MYTHS ABOUT SUICIDE

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Suicide is a topic of immense importance. Needless to say, we all find the topic of death in general a difficult one to face - but particularly death from suicide. Choron (1972) has stated that there have been 20,000 Americans dying annually from suicide according to actual statistics. However other authors have stated that a truer figure is probably closer to 50,000. Suicidal death seems to have a uniquely devastating effect on the survivors - more so than most any other kind of death - particularly when occurring of children who are of a vulnerable age - and when occuring in adolescents - as it does so frequently. The family members of a suicide victim often bear the scars of guilt for a long time. It is not only family, but friends and others, who may have helped that are also affected by suicide. Thus Schneidman (1969) has estimated that 14 people become intimately affected by one person's suicide - which total 750,000 persons a year in this country. Based on the suicide rate of 11 in every 100,000 people, a million people in a metropolitan area would likely realize 110 suicides with 1500 people intimately affected by those suicidal deaths.

I would like to discuss the subject of suicide in more depth, using the catchy title, Myths about Suicide. There are a lot of them but I have selected only a few.

Myth #1: Suicide victims always tell someone about their suicide plans before they do it.

Kobler & Stotland (1964 have said, "Those who follow suicide attempts with actual suicide have made efforts, directly or indirectly, to elicit help from significant others in their world; and have received in response.. a helpless answer."

In spite of the fact that 75% of all suicide victims reportedly saw a doctor during the previous month, they were unable to ask for help directly. It appears that suicide attempts follow a loss of hope about being able to tell someone about their helplessness or to expect that telling someone will make a difference. Nevertheless, suicide victims often give warning signals to friends or family members. They may be disguised signals, such as the sudden finalization of long uncompleted tasks, or less disguised ones such as buying a gun for no apparent reason.

One of my supervisors has told a story about one of his acquaintances who, while a resident in psychiatric training a number of years ago, appeared to be one of the most popular persons in the class. He knew all of the important persons. He seemed successful. But to everyone's shock he suddenly killed himself. After it happened, my supervisor, who was a resident himself at that time, was asked by one of their mutual friends: "What was wrong? You seemed to be one of his closest friends." He answered: "No, I was going to ask you the same question. I always thought you were one of his closest friends. I really never got close to him." As it turned out, no one had ever gotten close to him. His outward appearance of success - his apparent happiness - were all symptoms of narcissistic traits which had been a facade to look good, but which

covered over hidden feelings of failure and meaninglessness which he did not dare to admit, to himself nor to anyone else. Those who are unable to talk about failure, helplessness, and hopelessness make a final statement in the suicide act itself.

Myth #2: A suicide attempt is always a cry for help.

This statement is partly true. Many suicide attempts are in fact cries for help. Researchers studying suicides have found that most of them were apparently not meant to result in death. Since depressed persons may find it difficult to ask for help directly, then attempted suicides may serve the purpose. Rengel (1959) studied suicides in juveniles and estimated that only 30% of them were cries for help. The others included psychotic reactions to the loss of contact with internal emotional and physical vitality, or reactions to terminal illness, or reactions to existential meaninglessness.

Suicides in adults are frequently related to existential meaninglessness and in male adults, they often result in serious - no mistake suicides - usually with firearms. In such cases the suicides are angry denunciations of fruitless attempts to reach out to someone else. Or as Jung found (1939), failures in finding religious meaning in their lives. I am personally acquainted with a case of that type - where a seemingly happy professional person brought up in a religious home, decided that the religious belief of his youth had lost its meaning.

I was in a thological discussion group with him and was surprised one Sunday morning to hear him say, "I have more or less become an agnostic. A belief in God doesn't fit into my current understanding of human behavior." Three year later, he was dead from suicide.

Myth #3: Past suicide attempts are likely hindrances for future suicide attempts.

This would seem to be a logical conclusion - that people who have failed at a suicide attempt, and there are many such failed attempts, would not want to go through the same misery again. Sheidman and Farberow (1957) estimated that there have been eight attempts for every successful suicide. As a result, there are approximately 5 million survivors of suicide in our country today (Mintz, 1970). Do persons who have made an attempt try again? Heimerzham (1933) reported that 70% of survivors looked back upon their own suicide attempts with disdain, called them silly and never made another attempt. In another study, O'Hara, et al., (1962) found that 90% were glad to have been saved from death at their own hands suggesting that they never attempted suicide again.

However, Chron (1972) has reported that 25% of those who have failed suicide attempts subsequently kill themselves or get themselves killed in accidents.

Myth #4. New and "exciting" changes in life are good deterrents for suicide in depressed patients.

This may have some validity for many slightly depressed persons but does not hold true for those who are chronically depressed and would-be suicide victims. An example of a would be suicide victim is the improving psychotically depressed patient in a hospital environment. In a memorandum dated September 14, 1981, distributed by V.A. Central office, the director of clinical services stated that "the majority of suicides occur in long term schizophrenic patients who were diagnosed as being suicidal..but then began to improve. They are removed from suicide observation and

permitted more freedom of movement and home visits. Suicides then occur without warning, usually off the ward and most commonly by hanging. The rationale for understanding this is that the victims lose the protection of their delusions and the (retarding influence of the depression) and must again face life situations from which they were escaping in the first place."

I can cite a personal experience, in a patient with a 10 year psychiatric history, including numerous hospitalizations for paranoid delusions and several suicide attempts. He was a Vietnam veteran whom I met with periodically as an outpatient. It had seemed as if his life had taken a turn for the better when he got married about 1½ years ago. Although he had immediately improved, he was depressed within six months and then rehospitalized for a short period of time. I met with him just a year ago, when he and his wife came to my office. He was elated during that visit. He had decided to move to California where his father lived, start a new life and forget all of his past failures and painful memories. His wife supported the idea and I naively was caught up in the illusion of his over-idealization. The next thing I heard was that he died the night before they planned to move. His body was found, fully clothed but wet, lying next to a river. The coroner's report stated that he died from over-exposure. Apparently he had gone to a party that night, created a disturbance, was asked to leave, and from there walked to the river. The circumstances pointed to the fact that he probably intended to drown himself, but then changed his mind and fell asleep on the river bank. An accidental suicide?

Myth #5: Suicides are always purposeful acts.

Karl Menninger, wrote a whole book on the self-destructive nature of man and titled it Man Against Himself (1938) . He said that there are

many persons who die or kill themselves in some way or another without ever making conscious decisions to do so. While this is frequently accomplished in a fashion that would never be called attempted suicide, there are seemingly many others who, after having thought they wanted to kill themselves, discovered that they were not very eager to die. Menninger said, "Every hospital intern has labored in the emergency ward with would-be-suicides who beg him to save their lives."

Not only is there a large group of persons who make half hearted suicide attempts, but there is also a group who invite self-destruction in an omnipotent way, apparently blind to the risk of death. At the most self destructive end of this spectrum are those who drive under the heavy influence of alcohol. At the least self destructive end of the spectrum are those who choose very dangerous prefessions, avocations, or hobbies while proving to themselves and others the degree of their fearlessness. Watch the tevision show, "That's Incredible" for examples.

A patient told me last week that he always drove 80-100 miles an hour, sticking to back country roads where the risk of being clocked by a patrol car was minimal. Another patient said that whenever he drank too much alcohol, he took his motorcycle out on the highway and sped it to 110 miles an hour. These are examples of omnipotent risk-taking behavior with significant self destructive potential although they lack the clear-purposeful intent of suicide.

There are others who also put themselves in jeopardy and are willing to consciously risk their lives, but for a purpose. On one end of the spectrum are clear-cut suicides, like Tommy Sands of the IRA. On the other side are redemptive stands for a peaceful cause. For example, Anwar Sadat knowingly risked his life by taking a stand for peace in the MIddle East. And indeed it cost him his life. His decisive leadership had an omnipotent quality

to it, particularly as he fearlessly made decisions that made him enemies. He was defiant to the threat of death - right to the very end - even to the point of standing up to the assassins who approached him with guns firing.

What is the difference between Sadat's death, and the death of a risk-taking, drinking motorcyclist, and the death of a person who deliberately decides to starve himself to death. The latter example is deliberate - with clear purpose - the victim being omnipotent to the final moment of life as an attempt at controlling his own destiny. A drunken motorcyclist is also omnipotent but as a risk taker. Perhaps he is testing out whether fate will save him or let him die. He is similar to the Vietnam veteran I now have in therapy who played Russian Roulette; however when the gun failed to go off, he decided to give up his omnipotence and ask for help. Perhaps there was a power outside of himself that wanted him to live.

Anwar Sadat, Martin Luther King, and others - including Christian martyrs throughout history - even Jesus Christ - each had a purpose that many of us would call redemptive; but impossible without a surrender of personal omnipotence to the power of God.

The truth is that there is a difference between the quality of purpose with which one lives life or seeks death. Here are three examples: 1) Suicide is the purposeful, but self-destructive acting out of personal omnipotence - reflected in the need to control one's own life and death and the need to discharge rage and hopelessness. 2) Self-destructive risk-taking behavior, which includes driving while intoxicated, smoking, abusing addictive substances, indulging in self-destructive eating patterns, and pursuing sensation seeking risk-taking behavior, does not reflect a whole-hearted, clear-cut purpose for either life or death; rather the acting out of one's own omnipotence while impulsively grabbing at transient pleasures

in the midst of purposelessness. 3) The surrendering of one's own personal omnipotence - to willingly die for a meaningful cause, reflects a whole-hearted, purposeful decision - a decision which runs counter to the popular myth that happiness is to be found in the self-serving, pain-free pursuit of pleasure and the control over one's own destiny.

Rather, such an act of surrender may provide the most significant of life's meanings: Paradoxically finding control over life and death through letting go of that control.

Perhaps much suicidal behavior is not entirely purposeful but reflects the wish of the victims to give up control over their behavior. That explains why those victims leave signals and hope that someone else, stronger than they, will see them and take over.

Myth #6: Suicide may lead to something much better in "the life beyond."

This is a fantasy of some patients that I have interviewed. I recall being in a therapy group with a number of depressed Vietnam veterans. During one group session the members discussed near-death experiences which they had read about in the Readers' Digest. Several of them wondered if the life beyond might be as pain free and blissful as the article described. This prompted the question: would death, even by suicide, be a painfree, even pleasureable experience? Some research has been carried out, not to answer that question but to answer a second: do persons who have failed suicide attempts, have near death experiences? Of course, the answer to that question may have nothing to do with the answer to the first question. Ring and Franklin (1980) interviewed 30 suicide attempters who came close to death and reported that about one-third had near-death experiences which were similar to but not as frequent as those reported by persons

who nearly died from illness or accidents. Interestingly, these survivors of suicide attempts tended to develop a strong anti-suicide orientation following their experiences. Greyson (1981) reported on the findings of Rosen (1975) who interviewed seven survivors of suicide attempts by jumps from bridges and all reported feelings of tranquility, peacefulness, and transcendence of bodily death during the fall. On follow-up, only one had repeated a suicide attempt, which was not lethal. Greyson's conclusion was that a near-death experience (NDE), appears to promote a regression in the service of the ego, or a rebirth experience in that person who subsequently seems to resolve the meaninglessness in his or her life. Greyson and Stevenson (1980) also found that following NDE's from any cause, there were subsequently different attitudes toward material posessions, sex, personal power, and relationships with other persons.

This still doesn't really answer the question if the life beyond might be better than this life for those contemplating suicide. There have been reports by mediums, if you believe in that sort of thing, who have contacted suicide victims and found them to be lingering in a state of anguish - a view that fits with the Biblical admonition against suicide.

The opposition to death from suicide was recently affirmed by one of my patients who after significant improvement as a result of therapy told me that he would not be ready to die until he experienced himself, as whole. It had become his firm belief that being whole was a prerequisite to dying and being able to make the transition from this life to the life beyond. I too believe that achieving wholeness is the essential experience of fulfillment in one's lifetime - and is a prerequisite for a meningful death. I will not attempt to define wholeness, but I do not believe that suicide will result in finding it either.

Myth #7: Persons who are receiving or have received psychiatric treatment are unlikely to commit suicide.

While this is frequently true, I can tell you from personal experience that psychiatric treatment is not a guarantee against suicide and to have a patient kill himself, is very painful.

Eight years ago, a psychiatrist friend of mine killed himself - and it occurred within a few months after he completed his own therapy which everyone thought had been successful. Apparently he also thought it had been; at least he told his friends that. But suddenly late one night, he disappeared from his house. For two weeks, his family and friends, with the help of the police and others, looked for him. It was a terrible shock when his body was found with evidence of a drug overdose. The pain of that event shook the whole community. We all asked, "how could it have happened, particularly since he had completed his therapy?"

And why has it happened to others who are involved in or who have apparently completed psychiatric treatment successfully? There is no one answer of course, but for my friend, it was the unrealistic expectation that the completion of his psychotherapy should allow him to do all the things he always wanted to do and step into new responsibilities and new opportunities; without experiencing failure or depression. He was unable to admit to himself or others that he became depressed again.

It is generally true, that a depressed person involved in a therapeutic relationship, and I stress that point - involved in a therapeutic relationship, will not take his/her own life. But that means the therapist provides support, hope, and everything he can possibly do to prevent self-destructive action from being carried out. That kind of a therapeutic relationship has real power to sustain life.

What might fail during therapy? Failure might result from the half-hearted attempt to form a therapeutic relationship while disguising it as a fulfilled one. Failure might result when the therapist doesn't take action to prevent suicide when the risk was great. Failure might result when the therapist doesn't listen or elicit hidden information about depression, suicidal thoughts, or a clear-cut suicidal plan. And failure might result when the patient's decision to kill himself is deliberately hidden while at the same time he precipitates a power struggle with the therapist - and says to himself "I knew it all the time, he didn't really want to help me"..

One of my Vietnam veteran patients told me a few months ago, that four of his fellow Vietnam veterans have killed themselves accidently or on purpose during the past year. One of them committed suicide just after being discharged from the hospital and thought to be adequately recovered. My patient was enraged. "Do you know why he killed himself?" he asked, "Why?" I asked in return. "It was because nobody on that G__ d_____ ward gave a damn about him...nor wanted to hear about the stuff he did when he was in 'Nam. So he made everybody think he was doing good. He put on a good front. That's why they let him out of the hospital. But the next day, he killed himself."

Those of us in the helping professions must never stop learning about the ways we overlook suicide clues or fail to help the potential suicide victim.

Myth #8: Suicide is always perceived as a death of the self.

Menninger has differentiated between suicide from wanting to die, suicide from being willing to be murdered, or suicide from murdering oneself. Is there a difference? Perhaps Tommy Sands" death from starva-

vation was a clear wish to die. Others have killed themselves by asking a servant to carry out the act, like Saul in the old Testament, or Caesar in Roman times. Some patients attempt to kill themselves but are unaware it is themselves who are the victims.

It is a little known fact that patients with multiple personalities will, generally, make one or more suicide attempts, frequently during the course of therapy. These are never perceived as attempts to kill the self, but are always acts of killing a person who is not perceived as being within the same body.

I can give a personal example of a multiple personality patient who I had been treating for 8 months when this happened. The predominant personality warned me that he expected something to happen to him. One day in therapy, he came to my office, and within 10 minutes said goodbye to me and then fell over on the floor. He was without pulse and respiration for about a minute. I was frantic and thought I was witnessing some strange voodo death. Then suddenly he sat up, A different person with a different voice and paranoid look on his face, said, 'I had to kill him, I had no other choice. He was going to run off and leave me alone again. He didn't want me to exist. I suppose you are now going to call the police'.

Myth # 9: Recovery from a suicidal depression is usually spontaneous.

You may think that such spontaneous recoveries do happen. In fact, there have been some reported instances of spontaneous recoveries from depression resulting from religious conversions. Cavenar and Spaulding (1977) reported on four cases of religious conversion experiences in association with severe depression. In two of the cases, the persons had hysterical personality traits and had lasting recoveries from depressions following conversion experiences. In two other cases, the persons had obsessive compulsive traits and their depressions were only temporarily lifted by religious conversions. Unfortunately, in both cases, the persons with obsessive compulsive trates committed suicide. In one case, a middle aged man had a depression for about one month, then he had a sudden religious experience which he believed would alter the course of his future life. He even made a testimonial to the congregation where he attended church services, and reported that he was experiencing a profound inner peace. After a few days, the peace vanished and he began to question the authenticity of his religious experience. He denounced it angrilly a few days later, in front of the same congregation, and then took his own life. The authors concluded from these two examples, that guilt and rage in obsessive compulsive personalities are no more than temporarily alleviated by conversion experiences.

When we become aware that someone is severely depressed, we should not expect that depression to clear up spontaneously. I am a believer in the power of a therapeutic relationship to bring about recovery from depression - certainly to bring about a change in the desire to commit suicide. Let me cite one case example. Over two years ago, On a Thursday night in June, I got a call from a depressed patient of mine, whom I had been meeting with infrequently in supportive psychotherapy for the past year. Because of a business failure and expectation of bankrupcy, he was feeling devastated and suicidal. As he talked about his wish to kill himself, he revealed the fact that he even believed that God was directing him to do it. I spent the next 1½ hours talking to him and during that time I confronted the fact that he was becoming his own God by deciding to kill himself.

I made an interpretation of his character defense over the phone, saying, "It appears to me that you would like to kill the part of you that has given the impression of perfection and as I recall from what you've told me, it's the part of you that reflects your feeling of being phony. But even though you can't tolerate your failure, I can accept that part of you that has failed as well as the phony part of you. It's important to me that you live-and I believe that God - at least the God whom I know - wants you to live too." I continued to talk to him, hoping to change his mind about killing himself. He had a suicide plan in mind but would tell me no more. Over the next two days, he returned the calls twice, but refused to tell me where he was calling from. I continued to make it clear to him that it was important to me that he remain alive and that it was important to God that he remain alive. After he became convinced of my sincerity, he agreed to come into the hospital. During the next six months, while he remained in the hospital, I met with him in psychotherapy twice a week. After his discharge, I continued to meet with him weekly for about a year. To make a long story short, he recovered from his depression, went back to school, found a new profession and is now working at it successfully - enjoying it and apparently making a meaningful and fresh start in life.

Serious depressions do not usually lift spontaneously, and if they do, they generally recur. There is no substitute for the intervention of another human being who will take the responsibility to prevent the suicide behavior and remain with that person as he recovers.