BJPsych | The British Journal of Psychiatry (2009) 194, 377–378

Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

Contents

Psychological autopsy study of suicide in Karachi

We congratulate Khan *et al* for their study on suicide[1], 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 & Gaw[3] in their review of studies of suicide among immigrants from the Indian subcontinent (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 Taiwanese[6] and Indian[7] 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.

1 Khan MM, Mahmud S, Karim MS, Zaman M, Prince M. Case–control study of suicide in Karachi, Pakistan. *Br J Psychiatry* 2008; **193**: 402–5.

2 Harlem Brundtland G. Coping with stress and depression in Europe. 'Mental health: a priority for world action'. World Health Organization, 2001 (http://www.who.int/director-general/speeches/2001/english/20011025_copingwithstressbrussels.en.html).

3 Patel SP, Gaw AC. Suicide among immigrants from the Indian subcontinent: a review. *Psychiatry Serv* 1996; **47**: 517–21.

4 Office for National Statistics. *Mortality statistics, 1999. Cause*. TSO (The Stationery Office), 2000.

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.

6 Cheng AT. Mental illness and suicide. A case–control study in east Taiwan. *Arch Gen Psychiatry* 1995; **52**: 594–603.

7 Vijayakumar L, Rajkumar S. Are risk factors for suicide universal? A case–control study in India. *Acta Psychiatr Scand* 1999; **99**: 407.

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

doi: 10.1192/bjp.194.4.377

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

doi: 10.1192/bjp.194.4.377a

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 research[2] 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