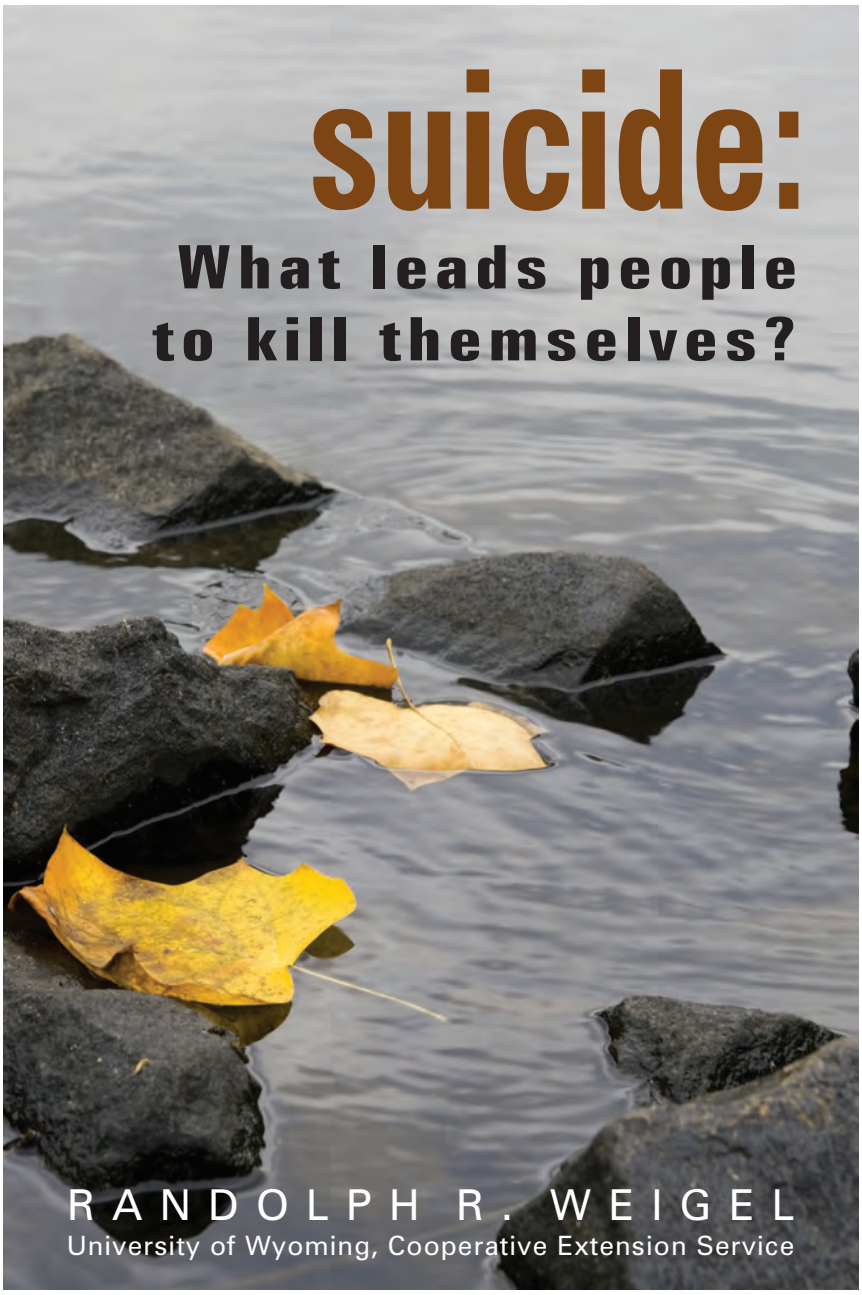

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Does the urge toward suicidal behavior develop as the outcome of debilitating physical illness, biological mental disorder, traumatic personal crisis, severe depression, alcoholism, or genetic predisposition? The answer is yes and more.

Factors that lead to suicide are complex, multi-dimensional, and often cumulative in nature. Suicide is the act of killing oneself on purpose. A simple definition of this self-destructive act is misleading because suicide is described in so many ways: tragic, shocking, enraging, relief, shame, selfish, the right choice, punishment, revenge, tempting, cop-out, devastating, unforgivable.[1]

For a few, suicide appears as a sudden act. For most, it is a long-considered decision based on prolonged despair or dreadful circumstance.[2] However one gets to the point of choosing to kill oneself, there is little doubt unbearable psychological pain is at the root of the decision.

Almost all suicides involve a combination of at least two major factors: mental disorder, particularly those including severe depression, anxiety, and/or substance abuse (especially alcoholism), along with extreme hopelessness often arising from distressing life events perceived by the person as overwhelming and unmanageable. Neither a mental disorder nor hopelessness and stressful life events alone may lead directly to suicide. When they come together and the psychological pain is unbearable, suicidal thoughts and behaviors may occur and can exceed the person's coping ability and capacity for tolerance.[3]

Of course, not everyone experiences distressing events the same way. Not everyone experiences suicidal thoughts and not everyone who does experience such thoughts engages in suicidal behaviors. What is unbearable for one person is not necessarily unbearable for another.[4] The absence or presence of positive ways to cope and constructively transform intensely difficult personal situations or experiences may be one major difference in whether someone finds their life stresses and situation intolerable or not. Researchers are studying suicidal experiences from the point of view of fostering strengths such as optimism, hope, and positive connection with others where despair, hopelessness, and isolation existed before.[5]

Suicide: The Toll and Pattern

- Suicide is the 11th leading cause of death for all Americans.
- Every day, 80 Americans die from a fatal suicide act.*
- It is the eighth-leading cause of death for males and 19th-leading cause for females.
- Suicide is the third-leading cause of death for people aged 15-24.
- Every day, approximately 2,000 Americans suffer a nonfatal suicide act.
- Four males die by suicide for each female suicide death.
- Three females suffer nonfatal suicide acts for each male who does.
- White males account for approximately 73 percent of all suicide deaths.
- Eighty percent of all firearm suicide deaths are white males.[7]

Suicide exacts an enormous toll from the American people. Our nation loses 30,000 lives to this tragedy each year, and another 650,000 receive emergency care after attempting to take their own lives. The devastating trauma, loss, and suffering is multiplied in the lives of family members and friends.[6]

David Satcher
Former Surgeon General

Increasing the Risk

A risk factor is a measurable characteristic, variable, or hazard that increases the likelihood of an adverse event. Risk factors may be thought of as leading to or being associated with suicide. People "possessing" a risk factor have a greater potential for suicidal behavior.[6] No single factor has been identified that reliably predicts suicidal behavior. Suicide is such a complex event that prediction, intervention, or treatment is often difficult. Still, there are known factors underlying suicidal behavior. By understanding these factors, a clearer picture can emerge as to how suicidal motivations develop and how family, friends, and others can intervene in a timely, appropriate manner when someone they know is at increased risk.

* Researcher Silvia Canetto argues that suicide should be defined in terms of outcomes rather than intent. She suggests avoid referring to suicidal acts that do not result in death as "attempted" or "failed" suicides. In addition, fatal suicide acts should not be labeled "completed" or "successful" suicides. Rather, she suggests fatal or nonfatal suicide behavior.[23]

Biopsychological Risk Factors

Acute psychiatric disorder is the single most common and dangerous precipitator – trigger – of suicide. Most people who suffer from depression, manic-depression, alcoholism, or schizophrenia do not kill themselves although a disproportionate number do. For some, the threshold of suicide is lowered because of the characteristics of the disorder itself. For example, the extreme irritability and impulsivity associated with mixed states or the mental and physical agitation of severe depression.[2] When risk factors are co-occurring (e.g., alcohol abuse when suffering severe depression), the risk of suicide is exacerbated.

Also, research indicates alterations in neurotransmitters in the brain such as serotonin are associated with the risk of suicide. Diminished levels of this brain chemical have been found in patients with depression, impulsive disorders, a history of violent suicide attempts, and in postmortem brains of suicide victims.[8]

Familial Risk Factors

There is some evidence suicide can occur at a higher rate in families with a history of suicidal behavior. Studies have also shown that psychiatric disorders are more prevalent among kin who are suicidal, and people with a family history of psychiatric disorder are at increasing risk for suicide.[10]

Suicidal behavior is not hereditary. Like exposure to any other risk factors, having a family history may indicate a person is at increased risk in comparison to people without such exposures. It does not predict the person is destined to engage in suicidal behavior.[8] One hypothesis suggests once the taboo of suicide is broken by a family member, "permission" is informally given to others to do the same.[9]

Personal Risk Factors

Adverse life events, in conjunction with an underlying mental disorder, can precipitate a suicide event in vulnerable individuals. The three most common groups of life stressors

associated with suicides are:

1. conflict-separation-rejection;
2. economic difficulties; and
3. physical illness.[11]

Conflict-separation-rejection – Stressors most frequently linked with nonfatal or fatal suicide in youth and young adults include interpersonal conflicts and rejection from others, separation or divorce, and legal problems such as being arrested.

Economic difficulties – Stressors such as financial crisis or job loss are important stressors in midlife, especially for men. For example, the 1998 Bovine Spongiform Encephalopathy (BSE) "mad cow disease" crisis in British agriculture took an enormous toll on Britain's farmers resulting in a suicide rate of two farmers per week during the outbreak.[12]

Physical illness – Medical illness is a dominant stressor in older adult suicides; however, a physical illness, cancer for example, is not an independent risk factor for suicide. Rather, it is when it is associated with a psychiatric or abusive disorder that the risk increases.[11]

In the Suicidal Mind

The sense of the unmanageable…of hopelessness…of no future is a consistent thought pattern and warning sign of suicide. Paul Quinnett, in the book, *Suicide: The Forever Decision*, maintains that whatever emotional state a suicidal person may be in, the state of hopelessness is the most dangerous. He asserts that without hope there is no thought of the future or any belief things will improve. In this frame of mind, thoughts of suicide grow strong and take on the shape of an acceptable or final solution.[13]

Other conditions that help describe the suicidal mind include:

Anhedonia – refers to the inability to gain pleasure from normally pleasurable experiences; for example, a mother gains no pleasure in playing with her baby. Anhedonia is a symptom in depression, though not everyone who suffers depression exhibits anhedonia. In severe depression, it can prevent the person from experiencing any mood at all or attempting to improve their depressed state.

Perturbation – refers to being upset, mentally disturbed, perturbed. Perturbation exists on a continuum from 1 to 9 with 1 being serene, content, and well adjusted to a rating of 8 or 9, which constitutes being extremely disturbed, frenzied, and possibly dangerous to oneself and others.[14]

When people are suicidal, their thinking is paralyzed, their options appear sparce or nonexistent, their mood is despairing, and hopelessness permeates their entire mental domain. The future cannot be separated from the present, and the present is painful beyond solace.[2]

Kay Redfield Jamison
Professor of psychiatry, The Johns Hopkins University

Lethality – refers to the probability that a specific individual will be dead, by suicide, within the next several days. In other words, the individual will act on his or her perturbation. There is no heightened lethality without perturbation, but there can be elevated perturbation without elevated lethality.

Constriction – refers to narrowing in the person's thinking. It is a fixation on a single pain-free solution – death. Choices seem limited to only one or two. A dangerous word uttered from a person with constricted thinking is *only*, as in, "It's the only thing left to do."[14]

Psychache – is the hurt, anguish, aching, psychological pain in the psyche or the mind. It is the pain of guilt, fear, loneliness, dread of growing old, or of dying badly. Suicide occurs when the psychache is deemed by that person to be unbearable and death is sought to stop the pain.[15]

The mind's pull toward suicide often comes in the form of a voice. Richard Heckler in the book *Waking Up Alive* describes it as:

> *The voice grows in volume with the stress of the suicide ordeal. It demands increasingly to be heard above everything, and it begins to occupy a greater part of the person's psyche until it smothers more reasonable voices altogether. Often people experience this voice as relentlessly driving them toward self-destruction.*[16]

Gender Differences and Suicide

Why do men commit suicide more often? Since women suffer from depression at a much higher rate than men, they would seem to be at higher risk for suicide. Yet women actually commit fatal suicides about one-fourth as often as men. The typical suicide fatality in the United States is an unmarried (single, separated, divorced, or widowed), European-American man, age 60 or older, who is unemployed or retired and socially isolated.[5] What are additional factors in men's fatal suicide behavior?

Traditional View of Being Male – Many men were raised to be "John Wayne" types. They were taught not to ask for or accept help and not to show emotion. Men have been told to be strong, successful, in control, and capable of handling problems. They were expected to perform and perform well. Warren Farrell, author of *The Myth of Male Power*, states male depression and ultimately suicide are tied to men's ability to provide. When that ability is eliminated, through unemployment, foreclosure, or retirement, men are at greater risk for suicide.[17]

Reluctant to Seek Help – The traditional view of being male causes many men to hesitate to seek help from others. Men are taught that masculine power, dominance, competition, and control are essential to proving one's masculinity. Vulnerabilities, feelings, and emotions in men are signs of femininity and to be avoided. Masculine control of self, others, and environment are essential for men to feel safe, secure, and comfortable. Seeking help and support from others is a sign of weakness, vulnerability, and potential incompetence.[18]

Gender plays a complex and important role in suicidal behavior. Even by early adolescence, males behave more lethally than females, and differences in mortality rates continue across the entire lifespan.[27]

Ronald W. Maris et al.
Past president, American Association of Suicidology

Attraction to Alcohol – Alcohol consumption is a gender-role-appropriate behavior for men – a symbolic practice for demonstrating masculinity. There is also a strong link between alcohol dependence or abuse and depression with depression being a consequence of alcohol abuse.[19] As alcohol acts as an agent of emotional disinhibition, it can foster impulsive behavior. It can also lead to a reduction in self-esteem due to failures in social relationships, which can create a sense of isolation and loss of support. All this increases the risk for depression and suicide.[19]

Suicide as Stress Response – Males who act according to traditional masculine models are not able to tolerate loss of control and mastery. Suicide may be viewed as a last attempt

to gain self-control over an unbearable situation. Studies have shown that surviving a suicide is considered "feminine" and inappropriate for males.[20]

Suicide Method of Choice – Men and women often use different suicide methods. Though firearms are the most commonly used method of suicide for both men and women, accounting for nearly 60 percent of all suicides, nearly 80 percent of all firearm suicides are committed by white males. The second most common method for men is hanging while for women the second most common method is self-poisoning, including drug overdose.[21] Methods of male suicide are more often impulsive, violent and lethal – shootings, hangings, jumping off buildings or in front of vehicles, and single car accidents.

Suicide in women remains a much under-recognized, under-diagnosed and under-treated problem. Major depression, which has repeatedly been found to be a significant risk factor for suicide, affects women at twice the rate of men. Yet, as stated earlier, women die by suicide at one-quarter the rate of men. Women also commit a greater number of suicidal (fatal and non-fatal) acts than do men.

Suicide as a "Cry for Help" – Women often choose "less-lethal means" (e.g. drug overdose or wrist cutting) than men. A less-lethal means may be seen as a "cry for help" with an anticipated rescue. Many consider the choice of means to be responsible for the disparity between women and men in fatal suicide behavior. While women may choose less-lethal means of suicide, in suicidal acts defined as severe (requiring immediate medical attention), the incidence among women and men are equal.[22] In addition, firearms continue to be the most common method of suicide for both men and women. In instances of non-fatal suicide behavior, self-poisoning is the predominate choice of both women and men.

Are Women Really Suicidal for Love? – It has been stated women become suicidal in response to problems in personal relationships. Is women's self-definition so dependent on love that the loss of love drives them to suicide?[20] In actuality, it is not the loss of love but the physical abuse, hostility, neglect, infidelity, or fear in relationships that may lead women into suicidal behavior.

Are Employed Women at Greater Risk? – It has been assumed employment increased the risk for suicidal behavior. The traditional theory was employed women suffered role conflict, role overload, and low status, which increased the risk. Studies suggest that being a "housewife" (especially for those women who are reluctant) can be a greater risk than employment.[23] Isolation, confinement, and dependence can lead to a heightened sense of depression. Depression, linked with a co-occurring risk factor, such as alcohol abuse, exacerbates the condition.

Postpartum Depression and Suicide – Media coverage of suicide attempts and deaths by new mothers raised concern about the fatal outcome of depression during pregnancy and postpartum.[24] During the postpartum period, up to 85 percent of women experience some type of mood disturbance. For most women, symptoms are relatively mild; however, 10-15 percent of women experience a more disabling and persistent form of mood disturbance (e.g., postpartum depression, postpartum psychosis).[25]

Relative to suicide rates in the general female population, pregnant women have lower suicide rates. Increased social support, concern for the unborn child, and more contact with health care providers may work to reduce the risk of suicide in this population of women. Likewise, suicide rates during postpartum are lower than those occurring in the general population.[24]

Protective Factors for Women – Women are less likely to engage in self-destructive lifestyles, such as chronic use of alcohol and drugs or criminality, or to die a violent death, such as a motor vehicle accident or homicide.[26] Women's rate of alcoholism is about one-sixth that of men. Given the increased risk of co-occurring conditions – depression and alcoholism – for fatal suicide behavior, men's greater rate of fatal suicide behavior could partly be due to their greater rate of alcoholism.[22]

Women are normally more open to sharing feelings, to receive emotional support, and to ask for and accept help. As already mentioned, men are less likely to ask for help, and they tend to view seeking help as incompetence or failure. In addition, men's decisive thinking style and need for control can be a barrier to reconsidering fatal suicide behavior. Once the decision of suicide is made, the likelihood of changing one's mind is limited. Women are more likely to weigh and reweigh the consequences of the suicidal act and may change their minds without losing self-esteem. Embarked on the path to suicide, they may rethink the decision before the overdose leads to unconsciousness or before pulling the trigger.[22]

Male suicide appears most significantly tied to an overall greater frequency and level of violence and aggression, and the relative lack of social sanction for accepting a dependent position in a help-giving relationship. On the other hand, the significance of relatedness to others and the importance of social supports appear to serve women both as a protection against suicidal urges and as a precipitant for nonfatal suicidal behavior.[27]

Misconceptions about Suicide

Because of the complexity of suicide, the emotionality attached to it, and the varied and extreme attitudes toward suicide, objective facts about suicide are often obscured by misconceptions. The book, *Suicide Risk: Assessment and Response Guidelines,* lists several public misconceptions about suicide:

People often commit suicide without warning or "out of the blue." Though it sometimes appears to be an impulsive act, people who engage in suicidal behavior, especially those who die, generally have given multiple obvious or subtle indicators such as saying good-byes or getting things in order.

If a person thinks about suicide, they are likely to commit a suicidal act. Fatal suicides are a relatively rare event. Across all age groups in the United States, completed suicide occurs annually at a rate of about 10-15 per 100,000.[27] More people attempt suicide, with or without serious intent to complete the act, than those who ultimately complete suicide. Far more people experience thoughts of suicide at least once in their lives than those who proceed to make a plan.[28]

If a person committed suicide, his or her situation was so bad death was the best solution. To say that a person's life is no longer worth living presumes to know the value of a human life. For example, it might be assumed patients with terminal illness might make suicide "understandable." Studies of patients with terminal illness showed they were rarely suicidal and those patients who do become suicidal also exhibited signs of clinical depression. Life circumstances

of suicidal people, while often bad, are survived by most people in similar circumstances.

People who want to die will find a way; it won't help to try to stop them. The majority of people who kill themselves were suffering from depression, schizophrenia, or alcoholism at the time of their deaths. These are treatable illnesses, and symptom relief can eliminate the wish and motive for suicide. Most suicidal people are ambivalent about suicide – at the same time they desire to stop the pain, they also wish to be rescued so they can have another chance at life.

One should not discuss suicide with depressed people; it might give them the idea or upset them enough to "push them over the edge." Suicide is seldom a novel idea to depressed people, and they are commonly relieved to be given "permission" to talk about it. The greater risk is that the topic is passed over because the depressed person considers suicide too shameful to mention. This can result in an even greater sense of isolation. At worst, inquiring about suicidal thoughts can produce a puzzled look or irritation from someone who is not at the point of being suicidal. At best, it can lead the depressed person to getting the help he or she needs.[21]

Suicide is a cowardly act, or, on the contrary, suicide takes courage. Suicide is not a matter of cowardice or bravery. Suicide is about despair. When a person can no longer contemplate any other solution to solve his or her problems, they then may consider suicidal behavior. Suicide will appear as the final solution to solve problems; to heal all pains definitively.

In Summary

A person is at risk if he or she has no strength to cope with problems, cannot envision a future, and is convinced suicide is the best way to end the misery. The person could be angry or frustrated or facing a problem they can't handle. They could be clinically depressed, anxious, or suffering from another emotional disorder. They could be physically ill or disabled. The person is at great risk if there is a history of suicidal behaviors, or a family history of suicide, has witnessed a suicide or violent death, and has access to the means to kill him or herself.[29] **If a person has the intent, a plan, and the means to complete the plan, that individual should be assessed as high risk and not be left alone. A helping professional should be contacted immediately.**

Additional Resources:

The Internet contains many helpful Web sites with suicide facts and resources including:

American Association of Suicidology
http://www.suicidology.org/

American Foundation of Suicide Prevention
http://www.afsp.org/

American Academy of Child & Adolescent Psychiatry
http://www.aacap.org/

National Suicide Prevention Lifeline
http://www.suicidepreventionlifeline.org/

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