Mental Health Monday
Understanding and Preventing Suicide
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A. Terminology

1. **Suicide:** self-inflicted death with evidence that the person intended to die.

2. **Suicide attempt:** self-injurious behavior with a nonfatal outcome and accompanied by evidence that the person intended to die.

3. **Suicide gesture:** any non-lethal self-injurious behavior in which there is no attempt to die, but instead an intent to give the appearance of a suicide attempt in order to communicate with others (not to be confused with "self-harming behavior").

4. **Suicidal ideation:** thoughts of suicide. Suicidal ideation may vary in seriousness depending on how specific a suicide plan is and the degree of intent.

B. Statistics (National Institute of Mental Health 2021 data)

- Suicide was the eleventh leading cause of death overall in the United States, claiming the lives of over 48,100 people.
- There were nearly two times as many suicides (48,183) in the United States as there were homicides (26,031).
- The suicide rate among males was four times higher than among females.
- Among females, the suicide rate was highest for those aged 45-64.
- Among males, the suicide rate was highest for those aged 75 and older.
- For both male and females, the most common method of suicide were firearms.

Additional 2022 data:

- Among adults across all age groups, the prevalence of serious suicidal thoughts was highest among young adults aged 18-25.

C. Debunking Myths about Suicide (Kristen Fuller, M.D. for NAMI)

1. **Suicide only affects individuals with a mental health condition.** Researchers have found that more than half of people who died by suicide between 1999-2016 had no known or diagnosed mental health conditions at the time of death.

2. **Once an individual is suicidal, he or she will always remain suicidal.** While suicidal thoughts can return, they are not permanent. An individual with suicidal thoughts and attempts can life a long, successful life.

3. **Most suicides happen suddenly without warning.**
   Verbal or behavioral warning signs precede most suicides. Many only show signs to those closest to them. Loved ones may not recognize what is going on, which is why the suicide may seem sudden or without warning.

4. **People who die by suicide are selfish and take the easy way out.**
   Typically, people do not die by suicide because they do not want to live; people die by suicide because they want to end their suffering.

5. **Talking about suicide will lead to and encourage suicide.**
   Talking about suicide reduces stigma/shame, and allows people to rethink their opinions, seek help and feel connected.

6. **If a person is intent on dying by suicide, it is inevitable that they will succeed.**
   Research on survivors of attempted suicide indicates that most people are ambivalent about ending their life up to and immediately following the attempt. (Golden Gate Bridge studies)

D. Theories of Suicide

Suicide and suicide attempts are a multifaceted, complex, and contextualized phenomenon (Hjelmeland & Knizek, 2019).

1. **Cognitive model**
   -Oversensitivity to signals of defeat.
   -Perceived "no escape"
   -Perceived "no rescue"

2. **Traits that interact with stressors model**
   -Impulsivity
   -Aggression

3. **Interpersonal model**
   -Thwarted belongingness: aliened and isolated, not just lonely.
   -Perceived burdensomeness: *my death is worth more than my life to family and friends.*

E. Realities We Need to Come to Terms With

1. Access to means is problematic.

2. The lethal triangle (especially for males)
   -Aggression
   -Alcohol
   -Access to means
   -I would now add impulsivity and make it a square!

3. The internet and social media are a horrific combination of "thwarted belongingness" and alienation, along with contagion.

4. Presence of a highly stressful life event and more prolonged stress are risk factors for suicide (unemployment, relational conflict, harassment, bullying, death of loved one, chronic pain).

5. We have ceased to treat those "outside of the norm" with compassion and dignity, resulting in bullying, alienating, isolating.

F. Preventative Factors and an Invitation to the Church

1. ***The most consistent protective factor found in suicide research is social support and connectedness.***

   Invitation to the church:
   -Divorced and separated people
   -Singles
   -Elderly
   -Home bound
   -Those outside our "norm"

2. **Easy access to a variety of clinical interventions and support for help seeking.**

   Invitation to the church:
   -Access within our walls
   -De-professionalizing what belongs to all of us
   -Supporting good community resources

3. **Restricted access to highly lethal means of suicide.**

   Invitation to the church:
   -Changing our frame of reference on "freedom of choice" issues.

4. **Cultural and religious beliefs that discourage suicide and support instincts for healthy self-preservation.**

   Invitation to the church:
   -Embracing a biblical life-affirming theology and practice rather than an escapist theology.
   -Threatening with hell does not always override the internal "hell" suicidal people are living in.

Resources:

- "988" 24-hour Suicide and Crisis Lifeline (call/text/chat)

- American Foundation for Suicide Prevention http://afsp.org/
  -books for survivors of all ages
  -books for understanding suicide

Just a Smile and a Hello on the Golden Gate Bridge

The Golden Gate Bridge is the premiere suicide venue in the United States. The lure of the bridge as a place to end one's life is such that individuals fly long distances to San Francisco, go directly to the bridge, and jump to their deaths. In preparing a talk on suicide prevention, I read about a man in his 30s who left a note in his apartment that said he would not jump from the Golden Gate Bridge if, on the way to the bridge, he met one person who smiled at him. He jumped. I also recalled the story that Nietzsche was dissuaded from committing suicide by a smile from a total stranger.

At the 2006 APA annual meeting, I attended a workshop on bridge suicide. It was sponsored by the Psychiatric Foundation of Northern California, an advocacy group for placing physical barriers to prevent suicide on the Golden Gate Bridge. At least 1,300 known persons have committed suicide by jumping from the bridge. Only 28 have survived a jump from the bridge since its completion in 1937. The workshop chairperson cited a 26-year follow-up study of 515 individuals who were restrained from jumping from the Golden Gate Bridge. Ninety-four percent were still alive or had died from natural causes 26 years later. He noted that the study provided a strong argument for suicide barriers.

"A smile may puncture the lethal bubble of isolation and aloneness that often precedes suicide."

Mr. John Kevin Hines, who said he was one of only two persons to survive a jump from the bridge since 2000, was a presenter at the workshop. Mr. Hines's description of his profound mental suffering and isolation that preceded his suicide attempt was gripping and emotionally moving. The audience asked many questions.

Mr. Hines described his struggle with a severe bipolar disorder that emerged during his adolescence and worsened over time. Mr. Hines was overwhelmed by paranoid delusions and command auditory hallucinations demanding that he kill himself. Unable to function, he withdrew from college and immediately took a bus to the Golden Gate Bridge. Like many people about to commit suicide, he was ambivalent about dying. He tarried at the bridge railing for about 40 minutes, trying to decide whether to go through with his plan to jump.

A number of people walked by him, oblivious to his anguish, unaware of his life-and-death struggle. Mr. Hines told us that "If someone had smiled and said, 'Are you okay?' I know I would have begged them to help me. I would have told them everything and asked for help. I would not have jumped. I just was unable to ask for help myself." In fact, a foreign tourist did stop and talk with Mr. Hines. She asked him to take her picture, which he did. As she walked away, he felt more than ever that "Nobody really cares." He jumped. On the way down, he changed his mind. He remembered thinking, "I want to live. Why am I doing this?" It was too late. Severely injured, Mr. Hines was kept afloat by a sea lion until rescuers arrived.

I asked Mr. Hines that if someone had smiled at him when he was on the bridge, given the severity of his mental illness, would it have prevented his suicide attempt? He answered, "Yes, a smile would have most definitely helped in my case. If the smile is genuine and caring, and it looks like the person is approachable, that person could have such an impact on a suicidal person at the moment of desperation. They could well save a life." I recalled the horror-stricken figure in Edvard Munch's "The Scream." One sees indifferent people strolling in the background.

What power does a smile hold for someone intent on suicide? When we smile and say hello to strangers or strangers smile and recognize us, what human transaction takes

place? What do we feel in either situation? Is the smile and hello saying, "You are a person just like me; I recognize and respect you"? Are we making a human connection that closes our separateness, even for a moment? Durkheim, in his early study of suicide, identified anomie, or social isolation, and impersonality as contributors to suicide. A smile may puncture the lethal bubble of isolation and aloneness that often precedes suicide. I recall Martin Buber's "I and Thou," a respect for the unique being of others. Perhaps a smile may convey the message, "You are a valued person. I respect your being. Live!" I also wonder if, in some instances, a smile stirs veiled, primal memories of a parent's loving smile. We should not overlook the power of simple human connection contained in a smile, even a smile between strangers. A smile or friendly word may tip the balance toward life, countering an impulsive urge toward a lethal act.

This is not to imply that simply smiling at someone who is at high risk for suicide is all that it will take to save a person's life. Psychiatrists recognize that many factors, both static and dynamic, ultimately determine the choice that a suicidal individual makes. A smile or a hello, however important and meaningful, must shine on a propitious moment in the person's ambivalent struggle for life.

Mr. Hines is now gainfully employed as an activities coordinator at a high school. He is a frequent speaker at high schools and other interested groups about his experience with mental illness and suicide. Mr. Hines is a strong advocate for physical barriers on the Golden Gate Bridge and other bridges. It is his contention that suicides are impulsive, overcoming the ambivalence about dying that is present to the last moment.

Psychiatrists routinely treat suicidal patients who feel alone and frightened. Powerful messages of kindness, hope, and healing can be conveyed in how we greet our patients. Who can know the beneficence that "little" kindnesses bestow upon our patients and others? For the most desperately ill and hopeless patients, sometimes just a smile and a hello from the psychiatrist can be a human barrier to suicide.

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