bipolar group is due to the lagging effect in suicide trends (Shahtahmasebi, 2013, 2018). Suicide rates by sub-groups (e.g. those with bipolar, age groups, gender, in violent relationship, with financial problems, unemployed) follow the same cyclic pattern as the overall suicide trend – but not all cycles start and complete at the same time or have the same duration, i.e. some groups' rise may coincide with downturn in some other groups. So when viewed over a short period, the trends may give the impression that one group has responded to the intervention policy whilst other groups haven't. But over a long period these cycles are repeated which renders the assumption of a working intervention useless. Thus, every few years the rise in a particular group (e.g. farmers, students, middle aged) becomes the focus of suicide prevention and media reporting. This artefact of suicide trend has in fact been used as a diversion to maintain the very strong medical modellers' stranglehold on suicide prevention policy.

We must however, remember that there are many psychiatric diagnoses in which a proportion will commit suicide. But, the total number of suicide cases who received psychiatric intervention form only between one-quarter and one-third of all suicides. Therefore, focusing suicide intervention on a selected sub-group with a psychiatric condition or, even on mental illness in order to prevent suicide would hardly have an impact on the total suicide numbers. In other words, intervention *is not* suicide prevention because in order to intervene suicidality must have already occurred!

This brings us to the claim that previous suicide attempts increases the chances of suicide. Statistically, this is complete nonsense not because it is not true – indeed if someone has survived the first attempt they should receive the most appropriate care – but to use an outcome as a predictor of that outcome summarises the mentality of the medical modellers.

When a suicide attempt is made the suicide prevention strategy has failed completely, how can suicide attempt be regarded as a sign of suicidality in order to prevent suicide? This is beyond comprehension – as mentioned above between two-thirds and three-quarters of all suicides successfully complete suicide the *first* time!

Ironically, in the psychiatric intervention process, it is the psychiatrists themselves who ignore their own guidelines and ignore previous suicide attempts in favour of the mental illness diagnosis. In other words, when dealing with a suicide attempt psychiatric intervention seeks to diagnose a mental illness instead of understanding the 'suicide' case, e.g. in the case of an adolescent who attempted suicide seven times, each time the psychiatrist involved dismissed the case's story in favour of an impulsive disorder – and following psychiatric treatment the parents were reassured that it won't happen again – the case completed suicide while away from home in a foreign country and in isolation (Shahtahmasebi & Smith, 2013).

Concluding comments

The biggest problem psychiatry faces is the lack of quality data. Psychiatric data is rarely available without case-control or audit type projects. It is very difficult to audit/evaluate psychiatric services.

It really does not make much difference whether or not the non-medical approach is valid or not, or whether alternative researchers are competent, or whether they are “graduate” statisticians or not – psychiatry cannot hide behind such frivolous reasons for its lack of relevance in suicide prevention. Research to date shows psychiatry has politicised suicide prevention and claims are often made based on personal opinions rather than any valid data. Psychiatric data is not readily accessible making it difficult for psychiatrists to make any claims (e.g. suicide is caused by mental illness, or bi-polar increases the risk of suicide). Interestingly, the World Health Organisation (WHO) has recently described as a myth the claim that all suicide is caused by mental illness (WHO, 2014), and the CDC has finally declared that suicide is not a mental health problem (CDC, 2018), (also see Hjelmeland et al., 2012; Shahtahmasebi, 2014).

Furthermore, psychiatry is irrelevant to suicide prevention as long as it sees prevention as having to wait for mental illness symptoms to develop and then intervene. Research shows that this approach does not work – examples are trends in suicide rates over time, the Canterbury earthquake experience, and 2015, 2016, 2017 record suicide numbers were documented three years in a row. Following the Canterbury earthquake in 2011, zero suicides were recorded. Despite the many warnings that suicide was likely to rise in Canterbury following the earthquakes, instead of suicide prevention - medical modellers and the authorities sat on their hands and waited for symptoms of mental illness to develop before they acted. As a result suicide rose and Canterbury now boasts the highest suicide rate in New Zealand (Shahtahmasebi, 2017).

In short psychiatry’s failure in the field of suicide and suicide prevention is the lack of quality data, an understanding of statistics, statistical concepts and relevant substantive theory.

Given the evidence (Hjelmeland et al., 2012; Hjelmeland & Knisek, 2017; S. Pridmore *et al.*, 2016; W. Pridmore *et al.*, 2018; Shahtahmasebi, 2003, 2005; Shahtahmasebi, 2013, 2014) and more professional organisations declaring that the mental illness-suicide link is a myth (CDC, 2018; WHO, 2014) why do policy makers, and researchers continue to pursue a failed policy based on a presumed relationship? The answer to this question may well lie in politicisation of suicide prevention and vested interests (Hjelmeland & Knisek, 2017) which in turn lead to the gambler’s syndrome.

For a start let’s stop pigeon-holing and sub-categorising suicidality and help the one-third of all suicide cases who seek help and prevent their suicide – thus reducing suicide rate by about one-third immediately.

References

Antidepressant use in New Zealand doubles. (2012). The government's drug-buying agency, pharmac, says it is monitoring the growing use of anti-depressants in new zealand.

<http://www.radionz.co.nz/news/national/117826/pharmac-monitoring-use-of-anti-depressants>.

- Associate Minister for Health. (2006). The new zealand suicide prevention strategy 2006-2016. Wellington: Ministry of Health, <http://www.health.govt.nz/publication/new-zealand-suicide-prevention-strategy-2006-2016>.
- Blair-West, G. W., Mellsoy, G. W., & Eyleson-Annan, M. L. (1997). Down-rating lifetime suicide risk in major depression. *Acta Psychiatr Scand*, 95(3), 259-263.
- CDC. (2018). Suicide rising across USA. *Vital Signs*(June, 2018), <https://www.cdc.gov/vitalsigns/suicide/>.
- Hjelmeland, H., Dieserud, G., Dyregrov, K., Knizek, B. L., & Leenaars, A. A. (2012). Psychological autopsy studies as diagnostic tools: Are they methodologically flawed? *Death Studies*, 36(7), 605-626.
- Hjelmeland, H., & Knisek, B. L. (2017). Suicide and mental disorders: A discourse of politics, power, and vested interests. *Death Studies*, 41, DOI: 10.1080/07481187.07482017.01332905.
- Ministry of Health. (2007). *Patterns of antidepressant drug prescribing and intentional self-harm outcomes in new zealand: An ecological study*. Wellington: Ministry of Health.
- Ministry of Health. (2017). *A strategy to prevent suicide in new zealand: Draft for public consultation*. Wellington: Ministry of Health.
- Moreno, C., Laje, G., Blanco, C., Jiang, H., Schmidt, A. B., & Olfson, M. (2007). National trends in the outpatient diagnosis and treatment of bipolar disorder in youth. *Archives of general psychiatry*, 64(9), 1032-1039.
- Parker, G., & Graham, R. (2017). Trends in the diagnosis of bipolar disorder: Has the story changed? *Australian Psychiatry*, 25(1), 15-17.
- Pridmore, S. (2014). Why suicide eradication is hardly possible. *Dynamics of Human Health (DHH)*, 1(4), http://journalofhealth.co.nz/wp-content/uploads/2014/2012/DHH_Saxby_Eradicating-suicide.pdf.
- Pridmore, S., Varbanov, S., Aleksandrov, I., & Shahtahmasebi, S. (2016). Social attitudes to suicide and suicide rates. *Open Access Journal of Social Sciences (JSS)*, 4(10), 39-58. URL: <http://www.scirp.org/Journal/PaperInformation.aspx?PaperID=71256>.
- Pridmore, W., Shahtahmasebi, S., & Pridmore, S. (2018). Mao zedong and suicide triggered by social predicament. *American Journal of Medical Research*, 5(1), 7-12.
- Sara, G. E., & Malhi, G. S. (2015). Trends in diagnosis of bipolar disorder: Have the boundaries changed? *Australian & New Zealand Journal of Psychiatry*, 49(11), 1021-1028.
- Shahtahmasebi, S. (2003). Suicides by mentally ill people. *ScientificWorldJournal*, 3, 684-693.
- Shahtahmasebi, S. (2005). Suicides in new zealand. *ScientificWorldJournal*, 5, 527-534.
- Shahtahmasebi, S. (2013). De-politicizing youth suicide prevention. *Front. Pediatr*, 1(8), <http://journal.frontiersin.org/article/10.3389/fped.2013.00008/abstract>.
- Shahtahmasebi, S. (2014). Suicide research: Problems with interpreting results. *British Journal of Medicine and Medical Research*, 5(9), 1147-1157.
- Shahtahmasebi, S. (2016). Bullying: A personal or social trait? *Journal of Socialomics*, 5(3), 178.
- Shahtahmasebi, S. (2017). Editorial: Suicide numbers a record high for the third year running. *Dynamics of human health (DHH)*, 4(3), http://journalofhealth.co.nz/?page_id=1160.
- Shahtahmasebi, S. (2018). What does a statistician know about suicide and suicide prevention? *Dynamics of Human Behaviour (DHH)*, 5(1), http://journalofhealth.co.nz/?page_id=1512.

- Shahtahmasebi, S., & Smith, L. (2013). Has the time come for mental health services to give up control? *J Altern Med Res*, 6(1), 9-17.
- Wattis, J. P. (1995). Difficulties in diagnosis of depression in the elderly. *Spectrum International*, XXXV(6-7).
- WHO. (2014). Preventing suicide: A global imperative.
http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/.