

# Correspondence

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## Decreasing suicide in Hungary

We read with interest McClure's (2000) report of a decrease in suicide in England and Wales between 1990 and 1997. Although the conclusion that improvements in the national economy contributed to this change is unproven, there is a large amount of evidence linking suicide and unemployment. It is, therefore, worth highlighting recent changes in Hungary, where in the 1980s the suicide rate was the highest in the world, four times the rate in England and Wales.

The suicide rate in Hungary has shown a steady decline from 45.9 per 100 000 in 1984 to 31.7 in 1997, a fall of more than 30%. This decline was greater after 1990 when the rate was 39.9 per 100 000 (Rihmer, 1997; Central Statistical Office, 1998) and when the political and economic changes in Eastern Europe began. During the same period there was a six-fold rise in unemployment, a four-fold rise in the number of people earning below the official minimum income, a 25% rise in official estimates of alcoholism rates, and a 21% rise in divorce. Other former Communist countries showed either no substantial change or a marked increase in their suicide rates after 1989/1990 (Sartorius, 1995; further details available from Z. Rihmer upon request).

It is not known why suicide in Hungary has fallen despite an adverse change in key risk factors but it is intriguing to note changes in mental health care. The number of out-patient psychiatric departments increased from 95 in 1982 to 136 in 1997, and the number of out-patient consultations annually increased from 731 000 in 1980 to 1 190 000 in 1997. The number of psychiatrists increased from 550 in 1986 to 800 in 1997. More extensive medical training on depression and suicide was followed by an increase in the use of antidepressants from 3.7 defined doses/1000 persons/day in 1990 to 12.0 in 1998. Between 1984 and 1997, the number of emergency telephone services also increased from 5 to

28 (further details available from Z. Rihmer upon request).

We are now conducting a psychological autopsy study of suicide in Hungary with the aim of identifying possible protective factors, both social and clinical.

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## Drug dependence and child abuse

In response to Marsden *et al* (2000) we were interested to note the prevalence of psychiatric symptoms in their group of clients seeking treatment for drug dependence, particularly the fact that female drug users reported higher levels across all scales, as this mirrors our experience in treating intravenous drug misusers. We would suggest that such symptoms may be sequelae of child abuse.

There is an established link between childhood trauma and psychiatric symptoms in adulthood (e.g. Briere & Runtz, 1993), and recent evidence to suggest a link between such early life experiences and substance misuse. Contemporary psychoanalytic theories of addiction also emphasise the relationship between experience of early life

trauma and later substance misuse (e.g. Wurmser, 1984), proposing that drug use is an attempt at self-medication (Khantzian, 1997), or a chemical means of inducing a dissociative state, so often apparent in victims of child abuse. McDougall (1989) suggests that substance misuse offers an external means of discharging painful internal states, through immediate action.

Our work in Cornwall indicates that of 111 randomly selected patients seen by the drug team, 46% of males and 73% of females reported childhood abuse to a degree that would have placed them on the at-risk register. Child sexual abuse was reported by 1.85% of males and 43% of females. This work provides evidence that there is a high incidence of early life trauma and abuse in the drug-misusing population. The figures account for the larger proportion of women presenting with drug dependence problems reporting abuse issues, which fits with Marsden *et al*'s report of a higher incidence of psychiatric symptomatology among their female clients.

We feel this is a very important area that needs to be evaluated further, as we find that the degree of trauma suffered by the patient can predict therapeutic needs and types of intervention required, including substitute prescribing, residential treatment and/or in-depth psychotherapeutic treatment. This is an aspect in the future that may enable drug services to tailor treatment packages to meet the individual's needs and to target appropriate interventions.

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