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SUICIDE: PART 1

Understanding and Overcoming the Myths of Suicide

What Goes On in the Minds of Those Who Attempt Suicide

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Myths about suicide abound in the therapeutic setting. They often inhibit the ability of clinicians (and families) to assess the severity and magnitude of a patient's suicide risk. This special report discusses some of those myths. In *Why People Die by Suicide,*[1] I argued that a kind of fearlessness is required to face voluntarily the daunting prospect of one's death, and that doing so necessarily involves a fight against ancient, ingrained, and powerful self-preservation instincts. In *Myths About Suicide,*[2] I used the framework developed in the previous book to contend that death by suicide is neither impulsive, cowardly, vengeful, controlling, nor selfish.

Impulsivity myths

The tragic death of a Florida television news reporter in 1974 illustrates the fallacy that suicide is an impulsive, spur-of-the-moment whim, much like casting off peanut shells at the ballpark. In July of that year, the reporter was covering the story of a shooting that had happened the day before. When the reporter called for the news station's video footage of the scene, the tape jammed. She shrugged and stated, "In keeping with Channel 40's policy of bringing you the latest in blood and guts, and in living color, you are going to see another first—an attempted suicide." She extracted a gun from beneath her desk and shot herself behind the right ear. She was rushed to a local hospital, but died 14 hours later.

The usual reaction to this tragic tale beyond shock and horror was to dwell on the seemingly impulsive nature of the act and ask, "How could the reporter have known that the tape would jam?" However, the reporter's behavior leading up to her suicide dispels the idea that she acted impulsively:

- For years, she openly told her family that she felt depressed and suicidal

- Four years before her death, she attempted suicide by overdose and frequently discussed the incident subsequently

- Weeks before she died, the news station granted her request to cover a story on suicide; and during one interview, she asked a police officer for details on self-inflicted gunshot wounds

- One week before, she told a colleague that she had bought a gun and joked with him about killing herself on the air

- On the day of her suicide (or possibly even before), she had put the gun in a bag that she brought to the set daily

- Finally, she had prepared news copy for a fellow reporter to read about her suicide after the fact

The news reporter's death illustrates that her suicide was premeditated. Death by suicide is extremely fearsome and daunting, and thus requires considerable thought, planning, and resolve. To consider her death impulsive is to assign primacy to that spur-of-the-moment decision as to precisely when to pull out the gun, instead of focusing on the many factors that led up to that planned moment.

In the book An Unquiet Mind,[3] Kay Redfield Jamison discusses her own experience with suicidal behavior and describes how it actually works: ". . . for many months I went to the 8th floor of the stairwell of the UCLA hospital and, repeatedly, only just resisted throwing myself off the ledge. . . ." Contemplating suicide is a signature of serious suicidal behavior. Jamison's months-long thought process and behaviors counter the notion of spontaneous death by suicide.

The suicide of President Bill Clinton's childhood friend and White House adviser Vince Foster was of this sort. Despite wildly irresponsible speculation to the contrary, Foster died of a self-inflicted gunshot wound. Foster snuck a gun out to his car in an oven mitt; he drove to a secluded area of a park, and he shot himself. To imagine that Foster's death was impulsive is to ignore all of the facts in what was by far the most investigated suicide in history (multiple Congressional inquiries and forensic investigations were conducted). It is also to ignore the character of Vince Foster; he was a well-organized, thoughtful, and deliberate person. No one who knew him would have described him as impulsive.

Foster's friends and family were stunned by his death; it seemed "out-of-the-blue." However, death by suicide can *both* shock loved ones *and* be planned for weeks, months, or even years. This is because of the human capacity, quite spectacular in some cases, for privacy and secrecy. Except in works of fiction, I have never encountered a death by suicide that was truly impulsive. Many clinicians have mistakenly deemed suicidal deaths impulsive merely because they seemed to be "out-of-the-blue."

Suicide note myths

Foster did not leave a suicide note, a factor that spurred conspiracy theories on cause of death. To my knowledge, no study has reported a rate of note leaving among suicide decedents to exceed 50%. Moreover, most studies find rates between 0% and 40%[4]; a reasonable average rate would be approximately 25%.

Why are suicide notes so rare? Some have reasoned that because impulsivity is involved in suicidal behavior, suicidal persons often kill themselves before they have a chance to write a note. There are problems with this viewpoint, however. A major problem is that it draws on the distinct myth that dying on a whim is common. Another problem is the lack of empirical support that compares those who leave notes with those who do not. If it were true that note leavers are much less impulsive than those who do not leave notes, then this distinction should be easy to demonstrate in forensic studies that examine the lives, characteristics, and personalities of decedents. This difference has not been clearly demonstrated.

The relative rarity of suicide notes reveals the state of mind of those about to die by suicide. To say that persons who die by suicide are lonely at the time of their deaths is a massive understatement. Loneliness, combined with alienation, isolation, rejection, and ostracism, is a better approximation. Still, it does not fully capture the suicidal person's state of mind. In fact, I believe it is impossible to articulate the phenomenon, because it is so beyond ordinary experience. Notes are rare because most decedents feel alienated to the point that communication through a note seems pointless or does not occur to them at all.

Diagnostic myths

Friends and family who have been surprised by a suicide often consider it to be deeply selfish. This is understandable because the bereaved are often convinced that the decedent did not consider the impact of his or her death on those left behind. However, those who die by suicide certainly do consider the impact of their deaths on others; but to them, death is a positive rather than a negative outcome. This is wrong, but nevertheless, it is the view of the person who attempts suicide.

Still another reason to question whether selfishness is involved in suicidal behavior involves the associations of various aspects of psychopathy to suicidal behavior. In its description of psychopathy, DSM-IV includes aggressive behavior and reckless, out-of-control disregard for others and for rules and norms. Another aspect of psychopathy—evidently to be emphasized more in DSM-5 and included in Hervey Cleckley's classic 1941 book, *The Mask of Sanity*[5]—describes psychopaths as controlled, callous, sometimes charming con men. They also demonstrate marked emotional detachment (ie, low anxiety; fake or shallow emotions; immunity to guilt and shame; and incapacity for love, intimacy, and loyalty).

In the current DSM, psychopaths are considered out of control but not necessarily unfeeling. Cleckley psychopaths are very much in control and very much unfeeling, except, that is, when it comes to themselves. One cannot be a Cleckley psychopath and not be selfish—it is part of the core of the syndrome; but on the basis of DSM, one can be a psychopath and not be selfish. In short, one group is selfish to the core; the other, less so.

If selfishness is key to suicidal behavior, it stands to reason that the group more prone to suicidal behavior should be the Cleckley psychopaths, but it is not. Genuine suicidal behavior is quite rare in this group.

Seasonal myths

Another common myth that even some professionals harbor is that death by suicide peaks around the winter holidays. In fact, far from peaking, the winter holidays represents a low point in suicide rates,[6] possibly because it is a time of togetherness.

My research group hypothesized that seasonality and suicidality are associated at least partly because of seasonal fluctuations in togetherness.[6] Consider a large college campus in this regard. Campuses provide numerous activities for belonging; anyone who doubts this should check out a nearby university's online master calendar. Universities offer many social, cultural, academic, athletic, and other events—many of them free of charge. Perhaps partly as a function of this high level of belonging inherent in these events, suicide rates of college students are relatively low compared with their same-aged peers not at college.[6]

Opportunities for togetherness are thus high on college campuses, but they are not uniform throughout the calendar year. During a standard academic year (the fall and spring semesters, roughly from

September to May), most schools are clearly in session, and chances for social engagement abound through classes, dormitory and apartment life, sports, and so on. However, summer activities continue but they ebb considerably. Therefore, it is conceivable that students' sense of belonging may be lower during the summer than during active semesters. We found that suicidal ideation was higher in the summer months than during the regular academic year, and we reasoned that this association might be partly explained by fluctuations in opportunities for socializing.[6]

Slow suicide myths

A final collection of myths involves the notion of slow suicide, by which a person engages in unhealthy behaviors despite knowing that these behaviors may ultimately lead to death. Genuine suicidal behavior involves a rather clear intent to die, not to do something else like smoking or taking drugs because they like it. Consider, for example, smoking. By the logic of smoking as slow suicide, we should have witnessed a most remarkable decrease in the suicide rate in the past half century, as smoking rates plummeted; alas, we have not. People know smoking puts them at risk, but they smoke anyway—not because they intend to die—but because they like it. They are willing to take the risks because of how much they enjoy smoking. Addicts continue to use drugs even though they have been told and understand that continued use might kill them; but because they like "doing" drugs, the risks do not matter.

Therapeutic implications

I articulated these perspectives in *Why People Die by Suicide*[1] *and Myths About Suicide,*[2] which encompass risk assessment, therapeutics, and suicide prevention. In addition to marked warning signs, such as talking about suicide and planning for it, the books discuss clinically severe agitation, insomnia, and nightmares (these latter 3 are themselves not considered acute risk factors in some clinical settings). Noting a patient's fearlessness of death, perceived burdensomeness, and accelerating alienation may improve risk assessment.

Myths About Suicide concludes with the following excerpt:

We need to get it in our heads that suicide is not easy, painless, cowardly, selfish, vengeful, self-masterful, nor rash; that it is not caused by breast augmentation, medicines, "slow" methods like smoking or anorexia, or as some psychoanalysts thought, things like masturbation; that it is partly genetic and influenced by mental disorders, themselves often agonizing; and that it is preventable (eg, through means restriction like bridge barriers) and treatable (talk about suicide is not cheap and should occasion treatment referral). And once we get all that in our heads, at last, we need to let it lead our hearts.

Therapeutic regimens and prevention protocols that target and acknowledge these factors should be given serious consideration.

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