Psychological autopsy study of suicide in Karachi

We congratulate Khan et al for their study on suicide, 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. Interestingly, none of the victims had been in contact with any health professional in the previous month, 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 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.

Third, risk factors for suicide do not differ greatly from the rest of the world, as reported by earlier Taiwanese and Indian 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.

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.\textsuperscript{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
series of women coming to term with an unwanted pregnancy. No
of those having an abortion are better than those of an equivalent
health risks 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
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.

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.

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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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