

Does Suicide Always Indicate A Mental Illness?

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Each year, on average almost 5000 people die of suicide in England and Wales. The 1992 Health of the Nation aimed to reduce suicide rate by 15% by 2000. The 1999 Department of Health National Service Framework sought to cut the suicide risk by a further fifth from this target.¹ There has been significant pressure on mental health services to improve risk assessment in order to reduce suicide rate. This implies that suicide is mainly seen as a medical or psychiatric issue – a mental illness.

Decisions regarding end of life are encountered more frequently than before. Recently there have been debates and disputes over physician - assisted suicide and euthanasia. The debate has become more intense following the Assisted Suicide Bill. The number of British people who have visited Dignitas in Switzerland for assisted suicide has doubled from 2005 to 2006.² Two high profile cases brought the issue of physician assisted suicide back into public discourse. First the 45 year old multiple sclerosis sufferer, Debbie Purdy, took her case to court in order to protect her husband from prosecution when assisting her to end her own life. Then Daniel James, a 23 year old rugby player who had become paralysed in an accident ended his life in Switzerland. These cases challenge the idea that suicide necessarily arises from a mental illness.

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Physician assisted suicide highlights this challenging question – is “intent to commit suicide prima facie evidence for a disease of the mind”?³

Burgess & Hawton highlight the difficulties psychiatry encounters when facing suicide.⁴ They claim that not all who commit suicide are mentally ill, and also that mental illness is often not clearly distinguishable from normal distress. Moreover considering the difficulties in treating mental illnesses the authors suggest “there seems to be no a priori reason why psychiatrists should always find themselves bound to try to prevent suicide”. The case of Dr Chabot provides some insight into this problem. Dr Chabot helped a 50 years old social worker to commit suicide. The case was taken to the Netherlands Supreme Court. The court did not question the rationality. The Dutch Society of Psychiatrists’ committee, following the Chabot’s case, took the position that suicide should not be considered as an a priori psychopathological phenomenon.⁵

The extent to which someone is expressing their free will and is capable of being responsible for their actions are important to establish when deciding whether suicide indicates a psychopathological state of mind. The principle of autonomy, integral to a free society, requires that a person's decisions regarding their own life should be respected wherever possible.⁴ According to the UK law every adult is assumed to have capacity until proven otherwise.

The idea of rationality of suicide has seemed “abhorrent” and “close to eugenics” to some professionals.⁶ This belief may be rooted in fear of

malpractice than a strong philosophical or ethical argument for it is clear that psychiatrists from time to time face cases in which suicide is a rational option. Ong & Carter reported a holocaust survivor who was detained under the Mental Health Act because of being suicidal. The patient accused the psychiatric team of acting like Nazis by wanting to exert control over who should live or die.⁷ As Loeffler put it: "suicide is not necessarily a matter of insanity, irrationality or despair, and it is not primarily of medical concern."⁸ To call all suicides mentally ill downgrades their individual responsibilities.⁹

Suicide is indeed a complex issue encompassing philosophical, ethical, legal and practical dilemmas. It needs open debate with due consideration to different aspects and points of view. Lack of precise measures to detect mental illness is not a sufficient reason to assume all suicides are due to abnormal mental states. It must be a drive towards developing measures that enable us to detect and exclude mental illnesses with more confidence and certainty.

Acknowledgement: I would like to thank Dr Stephanie Young for her kind input.

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