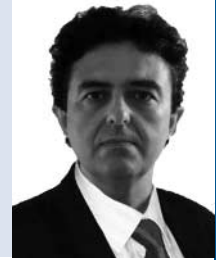


Editorial

Suicide and the economic situation in Europe: are we experiencing the development of a 'reverse stigma'?

Konstantinos N. Fountoulakis



Summary

The prevailing picture in both the scientific literature and mass media is that the increase in unemployment acts as a generic risk factor on the entire population and increases the rate of suicide, suggesting that the socioeconomic environment is the determining factor and measures to improve it are the most suitable in the struggle to reduce the number of suicides. As a result, 'horizontal' actions targeting the general population are proposed rather than 'vertical' actions that target specific vulnerable groups. This is not only

a mistake but it also constitutes a kind of 'reverse' stigma which deprives mental health patients of their right to receive special and targeted benefits, interventions and care, and deprives mental healthcare of valuable resources.

Declaration of interest

None.

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Since 2008 a global economic crisis has affected the whole world, especially Europe and the USA. Concern has been expressed regarding the possible adverse effects of austerity on healthcare, with specific focus on mental health. Mental health patients constitute a vulnerable group and are believed to be at a higher risk of being affected by such a crisis, but still they are not the focus of the debate. Instead, the focus has shifted and instead of the problems of psychiatric patients, the discussion focuses on the general economic situation. Thus, the specific consequences patients face are considered to constitute a generic problem of the general population, and mental health problems are essentially redefined as social. This general approach does not have any real effect on vulnerable populations.

Experience from previous crises suggests that deterioration in mental health happens with an increase in depression and anxiety. This has been reported after the economic crises in Hong Kong, south Australia, Greece, the UK and Spain, and the effect seemed more severe in population groups who experienced unstable employment or financial problems. However, these studies could not differentiate between general distress and clinically defined mood disorders.

It is important to note that it is widely believed that economic crises and austerity increase suicide specifically. In his seminal work in 1979, Brenner reported that for every 10% increase in unemployment there is an increase of 1.2% in total mortality, including an increase by 1.7% in suicidality.¹ In the past, economic crises such as the Great Depression, the Russian crisis in the early 1990s (although the data are not published reliably) and the Asian economic crisis in the late 1990s have been correlated with increases in suicide. There are several studies published more recently, suggesting a similar pattern concerning the impact of the 2008 economic crisis on suicidality in European countries² and the USA.³ It has been also suggested that stronger associations between increases in national suicide rates and unemployment rates are observed in countries with low

baseline unemployment rates than in countries with high unemployment rates.⁴ In line with this assumption it has been proposed that the variations in suicide rates relate to the severity of the recession as well as to varying social support and labour market protections in different countries, and consequently a reduction of unemployment through governmental action should lead to a reduction in suicidality.⁵

On the other hand, suicide rates show a substantial variation between continents, countries and regions, and this is particularly true for Europe – for reasons which are poorly understood – especially since psychiatric morbidity is similar around the globe. The accuracy of suicide documentation, the stigma associated with mental illness and suicide (possibly influencing help-seeking behaviour and reporting rates), the availability of lethal methods of suicide, and the availability of social/healthcare systems, but also differences concerning religion or even climate factors, should be considered as sources of heterogeneity.²

The causal relationship between the increase in unemployment and increase in suicide has been questioned for both the USA and Europe.^{6–9} Interestingly, when the unemployment rate is low, the suicide rate of unemployed persons is high, but when unemployment increases and the composition of unemployed persons shifts to include more mentally healthy persons, the suicide rate of unemployed persons decreases. Additionally, two recent studies clearly dispute this causal relationship by reporting that the number of suicides increase several months before unemployment increases (Fig. 1).^{2,10} Essentially in all papers published to date, a temporal advance of the suicide increase in relationship to the increase in unemployment is observed, although not always reported or commented on. Thus, the temporal sequence and correlation of events (suicide rate increase first, economic recession follows, synchronisation of suicidal rate changes across both Europe and the USA) suggest there probably is a close relationship between the economic environment and suicide rates; however, this relationship is not that of a direct cause and effect between unemployment and suicidality. One could argue that those people who are going to lose their jobs are stressed months before this happens, but 'fear' of unemployment is quite different from unemployment *per se*, especially since such an assumption suggests that employed people die by suicide before they become unemployed.

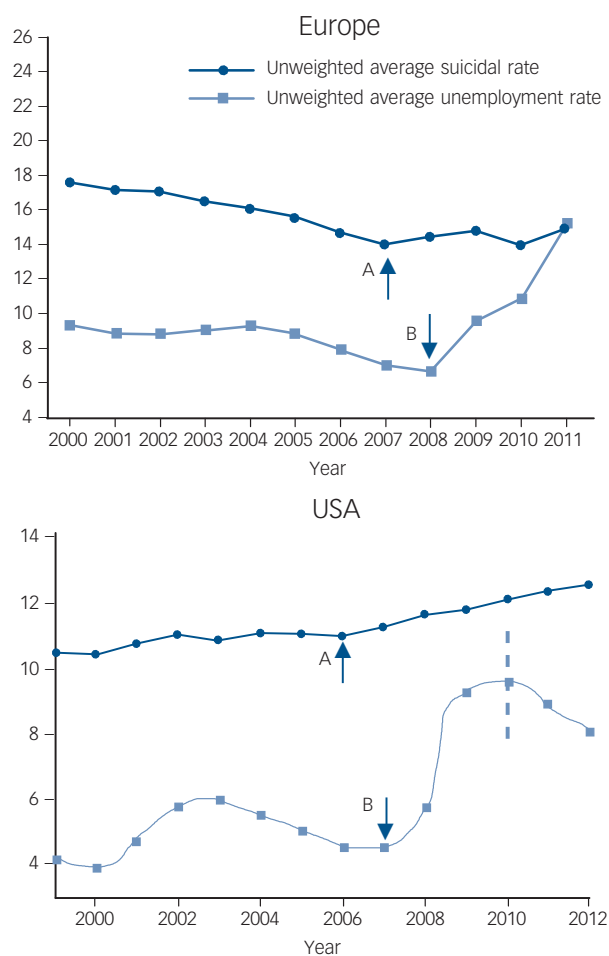


Fig. 1 Change in suicide rates and unemployment in Europe and the USA 2000–2011: pooled data. It is clear that the rise in suicides (A) precedes the rise in unemployment (B) in both continents, while in the USA the fall in unemployment in 2010 is not followed by a decrease in suicide rates.

Data from Fountoulakis *et al*² and from the US Center for Disease Control and the Bureau of Labor statistics.

However, the most likely explanation is that mental healthcare deteriorates during periods of economic crisis and austerity. Also, patients constitute a specifically vulnerable group which is hit harder by a crisis in a selective and accumulated way. This accumulation of stressors might be the cause behind the increase in suicide rates.

On the other hand, the prevailing picture, both in the scientific literature and in the mass media, is that an economic crisis acts as a generic risk factor on the entire population, putting at risk literally anybody. Of note, the vast majority of papers on this topic

are published by authors experienced in general public health and economics but with little background in clinical or research psychiatry.

Trivialising the risk of suicide suggests that it is generic rather than specific; that it can be managed through generic socio-economic interventions rather than specific psychiatric methods. This constitutes a kind of ‘reverse’ stigma. Patients at risk of suicide are not considered as such; instead they are considered as normal healthy people from the general population who respond to generic adverse events with suicide. This has an important consequence: there is no need for special intervention regarding psychiatric care; instead, improvement of the general socioeconomic situation is considered to constitute the right way to fix things.

Stigma in mental disorders is the prejudice against patients, depriving them from their human, political and other rights; the reverse stigma is depriving patients of their right to receive special and targeted benefits, interventions and care, and deprives mental healthcare of valuable resources.

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