

Correspondence

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Contents

- Effective suicide prevention measures for teenagers in Japan

Effective suicide prevention measures for teenagers in Japan

The editorial by Butler & Malone¹ focused on non-suicidal self-injury (NSSI), proposed as a new category in DSM-5, and described the criteria of this item. The authors also provided information about NSSI among young people. In Japan in August 2012, the Japanese Cabinet decided to enhance suicide prevention measures for younger people, given the increasing suicide rate among students, partly as a result of bullying.² Thus, suicide prevention measures that are effective among younger age groups in Japan, and particularly among teenagers, must be designed promptly.

There were 58 509 suicides in Japan in 2011 and 2012 combined, according to the National Police Agency (www.npa.go.jp). This number included 1209 suicides of young people under the age of 19 (2.1%). The causative factors were classified as 'family problems', 'health problems', 'economic and life problems', 'work problems', 'problems of relations between the sexes', 'problems in school' or 'others'. The most common causative factor for suicide among young people under the age of 19 was 'problems in school' (33.0%), followed by 'health problems' (23.7%); therefore, determining the detailed aspects of 'problems in school' for teenagers will contribute to effective suicide prevention measures for that age group.

'Problems in school' included 'worrying about entrance exams', 'worrying about one's academic progress', 'poor academic performance', 'poor relationships with teachers', 'bullying', 'discord with schoolmates' and 'others'. Of these, 'poor academic performance' (31.1%) was the most prevalent causative factor, followed by 'worrying about one's academic progress' (25.6%). The incidence of 'bullying' (which has been taken into account in currently used prevention strategies) and measures and responses to deal with 'poor academic performance' and 'worrying about one's academic progress' must be explored in conjunction with the results of the current study.

It is necessary to discuss specific and effective suicide prevention measures from various viewpoints.^{3,4} We therefore propose that understanding the criteria of NSSI in DSM-5 is important, as noted by Butler & Malone.

- 1 Butler AM, Malone K. Attempted suicide v. non-suicidal self-injury: behaviour, syndrome or diagnosis? *Br J Psychiatry* 2013; **202**: 324–5.
- 2 Nihon Keizai Shinbun. Cabinet decision to commit suicide outline comprehensive measures, emphasis on bullying suicide [in Japanese]. Nikkei, 2012 (http://www.nikkei.com/article/DGXNASFS2800P_Y2A820C1MM0000/).
- 3 Hirayasu Y, Kawanishi C, Yonemoto N, Ishizuka N, Okubo Y, Sakai A, et al. A randomized controlled multicenter trial of post-suicide attempt case management for the prevention of further attempts in Japan (ACTION-J). *BMC Public Health* 2009; **9**: 364.
- 4 Tochigi M, Nishida A, Shimodera S, Oshima N, Inoue K, Okazaki Y, et al. Irregular bedtime and nocturnal cellular phone usage as risk factors for being involved in bullying: a cross-sectional survey of Japanese adolescents. *PLoS One* 2012; **7**: e45736.

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doi: 10.1192/bjp.203.4.312

Authors' reply: Inoue & Fujita made the point that clarifying the criteria of NSSI in DSM-5 facilitated discussion on the topic of suicide prevention. The problem of rising suicide rates among the younger population of Japan was also highlighted. Suicide has been identified as a leading cause of death in young Japanese people, with a significant societal impact.¹ We would agree on the importance of fostering discussion and understanding of suicide at national and international levels. We would also agree that addressing suicide prevention among younger age groups is a public health priority for many countries.

Internationally, suicide rates in younger people have increased over the past 50 years.² This phenomenon is apparent in Ireland where we now have the fourth highest youth suicide rate (under 25 years) in the expanded European Union.³ In May 2013 the *Suicide in Ireland* survey was published, a national research study exploring Irish suicide statistics, with a focus on young lives lost to suicide.³ This study identified a fourfold rate of increased suicide risk in males between the ages of 16 and 20, compared with after 20 (113.1 v. 28.2 cases per year). A similar twofold increasing trend was noted for females (12.7 v. 7.4 cases per year). Contributory factors to suicide risk in young adults in Ireland included bereavement, relocation, relationship break-up, bullying and assault.³ Inoue & Fujita propose that bullying is a factor that should be explored in tandem with studies of youth suicidality. This is supported by a growing evidence base internationally that bullying is a key antecedent for suicide, particularly when experienced at an early age.⁴

Suicide rates and associated risks vary across countries and cultures. There is a need for regional suicide research to understand the complexities specific to suicide within nations as well as larger-scale, international, cross-centre research to continue to build a robust evidence base on this issue. Future suicide prevention programmes may need to be revised and tailored to address the needs of specific age groups.³ Targeted, high-priority suicide prevention strategies can work when based on robust national and international research; evidence for this can be seen in the UK where suicide rates have been in decline over the past 5 years, coinciding to a degree with the implementation of the National Suicide Prevention Strategy.⁵ However, suicide prevention remains a moving target – the recent national confidential inquiry into suicide in the UK does support a fall in suicide rates between 2001 and 2010 as well as a fall in male suicide rates under the age of 25, but it also showed a possible increase in suicide rates among mental health patients in 2011.⁶ This reiterates the point that the focus of prevention should potentially be group specific, depending on the needs of the population involved.

- 1 Yip PSF. *Suicide in Asia: Causes and Prevention*. Hong Kong University Press, 2008.
- 2 Patton GC, Coffey C, Sawyer SM, Viner RM, Haller DM, Bose K, et al. Global patterns of mortality in young people: a systematic analysis of population health data. *Lancet* 2009; **374**: 881–92.
- 3 Malone KM. *Suicide in Ireland 2003–2008*. 3Ts (Turn the Tide of Suicide), 2013 (<http://www.3ts.ie/wp-content/uploads/2013/05/Suicide-in-Ireland-Survey-2003-2008-Report.pdf>).
- 4 Geoffroy MC, Gunnell D, Power C. Prenatal and childhood antecedents of suicide: 50-year follow-up of the 1958 British Birth Cohort Study. *Psychol Med* 2013; Jul 29: 1–12. Epub ahead of print.

- 5 Mok PLH, Kapur N, Windfuhr K, Leyland AH, Appleby L, Platt S, et al. Trends in national suicide rates for Scotland and for England & Wales, 1960–2008. *Br J Psychiatry* 2012; **200**: 245–51.
- 6 Appleby A, Kapur N, Shaw J, Hunt IM, While D, Flynn S, et al. *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales*. The University of Manchester, 2013.

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doi: 10.1192/bjp.203.4.312a

Corrections

Computer-assisted therapy for medication-resistant auditory hallucinations. *BJP*, 202, 428–433. The heading of Table 3 (p. 431) should read: Comparison of the three main outcome measures between the delayed therapy and the immediate therapy groups after randomisation (baseline) and at the first follow-up, after some patients had dropped out of both groups.

Magic bullet thinking – why do we continue to perpetuate this fallacy (letter)? *BJP*, 203, 154. The name of the first author of this letter is Julia J. Rucklidge. The online version of this item has been corrected, in deviation from print, and in accordance with this correction.

Risperidone-induced hypersexuality (letter). *BJP*, 203, 233. Second paragraph, frequencies of intramuscular injection were reported

incorrectly. The paragraph should read: Mrs X, 71 years old, married once and widowed for 20 years, with no known history of hypersexuality, was started on risperidone 25 mg intramuscular (IM) injection three weekly. Two months later, she complained of 'having to' masturbate two to three times daily without being able to orgasm, lactating and losing 'too much fluids' vaginally. She became fixated on an imagined romantic relationship, took off her old wedding ring and attempted to hire a tourist boat for a wedding reception she planned for herself. Risperidone was stopped after 6 months and switched to pipotiazine 25 mg IM injection, three weekly, after a washout period of 5 days. Features of hypersexuality waned and resolved 10 days later, with no recurrence.

doi: 10.1192/bjp.203.4.313