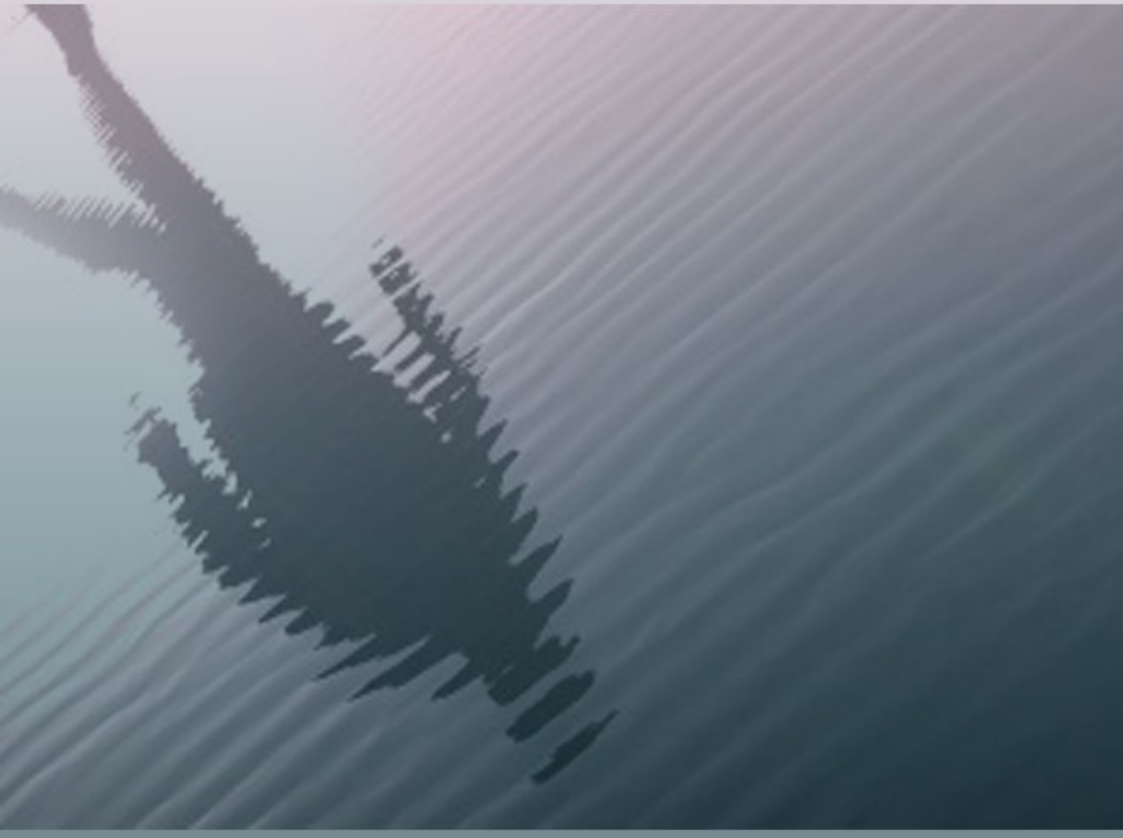
Symptoms, Prevention, and Treatment of Attempted Suicide



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Depressive Disorders

Symptoms, Prevention, and Treatment of Attempted Suicide

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In 1969 and 19701 was a National Institute of Mental Health Fellow in Psychiatry at the Johns Hopkins Medical School, Phipps Psychiatric Center, where, with a group of distinguished faculty and interested students, I studied suicide. At that time we considered eight questions essential to our understanding of self-inflicted death:

1. Are individuals who attempt suicide like those who commit suicide or are they different?

2. Are attempted suicide and completed suicide the same, or are they distinct entities?

3. Is suicide a disease or a symptom?

4. Can suicidal individuals be identified before the event?

5. What are the symptoms that put them at risk?

6. What is it that drives people to suicide?

7. Are people who attempt or commit suicide pathologically disturbed or can they be “normal”?

8. How can individuals be prevented from taking their own lives?

Twenty years later these questions are still crucial to the field—and 20 years later we have only a few of the answers. Let us look at each question.

ATTEMPTERS AND COMPLETERS

Are attempters and completers alike or are they different? There is consensus that suicide attempters and suicide completers need to be seen as separate, but overlapping, populations (Farberow, 1989). A prior suicide attempt may be a clue to future suicide, but as often it is not.

Are attempted suicides and completed suicides discrete acts? Twenty years ago I proposed, for purposes of research clarity, the continuum model of suicide, with suicide placed at the far end of the continuum and suicide attempts at the beginning. I suggested that individuals who attempted suicide should be seen, not as one homogeneous group, but rather as at least two subgroups divided according to motivation: those who attempted suicide but did not wish to end their lives, and those who attempted suicide with the intention of dying. Attempters in this latter category could be considered more like those who commit suicide, because the only difference between those who live and those who die is the lethality of their attempt (Cantor, 1972). Take, for instance, Carl, a young man who stabbed himself in the heart. He missed death by 1/16 of an inch. When someone like Carl dies, we look at his personality and life events as characteristic of completers. When the person lives, we examine him as an attempter. He would be no different either way. The difference is found in the 1/16 of an inch—not in the person.

Prior to 1970, the vast majority of studies on attempted and completed

suicide did not make any distinction beyond whether an individual survived or died. Anyone who lived was an attempter, anyone who died was a completer. This dichotomous approach made much of our research useless.

A second major flaw in suicide research was the absence of control groups. Researchers would study a group of suicidal individuals and make claims about them, only to realize later that the same claims could be made for other behaviors as well.

Even at the present time, research on attempters and committers is still so confounded that we are certain of only one crucial difference between the population who survive an attempt and the population who die. That difference is gender. The ratio of suicides committed by males to those committed by females is almost five to one, and the ratio of males to females for attempted suicide is the reverse. Rates for males committing suicide increased by 50 percent during the past decade while the increase for females was only two percent (Kupfer, 1989).

A DISEASE OR A SYMPTOM?

To the question, is suicide a disease or a symptom, finally there is a strong consensus of reply among the experts: Suicide is a symptom and not a disease entity. This means that suicide can be the outcome of any number of psychological or physical conditions and that attempted suicide can be an intermediate point in any number of circumstances.

Certain symptoms or behaviors do appear frequently, however, in the histories of individuals who attempt or commit suicide. Depression is the symptom most frequently mentioned. Even if an individual is suffering from depression, however, it does not mean that he or she is about to kill himself or herself. Not all individuals who are depressed are suicidal and not all individuals who are suicidal are necessarily depressed (Cantor, 1987a).

While depression is the symptom most often associated with suicidality, the significant factors that put a person at risk have more to do with behavioral and cognitive changes than with the diagnosis of depression.

A person is considered at risk if he or she has:

1. Made a suicide attempt or gesture.

2. Discussed or threatened suicide.

3. Made a specific plan to take his or her own life.

4. Been preoccupied with death.

5. Known someone who has committed suicide.

6. Identified with someone who has died violently, modeled his or her actions on that person's behavior, or been traumatized by that person's death.

7. Been abusing drugs or alcohol.

8. Poor impulse control; been known to act impulsively or violently.

9. No strength to tackle any problem and is blind to any way out.

10. Cognitive rigidity and constricted vision—has rejected all suggestions and is convinced that suicide is the only solution.

11. Perfectionist standards and is convinced that life should be perfect and nothing less than perfect is acceptable.

12. Recently experienced a loss. This could be an actual loss or it could be the loss of self-esteem. Loss may be the only factor on this list directly related to depression.

The symptoms of suicide that are related to depression are sleep and eating disturbances. These symptoms, however, can also be related to anxiety.

Individuals who have eating disorders and who are depressed or anxious appear to have a defect in the opiod systems and in the metabolic functions of

their brain. It is not entirely clear, however, whether the defect and neurochemical changes are the result of the anorexia or bulimia (known to affect the central nervous system through caloric deprivation), or the cause of the symptoms. Norepinephrine and serotonin levels are lower in individuals with anorexia and bulimia. Both remain low, however, in individuals who have maintained healthy eating patterns for almost two years, leading researchers to speculate that the lower levels of norepinephrine and serotonin were present prior to the eating disturbance. Thus, eating problems may have their origins in neurochemical dysfunction, and depression and anxiety may be symptoms of the underlying biological problems (Fava, Copeland, Schweiger, & Herzog, 1989).

A third symptom of depression associated with suicidal behavior is that of extreme lethargy coupled with pessimism. A fourth symptom is overt hostility. A fifth is withdrawal and isolation and the sixth recently identified risk factor, related to both depressive illness and suicide, is serotonin. Low serotonin level or difficulties in serotonin regulation predispose one to violent behavior and suicide (Asberg, et al., 1981).

ETIOLOGIC FACTORS

Twenty years ago, suicidologists did not mention biochemistry or genetic predisposition except to deny the fact that suicide could be inherited. Today suicidologists admit that suicide does run in families and cite the genetic basis for manic-depressive psychosis and schizophrenia and the inherited tendency to low serotonin level, which can put a person at risk.

What is it that actually drives people to suicide? I have stated that suicide is a symptom and not a disease, and suicide can be the result of psychiatric illness, physical illness, or biochemical imbalance. It is possible, as well, that some suicidal individuals may not be psychiatrically disturbed, but rather only temporarily stressed to the point of not wanting to live. It is also established that the symptoms of suicide potential can lead to other outcomes. If all of the foregoing statements are true, how can we ever identify the origins of suicide?

An example will further illustrate this dilemma. The break-up of a relationship might be the final straw that triggers a serious depression in a person with a history of manic-depressive illness. Is it the heartbreak, the depression, the stress, or manic-depressive tendencies that are responsible for the person's suicide attempt? And if this person also has a dysfunctional family or few friends, should we blame isolation or lack of social supports for the suicidal behavior?

The question then becomes: How do these different risk factors contribute

to the outcome of suicide potential, and with what weight? Or is the number of factors the important criteria? In order to answer these questions we might better ask: What is it that keeps people from attempting or committing suicide? To date, few have taken this approach.

It is clear that psychiatric illness does predispose one to suicide, but it is also clear that it is not a necessary variable. Further, it is not clear exactly which psychiatric illnesses predispose one to suicide (Cantor, 1989b; Shaffer, 1989).

The psychopathologies most frequently documented as related to suicide are affective disorders (primarily depression), conduct disorders, and substance abuse. Personality traits such as impulsiveness and aggression, and borderline and antisocial personality disorders are often cited as well. And one recent study claims anxiety and panic symptoms are the best indicator of future suicidal potential (Weissman, Klerman, Markowitz, & Ouellette, 1989).

The literature and folklore lead us to believe that suicide occurs among depressed individuals. Current studies, however, refute this and point to other areas of risk such as anxiety, substance abuse, biochemical and neurochemical dysfunction, and the psychosocial factors of lack of support, stress, chronic illness, and chance.

Moreover, the actual vulnerability of an individual to suicide may fluctuate from day to day. This raises the question of whether suicide is more often the

result of mental illness or of the vagaries and stresses of life, be they hormonal, biochemical, or situational.

For example, take a 16-year-old who breaks up with his girlfriend after he has been cut from the final tryouts for the hockey team and has been humiliated in front of his teammates. His former girl's new interest is the captain of the team and the 16-year old's pride is severely damaged. He goes to a party and gets high. He hopes to see his girl and patch things up, but he drinks too much and leaves feeling despondent. He does not have the life experience to know that tomorrow may bring a new love. He just lives for today and today was not so hot. As he drives into his family's garage, his eye catches his father's rifle hanging on the wall. He takes it down. He may be at risk for suicide. Is it the heartbreak, the humiliation, the alcohol, or the gun? Which of the factors is causing the vulnerability? Is it a temporary vulnerability or will this boy be at continual risk for suicide?

One goal of suicidologists is to identify individuals at risk so we can prevent people from killing themselves; yet we cannot seem to agree on something as basic as the significant factors for suicide potential. The most important breakthrough in research in the past 20 years has come from the identification of serotonin, and while this has great importance in the field of mental illness, it is of little practical value to most professionals or individuals on the front lines of prevention.

In sum, the factors that can lead to suicide and attempted suicide are diverse and nonspecific. The list of biochemical, behavioral, psychological, and social characteristics that are linked to suicide includes:

1. Alcohol and drug abuse
2. Mental illness—with much controversy as to which illnesses are most heavily represented
3. Impulsive and antisocial behaviors
4. Severe stress, shame, or loss

Those that are suicide-specific are now reduced to:

1. A history of previous suicide behaviors or a family history of violence or suicide
2. Witnessing a suicide
3. Low concentrations of serotonin metabolite, 5-hydroxinodoleacetic acid (5-HIAA), and homovanillic acid (HVA) in the cerebrospinal fluid
4. Access to a lethal weapon such as a gun, a car, or drugs.

We are now at a point where we can tackle the question: Is mental illness a necessary prerequisite for suicidal behavior or can “normal” individuals attempt or even commit suicide?

NORMALITY

There are four major perspectives on normality (Sabshin, 1967): normality as utopia, normality as process, normality as average, and normality as health. Normality as utopia is an ideal state of self-realization which is almost never realized. Normality as process is a longitudinal interpretation of behavior where only the successful unfolding of developmental tasks can adequately prove normality. Normality as average is a statistical perspective according to which the most common behaviors are considered normal for that group. Normality as health refers to a reasonable rather than an optimal state, and is defined by the absence of pathology, pain, or limitation of action.

Parents are concerned primarily with the last two definitions: Is my child like everyone else and is he free from pain? Kids are concerned with normality as average, especially when they want something their parents may not approve of. They invoke this definition when they say: “But Mom, all the kids are drinking; I don’t want to be different.” Or, “Everyone is having sex.” Parents may not consider these “normal,” but, they may, in fact, be average for this age group.

What is normal and average, however, may not be normal and healthy. Cavities, for instance, are average—more people have them than not—but on one would tell you that having holes in your teeth is a sign of health. Contemplating suicide is so common among teenagers that studies that span the past two decades show that teenagers who do not think about suicide are the ones who

deviate from the norm (Cantor, 1976; McCormack, 1987); but no one would tell you that contemplating suicide is a sign of health.

For clinicians, the most valuable definition of normal is that of health. Normality as utopia implies that just about everyone is disturbed and this is as clinically useless as implying that no one is disturbed. Normality as process is of concern to us, but it means that we have to wait a lifetime for the verdict. Relying on normality as average means we would not concern ourselves with adolescents who drink, as long as most of their peers drink as well, and we would not treat heroin addicts as long as they live in a community of addicts.

Yet judgments of normality cannot be free from the context in which they occur. One example is ritual suicide, a behavior that has a different meaning for the Japanese in Japan than it does for Japanese in the United States. Using the definition of normal as health, however, we can include the capacity for social interaction and harmony within an immediate society at the same time we assume the individual is free from pain, discomfort, and disability.

I see a lot of teenagers in my practice. Many are average and some are even healthy. Many of them function at a high level but have met very few of life's problems, and when they hit a snag, they do not know how to cope. It would be an error to ask: To what diagnostic category does their pathology belong? Rather, I must ask: Why is this young person suicidal at this time? How can I work to keep

this person alive? How can I help this youngster to face his problems and take control of his own life? How can I teach him to be more resilient? How can I help him to believe that he has value? These are questions of coping skills and self-esteem, not questions of pathology.

To stretch this point, it is possible that attempting suicide could be considered adaptive under the "right" circumstances. Consider the youngster who comes from a family where the adults are so wrapped up in their own affairs that they do not have the time to notice their child's distress. The adolescent decides to call attention to his problems in a very dramatic fashion. He does not intend to die, he only wants people to notice that he needs help. His suicide attempt might get that help; it might be an instructive way of rallying his family. It would be my job as a clinician to teach this youngster other, more constructive, less risky ways of getting the attention he wants, but I would not necessarily claim that this young man was self-destructive.

Consider another youngster who is in love and his girlfriend tells him she wants to break it off. He goes to a bar and drowns his sorrows in too many beers. As he is driving home, he is apprehended by the police for "driving under the influence" and taken to a holding cell to sober up. It is hours before his father can be reached. The boy has been intimidated and left alone. When his father receives the phone call he screams at his son in bitter disappointment. The boy is afraid of facing his father's rage. Rather than deal with the anticipated consequences, he

tries to hang himself with his belt. Is this young man pathologically disturbed, or a "normal" kid with less resiliency than we would like and a victim of circumstances at a vulnerable moment in time?

Perhaps, then, for many individuals who commit suicide, we need to consider psychopathology or biochemical deficiencies. However, many are individuals with reduced coping skills, who are without psychopathology but temporarily are without the will to live. They have passed their threshold of tolerance.

Suicidal behavior may fit the same paradigm as alcohol behavior. Thinking about suicide, like thinking about alcohol, may be both average and healthy. Attempting suicide, like drinking socially, could be average and could, under certain circumstances, be considered adaptive—if one attempts suicide to correct a situation one perceives as nearly impossible. This would be like drinking for health purposes. Attempting suicide or committing suicide with the intent of killing oneself, like abusing alcohol with the intent of never sobering up, would not be considered either statistically average or a sign of health.

Perhaps a better analogy would be to that of sex. Thinking about sex is normal—both average and healthy. Having sex is normal—both average and healthy. Doing nothing but thinking about sexual activity, to the exclusion of all else, is neither average nor good for your health.

If we think of all individuals who talk about, gesture, attempt, or commit suicide as seriously disturbed, we will stigmatize people and make them reluctant to go for help. If those whose job it is to identify individuals at risk only concern themselves with people who show serious pathology, we will miss many individuals whose lives we could save.

> Shneidman (1990) made this point strongly when he wrote: To understand suicide I would eschew the dreary demographic facts of age, sex and race, and I would ignore the obfuscating psychiatric categories of schizophrenia, depression and borderline states—and assume that 100 percent of individuals who committed suicide, were, in one way or another, significantly perturbed, not psychiatrically disturbed.

Debate on this question continues. Some professionals think that in order to be suicidal one must be psychiatrically disturbed. Others think that, given the "right" set of circumstances, almost anyone could be suicidal.

Without definitive answers to this and other questions, the prevention of suicide becomes an extremely elusive goal, but one that we continue to try to reach. Whom should we be targeting for prevention and how should we be trying to reach them?

PREVENTION

Suicide prevention can be approached on two different levels: the social and the traditional. The social approach encompasses public education and environmental risk reduction. The traditional view encompasses the different forms of clinical treatment. If suicide is the result of both social and psychological problems, for effective prevention, a combined approach would be best.

In the past 20 years, the focus of national suicide prevention programs has been on youth because the suicide rate for this age group has risen dramatically and continues to remain high. Every decade we expect 50,000 of our young people to commit suicide and in the same time period, we estimate about 5 million young people will attempt suicide (Cantor, 1987c).

We have managed to decrease the mortality statistics for every age group in the United States, with the exception of young people, who now have a higher death rate than they did 20 years ago. This is primarily due to increases in suicide and homicide, the two types of death that are more heavily influenced by social factors than any other. The discussion of the broader aspects of prevention that follows focuses on youth suicide.

Youth Suicide

Thus far, in suicide prevention, the social approach has meant education. To

make the point that education is a form of prevention, let me give you an example.

Ben was a high school student in Massachusetts. He came into school one morning and went directly to the nurse's office, where he called a crisis intervention center. He spoke for half an hour, hung up the phone, and walked to his classroom, gathering students along the way. "Come see me," he said. "Come see the most sensational act of the century. You don't want to miss this!" He walked into his classroom, opened his desk, pulled out a gun, and shot himself. After a few agonizing days in intensive care, Ben died, leaving a trail of devastation in his wake.

If anyone had been familiar with the risk factors, if anyone had known what to look for, it would have been noticed that Ben was in trouble. He had missed a lot of school, had bruises on his neck— probably from previous attempts at hanging himself—and gave away his favorite records saying he would not need them anymore. He had been writing about suicide, and he had been calling a crisis line. He had a gun. If anyone had knowledge about the warning signs or about how to intervene, Ben might be alive today (Cantor, 1987a).

Educational intervention is difficult to evaluate because of an absence of data. Over a period of years, however, it is estimated that public education could reduce the suicide rate among our young people by 20 percent (Cantor, 1987b).

The second aspect of the broad treatment approach to prevention is

limitation of the availability of lethal agents, particularly guns. Guns account for more suicides than all other methods combined: 65 percent of all teen suicides are committed with firearms. Some 25 million households have handguns and one-half keep their handguns loaded. Many more keep rifles. Suicidal individuals are impulsive and having a loaded gun in the house is an invitation to disaster.

I recognize that eliminating guns would not resolve the underlying problems that drive people to suicide, but it would result in fewer deaths. Consider the analogy of mandatory seatbelts: Seatbelts do not make people better drivers, but seatbelts improve the chances of surviving a collision. Removing guns will not make people more content with their lives, or healthier individuals, but the absence of lethal weapons gives them a chance to survive and work on their problems.

Studies estimate that 70 percent of gun victims could not have obtained them if there had been handgun regulations. Fifty percent of these individuals might have used another method. Thus, the reduction in firearm accessibility could save the lives of approximately 20 percent of our youngsters (Cantor, 1987c).

When highly lethal methods of suicide are less available, there is evidence to show that individuals do not necessarily switch to other means. When the English converted their home heating gas from deadly coke gas to low lethality natural

gas, their suicide rate dropped 33 percent. This rate remained constant despite the bleak economic picture in England, which would ordinarily have been expected to lead to an increase in suicide.

Poisoning, usually with prescription medicine, is the second most common method of suicide, accounting for 11.3 percent of all suicides. The availability of lethal drugs could be limited by restricting the number of tablets permitted with each prescription. This kind of legislative restriction on sedative and hypnotic drugs is thought to be largely responsible for the decline in the suicide rate in Australia in the 1960s and 1970s. In addition, tricyclic antidepressants could be sold with an emetic or antidote. If an individual overdosed and then had a change of mind or was found, an antidote could be given and a life could be saved. The projection is that this could save approximately 3 percent of teen suicides a year (Cantor, 1989a).

Thus, the prevention strategies that would appear to have the greatest impact on youth suicide are the limitation of the availability of firearms and medications, together with education programs in positive mental health.

DIAGNOSIS AND TREATMENT

The clinician's responsibility, in the more traditional approach to treating suicidal individuals, is to make an appropriate diagnosis and plan beneficial treatment.

The important point to remember in diagnosis is that if suicidal behavior is a symptom and not a disease entity it can appear in almost any diagnostic category and we would do better to approach suicidal individuals with a therapeutic model that looks for where they are well rather than where they are "sick."

Treatment is the final step in helping a person cope with the conflicts that generate a suicidal crisis. The most appropriate choices for treatment of suicidal individuals seem to be supportive psychotherapy, followed by insight-oriented psychotherapy or family therapy.

Supportive psychotherapy will reinforce the person's defenses and help control disturbing thoughts and feelings. Unlike psychoanalytic therapy, it focuses on present difficulties and avoids probing the past or the unconscious. It is most effectively used with a patient who is experiencing anxiety, stress, or turmoil (as in most suicidal states), or when an individual with psychotic potential becomes overtly psychotic or goes into acute decomposition with psychotic overtones.

In diagnostic terms, the therapist can use supportive psychotherapy most

effectively with psychotic and borderline patients and as an initial approach with patients who have neurotic difficulties or character disorders. With fragile individuals, a supportive approach may be all that can be accomplished. It may be the best initial approach for those who have less fragile organization but reduced capacity to cope.

The therapist might order medication, to relieve anxiety or decrease depression, or hospitalization, to protect the patient and ease the strain on the patient and the family. Medication or hospitalization can allow the family a chance to regroup their emotional resources.

Once the goals of supportive psychotherapy are achieved, the therapist can move to insight-oriented therapy focusing on the patient's life situation.

Family therapy is used when the patient's difficulties reflect ongoing difficulties with the family or when there is identifiable pathology in other family members. The goal is to help the family become aware of the underlying emotional conflicts and to open up the potential for change. The focus is on the process and not on the individual.

Regardless of the model one chooses—cognitive therapy, behavior therapy, psychoanalytic psychotherapy, family therapy, or any other method of therapy—the way in which treatment is conducted is a more important factor than the treatment model.

The key in working with suicidal individuals is to be warm and responsive without being too familiar or effusive. It is rarely (if ever) beneficial to remain aloof because suicidal individuals, already sensitive to rejection, will interpret analytic anonymity as rejection and feel alienated from the therapist.

Patients want to see their therapists as a powerful source of wisdom. Many suicidal individuals want to see their therapists as more than powerful, they want to see them as omnipotent. A therapist must tell the patient that as much as the therapist may want to be there when needed, no therapist can be available 24 hours every day and night.

Individuals who are suicidal very often are self-centered (even though they may feel they have no self and no center). They expect their therapist to be waiting by the phone and do not understand if their therapist is not there at precisely the moment they need intervention. There is often a fragile balance between life and death, a balance as fragile as a response on the other end of the phone. The therapist must make his or her human limitations known.

Another issue in working with suicidal patients is that of fatigue and burnout for the therapist. Freud said that a doctor who sees 10 patients a day is exposing a concealed attempt at suicide. Imagine what Freud would have said about the therapist who sees 10 suicidal patients a day—perhaps that the attempt is no longer concealed.

SUMMARY

It is now many years after Freud, more than 50 years since the publication in 1938 of Karl Menninger's landmark book on suicide, *Man Against Himself,* and nearly the end of the 20th century. Are we any closer to resolving the questions of self-destruction and suicide?

We have taken some steps forward: We now recognize the fact that children and adolescents can and do commit suicide, we have greatly improved methods of data collection, we have increased national awareness of the loss of life by suicide, we have implemented programs of public education and programs of community response to crisis, and we have furthered our understanding of the biological origins of depression, schizophrenia, manic-depressive psychosis, and violent behaviors.

In many ways, however, we seem to have taken steps backward. We are destroying ourselves and each other at ever increasing rates and in ever increasing numbers by homicide and suicide, with guns, automobiles, drugs, and toxic pollution, and we are threatened by total global destruction with nuclear weapons of our own making.

In the past half-century since Menninger wrote *Man Against Himself* we have continued to look to medical science, psychology, sociology, anthropology, biochemistry, epidemiology, psychiatry, and religion for the answers to our

questions on the etiology, the symptoms, the prevention, and the treatment of suicide. Yet, 50 years after Menninger, 20 years after Johns Hopkins, and almost into the 21st century, the answers of individual and global self-destruction still elude us.

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