

Highlights of this issue

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In 1822, French psychiatrist Jean-Pierre Falret published the first research paper on suicide, based on statistical data. He classified causal factors leading to suicide under the categories of predisposing, direct, indirect and general. These included the roles of heredity, relationships, temperament, illness and social unrest. As will be apparent from this month's Highlights, 200 years later, there has been considerable progress in our understanding of suicide and interventions for suicide prevention. This area will be the central focus of the current issue.

With great power comes great responsibility

The media have a key role in the responsible communication of how suicides are reported. In their editorial, Westers et al (pp. 415–418) shine a light on how a lack of sensitivity in coverage of the topic of suicide may reinforce stigma over the behaviour, with the end result being that help-seeking for people with suicidal ideation is reduced. There is often little portrayal of hope and alternative ways to cope with emotional pain, which can thwart the possibility of recovery. Graphic images may also be triggering for people vulnerable to self-harm. With such a position of power, the authors argue that the media have a responsibility to ensure that reporting of suicide is 'accurate, evidence-based and hopeful'. They also mention the 'Papageno effect', in which responsible media coverage of suicide can have a protective role against suicide by highlighting how individuals struggling with suicidal thoughts can use alternative strategies to cope in a healthy and positive way. Let us hope that free speech means active listening from media professionals.

Integration from dissociation

At least one million people in the UK will suffer from dissociative identity disorder (DID) during their life. In another editorial, Reinders and Weltman (pp. 413–414) discuss the debate surrounding whether this disorder arises from fantasy based on suggestibility or whether it originates in validated trauma. Such a dichotomy has meant that years of misdirected treatment could result in protracted personal suffering and high direct and indirect societal costs. The authors posit a wholly plausible argument for the role of non-genetic, environmental factors based on trauma that can affect multiple aspects of brain development in DID. It is this organic legacy from severe childhood trauma that means DID needs to be recognised as a mainstream psychiatric disorder.

Suicide: prediction, prevention and intervention

The suicide rate within the first month after discharge from a psychiatric hospital is over 190 times the global suicide rate. In a study

which examined the records of all individuals who had died by suicide over a 20 year time frame, Jiang et al (pp. 440–447) found that the strongest three predictors of suicide in males were being over 30 years old, living with an alcohol-related disorder and nicotine dependence. The strongest predictor in females was the prescription of progestogens and oestrogens in combination – a novel risk factor worthy of further consideration in future research.

A separate study by Nuij et al (pp. 419–426) represents the first meta-analysis on safety planning-type interventions (SPTIs) for suicide prevention – a central component of mental health crisis service interventions. Six studies were selected through a rigorous process of screening using multiple criteria to demonstrate the effects of SPTIs. They found that SPTIs were associated with significant reductions in suicidal behaviour but not in suicidal ideation, with the risk of suicidal behaviour reduced by 43% for patients who were using an SPTI. In spite of its limitations, including its lack of direct applications to children and young people, this approach still holds promise. Further research is needed to determine the most effective components of SPTIs.

In a third study on the subject of suicide, Stapelberg et al (pp. 427–436) explored the effects of the Zero Suicide framework, a pathway that includes screening and engagement, assessment, risk formulation, brief intervention, follow-up and transitions of care. The authors found a significant reduction in the risk of repeated suicide attempts by approximately 65% in patients receiving a suite of interventions following the Zero Suicide framework up to 90 days after a first suicide attempt. As with the previous study, the most effective components of these clinical interventions warrant further exploration.

Trauma is complex, complex trauma even more so

The Environmental Risk Longitudinal Twin Study tracked the development of a birth cohort of 2232 British children. This study formed the basis of a study by Lewis et al (pp. 448–455), covered by Oluwaranti Babalola in a separate blog (<https://elfi.sh/bjp-me30>), in which the authors examined the effects of complex trauma. This was defined as traumatic experiences in the form of multiple events that involved interpersonal assaults or threats and occurred in childhood or adolescence. Examples included complex repeated child abuse, severe bullying and witnessing neighbourhood violence. The authors found that young people exposed to complex trauma had more severe psychopathology and poorer cognitive function compared with non-trauma-exposed peers and those exposed to non-complex traumas. These findings suggest that features of the trauma such as its nature, severity, recurrence or timing, or responses to the trauma such as maladaptive cognitions, behavioural coping strategies or emotion processing could be the basis for the psychopathology. Let us hope that this study also paves the way to a better understanding of how trauma can be a marker for different aspects of thoughts, emotions and cognitions.