Discussed: suicide rates, the Golden Gate Bridge, hara-kiri, lithium, children, Oregon's law, depression

Suicide: The Common Tragedy

By Bruce Anderson

I need to forgive him. I have to forgive him.
But how much I have missed him. How much his widowed wife misses him.
How much his fourteen-year-old son, who has
entered the most God-awful teenage rebellion without him, misses him.
I called [radio station] KGO about the need for a suicide barrier on the
Golden Gate Bridge. What is the cost-effectiveness of saving one person?
Where is the price point for one human life?
How much I do miss him.

These are the comments of the forty-four-year-old businesswoman who sits in front of me. Although the purpose of our quarterly visit is to reassess her current functioning and review and prescribe her antidepressant medicine, her thoughts are on the incomprehensible decision of her pastor and friend of fifteen years to end his life in November 2004. Never suicidal herself, she has been successfully treated; her major depression is in remission. Our infrequent visits over the years are described as chemotherapy management.

However, our visits involve much more than writing a prescription; they also include brief reviews of her journey to date and changes in her professional life, and an update on the progress of her son's undergraduate education. But the painful residuals of suicide are the real theme of this visit.

Suicide is the old enemy, the final fatal solution to many treatable illnesses, the destroyer of families, of children's hopes and security, and of everything. It is frequently avoided, but never vanquished.

The topic of suicide carries personal meaning for me. It is said that there are two kinds of psychiatrists: those who have already lost a patient to suicide and those who will do so sometime in the future. Belonging to the former group, I recall the statistic that over the course of a career a psychiatrist can expect at least one suicide death among his patients. The risk is greater if one chooses to care for seriously ill and hospitalized people.

I encounter the possibility of suicide every working day—almost every working hour. My job as a psychiatric physician, like every physician, includes keeping my patients alive and treating the diseases that threaten to destroy them. Questions about suicide are part of the interview I give every new patient. Though the question may be asked in different ways, the intent is always the same: to assess the risk of self-harm in a depressed person and to use every means possible to do the impossible—to prevent suicide.

The philosopher Albert Camus once said, "Judging whether life is or is not worth living amounts to the fundamental problem of philosophy." For the depressed person in particular, making such a judgment rationally may be beyond reach.

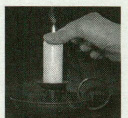
The case of Ingrid S. is a painful personal reminder of suicide's human cost, represented by a piece of art she gave to me more than thirty years ago. It is a watercolor painting of a flower she created by layering strokes of paint, and the effect is hauntingly beautiful.

Ingrid was a follower of Swiss mystic Rudolph Steiner, a nineteenth-century philosopher and the founder of Anthroposophy. During Holy Week, Ingrid became psychotically depressed and delusional with religious themes. She improved under my care, but later killed herself by hanging. Looking at this painting, I recall the enormous pain caused by this common tragedy.

Unfortunately, suicides are common events. About thirty thousand people die at their own hand each year in the United States, one every seventeen minutes. Every day eighty-six Americans take their own lives. Ninety-five percent of these people have diagnosable mental illnesses. For every successful suicide, twenty-three are attempted. The ratio of attempts to completed suicides is 200 to 1 among female adolescents; and 4 to 1 among men and women over the age of 65. About 500,000 Americans annually require emergency room treatment for attempted suicides.

Suicide is the ninth leading cause of death across all age groups in the United States. It is the third leading cause among young Americans fifteen to twenty-four, after accidents and homicides, and the second leading cause of death among college students. Suicides are much more common than homicides, which number about twenty thousand in the United States each year.

During the Vietnam War years (1961–73), almost twice as many Americans died from suicide (101,732) as from the war (54,708). Suicide occurs mainly among the depressed. These include persons with major depression and depressed bipolar disorder, and schizophrenic



patients with depression (schizoaffective disorder). Suicide is much more common among persons who have the added risk factors of alcohol or chemical abuse.

An awareness of demographic factors that affect suicide rates can heighten sensitivity to risk among certain segments of the population. These include age, gender, race, marital and occupational status, and physical health. One can summarize most of the known demographic risk factors by noting that being an older, white, divorced, depressed alcoholic male who is alone, ill, isolated, and with a prior history of suicide attempts places that person at greatest risk.

Suicide rates increase with age. Although the total in the United States is twelve per one hundred thousand, in men over sixty-five the rate is forty per one hundred thousand. In Caucasian men eighty-five and older, the rate is fifty per one hundred thousand. Among the young, suicide rates have risen threefold over the last fifty years. From 1980 to 1986, they rose 14 percent among persons aged fifteen to nineteen, and 100 percent among ten- to fourteen-year-olds.

Among Americans fifteen to nineteen, firearms have accounted for 96 percent of the increase since 1980. Also due largely to firearms, the rate of suicide among African American males in the United States increased 105 percent during the same period.

Men are four times more likely than women to kill themselves. Women, among whom depression is more common, are three to four times more likely than men to attempt suicide, but their attempts are less lethal. Suicidal men are more likely to be violent and use firearms.

This is changing, however; at present, 55–60 percent of all suicide deaths involve firearms. Sixty-six percent of suicides occur among white males. Suicide rates of Caucasians exceed those of Native Americans, which exceed those of African Americans, which exceed those of Hispanics, which exceed those of Asian Americans.

Suicide rates are higher for the unmarried. The rate for divorced men is sixty-nine per one hundred thousand, almost six times greater than for men who have not divorced. Although unemployment increases risk, risk is also greater for professionals, those of higher social status, and those living alone or in social isolation. Physical illness, especially chronic nonfatal and painful illness, also increases risk.

Suicide is common among those infected with HIV. In an epidemiological study of New York City residents, the suicide rate for men with AIDS was shown to be 680 per 100,000, 36 times higher than for men without AIDS.

Mental illnesses, especially depressive illnesses, are associated with high rates of suicide. In mood disorders such as major depression and bipolar depression, 15 percent or more die from suicide. Among persons with schizophrenia, 10 percent do. At least 7 percent of people suffering from anxiety and personality disorders die from suicide. Chemical dependency increases the risk of suicide fivefold.

Prior suicide attempts increase the risk thirty-eight fold. Among those who try, 10–15 percent eventually succeed. More attempts at suicide raise the likelihood of completion. A family history of depression, chemical dependency, or suicidal behavior increases the risk, as well.

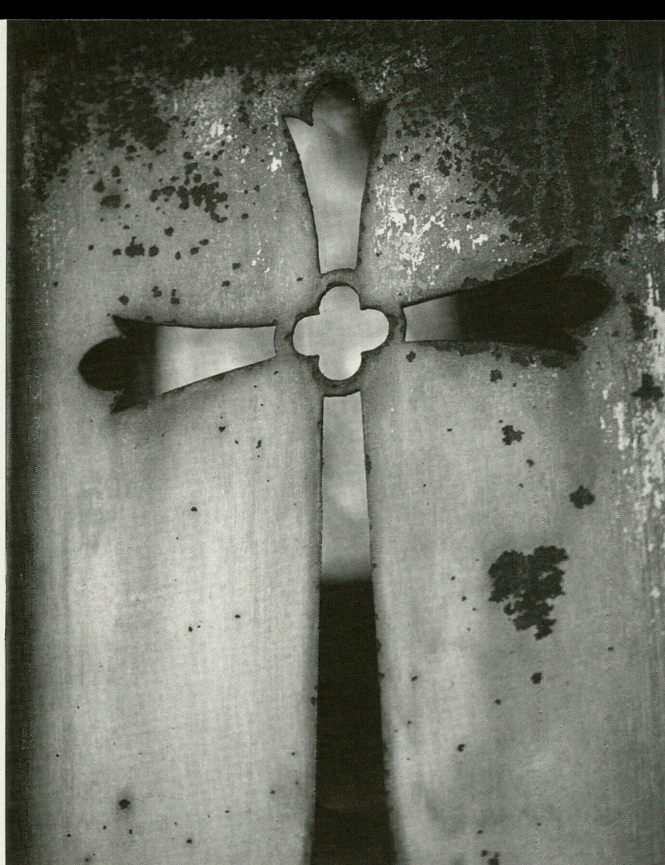
Geography and culture play an influential role in attitudes toward suicide, and in methods and frequency. For example Catholic countries such as Italy, Spain, and Ireland have lower suicide rates than countries such as Japan, Scandinavia, and Germany. Sociologists believe that Catholic cultures have more cohesive societies than Protestant or Jewish ones, which may contribute to lower rates of suicide.

In China, suicide is the fifth leading cause of death, and the leading cause of death in people aged fifteen to thirty-four. In China, too, the rate of suicide is 25 percent higher for women than for men. Chinese women who take their own lives are mainly young and live in rural areas. Fifty-eight percent of these suicides come from ingestion of pesticides, which are freely available. Many of these are thought to be impulsive actions that follow interpersonal conflicts.

Opinions of the ancient Greeks and Romans stand in sharp contrast to the Christian view that the body is the temple of God, and suicide a sin against him. Socrates was honored for drinking hemlock, heroically choosing death rather than exile in submission to a tyrannical democratic majority. Famous Romans such as Cassius, Brutus, and Cato took their own lives for similar reasons. Stoic philosophers believed in the right of individuals to chose the time and means of their own deaths.

Feudal Japanese believed hara-kiri was honorable and sometimes heroic. They considered it desirable for a condemned samurai. The term *hara-kiri* literally means stomach cut. Those who committed it did so by plunging a sword into their abdomens below the umbilicus (the *hara* or one-point), then cutting transversely, lacerating the bowel and great vessels. A second finished the process, assisting with another sword cut, then honorably removing the victim's head.

Among the most revered persons in Japanese history are the forty-seven *ronin* who, on the morning of February 4, 1703, committed hara-kiri, or *seppuku*, as a group after



they avenged the death of their lord, or *daimyo*, Lord Asano. Lord Asano had committed a grave offense by drawing his sword in the palace of the shogun and attacking his enemy, Lord Kito, who had insulted him. Lord Asano was condemned to the ritual hara-kiri death. His samurai thus became *ronin*, or samurai without a lord.

Pretending to be dissolute and shiftless vagrants, these ronin planned the death of their lord's enemy for months and carried out their plans on the snowy night of December 15, 1702. Japanese throughout the country admired these ronin for what they considered a noble action, for it avenged the spirit of their lord and allowed him to rest in peace.

Nevertheless, all forty-seven ronin were guilty of a crime. In his wisdom, the shogun granted them the honor of death by *seppuku*. The conduct of the ronin exemplified the code of *bushido* and galvanized the nation. Even today they are considered legendary heroes and celebrated in Japanese kabuki opera. In the temple of Sengakuji in Tokyo (Edo), forty-seven stones still honor them.

Suicide has remained a feature of Japanese society in more modern times. In 1936, at least six hundred people jumped to their deaths into the crater of Mount Mihara on the island of Oshima. As recently as 1970, novelist and playwright Mashima Yukio committed hara-kiri after failing to gain support from the military to change the Japanese constitution and restore power to the emperor.

Lest Americans consider themselves more logical, remember that the Golden Gate Bridge has claimed an estimated thirteen hundred lives since it opened in May 1937.

Although suicide prevention is a matter of special concern among mental health and medical professionals, it is also a major public health problem that demands attention from nonprofessionals. The following seven guidelines will increase awareness of life-saving interventions, which can be significant for anyone with a family member who suffers from depression, and for others who themselves suffer from the common scourge of depressive illness.

1. Don't overlook or ignore depression. Most suicides occur among depressed people. Most depressions are undertreated, if they are treated at all. It is important to continue long-term treatment in patients with depression or bipolar disease. Few people in the general public are aware that depression is usually a recurring and sometimes chronic condition.

   For major depression, treatment should continue for at least one year. Among people with severe or recurring depression, treatment should go on indefinitely. Acutely suicidal patients should be referred for immediate assessment, and usually require hospitalization. Remember that untreated depression carries a mortality rate as high as 15 percent.
2. Be very reluctant to discontinue use of lithium (in bipolar patients). In cases where lithium must be stopped, do so gradually. Lithium has a specific anti-suicidal benefit. In a review of twenty-two studies, the pooled risk of suicide in unipolar and bipolar patients fell 89 percent among patients who received lithium maintenance, in comparison to those who did not.

   In a study of two hundred bipolar patients, of whom half decided not to continue use of lithium, suicidal behavior increased twenty-fold within six to twelve months. With lithium, suicide attempts in bipolar patients fell tenfold, though they still remained two times higher than those of the general population
3. Don't be afraid to ask about suicidal thinking. Physicians and mental health professionals should ask specific questions such as, "Have you ever felt suicidal? Have you ever seriously considered suicide?

How close have you come? Have you ever tried to harm yourself? (Assume they have.) What did you do? What other means have you considered?"

4. Pay special attention to people with histories of suicidal acts. Ask about any history of violence or impulsive behavior. In addition to known demographic factors, consider the following acute risk factors for suicide: (a) severe anxiety, (b) global insomnia (difficulty falling asleep, staying asleep, and awakening early in the morning), (c) psychosis with delusions of poverty or doom, (d) hallucinations with commands or instructions to commit suicide, and (e) recent alcohol use.
5. Listen for expressions of hopelessness, desperation, and loss. These are common themes of the suicidal person, who typically sees suicide as the only solution to an intolerable existence. Suicidal persons invariably have a sense of loss that they feel deeply—whether or not this sense may seem reasonable to others. This loss may be interpersonal, financial, or health related.
6. Pay attention to your own attitudes and prejudices. Consider your own reactions toward suicidal people. It is common for medical personnel and others to feel disdain for unsuccessful suicide attempts. Somehow, like the ancient Japanese, we tend to admire the sincerely committed suicide effort. Depressed patients who have tried to harm themselves sometimes make the comment "I can't even do this right." Rather than agree with them, let us celebrate life-saving cowardice and "failure."
7. Never forget to consider those things that keep people living. Religious values may play an important role in the decision to say alive. The existence of children is often a deterrent to suicide, especially the presence of dependent children. A parent may think "I could not do that to them." Asking a woman, "Would you kill your children's mother?" may provoke thoughtful reconsideration of suicidal intentions. I sometimes ask patients, "What do you think has kept you alive the past few years?" in an effort to heighten awareness of reasons to preserve life.

Although there is no substitute for proper psychiatric and psychological treatment, the courage and hope of ill people can be an inspiring antidote to depression and fear. My wife and I recently spent a day with a dear friend who suffers from cancer and the effects of cancer treatment. She tired easily. She suffered painful nerve injury as a result of her chemotherapy. She covered baldness with a variety of scarves and hats.

However, her comments were as pointed and accurate as ever. She still suffered no fools. She zestfully lived each moment given her, making the barest concessions to her disease. She possessed the greatest confidence in her surgeon and oncologist, but had no magical expectations of their powers. She was not depressed.

It seemed that the awareness of her illness and its consequences sharpened her determination to live every moment, to treasure her friends and family and every beautiful thing that life can offer.

The frequency of self-murder is a challenge not only to the healing professions, but also to a culture rooted in the Judeo-Christian tradition. In the Christian view, life is a gift from God, and the value of every human life is measured in the priceless blood of Jesus Christ. Christians believe that God was willing to empty the riches of heaven to save one individual.

American individualism complicates matters, valuing personal autonomy, political and economic freedom, and individual opportunity and achievement. This same individualism in a secularized culture has led some to view suicide as a rational choice, the right of a person to chose death over life with physical or mental pain. These views are reflected in the Oregon assisted-suicide legislation, which asserts the right of individuals to receive physician assistance in carrying out the choice to end one's life.

However, I would argue that legally enshrining a new right to doctor-assisted suicide is not a solution. We must advocate both modern pain treatment and effective treatment of mental illnesses, especially depression, which is causal in the vast majority of suicides.

There is already evidence that wider use of new and safer antidepressants has decreased suicide rates in the United States. However, it remains a tragic and shameful fact that most suicides occur in depressed people who are untreated at the time of their death.

Suicide is usually not a calm, rational decision about the value of one's life. Rather, it is a decision often made by persons whose thinking is so impaired by illness that they are rendered incapable of logical decision making.

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