

Letter to the Editor

Without hope, no future: Why an “inevitable suicide paradigm” is inappropriate for psychiatric practice

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Abstract: Recently, Dr. Benjamin J. Sadock from the NYU School of Medicine suggested a new paradigm in psychiatry ‘which holds that some suicide may be inevitable’, in order to ‘improve vigilance’ and provide ‘a more realistic view of what can and what cannot be achieved with therapy’: the paradigm of ‘inevitable suicide’. In particular, Sadock uses the biography of Ernest Hemingway to exemplify this concept. In this comment we highlight why we think the concept is not valid from a theoretical perspective, and why E. Hemingway was not an ‘inevitable suicide’, in order to stimulate discussion around the (un)predictability of suicide, and how we can best deal with it in prevention.

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Sadock suggested a new “paradigm” (emphasis ours) for psychiatry, asserting that some suicides may be inevitable (Sadock, 2012). In our view, his opinion piece raises a number of substantive comments and concerns.

To begin with, the term “paradigm” has specific meanings attached in epistemology and philosophy of science. The prerequisites for a justified use of this term are evidently lacking in the account of Sadock. There is no sufficient conceptual background, coherent theory framework, or convergent empirical evidence to designate the opinion that some suicides may be inevitable as a “paradigm” of its own. Hence, this is a misnomer and a bogus concept.

A general problem with any statements about “inevitable” suicides is that completed suicide is a rare event. Trying to predict it is effectively impeded by what is known as the base rate problem. That is, individual suicide cases cannot be reliably predicted, because far too many false positives emerge from any prediction model. For this reason, any subgroup of suicide cases would even be less accurately predictable, thus rendering a concept of an “inevitable suicides” subgroup on mere statistical and epidemiological grounds infeasible for psychiatric practice.

The facts of the suicide of American writer Ernest Hemingway, as presented by Sadock to illustrate what an inevitable suicide is, are at the core of our criticism of Sadock’s elaborations. It is interesting to note that Sadock of all things draws on a case report to prove his case, when case reports are known to rank lowest in the hierarchy of medical evidence. We scrutinized the two psychiatric accounts on Hemingway’s suicide, as cited by Sadock, but found no assertions or clues therein describing Hemingway’s suicide as “inevitable” (Martin, 2006; Yalom & Yalom, 1971). On the contrary, one author (Martin, 2006), in the concluding part of the Abstract, wrote: “However,

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despite suffering from multiple psychiatric disorders, Hemingway was able to live a vibrant life until the age of 61 and within that time contributed immortal works of fiction to the literary canon." Hence, at a minimum, Sadock's presentation is a reinterpretation of the evidence.

Sadock emphasizes that suicides ran in the Hemingway family. On the other hand, one could also argue that the majority of the Hemingway family members did not commit suicide. Sadock also mentions that one Hemingway son suffered from major depression and repeatedly underwent electroconvulsive therapy, but eventually did not commit suicide. We opine that psychiatric practice could learn more from a psychological autopsy and from biographical information of this son of Hemingway than of those Hemingways who eventually committed suicide. The intriguing question here is: what constituted the apparent resilience of this one son, despite an apparent family loading for several psychiatric disorders?

What is more, we feel that the whole concept of "inevitable suicides" suffers from what in cognitive psychology is known under the term of hindsight bias (i.e., "knew it all along"). This is most conspicuous from the Hemingway family suicides, as presented by Sadock, because several of these actually occurred after Ernest Hemingway's suicide (1961): his sister Ursula, his brother Leicester Clarence, and his granddaughter Margaux completed suicide in 1966, 1982, and 1996, respectively. Only in retrospect (i.e., with hindsight bias), these further suicides seem to draw a gloomy picture on the odds of survival of Ernest Hemingway, but, of course, could not possibly have influenced his decisions and views of life. Coupled with the unpredictability of individual suicides, this type of cognitive bias in evaluating past events suggests the "inevitable suicides" concept is invalid.

Criticism on the concept was also highlighted in two comments that were published in reply to Sadock's publication in the *Journal of Psychiatric Practice* (Ellis, 2012; Manian, 2012). One of these reviews, coming, like Sadock's contribution, from the Menninger Clinic (Ellis, 2012) highlighted the difference between the (obvious) inevitability of some suicides occurring among psychiatrist patients and the statement that some individuals' suicides were inevitable. While the first statement underlines that suicide is likely to occur within a certain group, the latter statement applies this assumptions to specific individuals, and is highly speculative at best. While suicide is more likely to affect some individuals than others, based on risk and resilience factors, there is currently no scientific theory or model available that allows us to identify prospectively (and not even retrospectively, as erroneously suggested by Sadock (Sadock, 2012b)) individuals who must necessarily

belong to that group (i.e., will be or was an "inevitable suicide").

Sadock's final assertion in reply to a concerned colleague from Malaysia by Manian (2012) that "to consider a suicide inevitable, the patient must have received the highest standard of treatment and that treatment must have failed. Inevitability assumes among many other factors, that everything that could have been done was done—and done correctly" still does not relieve us from our concerns. As long as the best standards for all patients groups remain not fully understood, and in the light of limitations of evaluation efforts to determine if "everything was done correctly", we must remain more modest in the wording and acknowledge that, while not all suicides can be prevented, there is no scientific support to the labeling an individual suicide "inevitable".

Altogether, we strongly feel that labeling a group of individuals in retrospect as "inevitable" suicide cases would neither serve these suicide victims nor their families or practitioners. As such, the concept is devoid and useless. It may well be even dangerous, because, contrary to what Sadock asserts, it precisely carries along and fosters the kind of therapeutic nihilism which has been identified as a major risk factor for patient suicide (Finzen, 1988). This, in turn, would undermine the principle of vicarious hope, an essential therapeutic attitude comprised of the therapist bringing hope into seemingly hopeless constellations, thereby supporting positive change (Wolfersdorf, 1991; Sonneck et al., 2012) – Without hope, no future!

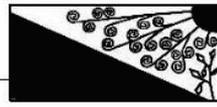
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