

Suicide: a disease or a (flawed) choice?

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Key words: suicide, media, decision, mental illness

Received: 16/1/2019; **Revised:** 29/1/2019; **Accepted:** 30/1/2019

A front-page headline story of the national newspaper of Australia (The Australian, December 19, 2018) told of a 24-year-old celebrity sportsperson who had been side-lined by injury, then argued with a romantic other, then took a sleeping medication and remained ambulant, then took a second sleeping medication and remained ambulant, and then descended from the Bolte Bridge, 25 meters, into the Yarra River. This celebrity was found alive. It was not stated whether this person could swim, but it was stated that the event caused fractures which required surgery.

The newspaper story states that the event is being considered a “suicide attempt”, that this was not the first time the celebrity has “self-harmed”, and that the celebrity has “waged a private battle with mental illness”. One witness stated that sub-groups and the broader community were “confronting mental health issues...with a desperate need for better services”.

It is widely believed that all suicide is the result of mental disorder. This belief adversely distorts our understanding of, and response to, suicidal behaviour.

This wrong belief was built and reinforced by both lay and medical individuals and groups. The lay view is simply, “You’d have to be mad to kill yourself” – a notion which makes perfect sense - to those who are not currently alone and desperately physically and mentally distressed. The professional view that all suicide is the result of mental disorder may have roots in the desire to be of service. However, the widespread acceptance of this repeatedly stated view has led to medical/health professionals in this field receiving authority and extensive taxpayer funding through suicide prevention programs.

Part of the difficulty of correctly grasping the nature of suicide has roots in 1946 when the credulous World Health Organization (WHO) ordained a not-fit-for-purpose definition of “health” as “a state of complete physical, mental and social well-being and not merely the absence of infirmity”. Dictionaries define “well-being” in terms of “health” and a semantic circle is complete.

All other subsequent academic attempts to define “health” and the related terms - “normal” and “mental disorder” (including those by the American Psychiatric Association) - have also failed. Thus, the designation of conditions as healthy or sick (normal or abnormal) can be problematic (Frances, 2013).

But common sense will do. The average person does not need an academic to explain that everyday worries, eccentricity, distress from failed relationships, and disappointment from loss of employment should not be classed as mental illness, but as average, run-of-the-mill experiences.

Similarly, the average person does not need an academic to explain that hearing voices, believing a man from Mars is controlling your movements and being unable to stop washing your hands even though you have washed them 99 times and the skin is now cracked and weeping, indicate mental illness.

Naturally, there is a middle area, a region of uncertainty. Certainly, unpleasant experiences and losses may trigger the onset of a mental disorder. Accordingly, assessment by an expert in mental disorder may be indicated. But, most cases of everyday unpleasant experiences resolve through our own efforts and resources, the support of friends and acquaintances and the passage of time.

Importantly, the WHO recently (2013) announced that the notion that all suicide is the result of mental disorder is a myth. In 2018 the authoritative US Centre for Disease Control stated that the rate of suicide in the US has been rising for the last 30 years and that 54% of those who die by suicide have no known mental disorder. Also, in 2018, Australian research showed that while funding for and the provision of mental health services greatly increased through the Better Access scheme (which commenced in 2006), the suicide rate progressively

increased from 2007 to 2015 (the last available data), rather than decreased (Jorm, 2018). Thus, not all suicide is the result of mental disorder and increased funding for mental health services does not reduce the rate of suicide.

It is possible the celebrity mentioned above suffers a mental disorder, which was the cause of the suicide attempt. But maybe not. Injury had rendered sporting participation impossible and there had been conflict with a romantic other, both of which would naturally lower spirits. In addition, two sleeping medications were ingested, which in the absence of an opportunity to sleep, could have triggered maladaptive behaviour.

It is noted the celebrity had previously “self-harmed” and had waged a “battle with mental illness”. This individual, as a deserving citizen and a valuable sporting asset, had probably already received standard, so-called “treatment” for suicidal behaviour – apparently with less than hoped for effect.

Calls for “better services” to prevent suicide are premature – for no one knows what to provide. Half of those people who suicide may suffer some form of mental disorder – but, significantly increased funding and mental health services under the Better Access scheme was associated with an increase rather than a decrease in the suicide rate.

Half of those who suicide suffer, not from a mental disorder, but from commonly occurring disappointment, worry, loss, rejection and all the other painful trials life has in store for us.

When mental illness is present, medical service must be provided (with particular care to exclude suicidality). When other forms of distress are present, medical services have little to offer. Non-medical distress may end in suicide. This is extremely regrettable. However, medical experts are no better at helping with non-medical distress (and may be less helpful). We hope for fair and supportive teachers and employers, sensible and mature parents, affordable housing, faithful lovers and warm and sober friends. Suicide prevention policies which have focused on mental illness have had no success – we need to include but look beyond medicine to develop policies which influence our cultural responses.

One of the implemented “strategies” to reduce the suicide rate is the establishment of rules about the reporting of suicide in the media – the notion being that media reports may glamorize or remind citizens of the suicide option – and lead to “copy-cat suicide”. There is no evidence that “copy-cat suicide” impacts on national suicide rates, or that restrictions on media reporting reduce “copy-cat suicide”. There is ample evidence those who claim knowledge of “copy-cat suicide” and how to prevent it, gain status and authority via their claims.

Suicide is not well understood by politicians, academics or the community. Society wide discussions are required. The danger of rules limiting the reporting of suicide in the media is that they will further quarantine suicide as the domain of self-appointed “experts” and further close down open discussion – open discussion, which may lead to understanding and more effective prevention strategies.

Postscript

Less than three weeks after the report discussed above The Australian (January 8, 2019) carried the story of a celebrity “anti-suicide campaigner taking her own life”. This celebrity had been a model - appearing on the front covers of *Cosmopolitan* (US), *Loaded* (UK) and *Maxim* (Italy). She had been a successful television actress – appearing in “Home and Away” and “Heartbreak High”. She was fluent in German and could speak Dutch, Italian, Spanish and Japanese. She designed jewellery and “eco-friendly” underwear and wrote television dialogue. She described having suffered anorexia in her early years and depression in her later years. She was described as having “been a huge voice for suicide prevention in Australia”. Following the end of her 15 year marriage to a stock-broker she was reduced to couch-surfing before acquiring a modest abode. In Instagrams she indicated the preceding 12 months had been difficult, but that she was feeling positive. The last sentence of the newspaper report begins, “The illness overcame her...” There is no evidence this suicide was the result of mental disorder – this conclusion is an example of the uncritical thinking which will have to be overcome if progress is to be made in reducing suicide.

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