

Correspondence

Edited by Kiriakos Xenitidis and
Colin Campbell

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Psychological autopsy study of suicide in Karachi

We congratulate Khan *et al* for their study on suicide¹, a topic that, to our knowledge, has not been formally studied in Pakistan. Their findings are very significant. First, 96% of suicide victims had a diagnosable psychiatric condition with a very high prevalence of depression. We know that depressive illnesses are steadily rising; in 2001, the World Health Organization warned that by 2020 depressive disorders are expected to rank as the second leading cause of disease and disability worldwide after coronary heart disease.² Interestingly, none of the victims had been in contact with any health professional in the previous month,¹ contrary to the pattern seen in the West.

Second, violent methods of suicide were used in the majority of cases, depicting the seriousness of the intent, a finding that has been replicated in a number of studies from Asia. Interestingly, the same finding was reported earlier by Patel & Gaw³ in their review of studies of suicide among immigrants from the Indian sub-continent (India, Pakistan, Bangladesh and Sri Lanka), who used violent methods such as hanging, burning and poisoning. None of the suicide victims took an overdose of medication, which is the most common method of attempted suicide/self-harm in the West. However, it should be noted that violent methods are becoming increasingly common in the West, with hanging as one of the common causes of completed suicide.^{4,5}

Third, risk factors for suicide do not differ greatly from the rest of the world, as reported by earlier Taiwanese⁶ and Indian⁷ studies, apart from alcoholism. However, one striking finding reported by Khan *et al* is that 62% of suicide victims lived in joint/extended families, which is supposed to be a protective factor.

It will be useful if the authors could clarify a couple of points. First, the results show that 24% of suicide victims were married and 51% were single, but the status of the remaining 25% is not mentioned. Were they widowed, divorced? As bereavement and divorce are considered to be major life events, it would be useful to know if either occurred just before the suicide. Second, there does not seem to be any mention of age groups. It will be an important finding to know the age group that is at greatest risk and especially if the trend differs from the West.

It will be interesting to see if the findings of useful studies like this will motivate health commissioners in Pakistan to pay attention to the population's mental health needs.

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- 5 Mittendorfer-Rutz E, Wasserman D, Rasmussen F. Fetal and childhood growth and the risk of violent and non-violent suicide attempts: a cohort study of 318,953 men. *J Epidemiol Community Health* 2008; **62**: 168–73.
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Imran Mushtaq, Milton Keynes Specialist Child and Adolescent Mental Health Services, Eaglestone Centre, Milton Keynes, UK. Email: imranmushtaq@doctors.org.uk; **Salman A. Mushtaq**, Crisis Resolution Home Treatment, Coventry and Warwickshire Partnership Trust, Coventry

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Author's reply: I thank Drs Mushtaq & Mushtaq for their comments. Regarding their queries of marital status and age groups, 25% of the victims were engaged, divorced or widowed, and the age groups of the victims were: 15–20 years (24%); 21–30 (41%); 31–40 (17%); 41–50 (7%); and >51 (3%). From our and other studies, it appears that in Pakistan the majority of people dying by suicide are young – under the age of 30 years. This is a massive loss to society and contributes to high years-of-life-lost. On the other hand, suicide is rare in the elderly in Pakistan, which is in contrast to findings in the West. This may be due to the status afforded to the elderly in the family-centered Pakistani society. The elderly continue to live with family members after retirement and rarely have to fend for themselves.

I agree with the other comments made by the authors: mental illness, especially depression, is underrecognised and undertreated in Pakistan; most suicide victims used violent methods such as hanging, firearms, burning and poisoning, while few used medications as a method, and none of the victims were in contact with health services in the month before the suicide. Although these findings have important implications for suicide prevention in Pakistan, we do not see the situation changing on the ground, as far as mental health or suicide prevention are concerned. Successive governments in Pakistan (military as well as civilian) have failed to address the basic health needs of the population; mental health does not have a separate budget but it is believed that less than 1% of the annual health budget is allocated to mental health. Unfortunately, what little is available is eaten up by massive corruption, mismanagement and poor governance. Until these fundamental issues are addressed, the population of the country will continue to suffer from high levels of distress and many of those affected will die by suicide.

Murad M. Khan, Department of Psychiatry, Aga Khan University, Stadium Road, PO Box 3500, Karachi 74800, Pakistan. Email: murad.khan@aku.edu

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Abortion and mental health

The clear and thoughtful commentaries by Casey and Oates *et al*¹ raise a number of important issues about the implications of our research² regarding the linkages between abortion and mental health.

The first of these is identifying vulnerable groups. Both commentaries raise concerns about the identification and treatment of vulnerable clients. These issues are most clearly stated by Oates *et al*, who record some disappointment that our paper did not identify the features of women who may be vulnerable to later mental health problems. An important reason for this was the length constraints imposed on our paper. Although the editors very kindly allowed us considerable latitude with the journal word limit, within the space we had the most we could

do is report the main analysis of the data. However, we have a further paper under preparation that looks at the very issue raised by Oates *et al*. Without releasing our findings prematurely, we are able to comment that we have: (a) identified a group of women who are at increased risk of subsequent mental disorder following abortion; and (b) these women are distinguished by high levels of guilt and distress at the time of the abortion. We hope to be able to publish these findings within the next 6–12 months.

Second, the Abortion Act Clause C. It is our collective view that the most important implications of our findings relate to the current legal justification for abortion in the UK, New Zealand and a number of other jurisdictions in which abortion is authorised principally on medical grounds.^{3,4} In all of these jurisdictions, the great majority of abortions are authorised on mental health grounds. Our findings strongly challenge the use of mental health criteria as a routine justification for abortion. Our results suggest that the mental health risks of having an abortion may be greater and are certainly no less than the risks of coming to term with an unwanted pregnancy. Further, as far as we can tell, there is no evidence that suggests that the mental health risks of abortion are less than those of continuing with an unwanted pregnancy. To establish this would require a series of replicated studies showing that the mental health outcomes of those having an abortion are better than those of an equivalent series of women coming to term with an unwanted pregnancy. No such evidence exists. This situation creates a clear conflict between evidence on the one hand, and practice and the law on the other. Although Oates *et al* argue that population-based studies showing a modest increase in mental health consequences are unlikely to help individual women or clinicians, this evidence does provide an important context for a discussion of the therapeutic benefits or otherwise of abortion. What emerges most clearly from the accumulated body of evidence on abortion and mental health is: (a) the primary reasons that most women seek abortion are personal, social and economic rather than relating to mental health concerns;^{5,6} and (b) there is no body of evidence that would lead a reasonable person to conclude that the provision of abortion mitigates the mental health risks of abortion. Under these circumstances, there is a clear need to develop more comprehensive and realistic criteria for the provision of abortion with these criteria recognising the range of social, economic, personal and related factors that lead women to seek abortions, and (we conjecture) doctors to authorise these procedures.

Third, regarding counselling and support, both Casey and Oates *et al* pick up on the theme of the need for counselling, although from different perspectives. Whereas Casey emphasises the obligations our findings impose on clinicians and others to inform patients and treat risk, Oates *et al* are more cautious and emphasise the dangers of mandatory procedures, and argue that the evidence is not strong enough to mandate either advice or treatment. We are inclined to agree with Oates *et al* about this matter, and we think that it would be premature on the basis of the available evidence to present strong claims about the iatrogenic effects of abortion. At the same time, we believe that there is now a strong case for conducting randomised controlled trials of the extent to which various forms of advice, counselling and support mitigate any mental health risks of abortion. The introduction of good randomised controlled trials could do much to mitigate the generally parlous state of the literature on abortion and mental health.

Finally, we would like to thank the authors for their thoughtful comments, and we were very grateful for the fact that both sets of commentators avoided the tendency to rehearse the usual set of reasons why no useful conclusions can be drawn from observational studies of abortion and mental health.

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David M. Fergusson, L. John Horwood, Joseph M. Boden, Christchurch Health and Development Study, University of Otago, Christchurch School of Medicine and Health Sciences, New Zealand. Email: joseph.boden@otago.ac.nz

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Correction

Increasing awareness of eGFR monitoring. *BJP*, 194, 191. The first sentence of this letter should read: We are grateful to the *Journal* for highlighting the important issue of estimated glomerular filtration rate (eGFR) monitoring in psychiatric patients prescribed lithium.

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