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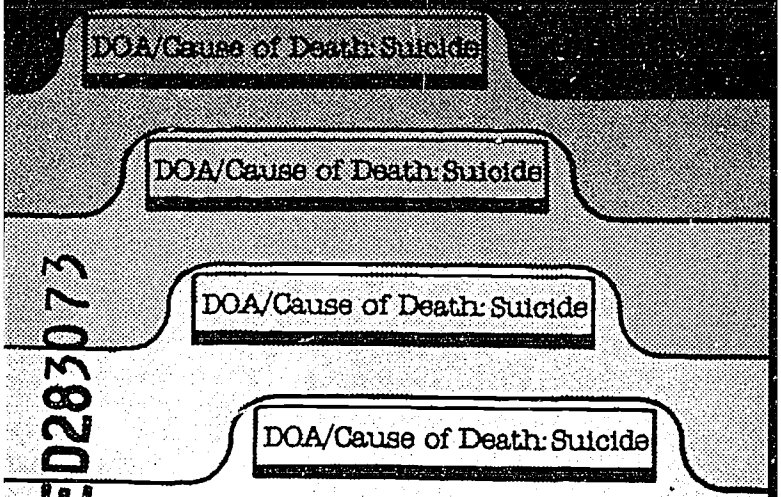
ABSTRACT

This booklet was written to provide information on suicide. It begins with a brief explanation of the role of suicide in history. A section describing those who commit suicide looks at various populations: elderly persons, children, adolescents and young adults, males, females, blacks, and persons of different marital status. The next section considers why people commit suicide. It distinguishes between suicide attempters and suicide completers and looks at the relationships between suicide and depression, hopelessness, alcoholism, and schizophrenia. Different theories of suicide are discussed and familial influences, biochemical clues, and other factors are considered. Warning signs of suicide are presented, including previous suicide attempts, talk about suicide, planning and making arrangements, personality or behavior changes, and clinical depression. Twelve suggestions are given to help readers prevent a suicide. Various treatments are discussed, including psychotherapy, drug therapy, hospitalization, and electroconvulsive therapy. Prevention efforts at the federal and state levels are identified, private and volunteer initiatives are described, ways of minimizing the means for self-destruction are discussed, and the role of suicide prevention centers and hotlines is explained. For further information, lists of organizations, readings, and places to find help are provided. (NB)

National Institute of Mental Health

Useful Information On . . .

Suicide



- **What are suicide's warning signs?**
- **What can you do if someone you know is suicidal?**
- **Is there a connection between mental illness and suicide?**

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

If you picked up this booklet because you are thinking about committing suicide, you should know that you can be helped and, with the aid of treatment, have a better life.

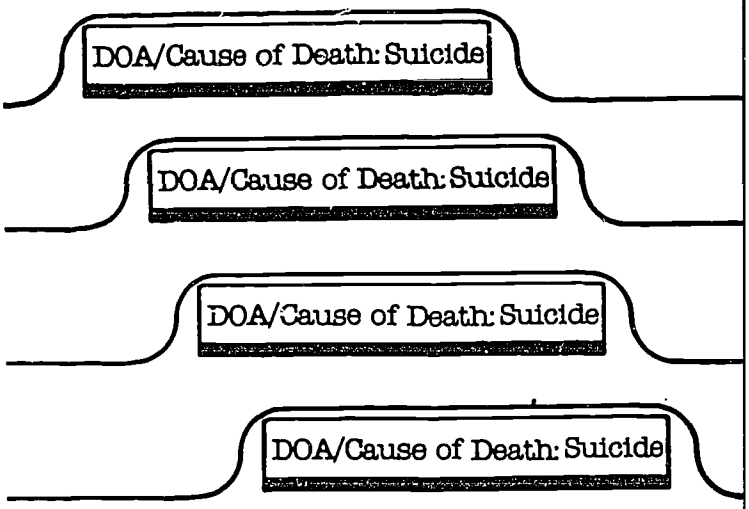
Most people who try to commit suicide, or who think about trying, feel overwhelmed by situations from which they want relief. They don't understand that even painful, complicated situations can be eased if they speak up and talk to someone who is trained to listen, evaluate what is said, and give advice.

Researchers have learned much about critical factors which contribute to suicidal behavior. Depression is generally the most important problem associated with suicide, and it can be treated effectively with psychotherapy and/or medication. The first step is to seek help from someone qualified to determine what type of help or treatment is needed. If suicidal feelings persist, a careful evaluation by a mental health professional and a physician is important.

Let someone know about your feelings. There is absolutely no reason for anyone to go through a painful period alone. Friends, relatives, members of the clergy, self-help groups, and mental health professionals are good sources of help during trying times.

Useful Information On . . .

Suicide



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Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

National Institute of Mental Health
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Table of Contents

Suicide In History

Suicide is as old as it is universal. People have been killing themselves since the beginning of recorded time. Suicide has meant different things among various cultures through the ages. It hasn't always evoked horror. It is mentioned matter-of-factly in the Bible. It was tolerated, even honored, as a particularly decent death in ancient Greece and Rome. Suicide continues to be so honored in Asian and Middle Eastern societies today. It was the ticket to salvation for early Christian martyrs and is now believed by Islamic martyrs to be their ticket to salvation. Suicide has meant delivery from military defeat and escape from enslavement.

Suicide survived religious and secular transformation in the sixth century, as a sin against God and a crime against the community, to become a major theme for Renaissance writers. It was a cause for enlightenment philosophers and a fashion among melancholy nineteenth century romantics. In the last century, suicide captured the interest of mental health scientists, and the modern study of suicide got under way. What had been defended as an intellectual choice by enlightenment thinkers came to be seen as, if not a sign of mental illness, a means of relief from psychic pain and sorrow.

Today, in industrialized countries where suicide statistics are available, suicide ranks among the 10 most common causes of death. Such countries include Finland, Austria, Denmark, Sweden, Hungary, and Japan. In the United States, suicide is the 10th leading cause of death. Approximately 30,000 people killed themselves in 1982. More than 10 times that number attempted suicide. Worldwide, more than 1,000 people kill themselves every day. In the United States, the toll is 73 people a day. Suicide has become the focus of serious

scientific inquiry and public health attention in most industrialized countries.

Until recently, suicide was a topic that few people would discuss in this country. It was considered shameful and evoked feelings of guilt in those whose lives were touched. Today, with the increasing rate of suicide among the young, many instances of suicide among two or more youngsters in the same school or community, and heavy media attention, more people are concerned and talking about it. Such people include:

Survivors: individuals, families, and friends who have lost a loved one by suicide and want to know how they can cope with their loss and what they could have done to prevent the suicide;

Families at Risk: people who feel they have reasons to be concerned about their loved one's behavior or threats, and want to know what steps they can take to prevent suicide;

Individuals at Risk: persons who are themselves distraught and need help in coping with loss, depression, pain, or other stressors in their lives;

Caregivers: volunteers, clinicians, and mental health professionals who have special skills to intervene in a suicide crisis and treat suicidal behavior. (These people always seek new information to upgrade their skills and knowledge so they may work more effectively with families and individuals at risk. Others in this category are researchers, students, legislators, ministers, and media personnel.)

People ask if something can be done to prevent this tragic loss of human life—if caring family members, friends, and work associates, aided by mental health professionals,

can prevent suicide. The answer is a qualified YES.

This booklet is written for people who want to understand and prevent suicide. It will provide some background information on why some people choose suicide, who they are, and how they feel. It will outline warning signs and steps to take if someone is believed to be suicidal. It will then provide information on what professionls can do to help, and what added avenues of help are opening up through research.

Who Commits Suicide?

Almost everyone in this country has been touched by suicide, either through knowing someone who committed suicide, hearing about someone who did, or thinking about it personally. Suicide cuts across all age, racial, occupational, religious, and social groups. But the greater frequency with which it occurs in some groups suggests that social and cultural factors play a significant and complex role. The most conspicuous and consistent demographic patterns of suicide are according to age, sex, and race. The most pronounced shifts in rates are showing up in age groups, however. Suicide rates are known to increase steadily with age, but current rates for young people, age 25-34, are rivaling those in older groups. While the overall rate of suicide has remained the same, the rate has soared for adolescents and young adults (who historically have had the lowest rates) and has declined somewhat among the elderly (who historically have had the highest rates).

Elderly: People over age 60 made up only 16 percent of the U.S. population in 1980, but accounted for 23 percent of those who committed suicide. Almost 3,500 white males over age 65 killed themselves in 1982.

Adolescents and Young Adults: Among adolescents in the United States, suicide is the third most common cause of death, after accidents and homicide. For college students, it is the second most common cause of death. The rate has tripled in the last 30 years. In 1968, the total suicide rate for 15- to 24-year-olds was 7.1 per 100,000. This accounted for 11.6 of the total number of suicides nationwide. By 1982, the rate had jumped to 12.2. Since 1977, over 5,000 youths, age 15-25, have killed themselves each year—about 20 percent of the total number of deaths by suicide. While suicide attempts generally outnumber suicide completions by 8-10 to 1, the ratio for youth is 25-50 suicide attempts for every one suicide completion. In addition to suicide attempts and suicide completions, there is a third area of consideration: the "suicide crisis." This refers to those moments or situations when individuals struggle with the idea of suicide, become obsessed with it, and even plan a suicide in detail, but who come to grips with the intense pain and agony that accompanies a crisis of this sort, and stop short of an actual attempt. While figures on the number of suicide crises are hard to come by, it is believed that approximately one million or more young people in this country experience suicide crises of varying degrees each year.

Children: Reports of suicide among very young children are rare, but suicidal behavior is not. As many as 12,000 children, age 5-14, may be hospitalized in this country every year for deliberate self-destructive acts, such as stabbing, cutting, scalding, burning, overdosing, and jumping from high places.

Males: The overwhelming majority of completed suicides are males. They comprise approximately three-fourths of the total who commit suicide, and white males account for about 70 percent of that total. Males tend to

use the deadliest weapons. Well over half shoot themselves, and the use of guns (mainly handguns) is increasing rapidly.

Females: Four times more women than men attempt suicide, usually using potentially less lethal means, such as drugs and wrist-slashing. However, one-third of the women and over half of the 15- to 24-year-old females who completed suicide used guns. Recent reports indicate their growing use. The suicide rate for women, relative to men, rises steadily until about age 50. Although the suicidal rate for women has tended to stay well below the national average, its pace has accelerated over time.

Blacks: Sharp increases in suicides among young black males have in some urban areas outdistanced rates for white males in the same age group. This is a startling increase, since the overall suicide rate for blacks traditionally is about half that of whites.

Rates among blacks, as well as for other non-Anglo groups, peak among males in their 20s, and those rates have been getting higher.

Married or Single: Because more adults are married, more adult suicides are married. But the greatest risk for suicide is among the widowed, separated, divorced, and those who live alone.

Why Do People Commit Suicide?

There are as many reasons people commit suicide as there are people who commit suicide. Among those commonly cited are: to find relief from feelings of hopelessness; to escape from an intolerable situation; to punish loved ones; to gain attention; to change other people's behavior or change one's circumstances; to join a deceased loved one; to avoid punishment; to avoid becoming

a burden; to escape the effects of a dreaded disease; to seek martyrdom; to express love; and even to pursue an irrational, impulsive whim. Notes left by people who have killed themselves usually tell of irresolvable life crises. Many eloquently describe what it's like to endure chronic pain, to lose loved ones, or to lack the money to pay bills or the ability to perform the simplest tasks. "No one ever lacks a good reason for suicide," noted Cesare Pavese, an Italian writer, who himself committed suicide. The question is why they give up when most people in similar circumstances somehow manage to cling to life through the worst of times.

Mental health investigators from varied disciplines have been trying to answer that question for decades. In recent years, a whole new field of study—suicidology—has grown out of that effort. It has given rise to a research model in which disease and genetic factors are incorporated with social, psychological, and environmental factors. Psychologists have observed that some people conduct their lives in a way that predisposes them to failure and self-destruction. Social scientists point to the social and economic dislocations that drive some people to suicide. Increasingly, biological investigators are studying how irregularities in brain chemistry affect impulsive and aggressive behavior which often goes along with suicide. They all emphasize that suicide is the result of an ever-changing interplay of many different factors.

Commonly cited reasons for suicide come from individuals with serious intentions to die, and from attempters whose actions may be designed to gain attention or manipulate other people. Reseachers are examining the problem of suicide from both perspectives. Studies of people who actually completed suicide show factors that are different from those found among individuals who at-

tempted but survived. Whether or not death is intended, it is clear that a serious problem exists, and it is best to take such self-destructive behavior seriously.

SUICIDE ATTEMPTERS/SUICIDE COMPLETERS

Research findings have led investigators to view those who attempt and those who complete suicide as representing two different but overlapping groups. Other investigators view the behavior of those who attempt and those who actually kill themselves as representing a continuum of suicidal behavior. Attempters tend to be younger and are more often women, and their attempts tend to be more impulsive and ambivalent. Completers are more often older and male and choose more clearly lethal techniques for self-destruction. But researchers stress that even among the most determined, suicidal individuals don't want to die as much as they don't want to live the lives they are leading. Whatever their type, many are desperately crying for help.

Those who have made attempts, but survived, talk about having been poised between life and death, living half in this world and half in the next. They describe an inability to make plans, even to set lunch dates, because they expected to be dead. Most of all, they describe their feeling that a suicide attempt was inevitable. However, followup studies of similar individuals reveal their intense ambivalence about dying. Not only are they glad to be alive, but, for many, a suicide attempt marked a turning point—it was a dramatic signal that their problems demanded serious and immediate attention. Most of those who survived their suicide attempts indicated that what they really wanted was a change in their lives.

Recent work—comparing the lives of those

who killed themselves, those who attempted, and those who died of natural causes—reveals that, in the main, the lives of those who kill themselves are often no worse than those of others who carry on. To the objective outsider, their situations are far from hopeless, and there are ways other than suicide to solve their problems. But because of stressful life situations and/or psychiatric illness, those who kill themselves don't see it that way.

Research has suggested that different disorders are linked to different suicidal behaviors. Nonfatal attempters are more likely to be characterized by neuroses, personality disorders, chemical dependence, and situational disorders. Personality disorders are frequently associated with suicidal behavior among young people, and young people tend to be attempters. Those who actually kill themselves have shown a predominance of major affective disorders including depression, alcoholism (or other chemical addiction), and schizophrenia.

SUICIDE AND DEPRESSION

It is obvious that most people who commit suicide are desperately unhappy. Moreover, scientists and mental health professionals believe the majority are suffering from a medically identifiable depression. A reported 40-70 percent or more of those who killed themselves have a history of serious depression. Depression is also a repeating factor among those who attempt suicide. Studies involving psychiatric patients indicate the average suicide rate is 30 times greater in those with serious depression than it is in the general population. Only one-fourth of the estimated 25-35 million people suffering from serious depression are getting help.

The most common depressive illness—and the one most often associated with suicide—is

"unipolar" depression. This is a frequently recurring condition characterized by behavior change, dejection, and even suicidal thoughts, but without the extreme impulsivity and elation of "bipolar" depression, or manic-depressive illness. Bipolar disturbance represents an estimated 25 percent of those with serious depressive illness. Much of the work on depression and suicide over the past decade has been devoted to finding a factor or group of factors which may help to determine who is most at risk. Considerable research has pointed to hopelessness as a key factor.

SUICIDE AND HOPELESSNESS

Recent studies tend to confirm earlier work showing that suicidal thoughts and behavior are more closely related to hopelessness than to depression per se. Researchers studying the attitudes of some severely depressed people have concluded that many *think* themselves into suicide. They misperceive the world and act accordingly. They are pessimistic, lack confidence in their ability to handle their problems, blame themselves, and set unobtainable goals on which they pin whatever hope they have. This finding has some treatment value, since it suggests that patients who feel hopeless need to learn how to think differently about the world. There are treatments that can help in encouraging such learning.

SUICIDE AND ALCOHOLISM

Alcoholics have extremely high rates of depression and suicide. An estimated 7-21 percent of alcoholics kill themselves, compared to about 1 percent of the general population. A recent study concerning alcoholics indicated that hopelessness is a stronger indicator of suicidal intent than depression or a previous attempt. Alcoholism is significantly

involved with nonfatal suicide attempts as well as completed suicides.

SUICIDE AND SCHIZOPHRENIA

Investigators have found that those suffering from schizophrenia and other serious thought disorders, particularly if delusional or hallucinating, have a high incidence of suicide attempts. Depression is also common in a large percentage of chronic, relapsing schizophrenic patients. Patients suffering from schizophrenia often have a long history of hospitalization and figure significantly in the group of patients who commit suicide while hospitalized or shortly after discharge.

Theories of Suicide

French sociologist Emile Durkheim proposed that social forces heavily influence suicide rates; he asserted that the critical factor was social integration. In the first major contemporary analysis of suicide published in 1897, *Le Suicide*, he theorized that lack of social interaction and isolation could bring about what he called "egotistic suicides," while "anomic suicides" would result from social disintegration, such as the Great Depression in the 1930s.

For Sigmund Freud, whose psychoanalytic theories followed a short time later, suicide was an internal matter. Thoughts about suicide arose, in the unconscious mind, from a natural impulse toward self-destruction. A key concept was that suicide was murder in reverse. When people kill themselves, they are turning inward the hostility they feel toward a rejecting loved one. Later theories expanded on the concept of ambivalence and the role of aggression. Such notions have influenced a variety of studies including research on the phenomenon of "victim-precipitated homicide," or provoking one's

own murder, and research that suggests accident-proneness and excessive risk-taking reflect underlying self-destructive tendencies.

FAMILIAL INFLUENCE

Recent research on family history and suicide suggests that, for whatever reason, families strongly influence suicidal behavior. Studies of families of suicide attempters and completers reveal more suicidal behavior among their parents and relatives than in families of other, nonsuicidal psychiatric patients. Another recent investigation found that almost half of the 243 psychiatric patients studied, with a family history of suicide, attempted suicide themselves.

Researchers emphasize that suicidal behavior, like depression, can be learned. But at least some findings from studies of identical twins have indicated that if one twin commits suicide, the other is at higher risk of attempting or committing suicide.

BIOCHEMICAL CLUES

Scientists now know that thoughts and feelings come from complicated interactions of chemicals and electrical impulses between nerve cells, and the keys to communication between the cells are the neurotransmitters. Various neurotransmitters have been linked to different emotions, and a small class of transmitters, the biogenic amines, have been linked to the affective disorders. Those specifically identified with major depression include norepinephrine and serotonin, among others.

More recent work indicates serotonin may be specifically involved with suicidal behavior as one of a wide range of behaviors marked by aggressiveness and impulsiveness. Researchers are asking if the same biochemical process at work in those who kill themselves

is also at work in those who murder others. Swedish researchers in the mid-1970s were among the first to spot serotonin as a possible distinctive marker for suicide. They found recorded low levels of the serotonin metabolite 5-HIAA (5-hydroxyindoleacetic acid) in the spinal fluid of depressed psychiatric patients. Patients with low levels of the metabolite went on to kill themselves at a much faster rate. Findings indicated that serotonin may have as much to do with regulating violence, aggressiveness, and impulsiveness as it has with causing depression. Researchers say that serotonin abnormality, which appears to be associated with suicidality across several psychiatric diagnoses, may represent a genetically linked trait.

OTHER FACTORS

Issues of illness and independence figure importantly in suicide among the elderly. Both the psychological drain of having a serious illness and the physiologically based emotional problems often caused by illness are frequent factors. Parkinson's disease, organic brain syndrome, and degenerative disease, in general, are frequently associated with suicide and, most frequently, with suicide among the elderly. The fear of physical decline alone, with possible institutionalization, can be enough to trigger a suicide attempt in some older people.

Losses of all kinds—of mates and friends, of health and work, of physical and financial independence, of status and self-worth—can overtake the elderly with relentless frequency and with greater finality than among younger people. A young person whose husband or wife dies is more likely to remarry. Young people face problems with work and even long stretches of unemployment, but older people generally leave the labor force permanently and often unwillingly.

Authorities repeatedly point to loss, the loss of a parent or other loved one, the loss of self-esteem caused by perceived failure or rejection, or the loss of a sense of security as a major reason young people kill themselves. They frequently come from families where a parent or loved one has died, sometimes through suicide, or where there is separation or divorce, financial stress, or parental illness. But while current research confirms the painful impact of parental loss on children at an early age, it also emphasizes the importance of a family's ability to cope with problems and loss and to pass along coping and survival skills. Studies show that perhaps as many suicidal youngsters come from intact homes as from broken homes, but many of those intact families have long histories of disorganization and instability.

Since homicide rates are high, investigators see the rise in suicides as part of an overall trend toward more violent deaths among the young, especially blacks. They link it to increased availability of firearms, changing family patterns, the breakdown in traditionally stabilizing institutions, the dissolution of a sense of community, rapidly changing social mores that aggravate already turbulent adolescent development, and the intensive pressures of competing for limited educational and employment opportunities.

Abusive family situations contribute to feelings of hopelessness, anger, and despair. Parents may be ill, use alcohol or drugs excessively, engage in impulsive or suicidal behavior, fail to provide for the emotional and physical needs of the child, fight continually, and maintain a generally high level of tension. It is well-known that chaotic environments, which leave children in constant insecurity, often contribute to depression and suicidal behavior. Although scientists debated, for some time, whether clinical

depression existed in children, it is now an accepted fact. Depression in children is frequently cited in recent studies of suicidal behavior among children and adolescents. Suicide-prone youth may show depressive symptoms of feeling sad, worthless, and hopeless and may appear lethargic and withdrawn. But they may also be verbally aggressive and physically assaultive. As a result, they may be tragically written off as sullen or as troublemakers.

Unemployment can undermine family stability and trigger marital problems, separation and divorce, conflicts with children, and child abuse or neglect. Recent studies of adolescent suicide consistently cite a high incidence of family disruption and instability, with employment or economic problems as a backdrop.

Unemployment is often associated with violence. Researchers have blamed recent high unemployment, especially among young black males, for some of the increase in violent deaths. Historically, rates have risen in times of intense competition for economic security. Unemployment, like alcohol abuse and social isolation, is a common problem associated with suicide among older white males. Even the impact of widowhood may be less severe than the effects of retirement, because loss of work frequently involves the loss of important social contacts, sense of purpose, and financial resources. The loss of power and status associated with employment seems to be particularly important to older white men; blacks and minority men, who typically have had less power and status all along, are less drastically affected.

A wide network of kin, friends, and activities is one of the best buffers against suicide in the elderly. Paradoxically, an increase in the

elderly population may protect old people, while a similar increase may crowd the young. Researchers note that the recent flattening of suicide rates among the elderly may be related to improved social security benefits and increased political organization and clout.

Marriage and children can help blunt other losses experienced in old age. Almost three-fourths of couples who account for the relatively rare double suicides in Western society are elderly. They are often in failing health, devoted to each other, isolated, and estranged from others.

Suicide's Warning Signs

Researchers believe that most suicidal individuals convey their intentions to someone in their network of friends, family, or coworkers, either openly or covertly. These people represent those who are most intimately and extensively in contact with a particular suicidal individual. They are probably in the best position to recognize the signs and render help.

There is no profile or checklist for identifying a suicidal person. Suicide, like much of human behavior, is difficult to predict. Despite their best efforts, even experts cannot say whether or when a person will try to commit suicide. But there are several danger signals which, particularly in combination, demand immediate concern and attention.

Previous Suicide Attempts: People who have made serious suicide attempts are at highest risk for actually killing themselves. The suicide rate for repeat attempters is up to 643 times higher than the overall rate in the general population. Between 20-50 percent of the people who commit suicide had previously made attempts.

Suicide Talk: People who commit suicide often talk about it first. Statements like, "They'd be better off without me," or "No one will have to worry about me much longer," can be give-aways, but a more off-hand, "I've had it," may also be a clue.

Making Arrangements: Some suicidal individuals take steps to put their affairs in order. They draw up or alter their wills, give away prized possessions, make arrangements for pets, and otherwise act as if they are preparing for a trip. They talk vaguely about going away. Such behavior is particularly alarming when other danger signals are also present.

Personality or Behavior Change: Often the tip-off is a change in personality or behavior. A normally buoyant person may seem increasingly down for no good reason. A regular churchgoer may stop attending services. An avid jogger may quit running. Such behavioral change, especially if accompanied by expressions of worthlessness or hopelessness, can be a sign that a person is suffering from a clinical depression, often a forerunner of suicide.

Clinical Depression: While 85 percent of depressed people are not suicidal, most of the suicide-prone are depressed. Thus, identifying and treating depression can prevent suicide. Depression is sometimes hard to detect, even for the sufferer, since its symptoms superficially resemble ordinary feelings and occurrences. But there is a pattern that can help to distinguish clinical depression from less serious mood problems. A person is likely to have a clinical depression if, in addition to depressed mood, at least four of the following symptoms continue nearly every day for at least 2 weeks:

- change in appetite or weight
- change in sleeping patterns
- speaking and/or moving with unusual speed or slowness
- loss of interest or pleasure in usual activities
- decrease in sexual drive
- fatigue or loss of energy
- feelings of worthlessness, self-reproach, or guilt
- diminished ability to think or concentrate, slowed thinking, or indecisiveness
- thoughts of death, suicide, wishes to be dead, or suicide attempt

A person who is depressed, uncommunicative, and withdrawn may be flashing a danger signal. And when suicide clues and depression appear against a backdrop of stressful events in a person's life, such as the loss of a spouse, relative, or job, a serious illness, or a major move, there is reason for even greater concern.

Individuals who are generally isolated, have few or poor social ties, abuse alcohol or other drugs, or have a history of physical and emotional difficulties are at even higher suicide risk when in the throes of depression. They can't think straight. While they may normally exhibit a rigid thinking style, they view life even more narrowly when in turmoil. Every issue is polarized—yes or no, black or white, life or death.

Researchers have pointed to an organiclike deficit in the thinking of severely depressed people which is similar to some neurological conditions known to cause thought and memory problems. Just when people need most to be clear-headed, they are not.

What Can You Do?

Listen: If a friend or family member appears depressed and exhibits any of the signals

above, talk about those feelings. A troubled person needs someone who will listen. It may not be easy to discuss a friend's or relative's suicidal thoughts, but it is critical for the suicidal person to be able to talk about why he or she wants to die. Every effort should be made to understand the problems behind the statements. Although you should show interest, refrain from making moral judgments or trying to talk the person out of it. Listening is the best action.

Access: Ask specific questions about the person's suicidal thoughts: Does he or she have a plan? Bought a gun? Where is it? Stockpiled pills? What are they? Contrary to popular belief, such candor will not give a person dangerous ideas or encourage a suicidal act.

Evaluate: It is possible that a person may be extremely upset but not suicidal. Often, if a person has been depressed, and then becomes agitated and moves about restlessly, it can be cause for alarm. If the person has made clear suicide plans, the problem is more acute than if their thinking was less definite.

Be Supportive: Let the person know you care. Most important, break through the suicidal person's sense of isolation, stay close, and make the person understand that he or she is not alone. Assure the person that suicidal impulses are temporary, that depression can be treated, and that problems can be solved.

Take Charge: Stress that help is at hand, and waste no time finding it. Don't worry about invading someone's privacy or taking charge. Since suicidal people don't believe they can be helped, you will probably have to do more than urge them to seek professional help. You may wish to enlist the support of other family members or friends. DO NOT WAIT.

Make The Environment Safe: If you live with or are closely related or associated with someone who may be suicide-prone, remove any weapons and ammunition, medication or other drugs, and household items such as knives, razors, or scissors which could be used as aids to suicide. They should not be hidden on the premises but removed completely.

Do Not Keep Suicide Secret: Suicide is not a secret to be kept. Suicide talk, threats, or plans are signals for help. Sometimes distraught individuals will confide in a friend about their suicidal thoughts or plans by swearing the friend to secrecy. This is not a test of friendship but a cry for help and must be treated as such.

Do Not Challenge, Dare, or Use Verbal Shock Treatment: It is fallacious to think that telling an ambivalent suicidal person to commit suicide will shock him or her into rational thinking. This should not be tried; it may precipitate an irreversible tragedy. Instead, acknowledge the person's feelings, and reassure them that help is available and that the situation can be resolved. If the crisis is acute, DO NOT LEAVE THE PERSON ALONE.

Seek Professional Help: Do not try to handle the problem alone. Get in touch with a professional immediately. Encourage the person to see a physician or mental health professional for evaluation. Start with the person's family doctor, a local hospital, or mental health center. You may also wish to seek help from a local suicide prevention or crisis intervention center, the clergy, or even the police.

Make a Contract: If you find yourself with a person who is obviously suicidal, and you need time to develop a plan of action, make a contract with that person. That is, get a commitment or promise, preferably in writing,

from the suicidal person stating that he/she will not attempt suicide before you are able to get together again to talk it over.

Beware of Elevated Moods and Quick Recoveries: Elevated mood can sometimes be misleading. Individuals may wrestle with the idea of suicide and, after having made a decision to kill themselves, behave as though they have had a heavy burden lifted from their shoulders. They proceed to kill themselves, leaving everyone stunned who had assumed they were on the road to recovery.

Quick Recoveries: On the other hand, there are individuals who experience psychological relief after sharing their problems with an empathetic listener and erroneously feel that the crisis is over. Subsequently, the crisis flares again. Followup is critical to any prevention effort.

In the words of one expert: "You can help best by taking the problem seriously, assuring the person that something can be done, encouraging the acceptance and use of professional help, being a good friend to talk to when you are needed, and getting advice from an expert. Your friendship and your actions could save a life."

Treatment

Because mood disturbances contribute so significantly to suicide, early identification and vigorous treatment of depression and other associated disorders would substantially reduce the incidence of suicide. Through recent research conducted with hundreds of patients at affective disorder clinics, it is now known that the coordination of adequate drug treatment, supportive psychotherapy, education, and, of most importance, long-term followup care can alleviate depression significantly.

PSYCHOTHERAPY

There are many different psychotherapies, including brief treatments aimed at undoing the thought distortions and repairing the broken relationships frequently associated with the suicide-prone. These could be short term or long term and involve the individual, family members, or a group of individuals with similar problems. There are therapeutic strategies for retraining patients whose ability to manage problems and interact with people may have been eroded by years of inappropriate behavior. Depression may have driven a patient deep into withdrawal so that important social skills need to be relearned.

DRUG THERAPY

Standard treatment involves prescribing a major antidepressant and using some form of active psychotherapy, often with family members. Drugs include the tricyclics, such as imipramine and amitriptyline, which stabilize mood and relieve many depressive symptoms; the monoamine oxidase (MAO) inhibitors, such as isocarboxazid, phenelzine sulphate, and tranylcypromine sulphate, which work on accompanying anxiety and excessive sleeping and eating; and lithium carbonate, which has proven most effective in controlling manic-depressive illness.

HOSPITALIZATION

For the patient who is suicidal and may have attempted suicide in the past, the immediate concern is safety, then recovery. Since drugs may take several weeks to start working, the question of whether to hospitalize a patient as a precaution becomes an important issue.

ELECTROCONVULSIVE THERAPY (ECT)

Although long recognized by psychiatrists as

a safe, painless, and effective treatment for depression, electroconvulsive therapy (ECT) is often avoided because of public criticism and the availability and acceptability of antidepressant drugs. But because it works quickly to dislodge a life-threatening mood, ECT is often recommended by psychiatrists as the immediate treatment for seriously suicidal persons who have not responded to other treatments. Improvements in ECT administration—in particular, the use of electrodes on only one side of the head (unilateral placement)—reportedly reduce the temporary memory loss and confusion that are its main side effects.

While clinicians can't predict suicide with precision, they can intervene effectively with patients who are in the throes of a suicidal crisis or who have attempted suicide. They can also help those suffering from a major disorder which ultimately could lead to suicide.

Prevention

FEDERAL AND STATE INITIATIVES

To prevent suicide, it is important to identify the factors that increase the risk for ending one's own life. The reasons people are committing suicide at an increased rate are being investigated extensively. Research studies currently funded by the National Institute of Mental Health (NIMH) should provide some answers and identify psychosocial and biological risk factors for suicide. Other areas of investigation that offer promising treatment and prevention strategies include research on the relationship of mood disorders and suicide; the identification of possible biological markers for suicide; and a better understanding of the contagion effect in adolescent suicide.

Educational efforts to increase the public's awareness of the signs and symptoms of depression and impending suicidal behavior are also needed. The NIMH has launched the Depression/Awareness, Recognition, and Treatment (D/ART) campaign to increase public and professional knowledge about this public health problem.

There is a need for States, counties, and communities to develop services related to the prevention of suicide. The Omnibus Budget Reconciliation Act of 1981 authorized block grants to States for mental health, alcohol abuse, and drug abuse services. Services related to suicide should be a component of these programs.

PRIVATE AND VOLUNTEER INITIATIVES

One example of an outstanding volunteer initiative is that of a New York City Minister, Chad Varah. He launched the Samaritans, a nonsectarian program now world-wide, whose trained volunteers operate a 24-hour suicide prevention hot line. They also provide a 24-hour walk-in service to people who are lonely or suicidal and want to talk to someone.

There is now a strong effort to establish an educational component on suicide in professional training for physicians. Since three-fourths of those who commit suicide visit a doctor a short time before they die, better education of physicians, including pediatricians, to recognize serious depression in their patients and to assess suicidal risk could save lives.

Some researchers have suggested that changing mandatory retirement rules, providing preretirement counseling, and making sure that every elderly person has a telephone are

potential ways to decrease isolation and possible suicide among old people.

Survivor support programs can help heal the psychological damage inflicted on the family and friends by a suicide and lessen the chances of another suicide in the process.

Experts have recommended programs designed to teach coping skills. People who commit suicide tend to have more risk factors which make them more vulnerable and less adaptable. Some authors suggest that schools should play a larger role in teaching coping skills.

MINIMIZING THE MEANS FOR SELF-DESTRUCTION

In institutions, such as psychiatric hospitals and prisons, where suicides are known to occur, specific precautions are developed to prevent residents from taking their lives. In many communities, suicide-risk areas—such as high bridges—have been identified for increased surveillance. Some urban areas receive greater attention and services on the basis of high-suicide-attempt rates or a concentration of high-risk demographic factors. Citizens in some communities have erected signs near popular suicide bridges, urging potential jumpers to call a local suicide prevention center. At some suicide sites, including the Empire State Building, physical barriers have been built to block attempts.

Such direct steps as lowering the carbon monoxide content of gas used in homes and limiting the number of pills that can be prescribed at one time have been cited as influencing the recent decline in British suicide rates. Even adoption of the catalytic converter in automobiles has been mentioned as a lifesaver. But in this country guns are the

primary method of self-destruction. It is argued that because guns and explosives account for more than half of the total suicides and because gun use is increasing dramatically, limiting their availability might curtail suicide rates. Evidence suggests that stricter handgun control laws do lower the incidence of suicides by firearms. Even if potential suicides switch to other means, they're likely to choose something less lethal.

SUICIDE PREVENTION CENTERS AND HOTLINES

In Los Angeles in 1958, the first Prevention Center opened its doors and its telephone lines; it quickly became a model for providing crisis services, training professionals and volunteers, and spearheading research. In 1961, the International Association for Suicide Prevention and Crisis Intervention was founded; in 1968, the American Association of Suicidology formed to foster research and information exchange. Centers have been expanding their efforts beyond crisis intervention, providing longer term care, contact, and followup. Recently, there is renewed emphasis on outreach programs aimed at educating the public, particularly school personnel and others in a prime position to identify and intervene with suicidal individuals.

Much of the organized prevention campaign in this country has been carried on by hundreds of centers and hotlines set up to respond to those in crises. While some centers have been involved in such wide-ranging activities as helping to design a suicide-proof jail, most have focused on providing emergency counseling. Recent studies have shown that, while callers may need help, most are not acutely suicidal. For those who may be potentially suicidal, short-term aid may be inappropriate. Evaluation and preventive intervention research needs to be conducted to

measure the efficacy of these programs and to find the most effective ways of preventing suicide and identifying and treating those people at high risk.

Conclusion

Most researchers insist that suicide and attempted suicide should be considered separate subjects. Although they are related, there are important demographic, social, and clinical differences. Researchers agree, however, that both suicide and attempted suicide represent desperate, painful cries for help.

The only cure for suicide is prevention. Since suicide has many facets, prevention efforts come in many forms, including treating depression and other mental disorders before they lead to suicide, providing crisis counseling for those who threaten suicide, providing treatment for those who make an unsuccessful suicide attempt, and minimizing the opportunity and means for self-destruction.

Right now, from what we know about suicide, the most important prevention strategy for acutely suicidal people is early detection and treatment of associated emotional disorders. Dissemination of information on what we now know about suicide holds the greatest promise for reducing the number of suicides. Greater awareness by family, friends, and significant others can lead to identification of more of those at risk and evoke more caring responses so that depressed and suicidal individuals are encouraged to seek professional help.

While the research continues, mental health professionals, health care specialists, and families and friends of suicide victims contend that it is everyone's business to help try to prevent suicide.

For Further Information

ORGANIZATIONS

American Association for Suicidology
2459 South Ash Street
Denver, CO 80222

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2932

National Alliance for the Mentally Ill
1200 15th Street, N.W.
Washington, DC 20005

American Psychiatric Association
1400 K Street, N.W.
Washington, DC 20036

American Psychological Association
1200 17th Street, N.W.
Washington, DC 20036

National Depressive and Manic Depressive Association
P.O. Box 753
Northbrook, IL 60062

FURTHER READING

Farberow, N. *The Many Faces of Suicide: Indirect Self-Destructive Behavior*. New York: McGraw-Hill, 1979.

Hendin, H. *Suicide in America*. New York: Norton, 1973.

Hoff, L. *People in Crisis: Understanding and Helping*. 2d ed. Reading: Addison Wesley, 1984.

Robins, E. *The Final Months: A Study of the Lives of 134 Persons Who Committed Suicide*. New York: Oxford Press, 1981.

Shneidman, E.; Farberow, N.; and Litman R. *The Psychology of Suicide*. New York: Aronson, 1983.

WHERE TO FIND HELP

Community Mental Health Center
Crisis Intervention Center
Suicide Prevention Center
Emergency Room or Psychiatric Department of Local Hospitals
State Hospital Outpatient Clinic
University or Medical School Affiliated Program
Mental Health Professional
Family Service/Social Agency
Private Clinics or Facilities
Family Physician
Members of the Clergy

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